Pamela Youde Nethersole Eastern Hospital announces investigation report regarding sentinel event

The following is issued on behalf of the Hospital Authority:

The spokesperson for Pamela Youde Nethersole Eastern Hospital (PYNEH) today (February 15) announced the findings and recommendations of an investigation report regarding an incident related to computed tomographic (CT) colonography (virtual colonoscopy):

Arrangements were made for a female patient to undergo virtual colonoscopy in the hospital on December 7, 2018. A rectal tube was inserted into the patient's rectum without patient discomfort and colonic insufflation was performed using manual insufflation with room air before the scan. During the examination, images revealed pneumo-retroperitoneum and pneumo-peritoneum, indicating the possibility of rectum perforation caused by the rupture of the balloon due to accidental inflation with gas. Surgical repair of the lacerated rectum was performed the same day. The patient remained stable all along and was discharged home, upon her recovery, on December 22.

PYNEH has reported the incident to Hospital Authority (HA) Head Office via the Advance Incident Reporting System. A Root Cause Analysis Panel was formed to investigate the incident. The Panel made the following conclusions:

1. The rectal tube used in this case for manual insufflation was adopted from the commercial set for Carbon Dioxide (CO2) insufflator. As both of the ports of balloon inflation and air insufflation were blue in colour, the radiologist might have confused and misidentified the port for manual insufflation;
2. The radiologist could have been distracted by the busy environment in the CT suite on the day amid urgent CT requests from multiple wards, and therefore identified the wrong port for manual insufflation.

The Panel made the following recommendations:

1. Not to alter the use of the commercial set for CO2 insufflator for the purpose of manual insufflation. Staff should follow the instruction from the supplier/user manual for proper use of equipment as far as possible;
2. To enhance staff awareness of the different ports of the rectal tube (e.g. by means of pictorial guide or instruction for quick reference).

The hospital has accepted the Panel's findings and recommendations and submitted the investigation report to HA Head Office. The hospital has explained the investigation findings to the patient's family and apologised

again for the incident. The hospital will continue to maintain close communication with the patient and the family and provide them with the necessary assistance.