Nursing Council of Hong Kong

Disciplinary Inquiry

Nurses Registration Ordinance (Cap. 164)

No.: NC 485/7/B

Dates of Hearing: 21st April 2022, 18th July 2022, 7th June 2023 and 4th October 2023

Defendants: Ms.X ([redacted])

Ms. Y ([redacted])

DECISION

1. By a Notice of Inquiry dated 31st January 2022 an inquiry was to be held against Ms. X ("Defendant X") and Ms.Y ("Defendant Y") in the matter as follows:

"[t]hat during the residence of [redacted] *(the Patient) at the Hong Kong Hospital -Tsuen Wan ("HKAH-TW"), on 28th September 2017, you, being a registered nurse of the HKAH-TW, failed to be responsible and accountable for individual nursing judgements and actions by failing to perform independent checking and/or confirm the correct dosage of the intravenous infusion drug (i.e.80mg of Gentamicin) according to medical prescription before administration to the Patient"*

2. Defendant X is charged with an additional charge of

"and/or

i) failed to administer the correct dosage of the intravenous infusion drug to the Patient according to medical prescription (i.e. administered 800mg instead of 80mg of Gentamicin), thus putting the interests and safety of the Patient at risk,

and that in relation to the facts alleged, either singularly or cumulatively, you have been guilty of unprofessional conduct."

3. Defendant X was represented by [redacted] ("[redacted]") of CHOW & HO, Solicitors and Defendant Y was represented by [redacted] of Counsel on instruction of CHEUNG & CHOY, Solicitors & Notaries.

4. Defendant X has been a registered nurse since July 2008 and Defendant Y since July 2016.

5. Both Defendant X and Defendant Y indicated their plea of guilty on the charges they face respectively.

Background and Facts

6. [redacted] ("the Patient") was admitted to the Hong Kong Adventist Hospital -Tsuen Wan ("HKAH-TW") on the night of 26th September 2017. The Patient was diagnosed with pelvic inflammatory on 27th September 2017, 80mg in 2ml (80mg) in 100ml of normal saline of Gentamicin was prescribed to be administered intravenously per 12 hours.

7. On the morning of 28th September 2017 at about 8am, 800mg in 20ml (800mg) of Gentamicin was administered to the Patient. At about 10am, the Patient complained to the nurses that she felt twitching on her face and lips, and there was substantial increased heart rate.

8. The doctors were informed and after allergic reaction was ruled out, the overdose was discovered.

9. It is not disputed that on the morning of 28th September 2017, Defendant X was the nurse who administered the Gentamicin while Defendant Y was the counter checking nurse.

10. Defendant X has been a registered nurse since 4th July 2008 while Defendant Y was registered on 14th July 2016.

11. While Defendant X has been working at the HKAH-TW since 2015 and was in a supervisory role, Defendant Y has only joined HKAH-TW 3 days before the incident.

12. Both Defendant Y and Defendant X admitted to the respective charge/charges against them on the bases of a set of admitted facts attached.

13. When the enquiry was heard in April of 2022, there was a diversity in what Defendant X and Defendant Y said in relation to the conversation between them at the material time. Defendant Y said she asked Defendant X and Defendant X told her to put the whole vial in the saline and the machine (infusion pump) will dispense 1/10. Defendant Y said she knew it was a 800mg vial and not 80mg. Defendant Y said she did not check the machine and that's the bases she admits the charge against her. Defendant X said she does not agree that Defendant Y had asked her but agrees that she misread the vial to be 80mg instead of 800mg.

14. As the hearing was in the midst of the Covid-19 pandemic and hearings were limited to half a day, the inquiry was adjourned for the parties to clarify and narrow down issues.

15. The inquiry was resumed on 18th July 2022. Defendant Y and Defendant X were unable to agree on what exchanged between them on the day of the incident. It was

then suggested independent evidence should be obtained from HKAH-TW such as incident report if any.

16. Defendant Y, when she answered questions from the Council member, said she thought the machine would be set to administer 10mg of the mixture of 800mg of Gentamicin and 100ml of saline intravenously and the machine will stop after dispensing 1/10 of the volume. Defendant Y explained that since the whole 800mg was to be added to the saline, the only way to administer the right dosage of 80mg would be to adjust the machine to stop when 1/10 of the mixture was administered. Defendant Y said she did not check the machine but she thought that it would be the only way the right dosage can be administered.

17. The hearing was then adjourned for information to be obtained from HKAH-TW on:

i) Whether there was a unit dose system and yet 800mg instead of 80mg was sent by the pharmacy.

ii) Whether there was an intravenous machine at the hospital which could be adjusted to stop at a certain interval.

iii) Whether there were any guidelines at the HKAH-TW for a full vial of medicine to be injected into the saline bag (unit dose system) when medicine was to be administered intravenously.

iv) Whether HKAH-TW made investigation of the incident and if yes, was there an incident report.

18. The inquiry resumed on 7th June 2023. Defendant X was absent and represented by [redacted]. Defendant Y was also absent and represented by [redacted] ("[redacted]") of Counsel instructed by [redacted].

19. The Council was informed by the Legal Officer [redacted] that HKAH-TW has provided its Policy: Administration of Medication of the Nursing Department and 3 statements by Defendant X, Defendant Y and another nurse present at the material time respectively.

20. The HKAH-TW letters were subject of an undertaking that they were not to be disclosed to Defendant X and Defendant Y unless they give their consent, and that was only in respect of their statements. The third statement was not to be disclosed unless consent was given by its author.

21. The hearing was adjourned for the purpose of obtaining consents for the statements to be disclosed to the parties.

22. Consents were obtained and the 3 statements were disclosed to the Council, Defendant X and Defendant Y.

23. The hearing resumed on 4th October 2023. Defendant X was absent but represented by [redacted]. Defendant Y was present and represented by [redacted] of Counsel instructed by [redacted].

24. Defendant X admitted both charges on the bases that her son was suffering from serious eczema and the hospital had before then exercised "unit dose system", Defendant X said she simply misread 800mg as 80mg.

25. Defendant Y admitted she knew the vial was 800 mg, but it was her 3rd day on the job with HKAH-TW, having worked with HA previously. Defendant Y said she had simply followed instructions of Defendant X, her immediate supervisor.

Finding of Facts

26. Defendant X was Defendant Y's supervisor at the material time.

27. Defendant X had misread the vial as the hospital had previously used a "unit dose system" where the correct dosage would be dispensed by the pharmacy.

28. Defendant X and Defendant Y were by the side of the Patient when the drug was administered to the Patient.

29. Defendant X was the registered nurse who administered the drug to the Patient.

Considerations

30. The double-check procedure is a safe guard system to ensure the safety of the patient. Ideally, nurses are expected to be at the top of their game at all times when they are on duty, but human is naturally tainted with faults, emotionally and physically. The double-check procedure is in place to minimize "human error". Both nurses bear the same accountability and responsibility.

31. [redacted] submitted a precedent case NC 371/7/B which is similar to Defendant Y's case and asked the Council to take that case into consideration.

32. Both Defendant Y and Defendant X pleaded guilty to their respective charges as in NC 371/7/B. The facts of NC 371/7/B are very different, significantly, the registered nurse who administered the drugs was the only nurse present at the time. Extra bottles of the drug, over and above the prescription, were placed on the patient's side table. It remained unknown who placed the extra bottles on the side table. The doctor gave the instruction for the rest of his prescription to be administered. The defendant nurse administered all the bottles without checking the prescription and without the presence of a second nurse. The defendant nurse who administered the extra drug was suspended for 3 months. The other nurse admitted that she should not have let extra bottles of drugs be left on the bedside of the patient and she was reprimanded.

33. Defendant X and Defendant Y have a clear record. The hearing has taken longer because of the Covid-19 pandemic.

Sentence

34. Both Defendant X and Defendant Y should, technically, share the same accountability and responsibility, the Council considers a 3 months' suspension appropriate.

35. Both charges Defendant X faces arose out of the same facts and the second charge is to reflect the act of administration which followed immediately after the first charge. A suspension of 3 months is sufficient to reflect both charges.

36. Defendant Y shared the same accountability and responsibility with Defendant X, but taking into account that she was only 3 days into her new job, she is to be suspended for 2 months.

Professor Agnes TIWARI
Chairman, Nursing Council of Hong Kong