Pok Oi Hospital announces root cause analysis report of previous sentinel event

The following is issued on behalf of the Hospital Authority:

The spokesperson for Pok Oi Hospital (POH) today (May 10) announces the root cause analysis report of a previous sentinel event:

POH announced a sentinel event involving the histological testing result on March 15 and appointed a Root Cause Analysis Panel to investigate the underlying cause of the incident and make recommendations. The Panel has completed the investigation. The report has been submitted to the Hospital Authority Head Office.

On January 5, a female patient with post-menopausal bleeding had a uterine biopsy, which indicated she had endometrial cancer. The patient received an operation at Tuen Mun Hospital on February 26 to remove the uterus, bilateral fallopian tubes, bilateral ovaries, and pelvic lymph nodes. After the operation, pathological examination of the patient's resected tissue showed no cancer. The hospital conducted a review and performed genetic testing on the specimens, which revealed that the biopsy taken on January 5 contained a tissue fragment from another patient who was diagnosed with cancer, leading to a deviation in the results.

After investigation, the Panel confirmed that during processing of the biopsies, a tissue fragment of a cancer patient was thrown off and landed on an unused mould that was subsequently used to hold the biopsy of the patient concerned, resulting in contamination of specimen.

The Panel commented that the chamber housing unused moulds was located immediately adjacent to the working platform and the moulds were placed facing upward. The unfavourable position should be improved to minimise the risk of mixing up specimens.

The Panel noted the laboratory guideline requires laboratory staff to ensure each mould is clean prior to tissue embedding. Although the staff concerned suspected there might have been a discrepancy between the biopsy fragments and the recorded gross description, the apparent discrepancy was considered within an acceptable range and hence the procedure was carried on without further follow-up.

The Panel made the following recommendations:

1. Covering the chamber housing unused moulds and placing the moulds bottom-up to minimise the risk of mixing up specimens;
2. Reinforcing training and supervision of laboratory staff on handling specimens, emphasising the importance of checking a mould to ensure

it is clean and empty and ready to use;

3. Establishing specific guidelines on risk mitigation in managing laboratory events, including the handling of suspected mixing of specimens; strengthening communication and raising alertness of laboratory staff who should seek further advice if in doubt; and

4. Improving the current system for macroscopic description of sampling with well-defined parameter to enhance traceability of the size of specimen.

â€‹The hospital has explained the report's findings to the patient and her family, extended sincere apologies to them again and will continue to closely follow up on the patient's clinical condition. POH has accepted the investigation findings and recommendations, and will take follow-up actions to implement the recommendations to prevent the recurrence of similar incidents in the future.

The hospital also expressed gratitude to the Panel. The membership of the 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 Cheuk Wah
Deputy Chief of Service, Pathology, Queen Elizabeth Hospital

Dr Lam Ming-cheung
Consultant, Clinical Pathology, Tuen Mun 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