Lewis Blackman Clinical Governance Case

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The purpose of this essay is to make use of the fishbone diagram to analyze the stresses that Lewis Blackman underwent, use the London protocol to highlight major events in a stepwise manner, and look at the possible causes of failure that were present while attempting to revive the patient. Eventually, a discussion of quality care and clinical governance will be seen to ensure that the patient is monitored safely. The Australian Charter of Healthcare Rights suggests that patients/consumers have the full right to be included in all aspects of healthcare (McCaffery et al., 2011). The clinical governance framework is a systemically designed approach that is used when tending to the quality of patient care (Acquaviva, Haskell & Johnson, 2013). Key attributes that fall within the jurisdiction are transparency, accountability, and improvement dynamics.

Case Study

The *London protocol* is used to look back at the events that transpired retrospectively. Lewis Blackman's case revolved around a life-threatening case of septic shock. It is an infection that results in a decrease in blood pressure, dizziness, increased heart rate, decreased urine output, in addition to lethargy, agitation, and confusion that can lead to death. The most common cause is gram-positive pathogens, though fungal roots are also seen. As per Martin (2013), deaths that are usually associated with septic shock are 40-80%, with sepsis (10-20%), and with severe sepsis (20-50%) (Haskell, Johnson & Barach, 2015). Moreover, septic shock is a side effect of Ketorolac, as confirmed by the FDA report. Lewis's case resulted in death as he was given very little fluid with a lot of Ketorolac. The key component that triggered a series of pharmacological, pathological, and physiological hindrances was the administration of Ketorolac (Haskell, 2014).

A failure to respond to patient distress was a huge part of the error. System errors were present where the protocol for assessing the IV rate and amount, along with Ketorolac, was not monitored. Individual errors were related to not noticing a decrease in urine output, along with a failure to tend to patient and family complaints. Even though his parents raised a concern about a decrease in urine output, that was overlooked. The events that surrounded Lewis's death were a result of systemic errors with a lack of quality care provided to the patient. Only young nurses and residents were left on duty to tend to these jobs with inadequate training measures instilled (Young-Xu et al., 2013). An inability to recognize a deteriorating patient was seen, and no responsible doctor or nurse was present to tend to the patient's vitals (Shever, 2011). No data was added to charts, and the objective monitor, the pulse oximeter, was silenced. The 15-year-old boy died only 4 days after undergoing

surgery. The patient and family members were not informed about the process clearly, which shows that communication was not a priority. Overall, the end result of the case is that nurses ought to communicate well with patients and act to rescue them during such calls of distress.

The clinical governance framework as applied to Blackman's case

Consumer participation

Essentially, it is to improve the quality of patient care and tend to the needs of the patient and family involved. According to Lewis Blackman's case findings, the family was constantly dismissed despite raising concerns about changes in urine output. When the nurses were called to inform a responsible attending, the requests were also ignored, which indicated that the rights of the family and patient were not upheld as important (Haskell, Johnson & Barach, 2015). The service quality was poor, and the patient's rights were not a primary concern. For instance, the hospital should have employed a proper system to regularly check the vitals of patients a few days after chest surgery (Shever, 2011).

Poor communication was a primary cause of the events that transpired between the family and professionals. Communication is vital, and information ought to be accurately conveyed ahead with clear and distinct language to ensure no discrepancies exist (Ghaferi, Sonnenday, Birkmeyer & Dimick, 2012). There are variations in the way that such governance is seen in Australia, but mechanisms ought to be put in place to ensure that there is supervision of consumer treatment decisions.

Clinical Effectiveness

There is a clear lack of clinical effectiveness in the case study, as there were many missed checkups by the hospital staff. It should have been common protocol to assess and weigh the side effects and well-known risks of medications such as Toradol. Since the autopsy showed that it was a deadly side effect of the drug that was being taken, Lewis developed peritonitis that eventually resulted in blood loss during those 30 hours. The attending physician should have been informed; however, only residents were informed, and this was a case of the staff being inadequately trained to tend to the complexities of common medications. The risk factors that are associated with peritonitis were clearly left untended. As such, it was essential to seek immediate medical evaluation and note the fever, lack of urination, and vomiting tendencies in the patient. The entire chain of transferring information to the nurse on duty and to the attending physician was not present, as the hospital did not have competent residents who were inexperienced in handling such complexities. A serious policy ought to be established to ensure that the doctor and patient/patient's family are entirely verbal about the worsening of symptoms, with an apt justification of medications being taken and vital signs

measured. Such measures will decrease the understanding gap about the patient's medical condition.

Effective Workplace

In order to create an effective healthcare environment, it is absolutely necessary that the hospital staff is fully aware of the knowledge, skills, and collaborative work required. The fishbone diagram identified that the possible causes of such a failure include a lack of proper skills and medical knowledge, a lack of interpersonal communication, and failure to inform authoritative members of the staff. Several recommendations exist to ensure that such events do not repeat; they include ensuring that a good relationship is built between the patient's guardians and the nursing staff (O'Connor, 2013). Moreover, a highly supportive environment and protocol are required, where septic conditions that Lewis faced were easily identified with proper screening after the surgery. The major issue that was present was the fact that the crisis developed during the weekend when many doctors were out of reach (Haskell, 2014). Moreover, no one was present to recognize his condition and take action.

Risk Management

The health centre ought to review mechanisms that relate to informing the attending or training residents to attend such distress calls with competence. Possible human factors need to be identified by articulating the process that is used in the centre. In case the patient is given medication after a serious surgery, vitals need to be recorded every few hours with perfect attention given to the patient and presented complaints. A lack of noting pertinent details will increase fatality risks. Also, there was a lack of professional accountability as the patient was not tested for the correct details at that time. Risk management gives an important insight into the way that lawsuits were dealt with in the United States. The main claims include controlling costs by knowing the evidence beforehand. Risk management techniques were not clearly defined in this case, and there were poorly established boundaries between the residents, nurses, and attending (O'Connor, 2013). The hospital knew that Lewis had a history of asthma and addressed all issues raised by him or his family members. However, these issues should have been taken seriously (Acquaviva, Haskell & Johnson, 2013).

Conclusion

As a whole, Lewis's death was very unfortunate, and the incident has echoed for many more years to date. One of the key reasons that he was overlooked was the fact that his surgery was minimally invasive. The complications he presented were dismissed as normal, and such complications were highly rare (Stanyon, 2008). The fact that the blood pressure would not show results when it was taken near the end of Lewis's life shows how inexperienced the staff was. The patient was a young and bright 15-year-old student who wanted to live his life and act out on personal goals and desires in the many more years to come (Stanyon, 2008). Despite that, it was in the best interests of the

hospital staff to do their best, and they inflicted harm on the patient and his family due to a lack of protocol and measures. Many humanistic, environmental, and situational factors led to the clinical event. It is necessary that the ultimate root cause be analyzed, and stakeholders across the world promote the importance of overcoming such weaknesses.

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