RISK ALERT

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A Risk Management Newsletter for Hospital Authority Healthcare Professionals

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Opening Message

Patient Safety – Beyond Safety

Modern treatment is very effective but at the same time, risky. With extra-ordinary therapeutic capability, our healthcare teams are increasingly engaged in the use of sophisticated medical therapeutics and interventions for patients with unstable conditions. In addition, modern treatments require coordinated work from many professionals from different disciplines and specialties. There is no room for error.

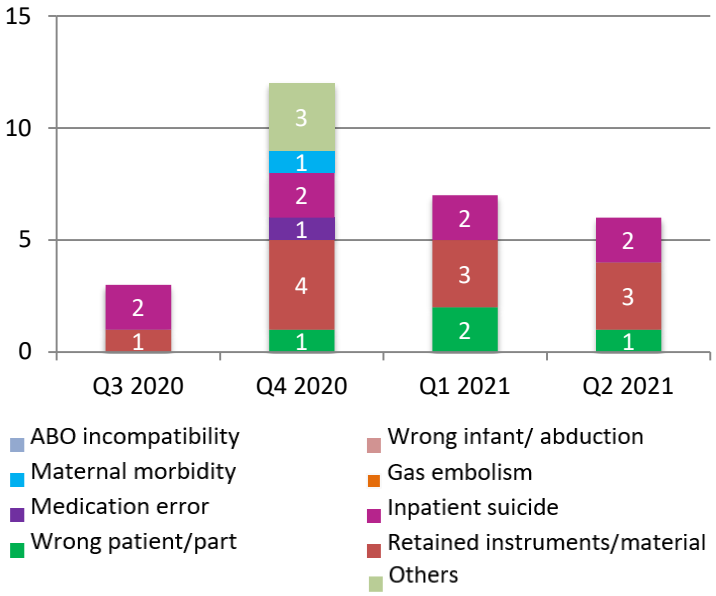
To reduce the probability of error, our usual solution is to add layers of checking and defenses. While this may prevent error in a specific task, this adds complexity to the operation and may impact on another corporate imperative – efficiency. Is it possible to address risk without sacrificing efficiency? Safety and quality is two sides of a coin. Focusing on efficiency and quality may be another way to tackle safety. One way to improve efficiency and quality is workflow re-engineering. By deriving a more efficient and effective way to deliver service, most often harnessing the power of modern information technologies, we may be able to "kill two birds with one stone". Digitalizing workflow with or without workflow re-engineering is two completely different games. In my opinion, although more complicated, all attempts to digitalize workflow should combine with workflow re-engineering in order to fully capture the advantage of digitalization. The Smart Hospital policy of HA is a golden opportunity for us to improve patient safety with the added dimension of improving efficiency.

Let's capture this opportunity.

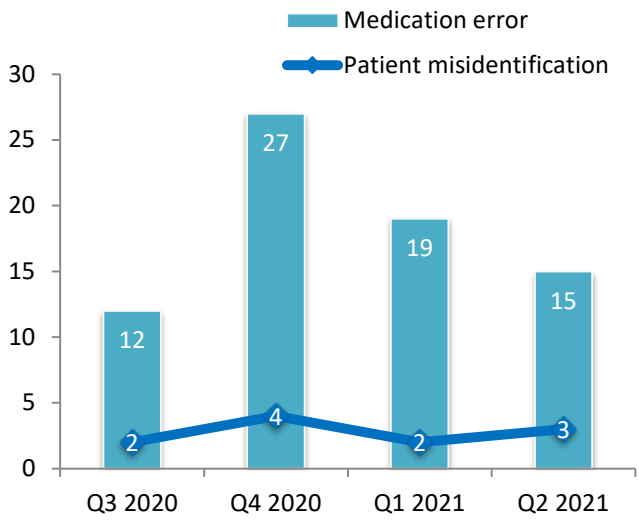
Dr LAW Chun-bon, Alexander
Cluster Chief Executive
Kowloon West Cluster

SE & SUE Statistics

Distribution of SE in the last four quarters



Distribution of SUE in the last four quarters



Sentinel Events

Wrong Patient / Part

Left femoral component of total knee replacement (TKR) implant placed in right knee

- Patient underwent robotic-assisted bilateral TKR. Details of implant components for LEFT and RIGHT knees were written on the white board in operating theater.
- After LEFT TKR, difficulty was encountered during RIGHT TKR. Surgeon decided to change the prosthesis system from Cruciate Retaining (CR) to Posterior Stabilizing (PS). Therefore, a new set of instruments and implants had to be arranged.
- LEFT femoral component was picked and given to circulating nurse.
- Nurse counter-checked with surgeon by reading out the package label information.
- After procedure, post-operative X-ray revealed a LEFT femoral component in patient's RIGHT knee. Revision RIGHT TKR was done afterwards.

Why did it happen?

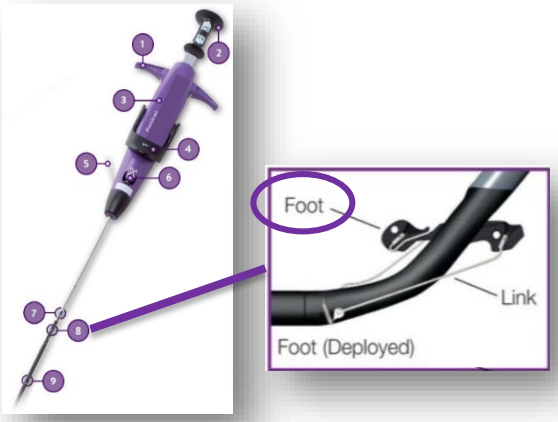
- The Team did not check the implant information and laterality against white board

- The change of surgical plan from CR to PS prosthesis system and the operation involving bilateral knees contributed to the risk of picking wrong prosthesis
- The printing on implant package was too small to be read clearly

How to prevent?

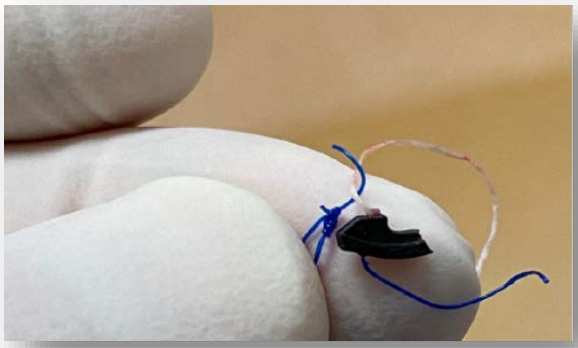
1. Read out package information by circulating nurse and whiteboard information by surgeon simultaneously during implant verification process
2. Introduce "Stop Moment" for implant verification
3. Enhance the clarity of whiteboard display by displaying one-sided implant information on the board at a time

Broken foot of a Vessel Closure Device (Device)



During a paediatric splenic artery embolization, after the vascular sheath was removed from the right femoral artery, a vessel closure device ("device") was deployed in view of patient's bleeding risk. The first device failed to achieve a secure knot and a second device was used. Following ultrasound and close monitoring, patient was stable and discharged on post-operative Day 4.

During follow-up, patient was noted to have right lower limb claudication with weak pulses. Urgent CT angiogram, followed by emergency right groin exploration revealed right common femoral artery stenosis and a broken foot from the device. Patient had an uneventful post-operative recovery after arterial bypass surgery.



Broken foot of Device

Learning Points

Root Cause

Checking the device foot following arteriotomy closure was not a routine

Why did it happen?

- Arterial wall spasm is common in children and may cause gripping on such device.
- Advancement of the device may result in arterial telescoping, causing vascular insufficiency.

Use of Device

- Integrity of device foot should be checked after removal from the body.
- Careful patient selection for device use, especially in children.
- Consider angiography or other appropriate imaging immediately before device application to accurately assess vessel size for children and if indicated.

Retained Instruments / Material

Broken catheter in patient's duodenum

- A non-communicable old-aged home resident had frequent admissions in the past few months. He was on nasogastric tube feeding, and had episodes of agitation with struggling.
- During a recent admission, esophago-gastro-duodenoscopy (OGD) was performed to investigate the cause of anemia. A 5cm long "broken catheter" was discovered in the duoduenum.
- After investigation, the "broken catheter" was likely the distal end of suction catheter used in hospital. However, how and when it was retained could not be identified.

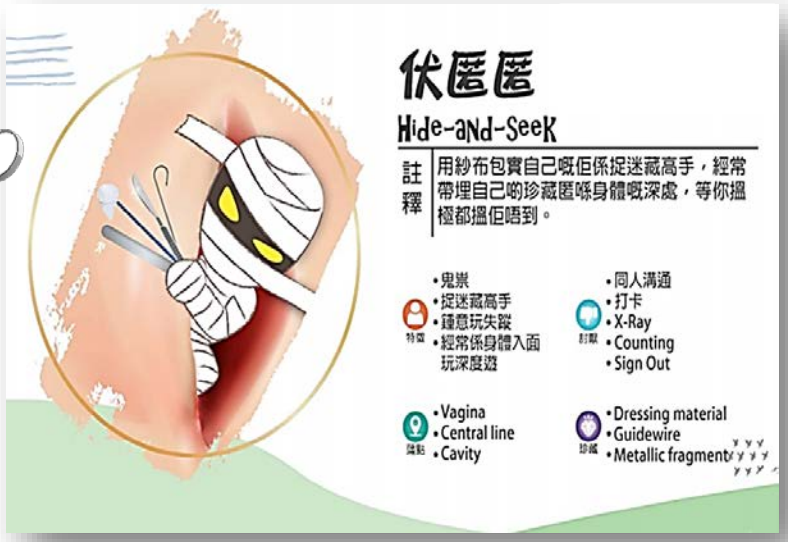
Broken catheter placed next to suction catheter in use in the hospitals

Learning Points

- Check suction catheter's integrity before and after use
- Enhance staff awareness in assessing patients' fitness for oro-pharyngeal (OP) suction
- Agitated or struggling patients may have increased risk of biting the catheter during OP suction

Gauze in sacral wound

- A patient with sacral wound was hospitalized. During wound nurse assessment, a retained gauze was found in the wound.



Acknowledgment: KEC Q&S Office

Wound assessment form (pressure injury)

Sex/ Age | Ward/ Bed

Date									
Time									
Location no.	Refer to diagram at back								
Staging System	1, 2, 3, 4, UN, DTPI (NA for healing ulcer)								
Size	(L) x (W) x (D) cm								
Tunneling	cm o'clock								
Undermining	cm o'clock								
Colour (25%, 50%, 75%, 100%)	Pink								
	Red								
	Yellow								
	Black / Brown								
	Maroon/ Purple/ Deep red								
Exudate Type	Serous / S / B / P								
Exudate Amount	L / M / S / No								
Odour	Yes / No								
Surrounding Skin (Please ☑ appropriate)	Normal								
	Erythema								
	Induration								
	Oedema								
	Maceration								
Infection	Present / Suspect / No								
Swab obtained	Yes / No								
Pain	0-10/ NRS								
Dressing Protocol/ Topical negative pressure therapy @____mmHg*	Cleansing lotion								
	Primary dressing								
	Secondary dressing								
	Outer dressing / Fixation								
*(Delete as appropriate)	Frequency								
For wounds with Cavity, Tunneling, Undermining	No. of dressing removed								
	No. of dressing packed								
Remarks:									
Nurse's Name									
Signature									

Wound assessment form (pressure injury)

How to Prevent?

1. Ensure standardized wound assessment and documentation to facilitate communication and enhance handover safety
2. Leave visible tail (at least 3cm) of packing materials outside the wound with proper anchorage to facilitate detection and retrieval
3. Check the removed packing quantity against the previous record
4. Consult wound specialist for complicated wound

Ensure the number of dressing removed same as previously packed in record

Inpatient Suicide by Suffocation

1 Patient in isolation room was found in cardiac arrest by nurse. During cardio-pulmonary resuscitation (CPR), pieces of tissue papers in ball shape were retrieved from the patient's throat. Despite active treatment, the patient succumbed afterwards. The case was reported to the Police and Coroner.

2 A metastatic lung cancer patient was admitted to an oncology ward for dyspnoea. On a weekend, doctor broke the bad news to patient that he was not suitable for targeted therapy. The patient appeared to have good acceptance to the prognosis and opted for supportive care and Do-Not-Attempt Cardiopulmonary Resuscitation (DNACPR).

In the next morning, the patient was found, with his head covered by quilt and wrapped by plastic bag. Despite resuscitation, the patient succumbed. The case was reported to the Police and Coroner.

Findings

- Both patients' mood was all along stable, without any sign of depression / suicidal tendency
- Suicidal risk assessment and monitoring were appropriate

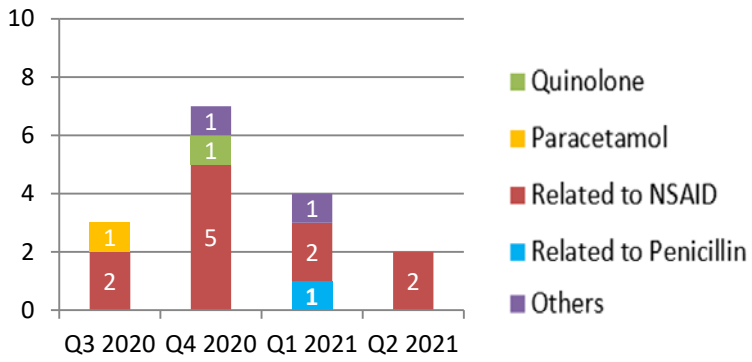
Psychosocial support, e.g. by chaplain and social worker, and more frequent compassionate visit in compliance with prevailing infection control policy may help alleviate patients' stress and facilitate ventilation of feeling, especially whom with declining health condition.

Clinical documentation regarding details of breaking bad news, followed by **additional verbal communication to nurses by doctor is a good practice**.

Serious Untoward Events

Of the 18 SUE cases reported in 2Q 2021, 15 cases were related to medication errors, involving known drug allergy (KDA) (2), anticoagulant (3), antiplatelet (1), insulin (3), chemotherapeutic agent (1), oral hypoglycemic agent (1), neuromuscular blocking agents (1) and others (3).

Number of KDA cases in the last four quarters



Known Allergy	Allergen prescribed
Aspirin	Ketorolac (Toradol)
Ketoprofen	Aspirin

Known drug allergy

1 During a consultation in Accident and Emergency Department (AED), a doctor documented "Aspirin and Acetylsalicylic acid" allergy on patient's AED attendance record and Clinical Management System (CMS). Doctor initially prescribed Tramadol injection for the patient.

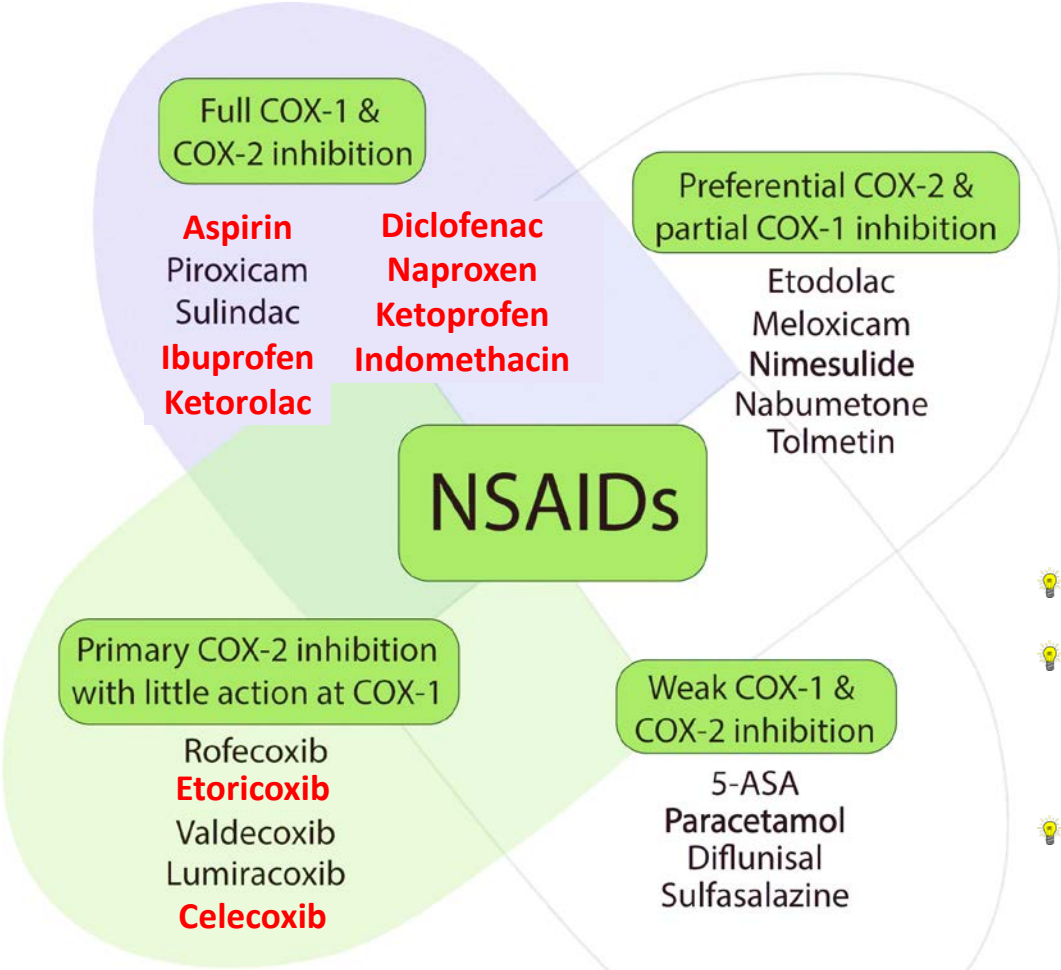
Due to persistent pain, Ketorolac injection was later prescribed and administered.

The doctor and nurse could not correlate the cross-sensitivity of Ketorolac and Aspirin, during prescription and administration process.

2 A patient with acute myocardial infarction was given Aspirin in ambulance. Upon arrival at AED, the patient verbally confirmed that he had no drug allergy.

Extra Aspirin and Ticagrelor were prescribed before percutaneous coronary intervention (PCI). Shortly afterwards, the doctor noticed the patient's allergy history to Ketoprofen in the CMS alert.

Upon further enquiry, patient explained that he was allergic to some kind of injectable medication but not oral drug. Patient was prescribed with steroid cover and did not develop allergic reaction.



- Check for cross-allergy
- Seek advice from senior colleague / pharmacist if in doubt
- Check for CMS allergy alert before prescription and administration

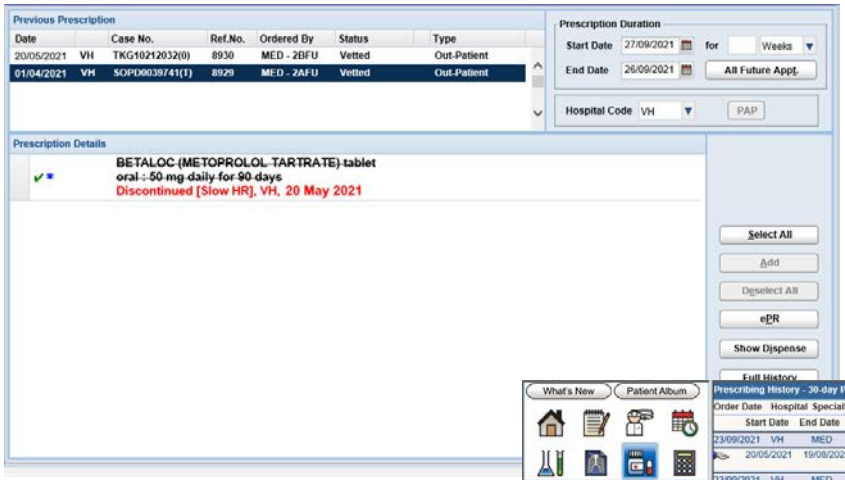
Extracted from Cavkaytar et al (2019). Characteristic of NSAID-induced hypersensitivity reactions in childhood. Pediatric Allergy and Immunology. 30, 25–35.

Local Sharing

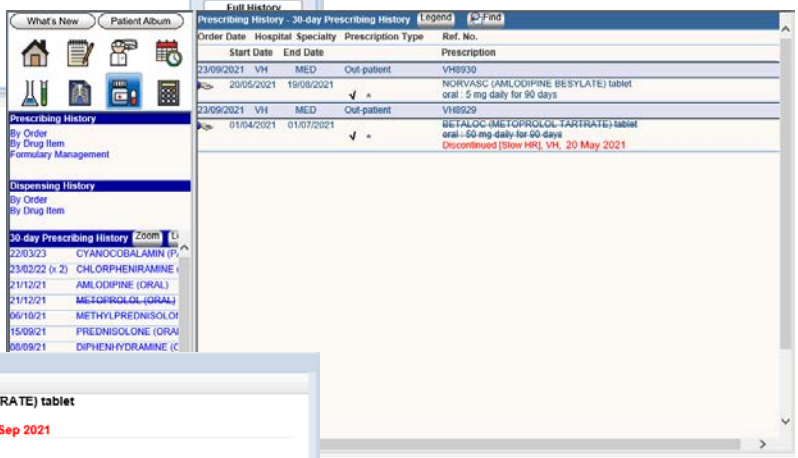
Please mark **Medication Discontinuation** to avoid repeating discontinued drug!

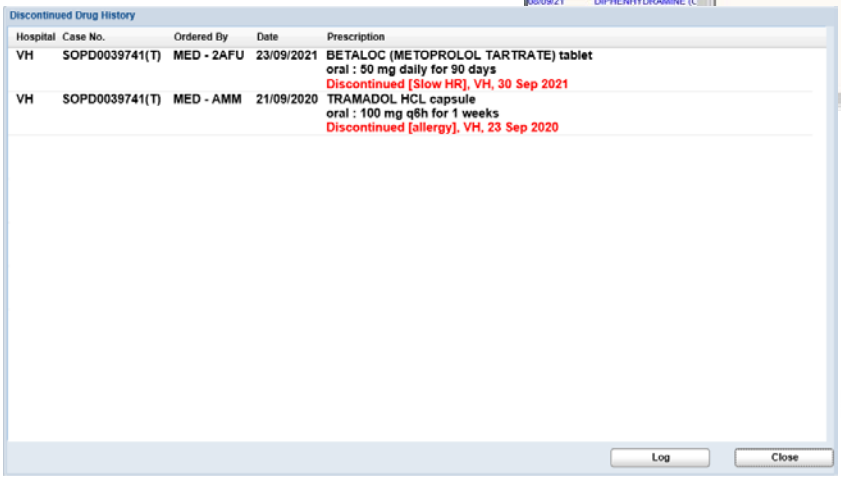
Discontinuation Function in Medication Order Entry (MOE)

- To facilitate doctor to mark discontinuation explicitly and to avoid unintentional repetition of drug, medication discontinuation function is available in Medication Order Entry (MOE).

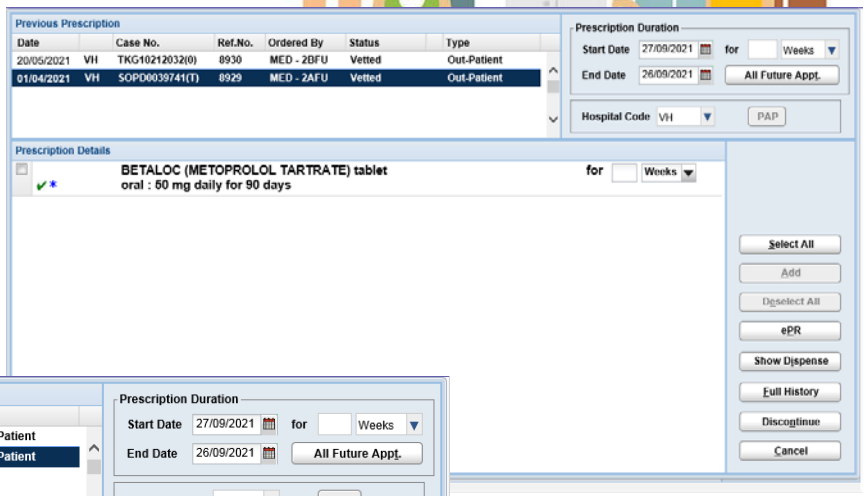


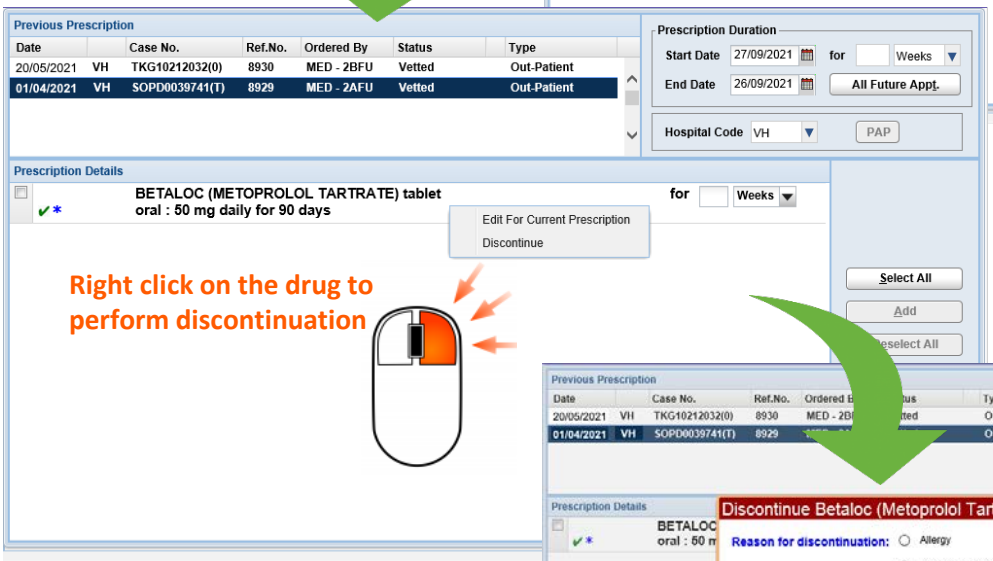
- Discontinued drug history can be reviewed through MOE, ePR and **Discontinued Drug History Enquiry in CMS** menu bar.



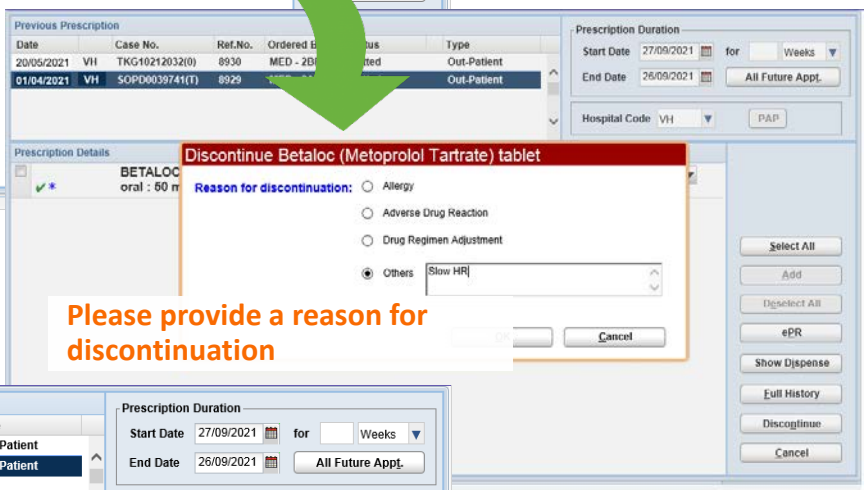


Medication Discontinuation Function in MOE

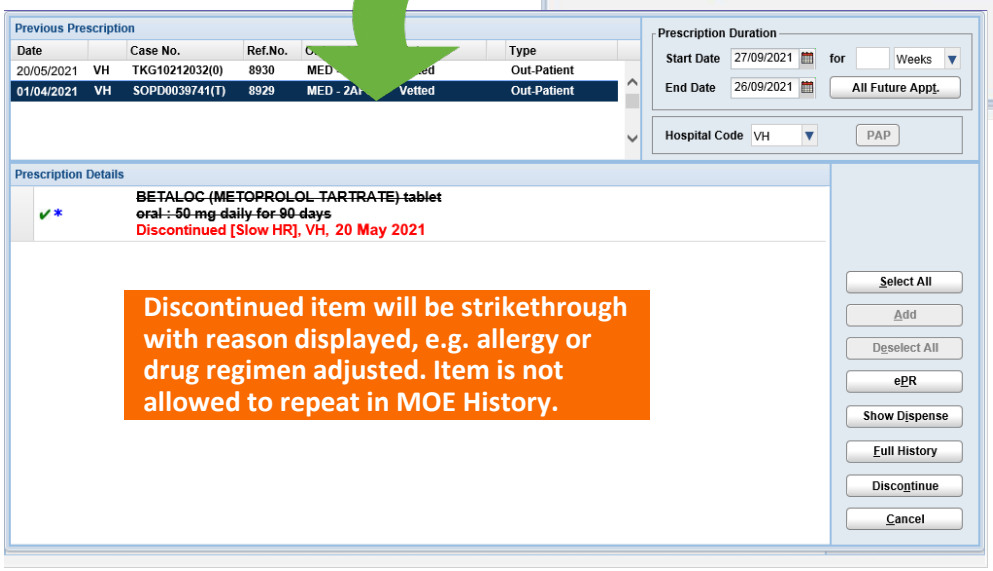




Right click on the drug to perform discontinuation



Please provide a reason for discontinuation



Discontinued item will be strikethrough with reason displayed, e.g. allergy or drug regimen adjusted. Item is not allowed to repeat in MOE History.