# RISK ALERT

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A Risk Management Newsletter for Hospital Authority Healthcare Professionals


IN THIS ISSUE



## OPENING MESSAGE

### *Translating Joy in Work to Better Patient Care*

While our healthcare system is facing huge demands from the ageing population, we also face the worldwide issue of manpower shortage and high turnover of healthcare workers. To save our healthcare workers from burnout and disengagement, the Institute for Healthcare Improvement (IHI) believes an important part of the solution is to focus on restoring joy to the healthcare workforce. There is ample scientific evidence that a joyful and engaged workforce is associated with safer patient care; fewer medical errors and better patient experience; less waste; higher employee productivity and reduced staff turnover.

What can we do then? "Joy in work" is not just a slogan. It is a consequence of synergism of management behaviour, system design, communication patterns, operating values and technical support. To restore, foster and nurture joy in our healthcare workforce, IHI advocates leaders to take four steps to find a path forward. The very first step is to ask staff, "What matters to you?". This is to engage colleagues to identify what matters to them in their work. Of course, leaders have to genuinely listen to their answers to identify what brings, or deprives, joy in work for staff. While leaders would not be able to solve all the issues with a magic wand, an open conversation can create a sense of "we are in this together." More importantly, leaders should not stop after listening from staff but should also enable feedbacks to be acted upon and remove the barriers to joy in work, in particular those at the system level, according to their urgency and priority.

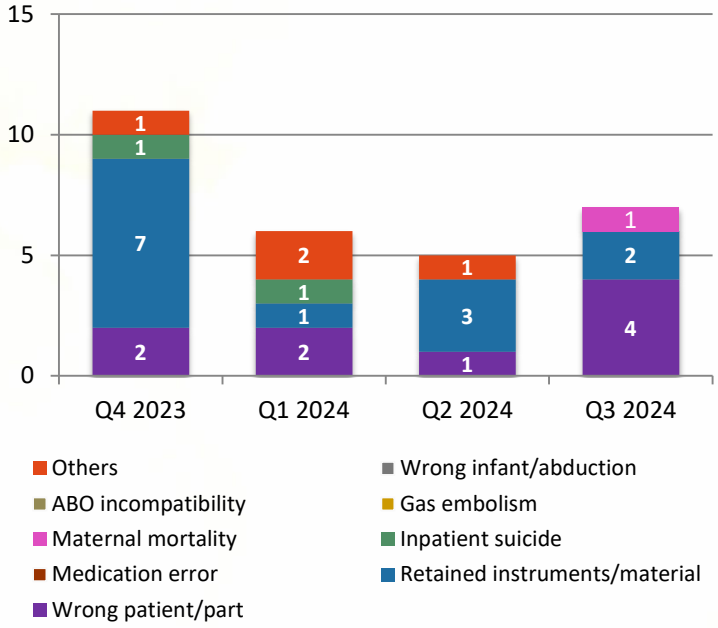
Joy in work in healthcare translates to safer patient care and better patient experience. By committing to fostering joy in work with a system approach at all levels of the organisation, we can co-create with our colleagues a thriving organisation that benefits both healthcare workers and the people they serve.

**Dr Eric CHEUNG**

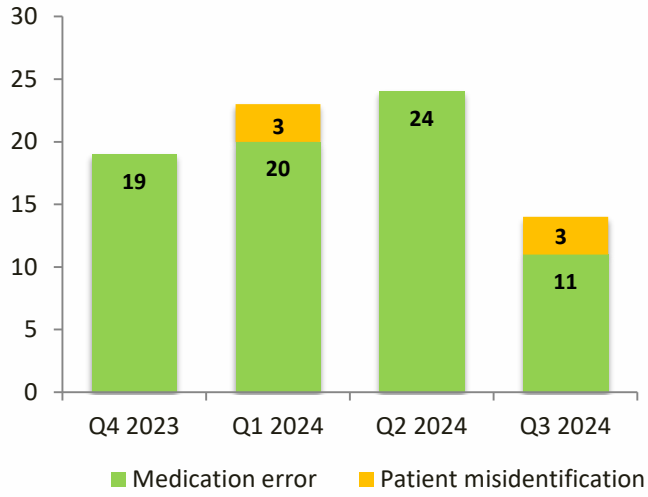
**Cluster Chief Executive, Kowloon Central Cluster**

# SE & SUE STATISTICS

## Number and distribution of SE in the last four quarters




## Number and distribution of SUE in the last four quarters




# SENTINEL EVENTS

## Wrong Patient/Body Part

### Local anaesthetic (LA) was injected to the patient's left middle finger instead of the affected left ring finger

A patient presented to the Accident & Emergency Department (A&E) with a splinter embedded in the left **RING finger,** specifically on the palmar aspect of the distal phalanx tip. The doctor ordered a "Foreign body exploration and removal" procedure, and a consent form was signed.

During the procedure, the patient was positioned with the **palm facing upward**. After confirming the site of the foreign body with the patient, the doctor placed a surgical drape with an opening exposing the left **RING finger**.

After preparing Lignocaine, the doctor decided to inject it over the dorsal side of the fingers. The doctor removed the sterile drape and asked the patient to turn her **palm downward**. Following the change in position, Lignocaine was inadvertently injected into the left **MIDDLE finger** instead of the intended **RING finger**.


### *Learning Points*

1. Confirm the procedure site with other parties e.g. patient/nurse before the procedure
2. Mark the procedure site with appropriate markings when needed
3. Check patient's clinical notes, consent and clinical condition before procedure/when distractions occur

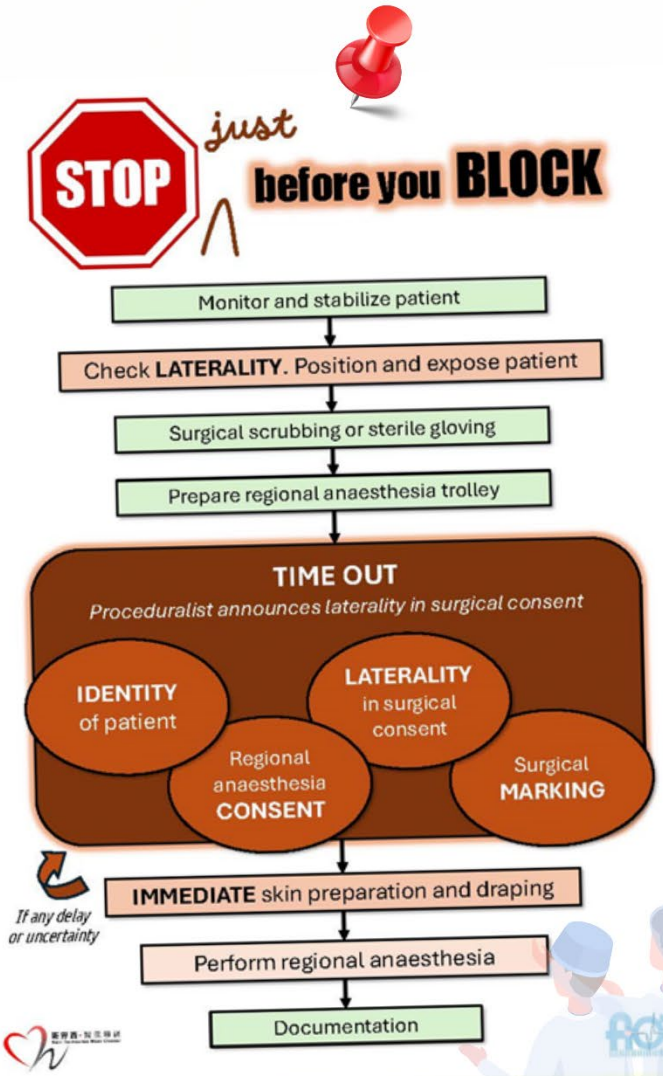
## A nerve block was performed at wrong side

A patient was admitted for an operation to repair **LEFT** inguinal hernia under spinal anaesthesia. The patient agreed to the anaesthetist's suggestion to place an ilioinguinal nerve block for post-operative pain management. Before the operation, SIGN IN was conducted to confirm the surgical procedure, laterality of the operation site and its marking. Spinal anaesthesia was then performed.

During the nerve block procedure, a trolley with materials was placed on the patient's **RIGHT** side, while an ultrasound machine was placed on the **LEFT**. The anaesthetist unintentionally stood on the patient's **RIGHT** side then performed the ilioinguinal nerve block. After the injection, a circulating nurse discovered that the ilioinguinal nerve block was performed at the **RIGHT** side instead of the intended **LEFT** side. After assessing patient's condition and confirming the dosage of medication, another nerve block was placed at the **LEFT** side of patient's lower quadrant area. The operation was uneventful.

### *Learning Points*

1. Reinforce the practice **"Stop before you block"**
2. Use "Pointing and Calling" technique to point to the site for regional anaesthesia and verbally confirm the procedure during "Stop before you block"




Credit: Coordinating Committees (COC) in Anaesthesiology

## A regional block was performed at wrong side

A patient was admitted for a **LEFT** proximal femur valgus osteotomy with a planned **LEFT** regional block for postoperative pain relief. During SIGN IN, the surgical site marking was verified.

During TIME OUT after anaesthesia induction, Doctor A and Nurse B confirmed the surgical site marking at the **LEFT** ankle, with Doctor C not involved in this step. Subsequently, Doctor A and Doctor C inserted an arterial line on the patient's **RIGHT** side. Doctor A secured the arterial line and Doctor C began preparing the patient's **RIGHT** groin for the regional block. Despite noticing the discrepancy, Nurse B did not promptly address the incorrect side preparation. Doctor A, under Doctor C's supervision, then performed a regional block on the **RIGHT** groin. After the completion of the **RIGHT** regional block, Nurse B questioned the absence of a **LEFT** regional block, leading to the discovery of the incident. The patient's right lower limb sensation and power remained unaffected.

### *Learning Points*

1. Include verification of **surgical marking** on TIME OUT checklist for planned regional procedures in the Anaesthesiologist Module of the Clinical Information System
2. Promote a culture of speaking up and open communication

# Wrong Patient/Body Part

## Laser therapy on wrong eye

A patient with diabetic retinopathy underwent panretinal photocoagulation on the **RIGHT** eye. Eye drops were applied to the patient's **RIGHT** eye. TIME OUT was conducted before the procedure. However, the doctor performed laser therapy on the **LEFT** eye. The error was noticed shortly after the procedure began. Laser therapy was then correctly administered to the **RIGHT** eye. Following an examination, it was confirmed that neither eye had sustained damage.

### *Learning Point*

Enhance vigilance in **TIME OUT** on the correct side by:

- Strengthen the process of verifying the operation **site marking**

# Retained Material

## Paraffin Gauze

A patient was admitted to Hospital X for right testicular pain, and underwent exploration of the scrotum and bilateral orchidopexy. He later developed a scrotal wound infection and underwent orchidectomy with incision and drainage. One ribbon gauze was packed into each scrotal wound, and the **left testis was covered with paraffin gauze**.

Post-surgery, the patient complained of groin pain. The surgeon replaced the two ribbon gauzes but left the original paraffin gauze in the left scrotum, documenting that **"all dressings were removed and two ribbon gauzes were replaced"**. The recovery room nurse verified with the surgeon and documented in the perioperative nursing record that **"one paraffin gauze still remained in the wound"**. Despite this, ward nurses replaced only the ribbon gauzes during daily dressing without noting the paraffin gauze. The patient was discharged for daily dressing at General Out-patient Clinic.

An ultrasound report from Hospital X and a subsequent ultrasound during the patient's later admission to Hospital Z both suggested suspected surgical material in left scrotum. The urology teams at both hospitals opted not to proceed with further wound exploration and recommended follow-up as planned.

Two months after the operation, the patient noticed discharge from the scrotum and self-punctured it, observing whitish material from the wound. Bedside exploration retrieved two pieces of **fragmented paraffin gauze** (Figure 1) from the scrotal wound.

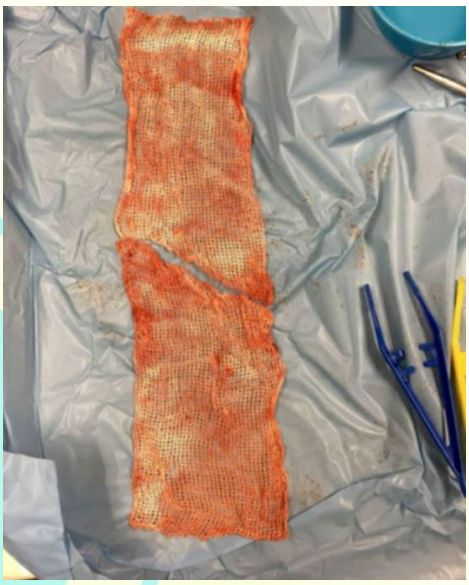


Figure 1. 6cm x 7.5cm and 18.5cm x 7.5cm fragmented gauzes

### *Learning Points*

1. Avoid using **paraffin gauze packing** in deep cavities
2. Keep all packing materials with **3cm tails** leaving at skin level
3. Reinforce accurate packing information on **operation record** by surgeon
4. Reinforce ward nurses to review **perioperative nursing record**
5. Reinforce alertness of suspected surgical material retention on ultrasound report

# Retained Material

## Metal Debris

A patient was admitted for a fracture of the right distal radius and ulna. She underwent open reduction and fixation. The operation was uneventful. The integrity of all instruments was checked both preoperatively and postoperatively and confirmed to be intact. An intraoperative X-ray did not reveal any foreign bodies. However, a postoperative X-ray showed a tiny radiopaque focus in the metaphyseal region, which was suspected to be a retained fragment from K-wire (Figure 2). The patient opted for conservative treatment after discussion.

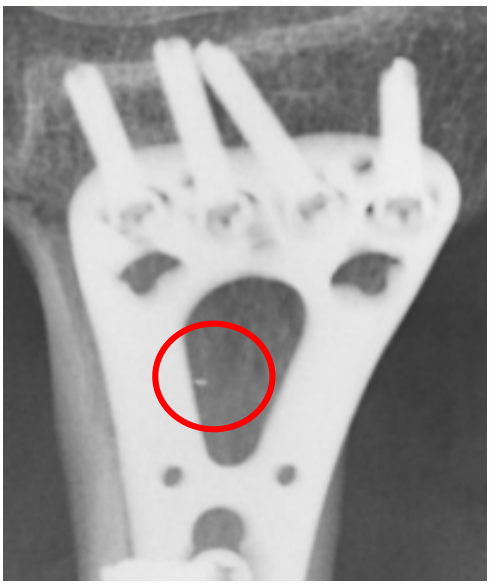


Figure 2. Retained fragment

### *Learning Point*

1. Reinforce staff alertness of the possibility of fragment detachment from K-wires during operation

# Maternal Mortality

## Maternal Death with Massive Pulmonary Embolism and Delivery of a Complete Hydatidiform Mole and Male Stillbirth

A woman at approximately 24 weeks of gestation, without prior antenatal checkups, arrived in critical condition at the A&E. She presented with tachycardia and hypertension and was classified as a Category 1 case. Emergency management was initiated, and she was diagnosed with suspected preeclampsia and per vaginal bleeding, along with uncertain fetal viability.

Intrauterine death (IUD) was confirmed at the delivery suite. A normal vaginal delivery was performed and a fresh fetus with no signs of life at birth was delivered. However, placental separation was noted, and emergency manual removal of the placenta was performed in the operating theatre.

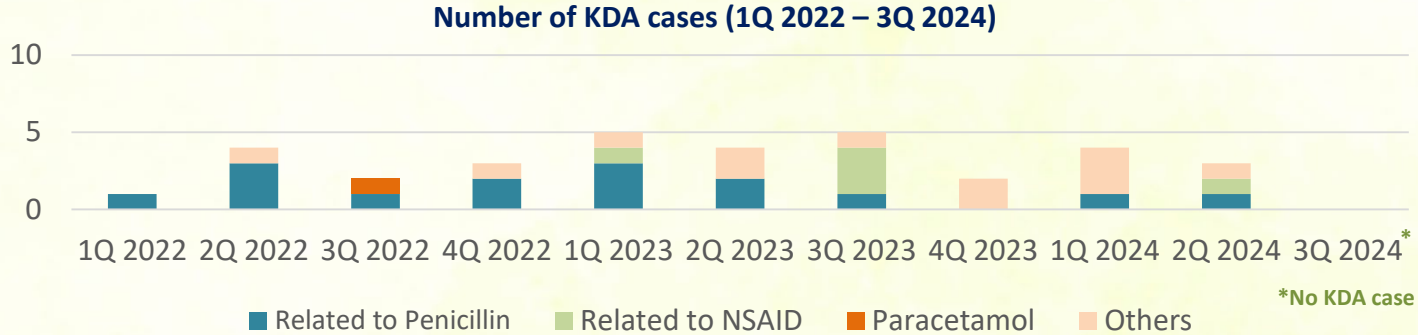
During the procedure, the woman experienced cardiac arrest and active resuscitation efforts were undertaken. An echocardiogram revealed a large mass in the right ventricle, and thrombolysis was administered. Despite intensive resuscitation efforts, the woman succumbed. The final diagnosis was massive pulmonary embolism, twin pregnancy with a complete hydatidiform mole, and a male stillbirth.

### *Concluding Remark*

1. After reviewing the case, the review panel concluded that the patient received timely management and appropriate treatment

# SERIOUS UNTOWARD EVENTS

Of the 14 SUE cases reported in 3Q 2024, 11 cases were related to medication errors, including anticoagulants (2), dangerous drugs (3), vasopressors and inotropes (3), insulin (2) and others (1).



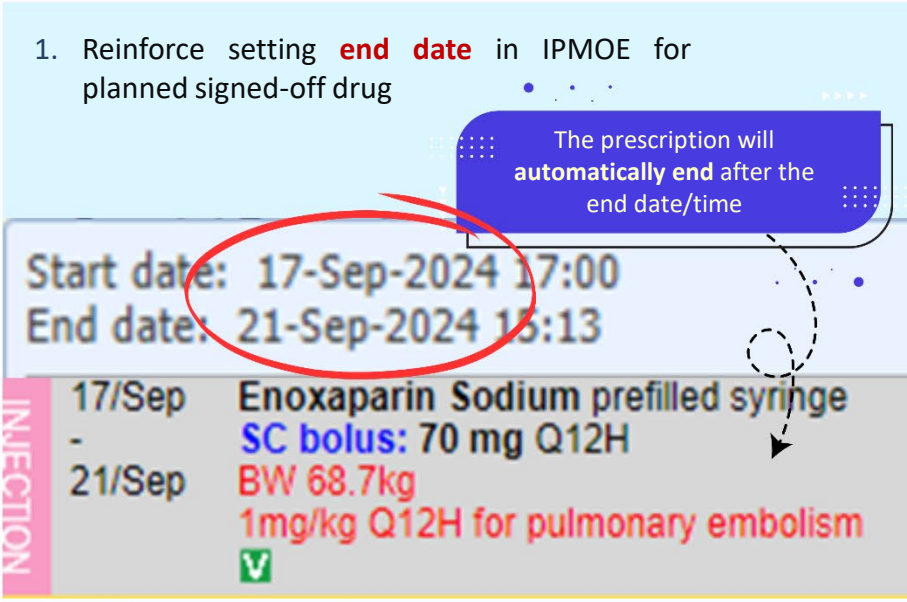
## Enoxaparin and Tinzaparin were administered simultaneously

A patient with a history of pancreatic cancer was admitted to the oncology ward for pulmonary embolism and prescribed Enoxaparin. To facilitate the planned discharge on 21 Sep 2024, the case doctor decided to **switch Enoxaparin 70 mg every 12 hours to Tinzaparin 12000 axa IU every 24 hours**. The plan was written clearly on the clinical management sheet and Tinzaparin was ordered in In-patient Medication Order Entry (IPMOE) with a start date of 21 Sep 2024. However, the **end date for Enoxaparin was not set in IPMOE**.

Both Enoxaparin and Tinzaparin were subsequently administered to the patient, as the co-existence of these two low molecular weight heparins (LMWH) was not identified during both the drug verification and administration processes.

### *Learning Point*

1. Reinforce setting **end date** in IPMOE for planned signed-off drug

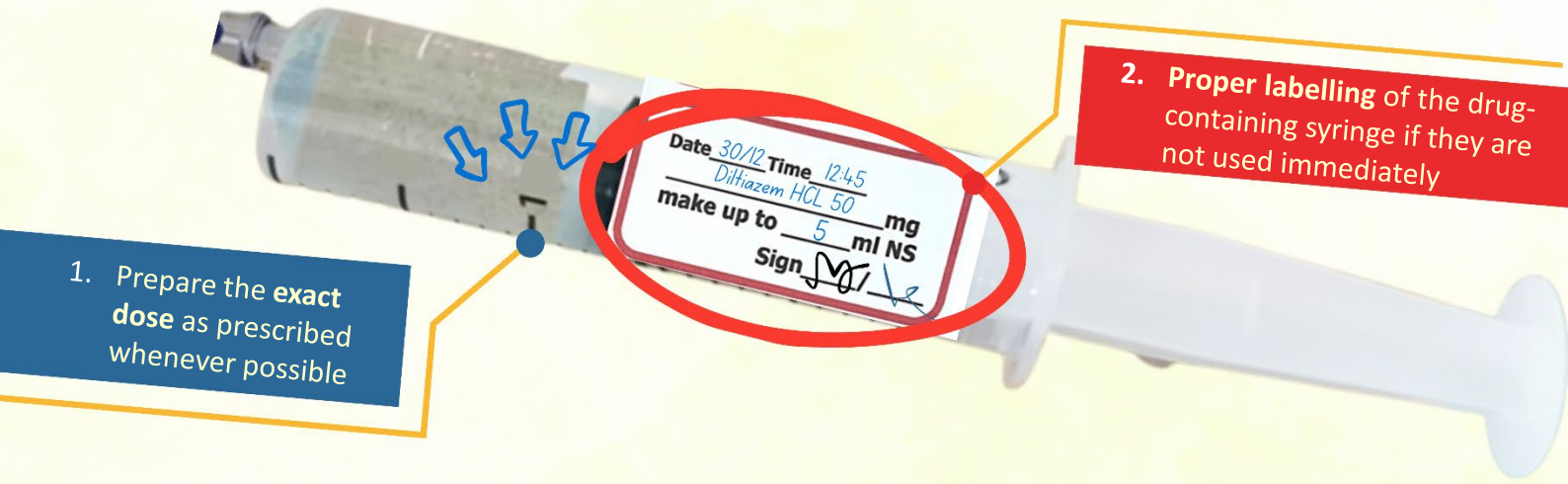



## Patient received IV Diltiazem HCL 50mg instead of the prescribed 10mg

A patient was admitted for pneumonia and placed on high flow oxygen. Later, the patient developed persistent tachycardia. Diltiazem HCL 10mg intravenously was prescribed.

Nurse X and Nurse Y checked the prescription and diluted a 50 mg vial of Diltiazem HCL with 5ml of water for injection. The entire 50mg (5ml) solution in the syringe was placed in an injection tray, but the syringe was not labelled. Doctor checked the unlabelled syringe in the injection tray against the IPMOE prescription. Nurse X reminded the doctor to inject only **10mg (1ml)** of Diltiazem HCL. However, **50mg (5ml)** of Diltiazem HCL was injected instead of the intended **10mg (1ml)**.

### *Learning Points*

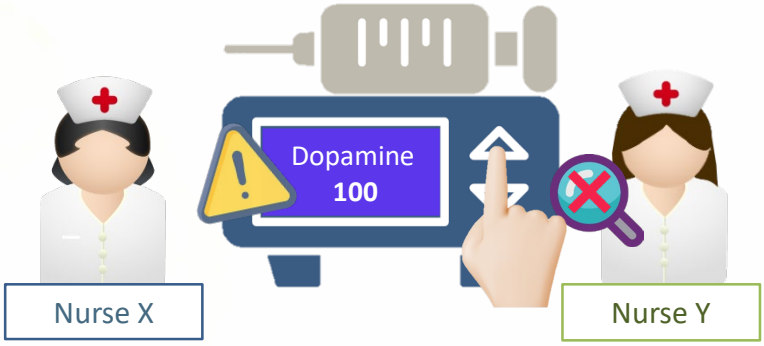


# Infusion Errors

## Wrong Dopamine infusion rate for a patient

- A patient was admitted with abdominal pain, fever and shock.
- As the patient's blood pressure (BP) remained low, **Dopamine 200mg in 100ml Normal Saline was prescribed with infusion rate 10ml/hour** and CT scan was ordered.

1

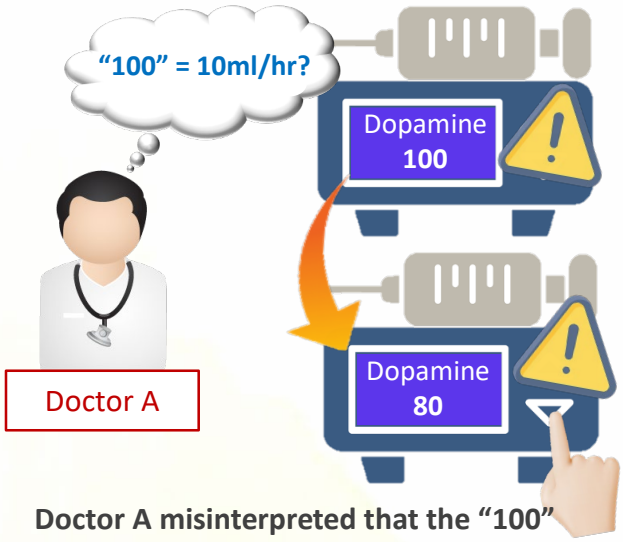



**Nurse X inadvertently set the infusion rate as 100ml/hr**

**Nurse Y did not counter-check the infusion rate**

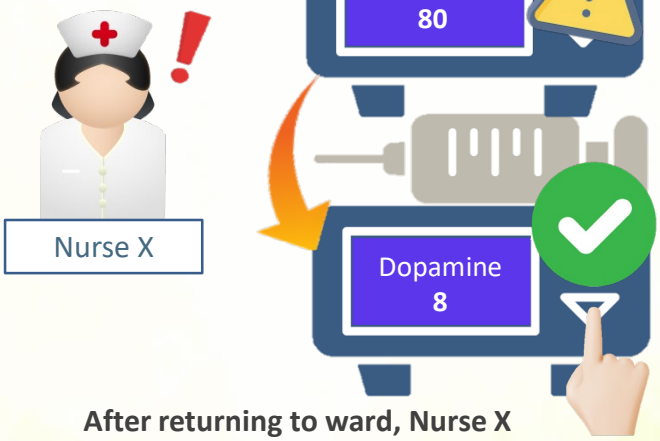
2

- The patient was transferred to CT suite
- As patient's heart rate shot up to 160 bpm, Doctor A intended to decrease the infusion rate to **8ml/hr**




**Doctor A misinterpreted that the "100" displayed on the pump indicated "10ml/hr and adjusted it to "80ml/hr"**

3




**After returning to ward, Nurse X corrected the infusion rate to 8ml/hr**

4

- At that time, the patient's BP was 126/66 mmHg, and the heart rate was 137 bpm. Extra dose of 65.67mg (32.83ml) of Dopamine was given
- The patient's condition was stable

## *Learning Points*

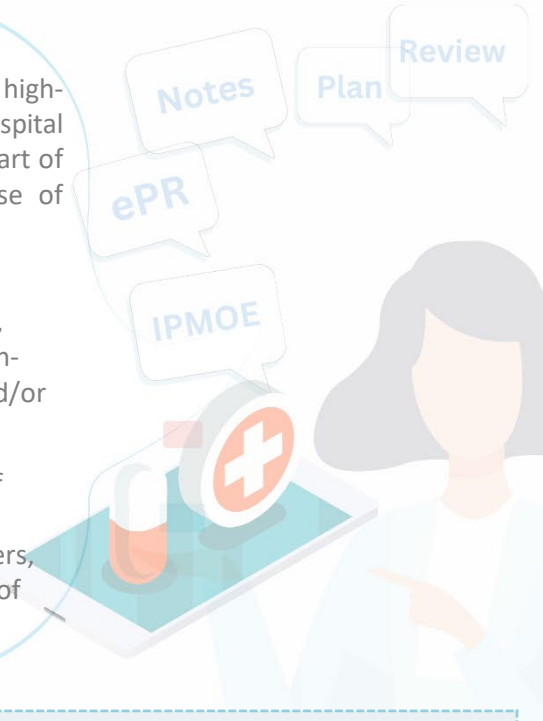
1. Reinforce staff compliance with **independently checking** medications
2. Conduct regular, mandatory infusion pump refresher training

# Clinical Ward Pharmacy Service to Optimise Patient Care with Discharge Medication Review

Authors: Vincent WONG, Senior Pharmacist, QMH and William CHUI, Chief Pharmacist, HAHO

## Clinical Ward Pharmacy Service

Introduced in 2021, Clinical Ward Pharmacy Service provides medication review for high-risk discharge patients in clinical areas of 15 Acute Hospitals, where Queen Mary Hospital is the pioneer of introducing Ward Pharmacy Service in the Hospital Authority. As part of integrated patient care, Clinical Ward Pharmacists ensure safe and effective use of medications at all stages of the medication management pathway.

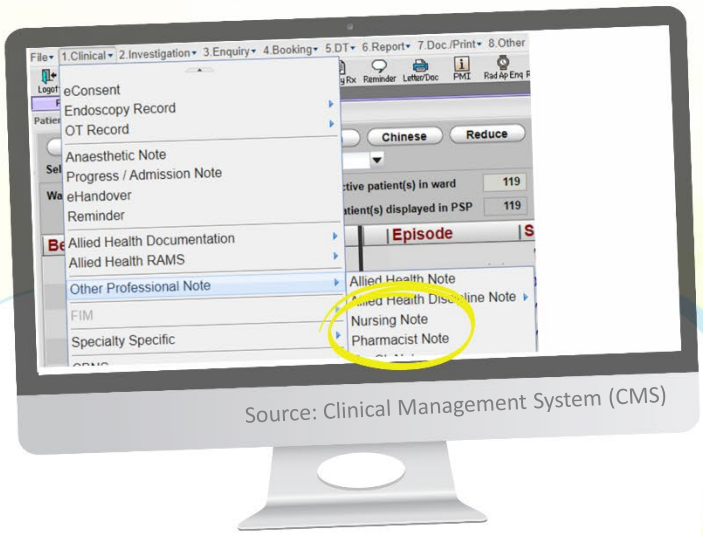



## How Clinical Ward Pharmacists Contribute

**Medication Review** is a systematic process of collecting patient-specific information, assessing medication therapies to identify and develop a prioritized list of medication-related problems, and creating a plan to resolve them with the patient, caregiver and/or prescribers.

As part of Medication Review, **Medication Reconciliation (MedRec)** is the process of creating the most accurate list possible of all medications a patient is taking, and comparing that list against the physician's admission, transfer, and/or discharge orders, with the goal of providing correct medications for the patient at all transition points of care within the hospital.

| Step 1: Facilitate Discharge Prescription | Step 2: Provide Comprehensive Medication Review |
|---|---|
| • Are discharge prescriptions **coherent with** IPMOE profile, recent consultation notes (see Screen Grab below), previous ePR medication records, and Plan of Management on discharge notes?<br>• Should medications **withheld** during hospital stay be **resumed** upon discharge?<br>• Do dispensed medications carry **updated dosing instructions** and **suffice** till the next follow-up? | • Is there a current **indication** for all drugs?<br>• Is **guideline-directed medical therapy** in place?<br>• Is **therapeutic duplication** present?<br>• Is **de-prescribing** possible (especially for PRN drugs)?<br>• Is all necessary **monitoring** carried out?<br>• Is **dosing schedule** appropriate?<br>• Are dispensed **drug quantities** and **duration** appropriate and synchronised? |




Source: Clinical Management System (CMS)

Review recent **consultation notes**, including **Pharmacist and Nursing Note** under "Other Professional Note", to identify any change or discrepancy of medication regimen

## Clinical Ward Pharmacists' Sharing on Medication Review Tips for Discharge Patients

- **Antihypertensive**: consider de-prescribing if blood pressure is too low – stop one Antihypertensive at a time if risks outweigh benefits; and restart if blood pressure rises above target
- **Digoxin**: use minimum effective dose upon chronic kidney disease or elderly, due to elevated risks of toxicity
- **Diuretic**: check if Furosemide is used for managing drug-induced side effects, e.g., ankle edema due to Calcium Channel Blockers
- **Anticoagulant**: review concurrent Anticoagulant-Aspirin use, and the duration of overlapping use
- **Insulin**: review prescriptions for duplication of Long-acting Insulin (e.g., Insulin Detemir, Insulin Glargine, Protaphane) and Mixed Insulin (e.g., Mixtard 30/70, NovoMix 30, Ryzodeg, Insulin Degludec)
- **Hepatitis B Antiviral**: ensure patients on long-term steroids (duration > 4 weeks) are prescribed with Hepatitis B Antiviral if Hepatitis B surface antigen (HBs Ag) is positive