



RISK ALERT



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A Risk Management Newsletter for Hospital Authority Healthcare Professionals

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- Medication Errors

OPENING MESSAGE

Right Patient Right Medication: Turning a Slogan Into Culture

Healthcare service has been rapidly advancing and becoming increasingly complex in the recent decade. The ageing population in Hong Kong adds further to the challenges. Against this background, we are not aiming to eliminate healthcare incidents but to minimise them. The Hospital Authority sees patient safety as her topmost priority and has been putting inexhaustible effort in various areas, e.g. infrastructure, workflow systems, technology and staff engagement. Importantly, enhancing and sustaining a safety culture in our organisation is fundamental.

Medication errors are always the commonest serious untoward events. To achieve the purpose of giving the right medication to the right patient, active staff engagement by sharing and discussion, instilling a sustainable culture by campaign activities are very viable strategies. In COC(Med) meetings, we have a standing agenda item on sharing of important incidents. Chiefs-of-Service from different Departments of Medicine can share, discuss and bring back to their workplaces for active staff engagement.

In the Kowloon West Cluster, the “Right Patient Right Medication Campaign” is planned to kick off in Q2 this year. The good behaviour of “I order I prescribe and I order I manage” will be promulgated. Apart from giving the right type of medications, timely switching from intravenous to the oral route will also minimise the risk of complications arising from prolonged indwelling of catheters. A cluster-wide practice of departmental medication safety rounds will be initiated. Effecting changes can be fun. As the campaign finale, an inter-hospital quiz competition will be organised! Last but not least, after the campaign, the information given to patients attending the Specialist Outpatient Clinics and those admitted to wards will be revamped. Patients will be empowered to better understand and manage the medications they are given. “Right Patient Right Medication” is not only a slogan but fundamental culture of our organisation and colleagues!

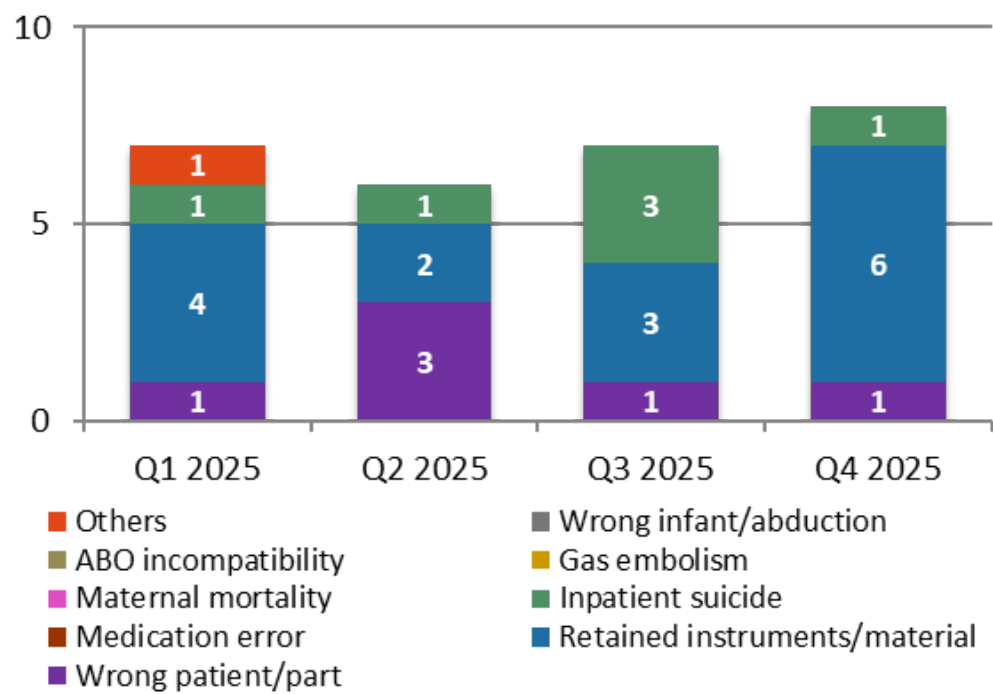


Dr N Y CHAN

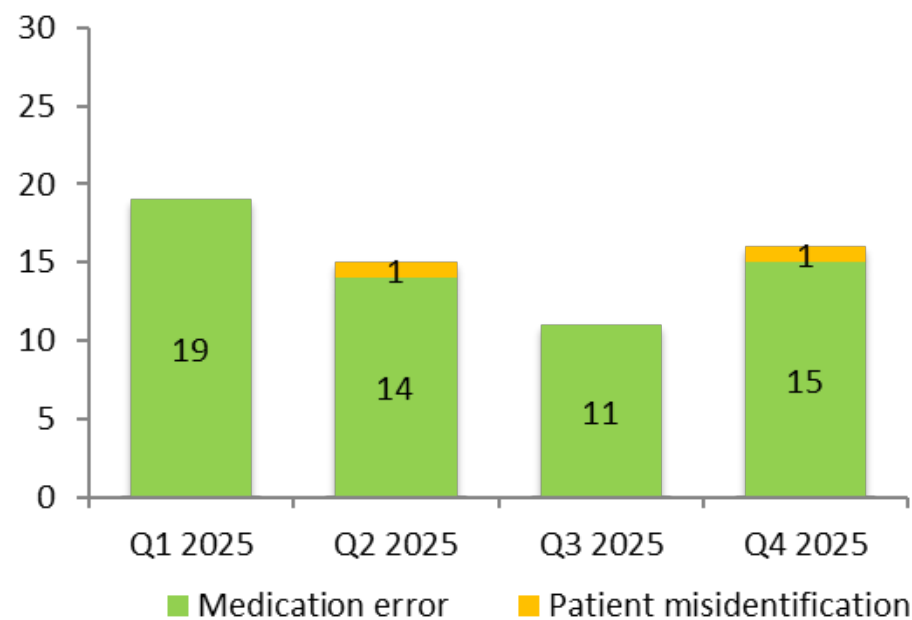
Chairman
Co-ordinating Committee
in Internal Medicine

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

Unintended Lumbar Decompression Level in Spine Surgery

A patient with history of lumbar stenosis, previous lumbar fusion surgery with Adjacent Segment Disease (ASD) and degenerative scoliosis, presented with worsening lower limb numbness and urinary leakage. The patient underwent an elective endoscopic laminectomy intended for the L1/2, L2/3, and L3/4 levels.

The procedure utilised a two-team approach. The spinal levels were identified using intraoperative X-ray imaging in the anteroposterior (AP) view only.

Post-operatively, the patient showed improvement but later developed right thigh weakness radiating to left buttock and lower limb. An urgent magnetic resonance imaging (MRI) revealed incomplete decompression at L2/3 and a hematoma at L1/2. Subsequent clot evacuation and decompression surgery at L2/3 were performed uneventfully.

LEARNING POINTS:

- **Enhanced Intraoperative Imaging:** Perform X-ray imaging in multiple views, including AP and lateral, to confirm spinal levels, particularly for patients with complex anatomy (e.g. scoliosis)
- **Workflow Optimisation:** Conduct pre-operative planning for the two-team approach to ensure the operating theatre layout allows for surgical instruments and the C-arm equipment to be positioned effectively
- **Enhanced Consent Documentation:** Document the planned spine level and method of operation (open or endoscopic) on the e-Consent form

SENTINEL EVENTS - Retained Instruments/Material

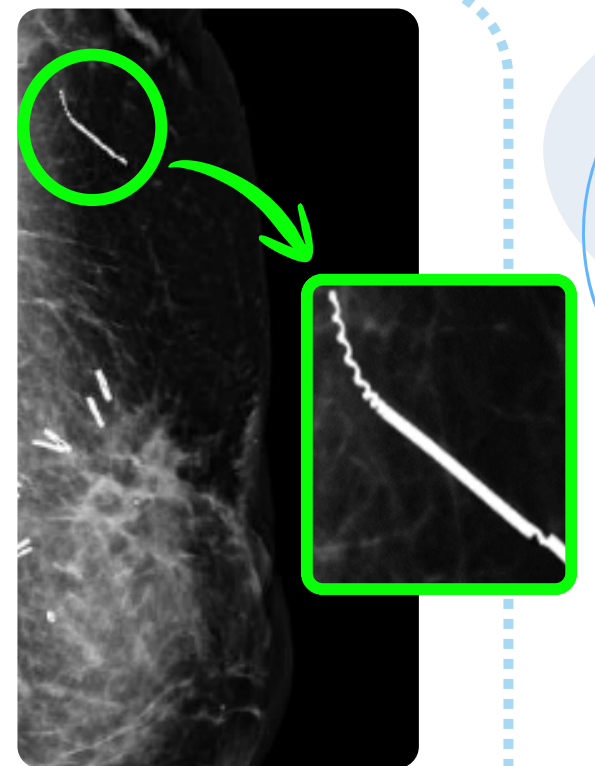
1

Hookwire Fragment in Breast Surgery

A patient with left breast cancer underwent an ultrasound-guided hookwire localisation and excision of a Level II axillary lymph node.

During the procedure, specimen radiography confirmed the “hook” portion of the wire was contained within the excised tissue. The surgery was completed uneventfully.

One year later, 3D mammography and ultrasound examination identified axillary scarring with a wire-like foreign body beneath the surgical bed. Surgical exploration retrieved an approximately 2 cm hookwire fragment uneventfully.



LEARNING POINTS:

- **Wire cutting & Documentation:** Ensure the hookwire is cut under direct visualisation and, where feasible, limited to a single cut. If multiple cuts are necessary, the number of cuts should be documented in the operation record
- **Minimising Mechanical Stress:** Avoid inadvertent retraction of the hookwire during dissection to reduce mechanical stress and subsequent risk of fragmentation
- **Vigilance & Intraoperative Imaging:** Maintain heightened awareness of fragmentation risk of hookwire; utilise intraoperative C-arm imaging if wire's integrity is in doubt

2

Fragment of Cytology Brush in ERCP

During an Endoscopic Retrograde Cholangiopancreatography (ERCP) for obstructive jaundice, a 3 cm cytology brush fragment was unintentionally retained in the common bile duct. The brush head was obscured by tissue and blood during the procedure, and the brush fragment was not detected during post-procedural integrity check. It was identified later on a follow-up CT scan, and was retrieved via a secondary ERCP.

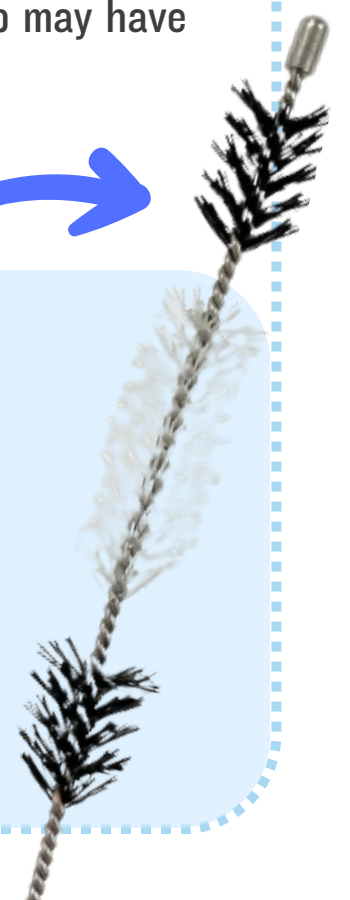
A potential structural weak point at the junction between the catheter tip and the filiform brush tip may have caused the component to deform or tear during the procedure.



Current brush head

LEARNING POINTS:

- **Integrity Verification:** Explore enhanced methods for verifying cytology brush integrity after use, e.g. rinsing in formalin before visual inspection
- **Enhanced Vigilance:** Reinforce thorough assessment of fluoroscopic and radiological images both during and after ERCP procedures
- **Equipment Selection:** Consider alternative cytology brush model with a clearly visible/distinctive brush head to facilitate easier visual confirmation of integrity



SENTINEL EVENTS - Retained Instruments/Material

3

Guidewire in Chest Drain Insertion

A tetraplegic patient underwent emergency bedside chest drain insertion for a large right-sided pneumothorax. During the procedure, the inner stiffener was misidentified as the guidewire.

Bubbling and swinging were observed in the drainage bottle following the insertion. A post-procedural instrument check was conducted. The retained wire was identified on a post-procedural X-ray and successfully retrieved. A new drain was inserted without further complication.

LEARNING POINTS:

- **Targeted Training:** Enhance Rocket Chest drain insertion training
- **Speak-Up Culture:** Encourage junior staff to seek timely senior assistance, especially when performing unfamiliar procedures or managing high-risk situations
- **Closed-Loop Communication:** Use verbal confirmation and acknowledgement between team members during critical steps to verify actions such as guidewire removal

4

Urethral Feeding Tube

A patient with right hydronephrosis and a ureteric stone was scheduled for an elective ureteroscopic lithotripsy. A 40 cm, Fr 8 infant feeding tube was used to facilitate irrigation and bladder drainage. During the initial count, the prepared tube was not documented in the count record of Perioperative Nursing Information System (PNIS) due to distractions from positioning, skin preparation, and X-ray setup.

The tube was then partially inserted into the urethra alongside the ureteroscope but the external end was not secured to the patient with adhesive tape. After ureteroscope removal, the external end of the tube was no longer visible and was presumed to have been expelled. This was not explicitly verified or communicated within the clinical team. The final count was completed without any discrepancy because the tube had not been recorded in PNIS.

The retention was identified around two hours post-operatively when the patient spontaneously voided the tube.

LEARNING POINTS:

- **Heightened Awareness:** Remain vigilant to the retention risk associated with urethral infant feeding tube
- **Closed-Loop Communication:** Strengthen communication among all members of the operating team so that insertion and removal of surgical items are explicitly specified; Utilise "read-back" process to ensure this information is clearly acknowledged and confirmed by the team for accurate real-time tracking of the surgical count
- Secure urethral infant feeding tube with adhesive tape to prevent the unintentional migration during surgical manipulation
- Reinforce accuracy and timeliness of counting documentation by circulating nurse, with verification by scrub nurse

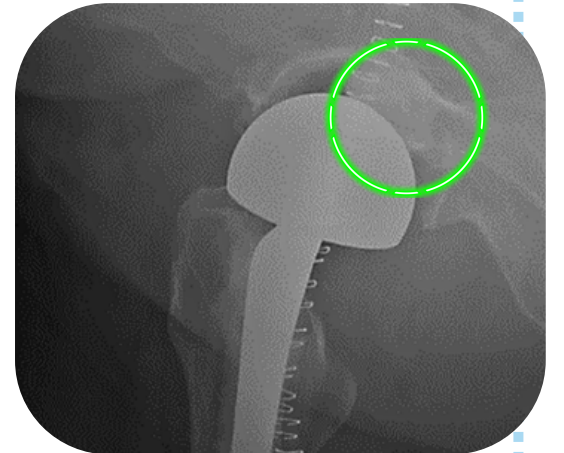
SENTINEL EVENTS - Retained Instruments/Material

5

Cement

During a right hip hemiarthroplasty for a patient with a right femoral neck fracture, two pieces of gauze were packed into the acetabulum and the lesser trochanter to prevent cement retention as per usual practice. The surgeon then applied cement into the femoral canal and inserted the prosthetic femoral stem. He subsequently used a piece of wet gauze to wipe the trunnion of the stem. After rinsing the acetabulum, he rechecked the acetabulum and surrounding areas by inspection and palpation, while his supervisor inspected these areas. The procedure continued, with the hip joint's range of motion and stability being confirmed as acceptable before wound closure.

Post-operative X-rays revealed a foreign body in the right hip joint causing subluxation of the hip joint. A revision bipolar hip arthroplasty was performed to remove the foreign body, which was subsequently confirmed to be cement.



LEARNING POINTS:

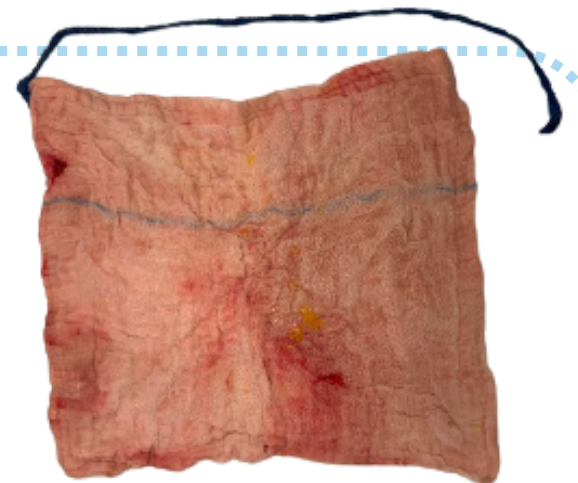
- Enhance training in preventing retained cement, e.g. gauze packing of acetabulum before cement application and palpation and inspection of the acetabulum after cement application
- Enhance the supervisory role of doctors when performing hip hemiarthroplasty to ensure no cement was retained, e.g. by palpating and inspecting the acetabulum after cement application

6

Abdominal Pad

A patient underwent an 11-hour elective Whipple operation for pancreatic cancer. During the first count, a wet gauze was observed in the basin after a surgeon stated "removed out". It was then assumed to be a previously packed abdominal swab, and was recorded as "out" in the PNIS.

During the final count, a used abdominal swab was reused for wound cleansing and suspected to have been double-counted, leading to the count being perceived as correct. A debriefing before anaesthetic reversal initially affirmed the count as correct. However, during a postoperative checkout count, it was discovered that one abdominal pad was missing. An environmental search was conducted but unsuccessful. A postoperative chest X-ray revealed a radio-opaque object in the right upper quadrant of the abdomen, which was subsequently retrieved uneventfully.



LEARNING POINTS:

- **Closed-Loop Communication:** Reinforce clear verbal confirmation between surgeons and nurses of the material type, specific location, and quantity during both packing and removal
- **Structured Verbal Counts:** During counting, the scrub nurse should provide a standardised announcement of all items (e.g., "three on the table, two packed in the field"). Surgeons should actively participate by performing a counter-verification of these locations and quantities before wound closure

SENTINEL EVENTS - In-Patient Suicide

A patient with a history of chronic heart disease and diabetes was admitted for anemia and epigastric pain. During hospitalisation, CT scan revealed suspected metastatic hepatic malignancy. The findings and management plan were discussed with the patient and his wife at bedside. The patient appeared calm and expressed understanding.

Five days later, he was discovered missing from the ward after messaging his family expressing suicidal intent. Following immediate local and hospital-wide search, the Police later confirmed that the patient had fallen from height at a residential estate.



- **Optimised Disclosure Settings:** Conduct disclosures in private, designated rooms to ensure confidentiality and a supportive environment
- **Timely Risk Reassessment:** Reassess suicidal risk after emotionally significant events, such as breaking bad news to detect subtle changes in emotional state and facilitate early psychological intervention

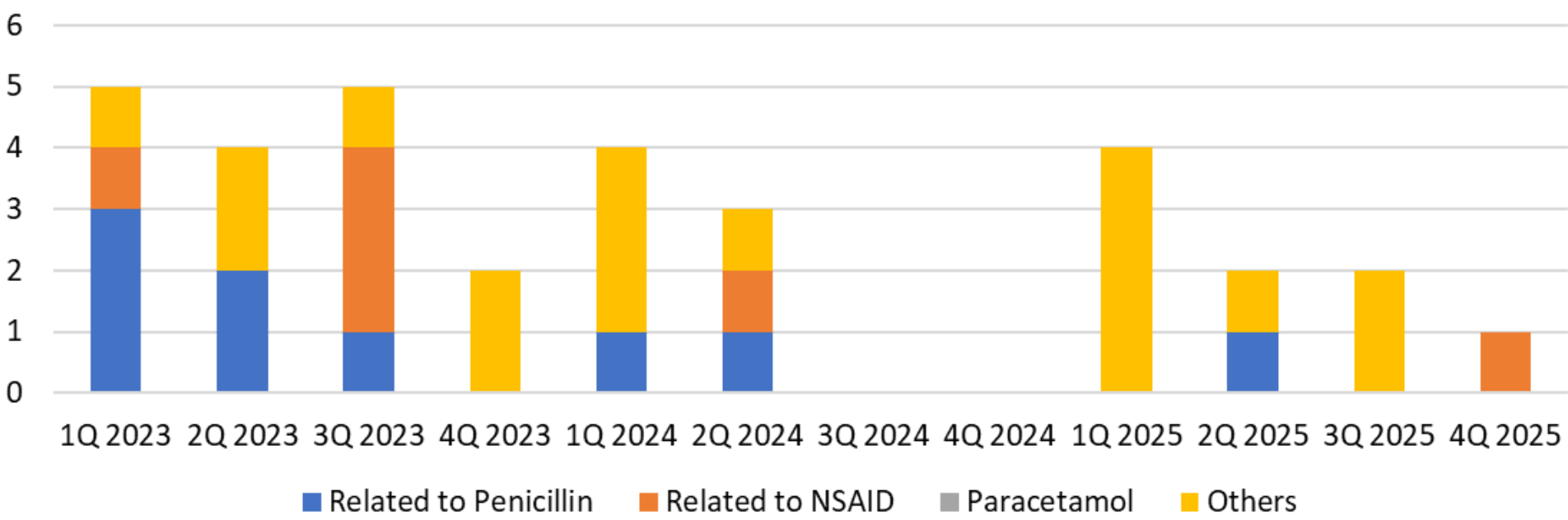
BREAKING BAD NEWS



SERIOUS UNTOWARD EVENTS

Of the 16 SUE cases reported in 4Q 2025, 15 cases were related to medication errors, including known drug allergy (KDA) (1), anticoagulants (4), anticancer drugs (1), vasopressors and inotropes (3), Concentrated electrolytes (1), insulin (2) and others (3).

Number of KDA cases (1Q 2023 – 4Q 2025)



Known Allergy	Allergen prescribed
Aspirin	Aspirin

SERIOUS UNTOWARD EVENTS - Medication Error

1

Unintentional Early Cessation of Dopamine Infusion

In two recent incidents, patients receiving Dopamine infusions (200mg made up to 100ml normal saline) for haemodynamic support experienced premature cessation of their medication following infusion pump alarms.

Responding to the alarms, nurses involved mistakenly identified the Dopamine infusions as a single-dose antibiotic and disconnected the set without verifying it against the prescription.

Both incidents were identified shortly after, and the patients involved remained stable throughout. These events underscore the risks of relying on assumptions and the critical need for verification before disconnecting any infusion.

LEARNING POINTS:

- Perform line tracing and pump check during the administration of intravenous infusion or whenever there is any change to the settings
- Before disconnecting any infusions, verify the label affixed to the infusion bottle against the medication order
- Use colour-coded labels on infusion bags +/- tubing sets to improve visual awareness

2

Wrong Dosage of concentrated Potassium Chloride (KCl) Added into 500ml 10% Dextrose for Intravenous Infusion

- A hypoglycaemic patient with hypocalcaemia and hypokalaemia was prescribed an infusion:
20 mL 10% Calcium Gluconate +
20 mmol 14.9% concentrated KCl in 500 mL Dextrose 10% (D10) solution Q12H
- Nurses misinterpreted the unit for **KCl** to be in “mL” and added two vials of **10 mL KCl 14.9% (total 40 mmol)** into 500 mL D10 solution.
- The error was discovered during a routine ward follow-up call by pharmacy for the concentrated electrolyte balance. The patient remained stable with no clinical adverse effects.

Concentrate 14.9%
KCl 14.9%
10 ml; 1 ml Δ 2 mmol (mEq) K⁺
+ 2 mmol (mEq) Cl⁻
Sterile, non-pyrogenic



LEARNING POINTS:

- Minimise the use of concentrated KCl 14.9% (20 mmol in 10mL) in general clinical areas
- Refine the design of warning labels for concentrated KCl on the dispensing package bags to highlight the concentration per vial



New Label

****MUST BE DILUTED****
Each vial of
CONCENTRATED
POTASSIUM CHLORIDE
(KCl)
14.9% INJECTION
contains
20 mmol K⁺ in 10ml

SERIOUS UNTOWARD EVENTS - Medication Error

3

Unintentional Daily Dosing of Weekly Methotrexate

- A patient with rheumatoid arthritis (RA) had been on Methotrexate 10 mg PO once **weekly** (every Monday).
- During an RA clinic follow-up, step-up dose of weekly Methotrexate was intended to be prescribed. In the electronic system, Methotrexate 12.5 mg PO **once per day** for 6 weeks, then 15 mg PO **once per day** for 10 weeks was selected from a drop-down menu, with **“every Mon”** specified in the special instruction box.
- The pharmacist overlooked the **“every Mon”** instruction and did not perform manual mapping during vetting, resulting in the weekly dosing regimen being omitted from the dispensing label; Daily dose was dispensed.
- The error was discovered and the patient was prescribed Folinic acid for recovery.

LEARNING POINTS:

- Perform independent double check of the drug, dose, and dosing frequency prior to medication supply
- For step up/down regimens of weekly Methotrexate, use the **“Supplementary Frequency”** field to prescribe the weekly frequency instead of the free-text entry in the **“Special instruction”** box as the latter lacks system mapping of order entries into the Pharmacy Management System (PMS)
- Use **Departmental Drug Sets** particularly for step-up/down regimens:

History Drug Set Std Regimen

Diagnosis/Procedure (Dx/Px) Enquiry X Discharge Prescri

Drug Set METH

Departmental CONFINED DRUG LIST (08-JOINT)

Departmental **METHOTREXATE STEP UP/ DOWN**

Personal PAIN

Departmental RHEUMATOLOGY NSAID

Departmental RHEUMATOLOGY SECOND LINE

Diagnosis/Procedure (Dx/Px) Enquiry X Discharge Prescription/OP Prescription X

Drug Name Browse History Drug Set Std Regimen PAP

Methotrexate tablet +Intent Adv. Option Preparatio

Dosage	Daily Frequency	Suppl. Frequency	RN	Route/Site	Duration	Quantity
7.5 MG	ONCE	EVERY 7 DAY		ORAL	2 Weeks	TAB
10 MG	ONCE	EVERY 7 DAY		ORAL	2 Weeks	
12.5 MG	ONCE	EVERY 7 DAY		ORAL	2 Weeks	
15 MG	ONCE	EVERY 7 DAY		ORAL	2 Weeks	

7.5 mg once (every 7 day) for 2 weeks, then
10 mg once (every 7 day) for 2 weeks, then
12.5 mg once (every 7 day) for 2 weeks, then
15 mg once (every 7 day) for 2 weeks

☐ Fixed Period ☐ Single Use Special Instruction

Action Status Dispense by Pharmacy Regimen Type STEP UP/DOWN Accept C

- A prompt alert for **“Weekly Regimen Prescription”** for Methotrexate has been added to the **“Pharmacy Management System (PMS) item alert message”** to remind vetting staff.

Message Code: 1007-I-1184

Item Alert Message:
WEEKLY regimen otherwise contact doctor

Proceed

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