Queen Elizabeth Hospital announces investigation report on oxygen supply during patient transfer incident

The following is issued on behalf of the Hospital Authority:

The spokesperson for Queen Elizabeth Hospital (QEH) today (December 14) announced the findings and recommendations of the Investigation Report regarding an incident related to oxygen supply during a patient transfer:

A male patient with chronic illness was admitted to the hospital on September 27 for severe acute pneumonia and later developed respiratory failure. He was connected to a ventilator to assist his breathing. He was transferred to the Intensive Care Unit on the following night as his condition had not improved. The healthcare staff later found that the self-inflating ventilation bag used during the transfer was not connected to an oxygen cylinder. The patient finally succumbed on September 30.

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

1. The healthcare workers in the ward had to resuscitate another critically ill patient at the same time that evening. The nurses involved were relatively inexperienced for handling such an emergency situation.

2. As the patient had deteriorated to an extremely critical condition, the clinical team had made every endeavour to salvage the patient. The clinical team intended to transfer the patient to the Intensive Care Unit as soon as possible. Due to lack of communication among the staff in the highly stressful emergency situation, the checking of equipment and medical documentation for patient transfer were not yet complete.

3. In view of the seriousness and the rapidly deteriorating medical condition of the patient, even without the incident during the transfer, the clinical situation of the patient might not be significantly different.

The panel made the following recommendations:

1. Enforce proper checking of all the medical equipment and documentation on the checklist for transfer and escort of critically ill patients before transfer.

2. Enhance communication and collaboration among members of the clinical team during transfer of critically ill patients to safeguard the safety of the patient.

3. Enforce the practice of optimally stabilising the patient's condition before transfer and seeking help and support from more experienced staff for

difficult situations.

The hospital is saddened by the patient's passing away and expresses its deepest condolences to the family. The hospital has explained the investigation report to the patient's family and will keep close contact with them. The hospital has accepted the Panel's findings and recommendations, and submitted the investigation report to the HA Head Office.