RISK ALERT

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A Risk Management Newsletter for Hospital Authority Healthcare Professionals

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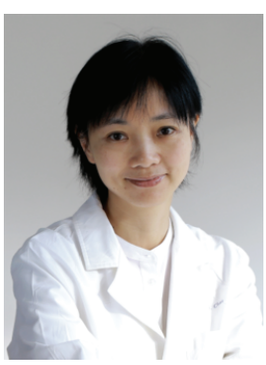
Opening Message

THE SECOND VICTIM OF CLINICAL INCIDENTS



There is an increasing concern on the psychological impact of clinical incidents on healthcare professionals. Indeed, from our local survey* of over 380 colleagues, 80% of the respondents were upset and worried about making mistakes again in future after an incident. Sixty percent had sleep disturbance, and nearly half had reduced job satisfaction and felt that their professional reputation and working relationship with others were affected by the incident.

Respondents emphasised that support from peers and supervisors was the most important factor in helping them cope with the incident. It could be a few kind words of reassurance, showing understanding, care and concern, or just being there for ventilation. Support and guidance from supervisors in handling the incident, such as helping to deal with complaints and to develop improvement actions were highly appreciated.

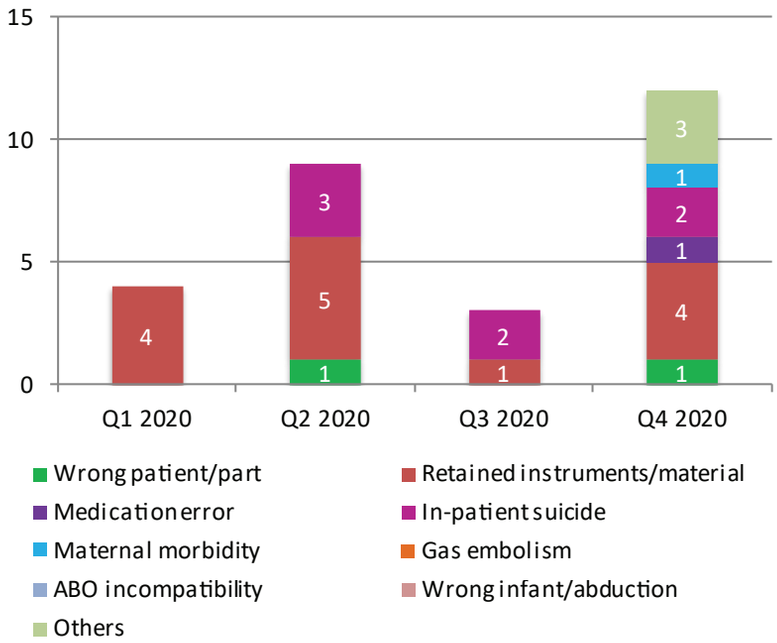
While patient safety is our primary concern, we should not forget the second victim in clinical incidents. Support from peers and seniors is essential to improve staff resilience in handling future challenges. We all play a role in building up a no blame and caring culture.

** Study was conducted as joint effort of OASIS, NTEC Q&S and Nethersole Institute of Continuing Holistic Health Education (NICHE)*

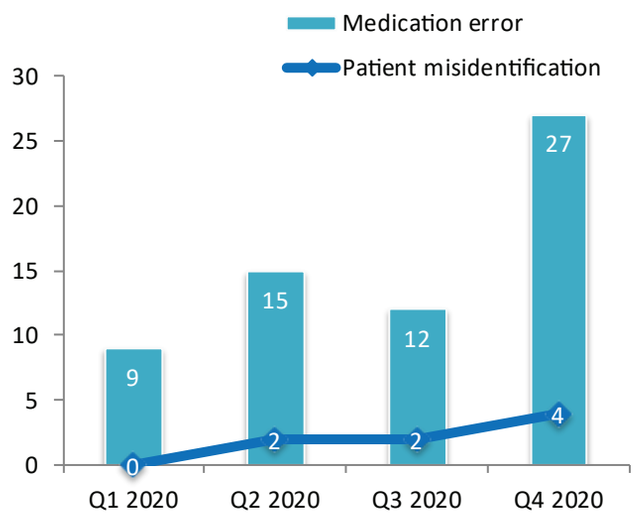
Dr W Y SO
Hospital Chief Executive (BBH/SCH/SH)

SE & SUE Statistics

Distribution of SE in the last four quarters



Distribution of SUE in the last four quarters



Sentinel Events

Retained Instruments / Material

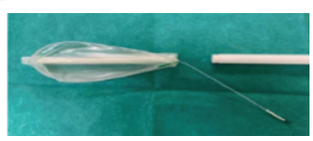
Endobags

Case 1

- A patient with phaeochromocytoma underwent laparoscopic LEFT adrenalectomy.
- An Endobag was inserted in the midst of scrub nurse handover, which detected a missing Raytec gauze.
- In an effort to search for the gauze and to achieve haemostasis, the patient had to be repositioned.
- A second Endobag was inadvertently deployed when the 8.8 by 6 cm vascular tumour was finally ready for removal.
- Patient was discharged home and later attended the Accident & Emergency Department for abdominal discomfort. Incisional hernia was suspected.
- CT scan of the abdomen revealed a retained foreign body.
- An operation was performed to remove the retained Endobag.

Case 2

- A patient with pancreatic cancer was admitted for operation.
- The gallbladder was resected first and placed in an Endobag inside patient's abdominal cavity.
- Due to extensive operation, patient had to be repositioned.
- At the end of the surgery, only the pancreatic tumour was sent for histology test while the gallbladder specimen remained in-situ.
- The Endobag inside the patient's abdominal cavity was not included in the nurse handover process, nor at the final counting as it was not an 'accountable item'.
- Upon review of the surgical specimen post-operatively, the gallbladder specimen was not found.
- X-ray revealed the retained Endobag, which was removed by a second operation.



Why did they happen?

- Both patients were repositioned during surgery and the Endobags became obscured from operators' view
- Endobag was not included as a surgical counting item, nor counted in the nurse handover

What can we do to prevent?

Review counting mechanism and specimen checking process to ensure all accountable items and potential retained or at-risk items including Endobag are included in the surgical counting and nurse handover

Plain Gauze

- A patient was admitted for elective total abdominal hysterectomy and bilateral salpingo-oophorectomy (TAHBSO).
- As part of the pre-operative preparation, a sterile 7 by 7 cm plain gauze was used for vagina swabbing after bladder catheterisation.
- The operation was completed uneventfully and the patient was discharged.
- Patient attended Specialist Out-Patient Department (SOPD) and reported that she had passed a plain gauze through her vagina.

Why did it happen?

Lack of robust gauze counting system for vaginal swabbing before knife-to-skin in TAHBSO

What can we do to prevent?

Adopt a structured team-based approach involving surgeon and nursing staff for gauze counting before and after the procedure of vagina preparation

Guide Wire

- An emergency operation was arranged for a patient with corpus cancer.
- A triple lumen CVC was inserted into the RIGHT internal jugular vein by an anaesthetist.
- The procedure was assisted by circulating nurse A under the supervision of nurse B, who was simultaneously assisting in instrument counting with the scrub nurse.
- Nurse A was called to support another operating room after having prepared the necessary items for the CVC procedure.
- Before completion of the emergency operation, nurse B found that the trolley for the CVC insertion had been set aside and all the sharp items had been cleared. Nurse B assumed that the guide wire had also been disposed of by the anaesthetist.
- Post-operation chest X-ray revealed the guide wire within the lumen of the CVC along the RIGHT internal jugular vein. Guide wire was removed together with the CVC eventually.

Why did it happen?

- The checklist was completed only at the end of the operation, not right after the CVC procedure
- Assumption was made on the status of the guide wire and confirmation was not sought from relevant staff

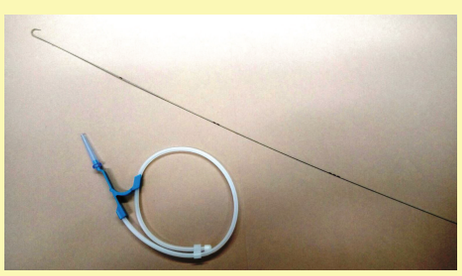
What can we do to prevent?

- Confirm clear visual identification of the guide wire with another responsible clinical staff right after the removal
- Perform and document the counting and checking of sharp instruments and guide wire right after the CVC procedure, not at the end of the operation
- Assign a designated nurse to assist the procedure
- Should designated assistance not be available, proper handover is essential

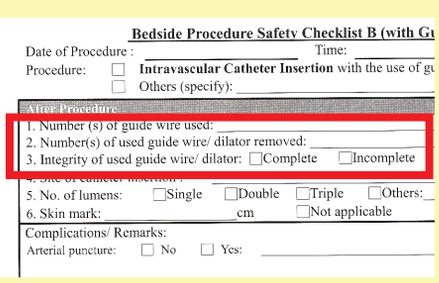
eLC course

Safety Precautions in Central Venous Catheter (CVC) Insertion

CONTROL the guide wire end and ensure it is always VISIBLE while advancing the catheter



CONFIRM the removal of guide wire before connecting to the infusion line



COUNT the number of used guide wire before the end of the procedure

Wrong Patient / Part

Laser Therapy Performed on the Wrong Eye

- A patient attended for LEFT eye laser therapy.
- Site marking with the letter 'L' was made by a nurse on the skin around 1 cm temporal to the lateral canthus.
- Laser premedication including topical anaesthetic was applied to the patient's LEFT eye.
- Lights were turned off in the procedure room during laser use. The macula laser lens was put over patient's RIGHT eye instead and a few shots of subthreshold laser were delivered by the doctor.
- Doctor realised the error and stopped the procedure immediately. Both eyes were checked.
- Procedure proceeded subsequently on the LEFT eye.
- Upon follow-up, no observable damage or problem was detected.

Why did it happen?

- The surgeon was not involved in the process of site marking
- Patient's correct site was not doubly checked before the laser therapy
- Having the laser goggles on in an unlit operating theatre had impaired staff's vision

What can we do to prevent?

- Involve the surgeon in site marking for patient
- Communicate with patient actively throughout the procedure
- Dim down the lights instead of turning off all lights to maintain adequate working visibility

Medication Error

Wrong Dose of Warfarin Prescribed to an Out-patient

- A patient attended medical follow-up for atrial fibrillation. The latest blood International Normalised Ratio (INR) was 3.3, slightly above the target therapeutic range of 2.0 – 3.0.
- The doctor intended to reduce Warfarin from '1.5 mg and 2 mg on alternate days' to '1.5 mg four times a week and 2 mg three times a week'.
- Doctor explained to patient that the new warfarin regime would have the lower dose of 1.5 mg increased from an average of 3.5 days to 4 days per week.
- Having said that, the doctor transcribed the figures of '3.5' and '4' into the dosage of Warfarin, and mistakenly prescribed Warfarin 3.5 mg four times per week and 4 mg three times per week for 14 weeks.
- The doctor arranged 2 blood-taking appointments: (i) 1 – 2 weeks after consultation and (ii) 1 week before next follow-up.
- The patient defaulted both appointments. The hospital was subsequently notified of the patient's death 3 weeks after the clinic consultation.

Why did it happen?

- The good practice of rechecking prescription print-out sheet was not performed
- A complicated drug regimen was involved

What can we do to prevent?

- Recheck the print-out of prescription sheet against the old regimen and the intended treatment plan
- Enhance the counseling service for patients who are taking warfarin (e.g. Protocol driven Anticoagulation Clinic supported by trained pharmacists or nurses)

Inpatient Suicide

In Q4 2020, two female patients (aged 60 and 74) had committed suicide: one by knife and one by jumping from height during home leave.

Case 1

- A patient was diagnosed with recurrent breast cancer in 2019 and was given palliative target therapy, hormonal therapy and chemotherapy.
- The patient was being cared for by two hospitals.
- Throughout the 10 weeks of hospitalisation, patient was repeatedly assessed by clinical psychologist and medical social worker (MSW) and no suicidal ideation was detected.
- Patient was found unresponsive one day and subsequently succumbed.
- Staff discovered a knife stuck at patient's LEFT chest wall during care after death.

Case 2

- A patient with history of lung cancer and inoperable pancreatic cancer was admitted to surgical ward due to duodenal stent obstruction.
- Suicidal risk assessment detected no suicidal ideation.
- However, the clinical team noticed that the patient had low mood and referred the patient to clinical psychologist. Supportive psychotherapy was provided.
- Patient was also referred to multi-disciplinary team including MSW, pain team, hospice care and dietitian for holistic care.
- Patient requested for home leave due to personal affairs and the leave was granted by the doctor.
- Patient left the ward accompanied by her son and was found missing about an hour later.
- Patient was found to have jumped from height afterwards.

Conclusion

- Both patients concealed their suicidal ideation and plan
- The overall assessment, treatment, management plan, including physical and psycho-social domains, provided to both patients were deemed appropriate and in line with standards of care

Maternal Morbidity

Maternal Death after Spontaneous Vaginal Delivery

- A lady was admitted for induction of labour at the 40th week of gestation and a baby was delivered.
- Uncontrolled primary postpartum haemorrhage occurred and emergency operation was planned.
- Patient developed cardiac arrest before operation and was certified dead despite active resuscitation.

Conclusion

- The overall management offered to the patient was timely and in line with standards of care

Wrong Laser Mode used in Macular Laser Treatment

- A patient with history of diabetes mellitus and hypertension was followed up at eye clinic for diabetic retinopathy and maculopathy. A series of macular laser treatment was arranged for the patient.
- In the second macular laser treatment, the doctor planned to perform subthreshold micropulse grid laser to patient's RIGHT eye.
- However, the micropulse function was not activated prior to treatment and 10 shots of conventional grid laser were given instead.
- The error was spotted after 2 seconds, when whitish laser marks were seen at the macula.
- The patient's visual acuity of RIGHT eye remained unchanged though increased macular edema was noted. Sub-tenon injection of steroid and oral non-steroidal anti-inflammatory drugs (NSAID) were given.

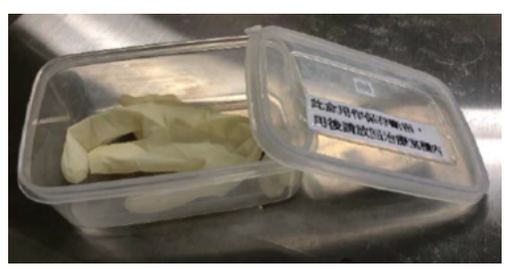
Why did it happen?

- Suboptimal ergonomics in the setting of the laser room increased the risk of concentration lapse
- No cross-checking system of the procedure was in place

What can we do to prevent?

- Explore means to improve the ergonomics in the laser room
- Review and refine laser preset program
- Introduce safety redundancy to reduce single point of failure

Misplaced Patient's Amputated Index Finger



- A patient was admitted for LEFT index finger amputation and multiple lacerations over LEFT hand, after being injured by an electric saw.
- An emergency operation was arranged for the patient. The amputated LEFT index finger was placed in a designated plastic box with ice in water and brought to the operating theatre (OT).
- The finger was taken out from the plastic box by a surgeon for bench work under the microscope. After completion of the bench work, the surgeon wrapped the amputated finger with a sterile glove and replaced it in the plastic box on the consumable trolley with declaration made.
- The amputated finger was later found missing and was finally found in a domestic waste bag designated in the OT scrub room after a search of 3 hours.

Why did it happen?

- The amputated finger was wrapped in a non-transparent glove with no standardised handling practice
- Ineffective communication about the amputated finger in multiple handover during the operation
- Lack of awareness to confine accountable item within OT

What can we do to prevent?

- Use transparent bag for storage of amputated limb inside OT
- Standardise perioperative documentation and checking system of amputated limb
- Strengthen clinical handover system to ensure correct handover of critical information for continuity of patient care
- Reinforce correct handling of accountable items within OT

Severe Hyperkalaemia

- A patient with history of diffuse large B cell lymphoma was admitted for unresolved pneumonia and transferred to Intensive Care Unit due to acute respiratory failure.
- Upon stabilisation, patient was discharged to general ward. Blood was taken 4.5 hours after the doctor ordered a renal function test (RFT).
- Blockage of nasogastric (NG) tube was noted but insertion of a new one failed. Scheduled feeding was skipped.
- Nurse received the alert of serum potassium (K) 7.5 mmol/L at night and informed on-call doctor.
- Patient was promptly given treatment including dextrose-insulin (DI) infusion, calcium gluconate and resonium C.
- Second result came back with another alert of K 6.7 mmol/L but repeat DI infusion was administered only 2 hours after the alert and calcium gluconate around 6.5 hours, due to blockage of venous access and failure to reinsert a new one.
- Third round of blood tests was ordered in the next morning but blood was taken about 8.5 hours later due to difficulty in blood sampling.
- NG tube reinsertion and setting a new peripheral venous access were performed successfully in the afternoon.
- Patient was later found unarousable and pulseless. Patient succumbed despite resuscitation and the case was referred to Coroner.
- An alert of K 8.4 mmol/L was received during resuscitation.

Why did it happen?

- Alert was not escalated when difficulties in management were encountered
- Service delivery was delayed in the management of hyperkalaemia, feeding, intravenous fluid administration and blood collection
- Inadequate supervision and communication between different disciplines

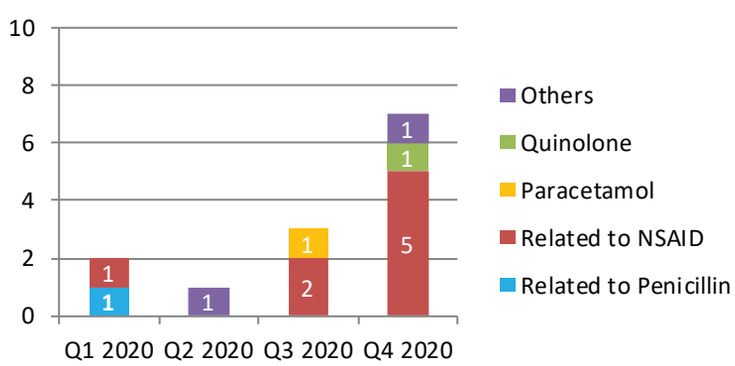
What can we do to prevent?

- Provide training on escalation mechanism to seek senior support among doctors and nurses
- Enhance clinical supervision on implementation of doctors' orders and follow up on patient's response to treatment
- Reinforce teaching and supervision to all doctors and nurses on clinical care of hyperkalaemia
- Enhance communication among staff, by strengthening clinical handover among doctors, exploring possibility of joint case doctor and case nurse ward round, especially on critical cases

Serious Untoward Events

Of the 31 SUE cases reported in Q4 2020, 27 cases were related to medication error and 4 were patient misidentification. Out of medication error cases, known drug allergy (KDA) (7), dangerous drugs (5), anticoagulant (1), insulin (3), oral hypoglycemic agents (2), sedative agent (1), vasopressors & inotropes (1) and others (7) were involved. Allergic reaction developed in 3 of the known drug allergy cases, which subsided after treatment.

Known Allergy	Allergen prescribed
Quinolone	Levofloxacin
Ibuprofen	Diclofenac
Diclofenac	Aspirin
NSAID	Ketorolac
NSAID	Diclofenac
NSAID	Aspirin
Lignocaine	Lignocaine



Number of KDA cases in the last four quarters

Patient Misidentification

Related to Medication

Nurse A prepared medications for Patient Y but scanned the bracelet of patient X before drug administration. However, the 'unmatched patient notice' on the scanner screen was not checked for confirmation. Patient Y's medications were given to patient X.

Lesson learned

Remember to check for patient's correct ID by verifying:

1. Message on the scanner screen AND
2. Patient's bracelet / patient's verbal confirmation

Related to Procedure

Case 1

- Patient X was called for treatment by Radiation Therapist via intercom but patient Y responded to the call.
- Two Radiation Therapists approached patient Y with Patient X's treatment record on hand and performed pre-intervention check.
- Patient Y provided own HKID number before being asked. Both therapists did not clarify the ID number nor the patient's name.
- Patient Y subsequently received one fraction of radiation treatment, which was supposedly patient X's treatment plan.

Case 2

- Patient X with suspected recurrent pyogenic cholangitis was admitted for endoscopic ultrasound (EUS) of biliary system in the endoscopy centre. Patient Y with suspected pancreatic mass was admitted for EUS and fine needle aspiration biopsy (FNAB) of the pancreatic head.
- While patient X was being transferred to the procedure room, doctor A accidentally logged onto the profile of patient Y in the Clinical Management System (CMS).
- Doctor B performed 'TIME OUT' with a nurse against the consent form ('EUS'), bracelet of patient X and 'Patient Safety Checklist for Endoscopic Procedures', without verifying that patient X was not consented for 'FNAB'.
- EUS and FNAB of pancreatic lesion (supposedly patient Y's treatment plan) was performed on patient X, instead of just EUS biliary system (patient X's treatment plan).

Case 3

- An emergency caesarean section was booked for a patient. The nurse noted there were not enough patient labels in the folder while preparing the documents for operation.
- The nurse left the delivery suite without taking any reference document and went to the nursing station to print patient labels. The nurse wrongly selected the profile of another patient in the CMS.
- Incorrect patient labels were affixed onto the consent form, anaesthesia assessment record and other documents related to the operation.
- Consent forms for operation and general anaesthesia were signed without checking the patient labels.
- The operation was completed and the incident was discovered when medical records were checked in the recovery suite.

Lesson learned

Check patient's name and ID BEFORE procedure AGAINST ALL documents including

1. Labels on paper documents such as consent forms and checklists
2. Name and HKID on electronic record