RISK ALERT

ISSUE 79 OCT 2025

A Risk Management Newsletter for Hospital Authority Healthcare Professionals

IN THIS ISSUE

OPENING MESSAGE

Together for Safer Care: From Reporting to Learning

Patient safety is a fundamental value we all embrace. At the Hospital Authority (HA), every staff member contributes to creating a safer healthcare system. Enhancing our safety culture is not about eradicating every error, but learning from them and continuously improving our practices.

Culture embodies the values and beliefs of an organization, and it starts with people. A positive safety culture isn't built overnight; it is crafted through daily actions, decisions and attitudes of each individual. When we consistently prioritise safety, these behaviours become our habits. Over time, these habits integrate into our teams, systems, and ultimately our organisational culture. In this way, every staff member helps to establish a culture where safety is not just a priority, but a way of working.

A culture of safety begins with openness. We commend all colleagues for their commitment to incident and near miss reporting. Every report signifies a dedication to transparency, playing a crucial role in identifying risks and protecting our patients from future harm.

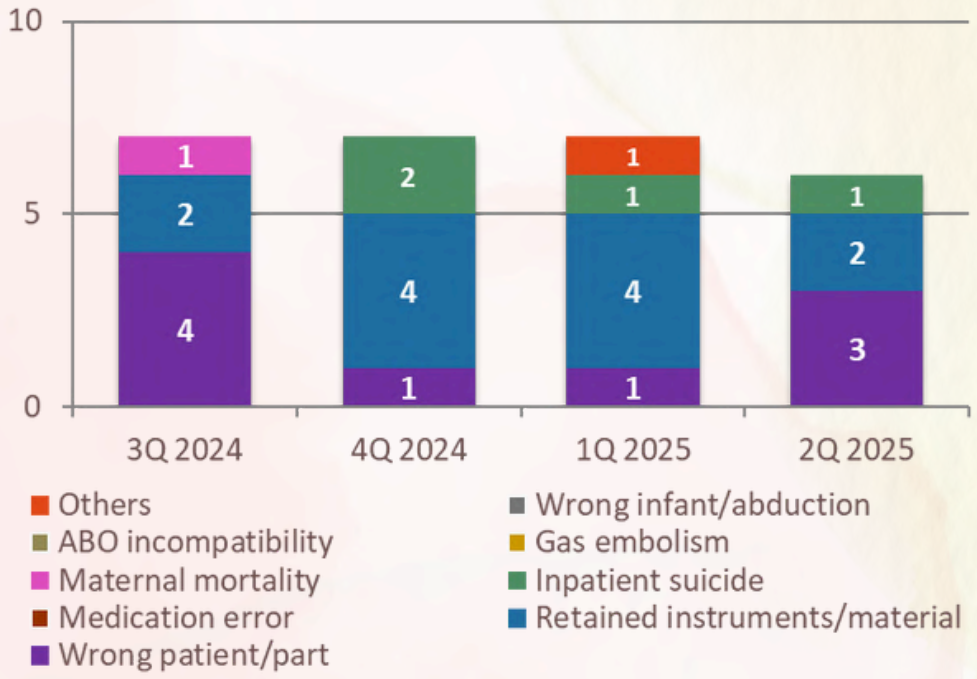
The HA Risk Alert (HARA) serves as a vital tool for transforming these incidents reports into shared learning. By analysing Sentinel Events (SE), Serious Untoward Events (SUE) and local case studies, we gain insights that help prevent recurrence and bolster our practices across HA.

Promoting a Just Culture and a Speak-Up Culture is key. Rather than relying on anonymous feedback, our focus should be on nurturing a supportive and trusting environment. Here, staff feel safe and respected to raise concerns openly, report incidents, and share ideas without fear of blame or reprisal. When staff trust that they will be treated fairly and that their voices will be heard, learning thrives and patient care advances. Let's remain united in our dedication to learning, collaboration and accountability, ensuring we continue to provide safer care for every patient, every day.

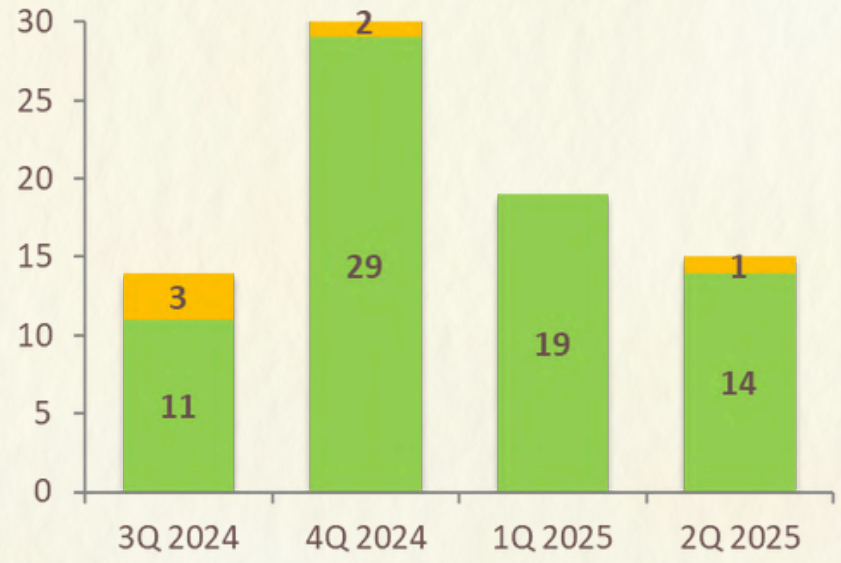
Dr Libby LEE
Chief Executive
Hospital Authority

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 Body Part

1 Wrong Intraocular Lens Implantation Based on Contralateral Eye Parameters

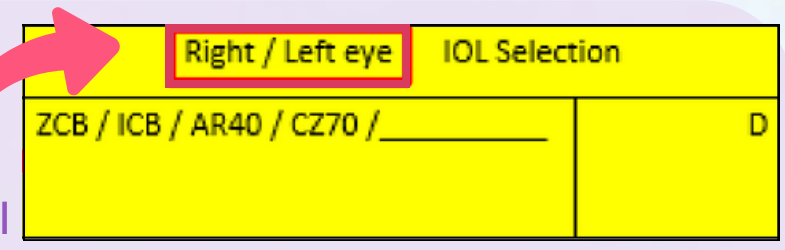
A refractive target of -1.5 diopters (D) was planned during the preoperative assessment for the patient's RIGHT eye cataract surgery, which was selected based on the patient's visual needs.

On the day of surgery, a reprint of intraocular lens (IOL) power measurement, A-scan and Keratometry (A&K) scan, was done by optometrist. The patient was transferred to the operating theatre (OT) and underwent the "SIGN IN" process just after the A&K result was reprinted. The **LEFT eye A&K data sheet** was inadvertently used instead, hence the corresponding IOL was selected. The error was not detected in subsequent "TIME OUT" process and the surgery was completed accordingly. The patient's right eye wound healed uneventfully and the cataract surgery for the opposite eye was scheduled at a later date.

The day before the patient was scheduled to undergo left eye cataract surgery, another surgeon reviewed the patient's records and noticed the left eye IOL selection label had been completed during the previous surgery, and the incident was subsequently identified. The surgical outcome for both eyes were acceptable, with no significant deviation from the target refraction.

LEARNING POINTS:

- Adjust patient flow to make sure A&K results are available before transfer to OT
- Include eye laterality on the IOL selection label



- Enhance A&K data sheet formatting to improve identification of the correct eye data
- Verify the IOL with the corresponding laterality and parameters at each critical step, including IOL collection, "TIME OUT" and just before implantation

2

SENTINEL EVENTS - Wrong Body Part

2 Fallopian Tube Inadvertently Excised During Laparoscopic Appendicectomy

A patient diagnosed with appendicitis underwent an emergency laparoscopic appendicectomy performed by a higher surgical trainee. During the operation, a mildly inflamed tubular structure, believed to be the inflamed appendix, was excised. The operation was complicated by a ruptured ovarian cyst with continue oozing; haemostasis was successfully achieved with specialist on site support.

Postoperatively, the patient developed fever and abdominal pain. A subsequent computerised tomography (CT) scan suggested the tubular structure to be appendiceal in origin, and the pathology report confirmed the excised tissue was a fallopian tube. A second laparoscopic appendicectomy was performed. The patient was subsequently discharged following an uneventful recovery.

LEARNING POINTS:

- Strengthen the framework on scope of practice for trainee with the use of workplace-based assessment guidelines which includes supervision, coaching and evaluation
- Strengthen Crew Resource Management (CRM) training to enhance situational awareness and team communication

3 Wrong-Sided Talc Pleurodesis

A patient with a history of breast cancer, multiple metastases, and bilateral pleural effusion was admitted for management of malignant pleural effusion. Bilateral chest drains were inserted and labelled as **LEFT side chest drain (Drain A)** and **RIGHT side chest drain (Drain B)**.

A flush of **Drain A** was ordered and a **RIGHT pleurodesis** was planned. The plan was documented as "proceed to **pleurodesis to right chest drain (Drain B)**" and talc powder was prescribed via In-Patient Medication Order Entry (IPMOE). The procedure was delegated to another doctor.

Pleurodesis was carried out at the bedside with nursing assistance. However, due to the bedside curtains limiting visibility of **Drain B**, and without confirmation through standard pre-procedure checks, the pleurodesis was inadvertently carried out via **Drain A**. The error was identified after the procedure.

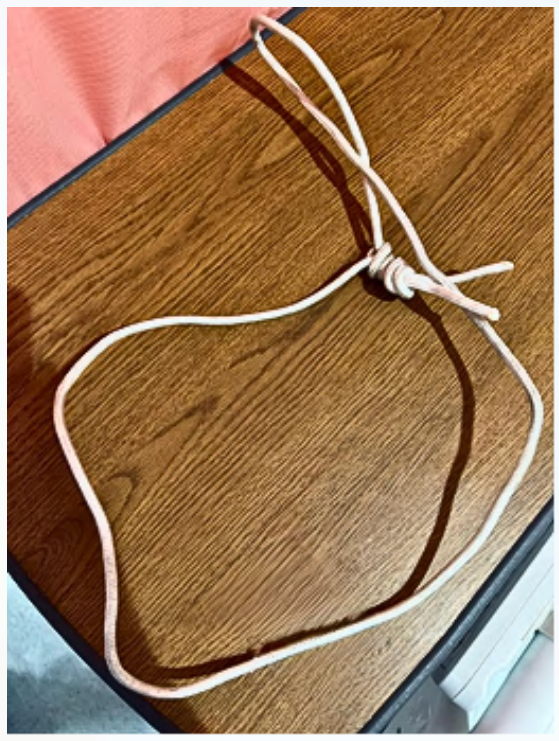
LEARNING POINTS:

- Strengthen staff adherence to mandatory pre-procedure verifications for bedside procedures

SENTINEL EVENTS - In-Patient Suicide

A patient with a history of metastatic pancreatic cancer was admitted for bilateral lower limb edema. On admission, the patient was emotionally stable and a suicide risk assessment revealed no identified risk.

Following clinical assessment, the patient was informed of the diagnosis of pancreatic cancer with liver and peritoneal metastases. He expressed keenness to proceed with palliative chemotherapy at that juncture. On the next day, the patient remained calm on bed initially, but later found unconscious with a rope around his neck attached to the bed hanger. Resuscitation was initiated immediately and the patient passed away. The origin of the rope remained unknown.



LEARNING POINTS:

- Ensure storerooms and passcode-secured rooms are locked and closed at all times to prevent unauthorized access to potentially dangerous items, such as plastic bags or ropes, which could pose a risk to patient safety

SENTINEL EVENTS - Retained Material

1

Segment of Nasogastric (NG) Tube

A case nurse instructed a Temporary Undergraduate Nursing Student (TUNS) to remove a NG tube prior to the Flexible Endoscopic Evaluation of Swallowing (FEES) test. The case nurse did not directly supervise the process to the TUNS and the tube's integrity was not checked prior to disposal. Following FEES, a chest X-ray (CXR) revealed a retained segment of the NG tube, which was subsequently removed.

LEARNING POINTS:

- Accentuate the importance of supervising the TUNS to ensure the nursing standards for patient care are followed
- Emphasise the checking of NG tube integrity and appropriate nursing documentation after removal
- Include this topic in new staff orientation and training programmes

SENTINEL EVENTS - Retained Material

2 Guidewire Coating

A patient underwent Percutaneous Nephrolithotomy (PCNL) for management of right upper urinary tract stone. Due to the presence of a full staghorn stone that rendered limited space between the stone and the calyceal system, the guidewire was manipulated multiple times within the metal needle. However, upon removal, the coating on the guidewire was found to be torn, exposing the inner wire. Intraoperative integrity checking suggested that the length and tip of the guidewire remained intact. Intraoperative nephroscopy failed to visualise the retained coating due to bleeding near the kidney puncture site.

Postoperative kidney, ureter and bladder (KUB) X-ray revealed that a portion of the guidewire coating was retained within the kidney. A second PCNL was performed.

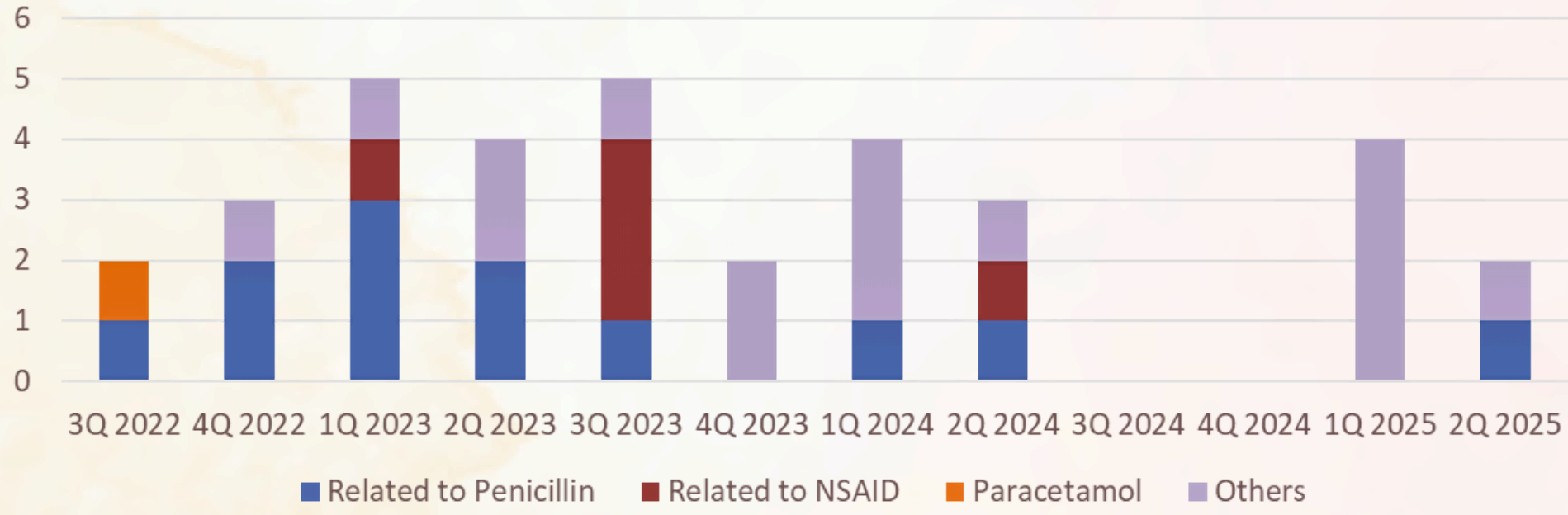
LEARNING POINTS:

- Use higher-dose X-rays intraoperatively to detect any retained foreign bodies
- Retain torn instruments for subsequent inspection and verification by the supplier if necessary

SERIOUS UNTOWARD EVENTS

Of the 15 SUE cases reported in 2Q 2025, 14 cases were related to medication errors, including known drug allergy (KDA) (2), anticoagulants (2), chemotherapy agents (1), dangerous drugs (4), vasopressors and inotropes (1), insulin (1) and others (3).

Number of KDA cases (3Q 2022 – 2Q 2025)



Known Allergy	Allergen prescribed
Betaloc	Betaloc
Augmentin	Augmentin

SERIOUS UNTOWARD EVENTS - Medication Errors

1 Incorrect Flow Rate of Remifentanil Infusion

- A patient admitted for elective thyroid surgery. Remifentanil infusion used to facilitate nerve monitoring
- The patient experienced bradycardia and hypotension shortly after the infusion began
- The infusion was immediately stopped upon realising a larger than required amount of the drug had been given
- Heart rate and blood pressure soon returned to normal with appropriate medications
- The surgery proceeded without further issues, and there were no complications post-operation
- Investigation revealed that the syringe pump was using the unit of nanogram/ml **"ng/ml"** instead of microgram/ml **"µg/ml"**, resulting in a high flow rate
- The pump had a **dim screen display (Figure 1)**, which had involved in this "incident" "passed" EMSD maintenance
- Diminished screen brightness, the availability of seldom-used and easily confused nomenclature units "ng/ml" were contributors of the incident

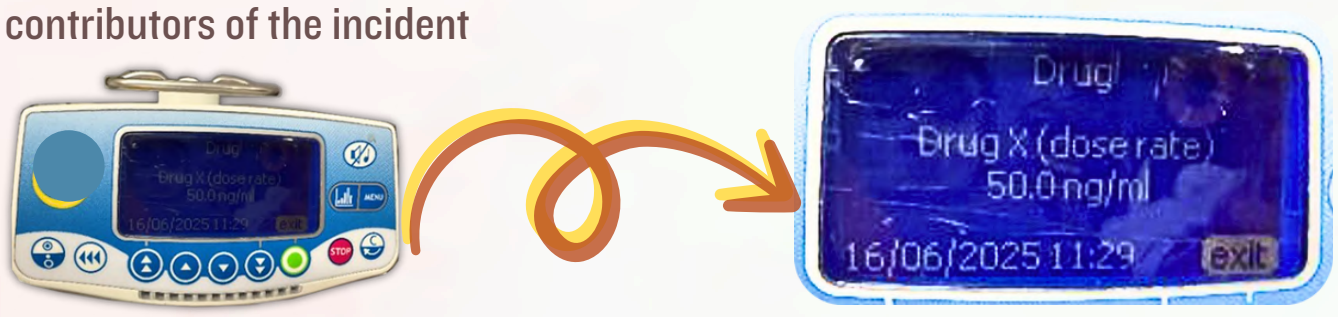


Figure1.
Dim syringe pump screen display showing dose unit as "ng/ml"

LEARNING POINTS:

- Eliminate seldom-used units on syringe pumps
- Re-evaluate the functionality of syringe pumps to ensure they meet current clinical requirements and develop a replacement plan
- Revise hard limits and introduce soft limits for infusions in drug library

2 Noradrenaline was Stopped Instead of Phenylephrine

- A patient with hyperthyroidism required resuscitation for hypotension and tachycardia
- Phenylephrine 10mg in 250mL D5 at 50mL/hr and Noradrenaline 8mg in 100mL D5 at 5mL/hr were prescribed and administered initially
- Due to persistent hypotension, Noradrenaline infusion was increased to 50mL/hr
- Phenylephrine infusion was decided to stop after systolic BP reached 170mmHg
- During transfer to ward, it was discovered that Noradrenaline infusion was mistakenly stopped instead of Phenylephrine

LEARNING POINTS:

- Implement strict **infusion line tracing** and **independent double checks** for infusion medication
- **Label medication name** on container and infusion line
- Add "Phenylephrine" and "Noradrenaline" to department drug library for displaying medication information on infusion device screen

SERIOUS UNTOWARD EVENTS - Medication Errors

Prescription of Medications with Positive History of Known Drug Allergy in Electronic Health Record Sharing System (eHRSS)

3

- A patient labelled with Betaloc allergy in eHRSS was prescribed and administered the drug
- The allergy information was not updated in the Clinical Management System (CMS) alert during Specialist Out-patient Department (SOPD) follow-up
- "No Known Drug Allergy" was displayed in the patient's allergy history, and the eHRSS information, which was displayed **in the lower section of the CMS alert box**, was overlooked

4

- A patient with a documented Augmentin allergy in eHRSS was prescribed and administered the drug
- The allergy information was entered by a Department of Health doctor in eHRSS shortly before his transfer to the Accident and Emergency (A&E) Department
- The referral letter mentioned the allergy information but was not noticed by HA doctor
- CMS was not updated in time and displayed "No Known Drug Allergy"
- Augmentin was administered **before the allergy data was synchronised with CMS/ Pharmacy Management System (PMS)**

LEARNING POINTS:

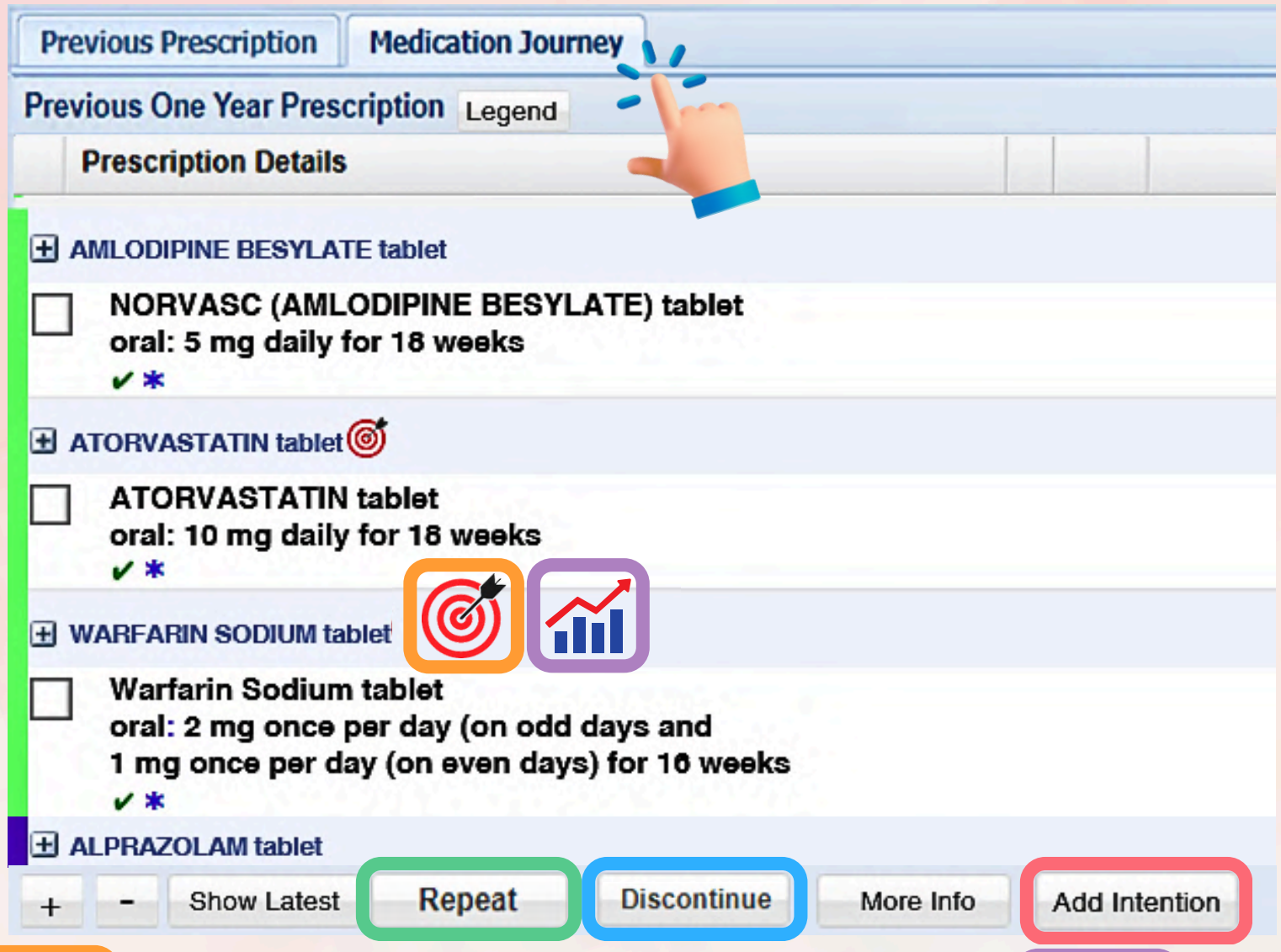
- Click Alert in the CMS to view the eHRSS information
- Beware of allergy information from eHRSS on CMS alert
- Recognise the time gap in syncing allergy data from eHRSS to CMS/PMS
- Confirm allergy history through multiple sources

For more information about allergy records from eHRSS to CMS, scan the QR code to access 78th Issue of HARA

SCAN ME

LOCAL SHARING
- Medication Journey and Clinical Intention

Mark Clinical Intention and Medication Discontinuation in Medication Order Entry (MOE)
to prevent unintentional prescriptions.



Add Intention

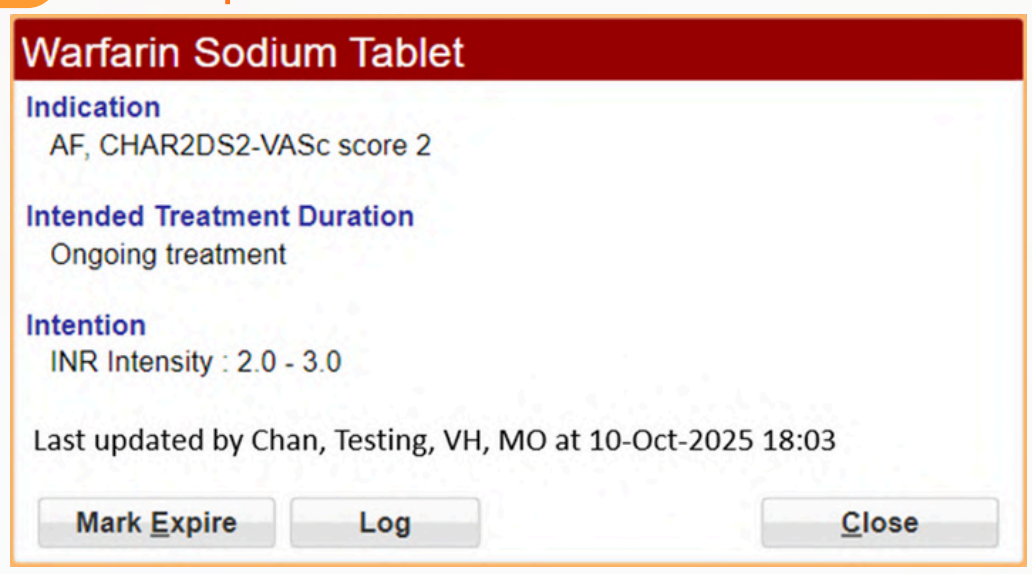
Add Intention

Consider using **Clinical Intention** to enter the **drug indication** & **duration**, especially for:

- Anticoagulants
- Dual Antiplatelet Therapy (DAPT)
- Thyroxine
- Antiviral for Hepatitis B

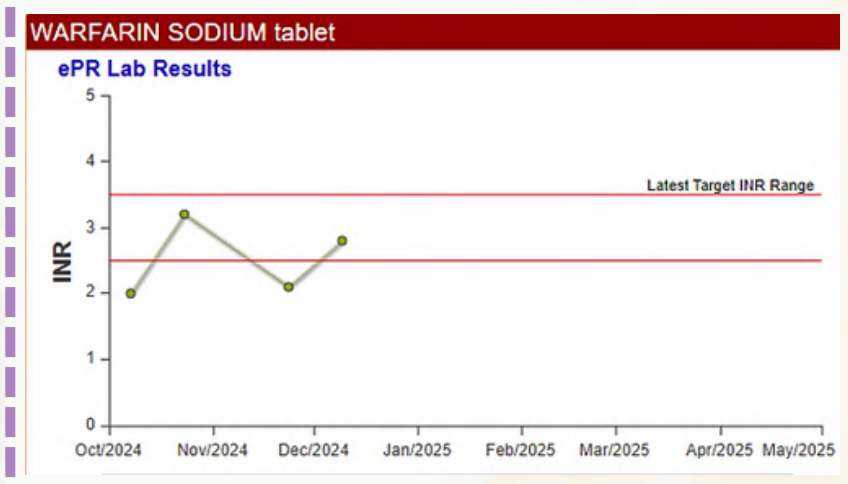
View Intention

View / update Clinical Intention information if indicated



View INR Chart

View INR trend & target range



Repeat

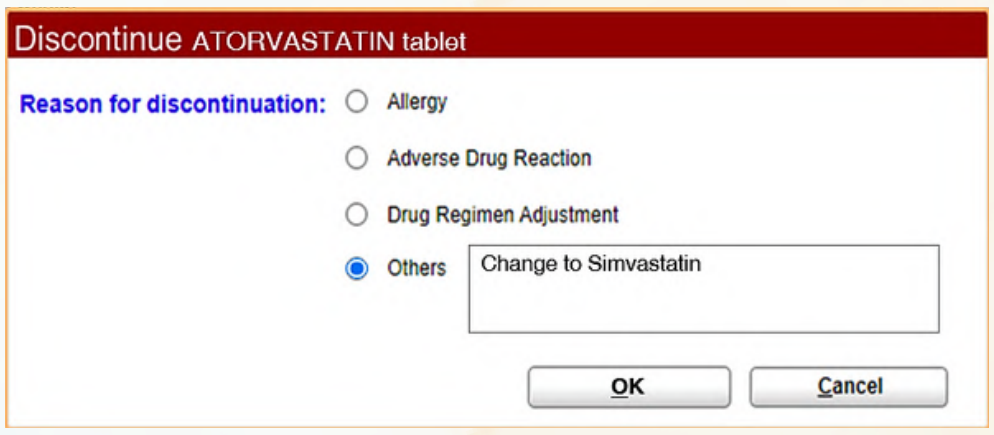
Prescribe Drug

Select & repeat the latest drug

Discontinue

Indicate Medication Discontinuation

Discontinue medication to prevent unintentional prescriptions



Credit: Information Technology and Health Informatics Division, Head Office

Suggestion or feedback is most welcome. Please email us through HA intranet at address: *HO Patient Safety & Risk Management*