RISK ALERT

ISSUE 78 JUL 2025

A Risk Management Newsletter for Hospital Authority Healthcare Professionals

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OPENING MESSAGE

Building a Strong Patient Safety Culture: Our Continuing Journey

The Hospital Authority (HA) oversees one of the world's largest and most complex healthcare systems, serving millions across Hong Kong. At the heart of our work is a robust patient safety culture, founded on fairness, transparency, vigilance, and collective learning. We support open reporting, share lessons learned, and are committed to continuous improvement of patient outcomes.

We conduct our first Patient Safety Survey in 2010, which marked a pivotal moment in strengthening our organisational culture. This is accompanied by a strengthening of our comprehensive incident reporting system in 2013 and active encouragement of near-miss reporting, turning every challenge into an opportunity for learning and innovation in patient safety.

The Review Committee on the Management of the Public Hospital System led by Professor Fok Tai-fai also acknowledged our progress, citing our dedicated workforce, advanced incident reporting system, and proactive adoption of information technology as key strengths. We are fully committed to implementing all 31 recommendations from the Review Committee to further enhance governance, advance patient safety, and drive vital reforms. These efforts reinforce our foundation and demonstrate our ongoing dedication to providing safe, high-quality care to the community.

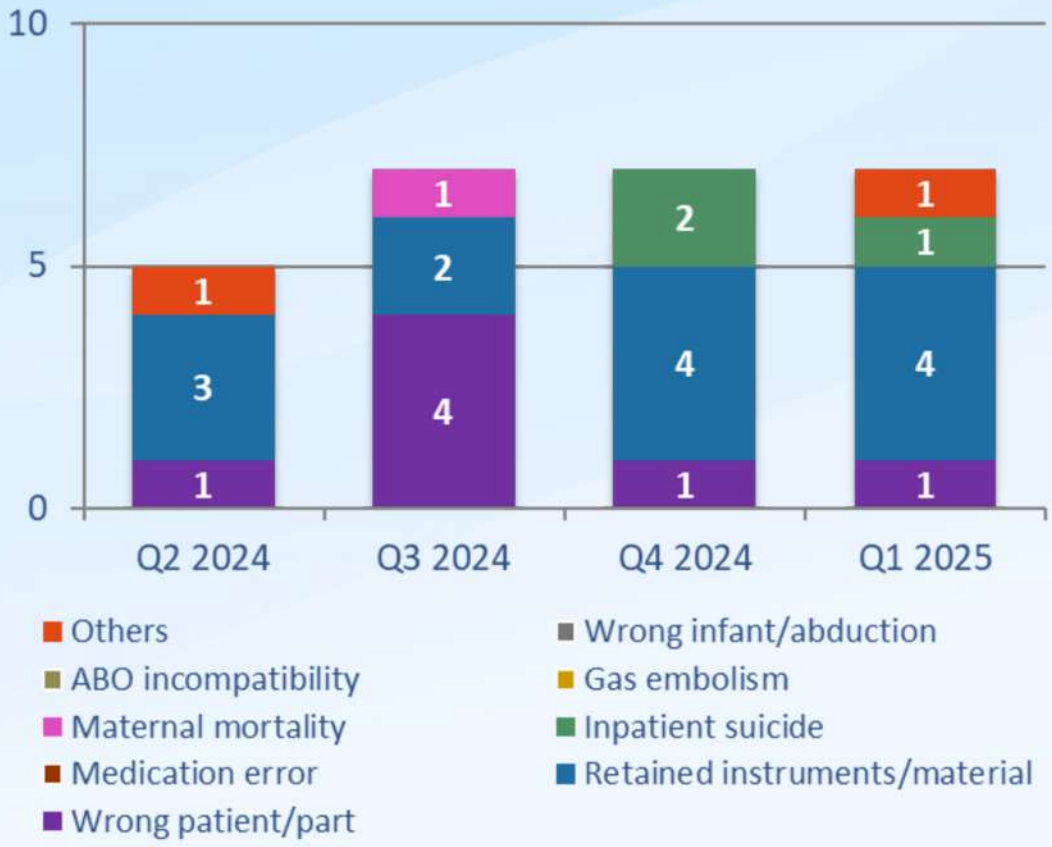
As we look to the future, our commitment remains unwavering. Through ongoing innovation and adaptability, the HA will continue to enhance its services — emphasising stronger governance, greater accountability, and a deeply embedded culture of safety to meet the changing needs of our community. The upcoming Patient Safety Survey in December 2025 will provide valuable feedback on our progress, while World Patient Safety Day in September allows us to celebrate achievements and reaffirm our commitment to safety. We will continue to launch new initiatives, adopt best practices, and strengthen our culture of safety.

Ultimately, the strength of our safety culture is built on the dedication and contributions of every healthcare professional. With our collective commitment, we will continue to set higher standards — ensuring safe, quality care for all the people of Hong Kong.

Dr Tony KO
Chief Executive
Hospital Authority

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 Patient/Body Part

Wrong Side of Hemithyroidectomy

During the investigation of suspected interstitial lung disease, a patient was diagnosed with a multinodular goiter. Following this diagnosis, ultrasound (US) of the thyroid and Fine Needle Aspiration Cytology (FNAC) were conducted. A suspicious lesion was identified on the **LEFT** side and hemithyroidectomy was scheduled for the patient. However, the diagnosis of **RIGHT** thyroid atypia of undetermined significance (AUS) nodule and operation of **RIGHT** hemithyroidectomy were inadvertently booked via Operating Theatre Management System (OTMS).

The patient subsequently attended the Pre-Operative Assessment Clinic (POAC) for pre-operative assessment where the eConsent was signed, but the site of operation was incorrectly indicated as **RIGHT**. The patient was admitted to Day Ward on the date of operation. Surgical safety 123 form for **RIGHT** hemithyroidectomy was prepared and site marking on **RIGHT** side was done. Subsequently, the operation of **RIGHT** hemithyroidectomy was proceeded. During the patient's recovery from anesthesia, the attending surgeon identified the laterality discrepancy while reviewing preoperative imaging and FNAC findings. The patient's relative was promptly informed of the situation. After discussion and consent, a **LEFT** hemithyroidectomy was performed in the same operation.

LEARNING POINTS

- Implement a system to double-check the laterality before confirming the operation list and signing the consent
- Document the laterality of diagnosis and planned surgical procedure clearly in the consultation notes

SENTINEL EVENTS - Retained Material

1 Insulating Coating of Coagulation Probe

A patient with intractable epilepsy underwent elective stereoelectroencephalography (SEEG) to localise the seizure onset zone. Following successful identification of the seizure onset region, the surgeon proceeded to therapeutic radiofrequency ablation and removal of SEEG electrode 2 weeks later.

A postoperative computed tomography (CT) brain revealed a high-density lesion in the right frontal region, located between the entry sites of two previous SEEG electrode leads. Subsequent inspection of surgical instruments found a 7mm missing segment of ceramic insulating coating from a single-use dura coagulation electrode. Follow-up radiological analysis confirmed the retention of the insulating coating fragment in the patient's brain. The removal of the retained fragment was arranged as part of the patient's epilepsy surgery.

LEARNING POINTS

- Raise clinical team's awareness about the potential breakage of the insulation coating of the dura coagulation electrode and inspect it thoroughly during each integrity check
- For new procedures, especially involved consignment items, conduct a pre-operative briefing to review specific instruments to be used during the surgery

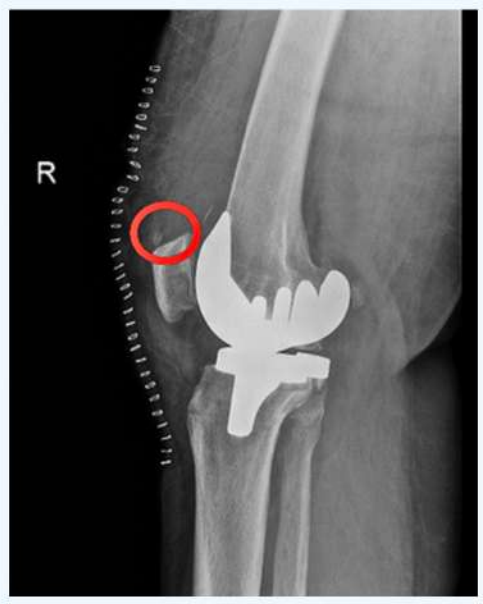
Cement

2

A patient underwent a right total knee replacement. A postoperative X-ray revealed a radiopaque material over the posteroinferior knee joint, suspected to be retained cement.

Subsequent CT scan of the right knee showed the presence of a radiopaque material in the suprapatellar lateral recess, potentially indicating intra-articular cement or a bone fragment.

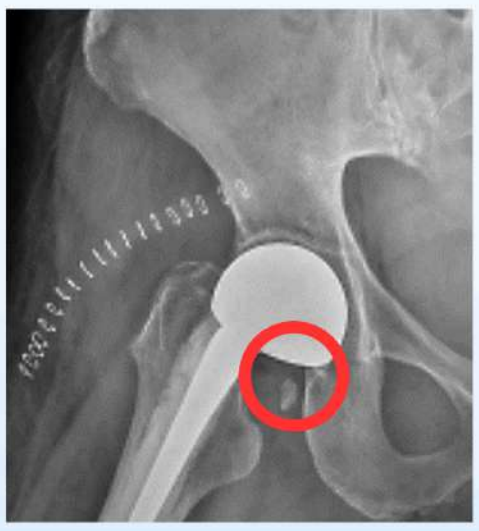
A second operation was performed to revise the knee arthroplasty and remove the foreign body. A 0.8 x 0.8 cm intra-articular cement fragment was found at the posterolateral aspect.



3

A patient with right neck of femur fracture underwent right bipolar hip hemiarthroplasty. A postoperative X-ray revealed a suspected retained cement fragment at the surgical site.

Subsequent CT scan confirmed the presence of a 0.9 x 0.3 × 0.9 cm radiopaque fragment in the anteromedial region of the right femoral neck, likely representing bone cement. The patient agreed with conservative management.



LEARNING POINTS

- Enhance training and coaching on the techniques and precautions for handling different types of bone cement

SENTINEL EVENTS - Retained Material

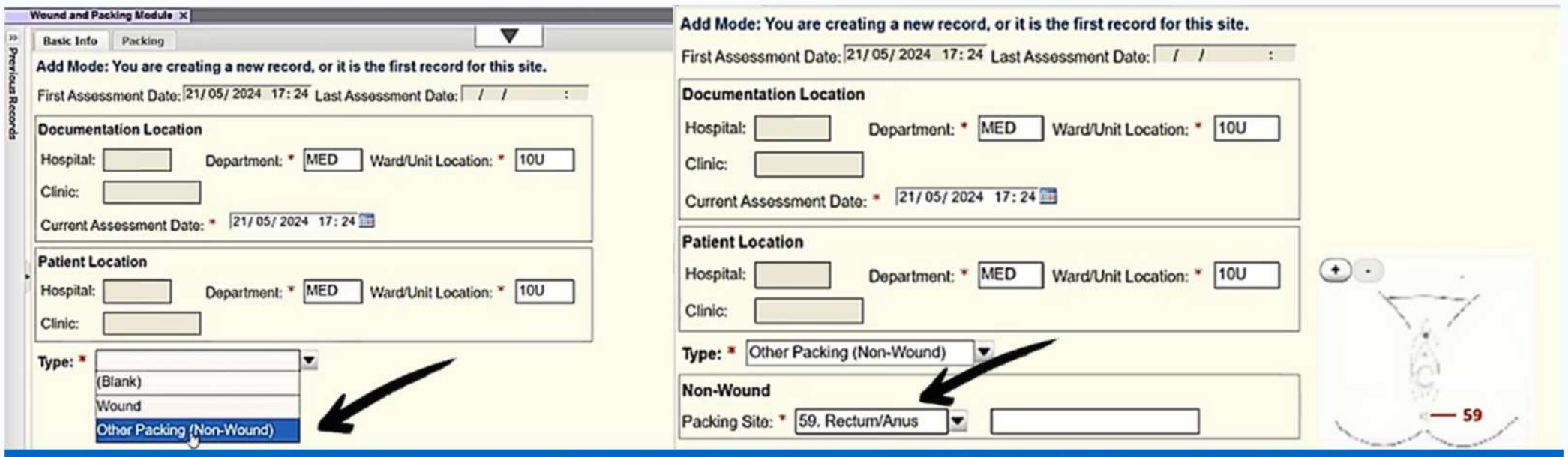
4 Gauze

A patient with multiple comorbidities was admitted to the medical ward for hypotension, and passed orange to red colored stool. An intern performed a per-rectal examination with proctoscopy and inserted an adrenaline-soaked packing gauze into the rectum to control bleeding, with an order for removal after a predefined duration. Due to persistent rectal bleeding, a nurse decided to keep the gauze for a longer period and secured the suture tip outside the anus with Tegaderm. During handover, Nurse B informed Nurse F that the gauze was not removed. However, Nurse F mistakenly believed that gauze had been removed and documented the information in the Intake & Output Chart.

As the patient's rectal bleeding continued, another adrenaline-soaked packing gauze was added without acknowledging the presence of a previously inserted gauze. Following the cessation of rectal bleeding, only one gauze was removed and documented. The patient was discharged with a follow-up appointment. Several days later, the patient was admitted to another hospital due to shortness of breath, where the first inserted gauze secured with a suture was discovered on the patient's napkin.

LEARNING POINTS

- Enhance staff communication and awareness of gauze packing through the use of **electronic systems**, such as "Wound and Packing Module", "Clinical Dashboard" and the "Electronic bed panel system"
- Check the integrity of gauze packing regularly and ensure proper documentation



Select **"Other Packing (Non-Wound)"** to document non-wound packing in "Wound and Packing Module"

SENTINEL EVENTS - In-Patient Suicide

A patient with metastatic prostate cancer was admitted for heart failure and later transferred to an isolation ward for disseminated herpes zoster. The patient had opted for Do-Not-Attempt Cardio-Pulmonary-Resuscitation (DNACPR). Suicide risk assessment was performed with no risk identified. A cardiac monitor and fall alarm sensor pad were applied for continuous monitoring.

During assessment in a nurse's round, the patient reported no complaints. 15 minutes later, the fall alarm was triggered. Supporting staff found the patient sitting on the edge of the bed and assumed that he was urinating. 30 minutes after that, the nurse noticed there was no signal from the cardiac monitor via the central monitor panel. Upon assessment, the patient's neck was found tied to the bed frame with a pair of trousers being fastened with a plastic bag urinal. Resuscitation was initiated immediately and the patient passed away.

Plastic bag urinal

LEARNING POINTS

- Provide disposable paper urinal instead of plastic bag to patient
- Ensure timely action is taken when equipment alarms are triggered

Disposable paper urinal

SENTINEL EVENTS - Others

A Patient Experienced Cardiac Arrest While Being Fed a Regular Diet

An old age home (OAH) resident was admitted for constipation and abdominal pain. The electronic Patient Assessment Form (ePAF) documented a "minced diet" based on information from relatives and the OAH note, stating that the patient was on a special diet. Doctor prescribed NPO (nil by mouth) except medications, with intravenous fluid replacement.

On the 4th day of admission, **"Diet as Tolerated (DAT)"** was ordered. As DAT was not a default option in the hospital's smart panel system, it was entered manually as free text, and the Dietetics & Catering Management System (DCMS) was not updated accordingly.

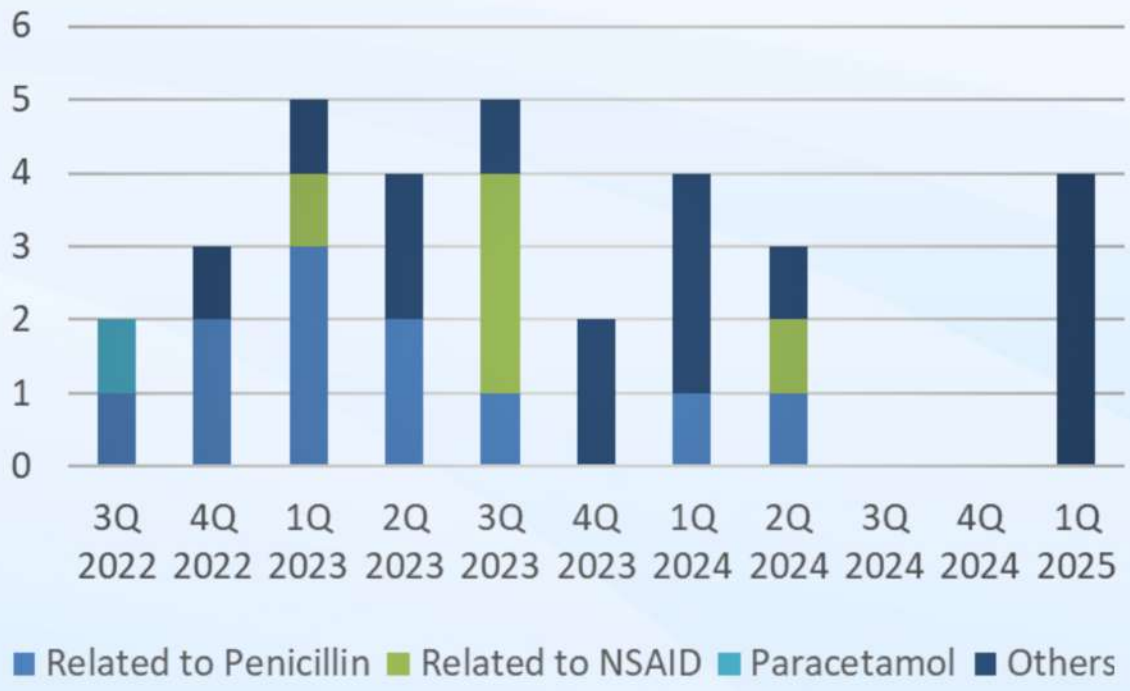
DAT was equated as a regular diet, and the patient was assisted with feeding. While initially tolerating some food, the patient began choking. Feeding was stopped and suction was performed. Shortly after, the patient suffered cardiac arrest and resuscitation was initiated. A piece of food residue from the patient's pharyngeal cavity was removed. Intubation was performed and resuscitation was continued. However, the patient was certified dead later.

LEARNING POINTS

- Provide training to align the interpretation of "DAT" across different discipline(s)
- Eliminate "DAT" as diet selection in all electronic systems and standardise hospital forms to ensures accuracy and clarity in dietary management

SERIOUS UNTOWARD EVENTS

All 19 SUE cases reported in 1Q 2025 were related to medication errors, including known drug allergy (KDA) (4), anticoagulants (5), chemotherapy agents (1), dangerous drugs (2), vasopressors and inotropes (2), insulin (1) and others (4).



Known Allergy	Allergen prescribed
IV Contrast for CT Scan (Iodinated)	IV Contrast
Lignocaine	Lignocaine
Levofloxacin	Ofloxacin eardrops
Fluorescein	Fluorescein

SERIOUS UNTOWARD EVENTS - Medication Errors

1 Lignocaine Administered to Patient With Documented Lignocaine Allergy in eHRSS

- A patient was admitted for marker insertion to left breast and informed Nurse A of allergies to Ibuprofen and Lysosome Chloride. The documented allergy to Epinephrine (as Hydrochloride) + Lidocaine Hydrochloride in Electronic Health Record Sharing System (eHRSS) and on the printed "Allergy/Alert Information" sheet was overlooked. Subsequently, only the patient - reported allergies were recorded on the pre-printed progress notes.

- At the breast clinic, the eHRSS record was not accessed. Based on the progress notes, 6ml of Lignocaine with 1: 200,000 Adrenaline was administered following completion of the "TIME OUT" procedure. The allergy to Lidocaine was identified during discharge documentation. The patient remained stable with no adverse reaction.

Allergy/Alert Information | Ward:

Drug Allergy
藥物過敏
Total (2)

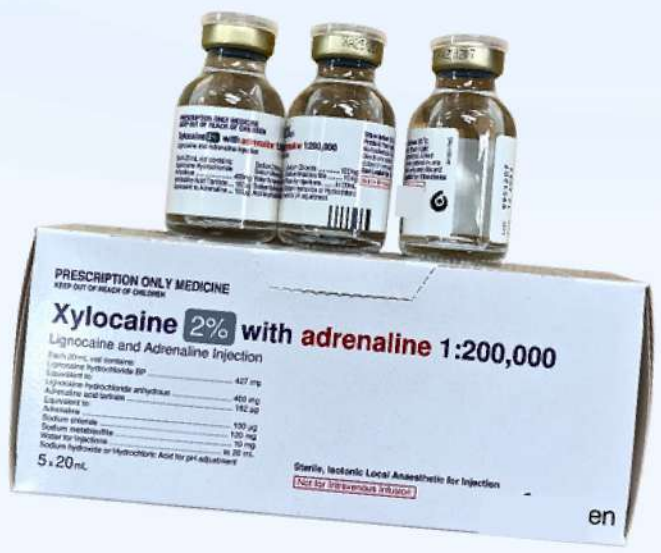
(1) IBUPROFEN
Angioedema, Suspected
facial and eye swelling
but symptoms were able to be tolerated by patient (according to letter from GP)

(2) LYSOZYME CHLORIDE
Angioedema, Suspected

eHRSS 電子健康紀錄互通系統

Allergy
過敏
Total (1)

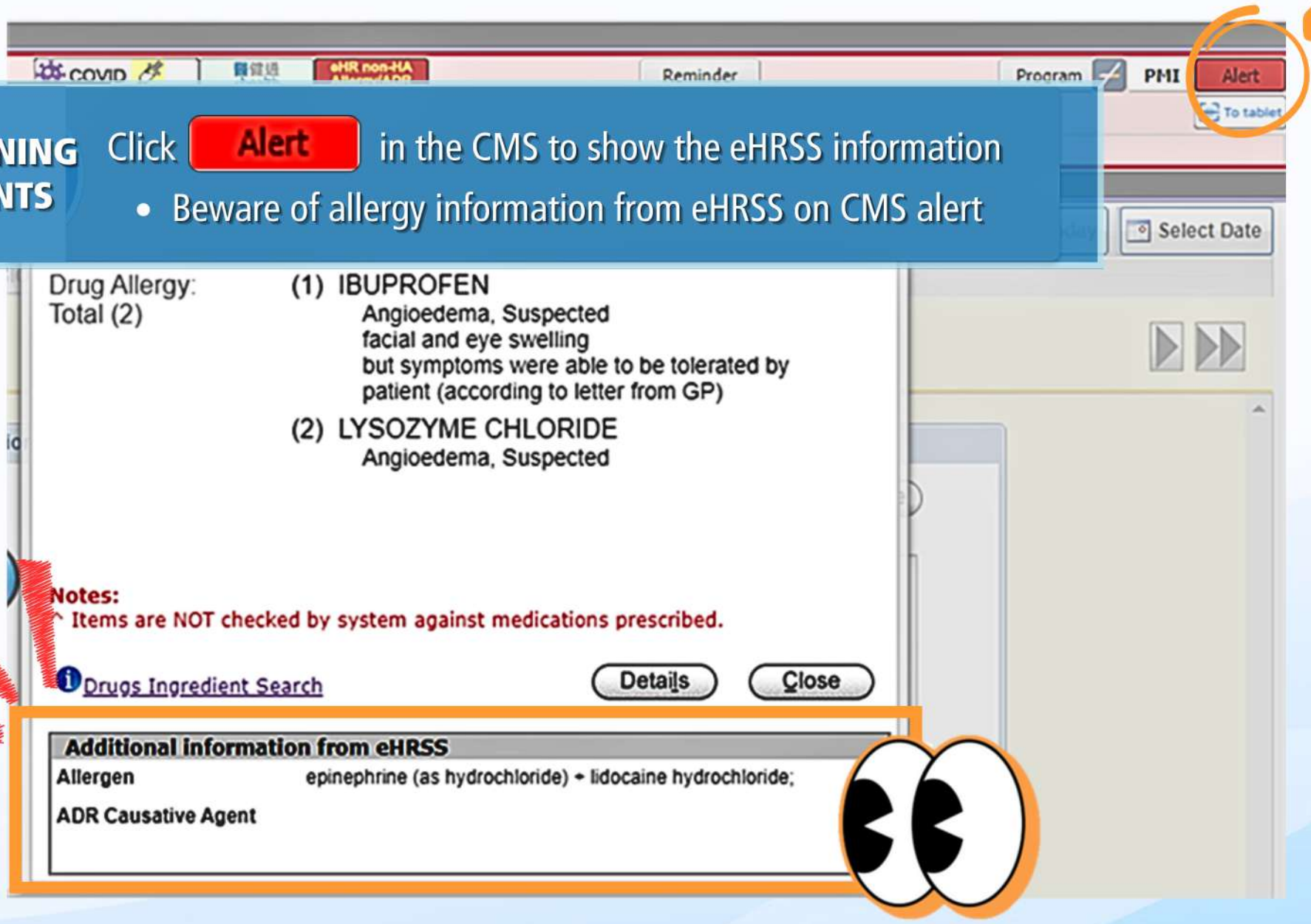
(1) epinephrine (as hydrochloride) + lidocaine hydrochloride
Manifestation uncertain, Certain
DENTAL SERVICE-WAN CHAI DENTAL CLINIC



LEARNING POINTS

Click **Alert** in the CMS to show the eHRSS information

- Beware of allergy information from eHRSS on CMS alert



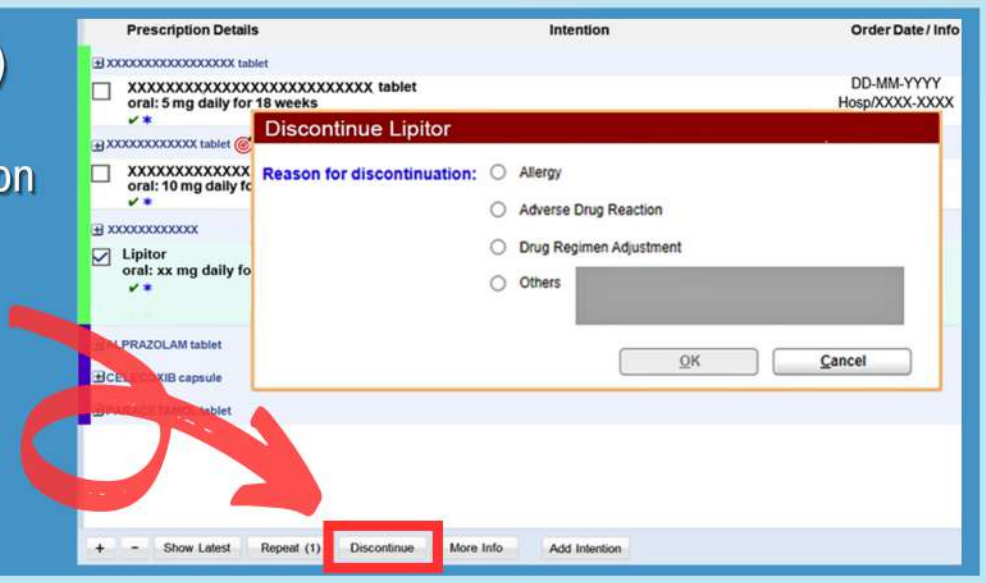
SERIOUS UNTOWARD EVENTS - Medication Errors

2 Unnecessary Resumption of Lipitor

- A patient was admitted for an ischemic stroke with right ataxic hemiparesis.
- Lipitor was prescribed during the hospitalisation and the patient was discharged two months later.
- One month after discharge, the patient was readmitted due to deranged liver function from Lipitor.
- Following discharge, Lipitor was withheld until her hepatitis clinic follow-up.
- In the hepatitis clinic, the patient was diagnosed with liver derangement related to Lipitor. A different class of lipid-lowering agent was prescribed.
- During a follow-up visit at General Out-patient Clinic (GOPC), Lipitor was inadvertently restarted.
- The patient presented with suspected jaundice and was readmitted for further management.

LEARNING POINTS

- Use the Patient MOE (PMOE) function with proper verification during prescription
- Use of the Discontinue function in PMOE and entering adverse drug reactions in the patient's alert



3 Warfarin was Administered to Patient with INR 4.1

- **Patient A** on regular Warfarin was admitted for acute exacerbations of chronic obstructive pulmonary disease.
- During medication round, a nurse used In Patient Medication Order Entry (IPMOE) **Toughpad** to check **Patient B's** blood pressure via "Vital Signs Chart Enquiry". After administered Lasix to **Patient B**, the nurse selected **Patient A** from the patient list **without clicking "Next patient" or closing the "Patient-specific Functions"** tab. He entered **Patient A's** drug administration page, where **"Warfarin 2mg once per day (on odd days), Give if INR</=3"** was scheduled. He noted that **Patient A's** INR result was unavailable from Medication Genie and then clicked the "Lab result" function button on the CMS to check the INR report, mistaking an **INR result of 1.2 (belonging to Patient B)** for **Patient A's**, and administered Warfarin to **Patient A.**
- Another nurse later discovered that **Patient A's latest INR result was 4.1** instead of 1.2. Doctor was immediately informed. The dosage of Warfarin was adjusted. No signs of bleeding were observed.

LEARNING POINTS

- The "Patient-specific Function(s)" and "Drug admin by ward" tabs allowed two different patient profiles to be assessed at the same time
- Click "Next Patient" button after completed reviewing a patient's record in CMS

Scan for Details

LOCAL SHARING

- Decoding "Diet as Tolerated" (DAT): A Guide for All Staff

A recent incident highlighted inconsistencies in the interpretation of "Diet as Tolerated" (DAT) within and across disciplines. These inconsistencies could lead to communication gaps.

To ensure consistent understanding and application, let's take a moment to get on the same page about DAT.

Unravelling DAT: Key Clarifications

What Does DAT Mean?

1. **DAT is a flexible dietary approach** that allows patients to consume foods and fluids based on their individual tolerance, preferences, and medical conditions
2. **DAT does not imply any specific food texture** but is subject to the assessment and judgment of healthcare professionals
3. **DAT is <u>NOT</u> equivalent to a regular diet**

To help us all apply DAT consistently:

Documentation:

- The DAT option in electronic and paper nursing forms has been removed (effective **28 March 2025**)

Communication and Training:

- The term DAT should **<u>NOT</u>** be used at the Smart Panel / bed-head signages
- The display on Smart Panel should match with the order in the Dietetics & Catering Management System (DCMS)
- Training materials should align with this clarified DAT interpretation

Key Takeaway

DAT does <u>NOT</u> imply a regular diet or any specific food texture. It is a flexible dietary approach based on professional judgment and patient assessment.

Acknowledgement: Cluster Q&S Offices, HO NSD, COC - Grade (Dietetics), COC - Grade (Speech Therapy)