



Service Priorities and Programmes
Electronic Presentations

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**PWH Operation Theatre Improvement Programme Extension
Post-implementation Review (2011 to 2012)**

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Introduction

This PWH Operation Theatre improvement program continuous post-implementation review (2011 – 2012) was extended from previous five year review (2006 – 2010). A continuation review cause of incidents and related corresponding improvement programs in maintaining of patient safety and prevention of incident since 2006.

Objectives

1.To promote perioperative patient safety. 2.To minimize and reduce the number of incident. 3.Prevent unexpected incident. 4.Increase efficiency of Operation Theatre. 5.To review the effectiveness of Improvement programme.

Methodology

This study is retrospectively reviewed. Details of incidents recorded which is used to review year of 2011 and 2012 incidents and compare with previous five years (2006 -- 2010). Root cause analysis (RCA) has been used to figure out the underlying reasons for the events. The effectiveness of corresponding improvement programs which are applied to minimize the risk of recurrence of similar events.

Result

Over past two years, the ratio of incident was still kept on low percentage (<0.3%). Meanwhile, several items of incidents were able to maintain zero record within two years (2011 – 2012), for example, loss of gauze, skin breakdown related to lateral positioning and pooling of skin disinfectants, skin breakdown related to patient poor skin condition, loss of teeth, improper specimen handling, improper blood product handling and improper use of instrument. But for the following four important items still have 0 to 2 incident reports each year: 1. The modify existing intra-operative Swabs, consumable counting chart and the implementation of the surgical safety 123 as well as to draw up Safety Points for the management of suspected retained surgical foreign body . 2. Modification of the existing peri-operative nursing record to ensure documented assessment of skin condition at entry and departure from the OT. A co-join research on positioning with CUHK is conducted so as to minimize patient injury in prone positioning. 3. Diathermy Burn is an occasional incident in OT and therefore our department made a structural training schedule and organized two talks

on diathermy safety for all new nurses and current staffs. 4. Medication error occurs due to misunderstanding during the communication process. Our department standardize the "On table medication" reference card in different specialties, provide different teams sterile drug label and encourage "Take Back Culture" among surgeons and nurses. Overall, all reinforcement measurements intend to maintain above four items to zero record each year.