United Christian Hospital announces incident involving insertion of nasogastric tube

The following is issued on behalf of the Hospital Authority:

The spokesperson for United Christian Hospital (UCH) made the following announcement today (May 30) regarding an incident involving insertion of a nasogastric tube:

On May 26, a patient in the Ear, Nose, and Throat Department underwent a surgery, during which a nasogastric tube was inserted to facilitate postoperative administration of medication and feeding of formula milk. Based on clinical needs, the patient was admitted to the Intensive Care Unit for close monitoring after the surgery.

Clinical team arranged an X-ray examination for the patient to verify the position of the nasogastric tube. In general, the X-ray results are uploaded to the Clinical Management System for review by on-duty doctor. At about 10am the next day (May 27), another doctor assessed the patient's condition and instructed a nurse to start feeding through the nasogastric tube. The nurse extracted fluid sample from the patient's nasogastric tube to perform the pH confirmatory test on the gastric aspirate. According to the established protocols, the nurse began nasogastric tube feeding for the patient with drugs and formula milk at about 11.30 am. The patient showed no abnormalities during the time.

When healthcare staff reviewed the patient at around 5pm, it is suspected that the nasogastric tube was misplaced. The feeding was terminated and the nasogastric tube was removed immediately.

Clinical team performed bronchoscopy, X-ray, Computed Tomography scan and ultrasound examination on that night and in the morning of May 28. The investigation showed a small amount of pneumothorax and pleural effusion in the patient's chest cavity. The clinical team has performed chest drain for the patient. Subsequently, the patient's clinical condition has stabilised. The patient is now conscious, breathing independently and able to communicate. The clinical team will continue to closely monitor the patient's clinical condition and provide appropriate treatment to the patient.

The hospital is very concerned about the incident and has contacted the patient's family to provide a detailed explanation and apology. The hospital will maintain close communication with the family, offering all possible assistance and follow-up care. Following an initial review of the incident, it was found that although the pH of the liquid extracted from the nasogastric tube matched that of gastric fluid, the X-ray images uploaded to the system were suspected of not being properly reviewed, which led to the failure to detect the misplacement of the nasogastric tube. The hospital has

reported the incident to the Hospital Authority Head Office through the Advance Incident Reporting System. A Root Cause Analysis Panel has been set up to investigate the incident. The report will be submitted to the Hospital Authority Head Office within eight weeks. The panel members are as follows:

Chairperson:

Dr Victor Ip
Service Director (Quality & Safety), Kowloon East Cluster, Hospital Authority

Members:

Dr Chan Ka-hing
Consultant, Department of Intensive Care, Tseung Kwan O Hospital

Dr Raymond Cheung
Chief Manager, Quality & Safety Division (Patient Safety & Risk Management), Hospital Authority

Dr James Wesley Cheng
Deputy Service Director (Quality & Safety), Kowloon East Cluster, Hospital Authority

Ms Ho Ka-man
Department Operations Manager, Department of Intensive Care, Prince of Wales Hospital

Mr Leung Lok-man
Cluster General Manager (Nursing), Kowloon East Cluster, Hospital Authority

Dr George Ng
Chief of Service, Intensive Care Unit, Queen Elizabeth Hospital

Dr Eddy Wong
Chief of Service, Department of Ear, Nose & Throat, Alice Ho Miu Ling Nethersole Hospital