醫院管理局 HOSPITAL AUTHORITY

# RISK ALERT

ISSUE 13 Nov 2009

A Risk Management Newsletter for Hospital Authority Healthcare Professionals

## IN THIS ISSUE



***Message from Patient Safety and Risk Management Department, Quality & Safety Division, HAHO***

The reporting of Sentinel Events (SE) has raised the awareness of clinical risks and together with the risk reduction measures being implemented, there is a reduction of reported SEs across HA. To further strengthen the management and prevention of serious adverse events, with effect from 1 Jan 2010, the mandatory reporting criteria and management process will be enhanced. In addition to the existing SEs, the Policy will include the reporting of Serious Untoward Events (SUE) - defined as *unexpected occurrence which could have led to death or serious physical or psychological injury.*

**Sentinel Events** (with modification to definition of item 2, 3, 9)

1. Surgery / interventional procedure involving the wrong patient or body part
2. Retained instruments or other material after surgery / interventional procedure
3. ABO incompatibility blood transfusion
4. Medication error resulting in major permanent loss of function or death
5. Intravascular gas embolism resulting in death or neurological damage
6. Death of an in-patient from suicide (including home leave)
7. Maternal death or serious morbidity associated with labour or delivery
8. Infant discharged to wrong family or infant abduction
9. Other adverse events resulting in permanent loss of function or death (excluding known complications)

**Serious Untoward Events** (only 2 categories will be included)

1. **Medication error** which could have led to death or permanent harm
2. **Patient misidentification** which could have led to death or permanent harm

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## A PATIENT UNDERWENT INCORRECT SURGERY

***WHAT HAS HAPPENED?***

A patient has a nodule at the base of the left ring finger
Consent to excise the nodule was obtained by **Doctor A** in the Specialist Out-Patient Clinic (SOPC)

⇓

The patient attended the Ambulatory Centre for the operation and was assessed by **Doctor B**

⇓

**Doctor B** noted a nodule on the palm along the flexor tendon of the left ring finger, which the patient indicated pain on applied pressure

⇓

**Doctor B** marked the operation site with an arrow on the left ring finger (without referring to the medical notes on the position of the nodule identified at the SOPC)

⇓

**OT Nurse A** checked the operation site and noted the nodule as pointed out by the patient

⇓

**Doctor B** and **OT Nurse A** conducted the Time-out process prior to the skin incision

⇓

**Doctor B** assisted by **OT Nurse B** performed a release operation for the left ring trigger finger

⇓

At the recovery room, patient realized the nodule was not removed

⇓

Patient underwent another operation to remove the nodule

**Key contributing factors:** **The surgeon did not verify the correct operating site with the patient nor refer to the medical notes on site marking**

**LEARNING POINTS:**

**(1) The operator should read all the relevant clinical notes before beginning an operation**

**(2) Encourage a "speak up" culture whenever an error is identified by a team member**

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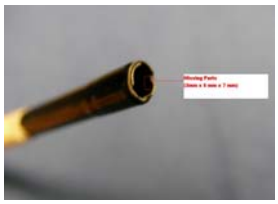
*WHAT HAS HAPPENED?*
*WHAT WAS LEFT BEHIND?*

# RETAINED INSTRUMENT, DEVICE AND CONSUMABLES

## Part of Laparoscopic Instrument

- During a laparoscopic appendectomy operation, there was difficulty in retrieving grasping forceps and another forceps was used to finish the operation
- During the cleansing process, a staff found the metal plate inside the lumen of the forceps was missing
- A round metallic object was noted in the abdominal X-ray and CT scan of the patient
- The patient was informed of the incident. It was agreed that it was not necessary to perform another operation to remove the retained part.



## Sponge Fragment

- During an intraocular lens implantation with trabeculectomy operation, a surgeon cut a sponge as usual into small pieces and soaked them with medication to apply to the operation site
- The surgeon removed all the pieces of sponge and the number was verified with the scrub nurse
- The surgeon examined patient's eye after the operation and noted a foreign body
- An operation was performed and a small (1mm x 1mm) sponge fragment was removed

**Key contributing factor: Tiny dislodged fragment of equipment or consumable is difficult to detect**

**LEARNING POINT:**
**Alertness on the integrity of the equipment during an operation**

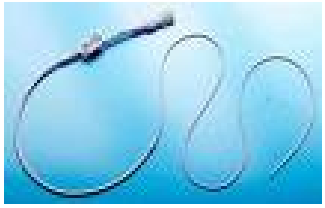
**LEARNING POINT:**
**Explore alternative appropriate material (small sponge) for the operation**

## Gauze

- After an incision and drainage operation for an abscess, the wound was packed with plain wet gauze to absorb the wound discharge
- Wound dressing and repacking was subsequently performed 10 times by different staff before final wound closure was performed
- Residual fluid collection was subsequently detected at the wound site
- On incision and drainage, a piece of gauze was found in the wound and was removed

## Segment of Broviac catheter

- A Broviac catheter which was inserted for a course of intravenous antibiotic therapy and was removed after the course, resistance was encountered during the removal process
- Six months later, the patient was admitted with fever
- A segment of catheter was noted on the CXR in the position of the patient's heart
- A long segment of catheter was retrieved by endovascular approach
- Patient made a good recovery after the procedure



**Key contributing factor: Staff failed to check the integrity or the number of the consumable after the procedure**

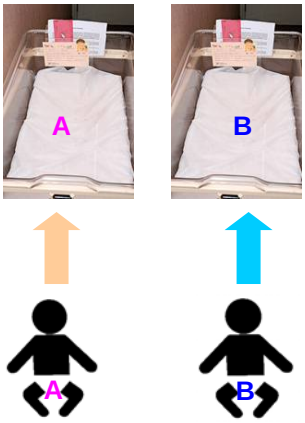
**LEARNING POINT:**
**Ensure clear documentation on gauze counting**

**LEARNING POINT:**
**Must check the integrity and completeness of catheter after removal**

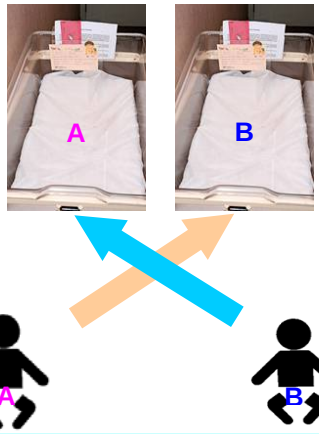
RISK ALERT LOCAL RISK SCREENING ISSUE 13 Nov 2009

## WHAT HAS HAPPENED?

# MISIDENTIFICATION OF BABIES




Baby A and B were put on separate incubators for warming after bath




- Baby A and B of the same gender and similar weight were born on the same day, 35 minutes apart
- The correct BASIC wrist bands (with correct patient identification) were applied to the wrists of both babies in the labour ward
- Both cribs were labeled with their names correctly

Baby A was suspected to be wrongly put onto the crib with the label of Baby B, and vice versa


The nurse gave the Baby in crib A to Mother A for breast feeding without checking its identification





- Nurse prepared two new 2D-Barcode bracelets for the two babies at the same time.
- Supporting staff applied the 2D-Barcode bracelet by referring to the name displayed on the crib without checking the name on the BASIC wristband on the baby's wrist. Hence, the 2D-Barcode bracelet for baby A was applied onto the baby in crib A (which is baby B)
- Without further checking, the other 2D-Barcode bracelet for baby B was applied onto the baby in crib B (which is baby A)


Mother B reported to the nurse that the original BASIC wrist band has left off from her baby and she noticed it carried the name of Baby A

On investigation, DNA test confirmed misidentification of the 2 babies – the 2D-Barcode bracelets were applied onto the wrong baby

**Key contributing factors:** 1. Did not properly verify the identification of baby before applying the identification bracelet
2. Fail to check baby's identity before a procedure

## LEARNING POINTS:

1. Baby identification must be checked before any procedures
2. Streamline the baby identification process

RISK ALERT GLOBAL RISK SCANNING ISSUE 13 Nov 2009

# TOP REPORTED CLINICAL INCIDENTS IN AIRS (JAN – JUN 2009)

| NATURE | GROUP* | Q1/2009 | Q2/2009 |
|---|---|---|---|
| Patient (Injury/ Behaviors) | Falls | 911 | 877 |
| Medication | Administration | 180 | 171 |
| | Dispensing | 80 | 85 |
| | Prescription | 183 | 137 |
| Investigation | Laboratory | 45 | 91 |
| | Patient identification | 83 | 48 |
| Access, Admission, Transfer, Discharge | Missing patient | 109 | 108 |

**AIRS reporting is voluntary** * Multiple groups can be selected for one case

# POTENTIAL RISKS ASSOCIATED WITH INFLUENZA ANTIVIRAL DRUGS

## Tamiflu (Oseltamivir phosphate):

### Risk of dosing errors

Because of shortage of commercially manufactured Tamiflu (12mg/ml) oral suspension, Pharmacies have to prepare oral suspension from powder in Tamiflu capsules, with a final concentration of 15mg/ml.

***Recommendations for clinicians:***

- ☑ Prescribers may consider prescribing 30mg and 45mg Tamiflu capsules depending on the weight of the child.
- ☑ Prescribers should specify the patient's dose in **milligrams (mg)**, instead of in milliliters (ml) or teaspoons (tsp) to avoid dosing errors.


The oral dosing dispenser with graduations in milligrams (mg) rather than in milliliters (ml) is provided in the packaging of manufacturer's oral suspension. There have been cases where the units of measure on the prescription (ml, tsp) do not match that on the dosing device (mg), which can lead to patient confusion and dosing errors.[1]

***Recommendation for Pharmacist:*** To remove the dosing device included in the product package and replace it with an appropriate measuring device to avoid dosing confusion.

### Adverse Drug Reaction (ADR)

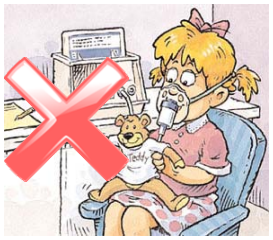
- ✧ Reports of suspected Tamiflu-induced neuropsychiatric adverse reactions in UK[2] and similar ADRs were also reported locally. Such neuropsychiatric adverse reactions, including convulsions and delirium are listed as possible side effects in the Tamiflu product information
- ✧ However, influenza infection itself can be associated with a variety of neurologic and behavioral symptoms. It remains unclear if these neuropsychiatric events may be a true side effect of Tamiflu or due to underlying infection (or a combination of both).

***Recommendations:*** Prescribers should be vigilant to the possibility of ADRs to Tamiflu.

## Relenza (Zanamivir) Inhalation Powder:

- ✧ FDA received a report of death of a patient with influenza who received Relenza inhalation powder which was solubilized and administered by mechanical ventilation.[3]
- ✧ Since the product is a mixture of zanamivir active drug substance (5mg) and lactose drug carrier (20mg), there is risk that the lactose sugar in this formulation can obstruct proper functioning of mechanical ventilator equipment

***Recommendations:*** Relenza should only be used as directed in the prescribing information by using the Diskhaler device provided with the drug product.



This formulation is not intended to be reconstituted in any liquid formulation for use in any nebulizer or mechanical ventilator.

References:

1. http://www.cdc.gov/H1N1flu/pharmacist/pharmacist_info.htm
2. http://www.mhra.gov.uk/home/groups/pl-p/documents/websiteresources/con060189.pdf
3. http://www.fa.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm186081.htm



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