# *立法會*
# *Legislative Council*

LC Paper No. CB(2)470/15-16(06)

Ref : CB2/PL/HS

**Panel on Health Services**

**Background brief prepared by the Legislative Council Secretariat for the meeting on 21 December 2015**

**Patient safety management in the Hospital Authority**

## Purpose

This paper summarizes the concerns of the members of the Panel on Health Services ("the Panel") on issues relating to patient safety management in the Hospital Authority ("HA") in the Fifth Legislative Council ("LegCo").

## Background

2. HA currently manages 42 public hospitals and institutions, 47 specialist outpatient clinics ("SOPCs") and 73 general outpatient clinics. As at 31 March 2015, HA provides about 27 600 hospital beds, accounting for almost 90% of inpatient services (in terms of number of bed days) in Hong Kong. In 2014-2015, HA provided 8.0 million patient days (including inpatient and day patient services), 2.2 million accident and emergency attendances, and 7.0 million SOPC attendances.

Clinical governance of HA

3. HA established the Division of Quality and Safety at the HA Head Office ("HAHO") level in 2006. Mirroring structures were set up under the hospital clusters in the following years to promote patient safety culture and implement programmes to reduce risk and enhance service quality. At present, the Chief of Services ("COS") is the overall manager of a clinical specialty department responsible for service delivery and development, planning and budgeting, quality assurance and staff development. The clinical management teams, which are assemblies of multi-disciplinary healthcare professionals providing medical services to patients under a team approach, emphasize close supervision

of staff in their daily practices, peer review exercises and clinical audits with a view to improving service quality and patient safety. The heads of all clinical management teams within an individual clinical specialty are represented in their respective HA-wide Coordinating Committee ("COC") which serves as a platform for clinical leaders to deliberate issues including manpower, training, services, quality, technology and therapeutics. Similar professional supervision and training frameworks are in place for nursing and allied health professionals.

Hospital accreditation

4. HA launched the Pilot Scheme of Hospital Accreditation in 2009 in collaboration with the Australian Council of Healthcare Standards ("ACHS"). The ACHS Evaluation and Quality Improvement Program 4 Hong Kong Guide with a set of locally adapted accreditation standards, which consists of three functions, 13 standards and 45 criteria that cover different aspects of hospital management has been developed. Patient safety, which includes the criteria of medication safety; infection control; pressure ulcer prevention and management; falls prevention and management; blood management; and correct patient, procedure, site, is one of the standards under the clinical function. According to HA, a total of 20 public hospitals will be accredited upon the completion of the second phase of the Pilot Scheme by 2015.

Incident management of HA

5. HA continues to promote patient safety through lessons learnt from medical incidents. With reference to the international practice in clinical governance and patient safety management, HA implemented in October 2007 a Sentinel Event Policy to standardize the practice and procedures for handling sentinel events in all public hospital clusters. It was further improved to become the Sentinel and Serious Untoward Event Policy in January 2010. The Policy defines sentinel event as an "unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof" and serious untoward event as an "unexpected occurrence which could have led to death or permanent harm". Clusters or hospitals are required to report to HAHO through the Advance Incident Report System sentinel events, serious untoward events and other medical incidents. HA will set up a Root Cause Analysis Panel to identify root causes of reported sentinel events and serious untoward events and make recommendations for improvement.

Other measures

6. To enhance service quality and safety, senior management of HAHO, hospitals and clusters will lead patient safety rounds and receive direct feedback from frontline staff on their areas of concern regarding protocols and procedures

in their daily work settings which concern patient safety. On surgery safety, a Surgical Outcome Monitoring and Improvement Programme ("SOMIP") has been implemented since 2008 to monitor clinical outcome and identify improvement opportunities in public hospitals.

7. As regards the safe use of medical equipment and products, HA requires equipment with various levels of complexity be operated by staff with corresponding experience and qualification; establishes protocols to ensure standards in sterilization of instruments; sets up a governance structure for the management of medical equipment; establishes guiding principles for vetting new medical equipment; develops an infrastructure for tracking medical equipment; and establishes the Medical Equipment Safety Alert System to facilitate prompt dissemination of hazard and alert notices involving medical equipment or devices. To safeguard the quality of pathology reports, HA has engaged an external quality assurance programme organized by overseas and local colleges of pathologists to assure the diagnostic accuracy of anatomical pathologists. Pathology departments in HA also undertake regular internal clinical audits. At the corporate level, the COC in Pathology set up by HAHO establishes clinical standards for quality assurance as well as identifies and manages risk inherent to the specialty.

Latest strategies adopted by HA

8. The following three broad directions are outlined in the Strategic Plan 2012-2017 of HA for improving the quality of services and ensuring that care provided for patients are safe and effective -

(a) to enhance clinical risk management strategies to improve patient and staff safety, with particular focus on building safety culture and developing safer models of service;

(b) to modernize HA by adopting modern technology and treatment options which have a proven track record of improving clinical outcomes and service efficiency in a cost-effective way, and by upkeeping the standard of medical equipment and facilities; and

(c) to improve clinical practice through enhancing clinical governance and implementing continuous quality improvement systems.

**Deliberations of the Panel**

9. Issues relating to the Sentinel and Serious Untoward Event Policy, surgical outcome management, mechanism to ensure safety in the use of medical

equipment and products, and quality management of pathology reports in HA were discussed by the Panel in the Fifth LegCo. The deliberations and concerns of members are summarized in the following paragraphs.

The Sentinel and Serious Untoward Event Policy

10. Members were concerned about the surge in the number of cases of medication error resulting in major permanent loss of function of death, and cases involving retained instruments or other materials after surgery or interventional procedure in 2013-2014. Question was raised as to whether the increased complexity of the surgical procedures and variety of equipment used during the procedures had contributed to an increase in the number of the latter sentinel event.

11. HA advised that it would implement an electronic Inpatient Medication Order Entry ("IPMOE") System in all public hospitals by phases to automate and check the prescription and dispensing of drugs in order to enhance the safety and efficacy of medication. The IPMOE System had been piloted in a few public hospitals and proved effective in reducing medication errors. As regards sentinel events involving retained instruments or other material after surgery or interventional procedure, it should be noted that with rapid technological advances in medical care and procedures, more procedures were performed outside the operating theatre and more outreach services were provided. HA would extend the "Time-out" process, which was a pre-procedure verification process carried out by the clinical team, and the practice of after-surgery counting to surgery or interventional procedures performed outside operating theatre to check vigilantly the completeness of instruments upon removal from patients.

12. Members were advised that to prevent sentinel events relating to "death of inpatients from suicides (including home leave)", HA would enhance environment risk control in the hospital setting, and conduct individual clinical risk assessment, undertake care planning and enhance communication with patients and their families to minimize suicidal risk of patients on home leave. There was a view that the services provided by medical social workers should be strengthened in order to identify patients having suicidal ideas and plans so as to facilitate the early implementation of suicide precaution measures.

Surgical outcome management

13. Members urged HA to implement follow-up actions for the Queen Elizabeth Hospital ("QEH") and the Prince of Wales Hospital ("PWH") which indicated opportunities for improvement in emergency surgical service, and for the Tuen Mun Hospital ("TMH") which indicated opportunities for improvement in both emergency and elective surgical services according to the SOMIP Report

covering the period from July 2012 to June 2013. In particular, members expressed grave concern that the performance of TMH had been statistically worse than other public hospitals since the introduction of SOMIP.

14. The Administration advised that it was observed that high bed occupancy of surgical wards was intensively correlated with their outcomes. In addition, the differential utilization of Intensive Care Unit ("ICU") beds by patients underwent elective and emergency operations might have an impact on surgical outcomes. QEH, PWH and TMH would set up surgical high dependency units in 2014-2015 to take care of those patients who underwent elective operations, so as to make more ICU beds available for taking care of those seriously ill patients undergoing emergency operations.

Mechanism to ensure safety in the use of medical equipment and products

15. Members were of the view that HA should enhance the monitoring over the procurement and inventory control of medical equipment and products at both the corporate and hospital levels to ensure patient safety. There was a view that HA should work out a target level of consumables stockpiling with reference to the shelf life of the consumables to avoid build up of stock and wastage. Some members considered that there was room for improvement in the information systems put in place by HA to manage the stock-take and disposal of medical consumables in order to ensure that no expired medical consumables would be used on patients.

16. According to HA, the current corporate measures had been focused on tracing the whereabouts of used medical consumables in case of an adverse incident, rather than on monitoring the procurement and inventory control process of each medical consumable. While HAHO would perform central sourcing and procurement of some medical items, certain slow-moving and specialty-use medical consumables, such as surgical sutures for heart surgeries, were procured by the relevant clinical departments or operating theatres. HA agreed that there was a need to put in place a clear guideline for the relevant clinical departments to estimate the quantities of various specialty-based medical consumables required subject to some degree of deviation. There was also a need to strengthen the expiry alert mechanism in respect of medical consumables.

17. On the mechanism put in place by HA to ensure the proper functioning of the medical equipment before they were used on patients, members were advised that general testing of the proper functioning of medical equipment was required before surgery. For life support machine, HA would ensure the availability of back-up machine for emergency. Apart from the scheduled preventive maintenance programmes for regular inspection by the contractors or

the Electrical and Mechanical Services Department in accordance with the recommendations of the manufacturer of the medical equipment, HA would perform corrective maintenance on medical equipment to timely repair or replace components which had failed or broken down.

Quality management of pathology reports

18. Members generally considered it important for pathology reports to be accurate as they had a direct bearing on the diagnosis of clinicians and hence, patient safety. There was a suggestion that reports issued independently by pathologists of less experience and those reports concerning diagnosis of brain cancer and leukaemia should be subject to a higher percentage of random audit or cross checking by another experienced pathologist.

19. According to HA, while pathologists who had completed training and become a Fellow of the Hong Kong College of Pathologists and the Hong Kong Academy of Medicine could, in principle, issue pathology reports independently, the existing practice of HA was to assign them with the more straight-forward and less complex cases. The existing percentage of audit check on pathology reports in histopathology service of HA, which stood at the level of 1%, was on par with the international standard. In addition, clinical auditing would be performed for all high risk or complex cases. HA agreed to relay the suggestion of introducing a higher percentage of audit check for reports issued by pathologists of less experience to its COC in Pathology for consideration.

**Recent developments**

Recommendations of the Steering Committee on Review of HA

20. The Steering Committee on Review of HA has made the following recommendations for enhancing the safety and quality of services of HA in its report published in July 2015 -

(a) HA should strengthen the roles of COCs on clinical governance, including the development of clinical practice guidelines, services standards, introduction of new technology and service development plan for its respective specialty to achieve more standardized service quality and treatment and to ensure safety;

(b) HA should review the role of COS with greater emphasis on clinical governance;

(c) HA should review the inter-relationship of COC/Central Committee and various services committees with a view to streamlining internal consultation on annual resource planning and clinical service development. HA should address the concerns of frontline clinical staff and review their administrative workload to ensure they can concentrate and focus on their core duty of providing care for the patients;

(d) HA should, through COCs, develop a system of credentialing and defining scope of practices to ascertain professional competence and to ensure patient safety;

(e) HA should step up the implementation of clinical outcome audits as a tool to assess and monitor clinical competence and service outcome for seeking service quality improvement; and

(f) in examining the root cause for the occurrence of a medical incident, HA should strengthen the sharing of lessons learnt among clusters to minimize the possibility of its recurrence, and consider measures to enhance communication with and support for patients.

21. On 22 October 2015, HA released its Action Plan for implementing the recommendations of the Steering Committee in three years. An extract of the relevant parts of the Action Plan on the implementation of the above six recommendations is in **Appendix I**.

Recent incidents of members' concern

22. Arising from the following recent medical incidents, Hon Alice MAK and Hon CHAN Han-pan wrote to the Panel Chairman on 22 July and 28 August 2015 respectively (LC Paper Nos. CB(2)1970/14-15(01) and CB(2)2062/14-15(01)) expressing concern on the safety of public hospital services -

(a) in June and July 2015, six patients were found infected with mucormycosis at the Queen Mary Hospital with the source suspected to be originated from patient linen items which were supplied by Shum Wan Laundry Centre. All these six patients were immunocompromised, and two of them passed away subsequently. An expert panel was set up by HA to determine the root cause of the contamination. The expert panel released the investigation report on 6 August 2015;

(b) on 22 July 2015, TMH announced an alkaline phosphatase ("ALP")

reference range deviation incident in which the reference ranges of male and female patients for the age group of 60 or above were swapped inadvertently when the ALP analyzer was installed in TMH in March 2013. The problem was recognized during the preparation of laboratory accreditation on 6 July 2015 and the reference ranges were rectified immediately. A total of 4 634 male patients and 4 809 female patients were involved in the incident. An investigation panel was set up to investigate the root cause of the incident and make recommendations for improvement. The New Territories West Cluster announced the outcomes of investigation on 26 September 2015; and

(c) on 26 August 2015, the Pamela Youde Nethersole Eastern Hospital ("PYNEH") announced a sentinel event related to contaminated lung biopsy specimen resulting in patient receiving unnecessary operation to remove part of the lung. An investigation panel was appointed to investigate the root cause of the incident and recommend improvement measures. PYNEH announced the recommendations of the panel on 30 October 2015.

The press releases of HA on the investigations of the above three incidents are in **Appendices II to IV**.

23. The Administration will brief the Panel on the management of patient safety in HA, as well as the handling of the above incidents and the follow-up actions taken by HA at the Panel meeting on 21 December 2015.

**Relevant papers**

24. A list of the relevant papers on the Legislative Council website is in **Appendix V**.

Council Business Division 2
Legislative Council Secretariat
18 December 2015

**Appendix I**

**E X T R A C T**

## Implementation of the Recommendations of the Steering Committee on Review of Hospital Authority

## Hospital Authority Action Plan

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| Strategic Goal and Target | Action | Timeline |
|---|---|---|
| **Overall Management and Control**<br>**Enhancing the safety and quality of services** | | |
| **Recommendation 10** | | |
| Strengthen the roles of COCs on clinical governance | 109. Require COCs/CCs to enhance their roles and responsibilities in clinical governance, specifically in setting service standards, developing clinical practice guidelines, education and training, conducting clinical audits, managing clinical risk management and introduction of new technology and service development | 1Q 2016 |
| | 110. Promulgate standardised set of Terms of Reference of COCs/CCs | 3Q 2016 |
| | 111. Evaluate the implementation by inviting COCs/CCs to conduct self-assessment on their enhanced roles and areas for improvement | 3Q 2017 |
| Enhance the role of Chief of Service (COS) with greater emphasis on clinical governance | 112. Engage COSs and doctor groups on the enhanced role of COS, particularly in quality of patient care and patient safety | 2Q 2016 |
| | 113. Specify COS management functions as related to clinical governance in COS appointment and staff appraisal procedure | 1Q 2017 |

| Strategic Goal and Target | Action | Timeline |
|---|---|---|
| Refine COC/CC/service committees relationship with a view to reducing their administrative work in annual resource planning and clinical service development | 114. Improve the annual planning process to further reduce the administrative work in annual resource planning. Key stakeholders in COCs/CCs will be engaged through training workshops and feedback processes to better utilise the annual planning cycle for prioritisation of resource bids put forward by hospital service units so as to reduce abortive work at frontline level | 1Q 2016 |
| Develop a system of credentialing and defining scope of practices | 115. Implement the established vetting mechanism of credentialing activities in the HA through the COCs/CCs, Central and Cluster Credentialing Committees | 1Q 2016 |
| | 116. In collaboration with Cluster Credentialing Committees, develop mechanism of defining scope of practice, maintenance of staff lists and regular reporting of HA endorsed credentialing activities | 4Q 2016 |
| | 117. Communicate with Hong Kong Academy of Medicine on HA's credentialing development and discuss the future development | Ongoing |
| Improve clinical outcomes and patient care through clinical audit activities | 118. Enhance and update the clinical audit guidelines to guide clinical specialties in performing clinical audits | 1Q 2016 |
| | 119. Support COC (Intensive Care Unit) to develop a local risk adjusted model for intensive care outcome monitoring programme | 4Q 2016 |
| | 120. Develop specific sets of clinical indicators for service quality improvement | Ongoing |

| Strategic Goal and Target | Action | Timeline |
|---|---|---|
| Strengthen medical incidents sharing | 121. Develop an electronic platform for staff communication on medical incidents | 1Q 2017 |
| | 122. Publicise and implement the Clinical Incident Management Manual, with focus of communication with and support for patients | 2Q 2016 |
| | 123. Publish HA Risk Alert (HARA) and annual report and organise incidents sharing sessions at HA Head Office, cluster forums and COCs | Ongoing |
| | 124. Continue to integrate patient safety in training to interns and junior doctors | Ongoing |

*Note:*

- *COCs: Coordinating Committees*
- *CCs: Central Committees*
- *HA: Hospital Authority*

*Source:* *Extract from the Administration's paper entitled "Action Plan for the Implementation of the Recommendations of the Steering Committee on Review of Hospital Authority" (LC Paper No. CB(2)97/15-16(01))*

醫院管理局 HOSPITAL AUTHORITY 新聞稿 PRESS RELEASE

Thursday, 6 August 2015

# Expert Panel Report Released with Improving Measures for Laundry Procedure

The Expert Panel (The Panel) to investigate the incident of mucormycosis infection at Queen Mary Hospital (QMH) released the investigation report (The Report) today (6 August) with a number of recommendations to enhance the process and practices for laundry services and linen item storage to ensure a clean and hygienic supply of linens for public hospital patients.

The Hospital Authority (HA) spokesman said HA has received the Report from the Panel and will actively study and follow up the recommendations in the Report.

In June and July this year, six patients were found infected with mucormycosis at QMH with the source suspected to be originated from patient linen items which were supplied by Shum Wan Laundry Centre. An expert panel was subsequently set up to determine the root cause of the contamination. In the course of investigation, samples from other laundry centres of HA have also been collected but none was tested positive for mucormycosis.

According to the Report, samples had been taken during the site visits conducted by the Panel members at Shum Wan Laundry Centre. Some of the samples were tested positive to the implicated zygomycetes. The Panel believed that the microbiological findings correlated with the visibly dusty environment and the failure of the washer to achieve the set temperature.

"The operation of Shum Wan Laundry Centre will continue to be suspended. Its linen items supply to public hospitals is to be taken up by other laundry centres to maintain normal supply. HA will follow up with the service contractor of Shum Wan Laundry Centre on the liability issues in accordance with the contractual terms," The spokesman added.

In the Report, the Panel made a number of recommendations to enhance good practices in laundry and linen storage. The HA spokesman highlighted that three improvement measures have been implemented with immediate effect in all laundry centres:

傳媒查詢：當值新聞主任傳呼機號碼：7328 3855 傳真：2504 0018 九龍亞皆老街 147B 醫院管理局大樓

Media Enquiries: News Duty Officer Pager: 7328 3855 Fax: 2504 0018 Hospital Authority Building, 147B Argyle Street, Kowloon

1) Reinforcing the checking of temperature sensors of the laundry equipment in all laundry centres
2) Enhancing the monitoring work process in particular moisture control during drying and packing of patient linen items
3) Ceasing the use of starch power for ironing of patient linen items.

Other recommendations included periodic and thorough cleaning and sterilising of laundry facilities and delivering vehicles, a clear segregation of used and clean linen to prevent cross-contamination. On the handling of linen items at the hospital front, the Panel recommended linen consumption should follow the first-in-first-out principle and topping up must not be allowed. In the long term, periodic microbiological testing for linen items will also be studied.

The Expert Panel was led by Professor Yuen Kwok-yung, Chair Professor of Infectious Diseases, Department of Microbiology of Li Ka Shing Faculty of Medicine of the University of Hong Kong. Other panel members included the Chief of Service (Medicine), Queen Mary Hospital, Dr Albert Lie; the Principal Medical & Health Officer (Epidemiology Section) of Centre for Health Protection, Department of Health, Dr Liza To; and HA Chief Manager (Business Support Services), Mr Desmond Ng. The HA would like to express its appreciation to Professor Yuen and the panel members for their hard work in completing the report within a short period of time with a number of valuable improvement recommendations.

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新界西·醫院聯網
New Territories West Cluster
屯門醫院 Tuen Mun Hospital
23 Tsing Chung Koon Road, Tuen Mun, New Territories, Hong Kong. Tel: (852) 2468 5111 Fax: (852) 2455 1911
新界屯門青松觀路23號 電話：(852)2468 5111 傳真：(852)2455 1911

**(Press Release)**

Saturday, 26 September 2015

**Attention News Editors:**

The spokesperson of the New Territories West Cluster made the following announcement today (26 September) regarding the investigation of the Tuen Mun Hospital Alkaline Phosphatase reference range deviation incident:

Tuen Mun Hospital (TMH) announced an Alkaline Phosphatase (ALP) reference range deviation incident on 22 July 2015. The New Territories West Cluster (NTWC) appointed a panel, with participation of independent member and pathology expert, to investigate the root cause of the incident and to make recommendations for improvement. The panel has completed the investigation and the report has been submitted to Hospital Authority Head Office and NTWC.

The panel has interviewed the staff concerned, examined the workflows and reviewed the relevant documents.

TMH Clinical Pathology Department procured a new Laboratory Automation System in March 2013. The system included major Chemistry and Immunoassay tests, which would provide many laboratory tests including the ALP test. The system installation was a major project involving the relocation of hematology services and renovation of the laboratory. There was a need for the department to launch the system on schedule so that the whole range of chemical pathology services could be maintained.

As part of the installation process of the system, a laboratory staff of the department collected reference data from manufacturer, academic journals and publications. The staff subsequently compiled those data into an excel file for cross checking by another two staff. In the excel file, the ALP reference ranges of male and female patients aged over 60 were accidentally swapped but this was not discovered in the cross-checking process. The data was eventually inputted into the system. This swapping of reference range was discovered on 6 July 2015 during the preparation of laboratory accreditation by the same staff who collected the data initially.

The spokesperson of NTWC said, “Having considered the information and reports reviewed, the panel acknowledged that there was an established workflow in the department to detect transcription error, but the error has escaped detection in this incident.”

The panel made the following recommendations:

- Review the workflow to ensure independent entries of data fields by different members with subsequent reconciliation
- Documentation of items cross-checked and different amended version is required
- Steps of reconciliation between reference ranges of laboratory report and source documents should be adopted
- A standard operating procedure on cross-checking procedure should be better communicated to staff

The panel also advised as a good practice in general to appoint multi-disciplinary project teams to monitor the installation and function test when major medical equipment system is being installed in future, taking into consideration manpower, workload and project timeline.

The spokesperson added, NTWC would implement the recommendations suggested to avoid similar incident happening again.

Among the 4634 male patients involved, 1425 passed away due to various reasons before the announcement of the incident. 2,973 did not require reassessment as the interpretation of their results was not affected by the ALP reference range deviation. 236 patients required calling back for reassessment.

Among the 236 male patients required call back, 185 of them had been examined and none of the patient was the treatment found to be adversely affected. 40 patients have at this time not decided whether to take examination or refused. 10 of them could not be contacted in this period of time or passed away due to various reasons after the announcement of the incident. 1 patient was followed up by private medical practitioner.

TMH has also conducted and completed review of the reports for the 2,973 male patients who did not require calling back. TMH is also reviewing the 1,425 reports of those patients who have passed away due to various reasons previously.

Among the 4,809 female patients involved in the incident, TMH has reviewed their records and noted that no unnecessary invasive treatment such as liver biopsy was performed.

The spokesperson reiterated, "The incident only involves reference range being swapped. There is no error in the test results and TMH so far has not identified any patient's treatment being adversely affected by the incident."

NTWC will thoroughly study the report and if necessary follow up in accordance with prevailing human resources procedures.

NTWC expresses sincere apology to all patients concerned again and will continue to provide necessary support. NTWC also expresses appreciation to the chairman and members of the panel. Membership of the panel is as follows:

**Chairman**

Dr Tang Kam-shing
Service Director (Quality & Safety), New Territories West Cluster

**Members**

Dr Chan Ho-ming
Consultant (Chemical Pathology), Prince of Wales Hospital
Dr Lam Kit-yi
Chief Manager (Patient Safety & Risk Management),
Hospital Authority Head Office
Mr Wong Wai-keung
Scientific Officer (Medical) (Clinical Biochemistry), Queen Mary Hospital
Ms Yan Hau-yee
Member, Tuen Mun Hospital Governing Committee

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Media enquiries: 7116-3228 a/c 6611

**Appendix IV**

東區尤德夫人那打素醫院
**Pamela Youde Nethersole Eastern Hospital**

Friday, 30 October 2015

**Attention News Editors:**

The spokesperson of the Pamela Youde Nethersole Eastern Hospital (PYNEH) made the following announcement today (30 October) regarding the investigation report on a Sentinel Event:

PYNEH announced a Sentinel Event on 26 August 2015 and thereafter appointed a panel, with participation of independent members, radiology experts and pathology experts, to investigate the root cause of the incident and to make recommendations for improvement. The panel has completed the investigation and the report has been submitted to Hospital Authority Head Office and PYNEH.

A 64-year-old male patient with lung nodule was arranged a CT-guided lung biopsy at PYNEH for diagnosis and treatment planning. The biopsy investigation result indicated malignancy of the lung nodule and the patient was referred to Queen Mary Hospital (QMH) for lobectomy of the right lower lobe. The pathological investigation of the patient's excised lung tissue confirmed the clinical diagnosis was pulmonary tuberculosis. DNA fingerprinting studies proved that the specimen taken was found to contain tissue of another patient with confirmed lung cancer. The discrepancy in diagnoses had resulted in patient receiving unnecessary operation to remove part of the lung. The hospital had a meeting with the patient and family members on 26 August 2015 to explain the incident in details, and expressed apologies. The incident was announced to the public on the same day.

The panel has interviewed the staff concerned, examined the workflows and reviewed the relevant documents, qualification of staff involved and manpower status on the day of the incident. The panel has concluded that three factors are believed to have contributed to the contamination of the specimen, including biopsy collection, tissue wrapping and embedding in the laboratory. A comprehensive review for improvement has been conducted.

The panel has made the following recommendations to the hospital:

- To ensure specimen bottle will not be used once the seal is broken or removed, to eliminate the additional use of rinsing bottle for biopsy procedure, to label the specimen bottle once it's designated to a patient and to enhance the documentation of specimen nature and quantity

- To stagger the sequence of handling specimen of similar nature whenever possible and to facilitate the ease of single use of forceps in tissue wrapping and embedding.

- To ensure adequate checking and traceability in laboratory, including double checking mechanism for tissue wrapping and ensure traceability in the entire specimen processing, in particular tissue wrapping and embedding procedures

PYNEH would implement the recommendations to prevent similar incident from happening again and would take other follow-up actions as and when necessary. The hospital has met the patient concerned to explain the report findings and expressed again sincere apology to him. The hospital will continue to follow up on his clinical condition. PYNEH also expresses appreciation to the chairman and members of the panel. Membership of the panel is as follows:-

**Chairman**

Professor To Ka-fai
Honorary Chief of Service (Anatomical and Cellular Pathology)
Prince of Wales Hospital

**Members**

Dr Wong Yiu-chung
Chief of Service (Radiology & Nuclear Medicine)
Tuen Mun Hospital / Pok Oi Hospital

Dr Tang Chung-ngai
Deputy Hospital Chief Executive and Chief of Service (Surgery)
Pamela Youde Nethersole Eastern Hospital

Ms Chiang Yim-ha
Advanced Practice Nurse (Imaging and Interventional Radiology)
Prince of Wales Hospital

Mr Wong Wing-ming
Department Manager (Pathology)
Tseung Kwan O Hospital

Dr Rebecca Lam Kit-yi
Chief Manager (Patient Safety & Risk Management)
Hospital Authority

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Media enquiries: 2595 6111 (Page Duty Public Affairs Officer)

**Appendix V**

**Relevant papers on the patient safety management in the Hospital Authority**

| Committee | Date of meeting | Paper |
|---|---|---|
| Panel on Health Services | 10.2.2014 (Item II) | Agenda<br>Minutes<br>CB(2)2083/13-14(01) |
| Panel on Health Services | 20.10.2014 (Item IV) | Agenda<br>Minutes<br>CB(2)2207/14-15(01) |
| Panel on Health Services | 17.11.2014 (Item V) | Agenda<br>Minutes<br>CB(2)1513/14-15(01) |
| Panel on Health Services | 16.2.2015 (Item IV) | Agenda<br>Minutes<br>CB(2)147/15-16(01) |

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