Initiatives to Enhance Peri-operative Practices through collaboration with Surgical Stakeholders

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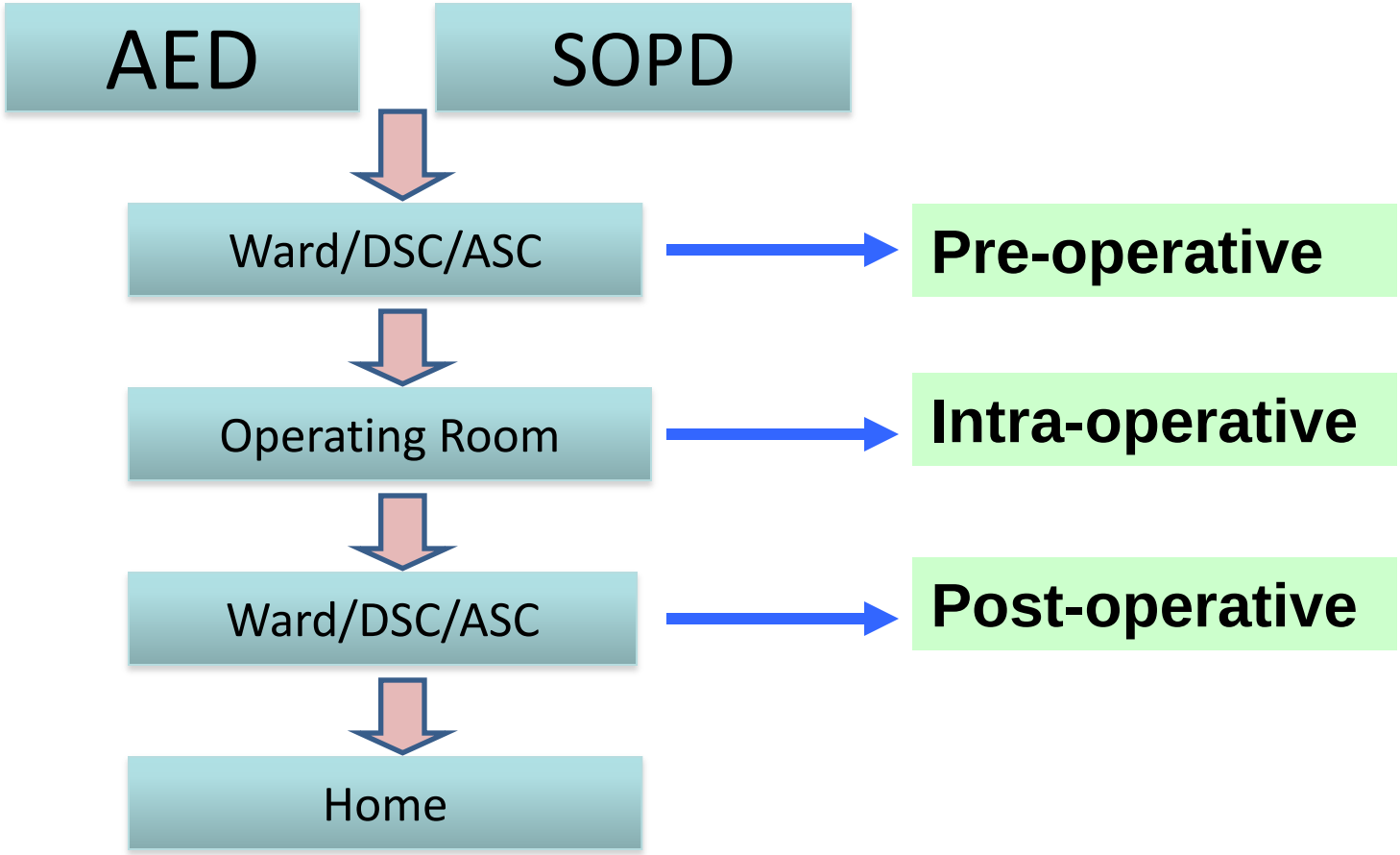
Overview

I. Risks at Peri-operative care	x
II. Quick look at Sentinel Events (HA-wide)	x
III. Attributes of Nurse Consultant to facilitate collaboration with Surgical Stakeholders	x
IV. Examples illustrating activities done to date	x
V. Keys to Successful Collaboration	x

Peri-operative Patient Journey



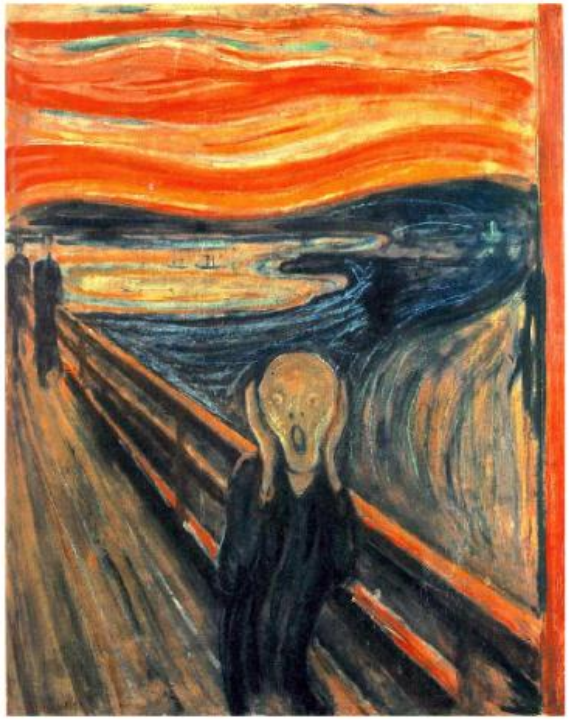
DANGER

The WHO has stated that "Problems associated with surgical safety in developed countries account for more than 50% of the avoidable adverse events that result in death or disability."

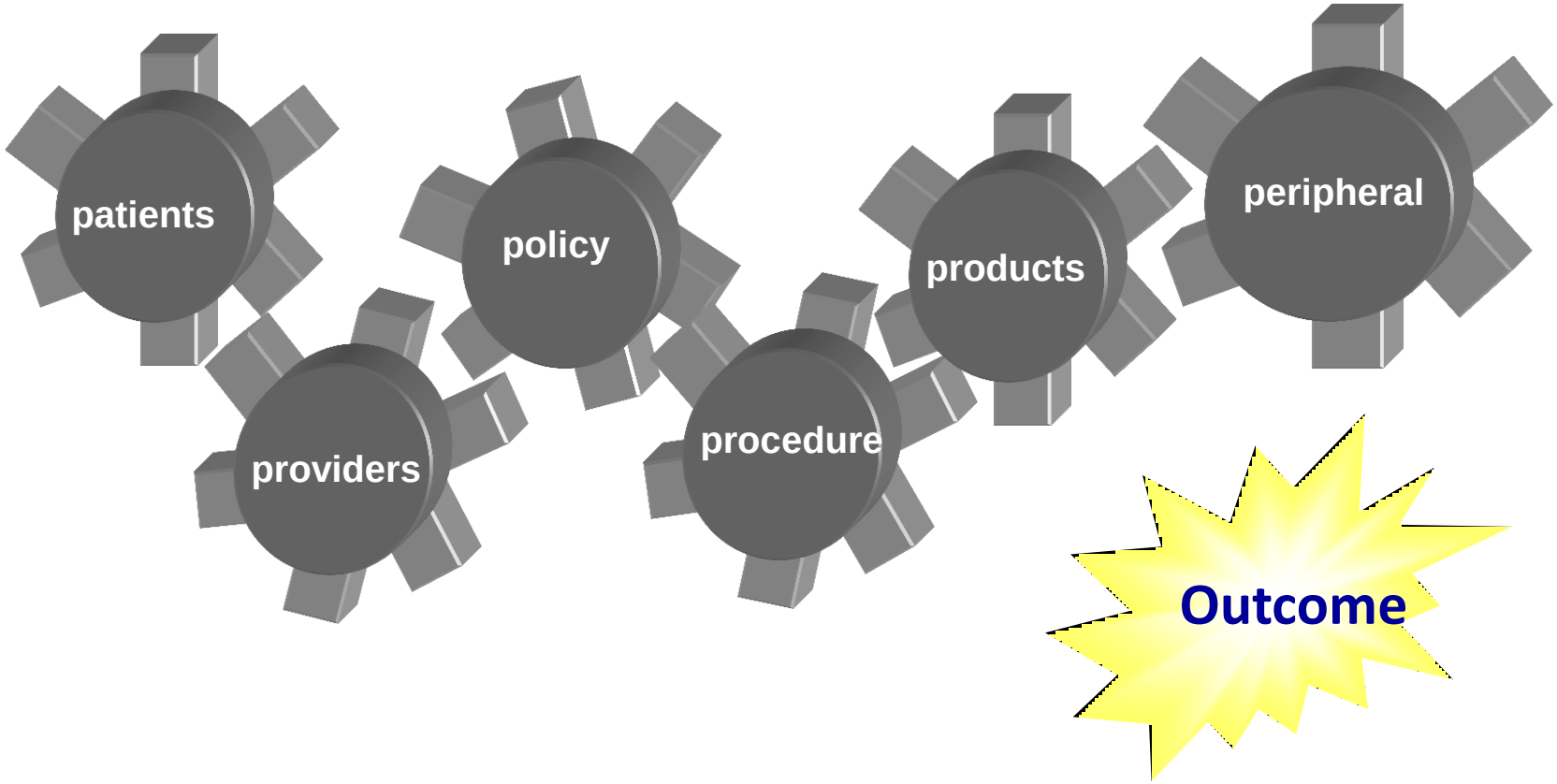
10 Facts on Patients Safety, 2012, WHO

Common Risks

1. Retained gauze/ parts of Instrument
2. Wrong patient / Wrong site / Wrong Procedures
3. Alcoholic- Burn
4. Medication error
5. Allergic reaction
6. Positioning risks
7. Pressure sore
8. Surgical Site Infection (SSI)



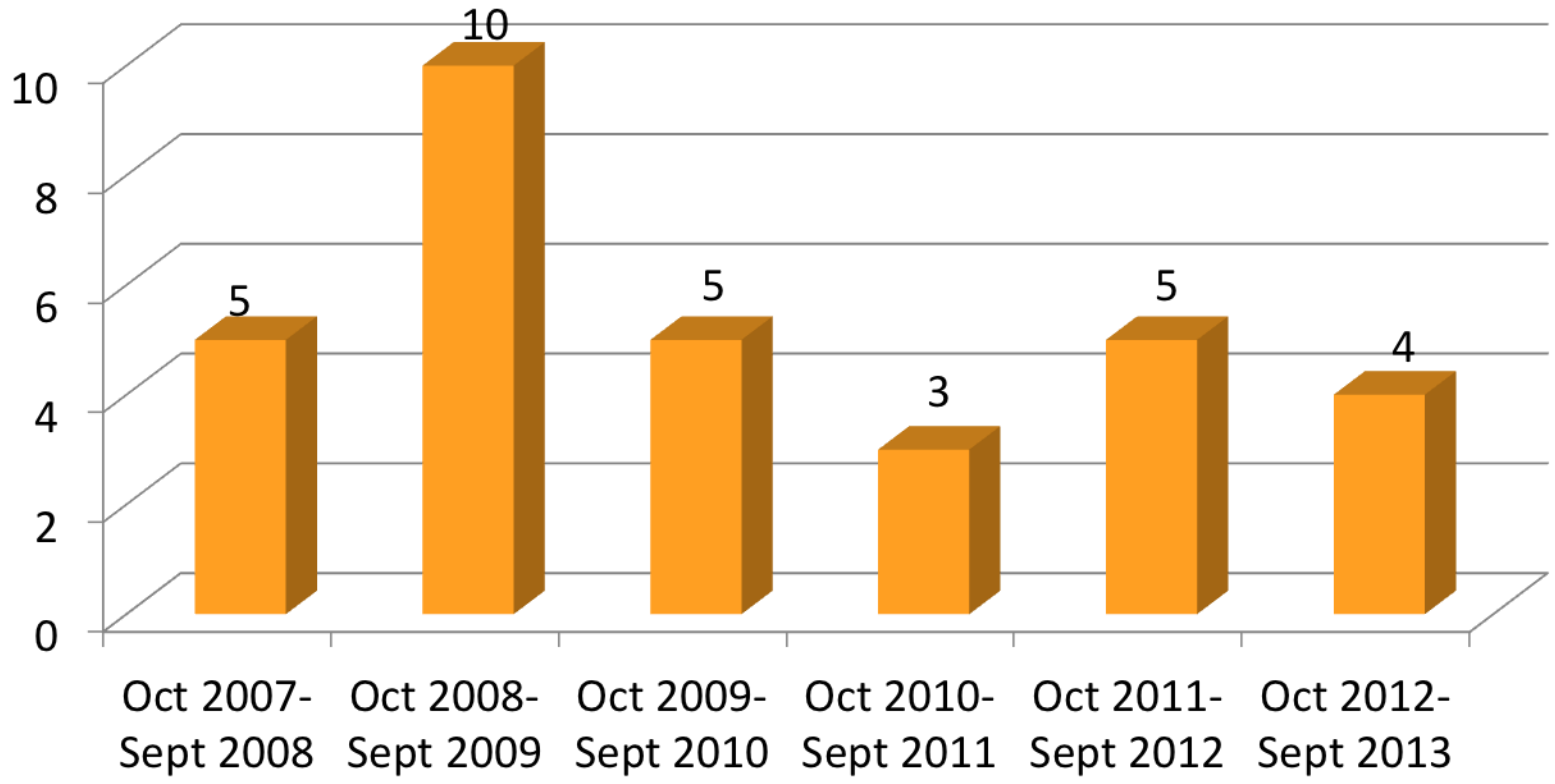
Healthcare system: interrelated or interacting elements forming a whole



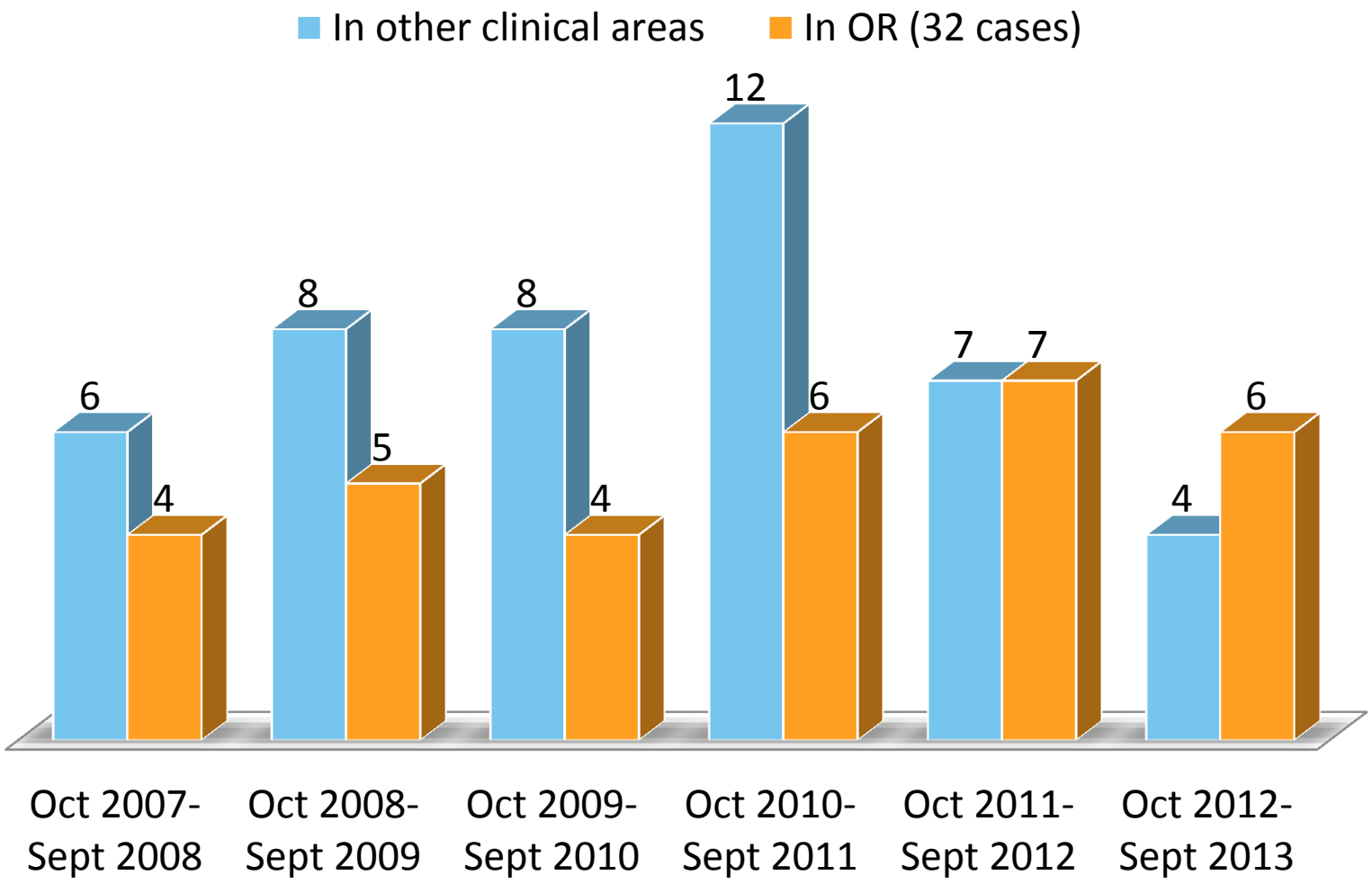
Sentinel Events (HA-wide)

		Oct 2007 to Sept 2013
1.	Surgery / interventional procedure involving the wrong patient or body part	32
2.	Retained instruments or other material after surgery / interventional procedure	77
3.	ABO incompatibility blood transfusion	2
4.	Medication error resulting in permanent loss of function or death	2
5.	Intravascular gas embolism resulting in death or neurological damage	1
6.	Death of an in-patient from suicide (including home leave)	90
7.	Maternal death or serious morbidity associated with labor or delivery	9
8.	Infant discharged to wrong family or infant abduction	2
9.	Other adverse events resulting in permanent loss of function or death (excluding complications)	6
	TOTAL	221

SE for Wrong Site Surgery (1 Oct 07-30 Sept 2013)



SE for Retained Surgical Items (1 Oct 07-30 Sept 2013)



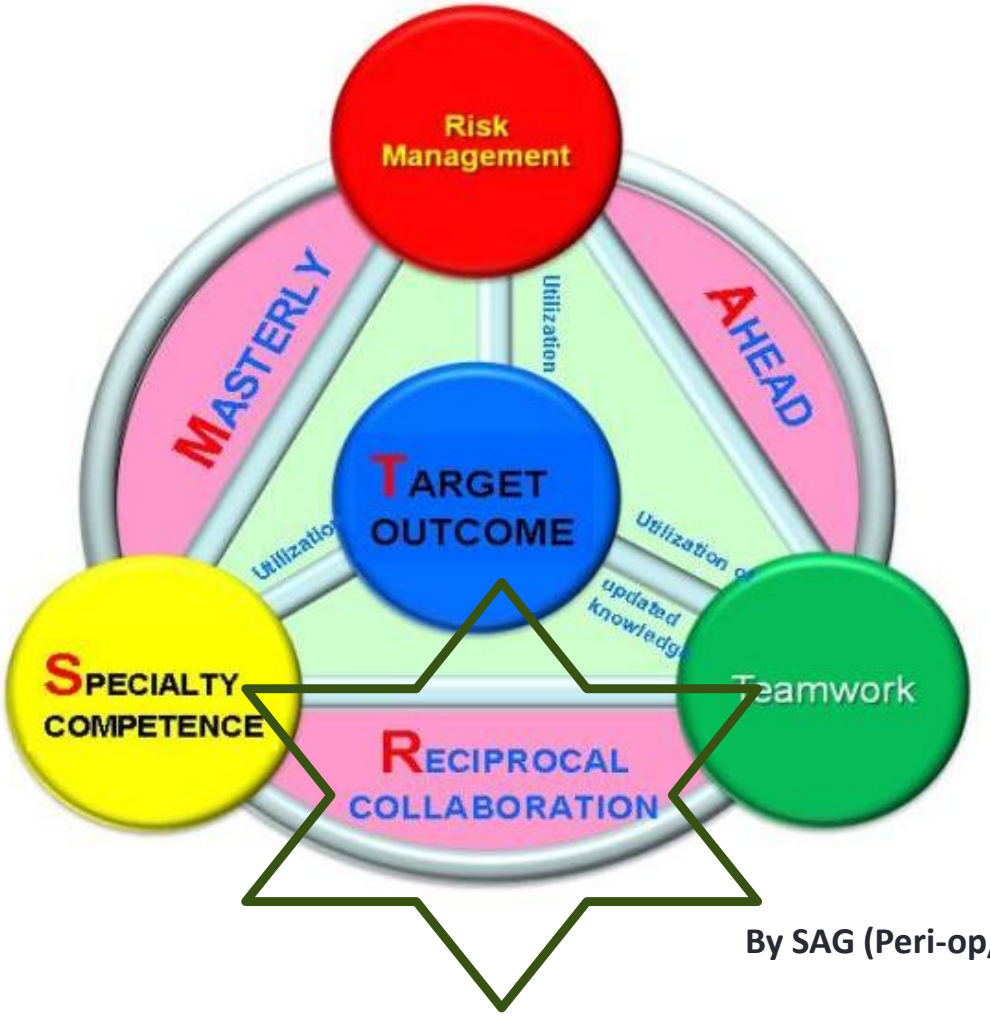
The leading root cause of Sentinel Events

Communication and Collaboration failures

We cannot change the human conditions, but we can change the conditions under which human works

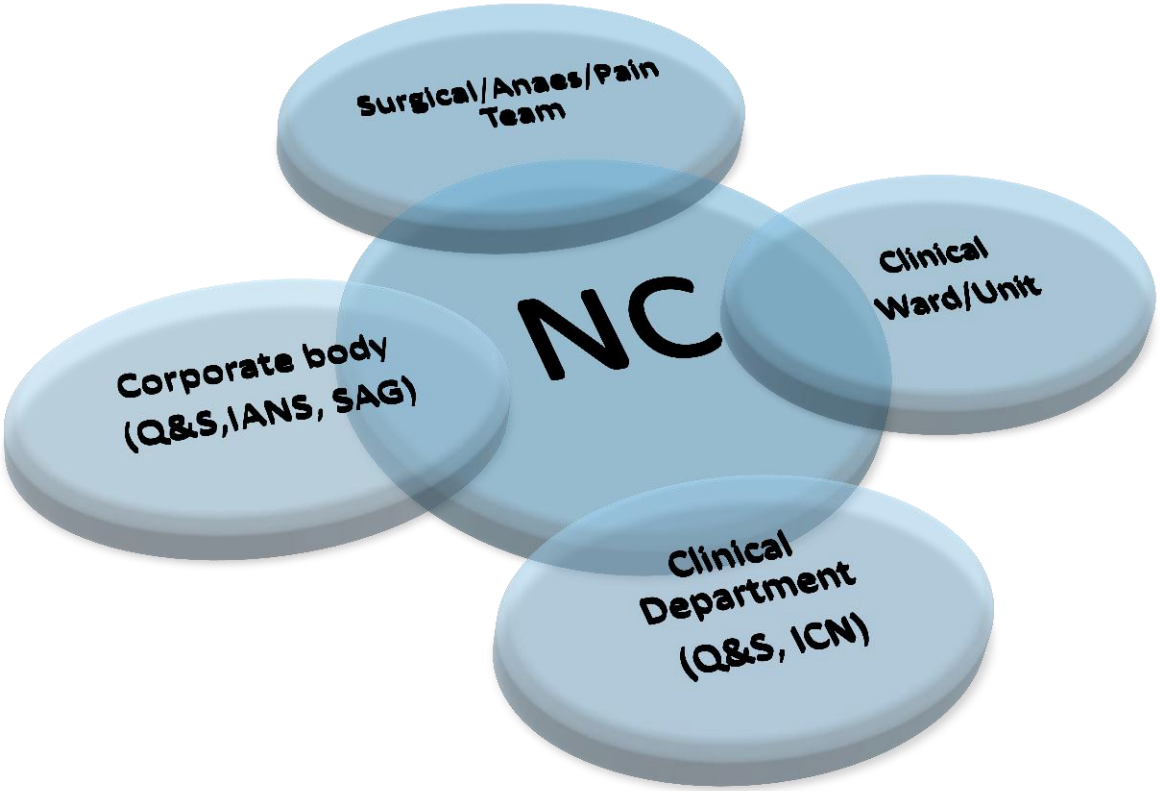
Professor James Reason
BMJ March 2000

SMART in TRUST Model for NC in Peri-operative Care



By SAG (Peri-op/Ana), HAHO

Consultative & Collaborative work with various stakeholders

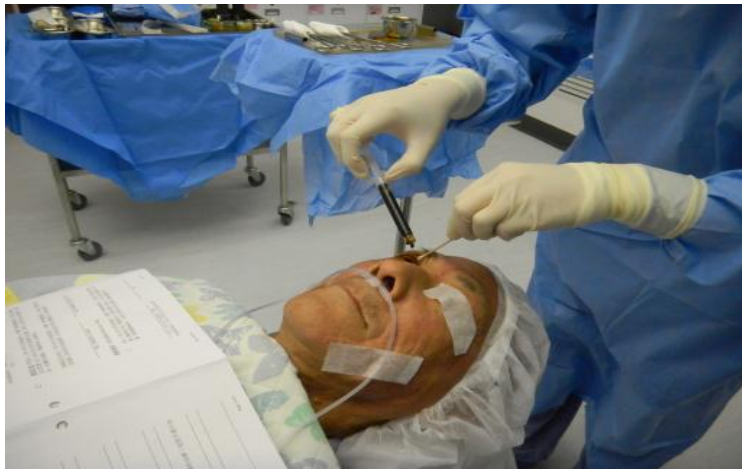


Cluster-based Measures

Wide applicability of 2% CHG in 70% Alcohol in Cluster- based skin disinfection

Compliance rate 96%

Standardized Cluster Practices



Standardize the cluster based practice on eye preparation & skin disinfection for eye patient

Ensure Compliance of surgical antisepsis at cluster level with specialty revised guideline

New Initiatives

Initiate the new practice to ensure efficient counting & reduce retained foreign bodies in laparoscopic surgery

Partial Count Technique

Gauze + Consumable item +
Used laparoscopic Instruments

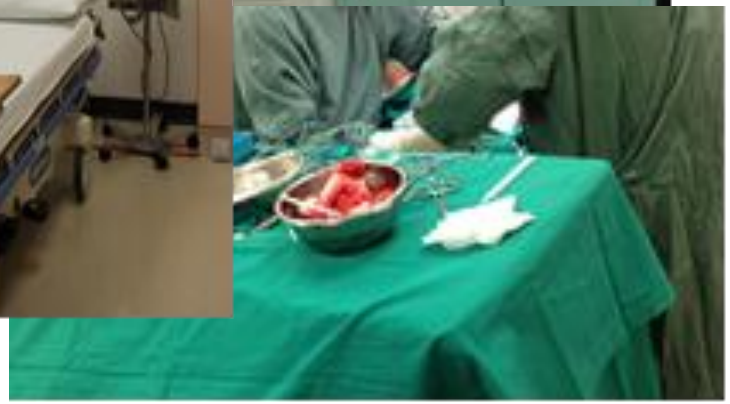
Governing Hospital-wide Safety Check

ACHS Criterion 1.5.6

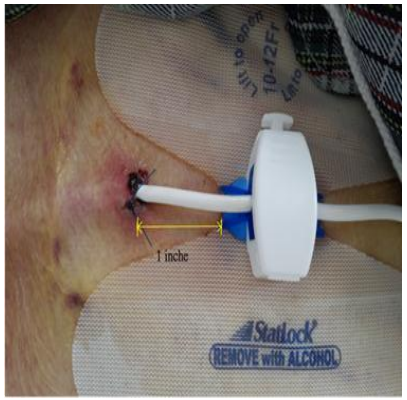
"Correct Patient, Correct Site, Correct Procedure"

Bedside consultation

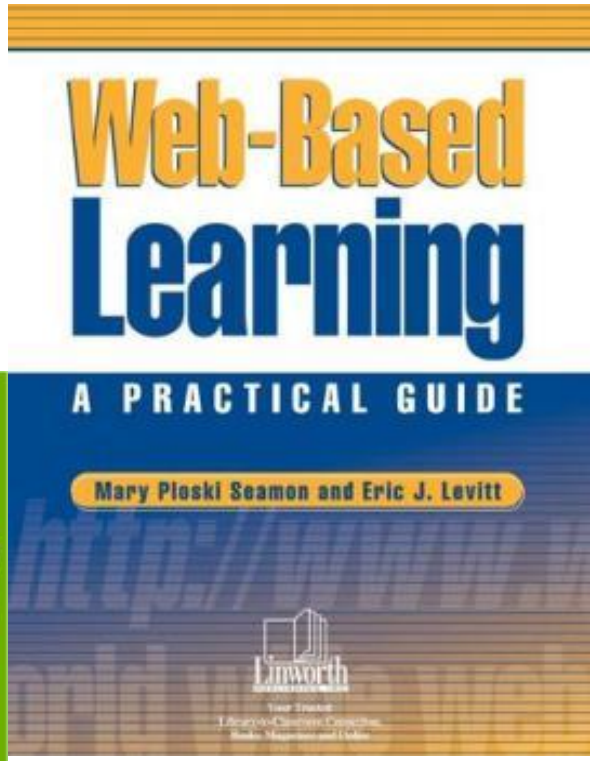
Recommended practice of counting in bed side procedures of Tenckhoff Catheter Insertion in Renal Ward



Recommended practice of anchoring exit site & dressing method of Hickman Catheter Insertion in Hematological ward



Sustaining competency of perioperative nurses



Recognition

- ❑ Extend to local applicability at intra-cluster & inter-cluster hospitals
- ❑ Open Sharing in Local & China conference
- ❑ Stakeholder's awareness
- ❑ Build up a Culture Safety

Keys to Successful Collaboration

- ❑ Encourage everyone to “buy in” and deliver the same message
- ❑ Let us put the Patient Safety onto the “table”
- ❑ Stakeholders get some benefits

Win / Win

Helping People
Happy Staff
Trusted by the Community

Presenter

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