For Discussion
on 10 December 2007

Legislative Council Panel on Health Services

Hospital Authority Sentinel Event Policy

PURPOSE

This paper briefs Members on the Sentinel Event Policy of the Hospital Authority (HA) for improving patient safety.

BACKGROUND

2. With the development of more advanced and diversified health care services, the health care delivery system has become more complicated. Medical errors sometimes occur, possibly due to problems with the system and work procedures. Noting that some of these medical errors are preventable, the health care providers worldwide, including the HA, have been working hard to explore effective ways to prevent / reduce these errors and to improve patient safety.

3. As one of the key measures to promote the safety of patients, since October 2007, HA has implemented a Sentinel Event policy to further strengthen the reporting, management and monitoring of adverse medical incidents classified as sentinel events in public hospitals. The objectives of HA's sentinel event policy and implementation details of the reporting system are set out in the following paragraphs.

OBJECTIVES OF HA SENTINEL EVENT POLICY

4. A sentinel event is defined as an "unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof[1]". The HA sentinel event policy statement stipulates that "hospitals must report, investigate and respond to sentinel events promptly, and make necessary efforts to prevent similar events from happening in the future.".

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[1] Definition adopted by the Joint Commission on Accreditation of Healthcare Organizations, USA

5. The sentinel event policy of HA seeks to ensure immediate and appropriate handling of sentinel events by senior management of the respective hospitals and if necessary, the HA Head Office in order to -

(a) minimize harm to patients;

(b) minimize the impact of such events;

(c) support the staff involved with the incident;

(d) investigate and understand the causes that underlie a sentinel event;

(e) improve the systems and procedures where necessary and appropriate to reduce the probability of recurrence of the event in future; to share the lessons learned among staff of different clusters of the HA; and

(f) maintain patients and the public's confidence on the public health care system.

IMPLEMENTATION OF THE REPORTING SYSTEM

6. Starting from 1 October 2007, nine specified types of sentinel events are required to be reported through a mechanism under HA within 24 hours upon awareness of their occurrence. These types of events include -

(a) Surgery / interventional procedure involving the wrong patient or body part;

(b) Retained instruments or other material after surgery / interventional procedure requiring re-operation or further surgical procedure;

(c) Haemolytic blood transfusion reaction resulting from blood group incompatibility;

(d) Medication error resulting in major permanent loss of function or death of a patient;

(e) Intravascular gas embolism resulting in death or neurological damage;

(f) Death of an in-patient from suicide (including suicide committed during home leave);

(g) Maternal death or serious morbidity associated with labor or delivery;

(h) Infant discharged to wrong family or infant abduction; and

(i) Unexpected death or serious disability reasonably believed to be preventable (not related to the natural course of the individual's illness or underlying condition). Assessment should be based on clinical judgment, circumstances and the context of the incident.

Action by hospital clusters

7. In the event that an incident falling with any of the above categories occur, the hospital cluster concerned should take the following actions -

(a) to undertake immediate remedial action to mitigate the harm to the patient;

(b) to support the staff involved with the incident;

(c) to report the incident via the HA-wide electronic Advance Incident Reporting System (AIRS) which has been in place since March 2006;

(d) to disclose the event to the patient and his/her family in an open and honest manner;

(e) to conduct a thorough root cause analysis on the incident, for the purpose of identifying possible underlying organizational deficiencies which may not be immediately apparent and which may have contributed to the cause of the event; and

(f) to submit the report of the root cause analysis, including any proposed risk reduction strategies to prevent recurrence of similar event, to the HA Head Office within eight weeks of the occurrence of the sentinel event.

Action by the HA Head Office

8. The HA Head Office will follow up on the reporting of a sentinel event by the following actions -

(a) if the event has immediate major impact on the public health care system, to disclose the event to the public;

(b) to regularly review, through the HA Head Office Sentinel Event panel, all the submitted reports and to make recommendation for HA to reduce the risk of further recurrence of similar incident through a sharing and learning process;

(c) to compile, every six months, a report on sentinel events for submission to the HA Board and release to the public. Appropriate level of confidentiality will be applied to the report to protect the identity of patients and staff concerned; and

(d) to issue, bi-monthly, a "Risk Alert" bulletin to all HA staff on the learning points from the reported sentinel events.

Accountability

9. If the investigation reviewed the staff involved in the sentinel event should be held accountable (partial or total) for the incident, the case would be dealt with in accordance with the prevailing HA human resources policy and established disciplinary mechanism. The HA takes a "Just Culture" approach in considering appropriate disciplinary action, having regard to the relevant factors such as the system issues, circumstances of the case, the past performance record of the staff concerned, any mitigating factors, etc.

10. Through the reporting system as detailed above, adverse medical incidents and serious medical errors will be reported and handled promptly to minimize the harm to the patient and the impact of the incident. The reporting of such incidents will be followed by collation and analysis of data related to the sentinel events so that any underlying problems could be identified and rectified, thereby preventing the recurrence of such medical incidents and errors. This system is in line with the norm in the international practices.

11. To further enhance the safety of patients, HA's staff are encouraged to proactively identify potential risks and offer suggestions on refining the daily work arrangements and procedures to reduce risks. Meanwhile, arrangements are already in place for HA to share the latest knowledge and experience of handling sentinel events from local and overseas with staff through a bi-monthly staff newsletter on sentinel events and staff forums / training programmes. The HA will continue to strive to maintain high quality service and enhance patient safety, and at the same time promoting accountability and a "Just" and learning culture among staff.

12. The first report on sentinel events, covering the period from October 2007 to April 2008, is expected to be released to the public in June 2008. The HA will keep its sentinel event policy and reporting system under regular review to ensure that the definition and principles of the policy are suitably aligned with the prevailing medical practices, and that the policy is implemented consistently across hospital clusters.

ADVICE SOUGHT

13. Members are invited to note the content of this paper.

Food and Health Bureau
Hospital Authority
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