SVIMS NEVER EVENTS

First introduced in 2001, the term 'Never Events' refers to shocking, egregious, unambiguous and measurable **events that should never occur in healthcare**. During the last 15 years, a list of such highly serious adverse events have been catalogued in many countries. These events result in death or significant disability and are preventable. SVIMS has started measuring each of these 'Never Events' and has put in place safety parameters to mitigate any harm with the goal to eliminate them. Thus, SVIMS become the First Health Care System in India, to voluntarily report safety record, towards continuous quality improvement. Never Events indicate fundamental safety problems within an organization or system. They are grouped into 7 categories SVIMS will choose one from each of these groupings as outlined above & will methodically put in place safety measures to eliminate them:

	Never Event Category	Indicator	
		Description	Benchmark
i.	Care Management Events	Stage 3 & 4 Decubitus ulcer during hospital	**0**
ii.	Administration of drug or biological	Mismatched Blood Transfusion with serious harm.	0
iii.	Radiological Events	Metallic object in MRI suite causing injury	0
iv.	Environmental Events	Falls in hospital premises with serious injury	1
v.	Procedure Events	Wrong site/wrong patient procedure	0
vi.	Device Events	Foreign object unintentionally left inside body during surgery	0
vii.	Patient Protection Events	Misidentification or missing baby	0

On 12-07-2016, Hon'ble Health Minister, Dr. Kamineni Srinivas garu unveiled SVIMS Website reporting of **one such never event, namely stage 3 / 4 Decubitus Ulcer.**On 9-12-2016, to coincide with **"World Patient Safety Day'** , Director-cum-Vc of SVIMS Dr.T.S.Ravi Kumar unveiled ('go live') the full spectrum of Seven Never Events listed, under the banner **'Serious Seven'**

NEVER EVENTS

i. Decubitus Ulcer - stage 3 / 4

Decubitus Ulcer is also known as Pressure sore/bed sore. Since the monitoring started in September 2015 after the arrival of the new Director and **during the period Sep 2015 to Jan' 2018, no stage 3 / 4 Decubitus Ulcer has developed in any patient as a result of stay at SVIMS.**

Even though only stage 3 and 4 Decubitus Ulcer are considered as never events, at SVIMS nursing section has started following all patients for the identification and corrective measures for stage 1 and stage 2 Decubitus Ulcer in order to prevent them progressing to stage 3 or 4. It is to be noted that stage 2 ulcers are observed only in patients who are transferred in with decubitus ulcers and no patients at SVIMS developed any stage 2 ulcers.

DECUBITUS ULCERS REPORT STAGE 1 (Sept'15 to Jan'18)

Month	Ulcers Developed at			Inpatients	
	SVIMS	Outside	Total	ICU Total	Hospital Total
Sept,15	5	13	18	388	2002
Oct,15	5	2	7	495	2539
Nov,15	1	0	1	397	1937
Dec,15	4	7	11	408	1999
Jan,16	9	9	18	521	2496
Feb,16	5	8	13	425	2085
Mar,16	3	3	6	451	2102
Apr,16	9	5	14	430	2100
May,16	2	7	9	410	2126
June ,16	1	6	7	431	2010
July,16	6	8	14	493	2860
Aug,16	2	4	6	466	2271
Sept,16	6	8	14	623	3121
Oct, 16	1	5	6	485	2484
Nov,16	4	8	12	464	2329
Dec,16	3	11	14	601	2973
Jan,17	6	14	20	499	2288
Feb,17	5	8	13	529	2573
Mar,17	6	8	14	634	3215
April,17	3	6	9	535	2594
May,17	5	6	11	525	2528
June,17	9	10	19	629	3142

Month	Ulcers Developed at			Inpatients	
	SVIMS	Outside	Total	ICU Total	Hospital Total
July,17	4	7	11	520	2608
Aug,17	2	4	6	554	2539
Sep,17	4	6	10	690	3069
Oct,17	4	7	11	531	2581
Nov,17	2	2	4	558	2557
Dec, 17	2	7	9	545	2547
Jan'18	**6**	**8**	**14**	**523**	**2325**
Total	**124**	**197**	**321**	**14760**	**72000**

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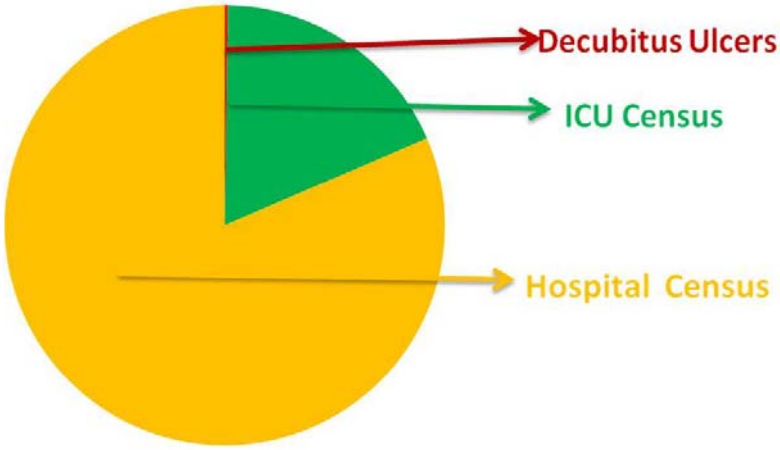
DEPARTMENT OF NURSING

DECUBITUS ULCERS REPORT (From Jan, 18)

Stage III- Full thickness destruction through dermis into subcutaneous tissue

Stage IV- - Deep tissue destruction through subcutaneous tissue to fascia, muscle, bone

NEVER EVENTS Incidence : NONE (0 / 2325 patients) From January, 2018



Note :	**Total Hospital Census :**	**2325**	
	ICU patients	**523**	**22.49%**
	Decubitus ulcer incidence :		
	Stage 1 & 2 : Developed at SVIMS	**06**	**0.25%**
	Present on Admission	**14**	**0.60%**

Stage 3 & 4: NEVER EVENTS

No Stage 3 or 4 , No NEVER EVENTS.

ii. Mismatched Blood Transfusions causing serious harm

Protocol for Prevention of Mismatched Blood Transfusion

1. SCOPE & APPLICATION

Never events are serious medical errors or adverse events that should never happen to a patient. Consequences include both patient harm and increased cost to the institution. Technicians and nurses provide a critical role in preventing never events through risk anticipation and adoption of evidence-based practice. Mismatched blood transfusion is one of the never events which should never happen in a hospital

2. RESPONSIBILITY

- Staff nurse in donor section to correctly label the blood bag.
- The technician on duty in Red Cell Laboratory to correctly receive the blood sample and to issue the blood for which requisition is received.
- The staff concerned in the ward/OT to correctly label the sample and to transfuse the blood unit.

3. REFERENCE

- Technical Manual, Directorate General for Health Services-2nd edition
- Model standard operating procedures for blood transfusion services, WHO
- NACO guidelines 2015

4. PROTOCOL

Checks at the donor blood collection section

- Each donor will be given a unique number and once his blood is collected, it is identified by that number only.
- Verify the donor's identity by tallying with the name on the donor card and the donor number.
- Write the segment number of the blood bag on to the donor card as a second check.
- Cross check the numbers on the bag, pilot tubes and donor card to ensure identity. Record the entry in the donor registers using the same number.

Checks while doing blood grouping and typing:

- One technician should do forward grouping from the segment of the blood bag by correlating the segment number and unique donor number with that entered in the donor card. Enter the results in the donor unit and in the donor cell grouping register.
- Another technician should do reverse grouping from the pilot tubes collected, by identifying the unique donor number. Enter the result in the serum grouping register. Both the forward and reverse grouping result should correlate each other

Checks at the component storage section

- All untested units should be kept in the unscreened Refrigerator/agitator.
- After testing is over, release the fully tested. Write clearly the unit number, date of collection and expiry and the volume on each colour coded label as per the grouping register records.
- After the bags are labelled, ask a second technician to double check the number and group on the bags tallying them with the records.

Checks in the cross matching section:

- Receive the requisition form along with the patient's blood sample. Check for patient's identity. Name of the patient, UHID number, age and sex should correlate with the blood sample and requisition form. Check the blood group with that of the blood group entered in the request. If there is any discrepancy, check the blood group of the received blood sample. If it correlates with the hospital information system, then ask the concerned ward staff to change in the request before proceeding with the crossmatching.
- If there is no discrepancy between the HIS and the blood group in the request, proceed with the blood grouping of the patient with the currently received sample
- If there is no discrepancy then proceed with the crossmatching. If still discrepancy persists, then the old blood sample might be a wrong sample. Trace back the old details and investigate where the fault is.
- Carry out compatibility testing using departmental SOP. In order to avoid outdating, implement FIFO policy
- The technician who is issuing blood should make entries in the crosmatching form with counter sign from the medical officer.
- Make entries in the issue register and in the request.
- The receiving person should check the blood unit and the crossmatching report from for any discrepancy

Checks at the ward/OT:

- Before administering blood component, FINAL IDENTITY -check of the patient, blood unit compatibility tag and the complete documentation should be done.
- Ask the patient, if conscious, to identify himself/ herself by name, spouse name, age or any other identification.
- If unconscious, ask relatives or any other staff to verify the patient's identity.
- Check that details on the compatibility tag exactly match with the documentation.
- Check the blood unit for any leakage and for any visible discoloration & expiry date
- Two different persons should do the check for patient's identity and the same should be documented.

5. DOCUMENTATION

- Make necessary entries in donor register, grouping register, cross matching register, issue register, incident report register, critical value reporting register, cross matching form, case file.

STATISTICS OF WHOLE BLOOD/BLOOD COMPONENTS ISSUES AND NEVER EVENTS

S.No.	Year	Total No. of Whole Blood/ Blood Components Issued	Never events Record
1.	2014	18,062	Nil
2.	2015	17,109	Nil
3.	2016	17,807	Nil
4.	2017 (upto 15/12/2017)	23,548	1

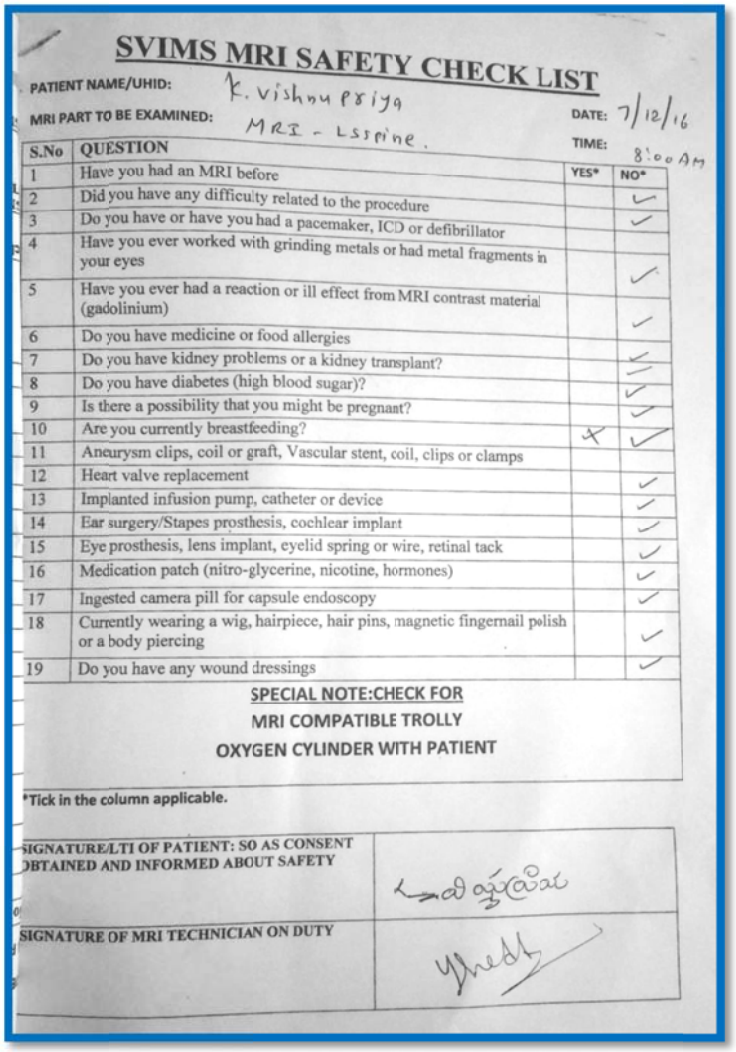
iii. Metallic Object in MRI Suite causing injury

MRI SAFETY REPORT

The last unexpected event in MRI occurred on 10th January 2015 at 2.30 PM where in Oxygen cylinder was pulled in the magnet. However **no patient / personnel injury** or hardware loss was suffered. **No adverse MRI events during 2016 & 2017.**

To totally avoid such situation in future following steps are being followed :-

1. Oxygen lines are made available in preparation area
2. Screening at inlet for oxygen cylinders is being done
3. Maintenance of routine duly signed MRI safety check list for all the patients is being done Since from that time no such incident has occurred in our department.



SVIMS MRI SAFETY CHECK LIST

PATIENT NAME/UHID: K. vishnu priya

MRI PART TO BE EXAMINED: MRI - L.S spine.

DATE: 7/12/16

TIME: 8:00 AM

S.No	QUESTION	YES*	NO*
1	Have you had an MRI before		✓
2	Did you have any difficulty related to the procedure		✓
3	Do you have or have you had a pacemaker, ICD or defibrillator		
4	Have you ever worked with grinding metals or had metal fragments in your eyes		✓
5	Have you ever had a reaction or ill effect from MRI contrast material (gadolinium)		✓
6	Do you have medicine or food allergies		✓
7	Do you have kidney problems or a kidney transplant?		✓
8	Do you have diabetes (high blood sugar)?		✓
9	Is there a possibility that you might be pregnant?		✓
10	Are you currently breastfeeding?	✗	✓
11	Aneurysm clips, coil or graft, Vascular stent, coil, clips or clamps		
12	Heart valve replacement		✓
13	Implanted infusion pump, catheter or device		✓
14	Ear surgery/Stapes prosthesis, cochlear implant		✓
15	Eye prosthesis, lens implant, eyelid spring or wire, retinal tack		✓
16	Medication patch (nitro-glycerine, nicotine, hormones)		✓
17	Ingested camera pill for capsule endoscopy		✓
18	Currently wearing a wig, hairpiece, hair pins, magnetic fingernail polish or a body piercing		✓
19	Do you have any wound dressings		✓

SPECIAL NOTE:CHECK FOR
MRI COMPATIBLE TROLLY
OXYGEN CYLINDER WITH PATIENT

*Tick in the column applicable.

SIGNATURE/LTI OF PATIENT: SO AS CONSENT OBTAINED AND INFORMED ABOUT SAFETY	
SIGNATURE OF MRI TECHNICIAN ON DUTY	

sample checklist

iv. FALLS IN HOSPITAL PREMISES CAUSING SERIOUS INJURY

FALL HUDDLE REPORT ON (9/11/15 to 311/1/18)

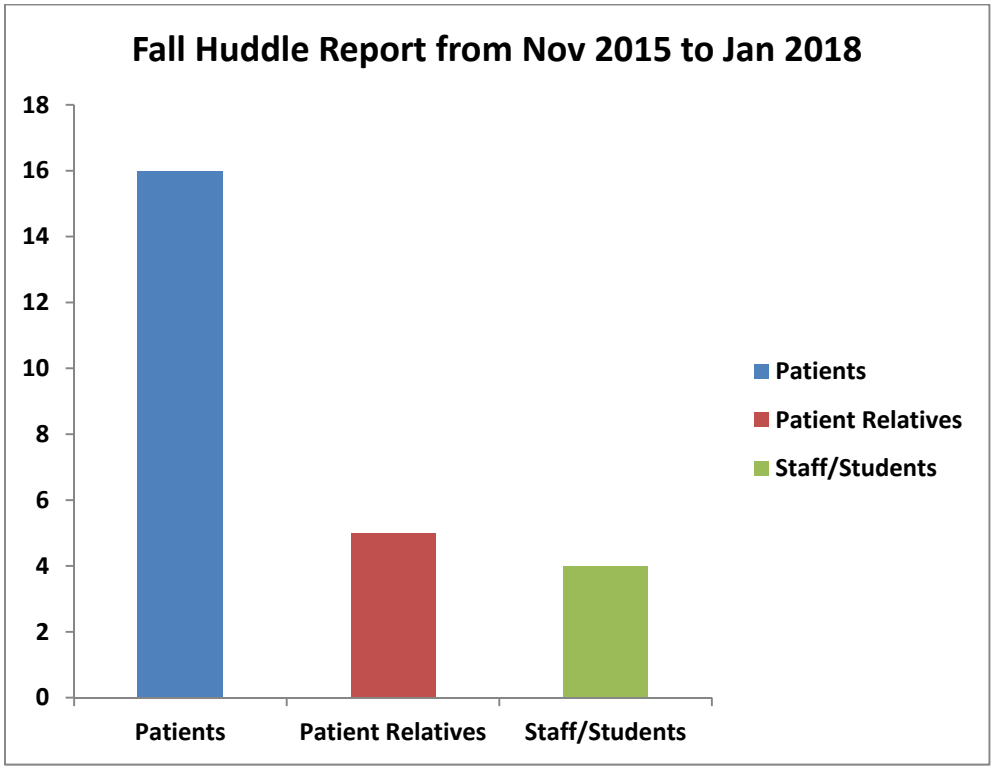
S/No	Name of the Resident	Injury after fall	Diagnosis	Date of fall	Time	Root Cause of fall	Treatment & status at discharge
1	Patient attender	Patella transverse #	Not Applicable	Nov 19, 2015	7.30PM	- Rain water stagnation &pt not taken diet more than 10 hrs	**T.Dolo 650, Ranctac, Physiotheraphy & shifted to BIRRD OT**
2	Staff Nurse	Patella swelling and back pain	N.A	Dec10 2015	1.15PM	Due to water stagnation	**Strict bedrest 14 days, Volini gel, myospase**
3	Fessy worker	Fracture ulnar bone	N.A	Jan 19, 2016	5.30PM	Slip from trolley while cleaning Roof	**POP applied, Immobilisation of hand,voveran, Rantac, myospase**
4	Patient Attender	Head injury	N.A	Jan 17, 2016	12.30AM	Giddiness due to not taken diet	**Inj –Rantac, Inj-Diclofenac- 1 Taxim given**
5	Patient Attender	Injury over chin 3x2 cms	N.A	Mar 8, 2016	3.45PM	Phobia regarding hospital instruments	**Suturings done, minor dressing,voveron, antacids**
6	Patient	Left humerus #	HTN	Mar 22, 2016	7 AM	Hypertension sudden giddiness	**POP applied & shifted to BIRRD**
7	Patient	Injury over Rt.eyebrow	Metabolic Encepahalopathy	Apr 26, 2016	11.45AM	Hypertension sudden giddiness	**Suturings done, minor dressing,voveron, antacids**
8	Patient	Rt.parietal region injury	Meningoma	May 4, 2016	5.30PM	Giddiness,reoccurence history of fall	**Suturings done, minor dressing,voveron, antacids**
9	Patient	Fracture Rt.femur	Dcmp with AFwith FVR	May 28, 2016	10.30pm	Giddiness, vomitings	**Skin traction, bird consultation sent plan for sub trachetic extension**
10	Patient	Mild back pain	CKD,HTNon MHD	May 29, 2016	12;45pm	Dizziness	**Tab;ultracet;local application of diclo gel**
11	Patient	Injury over Lt.fore head	Right occipital infract in parietal region	Jun 9, 2016	4.am	Sudden loss of muscle control,parathesia	**Suturings done, minor dressing,voveron, antacids**
12	Patient	Fracture Left femur	Rt.Lung consolidation	July 10,2016	7.30am	Obstructed dhothi of patient leeds fall	**Skin traction with 3 kgs of weight**
13	Patient	OP-Endo Giddiness	RVD with thyroid nodule& dysp	Jul 1,2016	12.00pm	Sitting on chair	**1 point DNS IV Fluid given, Foot elevation.**
14	Patient Attender	Fracture at Lt.elbow ulnar region	-	Aug 20, 2016	12.30pm	Slip while walk	**Pop applied on left elbow, Tab. Aceclopara, Tab.Rantac, Tab.Chymoralforte**
15	Patient	Injury Occipital region		Aug 29, 2016	10.30am	Slip	**Tab. Cefixime 200mg Tab. Aceclopara**
16	Student	Fracture medical condyle of Lt.humerus	-	Sep 19, 2016	2.30pm	Slipped leg	**Pop applied Tab. Dolpal Tab. Chymoral forte**
17	Staff	Fractured Rt.prosthetic femur	-	Sep 26,2016	9.30am	Slip	**Plan for LCLCP plate fixation.**
18	Patient attender	Lt.Distal radial and ulna fracture	-	Nov 5, 2016	6:20 Am	Power earthling	**Inj . Taxim 1g Tab .calpol BD Tab. Chymoral forte BD Tab. Ecosprin 75 mg**

S/No	Name of the Resident	Injury after fall	Diagnosis	Date of fall	Time	Root Cause of fall	Treatment & status at discharge
19	Patient	Bilateral fracture calcaneum D2-L2 spondylosis of both posterior calcaneum	Post of MVR	Nov 9, 2016	8.30pm	Disoriented, Anxiety	**Pop slab applied in both feet, suturing done at parietal region. Psychiatric consultation done.**
20	**In December month there is no falls reported.**						
21	**In January, 2017 month there is no falls reported.**						
22	**In February, 2017 month there is no falls reported.**						
23	Patient	Rt. temporal bone fracture & laceration over lower lip.	CKD with diabetic nephropathy, HTN, Hbs Ag+ve	Mar 11, 2017	6.30am	Wet floor.	**1.Inj.Pan.40mg IV given. 2.Tab.Chymoral forte BD. 3.Tab.Ultracet SOS. 4.Tab.Augmentin 625mg BD. 5.Neurosurgery consultation done and advised dressing.**
24	**In April, 2017 month there is no falls reported.**						
25	**In May to August, 2017 months there were no falls reported.**						
26	**In Oct 2017 Patient Right femur fracture**						
27	**No falls reported in Jan'18**						

Fall Huddle Report
Nov, 2015 to Jan 2018 : Monthly Statistics

Month	Patients	Patient relatives	Hospital Staff / Student	Total
Nov, 15	-	1	-	**1**
Dec,15	-	-	1	**1**
Jan, 16		1	1	**2**
Feb, 16	-	-	-	**-**
Mar,16	1	1	-	**2**
Apr,16	1	-	-	**1**
May,16	3	-	-	**3**
June,16	1	-	-	**1**
July,16	2	-	-	**2**
Aug, 16	1	1	-	**2**
Sep, 16	-	-	2	**2**
Nov, 16	1	1	-	**2**
Dec, 16	-	-	-	**-**
Jan,17	-	-	-	**-**
Feb,17	-	-	-	**-**
Mar,17	1	-	-	**1**
Apr,17	-	-	-	**-**
May,17	1	-	-	**1**

Month	Patients	Patient relatives	Hospital Staff / Student	Total
June17	Falls not reported in this month.			
July,17	2	-	-	2
Aug,17	Falls not reported in this month.			-
Sep,17	Falls not reported in this month.			-
Oct17	1	-	-	1
Nov,17	-	-	-	1
Dec'17	1	-	-	1
Jan'18	-	-	-	-
TOTAL	16	5	4	25



Corrective Action :

1. Side rails fixed to all trolleys in EMD and decided to be procured side rails Trolleys in future.
2. Fixed support handles in all toilets
3. Fixed support handles to Ramps.
4. For construction of new bathrooms/toilets anti-skid tiles arranged.
5. Arranged caution boards while mopping the floors.
6. Planning to Education programmes regarding prevention of falls to nursing, physicians, allied health & administrative staff.

v. Procedure Events & vi) Device Events

In order to prevent wrong site/wrong patient procedure , SVIMS has begun implementation of WHO surgical checklist in all procedure areas. Members of SVIMS quality council (SQC) group assigned this task, will monitor & report data monthly.

Department of Anaesthesiology and Critical care Sri Venkateswara Institute of Medical Sciences University	**WHO SURGICAL SAFETY CHECK LIST**

Hand over S/N **Ward---------- Date----- Time----**	**Take over S/N** **OT---------- Date-------- Time ------**	**Hand over S/N/Anaesth Tech.** **RR---------- Date----------Time---------**

BEFORE INDUCTION OF ANAESTHESIA (SIGN IN)								
Patient has confirmed	**Yes**	**No**	**Relevant Lab result**	**Yes**	**No**	**Anaesthesia safety check list**	**Yes**	**No**
Identity			ECG/ECHO/Angio			Known allergy		
Site marked/Not applicable			CXR/CT/MRI			Airway/Aspiration risk		
Consent obtained			Biochemistry			If, yes assistance/equipment available		
Procedure			Haematology			Risk of > 0.5L(>7mL/kg in children) blood loss		
Part preparation done			Microbiology			If, yes IV access and fluid planned		
Denture/Jewellery/contact lenses removed			Xylocaine/Antibiotic test dose given and encircled					
Double hair bun prepared for females			DVT Prophylaxis					
NPO status(write no of hours)			Patient warming system/Need for active warming					
Blood group and cross matching done			Blood and blood product availability					

BEFORE SKIN INCISION (TIME OUT)				
Entire surgical team confirms	**Yes**	**No**	**Surgeon shares**	**Nursing /Anaesthesia technician reviews**
Patient's name			Critical/Unexpected step	Sterility, including indicator results
Surgical procedure to be performed			Expected duration	Equipment Issues
Surgical site			Expected blood loss	Working suction
Essential imaging available			**Anaesthesiologist shares**	Baby tray/Crash cart
Antibiotic prophylaxis within the last 60 minutes			Anaesthesia plan	Catheter/Tube/Lines
Antibiotic re-dosing plan			Patient specific concerns	Other concerns

BEFORE PATIENT LEAVES OPERATING ROOM (SIGN OUT)			
Nurse reviews with Team	**Yes**	**No**	Equipment problems that need to be addressed.
Instrument, sponge and needle counts are correct			Entire team discusses concerns for patient recovery and management
Specimen labelling			
Name of the procedure recorded			

vi. Patient Protection Events

Measures taken in SPMC Hospital to prevent baby abduction

- Standard Operating Procedures have been developed for security& ward staff in order to prevent baby abduction .
- ID tags tied to the wrist of the mother and baby Immediately after delivery.
- Foot prints of the baby taken in the Case sheet/File immediately after delivery in the case sheet along with signature of responsible patient attender.
- Transfer out/discharge forms developed to transfer the baby with in hospital (Intra hospital) and outside hospital (Inter hospital), also for normal discharge.
- Baby will not be allowed to move outside of the ward without proper transfer out/discharge form and also without responsible attendant along with hospital staff.
- At the time of transfer out/discharge of the baby from the post natal ward/NICU the duty nurse along with doctor on duty and baby mother will sign on the transfer out/discharge slip which will be checked by security at Post natal ward & main entrance along with baby ID tag.
- Security guards at the Post natal ward and main entrance will record the details of the baby along with attendant details at the time of transfer out/discharge.
- CC Camera's were fixed at the entrance of the Post natal ward and at main entrance.

Quality and Patient Safety	**http://svimstpt.ap.nic.in/new/quality.pdf**
Code Blue	**http://svimstpt.ap.nic.in/new/codeblue.pdf**
Never Event	**http://svimstpt.ap.nic.in/new/neverevents.pdf**
Health Associated Infections	**http://svimstpt.ap.nic.in/new/HAI.pdf**
Biomedical Equipment	**http://svimstpt.ap.nic.in/new/hai-biomedical.pdf**
Performance List	
Mortality	**http://svimstpt.ap.nic.in/new/mortality.pdf**