



RISK ALERT



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A Risk Management Newsletter for Hospital Authority Healthcare Professionals

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Opening Message

Shifting from “Fixed” to “Growth” Mindset

The book “Mindset: The New Psychology of Success” was first published in 2006 by Professor C. Dweck on the research findings on “growth” versus “fixed” mindsets among individuals and within organisations. In summary, individuals with a **growth mindset** believe their talents can be developed and acquired through effort, practice and learning from setbacks, and thus failure represents an opportunity for improvement. Those with a more **fixed mindset** believe their abilities such as intelligence and talents are innate gifts, and thus a failure indicates a lack of ability. The employees of companies that embrace a **growth mindset** feel more motivated to do their best, work more collaboratively and drive the business for growth and success.

Studies have shown that healthcare workers may experience guilt, shame, fear, loss of confidence, social isolation and deep concerns about their professional skills after undesirable events in the clinical works and thus become the “second victims”.

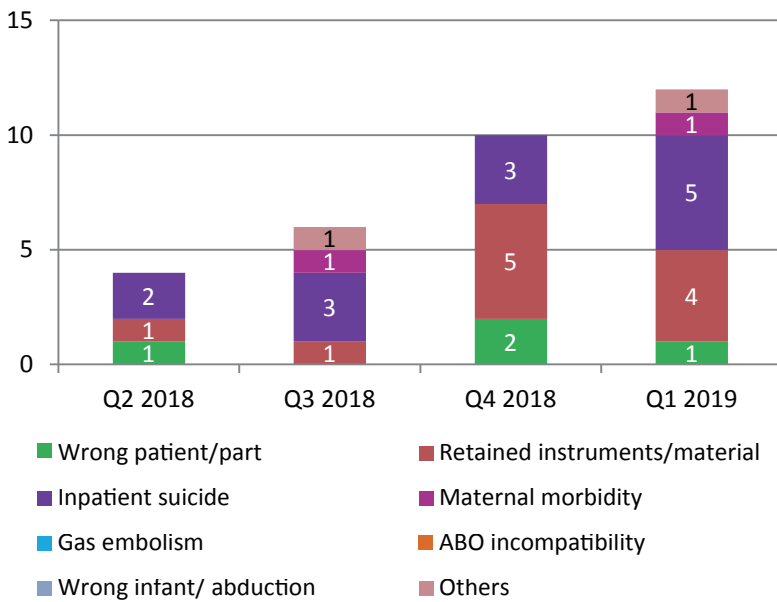
There have been programmes to provide psychological first aid to our healthcare workers in the aftermath of undesirable clinical events. Yet, more attention and effort would be beneficial to encourage the **growth mindset** among the healthcare workers, helping them to develop a resilient response and enabling them to learn and thrive when facing setbacks.

Ways to promote the **growth mindset** include sharing others’ experience of their learning from setbacks, simulation-based training and drills. It is important that a **growth mindset** approach is adopted and supported at an organisational level so that opportunities of improvement can be identified for patient safety and quality of care.

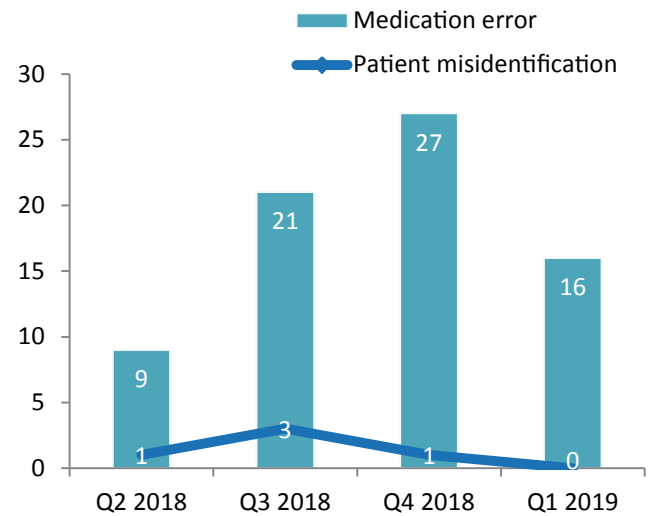


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Distribution of SE in the Last Four Quarters



Distribution of SUE in the Last Four Quarters



Sentinel Events

Wrong Part

Wrong Eye Injection

- A patient had a planned **RIGHT** eye cataract operation under local anaesthesia.
- The operating **RIGHT** eye was marked and was confirmed by the surgeon, and the non-operating **LEFT** eye was covered with gauze according to operating theatre practice.
- 'SIGN IN' and 'TIME OUT' were performed by surgeon, scrub nurse and circulating nurse.
- During local anaesthesia injection, in order to aid the fixation of the patient's operating eye in the correct direction, the **LEFT** eye gauze was flipped up.
- The surgeon injected the local anaesthesia to **LEFT** instead of **RIGHT** eye, with the assistance from a nurse not involved in 'SIGN IN' and 'TIME OUT'.
- The incident of wrong eye injection was noted by circulating nurse who had momentarily turned around.
- The **LEFT** eye was checked with no injury resulted. The patient consented to proceed for **RIGHT** eye operation under local anaesthesia and was discharged the next day.

Key Contributing Factors

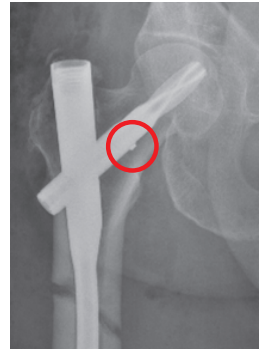
1. The practice of covering non-operating eye with gauze does not safeguard against wrong eye injection.
2. The environmental set up and restraints in the operating theatre led to local anaesthesia injection from the non-operating side.

Recommendations

1. To eliminate the practice of covering the non-operating eye with gauze.
2. To enable ophthalmologists to be stationed at the operating side by environmental enhancement.

Metallic Fragment

- An elderly patient with a displaced fracture of the femur shaft underwent an operation for internal fixation with an intramedullary nail.
- Cannulated reaming was performed to drill holes for blade insertion.
- After blade insertion, intraoperative fluoroscopic X-ray was taken to check implant alignment and position.
- The patient had a sudden drop in blood pressure and required resuscitation.
- All instruments were checked after use prior to completion of the operation.
- Sterile Services Department noted the tip of the blade reamer was broken later that day.
- A suspicious radio-opaque foreign body was seen in the post-operative X-ray image.



Key Contributing Factors

1. Despite checking instrument integrity, the defect was not detected. The patient had a change in condition and required intensive management during instrument check.
2. The blade reamer was an on-loan item from the supplier. The durability of such consignment items could not be ensured.

Recommendation

To allow reasonable time for “stop and check” of high risk instruments (i.e. those that are prone to breakage due to repeated use) before wound closure.

Guide Wire

- A patient with ruptured hepatocellular carcinoma developed shock and required inotropic support and intubation.
- An urgent angiogram and embolisation was arranged. The angiocatheter at the right neck was dislodged before transferal.
- A tri-lumen central venous catheter was inserted at **LEFT** neck under ultrasound guidance, but the inflow of the distal lumen was not smooth despite adjusting the catheter position. The distal lumen was clamped and inotropes were infused via the proximal lumen. The patient was then urgently transferred for angiogram.
- During angiogram, a guide wire was noted within the catheter and was removed.

Key Contributing Factor

Low awareness to remove the guide wire during the procedure, and failure to confirm its removal at the end of the procedure.

Recommendation

To include a mandatory checking point to ensure complete removal of the guide wire before proceeding to the next step such as suturing or connecting the infusion set.

Ribbon Gauze

- A patient requiring dressing for chronic sacral pressure injury was admitted for acute cholecystitis and septicaemia.
- There was no packing material inside the wound during initial wound assessment. One piece of ribbon gauze was packed in the wound.
- During daily wound dressing, one ribbon gauze was removed and a new gauze was packed in the wound.
- On the day of discharge, one piece of ribbon gauze was removed from wound cavity and discarded during assisted shower by healthcare assistant without nursing verification.
- A ribbon gauze was packed in the wound. The patient was then discharged back to residential home.
- During wound dressing by community nursing service on the next day, two pieces of ribbon gauzes were removed from the sacral wound.



Key Contributing Factors

1. Wound assessment, in particular undermining wounds, was suboptimal; appropriate referral to specialty wound nurse was not initiated.
2. Precise description of packing material was not documented.
3. No nurse verified that the ribbon gauze had been removed by the healthcare assistant after assisted bathing.



Recommendations

1. To review the roles and responsibilities of the wound assessor in the department.
2. To include and document the length and size of wound packing materials in the Wound Assessment Record.

Gauze-like Material

- A patient was admitted for rectal bleeding and was diagnosed to have rectal cancer.
- The patient consulted a private surgeon and underwent laparoscopic anterior resection in the private sector, which was complicated with wound infection. The patient stayed in the private hospital for wound management and was discharged 23 days later.
- After discharge from the private hospital, the patient attended various outpatient clinics in HA for follow up and wound dressing.
- After a month of wound care at outpatient clinics, the patient was referred to a HA hospital and was admitted for ongoing wound infection.
- The infected area was laid open at bedside. A piece of 'old half-cut plain gauze' was retrieved. However the gauze was discarded and was not available for further investigation.



Findings

1. The RCA team could not ascertain the specific cause and occasion in which the material was retained.
2. There was a lack of clinical handover between the public and private healthcare sector. There was also communication gaps amongst HA services in regards to wound care documentation.



Recommendations

1. Explore means to improve the communication between the public and private healthcare sectors to facilitate patient referral and flow.
2. Standardisation of the wound management documentation to facilitate communication within HA services.

Maternal Death on Day 4 Post-delivery

- A patient with gestational diabetes was admitted at 36 weeks of pregnancy for vaginal bleeding. The patient had high blood pressure and proteinuria and was diagnosed to have pre-eclampsia toxemia.
- Induction of labour was commenced.
- The patient required a crash lower segment Caesarean section due to severe fetal bradycardia.
- There was severe post-partum haemorrhage which required Bakri balloon insertion and relaparotomy. Intravenous antibiotics were given.
- The patient had fever and tachycardia. Investigations including septic workup were performed and intravenous antibiotics regimen was stepped up.
- Antihypertensive was prescribed for hypertension, and was last given when the blood pressure was 106/65.
- The patient had septic shock on day 4 post-operation, followed by bradycardia and asystole. The patient did not respond to resuscitation and succumbed.
- Post-mortem examination showed that the cause of death was sepsis.

Conclusion

The cause of death was sepsis, which did not appear to be related to or aggravated by labour, delivery or its management.

Inpatient Suicides

In Q1 2019, five patients (all males aged between 29 to 69) with malignancies or chronic illnesses had committed suicide: three by jumping from height away from hospital premises after absconding; one by jumping from height after breaking a window in the ward; one by stabbing in the chest by scissors. The management of these cases were considered appropriate following investigations. The patients' underlying conditions, such as physical discomfort due to terminal illness or psychotic influence due to substance use, could contribute to the incidents.

1

- Patient was admitted for workup of shoulder, hand and back pain. The patient was assessed to be not at risk of suicide on admission.
- Patient was informed of high possibility that he had a Pancoast tumour with metastasis. Further investigation was arranged.
- Patient was later found missing and the ward was informed by police that patient had jumped from height away from hospital premises.

2

- A patient who had metastatic lung cancer was referred for palliative care. Clinical psychologist and palliative home care service were referred.
- During an admission for sub-acute intestinal obstruction, patient was assessed to be not at risk of suicide.
- Patient was calm and did not complain of physical discomfort.
- Patient last responded to staff when he was in the toilet.
- He was found missing later with wristband, pajamas, nasogastric tube and intravenous line left in the toilet.
- Patient's family member was contacted who noted a message from the patient expressing hopelessness earlier in the morning.
- Patient was later found to have jumped from height away from hospital premises.

3

- Patient with benign prostatic hyperplasia was admitted for an elective laser surgery.
- On admission, patient was assessed to be not at risk of suicide.
- Patient was reported to have low mood. Clinical psychologist was referred and came for assessment while the patient was transferred to the operating theatre.
- Patient underwent the operation which was uneventful. His emotion was noted to be stable.
- In the morning of post-operation day 2, patient requested for home leave but was declined.
- Patient was later found missing and the ward was informed by police that patient had jumped from height at home.

4

- Patient had history of alcohol dependence syndrome, substance abuse and drug-induced psychosis, and was admitted for auditory hallucination, attempted suicide and self harm.
- Patient was assigned a bed near the nursing station and was put on hourly suicidal observation.
- Patient was assessed by a psychiatrist and was found to be remorseful and did not want to die. Psychiatrist planned to review patient later and transfer the patient to psychiatric ward after physical condition was stabilised.
- Patient was escorted for computed tomography scan of the brain and cervical spine to rule out injuries.
- Soon after patient returned to ward, nurses heard some banging sounds from the patient's cubicle which was just opposite to the nursing station. Patient was witnessed to have jumped through a broken window in the ward.



Observation

The windows in the ward were constructed up to the HA standards. The glass complied with the Architectural Services Department standard.

5

- A stage IV lung cancer patient with vocal cord palsy had recent tracheal stent insertion and was on palliative chemotherapy.
- After transferal to a convalescent hospital for pain control, the patient was given antibiotics for a chest infection.
The patient had 2 episodes of sputum retention with feelings of near-suffocation, and required transferal to acute hospital for bronchoscopy.
- During his third episode of sputum retention and transferal to the acute hospital, patient was assessed to be not at risk of suicide on admission.
- Two hours after the bronchoscopy which was uneventful, he was found to be unconscious in bed, holding a pair of scissors with four stab wounds on the chest wall. A death note was found on the bedside table.
- Patient suffered from a cardiac arrest and succumbed despite resuscitation.



Observation

Access to a potentially lethal means like scissors brought by family without notifying ward staff, despite family education on admission.

Liver Biopsy on a Patient Receiving Anticoagulation Treatment

- A patient was admitted for severe respiratory failure and necrotising pneumonia.
- Computed Tomography (CT) scan revealed multiple liver abscesses and deep vein thrombosis. A low molecular weight heparin (LMWH) anticoagulant was started.
- In view of persistent elevation of a liver enzyme (alkaline phosphatase), a subspecialty team was consulted and suggested a liver biopsy to rule out bacterial, fungal and mycobacterium infection.
- There was inadequate communication between the consultation team and parent team on performing a liver biopsy. The consultation team noted that the clotting profile was normal, but was not aware that the patient was on LMWH.
- Bedside liver biopsy was performed 2 hours after the last dose of LMWH.
- The patient developed haemorrhagic shock with bleeding from liver. The patient was resuscitated and underwent radiological and surgical haemostatic interventions. The patient further deteriorated and succumbed 3 days later.



Key Contributing Factors

1. Inadequate communication between and parent and consultation team regarding the risk of bleeding for the procedure.
2. There was no prompt for reviewing anticoagulants before the procedure, and the consultation team was preoccupied by the pre-procedural normal clotting profile.



Recommendations

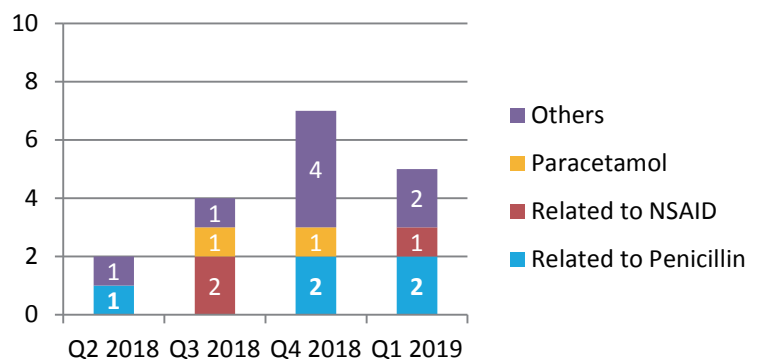
1. To enhance communication between parent team and consultation team, e.g. the recommendation of an invasive procedure by the consultation team and the decision made by the parent team should be well documented in clinical notes.
2. To develop a preparation guide for bedside liver biopsy.
3. To revise the local “Bedside Procedure Safety Checklist” and include checking clotting profile as well as anticoagulant medication before the bedside procedure.



Serious Untoward Events

Of the 16 SUE cases reported in Q1 2019, all were due to medication errors. The medication error cases involved giving known drug allergen (KDA) to patients (5), dangerous drugs (1), anticoagulant (4), insulin (1), concentrated electrolytes (2), vasopressors and inotropes (1) and others (2). One of the known drug allergen cases showed signs of allergic reaction with rash, which subsided after medication.

Known Allergy	Allergen prescribed
Cephalexin	Augmentin
Penicillin	Augmentin
Aspirin	Aspirin
Protaphane	Protaphane
Diltiazem	Diltiazem



Number of KDA Cases in the Last Four Quarters

“Previous IPMOE” Orders

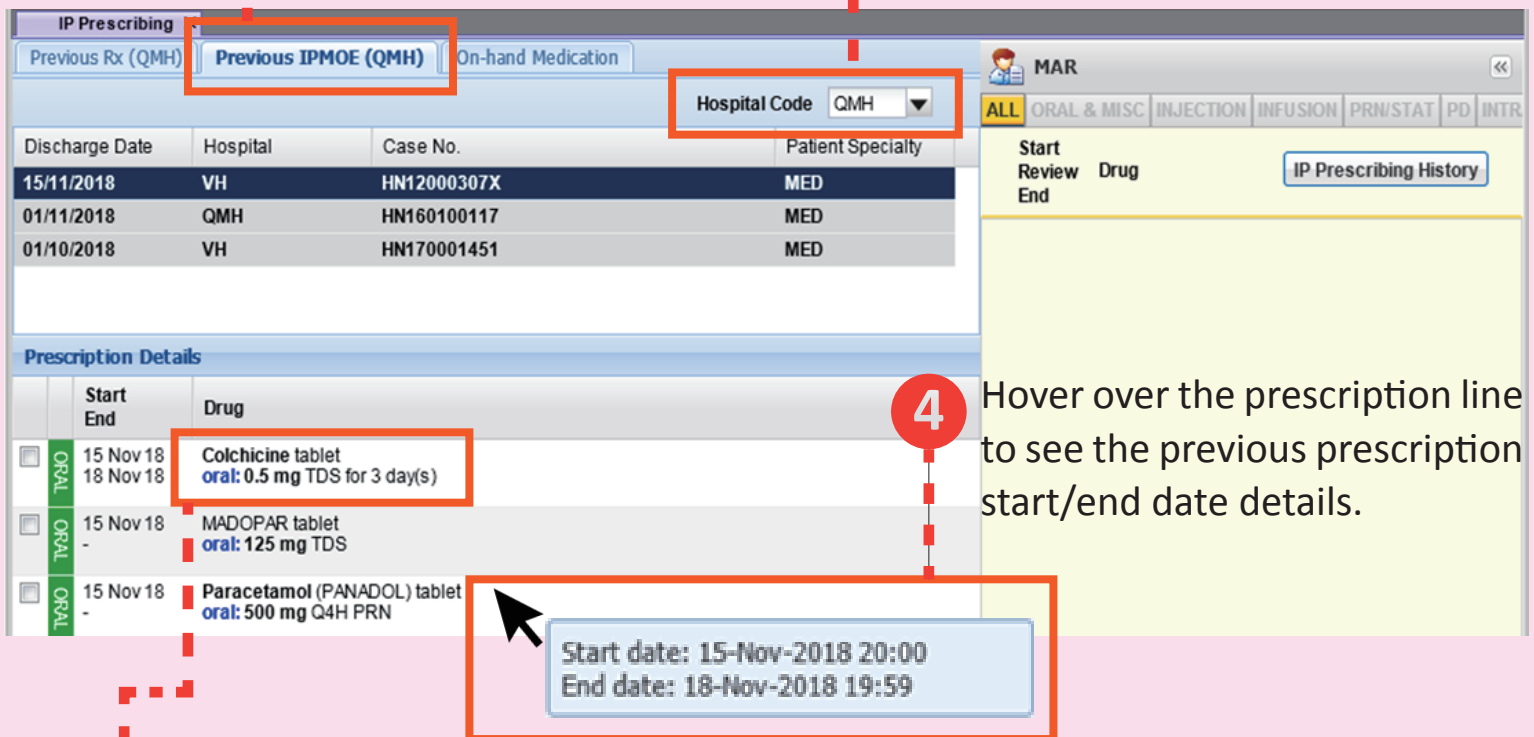
To enable clinicians to review previous prescriptions when handling patient care from acute to non-acute hospital setting, or when a patient is readmitted, an IPMOE feature “Previous IPMOE” was launched in Jan 2019:

- It enables doctors to review patients’ previous in-patient MAR.
- Prescription details, such as conditional dosing & infusion regimen can be reviewed.

Learning Points

1 This feature can be found under [History] > [Previous IPMOE].

2 Switch [Hospital Code] to view and access previous in-patient MAR of the corresponding hospital.



The screenshot shows the IPMOE interface with the following elements:

- IP Prescribing** menu with sub-items: **Previous Rx (QMH)**, **Previous IPMOE (QMH)** (highlighted), and **On-hand Medication**.
- Hospital Code** dropdown menu set to **QMH** (highlighted).
- MAR** (Medication Administration Record) section with tabs: **ALL**, **ORAL & MISC**, **INJECTION**, **INFUSION**, **PRN/STAT**, **PD**, **INTR**.
- Table of Patient History:**

Discharge Date	Hospital	Case No.	Patient Specialty
15/11/2018	VH	HN12000307X	MED
01/11/2018	QMH	HN160100117	MED
01/10/2018	VH	HN170001451	MED
- Prescription Details** section with a table:

Start	End	Drug
15 Nov 18	18 Nov 18	Colchicine tablet oral: 0.5 mg TDS for 3 day(s)
15 Nov 18	-	MADOPAR tablet oral: 125 mg TDS
15 Nov 18	-	Paracetamol (PANADOL) tablet oral: 500 mg Q4H PRN
- Tooltip** for the first prescription line:

Start date: 15-Nov-2018 20:00
End date: 18-Nov-2018 19:59

3 When the previous prescription is added to the MAR of the current episode, the quantity and duration would not be brought forward automatically. Please adjust the prescription quantity and duration with clinical judgement.

4 Hover over the prescription line to see the previous prescription start/end date details.

Acknowledgement: HO Health Informatics IPMOE Team

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Suggestions or feedback are most welcome. Please email us through HA intranet at address: [HO Patient Safety & Risk Management](#)