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Surgical Safety 1-2-3 - Patient Participation in Surgical Safety Counterchecking Process

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Proactive patients' participation in surgical safety can reduce patients' anxiety and frustration in multiple layers of patient identification process before surgery. A surgical safety 1-2-3 program has been launched since August 2016. The program is to enhance the communication between healthcare workers and patients. Patient is encouraged to take an active role in identification process and awareness on surgical safety. To engage the patients for the Surgical Safety 1-2-3 program, all patients are arranged to watch a video for introduction of use of surgical safety 1-2-3 bracelet during pre-anesthestic session and before operation. Program pamphlet is also distributed to the patients.

On the day of operation, each patient wears an additional bracelet comprised of 3 stickers representing three checkpoints (1) departure from ward, (2) arrival at the reception of operating theater and (3) before operation in the operating theatre. Patient is required to give a corresponding sticker to the nurse at each checkpoint after verifying patient's identity and related information, such as name of operation and site marking, etc.. Corresponding stickers would be attached to the pre-operation checklist.

Patients showed positive feedback on the Surgical Safety 1-2-3 program. A survey was conducted in September 2016 as interim review to evaluate the program effectiveness. In the survey, all patients were aware of the program and 93.3% of them agreed that the program would reduce pre-operation anxiety. Patients opined that the video and pamphlet helped them to know more about the core value of surgical safety checking. The survey results showed that patient's participation in the Surgical Safety 1-2-3 program enhances the patients' readiness and confidence to operation as well as increases patient awareness on surgical safety checking process before operation.

In This Issue:

Editorial Comments

This Patient Participation Program in Surgical Safety is an exemplary application of patient empowerment in enhancing patient safety. The design is innovative, simple and attractive for both patients and staff to participate. Hope more hospitals can adopt this good practice with modifications to fit into their own environment.

Ms Bonnie WONG
Cluster Manager (Quality & Safety), NTWC

Patient Discharge Information Summary (PDIS)

*By **Dr K S TANG**, Service Director (Quality & Safety), NTWC*

The Patient Experience and Satisfaction Survey (PESS) has consistently showed that our in-patients would like to have more information on drug side effects, danger signs to watch out for and self care for recovery upon discharge. Hospital based projects to cater for information need of specific patient groups has been implemented over the years. However, the PESS results suggested that a corporate wide initiative to address the information need from our general ward patients would be helpful.

The Patient Discharge Information Summary (PDIS) pilot project is designed to target such needs. An auto-generated PDIS will be given to elderly patients discharged from acute Medicine & Geriatrics (M&G) wards from the pilot hospitals. Information given in the PDIS will include Salient Medication Reminder (SMR) of medication at discharge, upcoming corporate wide Specialist and General Out-patient clinics appointments, upcoming corporate wide investigations appointments and other cluster/ hospital specific information. The SMR will not be a comprehensive list of side effects. Rather it will be more patient centered and serve as a reminder of crucial pieces of information that our doctors/ nurses/ pharmacists would like patients and their caregivers to remember and recall for self care and recovery.

A PDIS pilot project team together with an expert panel nominated by COC(Medicine) has been working closely to develop the content of the PDIS. It is planned to be rolled out in phases in pilot hospitals, starting at the end of 2017 to early 2018.

Editorial Comments

Patient's knowledge on self-care and disease management is important in the recovery process. SMR as one of the crucial feature of PDIS would definitely help elderly patients and their caregivers acquire necessary information on prescribed medication. I am sure that the project team and expert panel will take into consideration of findings in PESS in enhancing PDIS, making it a customized tool for specific patient groups.

Ms Susanna LEE
Manager (Nursing)/ Chief Nursing Officer, HAHO

Safe Handling and Effective Specimen Transport Programme in NTWC

*By **Mr Bembi TAM**, Senior Nursing Officer (Nursing Services Division), Tuen Mun Hospital*

Mishandling of specimens could result in severe and irreversible consequences. Past reports of lost specimens during their transportation from wards to laboratory in NTWC suggested that a standardised system for urgent delivery of specimens in reducing mis-communication and human errors and improving efficiency and safety during the transportation process was required. It was observed that there were also other specimen-related issues including (i) blood specimens were not put in an upright position and (ii) different specimens were put in the same plastic bag. Such practice had created the risk of contamination and threatened the accuracy of laboratory results. A quality improvement programme was therefore initiated in the NTWC to ensure safe handling of specimens and effective specimen transportation would be in place.

Methodology:

A Workgroup was formed in 2013 with members from Nursing Services Division, Supporting Services Unit (SSU), Quality and Safety Division, Clinical Pathology Department (PI) and clinical departments. Non-resealable and degradable plastic bags, specimen racks, and special specimen trolleys were tailor-made for safe specimen transportation. Designated specimens collection points were introduced in wards to streamline the transportation process. Funding was approved in 2014 for extending the programme by phases and implementation in all wards in the NTWC was completed in October 2016.

New Workflow:

Urgent specimens collection are requested by ward staff through the Automatic Dispatch System (ADS), which is a system for making request for specimens transportation request and marking attendance record of SSU staff when they arrive at ward. SSU staff then collect and deliver the specimens to PI according to the ADS request. The used specimen racks after specimens' collection by PI staff would be placed into a designated trolley pending for SSU staff for disinfection and replenishing the racks back to clinical wards.

Results & Outcomes:

The programme has minimized the risk of specimen loss during the transportation by standardization of workflow. There was no reported loss of specimen after implementation. Specimens were kept in the upright position to reduce chances of contamination. Staff were satisfied with the streamlined transportation procedures of specimens.

Editorial Comments

Laboratory investigation is an important component of patient care in modern medicine. Error in handling specimen may result in delaying the investigation result and affect the patient's treatment journey. A standardized system in handling specimen transport can reduce the chance of mishap and improve the occupational safety of the staff. In addition, it can also minimize patient's anxiety caused by the incidents.

Dr K H LAU
Deputy Service Director (Patient Safety & Risk Management), HKWC

CLUSTER SHARING

Hong Kong East Cluster

"Identity Crisis" of Specimens – How We Mitigate the Risks

By **Dr W L TANG**, Department of Clinical Pathology, HKEC

Patient identity remains one of the top 10 clinical risks in HA Risk Register for years. Specimen identity issue is a subset of patient identity risks. The subset is unique because - unlike patient's "identity crisis", specimen is never able to self-identify. The identify crisis can be a result of mis-labelling and/or contamination by other patients' material. Moreover, anomalies will accumulate throughout the specimen journey involving multiple handovers in pre-laboratory (e.g. harvest of specimen), intra-laboratory and post-laboratory stages. Measures have been taken in HKEC to reduce the risk of identity crisis of specimens.

by Mr Peter NG

The pre-laboratory risks are partially handled by the use of new specimen container (for histology & cytology) with novel designed seal. The post-laboratory transcription errors are greatly minimized by Information Technology (IT) innovation (e.g. Laboratory Information System, barcodes on slides). The followings are risk-mitigation measures taken within the laboratory.

1) Precious anatomical pathology specimen reception and acknowledgement by point-to-point delivery system
2) Stagger the sequence of handling of specimen of similar nature whenever possible
3) Checking and documentation of specimen nature at tissue wrapping station by 2 persons
4) Facilitate the one-off use of clean forceps for each new specimen
5) Develop SOP for handling and proper documentation of specimen spillage
6) Strengthen use of IT in laboratory workflow to match the identities of specimen and its derivatives
7) Enhance traceability in specimen journey by IT and extreme means of documentation

The implementation requires a committed team including the supervisors and frontline colleagues. Leadership, empowerment and trust from supervisors, Dr CC Lau and Dr KY Pang, in the management of quality issues in laboratory, as well as professional assistance and friendly support from HKEC Q&S team colleagues are keys to successful implementation.

Editorial Comments

"Right specimen → right histopathological diagnosis → right treatment to patient" is a simple logic. Nevertheless, getting the specimen right along the complex "specimen journey" is challenging. With careful workflow planning and procedural design, IT innovation and more importantly, teamwork, a great number of specimens can be handled in a safe manner.

Dr Jenny LAM
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