RISK ALERT

ISSUE 42 JUL 2016
A Risk Management Newsletter for Hospital Authority Healthcare Professionals

IN THIS ISSUE

Risk Mitigation Strategy - Surgical Safety

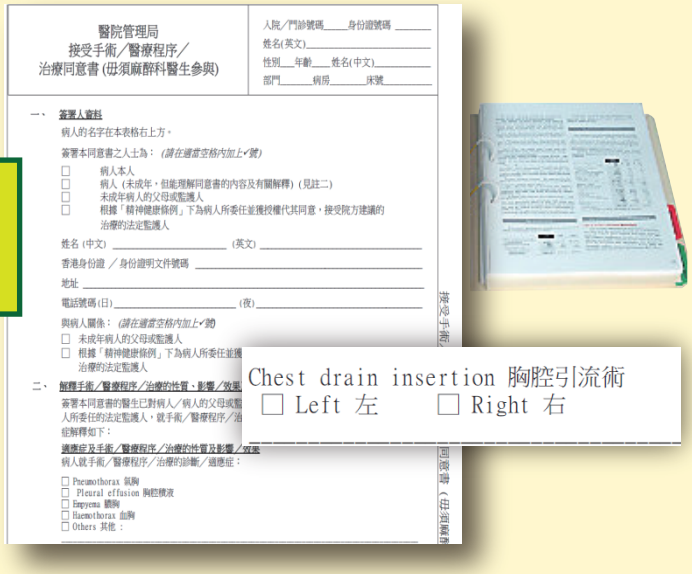
While surgical procedures are intended to save lives, a single incident of wrong site or wrong patient surgery can result in considerable harm.

To reduce the risk, the following essential safety checks should be made before the procedure.

Correct patient, Correct procedure, Correct site

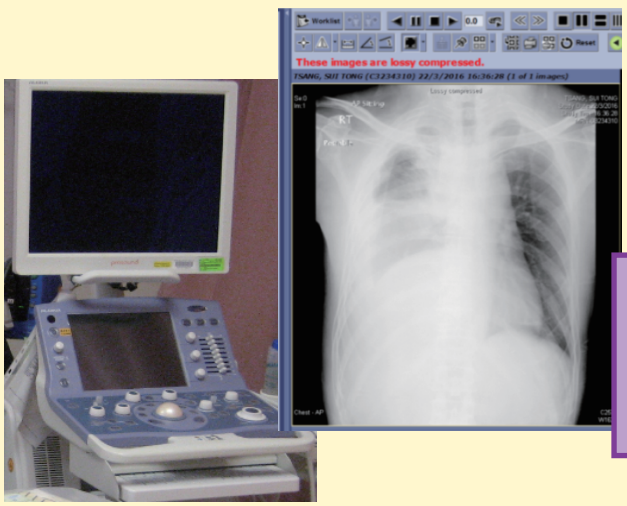
Correct Patient

Ask patient to state identity.
Verify identity against wristband.



Correct Procedure

Check the procedure as stated in the informed consent and medical records.



Correct Site

Confirm site of procedure through various tools and methods, e.g. checklist, site marking, and/or imaging.

Keeping Watch at the Tree

There is a very old Chinese idiom「守株待兔」 (literally "keep watch at the tree awaiting a rabbit") about a silly farmer who gave up his hard work and waited by the tree every day. It happened that he had witnessed a panic-stricken rabbit crash into the tree, killing itself. He had a 'free lunch' and expected more to come his way.

It is not surprising that the idiom originated from a story in the book Han Fei-zi (韓非子, ca. 281–233 B.C.). Han was one of the early legalist philosophers (法家) in China. This school of philosophy believes in rules, active controls, and system of clear rewards and penalties. A capable ruler must govern his people actively - it would not do simply to educate or cultivate them, nor is it a good idea to leave people alone getting on with their daily lives.

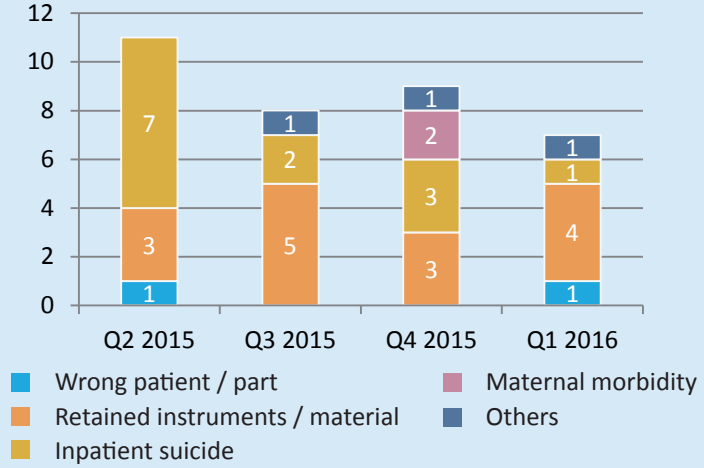
I recently read a poem of the same title (〈守株待兔〉) by a contemporary Hong Kong poet 飲江 (1949-), in which the lesson of the fable is turned upside down. Yes, this was a silly farmer keeping watch at the tree, but he was not waiting for another rabbit to come along and crash to die. In fact, quite the opposite – he was sitting there to alert and warn every rabbit coming this way. "Watch out! Danger! Be careful! You will break your neck running into this tree!" He shouted and shouted.

Being a silly farmer, he didn't really know the nature of rabbits too well. A few rabbits got the message and swiftly avoided the danger. Many other rabbits, scared by the very loud (and incomprehensible) shouting, simply panicked and dashed away to random directions, crashing into other trees and died anyway.

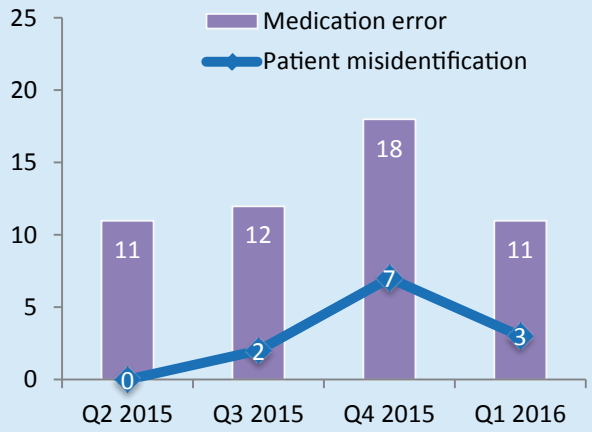
There is more than one way to read a poem, and I leave it to you to interpret in your own way. As I read this I thought of risk alerts. The tree is a common metaphor for an organization such as a hospital. Keeping watch is a noble mission, but shouting at the fast-running rabbit will not get us good outcome.

Dr Derrick AU
Director (Quality and Safety)

Distribution of SE in the last four quarters



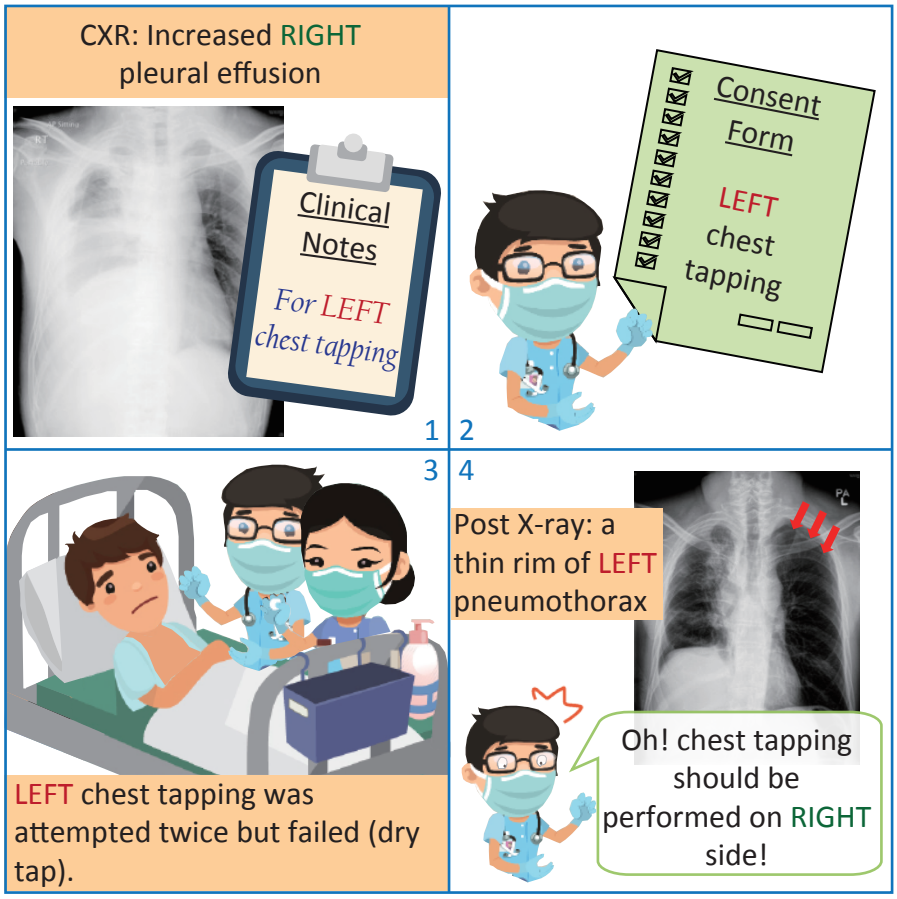
Distribution of SUE in the last four quarters



Wrong Patient / Part

Wrong side chest tapping

A patient had lung cancer presented with progressive dyspnoea.



Contributing factors:

1. Procedure site was not verified with chest X-ray before procedure.
2. Safety Procedure Checklist was not used for the procedure.

Recommendations:

1. Revise the design of the Safety Procedure Checklist by adding a checkbox for reminding staff to verify procedure side with appropriate imaging before procedure.
2. Conduct regular audit to monitor the compliance with the use of safety checklist.

Inpatient Suicide

A missing patient fell from height

- A patient had pancreatic cancer and alcohol dependence was admitted to Hospital A for abdominal pain and persecutory auditory hallucination.
- After psychiatric consultation, patient was transferred to psychiatric Hospital B for further management.
- On arrival to Hospital B, patient developed fever and abdominal pain. Hence, patient was transferred and admitted into Hospital C (an acute hospital).
- Intravenous antibiotic was started and ultrasonography of abdomen was arranged.
- One day after admission, patient was found missing. Searching in hospital was in vain.
- Patient was found fallen from height outside hospital.

Recommendations:

1. Transfer relevant patient's clinical records to receiving units timely.
2. Explore the possibility of transferring stable patients back to parent hospital for better continuation of care.

Others

Suprachoroidal haemorrhage during cataract extraction

- A patient had known history of pemphigoid was admitted to Hospital A for management of lip bleeding and anaemia. Patient was cared for by multiple clinical teams.
- The result of prolonged Activated Partial Thromboplastin Time (APTT), which indicated bleeding tendency, was not attended to by all clinical teams.
- Bleeding stopped after medical treatment.
- 4 months later, patient underwent elective cataract surgery in Hospital B. Surgeon initially planned for phacoemulsification but converted to extra-capsular extraction due to surgical difficulties. The operation was complicated with posterior capsule rupture and suprachoroidal haemorrhage.
- Patient was transferred to Hospital A for management.
- The result of abnormal APTT was noticed. Patient was subsequently diagnosed to have acquired Factor VIII inhibitors.
- Patient had permanent visual loss over one eye.

Contributing factors:

1. Suboptimal system on handling of blood results.
2. Clinical teams solely focused on their specialized care.

Recommendations:

1. Improve system of handling investigation result.
2. Share the incident to enhance awareness on handling of laboratory result.

What is Acquired Factor VIII Inhibitor?

Factor VIII is a coagulation factor that is essential for the formation of blood clot. By inhibiting the activity or increasing the clearance of Factor VIII, acquired Factor VIII Inhibitors can result in clinical bleeding.

Acquired Factor VIII Inhibitors (also called acquired haemophilia A) are sporadic cases of autoantibodies developing spontaneously, often in elderly, postpartum, in association with autoimmune diseases (e.g. SLE, pemphigus) or malignancy, or can be drug-induced (e.g. penicillin); patients with such disease typically present with spontaneous bleeding.

Laboratory tests: typically demonstrate a prolonged APTT uncorrectable by mixing patient plasma with normal plasma, while platelet count, Prothrombin Time (PT), Thrombin Time (TT) and fibrinogen are all normal. Bethesda test is a functional assay for the inhibitor.

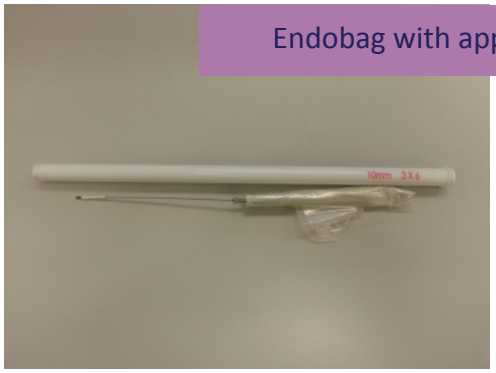
***Note: DO NOT indiscriminately prescribe heparinoid-containing cream (e.g. Hirudoid) to patients with bruises as it may aggravate underlying bleeding tendency.**

Dr Albert LIE, Convener of Haematology Working Group / Chief of Service (Medicine), QMH

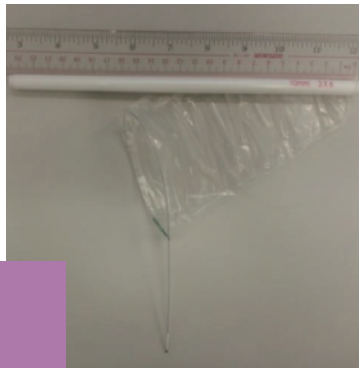
Retained Instruments / Material

Surgical specimen inside an endobag

- Emergency laparoscopic appendectomy was preformed for a patient with ruptured acute appendicitis.
- During the operation, both the circulating nurse and scrub nurse had shift change.
- The patient's appendix was resected and put into an endobag. Surgeon planned to remove the endobag with specimen before the end of operation.



Endobag with applicator



Specimen would be placed into the bag

- Distracted by sudden bleeding in the operating field, surgeon forgot to remove the endobag and to perform surgical site inspection before wound closure.
- Circulating nurse assumed the labeled specimen bottle contained the surgical specimen without direct visual checking.
- During handover in recovery room, nurse found the specimen container was empty.
- Laparoscopic removal of the endobag with specimen was performed immediately.
- Patient was discharged one week later uneventfully.

An empty bottle with label

Contributing factors:

1. Endobag was not included as a surgical counting item.
2. Ineffective handover between clinical staff.
3. Nurse assumed the labelled specimen bottle contained the specimen without visual verification.
4. Doctor was distracted by patient's clinical condition and did not perform surgical site inspection before end of the operation.

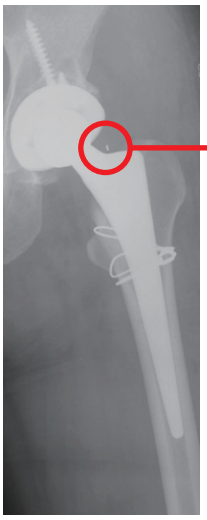
Recommendations:

1. Count all accountable items with the likelihood to be retained in patient's body.
2. Standardize the structure and framework of handover to ensure effective communication of important information between clinical staff.
3. Mandate visual confirmation of specimen by two staff.
4. Reinforce importance of routine surgical site inspection before the end of procedure.

Sentinel Events

A tip of wire

- A patient underwent total hip replacement surgery.
- Following insertion of orthopaedic implant, fracture of proximal femur was found. Surgeons used several wire loops for fracture fixation.
- After completion of fixation, the wires were tightened and tips were cut.
- Scrub nurse presumed surgeon would perform counting on the number of cut wire tips.
- Post-operative X-ray found a 2mm wire tip above the greater trochanter.
- Surgeon decided not for operation after discussion with patient.



Wire

Contributing factors:

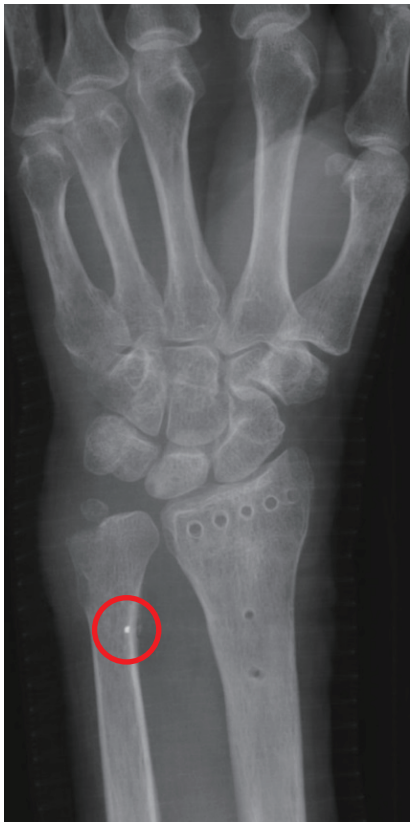
1. Surgeon was not aware of the safeguard method to cut wire tips.
2. Lack of communication between the surgeon and scrub nurse during handover of cut wire tips.

Recommendations:

1. Surgeons should adopt a safeguard method to prevent wire tip from dropping into the surgical field.
2. Count cut wire tips immediately when returning them to scrub nurse.
3. Build and reinforce the speak up culture.

A small metallic foreign body

- A patient underwent operation for reduction and fixation of wrist fracture in May 2015.
- 6 months after first operation, surgeon performed arthroscopic removal of implant and ulnar styloid repair. Procedure was uneventful and patient was discharged on next day.
- Follow up X-ray 2 weeks later detected a tiny metallic foreign body on ulnar side of patient's wrist.
- Patient preferred observation to intervention.



Contributing factor:

Failure to check the completeness of used accountable items.

Recommendation:

Perform intraoperative imaging if there are doubts of retained accountable items.

Plain gauze

A pregnant patient was admitted for per-vaginal bleeding at 33 weeks of gestation.

Doctor performed speculum examination. A bleeding endocervical polyp was avulsed.

A few pieces of non-woven plain gauze were used during the procedure.

Five weeks later, she underwent elective caesarean section.

2 days after operation, two pieces of plain gauze were passed spontaneously from vagina.

The condition of both the mother and newborn were stable and they did not show any signs of infection.

Contributing factors:

1. No surgical counting of gauze before and after the end of procedure.
2. Lack of awareness on the potential risk of retained gauze associated with speculum examination.

Recommendations:

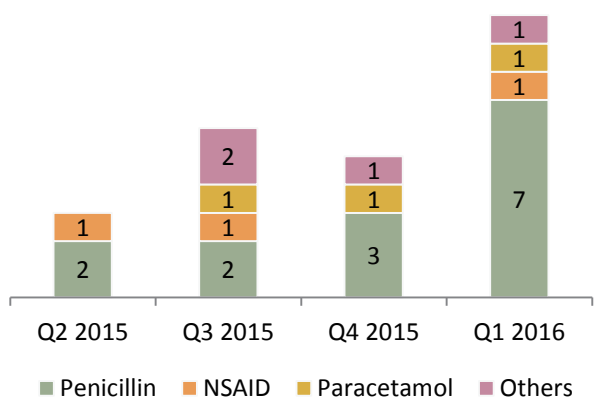
1. Include surgical counting of gauze and sponge before and after interventional procedures.
2. Share the incident to raise awareness on the risk.

Serious Untoward Events

Of the 14 SUE cases reported in Q1 2016, 11 were medication error and 3 were patient misidentification. The medication error involved giving known drug allergens (KDA) to patients (10) and others (1).

Of the 10 KDA cases, 1 developed mild symptoms which subsided after treatment. The others had no allergic reaction.

Distribution of drugs related to KDA



Known Allergy	Allergen prescribed
Augmentin	Augmentin (2)
Penicillin	Augmentin (2)
	Cloxacillin (1)
Amoxicillin	Tazocin
Cephalexin	Augmentin
Paracetamol	Paracetamol
Aspirin	Cocillana
Anti-tetanus toxoid (ATT) vaccine	ATT vaccine

Serious Untoward Events

Medication Error

Known drug allergy

- Cocillana (ward stock) was prescribed and administered to a patient, with known aspirin allergy, for symptomatic treatment.
- The patient did not suffer any allergic reaction.

Cocillana compound contains Senega root which is contraindicated in patient with aspirin or salicylate hypersensitivity.

Possible Cross Sensitivity with NSAIDS
Ammonia and Liquorice#
Benzydamine (Difflam®)
Cocillana compound#
Mesalazine
Neozep®
Salicylate / Salicylic acid
Sulphasalazine
Thymol gargle compound

Contain Senega root: Contraindicated in patients with aspirin or salicylate hypersensitivity

Reference:
HA Guideline on Known Drug Allergy Checking (HAHO-COM-GL-MSC-003-v01(MSC Ref: MSC/008(v1)))

Global Sharing

Patient safety is a top priority for every healthcare organization, but knowing where to direct initiatives can be daunting. ECRI Institute has compiled its third annual list of the Top 10 Patient Safety Concerns for Healthcare Organizations in 2016:

1. Health IT configurations and organizational workflow that do not support each other
2. Patient identification errors
3. Inadequate management of behavioral health issues in non-behavioral-health settings
4. Inadequate cleaning and disinfection of flexible endoscopes
5. Inadequate test-result reporting and follow-up
6. Inadequate monitoring for respiratory depression in patients prescribed opioids
7. Medication errors related to pounds and kilograms
8. Unintentionally retained objects despite correct count
9. Inadequate antimicrobial stewardship
10. Failure to embrace a culture of safety

https://www.ecri.org/EmailResources/PSRQ/Top10/2016_Top10_ExecutiveBrief_final.pdf