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Asking and Answering Questions

Opening Message

In an article I read recently about the top priorities for risk management in healthcare settings, improving patient safety and quality was rated the top priority as expected. But a little bit to my surprise, accreditation was cited as the second highest priority. The other areas included managing financial and cyber security risks.

Probably we all have reminiscences of the ACHS Accreditation era in HA. The excitements during the first few years of territory-wide implementation were painstakingly replaced by frustrations due to the extra workloads incurred along with the increasing service volume and complexity.

Many colleagues would agree that the hospital accreditation programme did bring along a healthcare quality improvement framework and some positive changes in the initial phase with enhancement of patient safety. Better team building was achieved and there was a change in organisation culture. However, the marginal benefits of the programme gradually diminished and there were growing doubts on its local applicability, sustainability and cost-effectiveness.

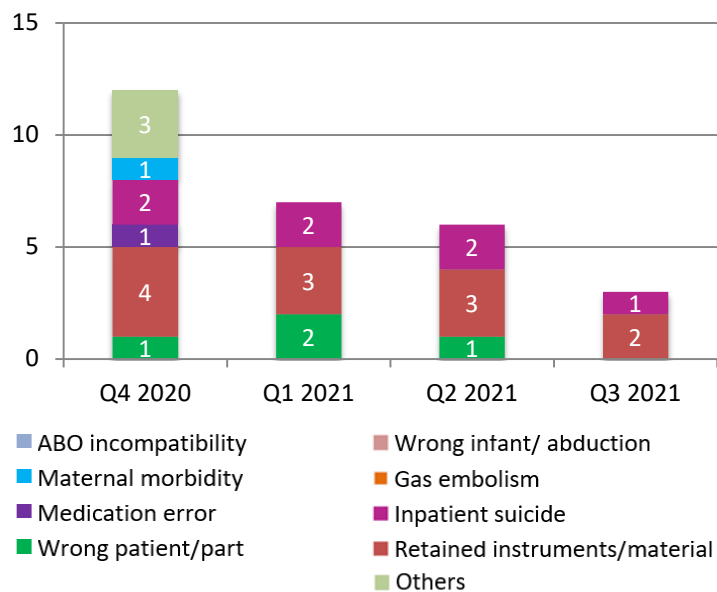
One of the training aspects for the surveyors of the accreditation programme was on asking insightful questions, with the aim of gathering as much information as possible from the clients. As the receiving end, we were taught how to prepare for and skillfully answer the questions from the surveyors.

We had experienced two exceptionally busy years amidst the COVID-19 pandemic. It will likely be another boisterous year ahead in 2022. Nonetheless, let us not forget asking ourselves the question of how we can improve patient safety, quality and experience. We will have different answers individually with our diversified roles in HA, and each will fit perfectly into the wonderful jigsaw of quality patient care.

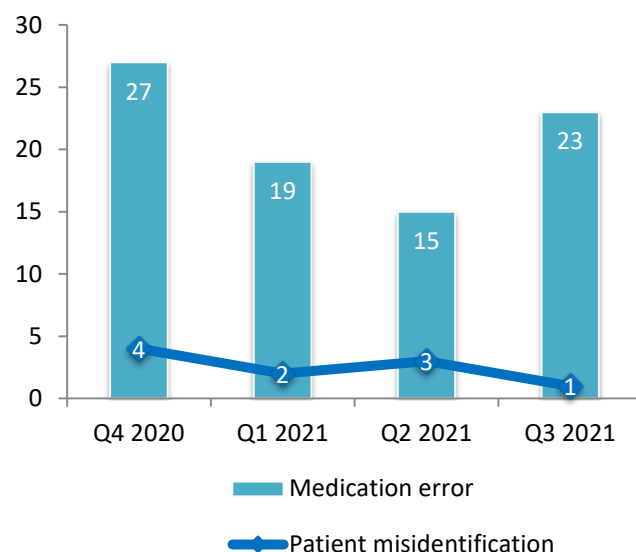


Dr Benjamin LEE
Chief Pharmacist
Hospital Authority

Distribution of SE in the last four quarters



Distribution of SUE in the last four quarters



Sentinel Events

Retained Instruments / Material

Corrugated Drain

- ❖ A female patient with mental history underwent mastectomy. Her wound was complicated with seroma. A corrugated drain was anchored to the wound with stitches and regularly dressed by community nurses.
- ❖ Around 2 weeks later, old age home staff reported that the drain was missing. Bedside ultra-sonogram and wound exploration were done by doctors the next day but search was in vain. Patient's wound was healing well afterwards.
- ❖ Patient later developed abscess from the wound. Upon re-exploration, the missing drain was identified and retrieved.



How did it happen?

- Patient's history of self-pulling out surgical drains and underlying mental condition increased the difficulty of communication between patient and healthcare staff
- The corrugated drain used is elastic and undulated, and generally considered not radio-opaque

How to prevent?

1. Enhance staff's awareness on the risk of foreign body retention
2. Consider imaging investigation whenever in doubt, regardless of the radio-opacity of materials
3. Explore sourcing of corrugated drains with radio-opaque marking
4. Enhance communication, including documentation of patient's wound condition between OAH and hospital

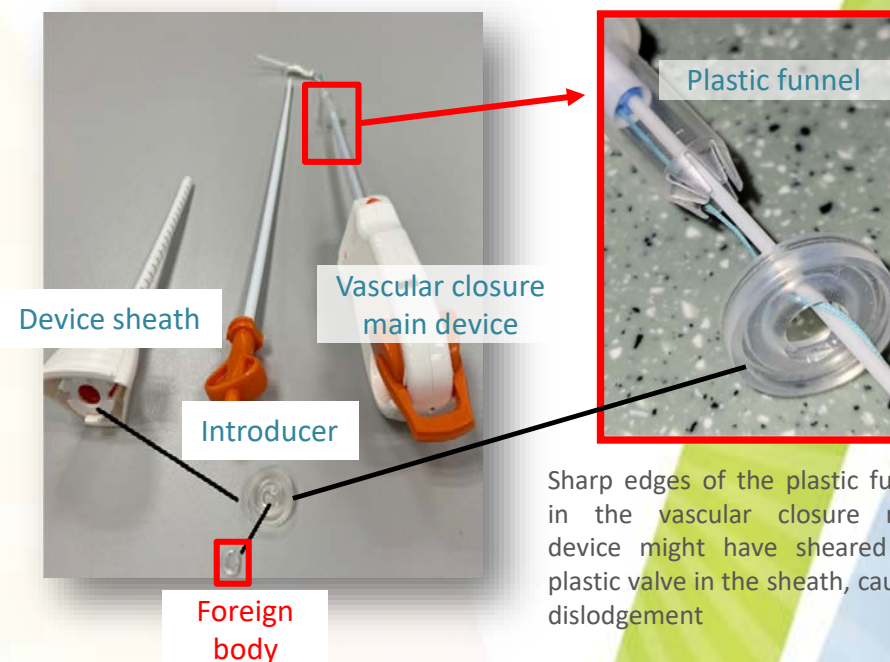
Vascular Closure Device

- ❖ During a Percutaneous Coronary Intervention (PCI) for a patient with myocardial infarction, a vessel closure device (“device”) was used for femoral artery access site closure. The procedure was completed uneventfully.
- ❖ Patient was monitored overnight. The next morning, patient reported limb numbness and absent right lower limb pulse was noted. Urgent CT angiogram revealed occlusion of right femoral artery.
- ❖ Emergency femoral artery embolectomy was done. A ball-shaped component was retrieved from patient’s right mid-common femoral artery, likely the cause of obstruction. Patient recovered well afterwards.



WHY?
did it happen

- ❖ The detached component was part of the silicone valve, in the device sheath which had possibly been cut by the sharp edges of plastic funnel in the main device (see picture).
- ❖ Further advancement of the main device through the sheath might have led to the dislodgement of the component into the patient’s vessel.



Sharp edges of the plastic funnel in the vascular closure main device might have sheared the plastic valve in the sheath, causing dislodgement

Observations

- ❖ Staff who operated the device followed the standard procedure, under the supervision of senior and supported by product specialist .
- ❖ Operator obtained proper training before operation.
- ❖ Procedure was smooth, without difficulty encountered.
- ❖ Once the main device is attached to the sheath, it is difficult to separate them to inspect for any broken/missing component.

Good Practices to Share

- Operator can check the device for any deformity before using, including any fraying of the "teeth" of the "plastic funnel" of the device.
- Advancing the vascular closure device through the sheath should be performed in a parallel direction, with no or minimal angulation or rotational manoeuvre.

Background

- ❖ A patient with history of mental condition was admitted for accidental ingestion of a mouthful of bleach. He remained calm and cooperative during hospitalization, and denied any intention of self-harm. Oesophago-gastro-duodenoscopy was performed and showed chemical erosion of the upper GI tract. A nasogastric (NG) tube was inserted for decompression and medications were prescribed.
- ❖ Two days later in a late evening, a staff found patient removing his NG tube near the back-door of the ward. Returning with more support, staff could not locate the patient but noted that one of the sluice room windows was opened with a slit. Upon local search, the patient was found lying on the ground next to the hospital building. Despite resuscitation, the patient succumbed. The case was reported to the Police and Coroner.

Learning Points

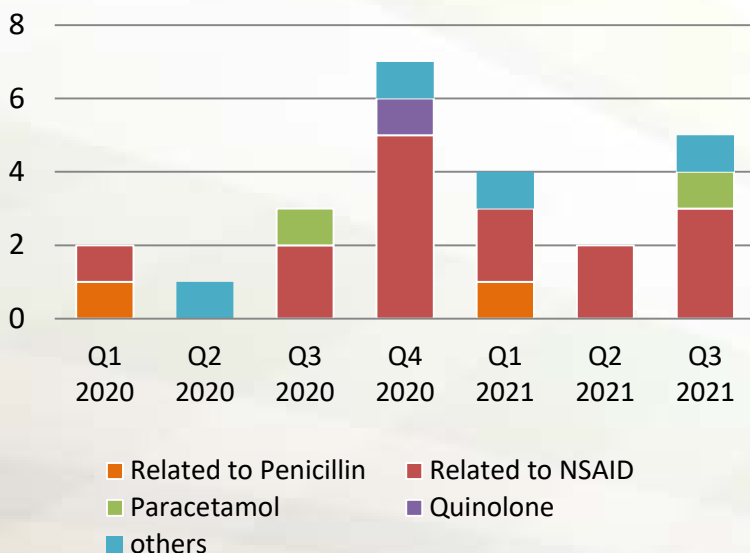
- ❖ Reinforce independent clinical assessment of patients with complete and detailed documentation
- ❖ Enhance staff training on suicidal risk assessment and identification of early warning signs of possible suicidal acts
- ❖ Enhance vigilance in detecting and reporting patients who might be of higher risk, for early referral to specialty care



Serious Untoward Events

Of the 24 SUE cases reported in 3Q 2021, one was related to patient misidentification. The rest were related to medication errors, involving known drug allergy (KDA) (5), anticoagulant (3), dangerous drug (3), insulin (3), oral hypoglycemic agent (1), inotrope (1) and others (7).

Number of KDA cases in 2020-21



Known Allergy	Allergen prescribed
Voltaren	Ketorolac
Panadol	Panadol
Voltaren	Aspirin
Voltaren	Ketorolac
Drug for H Pylori	Pantoloc



Serious Untoward Events



Paediatric Infusion Safety

To enhance staff awareness on this important topic, this issue shall highlight a few related incidents, as well as global and local wisdom on current risk mitigation measures.

Case 1

A newborn baby was transferred to Special Care Baby Unit for blood glucose monitoring. Dextrose 10% (D10) 500ml intravenous infusion at 5ml/hr was prescribed for hypoglycemia. A few hours later, the preset volume to be infused (VTBI) of the D10 was reached. Both the VTBI and infusion rate of the infusion pump were readjusted. The infusion rate was incorrectly adjusted to 55ml/hr instead of the intended 5ml/hr. The error was spotted by another nurse around 90 minutes later. Around 70ml extra D10 solution was given.

Case 2

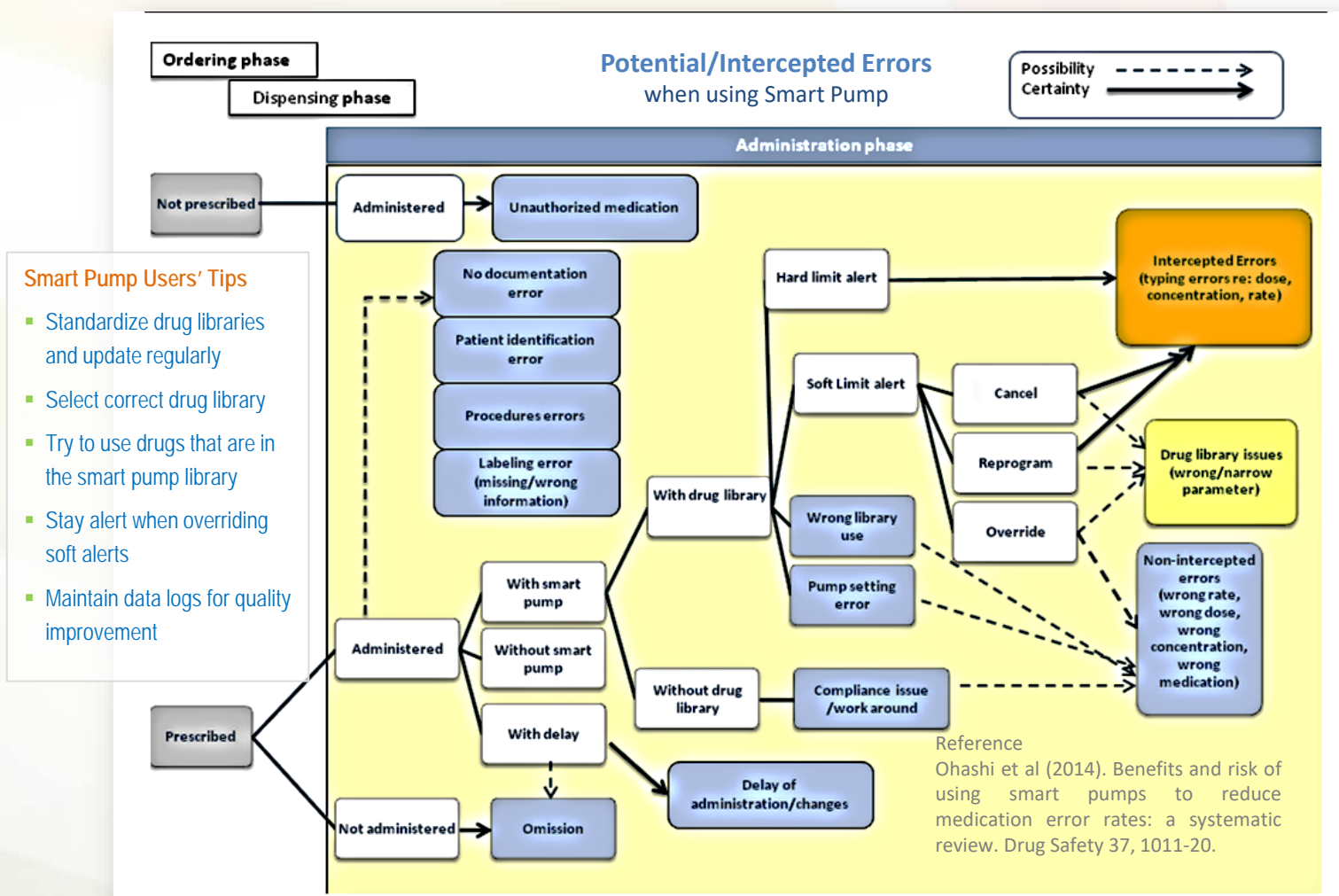
A baby with congenital cardiac problem was admitted to Neonatal Intensive Care Unit. Total Parenteral Nutrition (TPN) regime was prescribed, i.e. TPN aqueous of 8.3ml/hr for 24 hours and TPN fat of 2.04ml/hr for 20 hours. A few hours later, it was discovered that the infusion lines of TPN fat and TPN aqueous were mixed up while setting up the infusion pumps. An extra 28.2ml of TPN fat was given.

In these cases, close monitoring of the patients and corresponding treatment were promptly provided. Patients remained well after the incidents.



Global Sharing

Smart Pump is an intelligent infusion device with dose error reduction system and drug library, aiming to enhance infusion safety by reducing errors of oversight and dose miscalculation. It is more commonly used in paediatric settings. However, it does not eliminate programming errors. Below is an extract from a systematic review on using smart pump (Ohashi et al, 2014).





Initiatives to Enhance Paediatric Medication Safety

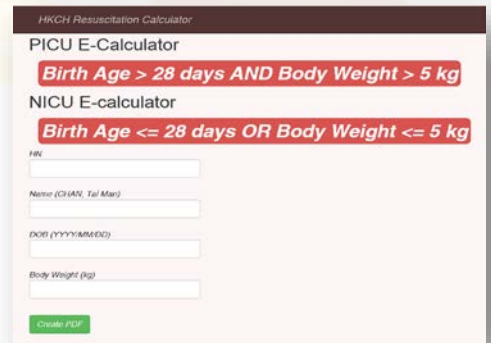
1. Standardization of Dangerous Drug Labelling

CloBAzam 10mg Tab (Frisium®)	CLONAzepam 0.5mg Tab (Rivotril®)
Morphine PR 10mg Tab (MST Continus®)	Morphine PR 30mg Tab (MST Continus®)

2. Look-alike & Sound-alike (LASA) Drug List with TALL-MAN Lettering

AmiloRIDE*	AmloDIPINE*
AmOXYcillin	AmPIcillin
Antithymocyte Immunoglobulin (HORSE)	Antithymocyte Immunoglobulin (RABBIT)
AzathioPRINE*	AzithroMYCIN*
CalciFERol*	CalciTRIOl*
CHOLEcalciferol	
CarbamazePINE*	CarbimaZOLE*
CARBOplatin	CISplatin

4. Paediatric Resuscitation Calculator



- To assist clinicians with weight based calculations in children
- It does not replace a medication prescription or clinical judgement

3. Cyto-set

A single-use, sterile infusion system for the preparation and administration of different cytotoxic drugs via one single closed line-system



Advantages

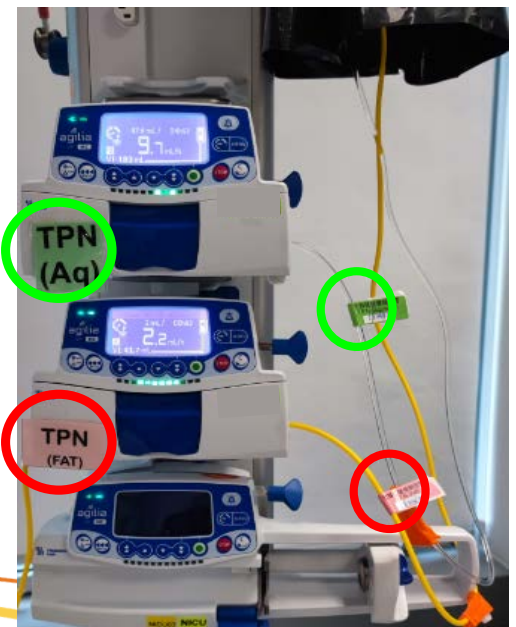
- ✓ Easy, drip-free priming
- ✓ Eliminates risk of cytotoxic contamination at connection site
- ✓ Needle-free system, prevent leaks and needlesticks



Acknowledgement:
Q&S Office, Hong Kong Children Hospital

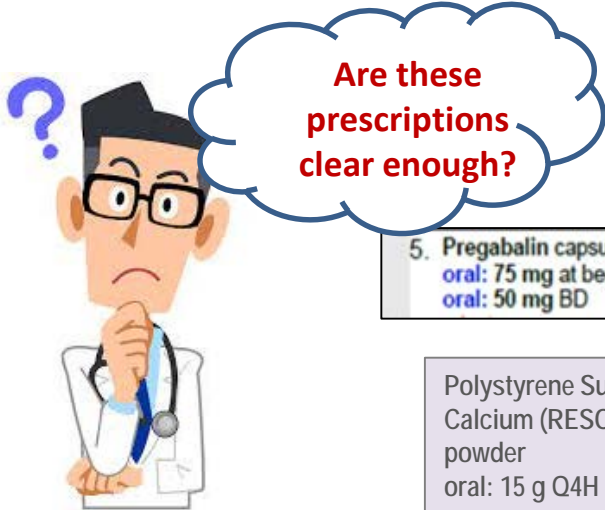
Good Practice on Infusion Line and Pump Management

- ✓ 3-Point (Patient-pump-medications) Physical Trace Back (not just visual) on the infusion line every time
- ✓ Standardize colour-labelling of infusion tubing and device, especially for patients with multiple infusion lines
- ✓ Stay alert on high-risk catheters, such as epidurals, intrathecal catheters and arterial lines
- ✓ Consider syringe pump instead to minimize error associated with over-infusion due to wrong setting of device





How to make a clear order?



<p>5. Pregabalin capsule oral: 75 mg at bedtime and oral: 50 mg BD</p>	<p>Lorazepam (ATIVAN) tablet oral: 1 mg OM and oral: 1.5 mg nocte and oral: 0.5 mg at noon</p>	<p>Calcium Gluconate injection 10 % 10 mL IV bolus: 10 mL Q12H To be given SLOWLY OVER 3 MINUTES</p>
<p>Polystyrene Sulphonate Calcium (RESONIUM CAL) powder oral: 15 g Q4H</p>	<p>Levofloxacin eye drops 0.5% 1 drop q4h</p>	<p>Sodium bicarbonate 8.4% Intermittent IV infusion: 75mL in 425mL D5 at 60mL per minute</p>



for making a **CLEAR** order

1. Prescribe in **chronological order** to facilitate drug administration

19/Mar	Pregabalin capsule <Special Drug> oral: 50 mg BD and oral: 75 mg at bedtime
19/Mar	Pregabalin capsule <Special Drug> oral: 50 mg OM and oral: 50 mg PM and oral: 75 mg at bedtime

2. **Specify applying location** for external medications, e.g. ointment, eye/ear drops

Levofloxacin eye drops 0.5% 1 drop q4h **for right eye**

3. **Specify number of dose / duration** of treatment whenever applicable

Item	Drug Details
1.	Calcium Gluconate injection 10% IV bolus: 10mL STAT for 1 DOSE(S) To be given SLOWLY OVER 3 MINUTES

Item	Drug Details
1.	Polystyrene Sulphonate Calcium (RESONIUM CAL) powder oral: 15 g Q6H for 3 DOSE(S)

4. **Specify and check** the details of parenteral medications (type of injection/infusion, route, diluent, dilution and pump settings) whenever applicable

Sodium bicarbonate 8.4% Intermittent IV infusion: 75ml in 425mL D5 at 60ml per hour

5. Make use of **Standard Regimen function** in prescribing whenever possible



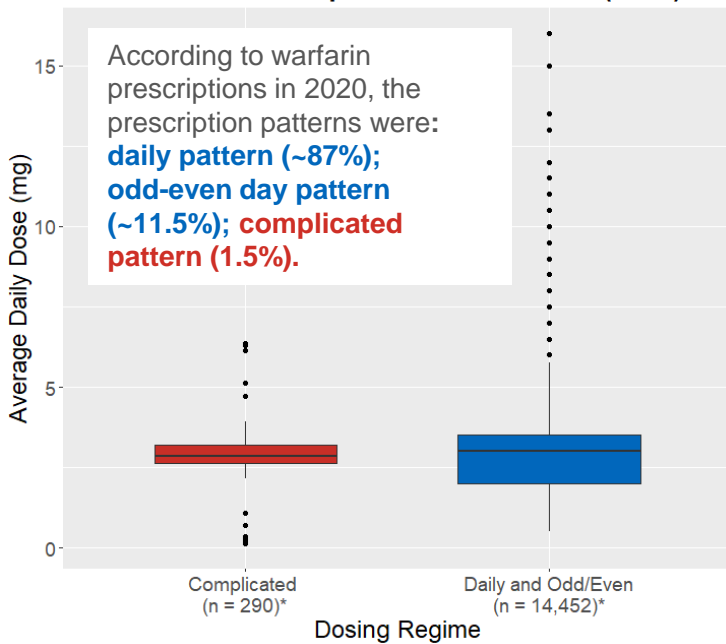
DO YOU KNOW?



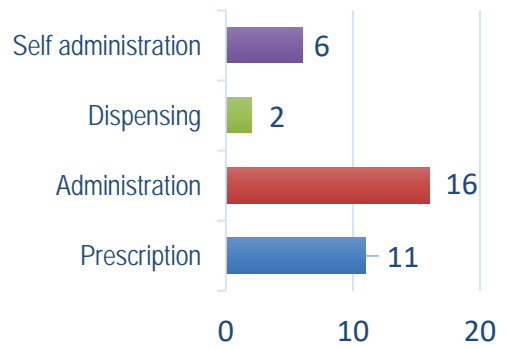
- 1. In 2020, around **19,000 HA patients** were prescribed warfarin
- 2. Around **2,200 of them** were new cases



Warfarin Prescription in HA Patients (2020)



35 Warfarin related incidents (From Jan 2019 to Jun 2021)



COMMON ERRORS from incidents

- 1. Actual prescription different from the intended prescription
- 2. Duration of prescription shorter than the next follow up
- 3. Staff did not refer to the most updated INR / did not check INR result
- 4. Complicated regime

Warfarin Safety Campaign

is coming soon!



We hope to raise staff awareness on warfarin safety through an open competition for all HA staff

Awards will be given to winners who have bright ideas in promoting warfarin safety

Watch out for email and HA Chat announcement!

