醫院管理局 HOSPITAL AUTHORITY

RISK ALERT

ISSUE 12 Sep 2009

A Risk Management Newsletter for Hospital Authority Healthcare Professionals

IN THIS ISSUE

A COC Chairman Perspective on Risk Alert

Our patients deserve the best attention and care that we can offer. Our professional callings require us to always do the best for our patients within our capabilities. With the upholding of human rights, increased transparency and accountability, and advances in information and medical technology, the expectation from our patients has increased more than ever before. Yet, mistakes and incidents are unavoidable as we are all human beings.

To err is human. However, we could improve our systems so that human errors could be minimized though not totally eradicated. While HA continues to improve the systems, promote reporting and just culture, and share good practices by using various platforms, we should also support our staff should mishaps occur as nobody wants to make mistakes. As a public healthcare organization, we strive to continually refine and perfect our systems and to overcome problems due to natural human weaknesses.

In my nearly 30 years of surgical career, I have come to understand that supervision is extremely important to ensure staff competence and patient safety. Coupled with good management, we could greatly enhance patient satisfaction, staff morale and hospital image.

Recently, HA has promulgated the use of surgical safety checklists which request all staff to halt momentarily in the already tight workflow and heavy workload of the operating theatre in order to ensure correct patient undergoing correct procedure in correct site. Is it worthwhile to follow strictly this 'Time-out' so that medical incidents and wrong site surgery could be prevented? To me, this is a definite yes.

Dr. Francis MOK, COC, SURGERY

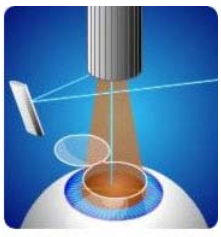
WHAT HAS HAPPENED?

LASER THERAPY TO WRONG PATIENT

- Patient A attended Out-Patient Clinic (OPC) for laser procedure to his RIGHT eye and Patient B was to receive laser procedure for his LEFT eye.
- Identities of both patients were checked. Patient A received eye drop to dilate his RIGHT pupil and Patient B received eye drop to dilate his LEFT eye.
- Doctor X in the laser room called Patient B to come into the room for the procedure but Patient A entered the room.
- Doctor X asked the patient if he is Patient B and he said YES.
- Doctor X obtained consent from Patient A after explaining the procedure.
  Doctor X examined Patient A's LEFT eye and found it not dilated.
  Doctor X asked the assistant to dilate Patient A's LEFT eye.
- Doctor X found retinal degeneration and performed laser therapy for Patient A's LEFT eye.
- Doctor Y in another laser room called Patient A to come into the room.
- Patient A told Doctor Y that he had already received a procedure.
- The mistake was then discovered after verifying patient A's identity.
- Patient A subsequently received laser therapy on his RIGHT eye and Patient B on his LEFT eye.

Key contributing factors:

1. Patient was not wearing wristband for identification in OPC.
2. Closed-ended question was used to verify patient's identity.
3. Patient's identity card was not used for on-spot verification of identity at the time of the procedure.



LEARNING POINTS:

(1). To check patient's identity against patient's identity card and medical record prior to a procedure in Out-Patient Clinic.

(2). To check patient's name by using open-ended question.

(3). To apply time-out practice in out-patient procedure.

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WHAT HAS HAPPENED?

INSERTION OF CHEST DRAIN TO A WRONG BABY

Baby **A** was on ventilator support after open heart surgery

Baby B with severe respiratory distress was just intubated

⇓

Doctor ordered urgent chest X –ray (CXR) for both babies. The two X-rays were taken at the same time

⇓

Both X-ray films were placed at the nursing station for the doctor to review

⇓

Doctor A found pneumothorax in one of the CXR and thought the CXR belonged to Baby **A**

⇓

Doctor A inserted a chest drain to Baby **A** but did not find air leak

⇓

Doctor A rechecked the x-ray films and discovered the film with pneumothorax belonged to Baby B

Key contributing factors: Staff did not check the identity of the chest.

LEARNING POINT:

To check patient's identity on the x-ray film prior to a procedure.

WHAT HAS HAPPENED?

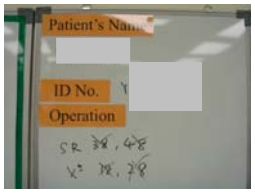
EXTRACTION OF WRONG TOOTH

- Patient was admitted for elective surgical extraction of right lower 5th (45), right upper (18) and lower (48) wisdom teeth.
- Dental Surgeon **A** obtained the consent from patient in ward.
- Dental Surgeon **B** and Doctor **C** were assigned as the operating surgeons on the day of surgery.
- Anaesthethetist, circulating nurse and Dental Surgeon **A** conducted the "Time-out" checking procedure prior to the operation.
- After induction, Dental Surgeon **B** injected the local anaesthesia into right & left, upper & lower mucosal sites.
- Dental Surgeon **C** extracted an unplanned LEFT LOWER WISDOM (38) tooth.

  The mistake was recognized by the nurse.

Key contributing factor:

1. "Time-out" was not performed by the operating surgeons.
2. The theatre nurse did not know who will be the operating surgeons before the time-out procedure.



LEARNING POINTS:

(1) To use the white board to show the tooth extraction plan.

(2) To comply with the Surgery Safety Guideline.

(3) The name of the operating surgeons should be known to the theatre team prior to the "time-out" procedure.

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TRANSPORTATION OF CRITICAL ILL PATIENT

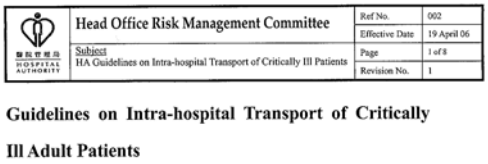
The Agency for Healthcare Research and Quality (AHRQ) report[1] - "Safety During Transport of Critically Ill Patients" cited that critically ill patients are frequently transferred between departments and are at high risk for complications en route. The reported rates of adverse events ranged from 5.9% to 66% for intrahospital transportation of critically ill patients. It is important to develop a practice to minimize the potential risk to these patients during transportation.

The Hospital Authority had developed a guideline on Intra-hospital Transport of Critically Ill Patients[2] in 2006 to enhance patient safety during transport. It is important to follow proper procedures to minimise the potential risks to these patients.

1 http://www.ahrq.gov/clinic/ptsafety/pdf/ptsafety.pdf

2 HAHO operations Circular No. 9/2006:

HA Guidelines on Intra-hospital Transport of Critically Ill Adult Patients



Head Office Risk Management Committee	Ref No.	002
	Effective Date	19 April 06
Subject: HA Guidelines on Intra-hospital Transport of Critically Ill Patients	Page	1 of 8
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Guidelines on Intra-hospital Transport of Critically Ill Adult Patients

What have happened?

Case 1 Portable ventilator was accidentally turned off during patient transfer from ward to operating theatre.

Case 2 Portable ventilator tubing was disconnected during patient transport to operating theatre.

Case 3 Portable ventilator inspiratory tube was disconnected during patient transport to operating theatre.

Possible causes:

- The escorting staff was inexperienced in escorting critically ill patient requiring portable ventilator.
- The positioning of the ventilator may be difficult for staff to observe for any abnormal setting.
- The ventilator tubing was covered by patient's blanket.

Improvement actions:

- To reinforce the training for new and inexperienced clinical staff to ensure proper use and operation of portable ventilator.
- To standardize the positioning of portable ventilator in patient bed to prevent or reduce accidental tampering of ventilator switches.
- To attach a diagram on portable ventilator for easy reference to ensure correct assembly of portable ventilator.
- To promulgate corresponding checklist to guide staff.

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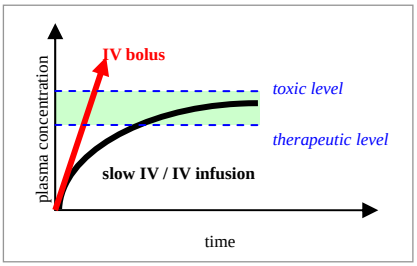
RATE OF ADMINISTRATION FOR A LOADING DOSE

A loading dose is one single dose of a drug that may be given at the onset of therapy with the aim of achieving the target plasma concentration rapidly. It usually refers to a higher dose than a maintenance dose.

Recently, a medication incident was reported locally involving the administration of a high loading dose of a drug given as an intravenous (IV) bolus to a patient, instead of being infused over a certain period as intended, resulting in toxic effects. In this connection, special attention should be paid to drugs with a narrow therapeutic index, such as phenytoin, which are at particular risk of exceeding their toxic level. Should a high loading dose of such drugs be given at a wrong rate of administration, it could cause serious harm to patients.



In general, it would be desirable (and particularly important in the case of administration of a loading dose of a drug with narrow therapeutic index) for a prescriber to clearly specify the rate of administration: as IV bolus, slow IV or IV infusion?

Suggested solutions

- ☑ Prescriber to refer to the package insert or consult pharmacy for the recommended rate of administration of a drug when in doubt.
- ☑ Prescriber to specify the rate of administration of a drug on the prescription.
- ☑ Pharmacist to provide information on the recommended rate of administration of a drug.
- ☑ Nurse to clarify the rate of administration of a drug with the prescriber or a pharmacist, if not specified, before drug administration.

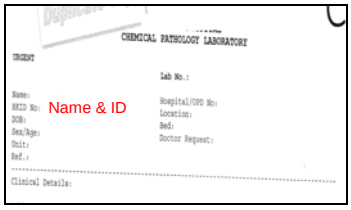
MISIDENTIFICATION OF PATIENT – FILING OF LAB RESULT TO WRONG PATIENT LEADING TO A MEDICATION INCIDENT

What has happened?

- ➢ A laboratory investigation report with a critical result of K (Potassium) 6.2mmol/L was printed out from CMS for patient of Bed 23.
- ➢ Nurse handed the report over to an intern immediately.
- ➢ Intern administered Calcium gluconate to the patient at bed 23.
- ➢ Ward staff later discovered that the RFT result belonged to a patient who was in Bed 23 discharged one week ago. The discharged patient had blood taking in SOPD on that morning, and the report was sent back to parent ward.

Key Contributing Factor:

Staff rely on the bed number printed on the lab report as identifier.



Learning Points:

1. The bed number printed on lab report is not an identifier for the patient.
2. Patient's identity on the laboratory report should be checked before filing.

Suggestions or feedback are most welcome.
Please email us through HA intranet at address:
HO Patient Safety and Risk Management Department