# Queen Elizabeth Hospital announces sentinel event

The following is issued on behalf of the Hospital Authority:

The spokesperson for Queen Elizabeth Hospital (QEH) announces a sentinel event today (June 19):

A 61-year-old male patient, feeding with a nasogastric tube, was arranged to feed with formula milk after replacing a new tube by healthcare staff in an Orthopedic ward of QEH. While the patient's condition deteriorated afterwards, it was revealed that the nasogastric tube was not placed in an appropriate position.

The hospital is highly concerned about the incident. After preliminary review, it was revealed that a new nasogastric tube was inserted by a nurse on June 16 noon according to the established arrangement. Another nurse examined the patient in the evening and considered reinsertion of the nasogastric tube was needed. The nurse followed the established protocol to collect aspirated fluid samples for pH test and to verify the position by auscultation. Feeding of formula milk was then resumed, followed by a chest X-ray examination for the patient.

The patient's condition suddenly deteriorated in the early morning of June 18. Doctors immediately performed resuscitation and arranged bronchoscopy examination for the patient, where a nasogastric tube was found placed in his bronchus. The tube was immediately removed by doctor and the patient was transferred to the High Dependency Unit for close monitoring. The patient is now hospitalised in the Intensive Care Unit with critical condition. The clinical team will continue to closely monitor the patient's clinical condition and provide appropriate treatment.

The hospital is saddened by the incident. QEH has met with the patient's family to explain the incident, extend sincere apologies and express deep empathy. QEH will continue to closely communicate with the patient's family and provide necessary assistance.

The QEH is very concerned about the incident, and has reported to the Hospital Authority Head Office through the Advance Incident Reporting System. A Root Cause Analysis Panel has been set up to investigate the root cause of the incident. The panel will submit report and recommend improvement measures within eight weeks. The panel members are as follows:

Chairperson:
Dr Tang Kam-shing
Hospital Chief Executive, Kwong Wah Hospital

Members:

Dr Fong Wing-chi
Chief of Service, Department of Medicine, Queen Elizabeth Hospital

Ms Li Wah-chun
Cluster General Manager (Nursing), Kowloon Central Cluster

Dr Leung Chi-shing
Consultant, Department of Medicine and Geriatrics, Caritas Medical Centre

Mr Yip Chun-ki
Department Operations Manager, Department of Medicine, Queen Mary Hospital

Ms Chiu So-yan
Manager (Patient Safety and Risk Management), Hospital Authority