醫院管理局 HOSPITAL AUTHORITY

RISK ALERT

ISSUE 5 JUL 2008

A Risk Management Newsletter for Hospital Authority Healthcare Professionals

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Editorial

We have published the first half-yearly sentinel event report and are into the 5th HA Risk Alert (HARA). What have we achieved so far? We have achieved the aim of promoting a new culture to share and learn from reported sentinel events, adverse events and risks reported locally and worldwide. We are now more at ease with the process and HARA has played an important role in disseminating information on risks.

However, to achieve our aim to enhance patient safety, the sharing and learning process must be followed up by active actions. It is important to ensure that measures to reduce the risks are taken at local level – such as to assess the risk at hospital / department level and to implement the various recommended risk reduction strategies and solutions as appropriate. To facilitate this, I would like to draw your attention to SERAE (Systematic Evaluation of Reported Adverse Event) developed by the Hong Kong West Cluster. It is a useful tool to assist frontline and hospital management to assess and manage reported risks (please refer to a link to the information on SERAE on page 4).

Dr SF LUI, Consultant (Q&RM), HAHO

LOCAL SENTINEL EVENT

RETAINED GAUZE IN VAGINA

A patient had marsupialisation for Batholin's cyst (2cm) performed in a day surgery center (DSC). A few months later, patient noticed that a piece of gauze was passed out from the vagina.

WHAT HAS HAPPENED?

The patient received marsupialisation for her Batholin's cyst under general anaesthesia in the operating theatre of DSC.

During operation, a sponge forceps was used to hold a pile of soaked plain gauzes for vaginal swabbing. Cusco speculum was not used for direct visualization of the vagina. It was suspected that a piece of plain gauze was left during swabbing. After the procedure, per vaginal examination was not performed. Gauze counting was not a usual procedure for minor day operation as in this centre.

The operation was otherwise smooth and uneventful. The patient was discharged home on the same day.

She was well when presented in the scheduled follow-up a month later. The wound in the vulva had healed. Per vaginal examination was not repeated because of pre-operative normal findings. No further follow up was indicated.

After a few months, the patient went back to DSC as she had passed a piece of plain gauze from the vagina. A course of antibiotics was prescribed and the patient was well afterwards.

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KEY CONTRIBUTING FACTORS

System factors

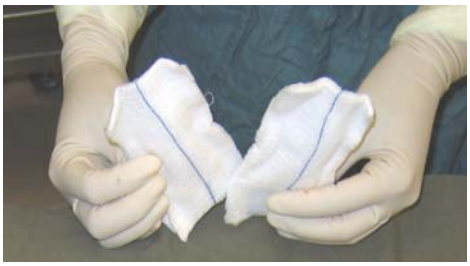
- No gauze counting for minor gynaecological operations.
- No internationally agreed standard practice in performing the swabbing procedure.

Process factors

- Difficulties in identifying the number of gauzes used in swabbing: gauzes were immersed in the receiver of antiseptics and stuck together making counting difficult
- Failure to detect the retained gauze: Cusco speculum for direct visualization was not used and vaginal examination was not performed.

KEY RECOMMENDATIONS (from Hospital RCA Panel)

- To perform gauze counting before and after the operation.
- To use raytec gauzes (which can be detected by X-ray) for all minor gynaecological operations.
- To adopt a more secure way to hold the gauze by wrapping it around the tips of sponge forceps
- To establish good practices for gynaecological procedures including:
  - to apply Cusco speculum during vaginal swabbing, and
  - to perform vaginal examination at the end of all gynaecological procedures which involve putting gauzes into the vagina.



LEARNING POINT

Gauze counting should be conducted in minor operations

LOCAL RISK SCANNING

MIX-UP OF SEX-SPECIFIC REFERENCE RANGES

There was a recent incident of mixing up sex-specific reference ranges of serum iron in laboratory printouts in one hospital. This led to unnecessary or delayed prescription of iron supplement when doctors acted on the results based on the wrong reference range.

The mix-up was believed to be caused by an error during manual input of the ranges after programme upgrade of the Laboratory Information System (LIS). Positive checking of the data was not performed after completion of input.

LEARNING POINT

Reference ranges must be checked and positively confirmed after programme upgrade

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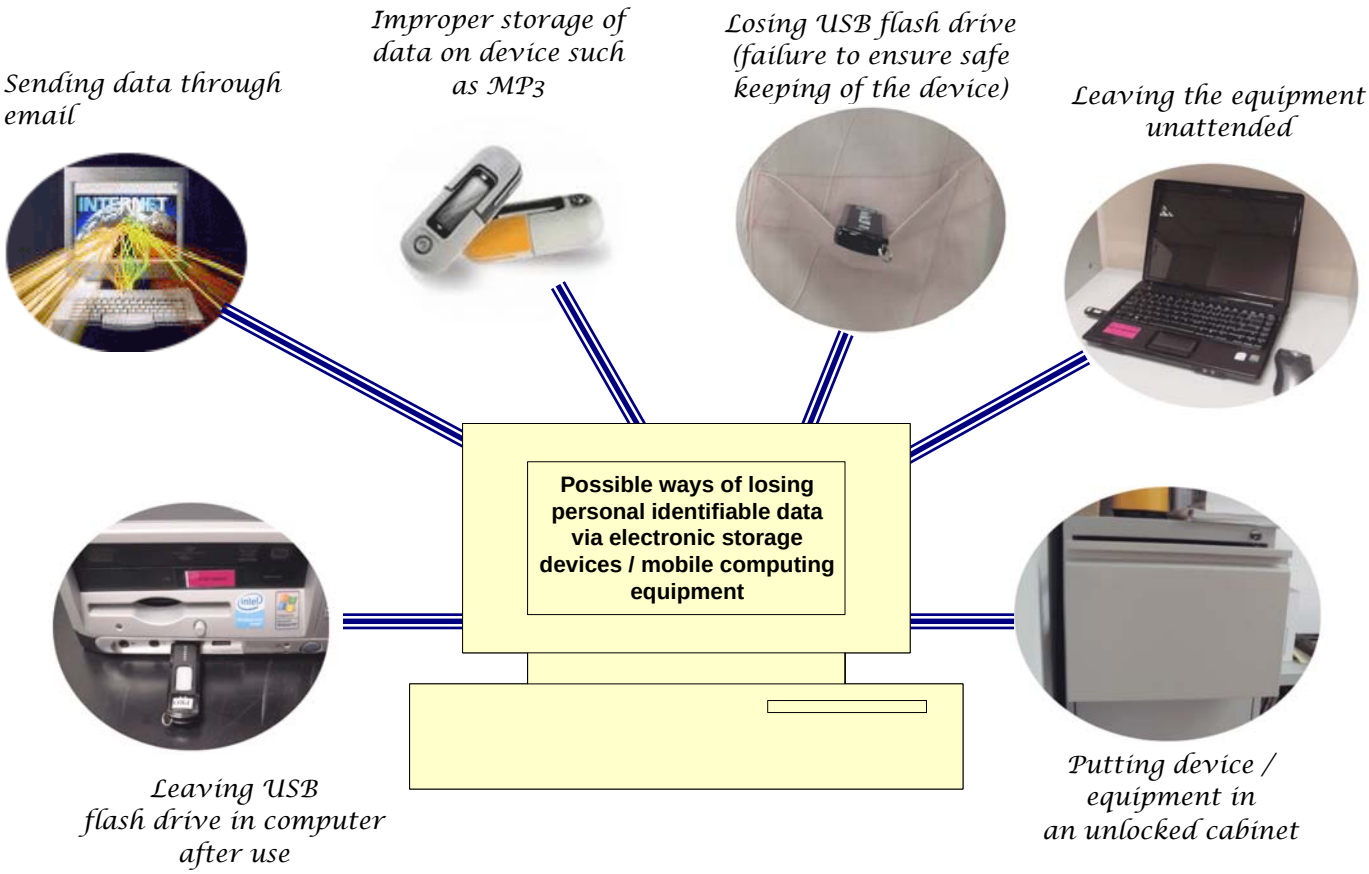
POSSIBLE LOSS OF PERSONAL IDENTIFIABLE DATA



To prevent loss of personal identifiable data

NOT to export / store confidential personal data (i.e. containing HKID and/or name) unless it is absolutely necessary for patient care / operational purposes.

NOT to send any confidential personal data through email unless it is absolutely necessary for patient care / operational purposes.

NOT to use mobile electronic storage devices such as USB flash drives for storing confidential personal data as far as possible.

If downloading / storing confidential personal data is really absolutely necessary,

- apply for a secure USB flash drive from HAHO ITS for storing identifiable personal data
- all files containing confidential personal data must be encrypted and password protected
- all confidential personal data must be deleted immediately after use
- the device / equipment must be kept under continuous and direct supervision when in use
- the device / equipment must be stored in physically protected area when not in use

ISSUE 5 JUL 2008 RISK ALERT GLOBAL RISK SCANNING

PAEDIATRIC MEDICATION ERRORS

Paediatric medication error has been identified as one of the major risk areas in most healthcare systems. Errors leading to adverse effects or unnecessary deaths have been reported in various countries. Below are several examples from the US and Canada.

Examples of paediatric medication errors		Safety recommendations
Misplacing the decimal point	➢ **1693mg** of cyclophosphamide was prepared instead of **169.3mg**. The decimal point was overlooked http://www.ismp-canada.org/download/ISMPCSB2003-08Chemotherapy.pdf	● To include patient's age and weight (in kg) in drug orders. ● To facilitate re-calculation, to include the mg/kg dose as part of drug order. ● To re-calculate the patient's actual required dose before administration. ● To use pre-established dose tables. ● To minimize the vial size stocked on ward. ● To compare the prescriber's order with the printed labels, and the printed labels with the final product. ● To perform **independent** double check. ● To maintain a heightened index of suspicion of error. ● To provide formal training to staff involved with prescribing, dispensing and administering paediatrics drugs
Mistyping the dose unit	➢ mcg to mg: **330mg** of zinc was administered instead of the prescribed dose of **330mcg** http://www.ismp.org/Newsletters/acutecare/articles/20070906.asp	
	➢ mg to ml: **4ml** of flecainide 5mg/ml suspension was administered instead of the intended **4mg** dose http://www.ismp-canada.org/download/ISMPCSB2005-06PediatricFormulation.pdf	
Misinterpreting the product labelling	➢ 1200mg **elemental calcium** was administered instead of the intended 1200mg **calcium gluconate salt** http://www.ismp.org/Newsletters/acutecare/articles/20001213.asp	
	➢ 2 entire bottles of arginine **10g/100ml, 300ml** was administered instead of the prescribed dose of **5.75g** http://www.ismp.org/Newsletters/acutecare/articles/20080131.asp	

RISKS ASSOCIATED WITH CHEST DRAIN INSERTION

The UK National Patient Safety Agency (NPSA) is alerting all healthcare staff to the risks associated with the insertion of chest drains.

The NPSA received reports of 12 deaths and 15 cases of serious harm relating to chest drain insertion between January 2005 and March 2008. At the same time, the Medicines and Healthcare Products Regulatory Agency (MHRA) also received reports of 9 incidents since 2003.

Some common contributing factors:

- Inadequate supervision of junior doctors and insufficient experience of clinicians in inserting chest drains
- inappropriate insertion site and poor positioning
- excessive insertion of dilator
- inadequate imaging
- anatomical anomalies

Key recommendations (from NPSA):

- To allow chest drains to be inserted only by staff with relevant competencies. Adequate supervision must be provided in the learning phase.
- To use ultrasound guidance when inserting a drain for fluid.
- To provide relevant training to all staff involved in chest drain insertion.

Suggestions or feedback on this newsletter will be most welcome. Please email us through the HA intranet at: ***HA Risk Alert***

Link to information on SERAE: http://ha.home/ho/rm/SERAE.pdf