Tuen Mun Hospital today announced incident regarding undue delay in clinical diagnosis of patient

The following is issued on behalf of the Hospital Authority:

Tuen Mun Hospital (TMH) today (December 5) announced an incident regarding the undue delay in clinical diagnosis of a patient:

A 57-year-old male patient with hypertension, cardiac disease and history of stroke was sent to the Accident and Emergency Department (A&E) of TMH by ambulance at about 7.30pm on November 30 for twitching and chest pain. Upon arrival at the A&E, patient developed twitching again and was classified as critical. The patient's condition improved after initial treatment at the A&E and he was transferred to a Medical Ward at around 8.15pm with relevant examinations arranged.

Results of the patient's Computed Tomography of the brain, electrocardiogram (ECG), troponin level, blood pressure and blood oxygen saturation revealed no abnormality. At around 4.30am, ward staff performed another ECG for the patient as instructed and the result showed abnormality. The on-call doctor has also reviewed the patient's clinical condition and blood result. However, the on-call doctor had not timely made the diagnosis of myocardial infarction as indicated by the abnormal ECG results. The doctor only prescribed antiemetic drug to treat patient's vomiting and continued to monitor the patient.

At around 11.00am, the patient told his case doctor about his chest discomfort. The doctor immediately reviewed patient’s clinical record and arranged blood test, urgent ECG and prescribed angina drugs. During the joint consultation with the cardiac team, the cardiologist decided to transfer the patient to the Cardiac Care Unit for an urgent Percutaneous Coronary Intervention. However, the patient deteriorated rapidly. He developed cardiac arrest and lost consciousness at 1.00pm. Resuscitation and intubation were performed to support ventilation. The case doctor contacted the relatives to inform them the deteriorating condition of the patient and suggested the option of Do-Not-Attempt Cardiopulmonary Resuscitation, which had made the family feel disappointed and disturbed. The patient developed cardiac arrest again at 2.00pm. Cardiopulmonary resuscitation was performed and adrenaline was injected. The patient eventually succumbed at 2.32pm.

TMH is very concerned about the incident and has met the family of the deceased on December 3 to disclose the incident. TMH expressed sincere apology for the wrong clinical judgment of myocardial infraction and failing to take into account family's feeling when discussing the patient's condition. TMH promised to follow up the incident proactively and work on improvement measures in order to prevent reoccurrence of similar incident.

The Medical Department has taken immediate actions to reinforce doctors' attention to ECG changes and the need to consult their seniors if in doubt. The clinical team are also reminded to enhance communication when handling severely-ill patients so as to devise and implement appropriate treatment plans. The clinical staff should also take into consideration families' concern towards the resuscitation arrangement of critically-ill patients.

The case has been referred to the Coroner for follow-up and reported to the Hospital Authority Head Office via the Advance Incident Reporting System. TMH will continue to provide fully support to the family.

As this patient has received COVID-19 vaccination within the past 14 days before admission, TMH also reported the case to the Centre for Health Protection according to the established mechanism.