United Christian Hospital announces event involving improper use of electronic vital signs recording system

The following is issued on behalf of the Hospital Authority:

â€‹The spokesperson for United Christian Hospital (UCH) made the following announcement today (March 1) regarding an improper use of electronic vital signs recording system (eVital) incident:

An 89-year-old male patient with diabetes and hypertension attended the Accident and Emergency Department (AED) of UCH due to vomiting and fever at around 10pm on February 20. Healthcare staff conducted detailed examination for the patient, including measuring blood pressure, heart rate and blood oxygen saturation level, conducting X-ray examination as well as blood taking. The patient was arranged to stay in the observation ward of the AED. The patient was in stable condition and conscious. His vital signs were also stable. At noon the next day (February 21), the patient was admitted to medical ward. His fever had subsided and his condition was stable.

Upon the patient being admitted to medical ward, healthcare staff monitored the patient's condition and measured his blood pressure, heart rate and blood oxygen saturation level. Healthcare staff also arranged intravenous infusion, blood taking and blood glucose level measuring. Since the patient's blood glucose level was relatively high, healthcare staff measured his blood glucose level three times from 1pm to around 8pm and injected insulin to control the blood glucose level. Healthcare staff also prescribed oral medication and assisted the patient to take oral medication at 4pm and 8pm respectively. During the period, the patient remained conscious and his condition was stable. Patient care assistant also helped him to change positions in bed every four hours for the prevention of pressure sores.

Healthcare staff replaced the intravenous fluid for the patient at around 11pm and the patient was given intravenous antibiotics at midnight. At 2am, healthcare staff went into the cubicle to check the patient's condition and no abnormality was found. At around 5am, when patient care assistant helped the patient change positions in bed, the patient had eye contact with the staff and no abnormality was found. At around 5.30am, the patient had cardiac arrest with vomitus noted at bedside. Healthcare staff performed active resuscitation for patient immediately. However, the patient passed away at 5.58am.

As healthcare staff reviewed clinical records, it was noted that after the patient was admitted to the ward at noon on February 21, doctor had requested the nurse to check patient's blood pressure, heart rate and blood oxygen saturation level every four hours, but the nurse did not input the

scheduling instructions into eVital. During the patient's stay in the ward, his blood pressure, heart rate and blood oxygen level were only measured once upon his arrival in the ward and there were no other relevant records.

UCH is very concerned about the incident and saddened by the passing away of the patient. Healthcare staff and Patient Relations Team have conducted open disclosure with the patient's family and expressed deep condolences to them. The hospital will continue to provide necessary assistance to the patient's family. The hospital supplemented that the omission of doctor's instructions for vital signs measurements into the system is suboptimal, but healthcare staff had been closely monitoring the patient's condition and provided appropriate treatments all along.

The hospital has reported the case to the Hospital Authority Head Office through the Advance Incident Reporting System. The incident has also been referred to the coroner for follow-up. A Root Cause Analysis Panel has been set up to investigate root cause of the incident and propose recommendations. The panel members are as follows:

Chairperson:

Dr Michael Wong
Director (Quality and Safety), Hospital Authority

Members:

Dr Victor Ip
Service Director (Quality and Safety), Kowloon East Cluster

Dr Jones Chan
Consultant, Department of Medicine and Therapeutics, Prince of Wales Hospital

Mr Tang Siu-keung
General Manger (Nursing), United Christian Hospital

Ms Chi Chui-yee
Department Operations Manager, Department of Medicine and Geriatrics, Tuen Mun Hospital

Dr Nicole Chau
Senior Manager (Patient Safety and Risk Management), Hospital Authority

The panel will complete the investigation and recommend improvement measures within eight weeks. The report will be submitted to the Hospital Authority Head Office.