PRESS RELEASE 新聞稿

Hospital Authority Building, 147B, Argyle Street, Kowloon, Hong Kong

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Investigation Completed and Recommendations Suggested for A Chemotherapy Incident in Prince of Wales Hospital

The Hospital Authority (HA) today (Friday, 24 August) released the "Report on a Medication Incident of Intrathecal Administration of Vincristine in Prince of Wales Hospital (PWH)" by the Special Investigation Panel commissioned by the Chief Executive of HA to look into the incident.

Mr Shane Solomon, Chief Executive of HA, thanked members of the Special Investigation Panel, especially Professor Ian Tannock of Princess Margaret Hospital in Canada and Professor Grace Tang, President of Hong Kong Academy of Medicine, for their efforts and valuable contributions in the investigation which help enhance the quality and safety of patient service.

Professor Ian Tannock, Chairman of the Investigation Panel, said that the Panel has completed investigation on the circumstances surrounding the medication incident and made recommendations to enhance the systems in place in PWH and the HA to minimise the possibility of human error.

"While the Panel recognised that there are guidelines in place to support the safe administration of intravenous and intrathecal chemotherapy in PWH and that no similar cases had been reported in any public hospitals, we are of the view that the causes of this unfortunate incident are multiple, and can be broadly separated into three components, namely; system factors, education factors and human error," said Professor Tannock.

Professor Grace Tang elaborated on the recommendations made in the report to prevent a recurrence of the incident, "To improve the system of administration of chemotherapy, the Panel recommends that standard operating procedures, based on international guidelines, should be established in all public hospitals which administer intrathecal chemotherapy. Such procedures will specify, amongst others, trained and designated staff for administering chemotherapy, formal checking procedure, special containers for transportation and storage of intrathecal drugs, labelling of and physical arrangements in administering such drugs, etc."

“The Investigation Panel considers that medication incidents are less likely to occur if all clinical staff are educated to recognise the potential hazards in the use of anti-cancer therapy,” continued Professor Tang.

To improve the education of staff, the Panel recommended that the training programme of medical oncologists should be modified in line with international trends to allow protected time from clinical duties for structured training and rotations when trainees can concentrate on particular types of malignancies.

“In addition, regular in-service education should be provided for pharmacists and nurses working in the oncology field,” Professor Tang remarked.

Mr Solomon said, “The report points to a mix of system and education factors, combined with human error.”

“On the system and education side, we plan to have Panel’s recommendations implemented at all our hospitals providing cancer service. These will introduce system and process changes to reduce the chance of human error.”

He said that HA would form an investigation panel chaired by the Head of Human Resources to meet and interview the staff concerned and make recommendation to him.

“As professional staff, I know we will all learn from this unfortunate event and work towards a safer and better hospital environment for our patients,” concluded Mr Solomon.

The “Report on a Medication Incident of Intrathecal Administration of Vincristine in Prince of Wales Hospital” is now available at the HA Homepage www.ha.org.hk/investigation_panel/pwh/report_eng.pdf.

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