



# RISK ALERT



ISSUE 57 APR 2020

A Risk Management Newsletter for Hospital Authority Healthcare Professionals

## IN THIS ISSUE

### ★ Sentinel Events (SEs) (Q4 2019)

- \* Wrong Patient / Part
- \* Retained Instruments / Material
- \* Others \* Patient Suicide

### ★ Serious Untoward Events (SUEs) (Q4 2019)

### ★ Global Sharing

- \* “Nothing About Me Without Me”

### ★ Local Sharing

- \* Magnetic Resonance Imaging (MRI) Safety

## Opening Message

### Infodemic, Publicity, Crowdsourcing

The World Health Organisation (WHO) describes the spread of false information during this COVID-19 outbreak an “**infodemic**”, which is elsewhere defined as “an excessive amount of information concerning a problem such that the solution is made more difficult”. Since SARS in 2003, the world of communication has been increasingly digitally-transformed, even more so after the advent of smartphones, and we are literally inundated with information. That said, computers and smartphones are but tools, and how we make use of them counts more than sheer possession.

Think about what could never have been possible without them. For example in HKEC, we have set up a “Volunteer **Publicity** Group” WhatsApp platform, now comprising 50 staff members. Aimed at encouraging our staff during this COVID-19 outbreak, we rewrote the lyrics of an old song, recorded it separately on our phones, mixed it, and published it on YouTube, all without needing to see one another physically! We organised and built a Japanese-style blessing board, now placed at the entrance of our canteen, and utilised online voting to decide on its name. Through casual online chatting, we made friends with each other, and this channel is used to reach out and explain the rationale of many policies, while at the same time gathering feedback and feelings. A dedicated webpage with all COVID-19 information is in place, and WhatsApp and emails are utilised to convey daily updates to our staff. Managers also utilise this platform to organise patient movement and share treatment experiences. With these platforms, many misunderstandings can be clarified instantly, and even more myths debunked. Staff feedback of this platform has been very positive!

There is indeed a lot more in the modern way of communications to harness, for our goal of providing quality and safe care. For example, we can use “**crowdsourcing**” to “obtain information or input into a task or project by enlisting the services of a large number of people, typically via the Internet”. This strategy is being used by scientists, organisations and governments, and has helped solve many problems around the world.

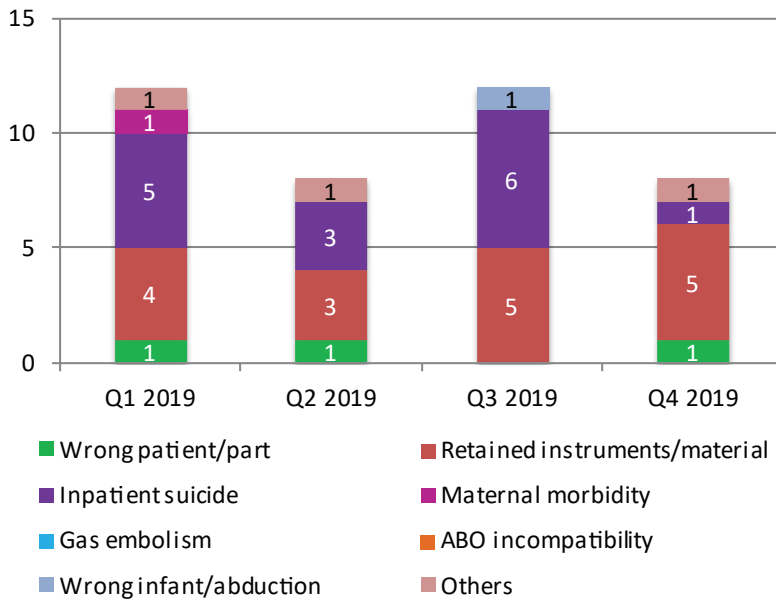
It is time for us to consider tapping into the smart brains of many people outside Quality & Safety to work with us, and we can turn an “**infodemic**” to work in our favour.

Dr Chun-Wing LAU

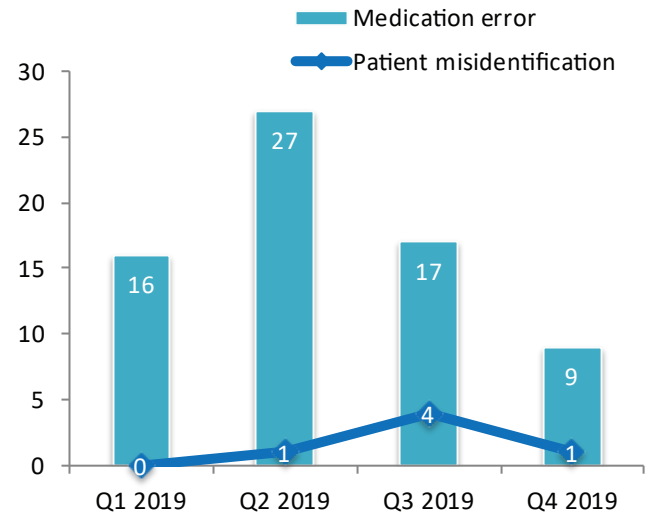
Service Director(Quality & Safety)

Hong Kong East Cluster

## Distribution of SE in the last four quarters



## Distribution of SUE in the last four quarters



## Sentinel Events

### Wrong Patient / Part

#### Wrong Side Ureteroscopy and Dilation

- A patient with pelviureteric junction stricture underwent an elective **LEFT** ureteroscopy and dilatation. Consent was obtained at the outpatient clinic.
- After the patient was admitted, site marking was performed at the **LEFT** back. It was checked at the operating theatre reception area.
- 'SIGN IN' and 'TIME OUT' were performed.
- The doctor inserted the ureteroscope to the **RIGHT** ureter. As there were concurrent **RIGHT** distal ureter stricture and hydronephrosis of **RIGHT** kidney, **RIGHT** ureteroscopy and dilatation was performed.
- The doctor noted that the **RIGHT** instead of the intended **LEFT** side was performed after the procedure. The on-call specialist was consulted and decided to proceed to **LEFT** ureteroscopy and dilatation.
- It was documented on the operation record that bilateral procedures were performed and open disclosure was done.

#### Key Contributing Factors

1. There was no cue on the correct operative site after a time lag between 'TIME OUT' and the entry of ureteric orifice.
2. The presence of co-existing pathology at **RIGHT** ureteric stricture.

#### Recommendation

Conduct second 'TIME OUT' on checking correct side of operation before entry of internal orifice in ureteroscopy.

## Raytec Gauze

- A patient with bilateral loin abscesses underwent an incision and drainage operation. 5 pieces of single-line long Raytec gauzes were packed at each side of the loin abscess wounds and it was documented.
- On post-operative day one, the case doctor inspected the wounds during the morning round. The Raytec gauzes were loosened but were not removed. The case nurse did not clarify with the case doctor if all the dressing materials were disposed of after wound inspection. The number of gauzes removed was not documented. Wound dressing was performed and continued in the remaining hospital stay.
- After discharge, patient received daily wound dressing at the general outpatient clinic.
- During specialist outpatient clinic follow-up, in view of increased swelling over the wound scar, the patient was admitted for incision and drainage. A single-line long Raytec gauze was found in the **LEFT** loin abscess wound.
- In that hospital, single-line Raytec gauzes are used only in the operating theatre while double-line short Raytec gauzes are used in the wards.

### Key Contributing Factors

1. The number of gauzes removed was not counterchecked.
2. Inadequate communication between doctor and nurse.
3. Multiple pieces of Raytec gauzes were used for packing due to complexity of the wound condition.

### Recommendations

1. Reinforce on counterchecking the number of gauzes removed, during wound inspection or wound dressing by nurses or doctors.
2. Strengthen the communication between doctors and nurses. In particular, to engage nurses in wound inspection during doctor's round.
3. Leave the tail end of packing materials above the skin level of the wound if possible.

## Segment of Nasogastric Tube

- An old age home (OAH) resident with a history of stroke required nasogastric tube feeding and was supported by the Community Nursing Service. During this time, there were multiple admissions and Accident and Emergency Department (AED) attendances to more than one hospital.
- One day, the patient was brought to the AED on suspicion of swallowing a piece of gauze in the OAH.
- The silicone nasogastric tube was removed to facilitate assessment. The tip was checked and documented to be intact.
- Subsequent abdominal X-ray revealed a linear opacity at the stomach region.
- Oesophagogastroduodenoscopy was performed and a segment of nasogastric tube was found in the stomach.

### Conclusion

1. The specific cause and occasion in which the nasogastric tube was broken and retained could not be ascertained.
2. As the patient was also taken care of at the OAH, the feeding tubes might not be solely provided by the hospital.
3. According to the information solicited, the checking of completeness of the removed nasogastric tube is a usual practice.

### Suggestion

Enhance documentation, including the completeness of removed nasogastric tube.

## Dressing Material

- A metastatic breast cancer patient had a sacral wound, and wound packing was performed by an outreach team.
- During this time, there were two admissions to two different hospitals.
- After the last admission, the outreach team continued to provide wound care for about 2 months, adopting the one-in-one-out principle for packing, and left a visible tail of packing out of the wound at all times.
- The packing materials were cut and stored in a sterile bottle at the patient's home for packing use. The family members were told not to perform wound dressing themselves.
- The patient was hospitalised for pneumonia. The outreach team handed over the case via the phone and documented the condition in the HA Clinical Management System. Neither the wound packing nor any visible tail was noted during simple wound dressing on admission.
- On the next day, during wound nurse assessment, an extra piece of retained wound packing material was noted, on top of the wound packing provided by the outreach team.

### Conclusion

1. The cause of the retained wound packing material could not be identified. Wound handling by the family could not be excluded.
2. It was a small wound with large undermining cavity. The wound packing might not be easily identified.

### Recommendations

1. Remind carers not to perform wound packing themselves.
2. Explore improvement measures with wound nurses on the management of difficult wounds handled by outreach teams.

## Segment of Suction Tube

- A patient was intubated for status asthmaticus and cardiac arrest.
- A closed suction system connected to the endotracheal tube (ETT) was used.
- When the ETT was being shortened to minimise the dead space of the ventilatory circuit, the suction catheter inside was not fully retracted.
- After reconnecting the ETT to the adaptor, the plastic sheath of the closed suction system was noted to be inflated with air. A product defect was assumed and it was replaced with a new system.
- Two days later, bronchoscopy was performed during bedside tracheostomy. A tubular foreign body was seen at the **RIGHT** lower lobe of lung which was compatible with the catheter tip of the closed suction system.

### Key Contributing Factors

1. The suction catheter was not totally retracted into the closed suction system before shortening the ETT.
2. When the plastic sheath of the closed suction system was inflated, it was assumed to be a product defect without further investigation. The chance of discovering the cutting of the suction catheter was missed.

### Recommendations

1. Revisit the current department practice of cutting the ETT. A good practice is to detach the ETT adaptor from the ETT before cutting the ETT, so that the suction catheter tip could be revealed if it is not retracted completely back to the closed suction system.
2. Share the incident with clinical departments which may need to cut the ETT and to conduct training.
3. Enhance product defect handling through education.

## Metallic Washer



- A patient sustained an ankle fracture and underwent an open reduction and internal fixation operation a year ago. The implants used, including two parallel K-wires, a figure-of-eight wire over cortical screw and a washer, were documented in the operation record.
- The patient was arranged to have the implants removed a year later.
- After admission, the patient's operation was advanced to be the first case on the OT list.
- The doctor reviewed the patient's pre-operative lower limb X-rays before the operation and did not notice the washer. The pre-operative X-rays were displayed in the theatre and were referred to during the operation.
- There was a discussion to arrange intra-operative X-ray screening amongst the team but it was finally deemed not necessary.
- Post-operative X-ray was performed, and a retained 3.5mm washer was identified. After discussion with the patient, the patient opted for another operation to have it removed.

### Key Contributing Factors

1. The team was not aware that the implants fixed in the patient's ankle included a washer. The 3.5mm washer was not commonly used in this kind of fracture as well.
2. The use of intra-operative X-ray screening was discussed among the team but was finally declined.
3. The washer was covered by soft tissue, obscuring the surgical field.

### Recommendations

1. Mandate the practice of intra-operative X-ray screening for all removal of implants operations.
2. Reinforce thorough pre-operative planning for removal of implant operations, including review of previous operation record and pre-operative X-rays.

## Others

### Misplaced Nasogastric Tube

- An alcohol dependence syndrome patient who was receiving thiamine treatment and rehabilitation had desaturation after breakfast one day. The patient was transferred to another hospital for the management of aspiration pneumonia.
- Speech therapist recommended non-oral feeding in view of dysphagia and risk of aspiration after assessment.
- Milk feeding commenced after the nasogastric tube (NGT) was inserted and its position was checked.
- The patient pulled out the NGT twice and new ones were re-inserted.
- As aspirate could not be obtained for acidity testing after the third NGT re-insertion, chest X-ray (CXR) was taken and it was perceived that the NGT was in-situ and feeding could be resumed.
- Before milk feeding was given that night and early morning the next day, aspirates could be obtained from the NGT and both were acidic (pH=4).
- Patient developed cardiac arrest later that morning. After 10 minutes of resuscitation, spontaneous circulation was returned. The CXR taken after the third NGT re-insertion was reviewed, and the NGT was found to be misplaced to the **LEFT** lung. Patient succumbed two days later despite maximal support.

### Key Contributing Factors

1. Cognitive bias in reading the CXR for NGT verification.
2. Nasogastric tube aspirate at pH=4 gave a false sense of security that the nasogastric tube was in stomach.

### Recommendations

1. Provide training to clinicians on reading CXR for NGT verification so as to lessen cognitive bias.
2. Review on the process to obtain NGT aspirate for pH verification.

## Patient Suicide

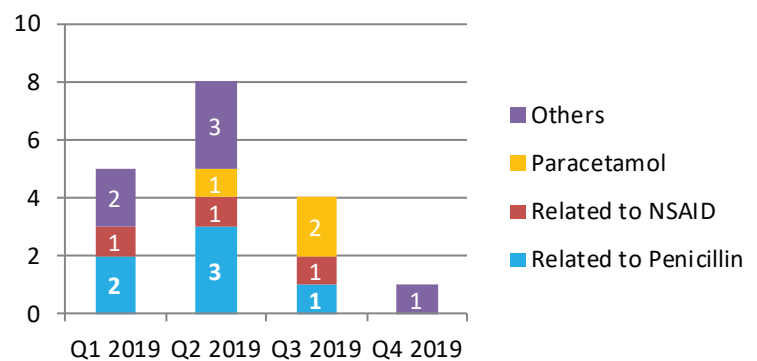
In Q4 2019, there was one case of suicide. A female patient committed suicide by jumping from height away from the hospital. The case was reviewed and the overall care provided was appropriate.

A lymphoma patient who had progressive disease for more than 6 years was admitted for neutropenic fever. The patient had mental health illness and suicidal ideations in the past. On admission, the patient was assessed to be not at risk of suicide. As the patient was unable to close the **RIGHT** eye, multiple investigations including computed tomography scan and fine needle aspiration cytology were performed. Multiple teams from Ear, Nose and Throat, Oncology and Dietetics were consulted. On the 8th day after admission, the patient was planned for discharge two days later after completion of antibiotics. That same afternoon, the patient was found to have left the ward after receiving a phone call. Ward staff were not informed. 2 hours later, the police informed the hospital that the patient was found to have jumped from height.

## Serious Untoward Events

Of the 10 SUE cases reported in Q4 2019, 9 were due to medication errors and 1 was due to patient misidentification. The medication error cases involved known drug allergy (KDA) (1), anticoagulant (4), insulin (1), vasopressors & inotropes (1), concentrated electrolytes (1) and others (1). There was no allergic reaction in the known drug allergy case.

Known Allergy	Allergen Prescribed
Anti-Tetanus Toxoid	Anti-Tetanus Toxoid



Number of KDA cases in the last four quarters

## Medication Error

### One Dose of Apixaban Omitted

- A patient with paroxysmal atrial fibrillation on Apixaban (self-financed item) twice daily was admitted for dizziness.
- Noting the family member would bring Apixaban back from home, 'Omit' was marked at the Inpatient Medication Order Entry (IPMOE) record with the reason 'Drug was not available' during the medication round at night. It was not documented in the case notes nor handed over, as it was assumed that the medication would be brought back soon that night.
- The family only brought the medication back next morning. The night dose was thus omitted.
- The patient developed left-sided weakness in the afternoon. Computed tomography of brain showed cerebral infarct.

There are differences between 'Omit' and 'Defer' in IPMOE:

#### Omit

Use this when the dose will not be given.  
Drug administration process is completed.  
There will not be system alert.

#### Defer

Use this when the dose is to be given later.





## “Nothing About Me Without Me”

*Valerie Billingham, Through the Patient’s Eyes, Salzburg Seminar Session 356, 1998*

More than twenty years have passed since this maxim established the cornerstone for shared-decision making. Fundamentally, it would be inconceivable that in this day and age this concept could be refuted by any healthcare professional. However, recent literature has shown that more needs to be done in patient engagement. Whether it is the Canadian guide “Engaging Patients in Patient Safety” led by the Canadian Patient Safety Institute, or the infamous “Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry” (Francis Inquiry), showed that there are significant gaps when it comes to hearing and responding to the needs of our most important stakeholders.

**Partnering with patients and families** is not only the right thing to do, it is also the safe thing to do. The 2014 Report of the Roundtable on Consumer Engagement in Patient Safety, “Safety Is Personal: Partnering with Patients and Families for the Safest Care”, described patients as being the extra sets of eyes and ears that should be integrated into the safety processes of all healthcare organisations because they are always present in their own care, and can often have insights into the processes of care that providers lack because the providers are focusing on getting the job done.

Increasingly, patient engagement is seen as a key driver for safe care, and patients and families are not just required to be engaged in service development, but they are also seen as partners in incident management, be it in reporting, disclosure, or incident analysis (including as panelists for RCA investigations). Patients often bring a different expertise to the table--the patient experience, and health organisations around the world have integrated patient involvement in quality governance activities. These include participating in organisation quality and safety committees that oversee monitoring and improvement at the organisation level, including follow up from incident reviews.

There is a strong body of evidence that tells us patients are willing to be involved in patient care and safety activities in hospitals.[1] The challenge for healthcare providers is how to tap into and harness this valuable resource.

*McGill University Health Centre’s ‘Transforming Care at the Bedside Initiative’ understands care through the eyes of the patient to co-develop new work processes:*

- *Reduced medication interruptions by 50% and medication transcription errors by 60%*
- *Reducing time to start chemotherapy by 57%*
- *Equipment re-location reduced hunting and gathering time and eliminated test cancellations related to lack of transport wheelchairs*
- *Joint interprofessional mental health admission reduced admission time from 4.3 to 1 hour*

**Dr Alastair MAH**  
**Patient Safety and Risk Management**

# Magnetic Resonance Imaging (MRI) Safety

2 cases related to Magnetic Resonance Imaging (MRI) safety were reported recently. Preventing or reducing hazards to patients and other personnel within the MRI environment is very important.



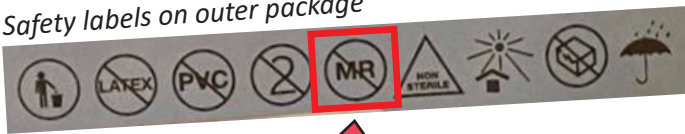
A **sandbag** with a metallic element was wrapped by bed linen and put under the patient's head & neck for support. This was not noticed during visual inspection for any metallic objects, and NO alarm signal was generated by the handheld metal detector.

In the scan room, the patient was secured and positioned. When the table was moving into the gantry, the sandbag was attracted to the facade of the scanner.

A patient with a **disposable warm blanket** required a spine MRI examination. No abnormality was detected by the handheld metal detector.

When the patient was transferred into the scanner, the blanket was attracted to the magnet of the MRI machine.

Safety labels on outer package



## KEY LEARNING POINTS



**MR Unsafe**  
Do not use this  
equipment in the MRI  
scan room

1. Screen patients for implants and appliances that may be hazardous.
2. Use a standardised checklist for safe working in MRI environment.
3. Adhere to any restrictions provided by suppliers regarding the use of MR-safe equipment and devices in the MRI environment.
4. If an object flies into the magnet, it should not be reached for until the MRI machine has stopped moving.
5. Follow MRI safety-related guidelines.

Reference: [Guidelines on Magnetic Resonance Imaging \(MRI\) Safety for HA Hospitals](#)

### EDITORIAL BOARD

**Editor-in-Chief:** Dr Sara HO, CM(PS&RM), HAHO

**Board Members:** Dr K S TANG, Deputising SD(Q&S), HKWC; Dr W M KWAN, SD(Q&S), NTWC; Mr Brian CHING, P(CPO), HAHO; Dr Alastair MAH, SM(PS&RM), HAHO; Dr Jackie CHAU, SM(PS&RM), HAHO; Ms Katherine PANG, M(PS&RM), HAHO; Dr Gary NG, M(PS&RM), HAHO.

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