Pok Oi Hospital announced sentinel event involving histological testing result

The following is issued on behalf of the Hospital Authority:

Pok Oi Hospital (POH) announced a sentinel event involving the histological testing result today (March 15):

A female patient with post-menopausal bleeding, had a uterine tissue biopsy at the POH on January 5 for diagnosis and treatment planning. The biopsy investigation result indicated the patient was with endometrial cancer. The patient received an operation at Tuen Mun Hospital (TMH) on February 26 to remove the uterus, bilateral fallopian tubes, bilateral ovaries, and pelvic lymph nodes. The operation was uneventful, and the patient was discharged four days after the surgery.

After the operation, the hospital conducted a pathological examination of the patient's excised uterine tissue, and no cancer cell was found. As the pathology result was inconsistent with the previous test results, hence the Department of Clinical Pathology conducted a review. The hospital performed genetic testing (DNA) on the specimens, which revealed that the specimen taken on January 5 contained tissue from another patient diagnosed with cancer, leading to a deviation in the results.

The hospital is highly concerned about the incident and has reported to the Hospital Authority Head Office (HAHO) through the Advance Incident Reporting System. After a preliminary review of the laboratory processing records and CCTV footage, the hospital suspected that during the process, the patient's specimen was mixed with a specimen containing cancer cells from another patient. The hospital had reviewed the specimen from other patients taken on the same day and did not find similar situations thus far. The hospital has reminded staff in relevant departments to strictly adhere to established guidelines when handling patient specimen.

The hospital has met with the patient and family members today to explain the incident in details and express the sincerest apologies to the patient and her family. The hospital will continue to closely follow up on the patient's clinical condition. A Root Cause Analysis (RCA) panel has been set up to investigate the root cause of the incident and make recommendations for improvement. The investigation report will be submitted to the HAHO in eight weeks. The composition of the RCA panel is as follows:

Chairperson:
Dr Alice Chan
Consultant, Department of Pathology, Kwong Wah Hospital

Members:

Dr Hau Lap-man
Service Director, Quality and Safety, New Territories West Cluster

Dr Mak Siu-ming
Chief of Service, Clinical Pathology, Tuen Mun Hospital/Pok Oi Hospital/Tin Shui Wai Hospital

Dr Cheuk Wah
Deputy Chief of Service, Pathology, Queen Elizabeth Hospital

Dr Nicole Chau
Senior Manager (Patient Safety & Risk Management), Quality & Safety Division, Hospital Authority Head Office

Mr Wong Chi-keung
Department Manager, Pathology, United Christian Hospital