RISK ALERT

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A Risk Management Newsletter for Hospital Authority Healthcare Professionals

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OPENING MESSAGE

Redesigning Safety with Human Factors

Human error refers to the failure of planned mental or physical actions to achieve their intended outcome, where the failure cannot be attributed to chance. It occurs even among competent, well-intentioned individuals due to cognitive, perceptual or execution limitations. Human factors experts such as James Reason describe human error as "both universal and inevitable" and emphasise that human fallibility can be mitigated but never entirely removed. Its frequency and impact can be greatly reduced through design, training and system improvements. Evidence from safety science and human factors research supports this view rather than the idea that error can be completely eliminated.

Human factors engineering (HFE) gives us practical tools to redesign these conditions. By applying HFE in patient safety work, we focus less on "who is wrong" and more on "what made it hard to do the right thing," such as poor layout, confusing forms or alert overload. While human error is inevitable, HFE empowers us to build resilient, intuitive systems that could reduce risks and enable staff to excel. Let's explore and apply HFE to turn challenges into opportunities for safer care and better outcomes.

Dr Natalie LEUNG
Service Director(Q&S)
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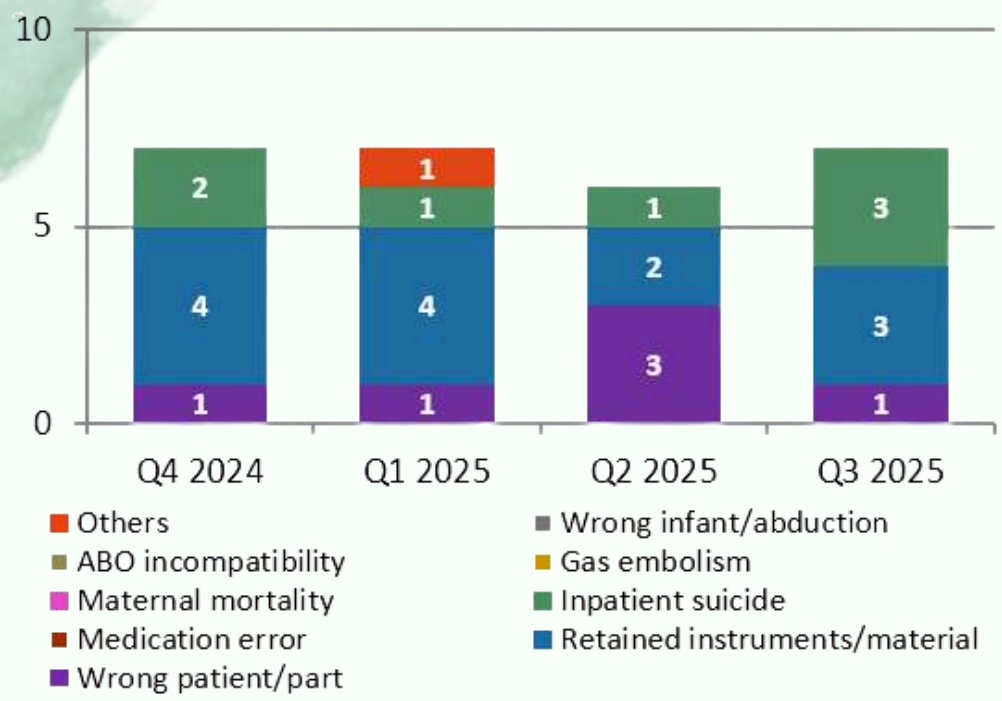
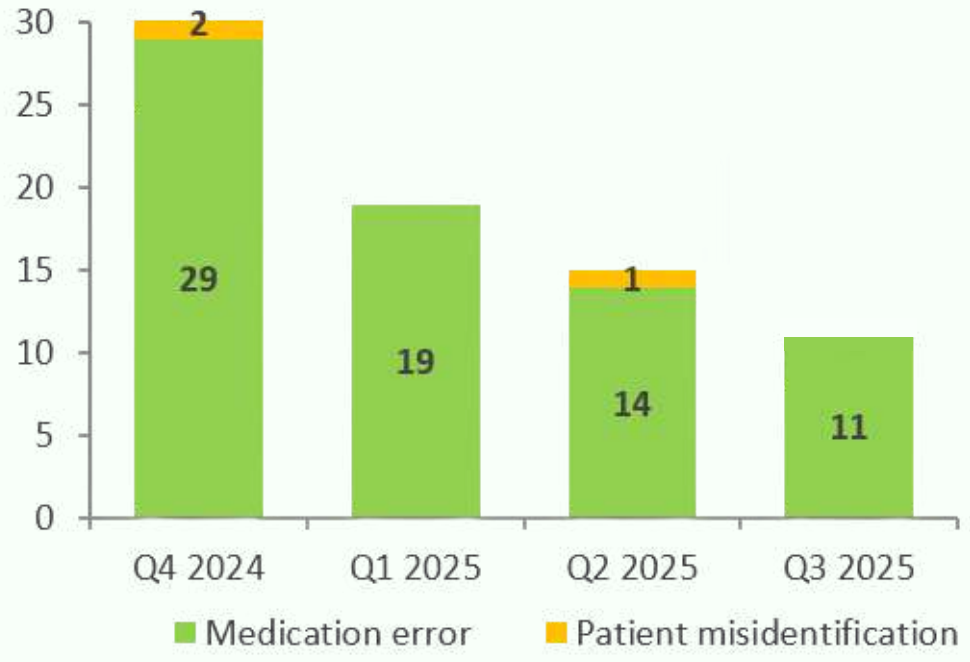
SE & SUE STATISTICS

Number and distribution of SE in the last four quarters



Number and distribution of SUE in the last four quarters

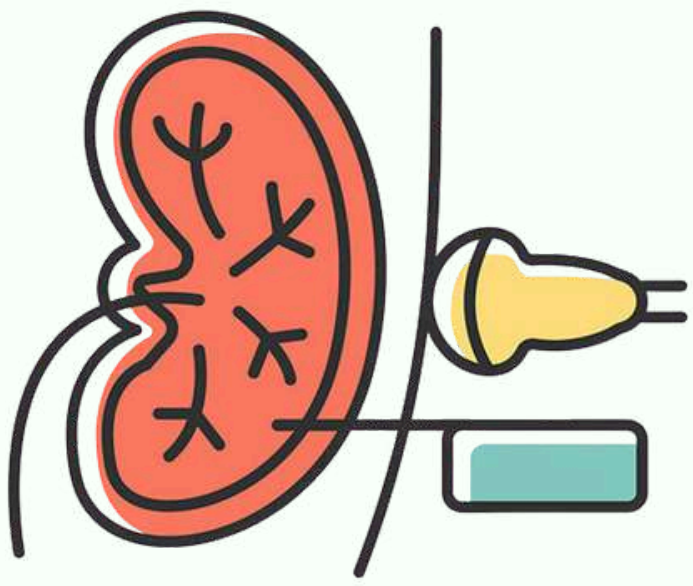


SENTINEL EVENTS - Wrong Body Part

Biopsy Performed on an Unintended Graft Kidney

A patient with end-stage renal failure had received two kidney transplants. The first graft was placed in the RIGHT iliac fossa and the second graft was placed in the LEFT iliac fossa.

Following the second transplant, post-transplant lymphoproliferative disorder was suspected, prompting the request of an ultrasound-guided kidney biopsy via the Generic Clinical Request System (GCRS). The request and the informed consent form did not specify the intended graft's laterality or location.



On the procedure day, during "SIGN IN" and "TIME OUT", both the nursing team and the interventional radiologist assumed that pre-procedural site marking was not required, as laterality was not documented in the GCRS or the consent form by the clinical team. The radiologist presumed the graft kidney was in the RIGHT iliac fossa —a typical location— and confirmed a graft kidney there via ultrasound before proceeding with the biopsy. The error was discovered in the recovery room after the procedure.

LEARNING POINTS:

- Emphasise the importance of complete clinical documentation and clear interdisciplinary communication to ensure procedural safety
- The second graft kidney on the left is suspected to have clinical pathology which warranted diagnosis by invasive renal biopsy. Site marking to indicate laterality will ensure procedure to be performed on the intended side/site

SENTINEL EVENTS - In-Patient Suicide

In 3Q 2025, three male patients (aged between 63 and 74) committed suicide: one by self-cut and suffocation in toilet, one by jumping from height after being found missing and one by hanging.

1

A patient was admitted for dyspnea with no identified suicidal risk during admission. He was informed of suspected malignancy with metastases and was referred to Clinical Psychology. Throughout the stay, he remained calm and was encouraged to report any discomfort.

The patient was last observed entering the toilet. Around 15 minutes later, staff did not hear the patient so they unlocked the door. He was found with a wrist injury and his head covered by two **plastic bags**. A **broken bowl** was found in the washbasin. Resuscitation was initiated immediately and the patient regained spontaneous circulation. However, he subsequently passed away.

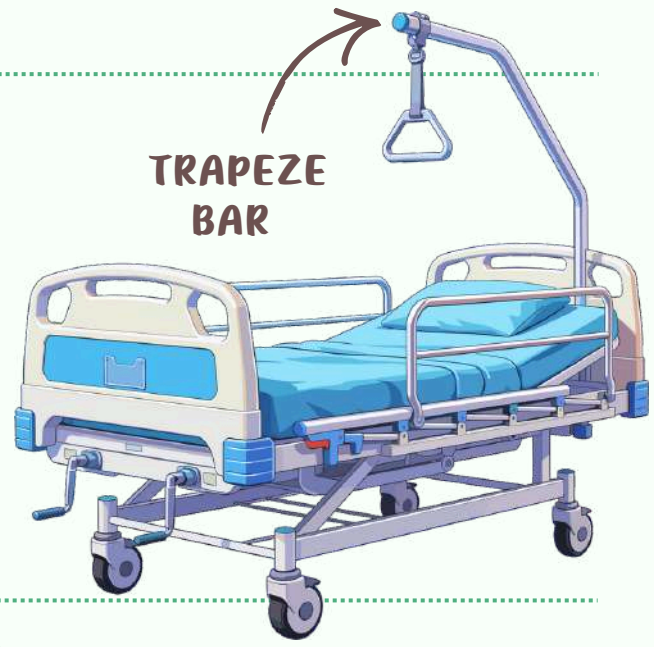
2

A patient with history of gastric ulcer and known lung mass was admitted for hypertensive urgency. Despite being informed about the progression of the lung mass, he refused the recommended CT Thorax. Throughout the stay, he remained calm and cooperative, showing no signs of distress.

On the day of event, the patient was found missing from his bed. Local ward search and hospital-wide search were conducted and the case was reported to the Police. The Police later informed that the patient had **jumped from height** outside hospital compound.

3

A patient with chronic kidney disease was admitted for chest discomfort and hypertension. No suicidal risk was identified upon admission. He remained emotionally stable with symptom improvement.



The patient was found sitting on the bed using his mobile phone. Shortly afterward, he was found hanging by his **own jacket** looped over the **trapeze bar** attached to the bed. Resuscitation attempt was unsuccessful.

LEARNING POINTS:

Emotional Support

- Provide holistic support and maximise patient comfort after breaking bad news

Managing Missing Patients

- Establish a hospital-wide workflow with defined roles for managing missing patients
- Reinforce staff awareness in handling missing patients

Environmental Safety

- Minimise the use of sizeable plastic bags in clinical areas
- Advise relatives of high-risk patients to avoid bringing in potentially dangerous items

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BREAKING BAD NEWS

Prevention of Inpatient Suicide

Emergency actions
(For various emergency situations e.g. high-risk patients found missing)

- Immediately call security / police
- Inform supervisor / senior management

Indicated actions
(For patients with overt / active suicidal ideation)

- Inform doctor
- Initiate suicidal precaution (e.g. close observation, remove dangerous items, etc.)
- Engage multi-disciplinary teams (incl. psychological support, MSW, etc)
- Urgent transfer if needed

Selected actions
(For patients at some increased risk e.g. documented history of previous suicide or presence of enabling context e.g. after breaking bad news)

- Reassess suicidal risk prn
- Increase observation frequency
- Limit access to dangerous items
- Maximise patient comfort
- Reassess before day/home leave or discharge

Universal actions
(For all in-patients)

- Universal admission screening
- Environment scanning (e.g. ligature points, hazardous items, etc.)
- Appropriate access control

Credit: Subcommittee on Prevention of Inpatient Suicide

SENTINEL EVENTS - Retained Material

1 Broken Drill Bit

A patient with osteogenesis imperfecta and a history of multiple fractures underwent revision of K-wire fixation and open reduction internal fixation (ORIF) of the left forearm. The surgery was performed under regional anaesthesia.

During the operation, the patient exhibited unexpected movement, requiring assistance from the circulating nurse. This left the scrub nurse to perform the surgical count independently. A suturing needle was reported as lost during muscle-layer closure, causing increased distraction for the surgical team. Instruments and implants were subsequently counted and their integrity checked. Later, the Sterile Supply Unit identified a 1.5 mm drill bit with a **1 cm segment** missing. Retrospective review of intraoperative fluoroscopic images revealed a metallic fragment beneath the plate within dense bone substitute that matched the missing segment. The patient agreed to conservative management.

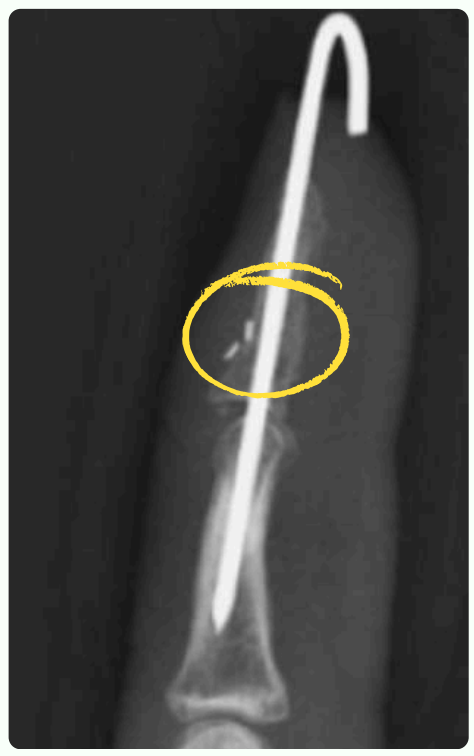
LEARNING POINTS:

- Establish an escalation protocol for nurses to promptly alert nursing management when a standard **two-person surgical count** cannot be performed
- Implement an education program for perioperative nurses on surgical counting standards and instrument integrity checks, with emphasis on high-risk items

2 Metal Debris

An emergency operation was scheduled for a patient with a cut injury to repair the extensor tendon of the hand, along with closed reduction and fixation to left phalange.

During the procedure, two attempts to insert a Zimmer 1.0 mm JuggerKnot suture anchor were unsuccessful. Device integrity was checked after each attempt. The surgeon then proceeded with K-wire fixation across the distal interphalangeal joint. Intraoperative fluoroscopy showed no foreign body. However, a follow-up X-ray revealed two small radio-opacities at the dorsal base of the distal phalanx, **suspected to be metal clips from the failed anchor attempts**. The patient opted for conservative management.



The metal clips would be retracted into the device's inner part after application of the suture, so the integrity of the metal clips cannot be thoroughly examined

LEARNING POINTS:

- Conduct pre-procedure briefings on new or rarely used equipment
- Reinforce the good practice for multiple angles of x-ray images after procedures

SENTINEL EVENTS - Retained Material

3

Nasal Packing

A patient underwent bilateral functional endoscopic sinus surgery (FESS), septoplasty, turbinoplasty, and nasopharynx biopsy. Three nasal packs were packed in each nostril. On post-operative day 2, the packings were removed as planned, and the patient was discharged.

During the first follow-up, the patient reported improved nasal obstruction. Nasal endoscopy (NE) crusting from the left nasal passage was removed and revealed clear nasal passages and open middle meatal antrostomies and ethmoid sinus openings. Subsequent follow-ups confirmed continued improvement, with NE showing clear nasal cavities and minimal crusting, particularly on the left side.

During the fourth follow-up, a retained nasal pack was found and removed from the left superior middle meatus.

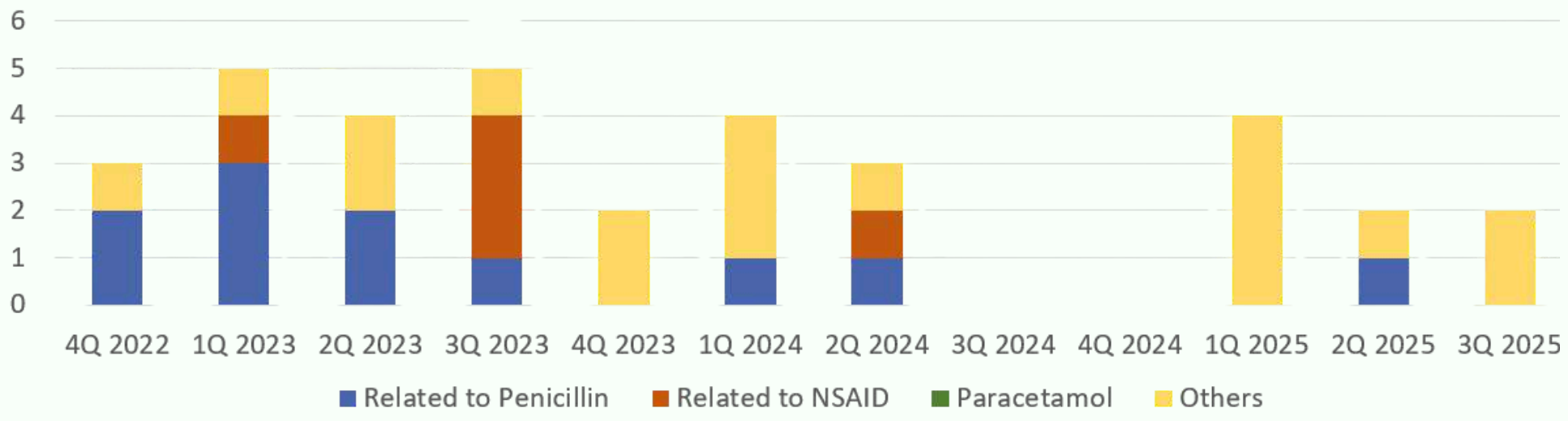
LEARNING POINTS:

- Establish written guidance for packing record review, counting, integrity check, and documentation
- Incorporate packing review standards into relevant training materials

SERIOUS UNTOWARD EVENTS

All II SUE cases reported in 3Q 2025 were related to medication errors, including known drug allergy (KDA) (2), dangerous drugs (I), vasopressors and inotropes (I) and others (7).

Number of KDA cases (4Q 2022 – 3Q 2025)



Known Allergy	Allergen prescribed
Streptomycin	Maxitrol eye ointment
Mydrin-P	Mydrin-P eye drop

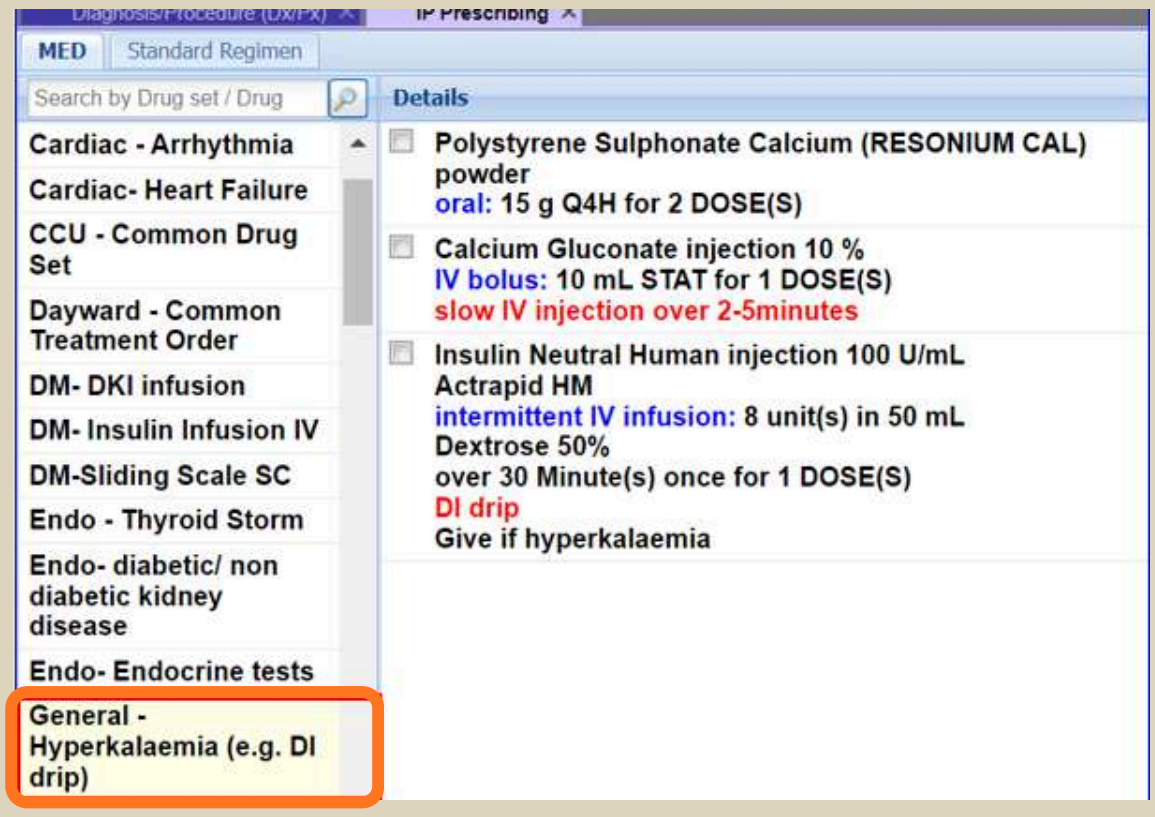
SERIOUS UNTOWARD EVENTS - Medication Error

1 Dextrose-Potassium-Insulin (DKI) Drip Instead of Dextrose-Insulin (DI) Drip was Prescribed and Administered to a Patient with Hyperkalaemia

- A diabetic patient was admitted for hyperkalaemia management. The initial plan was to prescribe Resonium C and **DI drip**, but only Resonium C was ordered via Inpatient Medication Order Entry (IPMOE)
- Following clarification, a **DI drip** was intended to be added, but **DKI drip** was mistakenly selected from the departmental drug set and prescribed instead
- The error was not identified during confirmation of the treatment plan; two doses of **DKI drip** were administered
- The incident was later identified, leading to discontinuation of the DKI drip and initiation of corrective treatment
- The patient remained clinically stable throughout

LEARNING POINTS:

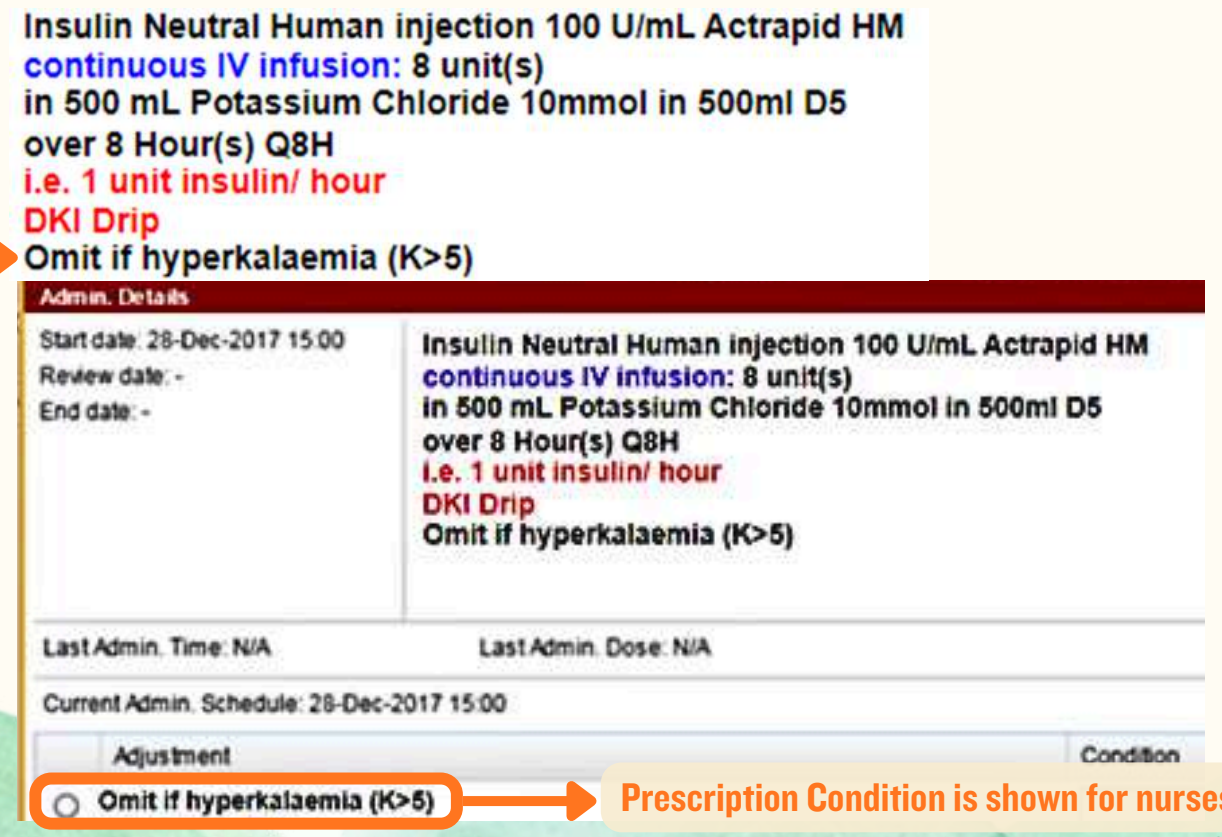
- Optimise **departmental drug sets** to incorporate distinctive names and more intuitive grouping



Safety Tip:

DI drip was the intended treatment in this case. The "Condition Function" applied to DKI drip, serves as a safeguard to ensure the patient is not hyperkalaemic if DKI drip is prescribed and administered.

- Utilise the **"Condition Function"** in the prescribing system to ensure both indication-based ordering and a safety check at the point of administration



SERIOUS UNTOWARD EVENTS - Medication Error

2 Thrombolytic Dose Errors in Stroke Cases

- A patient attended Accident and Emergency Department (AED) with sudden left-sided hemiparesis
- "Reperfusion Therapy for Acute Ischaemic Stroke" pathway was initiated following assessment
- The on-call neurologist recommended IV Thrombolysis by replying "**IV TPA**" via HA Chat
- The doctor mistakenly prescribed **IV Tenecteplase (TNK)** using the drug set for Acute Myocardial Infarction (AMI) thrombolytic therapy in IPMOE, **applying the AMI dosing protocol**
- The dose was administered without confirmation from the stroke team nurse
- The stroke team nurse later identified a dosing discrepancy. The patient remained stable and was later discharged

LEARNING POINTS:

- Reinforce the **designated role of stroke team nurse** in managing stroke case, in overseeing the assessment, **confirming prescription** and providing stepwise case management in collaboration with the attending doctor
- Modify the **stroke checklist** to specify **clear dosage instructions**
- Create a **specific drug set** for stroke management

3

- A patient attended AED with sudden left-sided weakness and facial drooping. CT scan showed no acute intracranial haemorrhage and an intra-arterial thrombectomy (IAT) call was activated
- **IV TNK** was prepared based on the **Alteplase (rTPA)** dosing table in the acute stroke screening folder
- The dose was confirmed as 4.8 ml without checking the drug name on the dosing table
- The TNK, prepared without a label indicating the drug name, was administered
- The discrepancy was identified when clarification was sought about infusion requirement. It was then identified that **TNK had been dosed according to the rTPA dosing reference**. The patient remained stable

LEARNING POINTS:

- Communicate the drug name clearly during **verbal orders** and perform a **read-back** to verify accuracy
- Check the drug name before administration
- Implement mandatory training and regular drills on acute stroke management

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