Hospital Authority expresses concern towards safety of laser eye procedures

The following is issued on behalf of the Hospital Authority:

The Hospital Authority (HA) is deeply concerned about two recent incidents involving laser ophthalmology procedures. The Coordinating Committee in Ophthalmology issued a reminder to the ophthalmology departments in all public hospitals today (October 17) to reinforce the importance of strict compliance to the Interventional Procedure Safety Policy, including the verification of energy level requirements of the laser procedure and relevant patient information.

A patient of Alice Ho Miu Ling Nethersole Hospital was arranged to undergo macular laser treatment procedure at the specialist outpatient clinic at the hospital on October 12. During the procedure, the doctor noticed a higher degree of laser energy output than what had originally been intended and discovered a deviation in the setting of the micropulse laser instrument. The laser instrument setting was readjusted to the appropriate energy level immediately and the remaining procedure was continued.

The doctor reported the incident to the supervisor. The patient was seen again on October 14 and examination revealed that the patient’s macular edema had increased and vision was slightly impaired. The incident was explained to the patient and treatment was provided accordingly. Another follow-up examination will be arranged.

A patient of the Pamela Youde Nethersole Eastern Hospital attended a Macular Grid Laser Therapy in the Specialist Outpatient Clinic on October 12. Two nurses performed pre-intervention checking and a marking was indicated next to the lateral canthus of the patient’s left eye. Two doses of prescribed medication were instilled to the left eye.

The patient later entered the laser treatment room and sat opposite to the doctor after confirmation of the identity. After the application of anesthesia eye drop to the left eye of the patient by an Eye Care Assistant, ceiling light in the room was dimmed for the procedure. The macular laser lens was put into the patient’s right eye by doctor during the procedure. No discomfort was raised by the patient. The doctor later discovered the wrong treatment and immediately stopped the procedure. The equipment was readjusted and the procedure was carried out uneventfully to the patient’s left eye.

Follow-up appointment was arranged and the patient was informed of the incident on October 16. The department will continue to closely monitor the conditions of the patient. Initially no obvious adverse condition is observed from the patient.

Both hospitals have already conducted open disclosure to the patients

and extended their apology. The clinical teams will continue to maintain close communication with the patients and provide necessary assistance.

The two hospitals will set up root cause analysis panels to investigate the incident and give recommendations for improvement. The report will be submitted to the HA Head Office within eight weeks. The panel results will also be published in the “HA Risk Alert” quarter bulletin to remind frontline healthcare staff to uphold patient safety during laser treatments.

The HA apologised to the public for the two incidents. The Ophthalmology Coordinating Committee will follow up the root cause analysis and investigation reports of the two hospitals. The Committee will also monitor the progress of the two hospitals in implementation of improvement measures to avoid a recurrence of the incidents.