Prince of Wales Hospital announces a sentinel event

The following is issued on behalf of the Hospital Authority:

The spokesperson for the Prince of Wales Hospital (PWH) made the following announcement today (December 18) regarding a sentinel event:

A 63-year-old male patient was admitted to the Accident and Emergency Department in the afternoon on December 16 due to left hand injury caused by an electric saw. All the fingers of his left hand were seriously injured with the index finger amputated and the blood vessels and nerve of the middle finger and ring finger transected. Emergency surgery was arranged to replant the amputated finger and repair the injured vessels and tissues.

At around 6.30pm, the patient was transferred to the operating theatre. The amputated finger was being wrapped in a sterile glove and kept in a plastic box filled with ice water with patient label and a remark that the box contained an amputated part on the outside. After assessment, the doctors performed sutures of vessels of the middle finger and ring finger first. At around 10.30pm during duty handover, theatre nurses could not find the amputated finger inside the plastic box. Immediate search was conducted. The amputated finger was later found wrapped in its original sterile glove among operating theatre waste at 1.30am. After examining the finger, the doctor was of the opinion that the structure of the finger was not damaged and the replantation surgery could proceed. The blood flow of the finger could not be restored though after replantation and the amputated finger has to be removed. The whole surgical procedure was completed at 6am on the next day (December 17).

The Hospital has met the patient and his family to explain the details of the surgery and extended sincere apology for missing the amputated finger for some time during the operation. The medical team will closely monitor the condition of the patient and provide appropriate treatment.

The Hospital was very concerned about the incident. It has been classified as a sentinel event and reported to the Hospital Authority Head Office (HAHO). A root cause analysis panel will be set up to look into the incident and propose recommendations to prevent its recurrence. A report will be submitted to the HAHO within eight weeks.