RISK ALERT

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A Risk Management Newsletter for Hospital Authority Healthcare Professionals

IN THIS ISSUE

OPENING MESSAGE

Cultural Transformation as a Multiplier for Surgical Safety Enhancement

Public Hospitals at Hospital Authority perform high volumes of surgeries and interventional procedures across varying levels of complexity, each carrying inherent risks. The guiding principle for healthcare professionals remains clear: Primum non nocere — First, do no harm. Relying solely on clinical skill and high-tech equipment is insufficient to ensure patient safety.

The adoption of the WHO Surgical Safety Checklist represents a global best practice that the Hospital Authority continuously refines and redesigns as a technical safeguard for operating rooms, interventional suites, and bedside procedures. In the early days, staff engagement and implementation faced challenges. Through persistent, collaborative effort, the practical execution gap has narrowed. Cultural transformation has occurred: cross-disciplinary ownership of surgical safety is now the norm. It is no longer a passive tick-box exercise but an active, critical step in safety verification. Staff are empowered to speak up and to report near-misses without fear of hierarchical barriers in operating theatres or other interventional spaces.

The Hospital Authority Risk Alert (HARA) system facilitates shared learning by analysing Sentinel Events (SE), Serious Untoward Events (SUE), and incident reports. These analyses reveal variations in the perception and engagement with the surgical safety checklist. Most errors were preventable when policies and checklists were fully implemented with complete and accurate documentation. Effective, open communication among teams would have made incidents such as retained materials avoidable. Early detection of any undesirable event during a procedure and on-site mitigation decisions are essential for damage control and the patient's best interests.

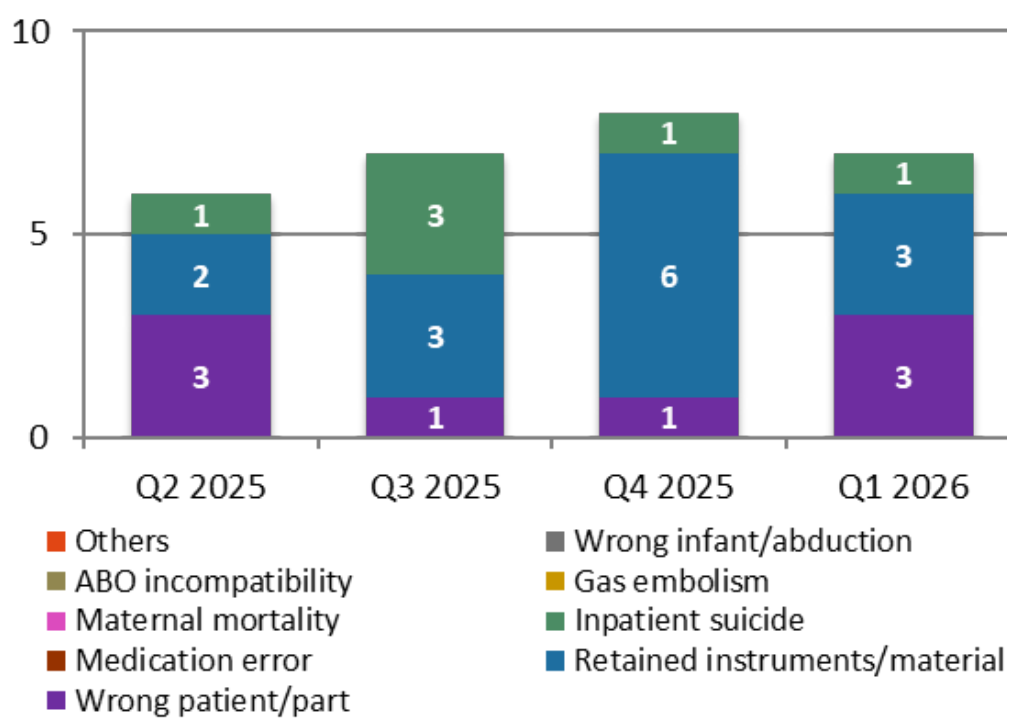
Bedside procedures are common, and the emphasis on compliance with Surgical Safety Policies and checklists remains uncompromised, regardless of the invasiveness of the procedure. This area represents high-volume service where healthcare professionals must maintain vigilance.

Technology, checklists, and protocols multiply their impact when embedded in a strong safety culture. By deepening transparency, teamwork, and a just culture of learning, we can sustain progress in reducing operative risk and ensure that patient care is guided by collective vigilance and shared accountability.

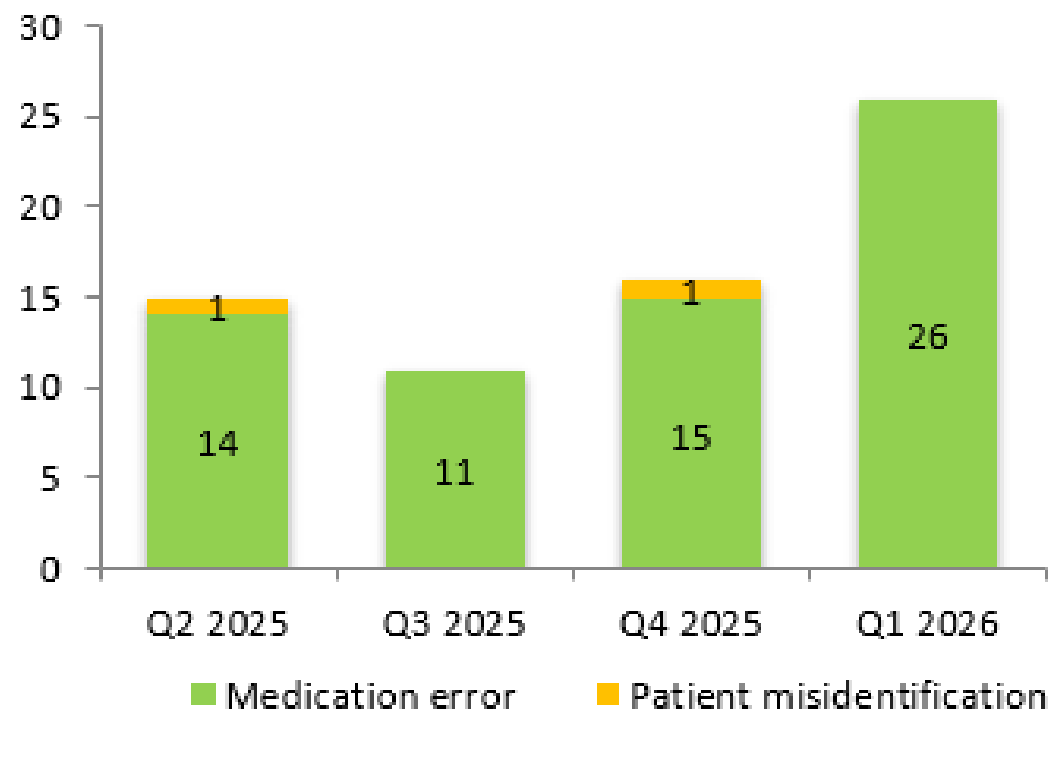
Dr Y C WUN
Chairman
Co-ordinating Committee
in Orthopaedics & Traumatology

SE & SUE STATISTICS

Number and distribution of SE in the last four quarters



Number and distribution of SUE in the last four quarters



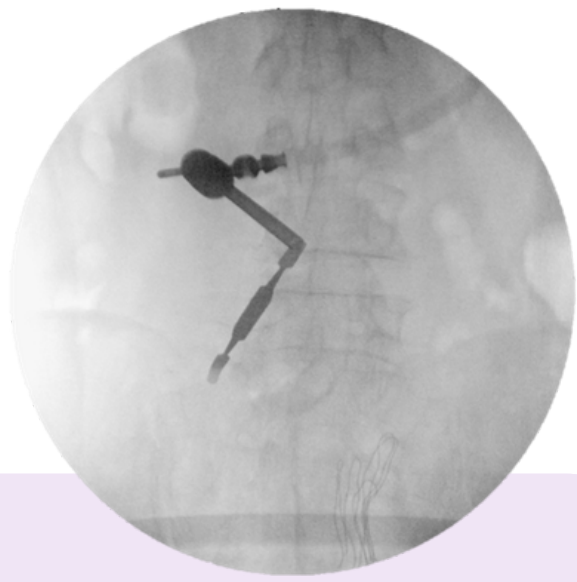
SENTINEL EVENTS - Wrong Body Part

1

Wrong-level Lumbar decompression

An overweight patient with spinal stenosis and neurogenic claudication **underwent lumbar decompression at L4/5**. Intra-operative imaging was performed, and the surgical level was considered confirmed. Postoperatively, the patient's symptoms initially improved, but later recurred. Repeat MRI subsequently showed **decompression had been performed at L3/4 rather than L4/5**. A successful revision decompression at L4-SI was subsequently performed.

Intra-operative L-S Spine



LEARNING POINTS:

- Wrong-level spine surgery can occur when spinal level confirmation relies on a single unclear intra-operative image
- If image quality is suboptimal, repeat imaging and use of multiple views or anatomical landmarks are essential before proceeding
- Patient factors such as overweight may increase technical difficulty and the risk of image misinterpretation
- Reinforce staff compliance with the HAHO Guidelines on Prevention of Wrong Level Surgery in Spine
- Review and standardise the spinal level confirmation process in the department

SENTINEL EVENTS - Wrong Body Part

2 Inadvertent removal of left ureteral (JJ) stent instead of the right JJ stent

A patient had **bilateral JJ stents inserted** after bilateral ureteroscopic lithotripsy. **Flexible cystoscopy was scheduled to remove the RIGHT JJ stent.** The intention to remove the **RIGHT** JJ stent was confirmed by the doctor before the procedure. However, the **LEFT JJ stent was misinterpreted as the RIGHT JJ stent** in the endoscopic view due to the crossing and coiling of the two JJ stents. The **LEFT JJ stent was inadvertently removed**. The incident was identified upon review of the post-cystoscopy Kidney, Ureter, and Bladder (KUB) X-ray.

LEARNING POINTS:

- Laterality of bilateral JJ stents is difficult to identify cystoscopically due to crossing and coiling of the stents, necessitating adjunctive measures (e.g., fluoroscopy, pre-procedural imaging).
- Utilise real-time fluoroscopic guidance during unilateral stent removal in bilateral cases to confirm correct stent identification.
- Conduct a cluster-wide review to standardise scheduling for such procedures in fluoroscopy-equipped settings.

3 Gastrostomy was performed instead of colostomy

A patient with sigmoid cancer and subacute intestinal obstruction underwent palliative transverse colostomy. After surgery, the patient was admitted to the Intensive Care Unit and surgical ward for monitoring.

The patient's stoma appeared healthy, but **daily output progressively rose** to over one liter. She was later transferred for rehabilitation, where intermittent **high stoma output, mildly dehydration, and intermittent gastrointestinal symptoms** persisted. Patient developed hypovolaemic shock and was transferred back to acute hospital. CT showed that the abdominal wall stoma was connected to the distal stomach/proximal duodenum, with no transverse colostomy identified. Coincidentally, the patient suffered a recurrent episode of hypovolemic shock followed by a cardiac arrest; despite successful resuscitation, her condition was further deteriorated and succumbed.

LEARNING POINTS:

- Atypical or unexpectedly high output from a newly formed stoma, even if intermittent, should prompt timely clinical review of the patient's fluid status and consideration of the stoma's function
- Strengthen the **involvement of the surgical team in the clinical management** after a post-operative patient is transferred for rehabilitation
- Ensure **accurate measurement and documentation of intake, output, and fluid balance** to support timely clinical decision-making, especially during transfers between care settings
- Establish a mechanism to ensure that **stoma and wound care nursing specialists** conduct assessments for post-operative stoma patients

SENTINEL EVENTS - Retained Instruments/Material

1 Gauze

A patient underwent loop ileostomy closure. The operation was uneventful, and the wound was left open and packed with **four pieces of plain gauze soaked in aqueous hibitane with documentation** completed at the time of surgery and handed over to the ward.

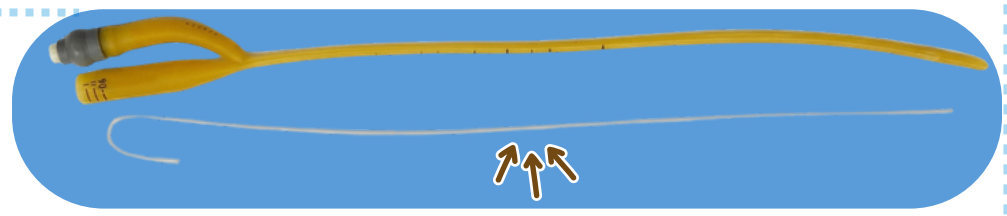
On postoperative day I, **the packing was removed during wound review, but the number of gauze pieces removed was not counted or documented** before the wound was repacked with one ribbon gauze. Over the following days, dressing changes continued, with packing materials being removed and replaced, but the reconciliation of previously inserted and removed gauze was not consistently verified, and the documentation of the number and type of packing materials was inconsistent. As the wound condition improved, it was closed by tightening the stitches.

During a subsequent admission shortly after discharge, purulent discharge was noted from the healed old ileostomy wound site. Bedside wound exploration retrieved **two retained gauze pieces**, and further exploration on the following day identified **a third retained plain gauze**.

LEARNING POINTS:

- Packing materials inserted during surgery and postoperative dressing changes should be clearly counted, documented, and reconciled at every episode of wound care, including the number and type of materials inserted and removed, to support traceability of wound packing information
- Strengthen **interdisciplinary communication and handover processes** to maintain continuity of wound packing information across dressing episodes
- Leave a **visible tail of the packing material** at the skin surface to facilitate detection and removal during subsequent dressing changes

2 Stylet of paediatric foley catheter



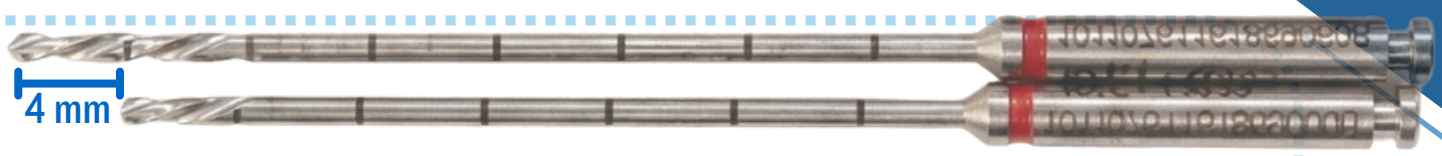
A patient with acute appendicitis underwent emergency laparoscopic appendicectomy, during which a **paediatric Foley catheter** was inserted. However, the **preloaded plastic stylet** within the catheter was neither recognised nor removed. Intraoperatively, **urine output was minimal**. The urinary catheter was inspected, but was not disconnected to assess lumen patency. No abnormality was noted. The low urine output was attributed to dehydration. On postoperative day I, a nurse discovered the retained plastic stylet inside the catheter while changing the urine bag. The stylet was removed, the catheter tip was confirmed to be intact, and the urinary catheter was removed the following day.

LEARNING POINTS:

- **Some paediatric Foley catheter sizes contain preloaded stylets** that must be removed after insertion
- Strengthen training for surgical trainee on identifying/removing preloaded stylets in paediatric Foley catheters
- When **urine output remains unexpectedly low, catheter patency** should be reassessed
- **Clear team communication** about catheter size and the possible presence of a preloaded stylet can provide additional safety check during preparation and insertion
- Documentation templates for urinary catheterisation should include **prompts for paediatric catheter size and confirmation of stylet removal**

SENTINEL EVENTS - Retained Instruments/Material

3 Drill bit



A patient underwent **open reduction and internal fixation for left middle finger fracture** using an on-loan instrument set — Synthes Variable Angle (VA) locking plate and screw system. While inserting the third screw using 1.1 mm drill bit, the surgeon experienced a brief "loss of control" sensation but did not suspect drill bit breakage and continued the operation. Nurses noticed that the **drill bit tip appeared flattened**, but this was thought to be a design feature of the unfamiliar borrowed equipment.

Before completion, mini-C-arm images were reviewed but the **retained fragment was not detected, likely because it was superimposed on the implanted plate or screws** (Figure 1). The final instrument counts and visual checks on instrument integrity were unremarkable. Routine postoperative X-ray (Figure 2) revealed a suspected retained foreign object. Inspection of the used instrument set confirmed the used drill bit was approximately 4 mm shorter than a drill bit of the same model. As the retained fragment was deemed harmless, the patient agreed to conservative management.

Figure 1: Perioperative X-ray

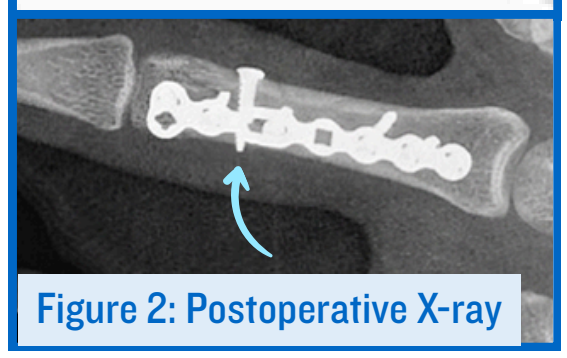


Figure 2: Postoperative X-ray

LEARNING POINTS:

- Raise awareness that **small-diameter drill bits are fragile**; **breakage at multiple locations** is relatively common
- **Abnormal tactile feedback during drilling** (e.g. sudden loss of control) may indicate possible drill bit breakage and should prompt careful inspection of the drill bit
- **Unfamiliar on-loan instruments** may make damage or abnormal features harder to recognise
- Team members should **speak up and escalate concerns** when equipment appearance/function seems unusual
- Develop a protocol for **side-by-side comparison of used drill bits** ⩽2 mm in diameter with a new or unused drill bit of the same model, where available, to verify integrity and help prevent retained fragments

SENTINEL EVENTS - In-Patient Suicide

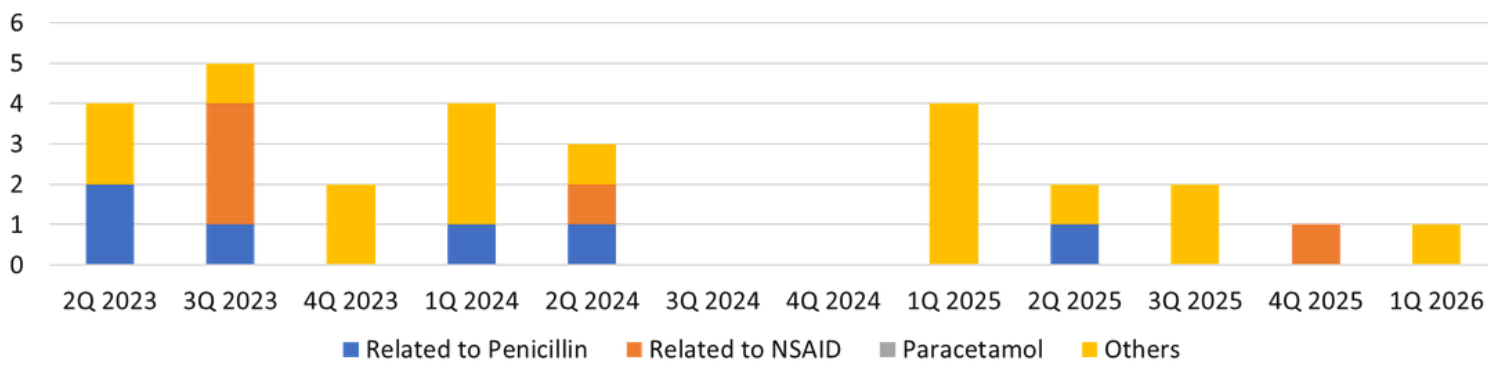
An oncology inpatient with advanced metastatic cancer, history of depression and past suicide attempt, and who had defaulted from psychiatric follow-up for several years, was admitted for anaemia and poor appetite. Following palliative therapies, he **developed pancytopenia with grave prognosis**. During the admission, he remained ambulatory and independent, and **no overt suicidal ideas or marked emotional distress were identified**. Suicidal risk was assessed as low-risk. The patient's grave prognosis was explained, and the **patient agreed to a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)**. He was last seen in the early morning (05:15) sitting in a chair near the ward entrance, consistent with a documented pattern of nocturnal wandering, and was found missing about 30 minutes later. Following immediate local and hospital-wide search, the Police later confirmed that the patient jumped from a height outside the hospital compound.

- **Reassess suicide risk and psychological distress** when there are **major clinical changes**, including grave prognosis discussions or significant disease progression
- Behavioural changes such as **nocturnal wandering or staying near ward exits** should prompt assessment of elopement risk and further review
- **Volunteer befriending services** may provide companionship and informal conversation to patients, helping identify emotional distress or emerging risk early and enabling timely escalation to clinical staff

SERIOUS UNTOWARD EVENTS

All 26 SUE cases reported in IQ 2026 were related to medication errors, including known drug allergy (KDA) (1), anticoagulants (12), anticancer drugs (1), vasopressors and inotropes (2), Dangerous Drugs (1), insulin and oral anti-diabetic drugs (5) and miscellaneous (4).

Number of KDA cases (2Q 2023 – 1Q 2026)



Known Allergy	Allergen prescribed
Chlorhexidine acetate	Chlorhexidine solution

SERIOUS UNTOWARD EVENTS - Medication Error

Omitted Anticoagulants due to Pseudo-ID Issues

In both incidents, patients without valid identity documents on admission were registered under pseudo-IDs. Their full medication histories were not readily visible in the CMS because the linked records were not fully identified or reviewed.

1

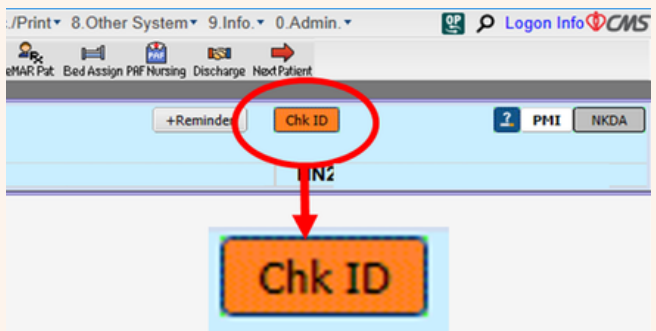
- A patient on long-term Warfarin was admitted for fever
- A pseudo-ID with claimed ID was created
- His allergy and alert information were automatically copied to his pseudo-ID profile by the CMS default function
- Doctor did not use the Chk ID function, the patient's regular medications were omitted
- Warfarin was omitted for two days, leading to a subtherapeutic INR. The patient remained stable.

2

- **Episode 1 Admission**: The patient's first pseudo-ID with claimed ID was created. **Apixaban** was prescribed for **pulmonary embolism**
- **Episode 2 Admission**: A **second pseudo-ID** was created, but Apixaban was not prescribed because the patient did not report taking it and the doctor did not use the Chk ID function
- The patient remained stable.

Pseudo-ID? Check ID First

- When a patient is admitted under a pseudo-ID, Use the "Chk ID" function to actively review linked records and not rely only on the immediately visible medication profile.



- Do not assume the current CMS record shows the full medication history. Important medications may be recorded under another pseudo-ID or linked profile.
- Encourage patients/relatives to provide identity documents early so that record merging can be completed promptly and the full profile can be accessed.

Terms Explained

- **Pseudo-ID**: a temporary patient identity used when the patient's real identity is not yet confirmed.
- **Claimed-ID**: the real identity that the patient or family says belongs to the patient.
- **"Chk ID" function**: a button in CMS that allows staff to review possible linked patient records when a patient is registered under a pseudo-ID but may already have a claimed or real ID profile. It supports safer care by enabling review of previous records, relevant clinical history, drug allergy information, and linked pseudo-ID records from the real ID profile.

SERIOUS UNTOWARD EVENTS - Medication Error

3 Omitted prescription of usual medications, including Thyroxine

- A patient with **hypothyroidism** and other chronic conditions, was admitted for sciatica. The doctor started symptomatic treatment and resumed usual medications by searching **"on-hand medication"**.
- The usual medications from latest specialist outpatient follow-up, including **thyroxine** were not prescribed.
- The omission continued after her transfer to a rehabilitation ward.
- As a result, **thyroxine** and other regular medications were omitted throughout the admission and at discharge for 42 days.

LEARNING POINTS:

- "On-hand medication" is **NOT** always equivalent to the medications that the patient is currently taking
- Usual medications should be reconciled at **admission, transfer, and discharge**, and not based only on the "on-hand" medication list
- When resuming usual medications during admission, **cross-check previous IPMOE prescriptions and use "Medication Journey"**
- "Clinical Intention" should be entered for critical medication prescription to reduce the risk of omission

4 Ifosfamide 4300mg + mesna 4300mg infusion Q12H set at 275ml/hr instead of intended 27.5ml/hr

- A patient with follicular lymphoma was admitted for second cycle of Rituximab, Ifosfamide, Carboplatin, and Etoposide (R-ICE) chemotherapy.
- While the patient was receiving the second dose of **Ifosfamide** 4300mg with Mesna 4300mg in 330ml via an infusion pump over 12 hours at the prescribed rate of **27.5 ml/hour**, an occlusion alarm sounded.
- The nurse stopped the pump to check the Peripherally Inserted Central Catheter (PICC) line patency, but she accidentally cleared the previous settings and re-entered the rate incorrectly as **275 mL/hour** instead of **27.5 ml/hour**.
- The restarted infusion proceeded without structured re-verification against the prescription or drug label, and the required independent double-check was not repeated after the reset.
- The error was identified 1.5 hours later when the patient later developed nausea and the infusion bag was found to be nearly empty.

LEARNING POINTS:

- Reinforce compliance with the "**5 Rights**" of drug administration
- When infusion pump settings are cleared or re-entered, all parameters should be **re-verified against the prescription or drug label** before restarting.
- High-alert medication administration should require a repeated independent double-check after any interruption, reset, or data re-entry.

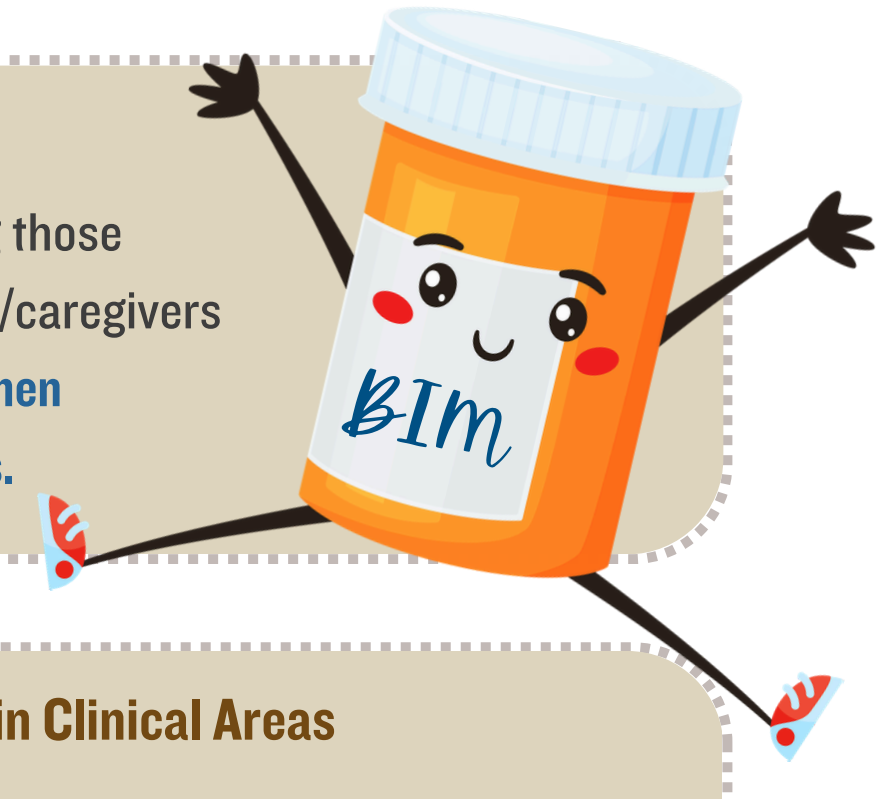
Infusion Safety Animation

SCAN ME

Best Practice of Handling Patient's Brought-in Medications (BIMs) in Clinical Areas

Brought-in Medications (BIMs):

Brought-in Medications (BIMs) are any medications (including those prescribed by private doctors) **physically brought in** by patients/caregivers during hospital stay; and they should **only be used in hospital** **when identifiable, clinically appropriate and prearranged with patients.**



Principles for Brought-in Medications (BIMs) in Clinical Areas

1. Prescribing

- Communicate with the patient/caregiver the need to use BIMs; use medications listed in the hospital drug list as far as possible.
- To identify a BIM, medical and nursing staff should check its name, dosage, route, and other relevant information. When necessary, please consult your hospital pharmacist, or visit the website of Department of Health for registered pharmaceuticals in Hong Kong.
- If a BIM is **identifiable and clinically appropriate**, doctors **should prescribe** it in Medication Administration Record (MAR) or In-patient Medication Order Entry (IPMOE) as "**continue with own stock**" Ⓡ.
- BIMs should be **properly labelled** and stored in a designated location.

2. Administration

- Medications (including BIMs) should be **administered by nurses** according to the prescription in MAR or IPMOE.
- **If BIMs cannot be identified, they should NOT be administered**; and they should be returned to the patient/caregiver.

3. Documentation & Handover

- All BIMs handled upon admission/transfer-in/discharge should be **documented** as appropriate.
- Return the BIMs upon patient discharge with clear instructions.