RISK ALERT

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A Risk Management Newsletter for Hospital Authority Healthcare Professionals

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Opening Message

Speak-up

We have been promoting a "speak-up" culture at HA for a number of years now. Over time we may lose sight of what it actually encompasses and why we are encouraging it in the first place.

To improve the quality and safety of our services, we need to know when things go wrong. We can only start to identify the underlying causes and prevent similar incidents from happening again if we are aware of these incidents in the first place. In a majority of cases, no patient harm is done but that doesn't mean those incidents shouldn't be reported. There is still a lot to be learnt from these cases and through these cases we can potentially identify problems before any harm is done.

"No one wins playing the blame game" – S.E. Love

In order to promote a "speak-up" culture, we need to also establish a "no-blame" culture. Staff must be able to feel comfortable about telling management about incidents knowing that individuals will not be punished as a result. Once we start assigning blame, people will be reluctant to speak-up.

"The guilty one is not he who commits the sin, but the one who causes the darkness."

– Victor Hugo, Les Miserables

Management's initial reaction to staff reporting an incident is critical. No matter how emotional we may be at the time, we must remember that the cause of most medical incidents is multifactorial. Before gathering all the facts and doing a proper analysis, we should not jump to any conclusions. Our first priority should be to ensure patient safety and also take care of our staffs' emotional state. To foster a "no-blame" culture, management should avoid making the staff feel guilty or incompetent. If a member of staff encounters a "bad experience" when speaking up, they will be more reluctant to speak-up in the future. Often, these "bad experiences" will spread through gossip and have a negative institution-wide effect. Rather than falling into the trap of playing the blame game, we should focus on staying positive, helping the team manage the situation and upkeeping staff morale.

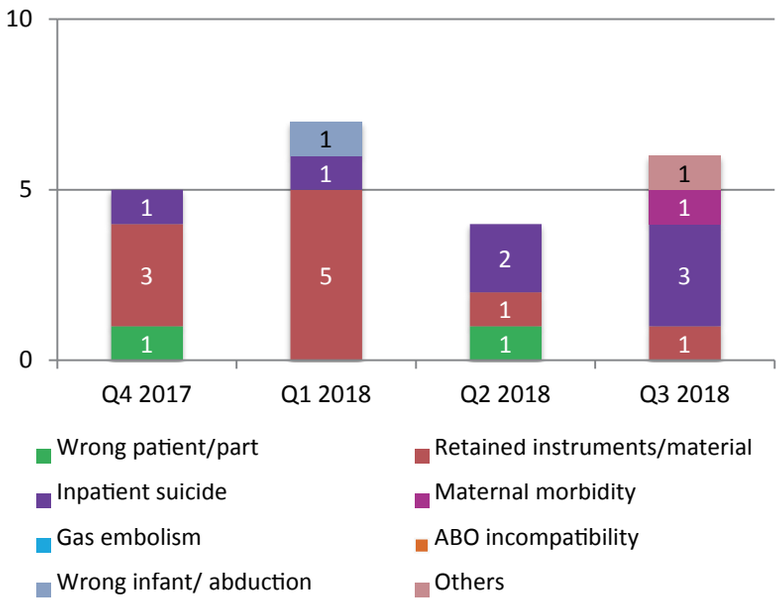
A positive "speak-up" culture takes a long time to build as it entails having trust between colleagues and between subordinates and their superiors. Once the trust is broken, it is very difficult to rebuild.

Medical clinicians are required to be highly professional and that professionalism can sometimes lead to a strive for perfection, which is not always good. They often don't want to speak-up when something goes wrong as they may see it as admitting to mistake and being imperfect. In my mind, any system that relies on people not making any mistakes and processes to run flawlessly is definitely imperfect. A good system should allow mistakes and errors to rapidly surface so that they can be rectified in a timely manner. That is why we need to promote both "speak-up" and "no-blame" cultures at HA.

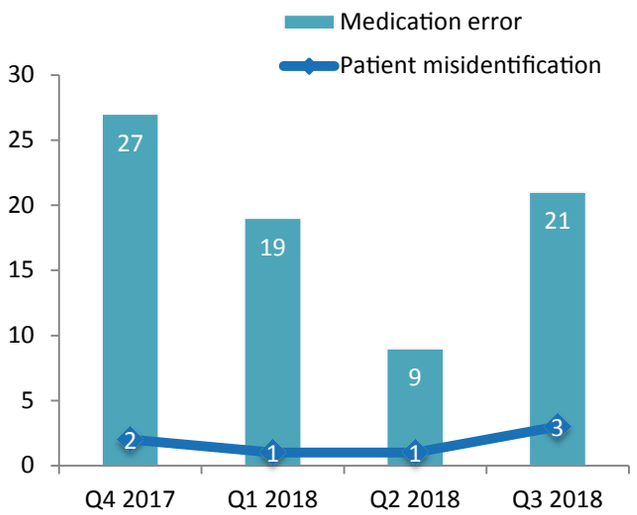
Dr K L CHUNG, Director (Quality & Safety)

SE & SUE Statistics

Distribution of SE in the last four quarters



Distribution of SUE in the last four quarters

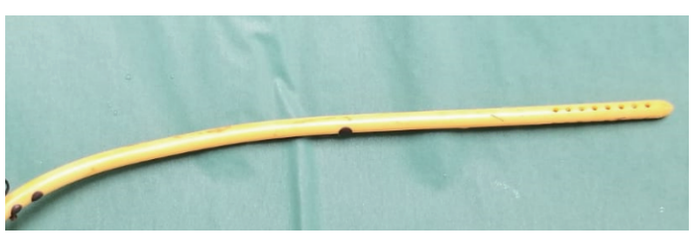


Sentinel Events

Retained Instruments / Material

Retained ventricular catheter

- In a patient with a history of recurrent brain tumors and multiple excision surgeries, a ventricular catheter was noted in the follow-up magnetic resonance imaging for tumor progression monitoring.
- After reviewing the images, it was suspected that a ventricular catheter was retained after removal of the external ventricular drain.
- The patient was informed that the catheter is a biomedical compatible product with a low risk of infection. The patient agreed to the plan for removing the catheter during the next operation.
- A craniotomy for excision of the recurrent brain tumor was performed 4 months later.
- The old ventricular catheter was retrieved and replaced with a new catheter for drainage of cerebrospinal fluid.



Key contributing factors

- Not checking the completeness of the ventricular catheter after removal.
- Lack of knowledge and experience in the removal of ventricular drains.
- Suboptimal supervision as the concerned staff was new and has just joined the unit for one week.

Recommendations

1. Conduct cross-checking on the removed catheter.
2. Review the training material on the removal of ventricular drains.
3. Enhance the training on removing ventricular catheters which includes checking the completeness of the drains after removal.
4. Strengthen supervision to new comers.

Others

A patient who had vaginal laceration after Barium enema

- An elderly female patient was scheduled to undergo a barium enema examination.
- A radiographer tried to insert the enema tip into the patient's anus but had improperly inserted it into the patient's vagina.
- The radiographer did not perform visual check.
- The balloon (retention cuff) of the enema tip was inflated to avoid leakage of barium during the examination.
- After instillation of barium into the catheter, the radiologist noticed, in the X-ray images, the presence of barium inside the patient's pelvis, suspecting that enema tip was improperly inserted into the vagina.
- The radiologist immediately stopped the examination and asked a radiographer to check the position of the enema tip.
- The radiographer removed the enema tip after discovering that it was inserted into the vagina.
- The radiologist then examined the patient and found blood stained barium contrast in the patient's perineum.
- The patient was escorted to the Accident and Emergency Department for assessment immediately.
- An urgent computed tomography scan was arranged. The result showed that there was barium in her vagina, uterine cavity and bilateral fallopian tubes, and there were also possible signs of vaginal tear.
- The patient was transferred to the Intensive Care Unit and a joint assessment was conducted by a Surgeon, a Gynaecologist and an Intensivist.
- An emergency laparotomy was performed during which the laceration of the vagina was sutured, the residual barium was removed and a bilateral salpingectomy was performed in order to avoid the risk of peritonitis.
- The patient was stable after the operation. She had made a satisfactory recovery and was discharged home 20 days later.

The Panel has made the following conclusions:

- During the insertion of the enema tip, the radiographer did not clearly see the patient's perineum. Visual checking was not performed after insertion. The radiographer should identify the patient's anus before and immediately after inserting the enema tip to prevent similar incidents from happening again.
- The inflated balloon of the enema tip caused injuries to the vagina and forced the barium into the uterine cavity and the fallopian tubes.
- The incident is rare according to medical literature.

Recommendation

Review and revise the workflow of barium enema examination to ensure:

a. the correct positioning of the enema tip in anus is visually reconfirmed by another professional staff immediately after enema tip insertion;
b. an assessment is conducted on the benefits of inflating the retention cuff of the enema tip against the risks and needs of individual patients; and
c. the balloon is inflated only after confirmation of the correct positioning of the enema tip by a doctor.

Inpatient Suicides

In Q3 2018, three patients (two male and one female, aged between 52 and 86) who had malignancies or chronic illnesses had committed suicide. One patient had left the hospital and then jumped from height nearby. The other two patients committed suicide by jumping from height during home leave.

The overall assessment and management of these cases was determined to be appropriate by investigation panel.

Case 1

- A patient was admitted for pleural effusion and ankle edema.
- The patient had no previous history of suicidal attempt or ideation, had not expressed any self-harm behavior and appeared emotionally stable.
- Malignancy was suspected and explained to the family. The family requested not to disclose the condition to patient immediately, and planned to explain the condition to the patient later.
- Diagnostic pleural tapping was performed and no evidence of malignancy was found. The patient underwent a PET-CT scan but results were not available until after the event.
- On day 9 of hospitalisation, the family requested home leave for the weekend and public holiday. The next day, the patient went on home leave with relatives.
- Ward staff was informed that the patient committed suicide by jumping from height the day after.

Case 2

- A patient with a history of adjustment disorder and lung cancer with metastasis, was admitted for relief of symptoms brought on by superior vena cava obstruction.
- The patient's breathlessness and pain had improved after receiving treatment.
- The patient was emotionally calm with no suicidal ideation.
- On the day of the event, the patient left the ward with his wife on home leave. On that evening, the patient committed suicide by jumping from height.

Case 3

- A patient with a history of colon cancer with multiple metastasis was receiving palliative therapy.
- During one admission for palliative therapy, no suicidal risk was identified and the patient was emotionally stable.
- The nature and the stage of the disease were explained to the patient and the treatment plan was discussed.
- On the day of the event, the patient's condition was stable with calm mood. The patient requested home leave, but was declined in view of the need to give intravenous fluid replacement.
- The patient left the ward without notifying ward staff and jumped from height in a premises near the hospital.

Maternal Death

A pregnant woman developed cardiac arrest during induced labour

- The patient who had been receiving regular antenatal check-ups was diagnosed with oligohydramnios and proteinuria, was admitted for induction of labour at 38 weeks of gestation due to suspected pre-eclampsia and signs of oligohydraminos.
- Induction of labour was performed in the morning using prostaglandin per vagina and monitoring for patient and fetus was normal.
- Later that evening, the woman suddenly developed a seizure of short duration and the medical staff immediately examined and monitored her condition.
- The patient developed cardiac arrest a few minutes later. Cardiopulmonary Resuscitation was initiated and the patient was intubated. An emergency bedside caesarean section was then performed.

Patient

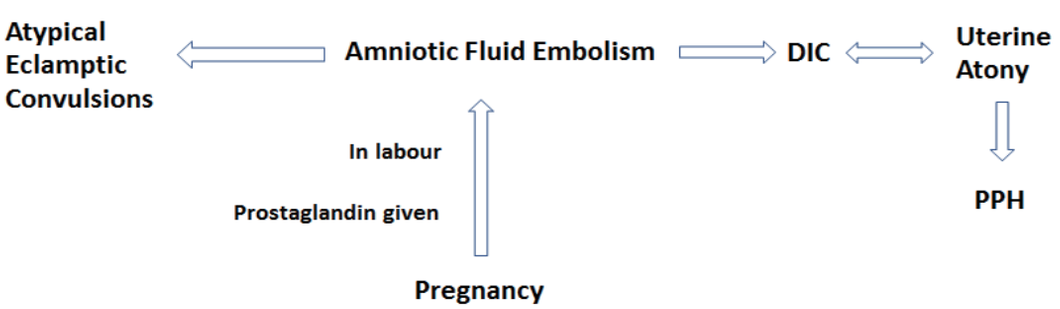
- The patient had a return of spontaneous circulation, but then developed another episode of cardiac arrest followed by Post-Partum Haemorrhage (PPH), which was complicated by Disseminated Intravascular Coagulation (DIC), resulting in uncontrolled bleeding.
- Massive blood transfusion and multiple doses of coagulant medications were given. The patient underwent several emergency procedures to control the bleeding but succumbed in the early hours of the following day.

Baby

- The delivered baby was resuscitated by the Paediatric team and transferred to the Neonatal Intensive Care Unit for further care and monitoring.
- The baby was discharged on day 18.

The RCA panel made the conclusions:

1. The decision for induction of labour at 38 weeks was supported and reasonable.
2. The sudden deterioration of patient condition was unpredictable but promptly recognized and acted upon accordingly.
3. There was prompt support from multi-disciplinary teams.
4. An emergency cesarean section was timely performed and the baby was delivered. The baby was discharged from hospital 18 days after birth.
5. The woman developed post-partum hemorrhage about one hour after the cardiac arrest. According to her clinical conditions, the cause resembled an amniotic fluid embolism resulting in DIC and uterine atony. The multi-disciplinary clinical teams had already provided various resuscitative treatments, blood transfusion and medications.



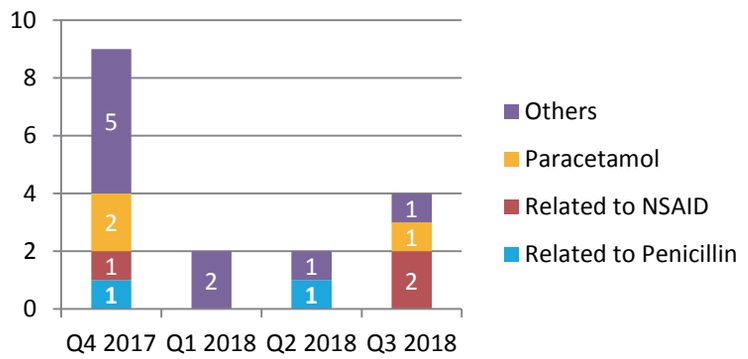
6. Probable differential diagnosis including amniotic fluid embolism had been considered by clinical team. They had endeavored to provide all possible resuscitation and treatments.

Serious Untoward Events

Of the 24 SUE cases reported in Q3 2018, 21 were due to medication errors and 3 were due to patient misidentification. The medication error cases involved giving known drug allergen (KDA) to patients (4), dangerous drugs (2), anticoagulant (1), antiplatelet (1), insulin (1), vasopressors & inotropes (2) and others (10). 1 of the known allergen cases had developed skin rash, subsided after receiving medication.

Known Allergy	Allergen prescribed
Lignocaine	Lignocaine
Brufen	Ketorolac
Paragram	Paracetamol
Aspirin	Aspirin

Number of KDA cases in the last four quarters



Medication Error

Paracetamol prescribed to patient with known allergy to Paragram

- A patient who attended AED for chest pain, had an allergic history to "Paragram" which was documented in the patient Clinical Management System (CMS) using "free text".
- Doctor A checked the information from CMS then wrote "Paragram" on the "allergy / drug sensitivity" box in the AED record .
- Doctor A prescribed paracetamol to the patient after the assessment but did not check the ingredients of Paragram. ***Paragram contains the active ingredient paracetamol***
- A nurse noted "Paragram" in the allergy box on the AED record and asked the patient about any drug allergy history before giving paracetamol to the patient. The patient replied that there was "no history of allergy to paracetamol". One dose of paracetamol was given to patient afterward.
- Doctor A reassessed the patient and then arranged admission for the patient.
- Doctor A entered the prescription of paracetamol on the Inpatient medication order entry (IPMOE) system before the patient was transferred to the ward.
- An alert was prompted when the pharmacist verified the IPMOE order.
- Pharmacist B overlooked the free text entry of allergy and did not check the ingredients of "Paragram" before verifying the prescription.
- On the next day, another pharmacist discovered that the active ingredient of "Paragram" is paracetamol. The prescription was suspended. In total, 3 doses of paracetamol were given to patient.
- The patient had no signs of drug allergic reaction.

Key contributing factors

- Failure to check the ingredient of a drug entered under free text allergy.
- Not complying with the guideline on known drug allergy checking.

Recommendations

1. Avoid free text allergy entries wherever possible.
2. Look up content of drug trade names, and enter structured drug allergy information into CMS to enable intelligent checking by the system.

What is important in an RCA?

Performing a Root Cause Analysis (RCA) is actually not an easy task. As the name suggests, it is a method of investigation, a probe into the 'root causes' that led to system failures. It often involves asking difficult and confronting questions that might not have been considered in the past, or perhaps been put into the 'too hard' basket. It is important to remember that we go through all this trouble simply because we are genuinely trying to improve. If we do not know what the real issues are, by definition there is no way we can address them! As Albert Einstein said, ***"If I had an hour to solve a problem I'd spend 55 minutes thinking about the problem and 5 minutes thinking about solutions."*** This quote probably best reflects the intent of an RCA.

To be anywhere near competent at performing an RCA would require much more than space afforded on this page, but perhaps we can identify some critical elements here.

Contributing factor and root cause statements must clearly address why something occurred, with a focus on process and system vulnerabilities, not individuals. The **'rules of causation'** are:

Rule 1. Causal statements must clearly show the 'cause and effect' relationship.
Rule 2. Use specific and accurate descriptors for what occurred, rather than negative and vague words.
Rule 3. Identify the preceding cause(s) not the human error.
Rule 4. Identify the preceding cause(s) of procedure violations.
Rule 5. Failure to act is only causal when there is a pre-existing duty to act.

Actions should look at eliminating, controlling or accepting conditions. They are classified into **strong**, **medium** and **weak**. Obviously the stronger the action, the more likely it is able to prevent future occurrences:

Strong

(Eliminate) These are strong actions that may include to remove, fix or replace a piece of equipment or put a measure in place so as the problem will not occur (simplify a process and remove unnecessary steps).

Medium

(Control) These are intermediate actions that may include putting up a warning notice, advising people at orientation, development of a checklist or cognitive aid, enhanced documentation/communication, software enhancements etc.

Weak

(Accept) These are the weakest actions – acknowledge that there is an associated risk and accept it. The successful implementation of actions will be increased if they are specific and clear (ie a 'cold' reader should be able to understand what to do next).

Each recommendation/action will have an accountable executive, and draft timelines for its implementation.

Outcome measures are designed to show whether or not the actions have actually prevented or minimised additional adverse events or close calls.
Outcome measures work best at demonstrating change over time if they are as specific and quantifiable as possible. Use numerators, denominators, thresholds and timeframes whenever possible.
Outcome measures should target what you want to address – if you have a 100% target for your measure, the vulnerability should be eliminated.
It is actually more important to measure the effectiveness of the actions, not just the completion of the action, thus it is important to set realistic thresholds.

If you are interested in becoming an expert RCA facilitator and drive change, please get in contact with the Patient Safety and Risk Management team!

Reference: http://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0007/313297/rca-flipchart.pdf

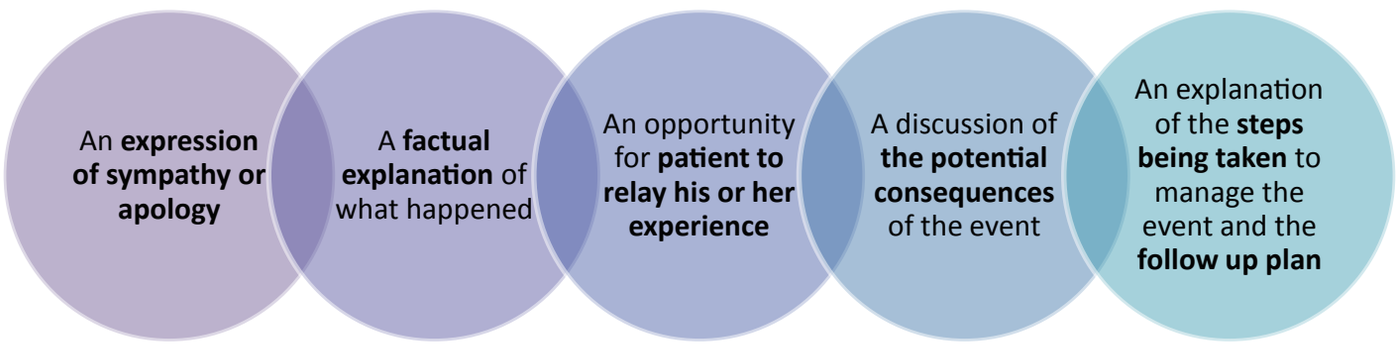
Open Disclosure Training Module

on Healthcare Service Management Training Platform

What is Open Disclosure?

Open disclosure is an essential and important part of clinical management. Healthcare providers have the responsibility to maintain honest communication with patients/ family/ carers even when adverse incidents occur.

In open disclosure, the following elements must be included while respecting the confidentiality of the patient:

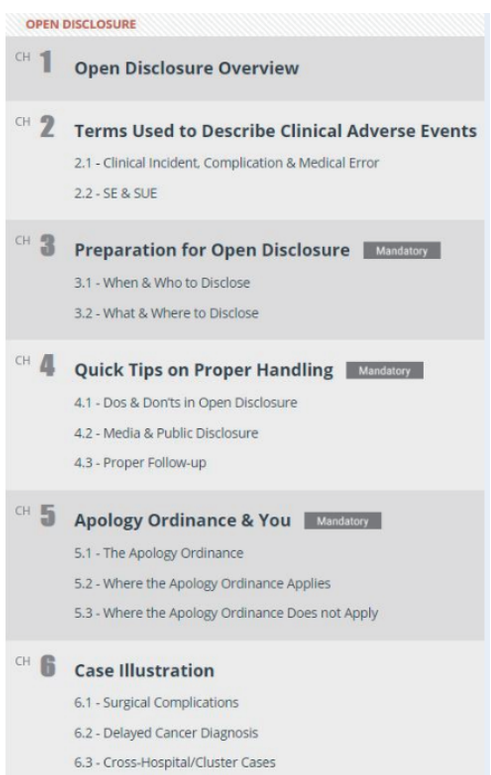


HA policy and e-Course for Open Disclosure in HA

A corporate wide policy on Open Disclosure for Clinical Incidents has been in place since 1 July 2018. The purpose of the policy is to set the standard the community should expect of HA, to ensure that patients, families, carers and healthcare providers are communicating effectively when clinical incidents occur, and to align practices across the organisation.

Open Disclosure Policy for Clinical Incidents

An Open Disclosure module has been newly developed and is available on the Health Service Management Training (HSMT) electronic platform since 31 October 2018 for a knowledge-based education and will be available to all HA professional staff.



To learn more, please access HSMT platform by:
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