Paper No. CB(2)2237/02-03(03)

For information
on 28 May 2003

LegCo Panel on Health Services

Report on the Incident of Mixing Up the Identity of Two Patients at the North District Hospital

This paper provides Members a report on the incident of mixing up the identity of two patients at the North District Hospital (NDH), and sets out the measures taken to prevent future similar incidents.

The Incident

2. On 4 May 2003, two patients, Madam Ho (aged 88) and Madam Sum (aged 79), were brought to the Accident & Emergency (A&E) Department of NDH at 13:02 and 14:15 respectively. The two patients were residents of two different Old Age Homes (OAH) and both of them presented with fever and respiratory symptoms. The attending doctor decided to admit both patients to the 3H fever ward for observation and investigation so as to confirm whether they have Severe Acute Respiratory Syndrome (SARS). The admission of both patients took place at around the same time.

3. As both of the patients had difficulty in communication because of their other antecedent medical conditions, a possible mix-up occurred during their admission procedures from the A&E department to the 3H ward, resulting in the two patients each being labeled the other's identity by way of a wrist bracelet carrying the other's name.

4. Both patients were given appropriate clinical management for their clinical conditions, including clinical consultation, investigation and treatment. One of the patients was confirmed to have contracted SARS and was transferred to the Prince of Wales Hospital on 8 May 2003 where

she passed away on 12 May 2003. The other patient's condition became stable after treatment and was discharged on 15 May 2003.

Cause of the Incident

5. At the NDH, there are standard procedures for checking patients' identity. These include checking the patients' ID documents, as well as checking the identity with the patients' relatives or caretakers at the A&E Department Observation Ward and designated Admission Ward for hospital admission. However, because of the implementation of the "no visiting" policy during the current SARS outbreak for infection control reason, visitors and relatives were not allowed to enter the wards. Hence, the hospital was unable to check patients' identity and apply identification wrist bracelet on patients in front of their relatives or caretakers in the ward environment. The two patients involved in the incident were both unable to identify themselves when being asked.

6. Investigation into the incident revealed that the unfortunate event was due to the standard procedure for verifying patients' identity in front of their relatives or caretakers being compromised by the "no visiting" policy implemented for infection control purpose during the SARS outbreak. The "no visiting" policy further makes it not possible for the mix-up to be discovered during the hospital stay of the patients. Eventually the mix-up was discovered upon the discharge of Madam Sum (labeled as Madam Ho) to the wrong OAH.

Actions Taken after the Discovery of the Mixing Up

7. Upon discovery of the mix-up on 15 May 2003, NDH immediately took action to further verify and confirm the identity of Madam Ho and Madam Sum and informed their relatives of the incident. At the same time, NDH had extended apologies to the relatives for the mix-up as well as for all the inconvenience and confusion caused. The management of NDH also assured the relatives that the hospital would offer all necessary assistance, and admitted responsibility for the mix-up.

8. The Department of Health, Death Registry and Immigration Department were contacted to amend the corresponding patients' data and

issue new ID card for Madam Sum.

9. The OAH the deceased Madam Ho resided was surveyed for contact tracing. It was confirmed that no other residents or staff in the OAH had symptoms of SARS during the observation period after their last contact with Madam Ho.

10. The incident had been reported to Hospital Authority Head Office (HAHO), and a press release on the incident was issued on 16 May 2003.

Measures to Prevent Future Similar Incidents

11. The following measures have been taken immediately by NDH to prevent future similar incidents from happening –

(i) For all elderly or unconscious patients, it is mandatory to apply the patient identification bracelet in the presence of their relatives or caretakers before their admission to ward

(ii) On admission to ward, ward staff would immediately check the patient's identity bracelet against the patient's file to ensure that the correct patient file is received.

12. To strengthen admission procedures, HAHO have also issued alert to all hospitals to require verification of patients' identity for unconscious patients or those with communication problem in the presence of their relatives or caretakers before affixing the identification bracelet. Appropriate disciplinary procedure and further risk management would also be considered by HA.

13. Members are invited to note the contents of this paper.

Health, Welfare and Food Bureau
May 2003