RISK ALERT

ISSUE 75 Oct 2024

A Risk Management Newsletter for Hospital Authority Healthcare Professionals

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OPENING MESSAGE

Back to Basics

First and foremost, do no harm. Ensuring our patients' safety and well-being extends beyond mere regulatory compliance - it's a moral and ethical obligation that shapes every decision and action we undertake.

In the multifaceted world of modern healthcare, maintaining patient safety demands relentless dedication, collaboration, and innovation. We occasionally stumble into pitfalls of miscommunication, assumptions, distractions, or unfamiliarity with emerging medical technologies. So how can we avoid these pitfalls? The answer lies in shunning quick fixes and assumptions, fostering a speak up culture, and seeking guidance or help when in doubt.

Returning to our core values: patient-centered care, committed staff, professional service, and teamwork. By keeping these values and a culture of patient safety at the forefront, we can appreciate the potentially significant consequences of our actions or inactions.

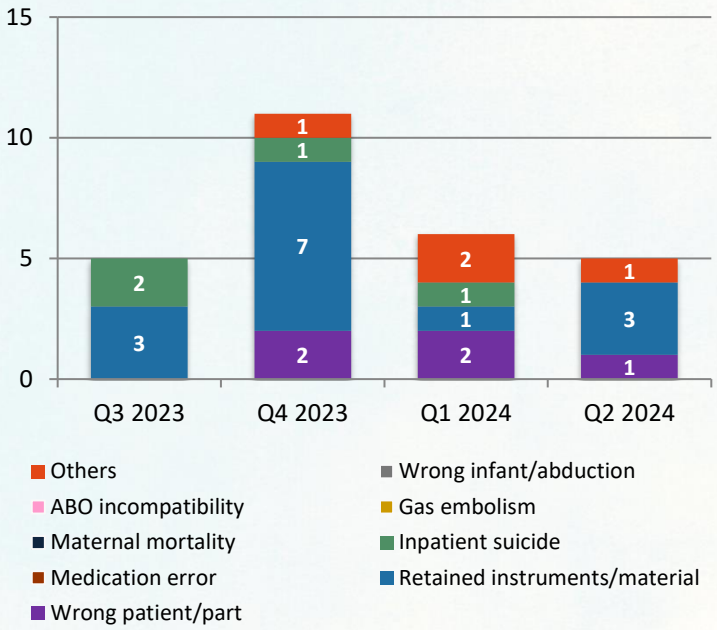
By adopting a policy of openness, learning from our mistakes, we can progress towards our objective of delivering safer and superior quality care to everyone who relies on us. Let's embrace this journey together!

Dr Linda YU

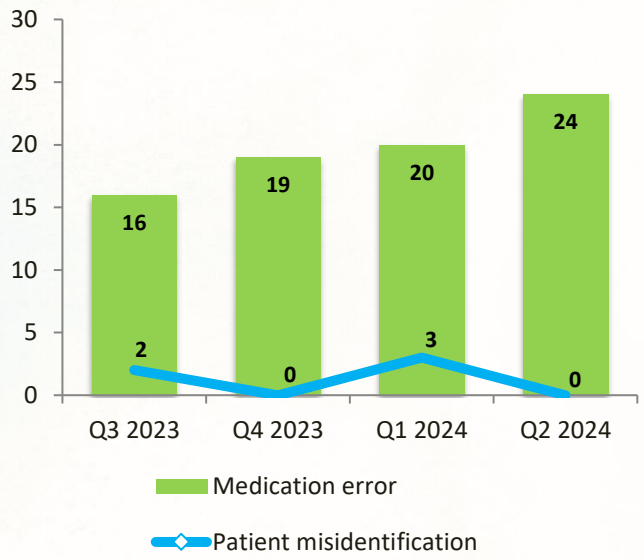
NTEC Service Director (Quality & Safety)

SE & SUE STATISTICS

Distribution of SE in the last four quarters



Distribution of SUE in the last four quarters



SENTINEL EVENTS

Wrong Patient/ Body Part

Pleural Tapping Was Done At Right Side Instead Of Left Side

A patient with metastatic lung cancer presented with **left** pleural effusion. Doctor A ordered pleural tapping for **left** side and signed the consent form prepared by a Physician Assistant, who mistakenly indicated **"right-sided"** pleural tapping. No site marking was performed.

Doctor B performed bedside handheld ultrasound from the patient's **right side** for site confirmation. The ultrasound showed solid features and minimal fluid. Nurse C noted that the consent form indicated the procedure should be on the **right side.** Doctor B proceeded with a testing needle for pleural tapping on the **right side** and aspirated only 2ml of blood and air. The procedure was stopped immediately.

Eventually the correct **left-sided** pleural tapping was performed uneventfully.

Learning Points

1. Ensure **site marking** for pleural tapping procedure according to Bedside Procedure Safety Policy
2. Reinforce training in interpreting ultrasound to identify correct side for pleural tapping

Plain Gauze

A patient with a stage IV cervical cancer was hospitalised for abdominal and back pain. Due to significant per vaginal bleeding (PVB), the patient underwent several per vaginal (PV) examinations with gauze packing for haemostasis. “One-gauze-in, one-gauze-out" method had been adopted and the used gauzes were discarded in the designated container. A long gauze was packed with a visible tail as documented. After finished the examination, a Patient Care Assistant counted the number of used plain gauzes and asked involved doctor/ case nurse to counter-check. However, the counter-check step was not completed.

Two weeks later, a plain gauze was found at the vaginal opening and removed.

Learning Points

1. Revise the guideline on the gauze counting procedure during PV examination, including:
   - Clarify the **role delineation** of doctors, nurses, and supporting staff on the counting process
   - Ensure that the performing doctor is engaged in the counting process and is responsible for confirming the number of accountable items placed inside patient's body

Draining Tube

A patient underwent lumbar 4-5 (L4-L5) Transforaminal Lumbar Interbody Fusion (TLIF) surgery. A Redivac drain was inserted and anchored in position.

On post-operative day 4, a nurse removed the drain and encountered mild resistance. The nurse noticed that the tip of the drain was missing with irregular cut end. The operating surgeon was called to enquire about the shortened end, and the surgeon explained that the tip had been cut between the side holes during the operation. No further clarification was requested regarding the irregularity of the cut end.

X-ray revealed a segment of linear opacity. A computer tomography (CT) scan confirmed a 5.5 cm radiopaque foreign body at the posterior column of L4. A surgery was performed to remove the retained drain.

Learning Points

1. Establish a handover system to **measure and document length of the drain inserted** in operating theatre, **verify length of drain segment removed** in ward against the operation record
2. Implement a structured **communication** process between interdisciplinary teams using **Situation, Background, Assessment and Recommendation (SBAR)**
3. Procure **drains with different lengths** to avoid drain cutting

Retained Material

Post total hip replacement metallic fragment

A patient was admitted for a right total hip replacement (THR) due to osteoarthritis. During the operation, the flex shaft (Figure 1) broke into pieces. The pieces were retrieved by the scrub nurse and checked for integrity by surgeon. The wound was closed without complications. An X-ray on post-operative day 3, revealed no foreign body. The patient recovered uneventfully.

Figure 1. Flex Shaft

At a follow-up appointment, a 6mm curve radio-opacity over lesser trochanter was identified. A subsequent CT confirmed the 6mm metallic density close to the right hip joint (Figure 2). The patient opted for conservative treatment.

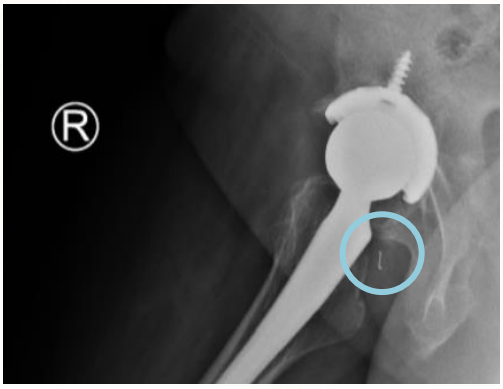


Figure 2. 6mm Metallic Density

Learning Point

When a retained foreign body is suspected, early investigation, follow up of abnormal result and open disclosure should be considered with reference to the clinical condition

Others

Nasogastric tube was found in the patient's bronchus

A tetraplegic patient had a nasogastric (NG) tube replaced, with a chest x-ray (CXR) ordered. After the tube's position was confirmed through a pH test, feeding was commenced. However, the CXR did not clearly show the tip of the NG tube, and an intern reviewing the CXR did not identify the tube's incorrect placement. Subsequently, the patient's condition deteriorated. Immediate resuscitation was performed and the NG tube was found to be misplaced in the left-sided bronchus. The patient was transferred to Intensive Care Unit (ICU) for further care.

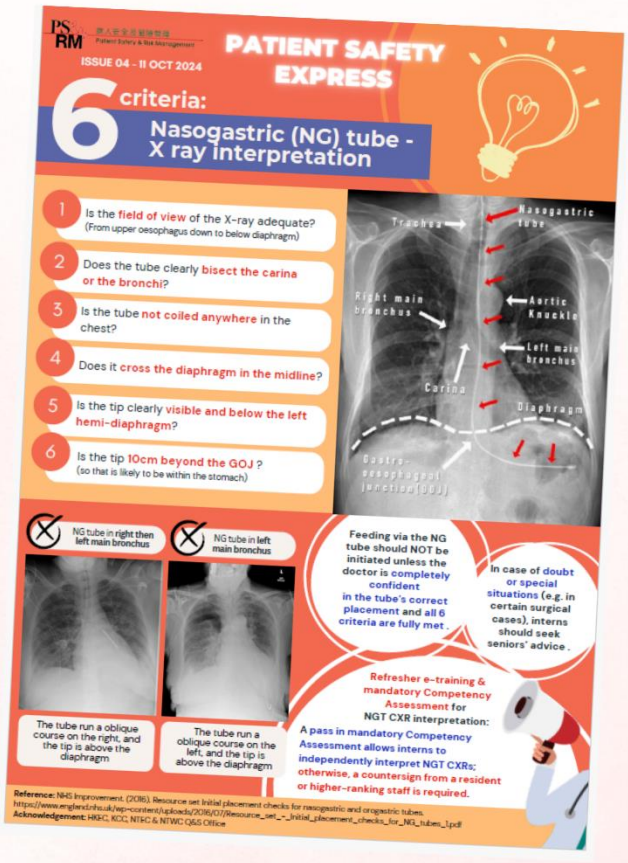
Learning Points

1. The incident occurred despite the nurses had confirmed the NG tube position by the pH test before feeding. In retrospect, the NG tube was mistakenly inserted into the left bronchi and the tip of the NG tube might have entered the left pleural cavity. With the existence of possibly infected pleural effusion, **false-positive result** to the pH test might have occurred

2. To **widen the use of CXR** to confirm the position of NG tubes, in view of the possibility of false-positive results of pH test

3. To enhance training and education for doctors on **radiological confirmation of NG tube position** and **recognition of abnormality** related to NG tube position

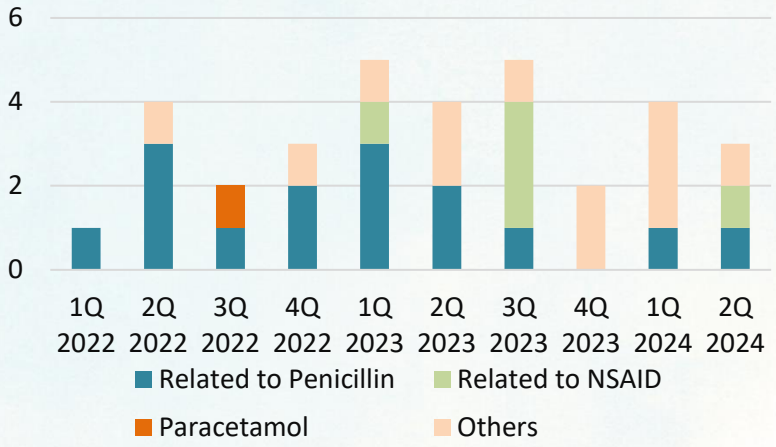
4. To introduce a new and **specific X-ray examination request** in the clinical management system to ensure radiological image quality for NG tube confirmation



SERIOUS UNTOWARD EVENTS

Of the 24 SUE cases reported in 2Q 2024, all cases were related to medication errors, including known drug allergy (KDA) (3), anticoagulants (4), chemotherapy agents (1), dangerous drugs (2), vasopressors and inotropes (3), insulin (4) and others (7).

Number of KDA cases (4Q 2021 – 2Q 2024)



Known Allergy	Allergen prescribed
Gentamicin	Maxitrol eye ointment
Penicillin	Augmentin
Ponstan	Voltaren

Medication Errors

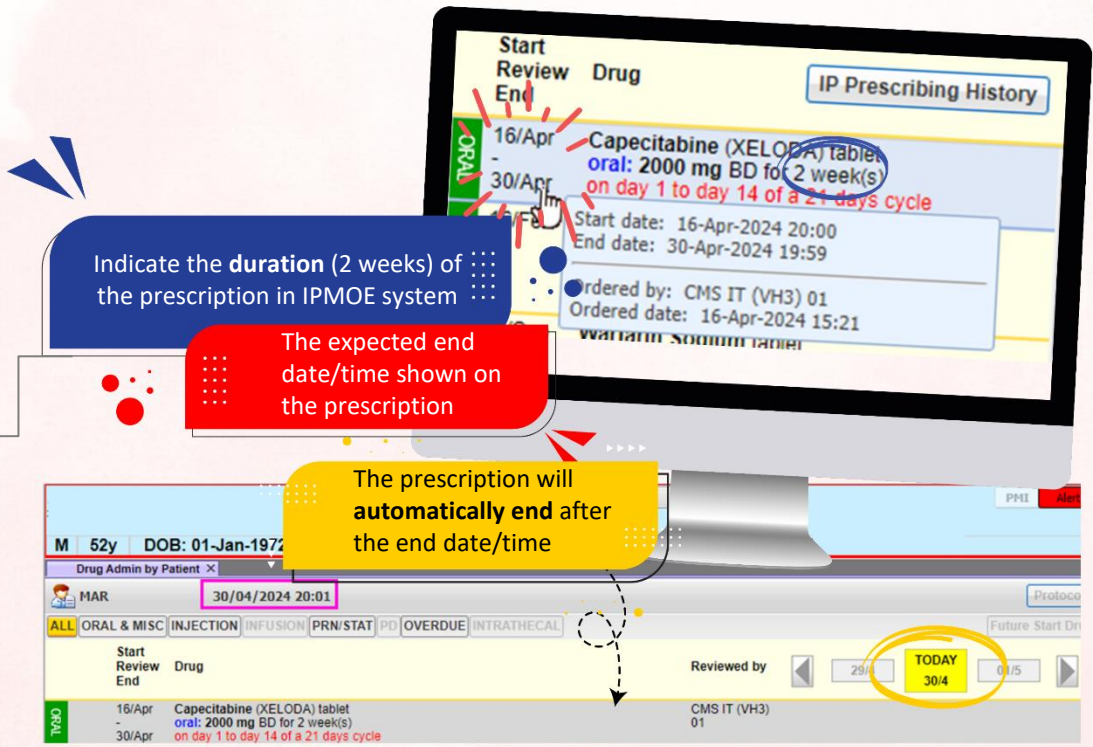
Capecitabine tablet was administered beyond the specified regimen of D1-14 of 21-day cycle

A patient with lung cancer and bone metastases underwent palliative radiotherapy at Hospital A. **Capecitabine (Xeloda) tablets** were prescribed at **2000mg BD**, with special instruction "on day 1 to day 14 of a 21-day cycle". The patient was later transferred to the palliative unit of Hospital B with the same prescription.

The prescription of **Xeloda** was continued in Hospital B and the patient developed gastrointestinal symptoms on the 4th day after admission. Despite a titration of laxatives was provided, the patient still experienced persistent gastrointestinal symptoms. During case round, it was discovered that the patient had received Xeloda for an **additional 12 doses**. Xeloda was discontinued immediately.

Learning Points

1. Enhance the clinical handover for **inter-hospital transfers**, especially on the **special regimen of high alert medications**
2. Reinforce **setting initial start date** and **end date in In-Patient Medication Order Entry (IPMOE) system** for prescribing and administrating cyclic drugs
3. Reinforce **review of IPMOE drug administration profile** during ward round and shift handover



Credit: HO IT&HI Division

Oral Azathioprine instead of Azithromycin was prescribed and administered to a patient

A patient was admitted due to fever and prescribed antibiotics after a sepsis workup. Following a diagnosis of Salmonella Group D, the microbiologist recommended oral **Azithromycin 500mg** daily. However, this was mistakenly transcribed as **Azathioprine 500mg** daily in the IPMOE system.

Despite pharmacist's alert, the intern adjusted the prescription to **Azathioprine 50mg** daily without counterchecking microbiologist's notes and wrote down "**Azathioprine 50mg** PO daily" on the progress notes.

Two nurses checked the prescription in the IPMOE system against the intern's note instead of the microbiologist's notes and administered **Azathioprine 50mg** daily to the patient.

Three days later, the microbiologist discovered the error. The oral Azathioprine was immediately discontinued.

Learning Points

1. Enhance the education to doctors on prescribing medications based on **appropriate indications**
2. Strengthen the practice of case doctor on reviewing the patient's **medication profile** in the IPMOE during patient round
3. Enhance a **safety culture for avoiding assumptions** and **seeking clarification** through training

Infusion Error

1ml/hr instead of the intended 12ml/hr of dopamine infusion was administered

A patient with COVID-19 and deteriorating condition was admitted to an isolation ward. Intravenous **dopamine infusion at 12ml/hr** was initiated due to low blood pressure (BP).

Three days later, Nurse A inadvertently **omitted resetting the Volume to be infused (VTBI)** after refilling dopamine in the infusion pump. One and a half hours later, another nurse performed vital signs checking for the patient and noticed that the dopamine rate was running at 12ml/hour. A few minutes later, the "**Near end of infusion alert**" alarm was triggered, it went unheard due to the double door setting in the isolation room.

Subsequently, the infusion pump **automatically switched to Keep Vein Open (KVO) infusion mode (default at 1ml/hour)**. The error was discovered after the patient's son alerted the nurses.

Learning Points

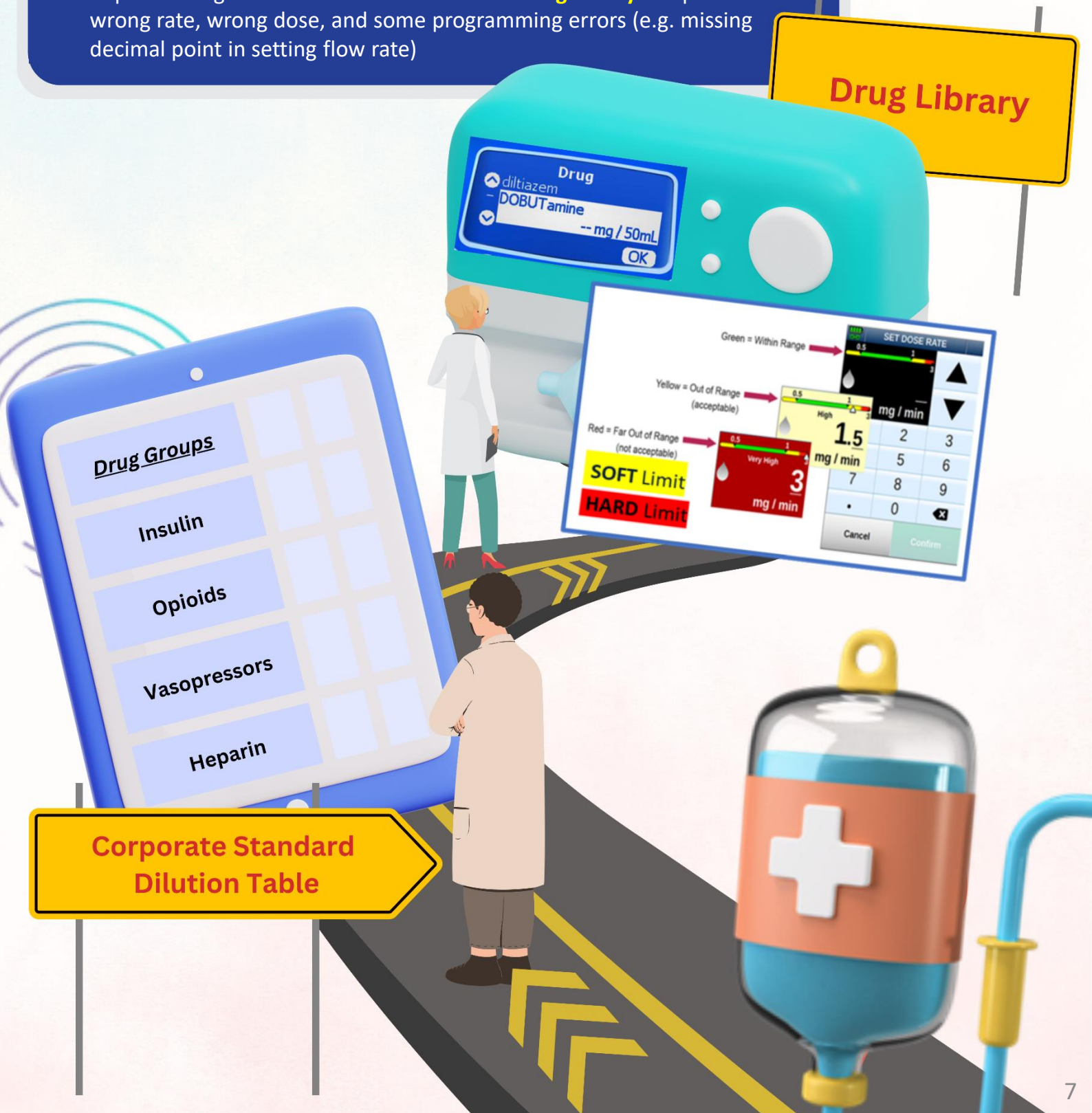
1. Reinforce **independent double checks** by two nurses for intravenous infusion administration changes or drug chamber refills
2. Enhance close monitoring on operation of infusion machine in the isolation ward. e.g. Explore the use of **smart infusion pump with central monitor** with alarming system
3. Activate the intercom system with regular checking on the volume to ensure the alarm of infusion pump inside the isolation room could be reached

LOCAL SHARING

Corporate Standard Dilution Table

SUE medication incidents related to infusions have been a significant concern:

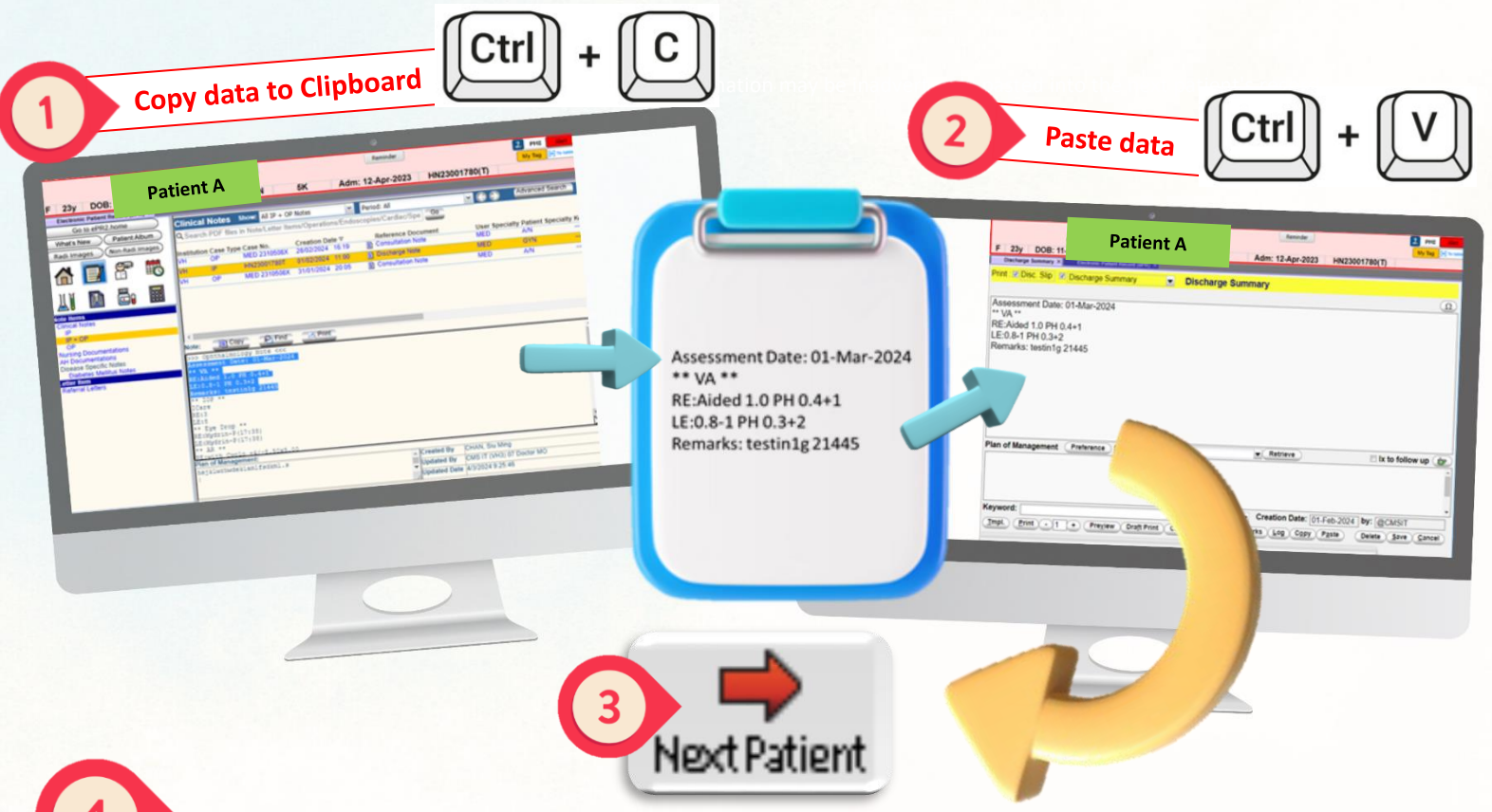
- Most of the incidents occurred in general adult wards and often involved 4 drug groups: **Insulin, Opioids, Vasopressors and Heparin**
- Among the infusion-associated incidents, the two most common errors were starting the **infusion rate outside the therapeutic range** and **incorrect prescription**
- Implementing a **standard dilution table** and **drug library** can prevent wrong rate, wrong dose, and some programming errors (e.g. missing decimal point in setting flow rate)

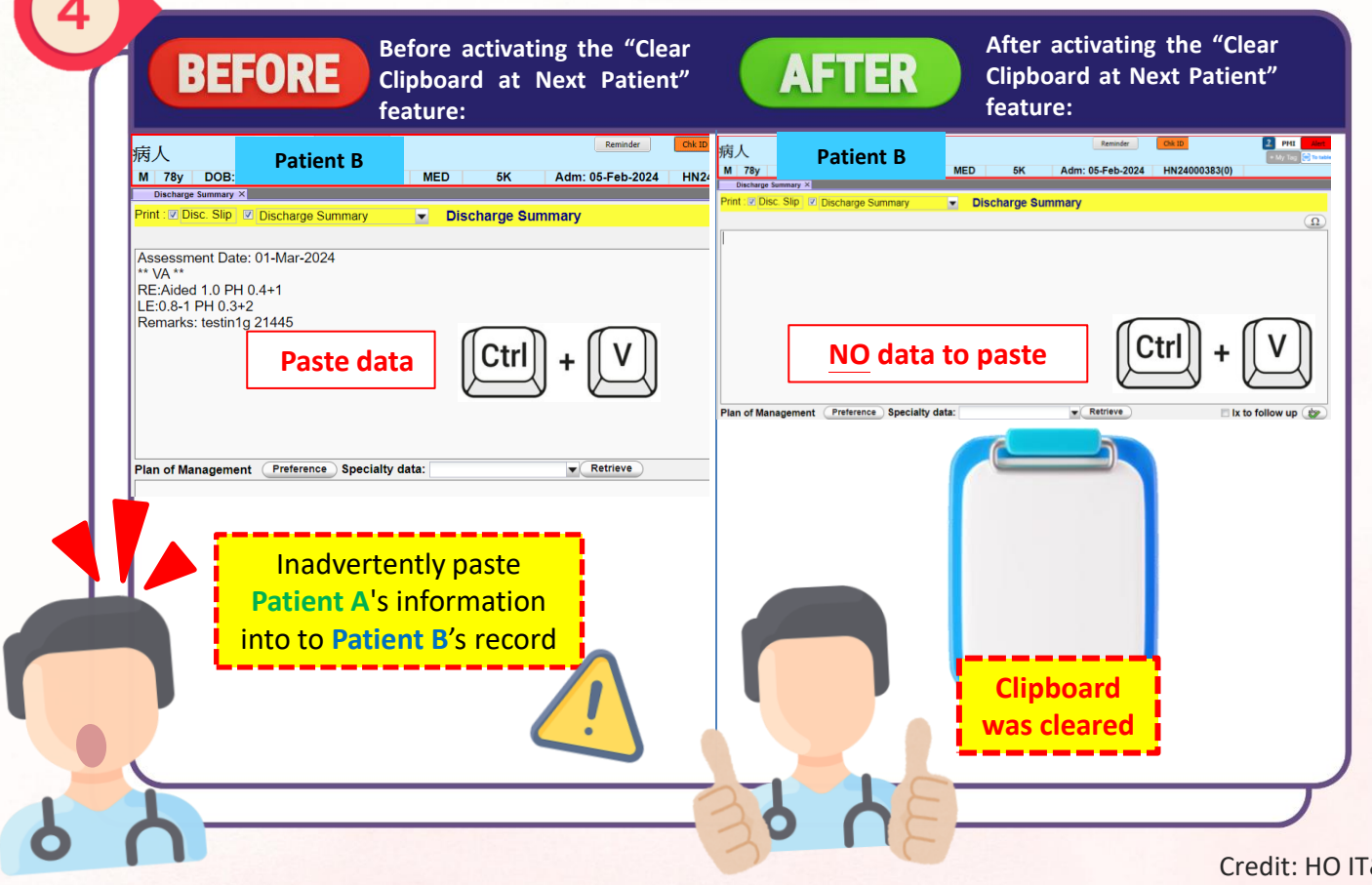


LOCAL SHARING

Clear Clipboard at Next Patient Feature

To prevent pasting incorrect patient information into another patient's electronic medical records, it is a good practice to implement the "**Clear Clipboard at Next Patient**" feature in your cluster.





Credit: HO IT&HI Division