MESSAGE FROM THE AUTHOR/SPEAKER

●This presentation can be used for **THE PURPOSE OF EDUCATION ONLY** and **should not be misused for other purposes.**

●The sharing of statistics, cases and root cause analysis findings are mainly to "learn from past incidents and share with others" in order to improve patient safety.

● Acknowledgment need to be given to the original speaker/author in each slide.

●No modification of the slides is allowed.

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Introduction to Safe Surgery Saves Lives Programme MoH Malaysia & Burden of Unsafe Surgery

PATIENT SAFETY SEMINAR 2018:
Safe Surgery Saves Lives
3rd-4th July 2018, Putrajaya

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Kenya doctors 'perform brain surgery on wrong patient'

2 March 2018 Share

The man who was operated on was suffering a brain swelling that did not require surgery

Staff from nurses to the CEO have been suspended at a Nairobi hospital after the wrong patient underwent brain surgery.

One patient needed surgery for a blood clot on the brain, the other only non-invasive treatment for swelling.

Cedera kepala, bedah kaki

'You're taking out wrong kidney, surgeon was told'

by CLARE KITCHEN, Daily Mail

A surgeon accused of killing a patient by taking out the wrong kidney was warned he was making a mistake by a medical student watching the operation, a court heard yesterday.

Dr Mahesh Goel dismissed the concerns of student Victoria Fern and pressed on with the surgery, it was said.

Utusan Borneo Online

Sarawak | Sabah | Nasional | Dunia | Iban | Sukan | Ekonomi | Mahkamah | Rencar

Halaman Utama » Sarawak » Wanita saman doktor, dakwa cuai jalankan pembedahan

Wanita saman doktor, dakwa cuai jalankan pembedahan

2015-06-25

KUCHING: Seorang wanita dari Bau mengemukakan saman terhadap pegawai perubatan atas kelalaian ketika menjalankan pembedahan ikat saluran beranak (bilateral tubal ligitation).

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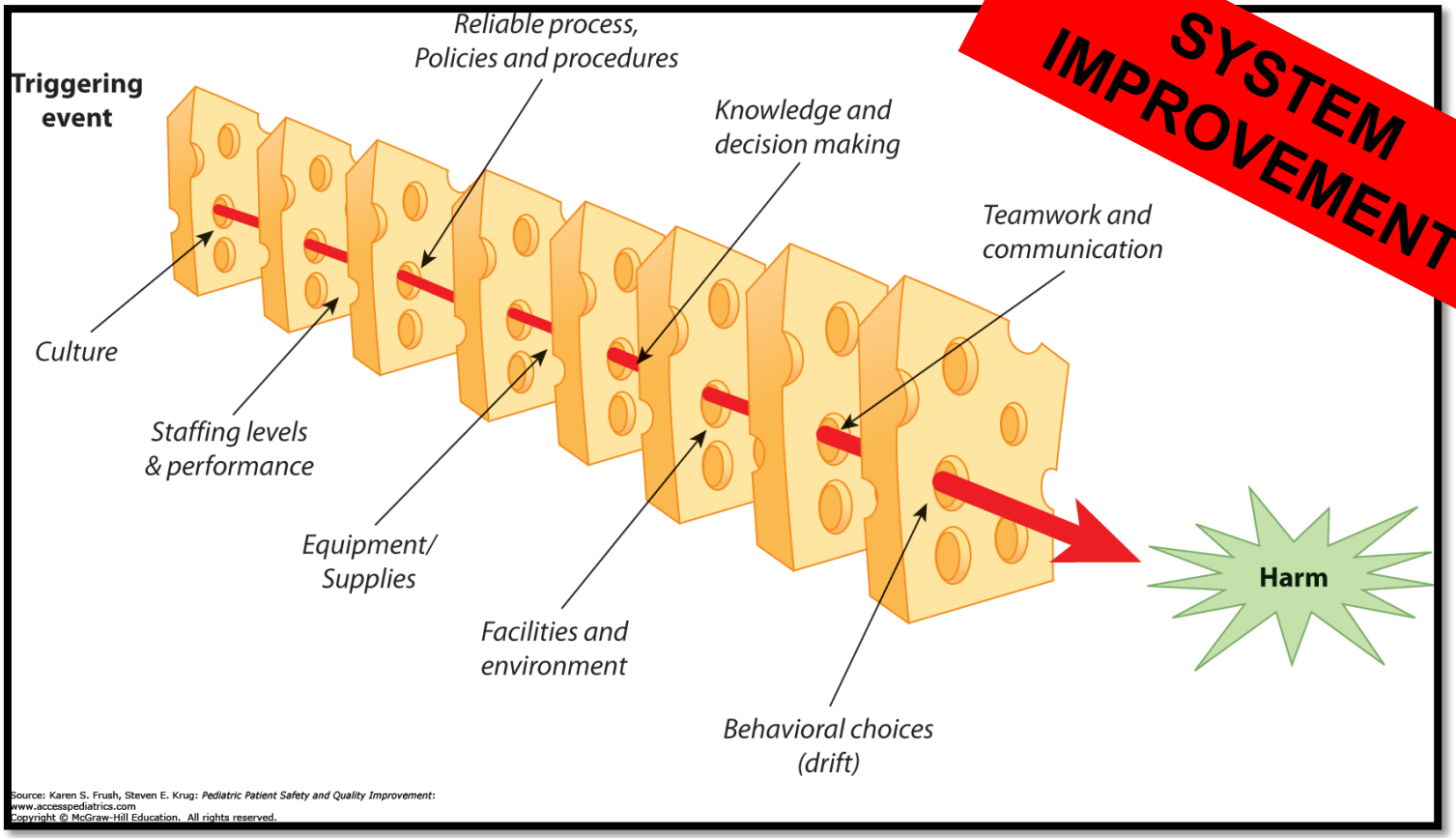

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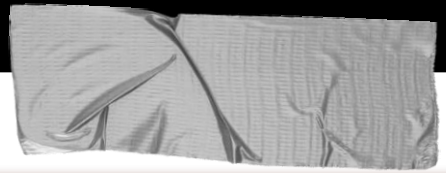
CONTENT



- ➔ Introduction
- ➔ The Figures: Surgery, Surgical Complications & Adverse Events In Surgery
- ➔ The Issues: Wrong Surgery & Unintended Retained Foreign Body
- ➔ The Answer: Safe Surgery Saves Lives Programme
- ➔ Barrier & Tips to Implementation
- ➔ What To Do Next?

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Introduction

- Principle objective of healthcare is **TO DO NO HARM** & ensure benefits of treatment outweigh the risk.

- Ensuring patient safety is **ethical, moral responsibilities** to patients and their families; **economic investment.**

- It was estimated that **"Patient Harm" is the 14th leading cause of global disease burden",** same level as tuberculosis, malaria.

- 15% of hospital activity & expenditure consumed by direct sequelae of patient harm.

- Most frequently adverse events were related to surgical procedure.

(Source: Slawomirski et.al. 2017. The Economics of Patient Safety, OECD)

Volume of Surgery – Globally & Malaysia

Total surgery globally 2012:
312.9 million operations

Mean global surgical rate:
4,469 operations per 100,000 people per year.

(Source: Weiser et.al. Size & Distribution of Global Volume of Surgery in 2012. Bull WHO.2016.94201-209F:)

Total surgery in MOH facilities 2010: 913, 256

Total surgery in MOH facilities 2016: 1.103 million

(Source: Health Informatics Centre, Ministry of Health Malaysia)

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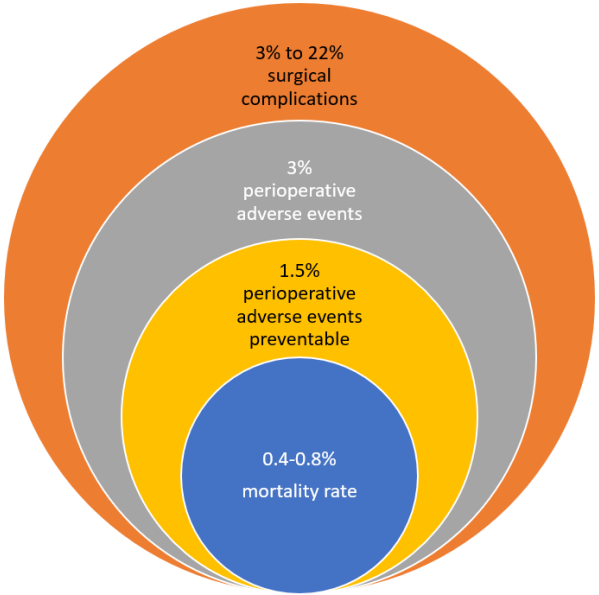
Surgical Complications & Adverse Events



Industrialised Countries:

- ❑ Major complications during surgery - 3 to 22% of inpatient surgical procedures
- ❑ Death rate - 0.4 to 0.8%
- ❑ 3% adverse events
- ❑ 1.5% preventable adverse events

Developing Countries:

- ❖ Death rate – 5 to 10%

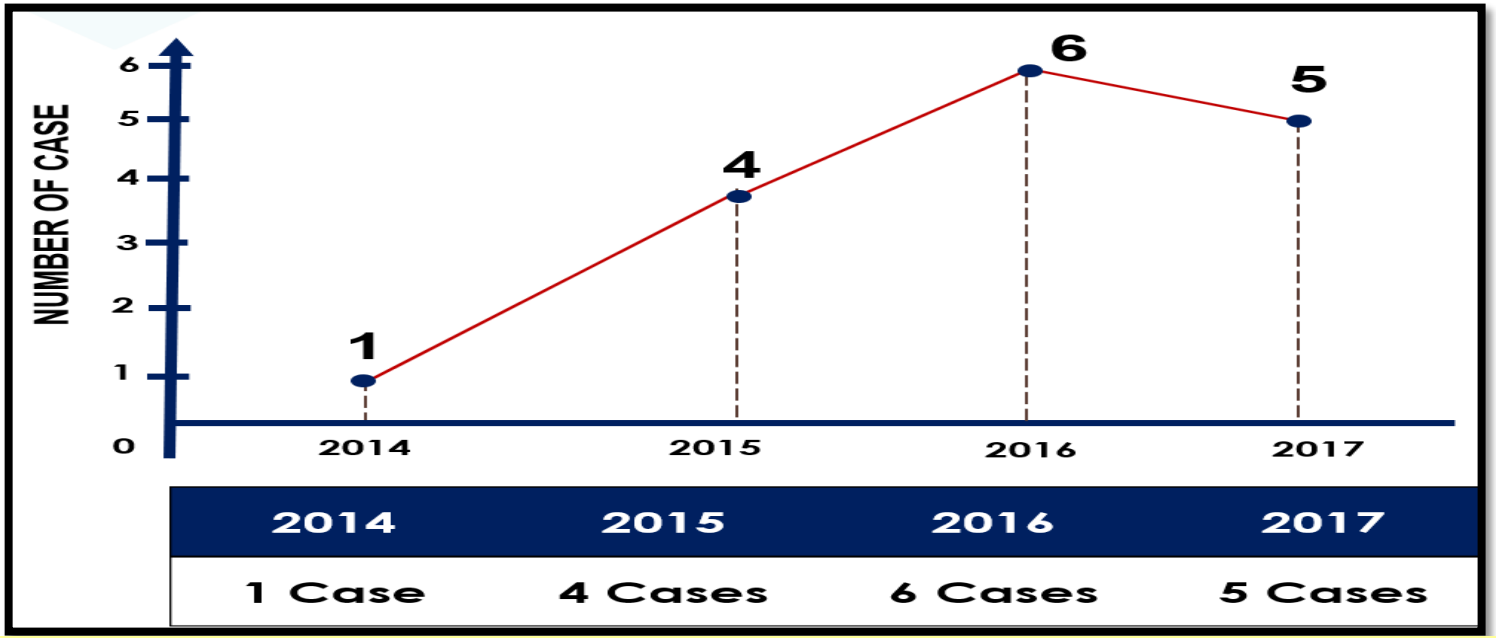
Extrapolate to MoH data 2016:Total surgeries 1.103 million

- ❖ Death rate 5 to 10%.....?55,150 to 110,300 surgical death
- ❖ Adverse events 3%….?33,090 cases
- ❖ Preventable adverse events 1.5%…?16,545 cases

***Adverse events:** An injury caused by medical management or complication instead of the underlying disease and resulted in prolonged hospitalization, disability at the time of discharge

(Source: WHO Guidelines For Safe Surgery : Safe Surgery Saves Lives, 2009.)

Wrong Surgery Reported to Malaysian Patient Safety Goals 2014-2017 (Target: Zero)



2014	2015	2016	2017
1 Case	4 Cases	6 Cases	5 Cases

(Source: Patient Safety Unit, Ministry of Health, Malaysian Patient Safety Goals Reporting)

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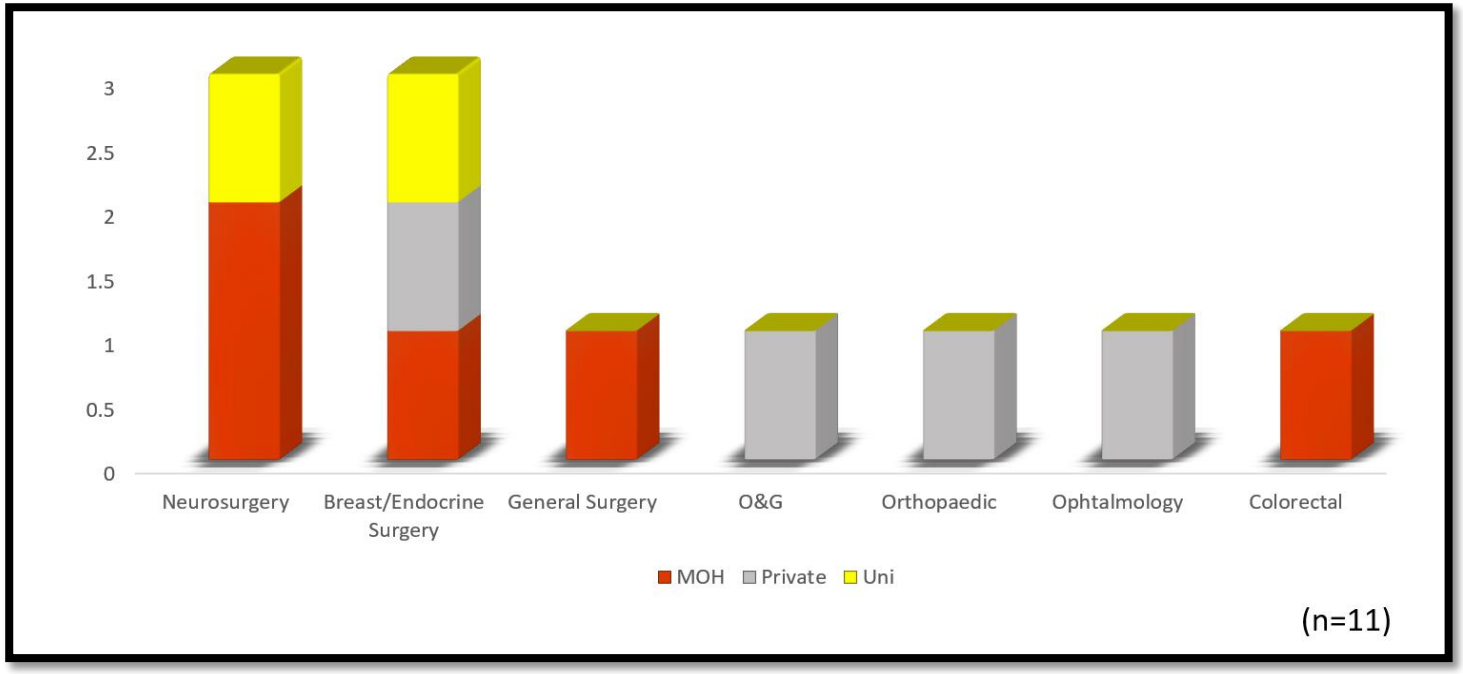
Wrong Surgery By Discipline MPSG Reported Cases 2014 to 2016



(Source: Patient Safety Unit, Ministry of Health, Malaysian Patient Safety Goals Reporting)

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Details of Wrong Surgery MPSG Reported Cases 2014-2016

DISCIPLINE	DESCRIPTION
BREAST & ENDOCRINE	RIGHTT AXILLARY TAIL REMOVAL OF LYMPH NODES INSTEAD OF RIGHT CHEST WALL EXCISION
COLORECTAL	RUBBER BANDING FOR HEMORRHOID INSTEAD OF SEBACEOUS CYST EXCISION
NEUROSURGERY	RIGHT CRANIOTOMY INSTEAD OF LEFT CRANIOTOMY
BREAST & ENDOCRINE	WRONG SITE OF BREAST LUMP REMOVAL
GENERAL SURGERY	RIGHT OVARY WAS REMOVED INSTEAD OF APPENDIX FOR ACUTE APPENDICITIS
NEUROSURGERY	RIGHT CRANIOTOMY INSTEAD OF LEFT CRANIOTOMY FOR LEFT EXTRADURAL HEMORRHAGE
NEUROSURGERY	LEFT CRANIOTOMY INSTEAD OF RIGHT FOR BRAIN TUMOR REMOVAL

(Source: Patient Safety Unit, Ministry of Health, Malaysian Patient Safety Goals Reporting)

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Details of Wrong Surgery MPSG Reported Cases 2014-2016 (cont'd)

DISCIPLINE	DESCRIPTION
ORTHOPAEDIC	LEFT KNEE ARTHROSCOPIC REPAIR INSTEAD OF RIGHT KNEE
OPTHALMOLOGY	LEFT ORBITAL REPAIR INSTEAD OF RIGHT
OBSTETRIC & GYNAECOLOGY	UNCONSENTED BILATERAL TUBAL LIGATION
BREAST& ENDOCRINE	WRONG SIDE ADRENALECTOMY

n= 11 cases

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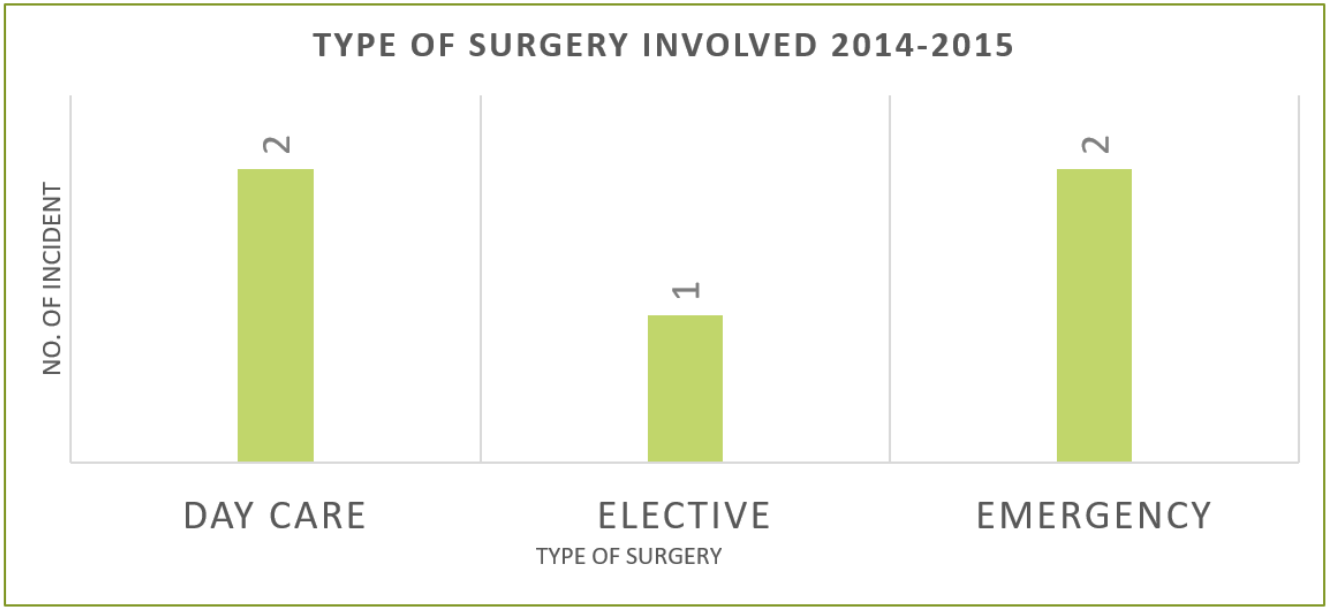
Wrong Surgery By Type of Surgery MPSG Reported Cases 2014-2015



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Why Wrong Surgery Occurred?

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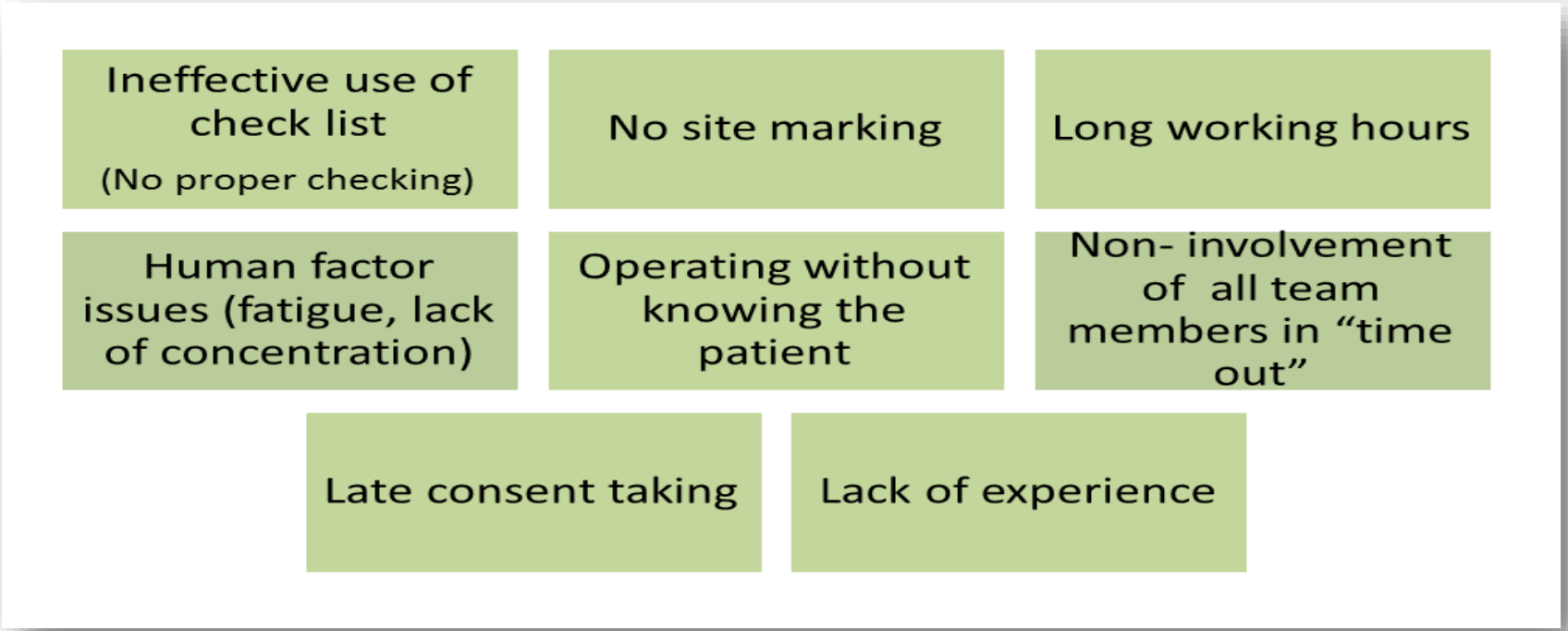
Wrong Surgery - Contributing Factors
(Based on RCA Reports received by Patient Safety Unit, Ministry of Health Malaysia)



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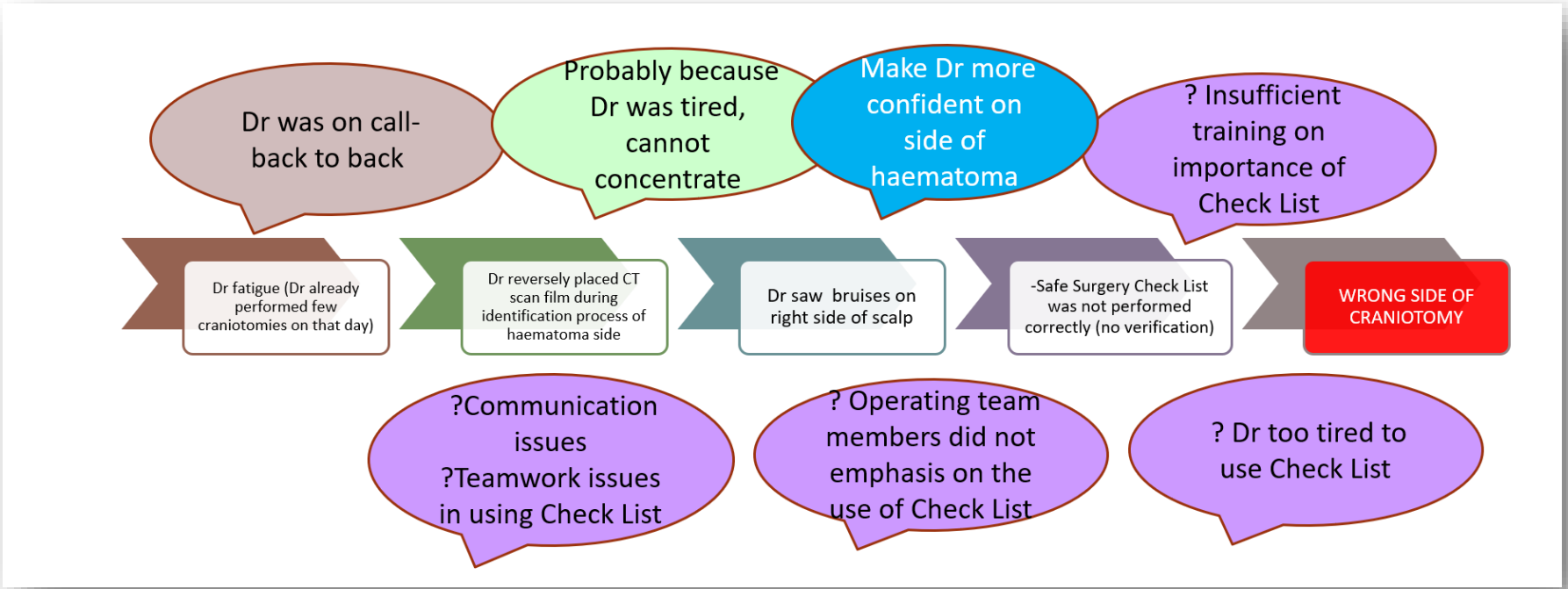
Example –Wrong Side Craniotomy



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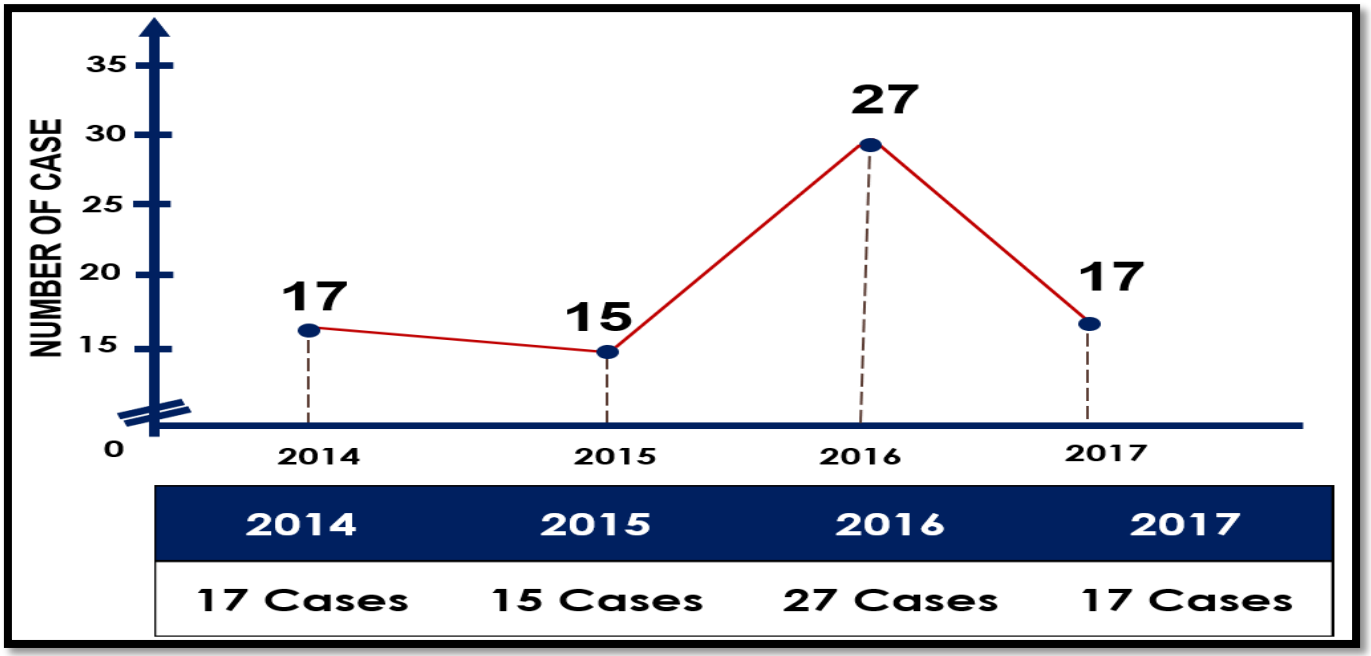
Unintended Retained Foreign Body Reported to Malaysian Patient Safety Goals 2014-2017 (Target: Zero)



2014	2015	2016	2017
17 Cases	15 Cases	27 Cases	17 Cases

(Source: Patient Safety Unit, Ministry of Health, Malaysian Patient Safety Goals Reporting)

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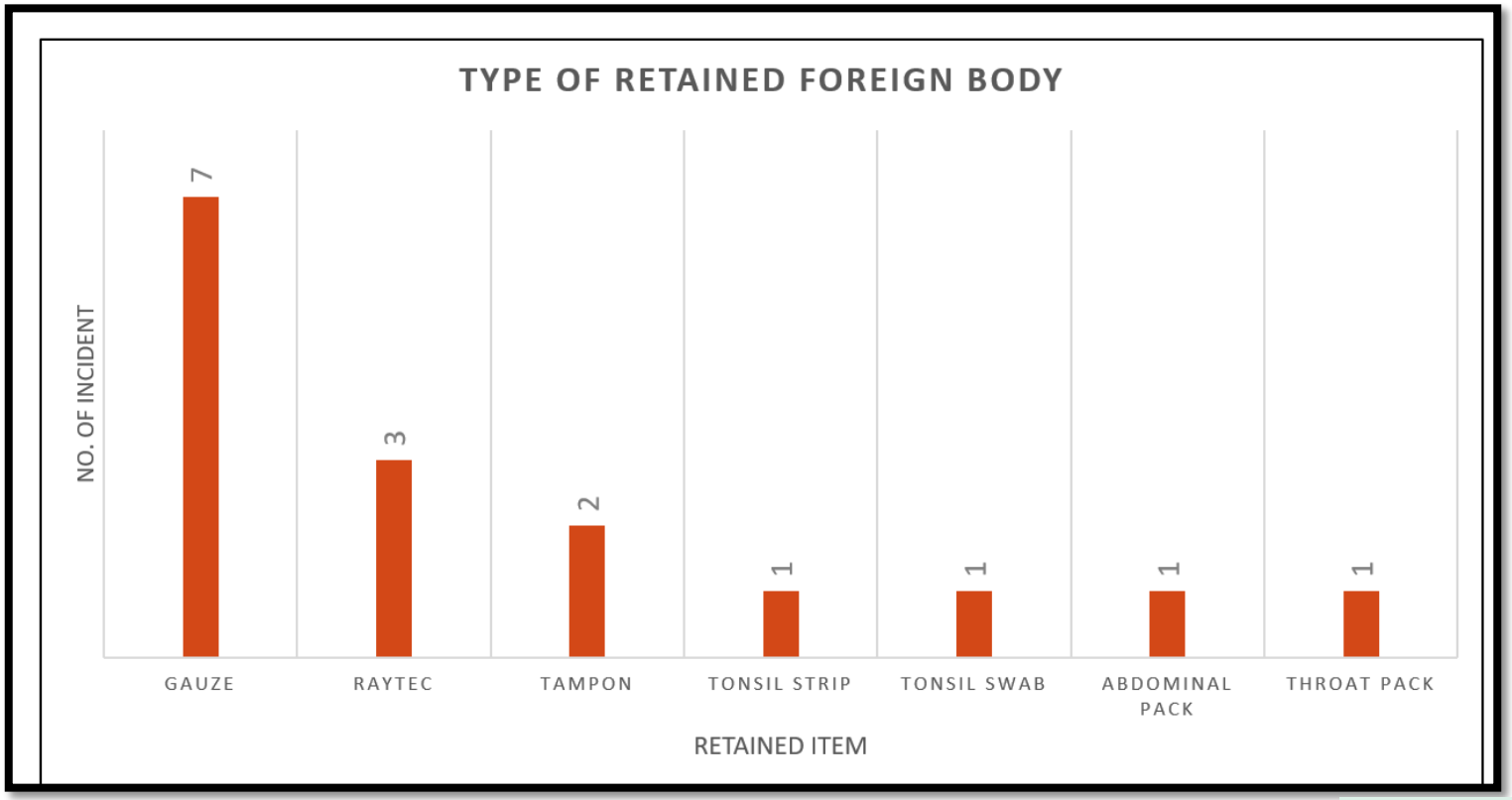
Type of Retained Foreign Body MPSG Reported Cases 2014-2015



n= 16 cases

(Source: Patient Safety Unit, Ministry of Health)

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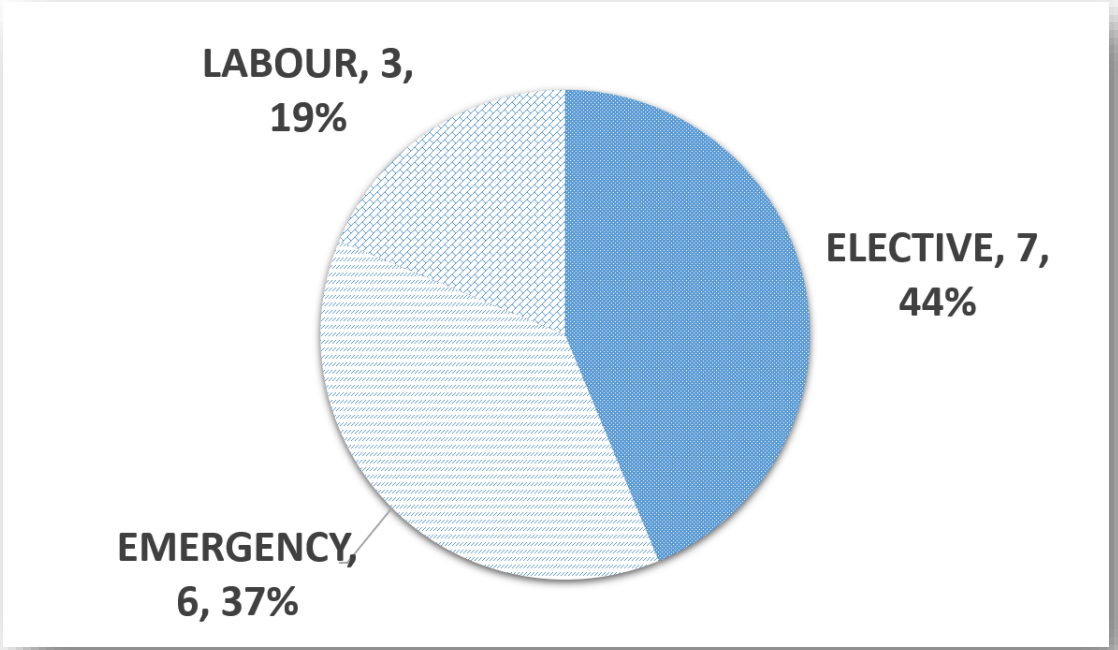
Type of Surgery Involved In Unintended Retained Foreign Body
MPSG Reported Cases 2014-2015



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Unintended Retained Foreign Body- Contributing Factors
(Based on RCA Reports received by Patient Safety Unit, Ministry of Health Malaysia)

1. Failure to properly do swab counting - pre and post operation. Almost half of the cases did not do swab counting properly causing this incident to happen.

2. Failure to document any inserted gauze or tampon especially after delivery in the patient's case note . This lead to unnoticed retained foreign body where the doctor or nurse forget to remove them before patients are allowed to go home.

3. Surgeon took any swab by himself during procedure and failed to inform the scrub nurse or other relevant staff regarding the swab.

4. Inadequate passing over of information including some miscommunication between the staff doing the procedure and staff managing the patient in the ward post-surgery

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The answer…

Safety thinking, safe practise, safe system, safety culture…

SAFE SURGERY SAVES LIVES PROGRAMME

Use of Perioperative Checklist

- Simple, efficient priority checks
- Effective Communication
- Improve Teamwork.
- Ensure consistency in patient safety during surgery
- Improve safety culture

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JOURNEY OF SAFE SURGERY SAVES LIVES INITIATIVE IN MALAYSIA

12th May 2008
Presentation on "Safe Surgery Initiative" proposal at Malaysian Patient Safety Council Meeting
(MoH , Putrajaya)

5th Feb 2009
Training of 6 hospitals on pilot project
(Langkawi)

12th Nov 2009
Signing of DG Circular No. 23/2009 on implementation of Safe Surgery Saves Lives Initiative
(MoH, Putrajaya)

15th Nov 2009
Launching of Safe Surgery Saves Lives Initiative & Implementation Guideline
(Langkawi)

2008

2009

2010

3rd July 2008
Formation of "Safe Surgery Steering Committee"
(MoH, Putrajaya)

25th – 27th Aug 2008
Formation of scope, approach, 'Safe Practices'
(H. Kuala Terengganu)

15th–17th Dec 2008
Formulation of materials for pilot project
(Langkawi)

24th Oct 2009
Presentation and endorsement of initiative at *Mesyuarat KPK Khas*
(MoH, Putrajaya)

Nov 2009 – 2010
Training of hospitals on the Safe Surgery Saves Lives Initiative

1 Jun 2010
Implementation of Safe Surgery Saves Lives Initiative in all MoH hospitals performing surgery

2011 - 2018
SSSL is included in various Patient Safety programmes such as Malaysian Patient Safety Goals, Incident Reporting & Learning System, Mandatory Patient Safety Awareness Course for House Officers

START

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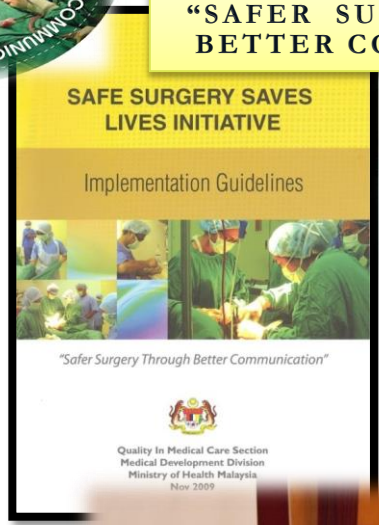
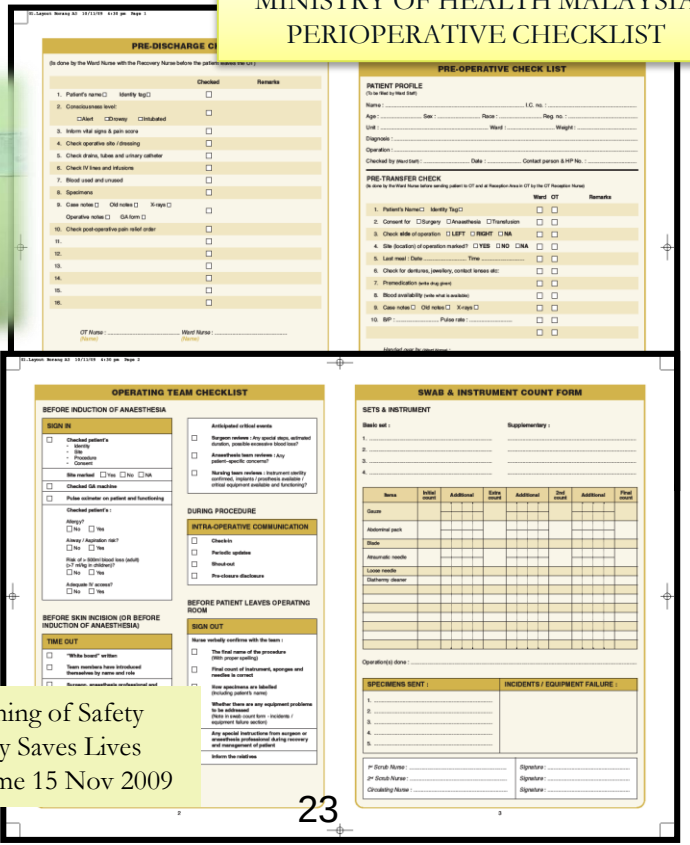
2nd GLOBAL PATIENT SAFETY CHALLENGE
"SAFE SURGERY SAVES LIVES"

THEME

"SAFER SURGERY THROUGH BETTER COMMUNICATION"

MINISTRY OF HEALTH MALAYSIA
PERIOPERATIVE CHECKLIST





Launching of Safety Surgery Saves Lives Programme 15 Nov 2009

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What Have We Achieved So Far?

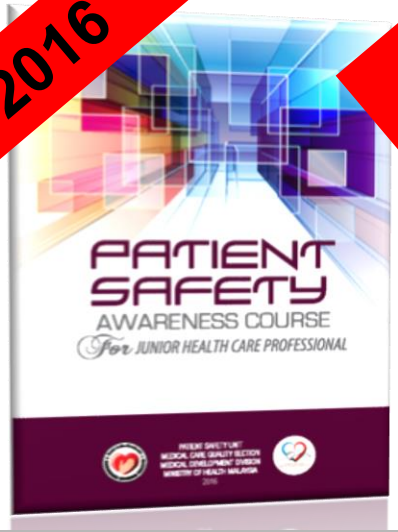
2009

Implement Safe Surgery Saves Lives Programme

2013

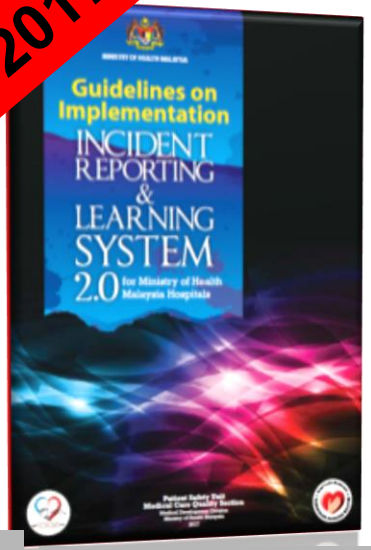
"Never Event" – Wrong Surgery & Unintended Retained Foreign Body

2016



Safe Surgery Saves Lives Programme Part of Mandatory Patient Safety Course for HO

2017



All incidents & near miss need to be reported, investigated, prevented

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Barriers to Implementation

-Insufficient coverage of training
-Ineffective training
- Non understanding on importance of programme
-Deny benefits of check list

-Unfamiliar with use of check list
-Time consuming
-Using check list as “tick box exercise”

-Resistant to change
-Lack of safety culture
- No support from leaders, teams

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Tips For Successful Implementation

Leadership

Effective Training of Staff, Team

Good teamwork

Resources

Documentation

Data Collection & Feedback

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Safe Surgery Check List – Is It Used In MoH Hospitals?

- ✓ Compliance audit conducted for surgery 1st Jan-30June 2017.
- ✓ Overall compliance is still low.
- ✓ Overall Full Compliance Rate 32.14% of 2,100 checklist
- ✓ Elective Surgery 38.13%
- ✓ Emergency Surgery: 23.76%
- ✓ Day Surgery: 0%

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What Do We Need To Do?

It is time for us to be the **GAME CHANGER!!!**

-Enhance Surgical Safety

-Promote, educate & motivate others to use Safe Surgery Checklist **EFFECTIVELY**

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Thank you…

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