二零零八年十二月八日
資料文件

立法會 CB(2)388/08-09(05)號文件

立法會衞生事務委員會

提供優質醫療服務—
醫院管理局在事故呈報及投訴處理以外所採取的措施

目的

本文件旨在告知委員，醫院管理局（醫管局）為提升公營醫院服務質素和加強病人安全所採取的方針和措施。

背景

2. 現時，醫管局提供廣泛的醫療服務，並管理 41 所醫院及醫療機構、48 間專科門診診所及 74 間普通科門診診所。在二零零七至零八年度，住院及日間病人出院人次達 120 萬，而急症室、專科門診診所及普通科門診診所的就診人次分別為 215 萬、795 萬及 481 萬。

3. 醫管局為提供優質醫療服務，一直堅持不斷提高服務質素和加強病人安全，故已設立了一套有效的事故呈報機制及投訴處理系統。為進一步提升服務質素和加強病人安全，醫管局正計劃進行一個病人滿意程度調查，並將會推行醫院評審先導計劃，作為下一階段的改善措施。

透過投訴處理改善服務質素

4. 醫管局認同妥善處理投訴是提供優質醫療服務的重要一環。醫管局以積極態度調查所有投訴，並視之為有效衡量病人滿意程度和改善服務質素的工具。醫管局自成立以來已設有一個有效的兩層機制，以妥善處理投訴。為了從源頭處理投訴和確保改善措施能迅速執行，所有初步投訴及意見均先由有關醫院/診所直接處理和回覆。若投訴人對醫院的處理或對投訴結果尚有其他意見或不滿，可向醫管局公眾投訴委員會(委員會)提出上訴，要求覆檢。

5. 委員會負責獨立審議和裁決所有上訴個案。委員會由社會各界人士組成，成員均非醫管局僱員，與醫管局醫院各運作部門／服務單位並無從屬關係。由於成員身分獨立，故此委員會能以獨立身分公平公正地處理所有投訴。委員會亦會根據在處理投訴時觀察所得，向醫管局轄下所有醫院提供改善服務的建議。委員會二零零七年年度報告現載於**附件 A**(只有英文)。有關報告亦包括醫管局投訴處理機制的運作詳情及相關數據。

以提升質素和安全為目標的事故呈報機制

6. 為了提升服務質素、減少病人的風險，及防範醫療事故再度發生，醫管局設有機制及指引指示醫護人員呈報醫療事故，及採取適當跟進行動。在現行機制下，醫院員工會透過醫管局內部的電子系統，即「醫療事故匯報系統」，適時向醫院／聯網管理層和醫管局總辦事處通報醫療事故。醫管局一直向員工推廣以病人為本和學習的文化，鼓勵員工以開放態度迅速呈報醫療事故，並交流處理醫療事故的經驗。

7. 此外，醫管局自二零零七年十月起實行嚴重醫療事故呈報政策，加強呈報、管理和監察在公營醫院發生的嚴重醫療事故，以進一步提升服務質素和加強病人安全。在該政策下，各醫院／聯網必須在24小時內透過「醫療事故匯報系統」呈報嚴重醫療事故，並按既定程序恰當處理事件，盡量減少事件對病人的傷害，及支援涉及事件的員工。有關的醫院會調查嚴重醫療事故的成因，並向醫管局總辦事處提交報告。進行調查是為了改善服務，而並非為責難員工。至於醫管局總辦事處則負責在機構層面監察和統籌嚴重醫療事故的處理工作，及推行措施改善制度和工作程序。醫管局實施的嚴重醫療事故呈報政策，詳情載於**附件 B**的醫管局嚴重醫療事故半年度報告(只有英文)。

提高服務質素和加強病人安全—由被動改為主動的方針

8. 隨著醫療服務日益先進及多元化，醫療系統亦發展得更加複雜。醫管局認為，除了圓滿解決個別投訴個案及妥善處理嚴重醫療事故外，有必要設立一個更健全的質素保證機制，以滿足日漸提高的公眾期望和加強公眾對醫管局服務的信心。為此，醫管局正積極籌劃兩項新措拖，分別是病人滿意程度調查及醫院評審先導計劃。

透過病人參與以改善質素 — 病人滿意程度調查

9. 為協助有效監察和進一步提升服務質素，醫管局會透過病人滿意程度調查，主動和有系統地評估病人對醫管局服務的意見及個人體驗。病人滿意程度調查的主要目標是：

(a) 監察和匯報病人對特定服務範疇的個人體驗及滿意程度，；

(b) 找出服務可予改善之處，以便醫管局跟進；

(c) 對照不同醫院、不同的專科服務及不同的服務使用者組別之間在不同領域及範疇的病人滿意程度；及

(d) 建立系統／機制，讓醫院／服務提供者可透過檢視病人在不同範疇和病人滿意元素方面的評分、指數和意見，制訂改善質素的工作計劃。

10. 經參考海外經驗，並與病人團體(包括不同疾病的病人團體和殘疾病人團體)討論後，醫管局會在病人滿意程度調查中評估醫院以下各方面的服務：

(a) 獲得服務的便捷程度

— 輪候入院和病牀所需時間

— 臨牀人員作出回應的時間

(b) 實際環境

— 環境潔淨程度

— 食物質素

— 私隱

— 環境舒適程度

(c) 處理不滿的機制

— 員工對問題的回應和處理

— 員工是否願意聆聽

(d) 人際關係

— 病人受到尊重

— 病人與臨牀人員之間建立合作關係

— 員工態度

— 員工是否願意聆聽

— 員工普遍為病人提供協助

— 員工耐心講解

(e) 治療的統籌

— 員工為提供以病人為本的服務而進行的溝通

— 員工對病人需要的回應

— 有關治療和護理的資訊

— 對痛楚／不適的處理

— 出院和覆診安排

11. 醫管局現正物色合適機構進行病人滿意程度調查，並預計調查會於二零零九年年中展開。

醫院評審

12. 醫院評審獲國際廣泛採用為改善醫療服務質素的有效措施。醫院評審不但可大力推動變革，亦是有系統監察表現的管理工具。在接受評審的過程中，醫院實際上是向市民承諾會以業界的“最佳作業方式”和國際標準作為參照基準。

13. 在醫管局方面，直至二零零八年，已有 11 間公營醫院的病理學部門自願參與由本地或國際評審機構(例如香港認可處、澳洲國家測試局協會(National Association of Testing Authorities of Australia)及美國病理學家學院(College of American Pathologists))舉辦的病理學服務評審計劃。為把公營醫院服務與國際標準作對照，醫管局現正籌備為香港公營醫院進行評審先導計劃。醫管局希望通過此計劃達致以下目標：

(a) 設定公營醫院服務達到國際標準的目標，藉以改善醫療服務質素；

(b) 改善醫院服務的管理；

(c) 加強市民對醫療服務質素的信心；及

(d) 提高公營醫院在服務質素方面的問責。

14. 待進一步研究計劃的實施安排後，醫管局會聘請外間的醫療服務評審機構進行評估，按預定的標準衡量公營醫院的服務。此外，醫院亦會定期獲頒發評審認證，務求醫院服務得以持續改善。

徵詢意見

15. 請委員閱悉本文件的內容。

醫院管理局
二零零八年十二月

附件 A
Annex A

Annual Report of the Public Complaints Committee and the Complaint Management Section of Hospital Authority Head Office

2007

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SECTION I Corporate Function

A. HA corporate governance and public accountability in complaint management

Section 5(m) of the Hospital Authority (HA) Ordinance requires the HA to establish and maintain a system which provides for proper consideration of complaints about its services from the public.

2. The HA has established a two-level complaints system to handle complaints. The system aims to provide a readily accessible mechanism to deal with all complaints. Since complaints are generally most effectively handled at the point of service delivery, all complaints are handled by the respective hospitals/clinics in the first instance. Complainants who are dissatisfied with the outcome of their complaints can appeal to the Public Complaints Committee (PCC).

B. The Public Complaints Committee

3. The PCC was established under the HA Board in 1991-92 to independently consider and decide on all appeal cases. The Committee is the final appeal body within the HA in respect of complaints.

Membership

4. The PCC comprises the Chairperson, 4 Panel Chairpersons and 18 members. Of the 23 members, 3 are members of the HA Board and 20 are from the community. None of the members is an HA employee and the majority (17 out of 23) are outside the medical field with diverse backgrounds. The membership list is in Appendix 1.

Terms of Reference

5. The PCC's terms of reference and complaint handling guidelines are in Appendix 2.

Leadership role and responsibilities in complaint management

6. In addition to its role as the final appeal body, the PCC also assists the HA to ensure effective governance and public accountability in complaint management. Thus, the PCC formulates and reviews policies and guidelines, and introduces initiatives. In accordance with its terms of reference, the PCC also monitors the effectiveness of the HA's complaints management (see Section III).

Mode of operation of the PCC

7. For efficient handling of complaint cases, the PCC has established three Case Panels and an Interview Panel:

(a) The Case Panels

Three Case Panels have been established to deal with individual appeal cases. Recommendations to HA/hospitals for improvement are made by the Panels where deficiencies are discovered in the course of examining complaints.

(b) The Interview Panel

The Interview Panel comprises a convenor and at least 2 regular members of the relevant Case Panel. It conducts separate interview sessions with the complainant/patient, the staff under complaint and witnesses. The aim of an interview session is to seek a fuller picture to assist a Panel in making a decision.

8. When an appeal in respect of a complaint is received, one of the Case Panels will undertake a fundamental review of all available evidence including the medical records and statements from witnesses. It will also seek expert opinions whenever necessary. Separate interviews by the Interview Panel of the complainant, staff under complaint and witnesses may be arranged at the discretion of the Case Panel.

9. The PCC conducts full meetings at regular intervals to monitor the work of the panels, and formulate and review policies and initiatives for continuous improvement of the complaints system. Initiatives are also made in areas of internal and external communications, public education, and learning and sharing on complaint management.

10. The PCC considers it essential to be just and fair to both the complainant and staff/matter under complaint, and adopts the following approaches:

a) Both the complainant's and staff's versions of the incident are given due consideration.

b) All the concerns and allegations of the complainant should be addressed and the decision reached is clearly explained.

c) If a complaint is justified there should be a suitable acknowledgement. Where a complaint is not justified, a suitably firm stance should be taken as staff must be fairly treated.

d) For frivolous and vexatious complaints and cases in which the patient and/or complainant has displayed unacceptable or undesirable behaviour, e.g. harassing staff with foul language, the complainant should be made aware that such conduct is unacceptable.

Performance target

11. The PCC's target response time for complaint is 3 to 6 months. Complex cases would take longer. For details, please see Section II entitled "Monitoring and analysis of trends" and Appendix 4 to this Report.

Liaison with the Coroner's Court on PCC cases

12. In accordance with the Coroner's Ordinance, the HA and its hospitals are required to report certain death cases. It is not uncommon to find that the relative of the deceased patient has lodged a complaint with the HA while the death is simultaneously reported to the Coroner. In such cases, the PCC will suspend its deliberations until the Coroner has taken a decision. The Coroner's court has made an arrangement whereby the PCC is informed of the cases under the Coroner's consideration. This helps to ensure timely reactivation of cases once the Coroner has made a decision.

C. Complaint Management Section (CMS) of HA Head Office (HAHO)

13. The CMS has dual roles:

a) As Secretariat of the PCC

It provides support for the PCC in the following areas:

(i) handling of appeal cases.
(ii) regular monitoring and review of the complaint handling mechanism at the hospital and PCC levels.
(iii) research and survey.
(iv) formulation and implementation of policies and initiatives to enhance the efficiency, transparency and credibility of the HA Complaints System.

b) Overall coordination of the HA's complaint management

Please refer to Section III of this Report.

SECTION II Major Activities of the PCC

A. Monitoring and analysis of trends

Overall trends of Complaints, Appreciation & Feedback

14. The PCC through its Secretariat collates and monitors the volume, nature and trend of complaints, appreciation and feedback, received by all HA hospitals and clinics. These data provide an overall perspective of the public on HA services. The 5-year statistics on complaints, appreciation, and feedback are presented in Appendix 3. The statistics for 2007 are summarized as follows:

	Complaints[1]	*Appreciation* [2]	*Feedback* [3]
HA hospitals	2,165	24,282	10,928
General Outpatient Clinics (GOPCs)	318	2,048	1,375
Total	2,483	26,330	12,303

Total no. of appeal cases taken to the PCC: 258
(out of the 2,483 "first-level" complaints)

15. The HA and its hospitals provide a substantial volume of services each year. The majority of patients appear satisfied with the healthcare they receive. To put the complaints in perspective, the volume of services the HA provides (see table below) and the number of appreciation received should be taken into consideration.

Type of Services	Volume in 2006-07
Inpatient and Day patient discharges	Over 1.13 million
Patient days (including day patient discharges)	Over 7.65 million
Accident & emergency attendances	Over 2.10 million
Specialist outpatient attendances	Over 8.26 million
General Outpatient attendances	Over 5.30 million

(Source: HA Annual Plan 2006-07)

Since appreciation is an indicator of good service quality, the PCC recommends that the HA should consider adopting a more systematic and

[1] Complaint - an expression of dissatisfaction
[2] Appreciation – an expression of gratitude
[3] Feedback - an expression of opinion

structured approach for proper capturing and analysis of statistics on appreciation in order to identify good practices and areas of success.

16. The volume of feedback (10,928 for hospital services and 1,375 for GOPCs) received tallies with the PCC's observations of escalating public expectation and the readiness of the public to express their opinion.

17. The total complaints received by GOPCs dropped by 25% from 423 in 2006 to 318 in 2007; and feedback increased by 49% from 923 to 1,375 during the same period. Analysis of GOPC statistics and content of complaints and feedback revealed that the issues were mainly related to disc allocation, appointment and queuing systems, and the overwhelming service demand. To provide support, the Secretariat staff share their experience of handling complaints with the GOPC staff on a regular basis.

Appeal cases handled by the PCC

18. During the reporting period, the Committee held 23 meetings. The total number of cases taken to the PCC in 2007 is 258 cases. Of these 258 cases, 218 cases (84%) have been concluded while 40 cases are still under investigation.

19. The performance target of the PCC is to conclude an appeal case within 3 to 6 months. During the reporting period, the performance (of 218 concluded cases) was as follows:

148 cases (68%) concluded within 3 to 6 months
39 cases (18%) within 9 months
17 cases (8%) within 12 months
11 cases (5%) within 18 months
3 cases (1%) within 19, 21 & 25 months

20. The 31 cases which took more than 9 months were highly complex cases requiring lengthy investigation, repeated clarifications and the commissioning of independent local or overseas medical expert reviews.

21. The trends and categories of all PCC cases were also monitored, and data on the categories of complaints over the past 5 years are shown in Appendix 4.

22. In the great majority of appeal cases, the PCC found that the subject matter of the complaint had been properly dealt with by the hospitals concerned. Out of the 218 appeal cases only 8 were found to have been substantiated and 4 were found to have been partially substantiated. Analysis of the unsubstantiated cases showed that these complaints arose mainly because of:

a) lack of understanding or unrealistic expectation of medical care. For example, recognised complications in surgical procedures are mistaken as medical negligence. Inability to reach a diagnosis within a short time of a rare condition or a complicated case is misconstrued as incompetence.

b) unmet expectation of the HA services. An example is complaints about the relatively long waiting time in the Accident and Emergency Department for non-urgent cases.

c) misunderstanding of hospital practices. For example, investigations and hospital admissions are arranged based on clinical indications and doctors' clinical judgement and not on patient's request although the latter would also be given due consideration.

d) inappropriate use of the HA complaints system.
Example 1: Many patient-employees complained against doctors for not granting sufficient sick leave to cover their absence from work with pay. On the other hand, some employers of patients complained against HA doctors for granting to their staff what they perceived as excessive or prolonged sick leave. Both parties do not understand that the doctor's decision on sick leave is based on the evaluation of the sickness and work nature, and not on other matters.

Example 2: Complaints against the hospitals for not being able to produce medical report in the patient's favour for his/her private medical insurance claim (for reimbursement of medical fees).

<u>Observations</u>

23. The PCC places great emphasis on justice and fairness, effective communication and compassion in complaint management.

24. In many of the cases handled, the PCC notes that patients and the public in general have a misconception in that they automatically equate medical mishaps with medical negligence, and tend to assume that public hospitals provide inferior services until proven otherwise. This not only creates difficulty in the relationship between patients and hospital staff, but also damages morale of healthcare workers. In the end, both parties lose out. International research indicates that adverse outcome in medical care arises from two major sources as follows.

25. The first is the limitations of medicine. Certain diseases are difficult to diagnose in the early stage. Some are known to deteriorate rapidly and many are without cure. Surgery is associated with risk and the outcome may not be as expected. Many of the allegations of delayed diagnosis, misdiagnosis, inadequate or incompetent care, arose because of lack of understanding of or inability to accept these limitations.

26. The second is substandard practice arising from system errors or incompetence of individuals. As modern medical care involves many parties and procedures (often complex), errors occur from time to time. The HA and its hospitals are making consistent efforts to identify and rectify system errors (that might lead to mishaps) to a minimum. The structured training of doctors, nurses, and other hospital staff has further enhanced the effectiveness of the public hospital system.

27. To reduce categories (a), (b) & (c) complaints (Para 22), the PCC recommends the HA to intensify its efforts in public education, especially on the nature and limitations of medical care, and the level of services it is able to provide. For category (d), the public need to appreciate that issues such as the granting of sick leave and medical report writing are matters of clinical judgement. Moreover, at the macro level, concerted efforts should be made by the HA and other complaint redress organizations to promote a positive and just complaint culture and mutual respect between service providers and recipients.

B. Initiatives to improve the HA's Complaint handling work

28. Complaints systems have two main functions. The first provides a way for people who are dissatisfied with the service they have received to air their grievances and to obtain a proper response. The second function reflects a societal interest in the efficient and effective resolution of grievances, as well as the management of the aftermath. Complaints can provide a way of finding out the views of service users, and shed light on the problems that occur.

29. The PCC advocates an independent, accountable and effective complaints system with the ultimate objective of improving quality. The initiatives/activities undertaken in 2007 are as follows.

a) System/procedural improvement

b) Communication to promote leadership, culture and governance in complaint management

Complaints system/procedural improvement

30. Through evaluation of the complaints system on a regular basis, taking reference of the progress and practices of both overseas and local complaint redress organisations, we are able to assess where it is working well and where improvement is needed.

a) Meeting with UK Consultants

The PCC met with two UK consultants on Quality & Safety in Healthcare in July 2007. Having reviewed the HA's complaint and feedback system and the PCC's role and mode of operation, the consultants recognised that there are good practices in the system that should be transferred across the clusters, and recommended the HA to proactively engage patients in the quality feedback loop.

b) Engaging patients and proactive collection of feedback

Three members of the PCC (two of whom are patient group representatives) are among other stakeholders sitting on the Task force of the HA Flagship Project "Patient Satisfaction Survey" to gauge patients' feedback on hospital services. It is envisaged that the findings of the survey would enable the HA to better understand patients' experience and perspectives; in turn this would help moving towards the goal of providing patient-centred care.

c) Appointment of independent medical specialist(s) to enhance the robustness of early assessment of complaints

To further improve efficiency and standards in complaint handling, particularly at the early processing/assessment stage by the Secretariat, honorary medical specialists will be appointed to support the PCC on a need basis to provide independent advice and assessment on specific complaints. This practice is in line with that of the UK Healthcare Commission.

d) Sharing of observations and mutual exchange with medical experts

The PCC regularly invites medical specialists to share their expertise. In February 2007, arising from a case which alleged maladministration of compulsory admission of a suspected mental patient, we shared with the Clinical Coordinating Committee of Psychiatry our observations and concerns. Similar arrangement was made in November 2007 with experts in Paediatrics and Ear, Nose & Throat on a paediatric case involving long-term management of problems of tracheomalacia and narrowing trachea.

Communication to promote leadership, culture and governance in complaint management

31. Neither healthcare workers nor patients are comfortable with complaints. The former tend to view complaints as unwarranted attacks on their commitment and competence. Changing the way healthcare workers feel about complaints requires the presence of a credible, fair and just complaints system. To instil HA values in complaint management, we organized a workshop on 31 October 2006 with the following objectives:

i) To raise awareness in relation to current societal values, complaint culture, political environment and escalating demands/expectations, etc.

ii) To communicate the corporate message that HA will ensure justice and fairness to both the complainant and staff under complaint in complaint management.

iii) To inculcate a positive complaint culture: to appreciate complaints as a form of quality control; the hospital management has to do justice; staff have the responsibility to prevent situations which may lead to complaints.

iv) To enhance the capability of the management and staff in protecting the interests of patients, themselves and the HA.

v) To highlight some basic principles and strategies in complaint management, i.e. the ultimate goal is to find the balance between patients' interest on the one hand and staff's interest on the other.

vi) To encourage ownership of complaint management.

vii) To build trust and develop partnership between HA management and staff on complaint management.

32. Building on the momentum of the 2006 workshop, the following forums were conducted in 2007 to achieve the above objectives. In time, it is hoped that HA staff will become part of this positive corporate culture:

i) for Patient Relations Officers of all hospitals in February 2007

ii) for members of the Doctors' Staff Consultative Committee in June 2007

C. Recommendations

33. Where appropriate, recommendations on clinical management and administrative issues are referred to the respective committees and departments for consideration. The following are examples of recommendations made.

a) Care for dying patients and acute bereavement for relatives

Case background

A terminally-ill patient was treated upon arrival to the AED and then transferred to the medical ward. A CRASH team soon rushed in to continue with emergency treatment. Fifteen minutes later, the patient's husband was asked to enter the ward to see his wife and found her unresponsive and with cold limbs. Later, a nurse came to the patient's bed and told him that his wife had died already. He was extremely shocked by the news.

The husband alleged clinical mis-management, and was not satisfied with the hospital's reply to his complaint. He appealed to the PCC.

Observation and recommendation

The PCC found that the medical management of the deceased was appropriate, but there were communication problems between staff of the AED and ward and the patient's husband, resulting in the latter's misgivings, doubts and misinterpretation of the situation.

We note that breakdown or inadequacy of communication in the care of dying patients forms a major cause of complaints in Hong Kong and the UK NHS.

In this and other similar cases, the complainant was unprepared for the sudden death of his wife, and was not kept informed of the critical condition of the patient at both the AED and medical ward.

In some long-stay cases, the common problem is misunderstanding between staff and family members as to the treatment and care. In some cases, family members know well about the patient's deterioration and impending death, but still have difficulty coming to terms with the patient's sudden death. In the Chinese culture, keeping vigil by family members around the death-bed is considered desirable, and inability to do so may result in extreme grief and bereavement. In severe cases, this may manifest as loss of emotional control and/or aggressions on site, requiring intervention by the security staff or Police. A small number of such cases unfortunately ended up in escalation of complaints.

Based on these observations, the Secretariat shared this case with all hospital clusters. The PCC also recommended the HA to enhance staff' awareness of the sensitive feelings of patients and their family, and to explore appropriate measures to better handle dying/deceased patients and bereaved families.

b) Quality and choice of clinical care

Case background

A patient with history of hypertension and ischemic stroke was admitted to the hospital because of shortness of breath, fever, dizziness and numbness of the right upper limb. Findings on examination and investigations (including CT brain scan) indicated chest infection and recurrent stroke. She was treated with intravenous fluids, antibiotics, aspirin, potassium supplement and put on close observation. The next day, the patient's relatives strongly requested for discharge because of the patient's visa problem. The doctor advised the patient to seek medical advice as soon as she returned to her home country. A discharge summary and a referral letter were given to the patient upon discharge.

The patient's relatives complained that the patient had not been given thrombolytic therapy (as recommended by the American Stroke Association Stroke Council), and alleged that the lack of this treatment led to the patient's neurological deterioration.

Observation and recommendation

The PCC found that the medical management of the patient had been appropriate. She was not given thrombolytic therapy because she did not meet the strict criteria for this treatment as stipulated by the American Stroke Association Stroke Council. If she were given this treatment, she would be exposed to the risk of severe cerebral haemorrhage.

Since there had been several similar complaint cases in the past, the PCC notes that thrombolytic therapy is becoming an issue of contention. Whilst there is increasing awareness of the therapy, patients and the public have little knowledge of the eligibility criteria and contraindications. In order to dispel misunderstanding and misconception, we suggested that the HA Clinical Coordinating Committee(Neurology) develop local protocol and provide public education on thrombolytic therapy. This would help front-line clinicians manage unrealistic expectations of patients/the public, and in turn reduce unnecessary complaints.

Section III Major activities of the Complaint Management Section (CMS) of HA Head Office (HAHO)

34. In accordance with the PCC's terms of reference, the PCC shall independently monitor the HA's work in complaint handling which cover broadly the work of the CMS and complaint handling of all hospitals.

A. Objectives and scope of the work

In addition to servicing the PCC, the CMS also assumes an overall corporate function in the HA Head Office in leading and coordinating the complaint management work of all HA hospitals, and seeks to improve the HA's complaint management and hospital services through learning and sharing:

(a) Strategic and tactical support

(i) To offer suggestions and advice on difficult cases and issues; to provide consultancy and to participate in crisis management on complaint issues with corporate-wide implications.

(ii) To build up the HA's knowledge base for corporate policies on complaint management.

(b) Quality Assurance and Risk Management

- To incorporate complaint management into the quality and risk management framework, in collaboration with the Quality & Risk Management Section (Q&RMS).

(c) Training, Research and Development in complaint management

(i) To collect and collate corporate statistics on complaints, feedback and appreciation for analysis and monitoring.

(ii) To research into and monitor the trends, practice and latest development of overseas and local complaint redress organizations.

(iii) To conduct surveys at regular intervals to assess the training needs of complaint handling staff.

(iv) To run specialist training courses, workshops and seminars to meet the different needs of staff of different levels, e.g. clinical specialists (on expert review); patient relation officers who deal with complainants on a day-to-day basis; frontline and operation staff who are the first contact point for prevention/resolution of complaints.

(d) Corporate Communication

- To network with overseas and local complaint redress organizations and various stakeholders to share and exchange the expertise and views on complaint handling.

(e) Complaint Hotline

- The complaint hotline is a very popular and effective one-stop service providing an easily accessible service for patients and the public. Manned by trained staff with patience and broad general knowledge of the public healthcare system, the complaint hotline receives patient complaints and helps resolve grievances arising from misunderstanding of hospital services.

(f) Case handling Section in HA Head Office

- Being an HA Head Office functional unit in complaint handling, the CMS also handles cases referred from all other complaint redress organizations outside HA, including the Office of the Chief Executive/SAR, Legislative Council Secretariat, Secretary for Food & Health, District Councils, The Ombudsman, the Equal Opportunities Commission, and the Office of the Privacy Commissioner for Personal Data.

Cases handled by the CMS

35. In addition to the appeal cases, the CMS handled/resolved a total of 9,906 cases of feedback/informal cases from complainants, and took up 55 cases referred by The Ombudsman and 2,299 cases channelled to the HA Head Office from various sources (see Appendix 5 for the workload statistics).

The Ombudsman's Award

36. In 2007, a Complaint Manager of the CMS (along with 16 officers selected from over 60 government departments and public organisations) received The Ombudsman's Award for outstanding performance in complaint handling. This is the second consecutive year that staff of the CMS was given this important award which signifies recognition of the CMS's efforts, positive approach and robustness.

B. Work of the CMS in improving the HA Complaints System

Engaging patients and proactive collection of feedback

37. As a result of an internal audit exercise "Public & Patient Feedback", it was recommended that the CMS to be put in charge of HA's Quality Improvement Standard No. 12 : "A structured mechanism is in place to collect public and patient feedback for service and organisational improvement." We subscribe to the world trend of treating complaints as part of the wider patient feedback strategy encompassing compliments as well as criticism, and the recent directions from the WHO of engaging patients for quality improvement.

38. The CMS has been tasked to develop and coordinate the HA Flagship Project of launching Patient Satisfaction Survey (PSS) across all hospital clusters. It is envisaged that the findings of the survey would enable the HA to better understand patients' experience and perspectives; in turn this would help moving towards the goal of providing patient-centred care.

39. To ensure that these new directions and initiatives become permanent commitments of the HA, a formal unit will be established to take up the function of promoting patient involvement/engagement in the new management structure of the Patient Relations and Engagement Department of the Quality & Safety Division, HA Head Office in 2008-09.

External liaison with relevant complaint handling bodies

40. As a result of regular exchange of views, experience and expertise on complaint management with The Ombudsman's Office (OMB), a seminar was jointly organized by OMB and HA Complaint Management Section on 9 July 2007 for all HA staff.

Promotion of a learning culture on effective complaint management

Specialist training to enhance the competency of the hospitals in complaint management

41. For healthcare workers, complaint management is particularly challenging as it requires competencies over and above clinical skills. These include: awareness of political and societal trends; investigative skills; mediation/counselling, empathy and tact; complaint-related communication (verbal and written) and public relations skills.

42. In 2007, a total of 1,176 hospital front-line staff and supervisors received complaint specialist training organised by the CMS. Thirteen workshops were conducted for all hospital clusters. The titles for these workshops were "Leadership in complaint management for front-line managers" and "Handling of dissatisfied patients and difficult cases". The attendees received intensive training on representative cases; practical tips for early recognition and prevention of common problems, as well as on effective complaint resolution. The Clinical Coordinating Committee (Accident &Emergency) also invited the CMS to share expertise with staff of A&E Departments of all public hospitals.

Promotion of a learning & sharing culture for quality improvement

43. Structured time and schedule for clinicians and staff to discuss complaints is one of the most important strategies for supporting a quality improvement culture.

a) Sharing of best practices and complaint handling structure at hospital/cluster level

Routine monitoring and review of the complaints system in the 7 hospital clusters is necessary to check that the system works in the way the complaint policy is intended. Sharing sessions on the following topics were arranged:

i) Queen Elizabeth Hospital's Electronic Complaint Handling System and Princess Margaret Hospital's Electronic Risk Register

ii) Complaint management structure and best practices of 7 hospital clusters

iii) Experience of the New Territory West Cluster in promoting an appreciation culture (to properly recognise patients' praises of the care they receive as part of the patient feedback strategy)

b) Sharing of lessons learned from complaints

Learning from mistakes is an essential element of effective quality improvement, and can assist in identifying system errors (at operational or organisational levels) and instituting preventive measures. The CMS regularly shares with the clusters lessons learnt from cases with HA-wide implications. The following cases and the lessons learned were shared in 2007:

i) **Management of dying patients and their bereaved families**

ii) **Pitfalls in the reply letters which may lead to escalation of complaints**

iii) **Appropriate handling of cases involving amendment of medical records**

Enhanced linkage between the complaints and quality/risk management systems

44. In 2007, the CMS had started to develop two reporting systems in order to provide reliable complaint data for quality improvement :

a) Development of a Patient Relations System

To encourage staff and clinicians to record complaints and concerns, the CMS is working with the Quality & Risk Management Section on the development of a Patient Relations System to streamline the complaint reporting systems of 7 hospital clusters. It is hoped that by capturing and codifying a set of uniform complaint data, and analysing the types and issues raised in the complaints and outcomes, the HA can identify problems in particular areas so that strategies can be developed to address recurring problems and prevent their recurrence.

b) Complaints as part of the Quality & Risk Management Monitoring Framework

Complaint feedback data can be used for formulating strategic and operational decisions about planning, professional development and quality improvement. Thus, such data are channelled to the Central Committee on Quality & Risk Management (CC(Q&RM)) which was established in April 2007.

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Appendices

Appendix 1

Public Complaints Committee
Composition and Membership

Chairman :	Mr Peter Lo Chi-lik* - HA member
Vice-chairman:	Dr Lam Ching-choi, JP
Members :	Mr Chan Shu-ying, SBS, JP*
	Dr Jennifer Cheung Ng Chui-yiu*
	Mr Choi Chi-sum*
	Rev Dr Eric Chong Chee-min*
	Ms Sandra Chow Mun-yuk*
	Mr Rowland Chow Ting-kwan*
	Mr Antonio Chu Lok-sang*
	Dr Margaret Chung Wai-ling* - HA member
	Prof Joanne Chung Wai-yee
	Mr Andy Lau Kwok-fai*
	Mr Lawrence Lee Kam-hung, JP* - HA member
	Mr Carlos Leung Sze-hung*
	Dr Pamela Leung, JP
	Mr Lawrence Li Shu-fai, SBS, JP*
	Mrs Pauline Ng Chow May-lin, JP*
	Prof Wan Chin-chin*
	Mr Anthony Wong Luen-kin, JP*
	Mrs Elizabeth Wong Yeung Po-wo, MBE
	Sr Catherine Wu Boon-biam
	Ms Virginia Wu Wei-kin*
	Dr Yu Yuk-ling

Legend

* - lay member

Hospital Authority
1.12.07

The Hospital Authority
Public Complaints Committee
Terms of Reference

1. The Public Complaints Committee (PCC) is the final complaint redress and appeal body of the Hospital Authority ("HA").

2. The PCC shall independently :

   a) consider and decide upon complaints from members of the public who are dissatisfied with the response of the HA/hospital to which they have initially directed their complaints.

   b) monitor HA's handling of complaints.

3. Pursuant to Para 2 above, the PCC shall independently advise and monitor the HA on the PCC's recommendations and their implementation.

4. In handling complaint cases, the PCC shall follow the PCC Complaint Handling Guidelines (Annex) which may be amended from time to time.

5. The PCC shall from time to time and at least once a year, make reports to the HA Board and public, including statistics or raising important issues where applicable.

Annex

Guidelines on the handling of complaint cases in the Public Complaints Committee ("the PCC")

1. The PCC is an appeal body within the Hospital Authority ("the HA") to consider appeals made by the public relating to its services. Based on its Terms of Reference, the following are guidelines set by the PCC to facilitate the handling of complaints.

2. The PCC shall not normally handle a complaint:

   (a) if the complaint relates to services provided by the HA more than 2 years before the date of the lodging of the complaint, unless the PCC is satisfied that in the particular circumstances it is proper to conduct an investigation into such complaint not made within that period;

   (b) if the complaint is made anonymously and/or the complainant cannot be identified or traced;

   (c) if the complainant has failed to obtain the proper consent of the patient, to whom the services were provided, in the lodging of the complaint (this restriction will not be applicable if the patient has died or is for any reason unable to act for himself or herself);

   (d) if the subject matter of the complaint has been referred to or is being considered by the coroner;

   (e) if the complaint relates to a matter for which a specific statutory complaint procedure exists;

   (f) if the complainant or the patient concerned has instituted legal proceedings, or has indicated that he/she will institute legal proceedings, against the HA, the hospital or any persons who provided the services (in any event, the Committee shall not entertain any request for compensation);

   (g) if the complaint relates to dispute over the established policies of HA, for example fees charging policy of the HA in respect of its services;

(h) if the complaint relates to an assessment made by a medical staff pursuant to any statutory scheme whereas such scheme provides for a channel of appeal, for example, the granting of sick leave under the provisions of the Employees' Compensation Ordinance, Cap. 282;

(i) if the complaint relates to personnel matters or contractual matters and commercial matters;

(j) if the PCC considers that the complaint is frivolous or vexatious or is not made in good faith; or

(k) if the complaint, or a complaint of a substantially similar nature, has previously been the subject matter of a complaint which had been decided upon by the PCC.

3. Taking into account the following:

(a) the disclosure of legal privileged documents in an open hearing;

(b) the disclosure of personal data in an open hearing;

(c) the PCC is not a judicial or quasi-judicial body;

(d) an aggrieved party has other channels to seek redress; and

(e) the PCC should not duplicate the functions of other institutions such as the courts or the Medical Council;

the PCC considers that its meetings shall not be open to the public.

4. In considering the merits of a complaint, the PCC may from time to time obtain expert opinion by medical professionals or other experts relating to the subject matter of the complaint. If the PCC considers appropriate, it may also invite the complainant, the patient, the medical staffs or any other relevant persons to attend an interview.

(The above Guidelines on the handling of complaint cases may be amended from time to time as appropriate.)

Complaint Statistics of All HA Hospitals from 2003 to 2007

Year / Nature of Cases	2003	2004	2005	2006	2007
Medical Services	782	914	1006	983	1025
Staff Attitude	558	622	650	648	611
Administrative Procedure	262	277	176	173	199
Others	280	335	410	404	330
Total	1882	2148	2242	2208	2165

Feedback Statistics of All HA Hospitals from 2004 to 2007

Year / Nature of Cases	2004	2005	2006	2007
Medical Services	2729	3183	3131	3791
Staff Attitude	2419	2286	2256	2280
Administrative Procedure	1708	1727	1714	2190
Environment	293	338	334	233
Others	2240	2342	2311	2163
Overall	164	158	156	271
Total	9553	10034	9902	10928

Appreciation Statistics of
All HA Hospitals
from 2003 to 2007

Year / Nature of Cases	2003	2004	2005	2006	2007
Medical Services	5951	8243	8760	8685	7465
Staff Attitude	3104	3578	3656	3625	4040
Others	3794	2568	2319	2299	2487
Overall Service	12801	10700	10350	10262	10292
Total	25650	25089	25085	24871	24284

Appendix 3B

Complaints Statistics of All HA GOPCs from 2004 to 2007

Year / Nature of Cases	2004	2005	2006	2007
Medical Services	142	145	128	84
Staff Attitude	249	258	181	127
Administrative Procedure	130	166	72	84
Environment	11	11	11	4
Others	49	81	31	16
Overall	3	3	-	3
Total	**584**	**664**	**423**	**318**

Feedback Statistics of All HA GOPCs from 2004 to 2007

Year / Nature of Cases	2004	2005	2006	2007
Medical Services	185	200	237	277
Staff Attitude	199	231	311	296
Administrative Procedure	268	288	271	605
Environment	30	18	19	10
Others	68	81	77	173
Overall	25	12	8	14
Total	**775**	**830**	**923**	**1375**

Appreciation Statistics of
All HA GOPCs
from 2004 to 2007

Year / Nature of Cases	2004	2005	2006	2007
Medical Services	739	708	679	624
Staff Attitude	1122	1344	1001	1052
Administrative Procedure	31	42	14	24
Environment	51	27	26	36
Others	75	46	5	11
Overall	219	178	302	301
Total	**2237**	**2345**	**2027**	**2048**

Public Complaints Committee

Cases concluded by the Public Complaints Committee
from 2003 to 2007

I. Nature of Complaint Cases

Year / Nature of Cases	2003	2004	2005	2006	2007
Medical Services	103	127	128	127	137
Staff Attitude	16	14	2	11	25
Administrative Procedure	27	17	31	39	50
Others	6	15	5	10	6
Total	152	173	166	187	218

II. Decision on the Complaint Cases

Year / Decision	2003	2004	2005	2006	2007
Substantiated	3	3	2	6	8
Partially Substantiated	5	2	7	8	4
Not Substantiated	139	156	147	166	191
Complaint withdrawn by complainant	-	2	2	1	-
Incapable of determination	-	2	3	-	4
Outside PCC's Ambit	5	6	5	6	11
*Frivolous Complaint	-	2	-	-	-
Total	152	173	166	187	218

Note : * The subject matter under complaint was frivolous. The complainant was unable to produce a valid consent from the patient.

Appendix 5

Workload Statistics of the Public Complaints Committee Secretariat For the period from 1.1.2007 to 31.12.2007

				Total
I.	**Appreciations received by HAHO**			**137**
II.	**Feedback/Cases resolved after discussion/ informal mediation with the complainant**			**9,906**
III.	**Cases required institution of formal actions**			
	(a)	Appeal cases taken up by PCC	258	
	(b)	Ombudsman cases	55	
	(c)	Cases channeled to HA Head Office	2,299	**2,612**

附件 B
Annex B

PROGRESS REPORT ON SENTINEL EVENTS

1 October 2007 – 31 March 2008

HOSPITAL AUTHORITY
HONG KONG

July 2008

TABLE OF CONTENTS

1 EXECUTIVE SUMMARY

1. On 1 October 2007, the Hospital Authority (HA) introduced a Sentinel Event Policy (the Policy) to assist in continuously enhancing patient safety through further strengthening the reporting, management, monitoring of serious incidents and learning from the reported events.

2. The Policy has been implemented across all HA hospitals and has gained increased acceptance from the staff. It is a significant step and a landmark in the journey to improve patient safety. The Policy and its procedures have ensured appropriate reporting, management and investigation of sentinel events.

3. During the six months ending 31 March 2008, a total of 23 sentinel events were reported. The most common type of event was the death of an inpatient from suicide including suicide committed during home leave (12 cases, 52.2%). The second most common event was retained instruments or other material after surgery / interventional procedure requiring re-operation or further surgical procedure (5 cases, 21.7%). The third most common type of event was surgery or interventional procedures involving wrong patient or body part (3 cases, 13%).

4. The outcomes of the reported sentinel events were death in 13 cases (12 suicidal events and one maternal death associated with delivery), major or moderate consequences in 4 cases and minor or insignificant consequences in 6 cases.

5. Important lessons learned from the reported events have been shared amongst all HA staff in the bi-monthly newsletter ‘HA Risk Alert’. Appropriate risk reduction strategies, such as the structured assessment of a patient’s psychological and emotional status before home leave, strengthening of checking procedure on gauze, equipment and guidewire counting, and the use of barcode scanning system, are being implemented to reduce the recurrence of similar incidents.

6. Based on the valuable experience gained in the past six months, a series of improvement activities will be undertaken to further enhance patient safety. They include:

(a) further clarification of some of the reporting criteria for the Policy;

(b) enhancement of some of the supporting processes, such as the methodology of conducting effective root cause analysis and application of open disclosure;

(c) implementation of effective risk reduction measures; and

(d) further enhancement of safety culture through strengthening proactive, sharing and learning, and 'Just' culture. A HA-wide survey on patient safety culture will also be conducted to enhance the understanding of the organizational factors that have an impact on patient safety.

2 INTRODUCTION

7. With the development of more advanced and diversified healthcare services, the healthcare system has become more complex. Medical incidents sometimes occur, possibly due to problems with the system and work procedures or human error. Noting that some of these medical errors are preventable, healthcare providers worldwide, including HA, have been striving to introduce effective measures to prevent medical errors and to improve patient safety.

8. 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 the Policy and implementation of the reporting system are set out in chapter 3.

9. After an initial period of adaptation, the Policy is now fully implemented. Adverse events which fulfilled the sentinel event criteria have been appropriately managed, reported in a timely manner and thoroughly investigated as stipulated. Risk reduction strategies have been formulated and necessary follow up actions taken accordingly. The Policy has strengthened the sharing and learning culture across HA as the reported cases and learning points are shared via the bi-monthly newsletter 'HA Risk Alert'. These activities have facilitated the identification and reduction of clinical risks and improved patient safety as a result.

10. This document serves as the progress report of sentinel events reported by HA hospitals from 1 October 2007 to 31 March 2008, covering a review of the reported cases, learning points, recommendations made and actions taken.

3 HA SENTINEL EVENT POLICY

Objectives of HA Sentinel Event Policy

11. A sentinel event is defined as an "unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof[1]". The 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."

12. The Policy seeks to ensure immediate and appropriate handling of sentinel events by senior management of the respective hospitals and if necessary, the HA Head Office (HAHO) in order to:

(a) minimize harm to patients;

(b) minimize the impact of such events;

(c) support the staff involved with the events;

(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 healthcare system.

Implementation of the reporting system

13. From 1 October 2007, nine specified types of sentinel events are required to be reported to HA within 24 hours of awareness of their occurrence. These types of events include:

Category 1 Surgery / interventional procedure involving the wrong patient or body part;

[1] The US Joint Commission, sentinel event policy and procedures (2008) http://www.jointcommission.org/SentinelEvents/PolicyandProcedures/

Category 2 Retained instruments or other material after surgery / interventional procedure requiring re-operation or further surgical procedure;

Category 3 Haemolytic blood transfusion reaction resulting from blood group incompatibility;

Category 4 Medication error resulting in major permanent loss of function or death of a patient;

Category 5 Intravascular gas embolism resulting in death or neurological damage;

Category 6 Death of an inpatient from suicide (including suicide committed during home leave);

Category 7 Maternal death or serious morbidity associated with labour or delivery;

Category 8 Infant discharged to wrong family or infant abduction; and

Category 9 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.

Actions by the hospital concerned

14. In the event that an incident falling within any of the above categories occurs, the hospital concerned should take the following actions:

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

(b) support the staff involved with the event;

(c) report the incident via the HA-wide electronic Advanced Incident Reporting System (AIRS);

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

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

Actions by the HA Head Office

15. The HAHO will follow up on the reporting of a sentinel event as below:

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

(b) regularly review, through the HA Sentinel Event Report Review Panel, all the submitted reports and recommend strategies across HA to reduce the risk of further recurrence of similar incidents through a sharing and learning process;

(c) issue, bi-monthly, a "HA Risk Alert" newsletter to all HA staff on the learning points from the reported sentinel events; and

(d) 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.

4 SENTINEL EVENTS REPORTED FROM 1 OCTOBER 2007 TO 31 MARCH 2008

Number of reported cases

16. Twenty-three sentinel events were reported during the six months from 1 October 2007 to 31 March 2008. Monthly statistics are as shown in Figure 1:

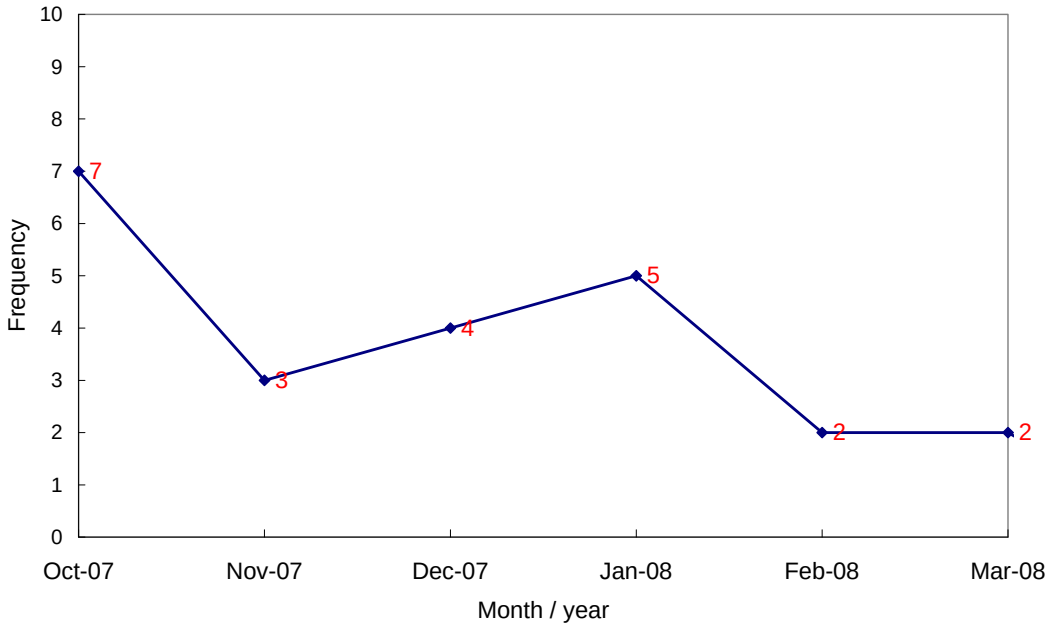

Figure 1: Number of sentinel events by month

The incidence rate (for six months) was 2.8 per 1,000,000 episodes of patient discharges and deaths / attendances.[2]

[2] including total inpatient and outpatient discharges and deaths and ambulatory service attendances defined in HA Controlling Officer's Report: 2008-2009

Types and frequency of reported sentinel events

17 Types and frequency of the reported events are as shown in Figure 2:

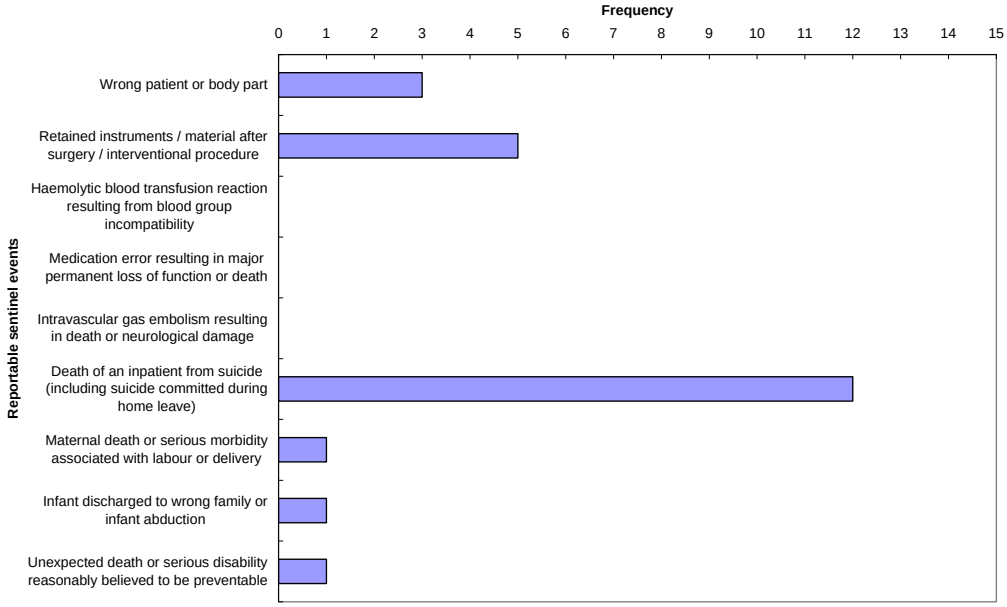

Figure 2: Frequency of sentinel events by type

These events are further analysed as follows:

- Death of an inpatient from suicide (including suicide committed during home leave): 12 cases (52.2%)

  - *1 patient committed suicide in hospital, another was missing and found committed suicide outside hospital, 10 committed suicide during home leave.*

  - *half of these patients suffered from psychiatric illnesses while the other patients were suffering from malignancies, chronic illnesses or permanent disability.*

  - *distribution of their care units is as shown in Table 1:*

Setting	*Frequency*
General acute hospitals	*5*
Psychiatric units within general hospitals	*4*
Psychiatric hospitals	*2*
Convalescence hospitals	*1*

Table 1: Care units of the suicide patients

- Retained instruments or other material after surgery / interventional procedure requiring re-operation or further surgical procedure: 5 cases (21.7%)

    - *3 cases were retention of intravascular guidewire*

    - *1 case was retention of surgical gauze and*

    - *1 case was retention of a piece of peeled off laparoscopic instrument coating.*

- Surgery or interventional procedures involving the wrong patient or body part: 3 cases (13.0%)

    - *mix-up of blood specimens of two patients leading to unnecessary blood transfusion to one patient and delayed transfusion to the other.*

    - *mix-up of biopsy specimens of two patients leading to delayed diagnosis of prostate cancer for one patient and unnecessary radiation for the other*

    - *wrong patient's treatment regimen was retrieved from computer system leading to a patient receiving wrong radiation dosage*

- Maternal death associated with delivery: 1 case

- Infant abduction: 1 case

- Unexpected death or serious disability reasonably believed to be preventable: 1 case

Outcomes of reported sentinel events

18. The outcomes of the reported events are as follows:

- Extreme consequence (i.e. death): 13 cases (56.5%)

    - *12 cases due to suicide*

    - *1 case of maternal death associated with delivery*

- Major / moderate consequence: 4 cases (17.4%)

  - *1 case due to unnecessary blood transfusion to one patient and delayed transfusion to the other*

  - *1 case due to retention of surgical gauze*

  - *1 case due to delayed diagnosis of prostate cancer for one patient and unnecessary radiation for the other*

  - *1 case due to retention of a piece of peeled off laparoscopic instrument coating*

- Minor or insignificant consequence: 6 cases (26.1%)

Hospital settings where the sentinel events occurred

19. Most of the events (69.6%) took place in general hospitals (Table 2):

Setting	Frequency (%)
General hospitals	16 (69.6%)
Psychiatric units within general hospitals	4 (17.4%)
Psychiatric hospitals	2 (8.7%)
Convalescence hospitals	1 (4.3%)

Table 2: Settings where the sentinel events occurred

Individual sentinel events

20. A summary of individual sentinel events are set out in Appendix 1.

5 ACTIONS TAKEN AND DISCUSSION

Implementation

21. The Policy, implemented on 1 October 2007, is a landmark policy addressing patient safety. Forums were held to introduce it and the operational logistics to facilitate staff's understanding and acceptance of the Policy.

22. Initially the frontline staff and hospital management have to familiarize themselves with the reporting criteria and process, and were uncertain of the interpretation of some clinical situations as sentinel event. Frontline staff also required support and training on effective investigation process (root cause analysis) and application of open disclosure incident to the patient / family member. Further forums were held to clarify some of these operational issues. A series of seminars and training workshops on root cause analysis were conducted.

23. Some frontline staff have expressed different views on the need to report suicide case while the patient was on home leave. While understanding it is necessary and valuable for some patients with psychiatric illnesses to undergo a period of "home leave" in preparation for discharge from hospital and that suicide may not be totally preventable, nevertheless, worldwide, it is common for most organizations to define suicide of an in-patient as one of the reportable sentinel event types. This issue will be reviewed after 6-month implementation.

Management of sentinel events and follow up

24. Individual hospital has taken timely actions upon the reporting of a sentinel event, especially to minimize the harm and the impact of an incident to the patient concerned, to support the staff involved and to disclose the event to the public as appropriate. The HAHO has also worked closely with the hospitals on the management of the sentinel events.

25. The hospitals have conducted appropriate root cause analysis on the events and submitted reports within the stipulated time of eight weeks.

26. A Panel has been set up by HA to review the submitted root cause analysis reports and to make overall recommendations on risk reduction strategies / actions.

27. The HAHO has visited respective hospitals to gain a better understanding of some of the major or significant sentinel events and to discuss recommendations to reduce the recurrence of such events. To evaluate the

effectiveness of the improvement measures, half-year follow-up visits to the hospitals are also conducted.

Analysis of reported sentinel events

The trend of reporting

28. There is a downward trend of reported cases over the six months. Worldwide, no international reference is available regarding the "acceptable" level of sentinel event reporting for benchmarking. In Australia, the Victorian Department of Human Services received 82 reports of sentinel event in 2006 – 2007[3] (for approximately 1.3 million admissions to public health facilities during the above period). In the US, the Joint Commission (JC) received an average of 383 reports of sentinel case per year[4].

Types of sentinel event reported

29. In HA, patient suicide was the top reported sentinel event (12 /23 cases, 52.2%). Retained instruments or other material after surgery / interventional procedure was the second most commonly reported sentinel event (5 cases, 22%) whilst surgery / interventional procedure involving the wrong patient or body part was the third (3 cases, 13%).

30. The JC and the Victorian Department of Human Services of Australia have also listed in their reports suicide and wrong patient or site amongst the top three categories. In Victoria, 11 out of 82 sentinel events were suicide in an in-patient unit and 20 were wrong patient or body part in 2006-07.

31. According to the World Health Organization (WHO), in 2000 approximately one million people died from suicide with a "global" mortality rate of 16 per 100,000[5]. In Hong Kong, the suicide rate has increased from 11.5 per 100,000 in 1990 to 18.6 (n = 1278) in 2004[6]. The 12 suicidal cases reported as sentinel events represented a rate of 2.6 per 100,000 inpatient admissions during the reporting period.

Contributing factors for the sentinel events

32. The small number of cases reported and the varied nature of the reported sentinel events limit the value in determining the contributing factors of all the reported sentinel events. However, it is of value to identify contributing factors for similar type of events such as surgery / interventional procedures involving the wrong

[3] The US Joint Commission, sentinel event statistics: as of March 31, 2008, http://www.jointcommission.org/SentinelEvents/Statistics/
[4] The Australian Victoria Government Department of Human Services, sentinel event program: annual report 2006 – 2007.
[5] World Health Organization: suicide prevention (SUPRE). http://www.who.int/mental_health/prevention/suicide/suicideprevent/en/
[6] World Health Organization: suicide rates , by gender, China, Hong Kong SAR, 1955 - 2004. http://www.who.int/mental_health/media/chinzhongk.pdf

patient or body part, retained instrument and material as below:

- Key contributing factors for surgery / interventional procedures involving the wrong patient or body part:

  - Failure to verify patient's identity against all relevant documents before procedure.
  - Specimens / label sheets of more than one patient were handled at the same time.
  - Computer system design was error prone or failed to alert possible error.

- Key contributing factors for retained instruments or material:

  - No protocol to confirm the removal or counting (for guidewire).
  - Counting / checking not thoroughly conducted (for gauze and coating)

Risk reduction programmes

33. To prevent the occurrence of similar incidents, HA is implementing various system and process improvements. Some of the major activities are highlighted below:

<u>For prevention of patient suicide</u>

- enhance the assessment of patient's psychological and emotional status before home leave to identify suicide risk

- set up a multi-disciplinary group to explore risk reduction strategies and programs to reduce suicide risk, especially for patients with chronic and terminal diseases

<u>For prevention of wrong patient, procedure or site</u>

- make use of barcode scanning system to prevent misidentification of patient

- adopt a "time-out" policy to ensure verification and documentation of correct patient identity and operation procedures before surgery

<u>For prevention of retained instruments or material</u>

- strengthen the checking procedures to ensure correct gauze, equipment and guidewire counting

For prevention of infant abduction

- explore advanced security tag for infants to strengthen security measure

Learning and sharing

34. The sentinel events reported and the learning points have been shared in the bi-monthly newsletter 'HA Risk Alert' since November 2007. It also updates HA staff on other identified local and overseas healthcare risks so that precautionary measures can be taken to prevent or mitigate such risks.

6 CONCLUSION

35. The Policy has been smoothly implemented and accepted by staff and stakeholders. It has enhanced and ensured appropriate management of serious incidents. It is an important step in enhancing patient safety, as over this short six-month period, the Policy has highlighted some known and unknown clinical risks. Appropriate risk reduction strategies are being implemented for greater patient safety. The learning and sharing process is a positive step forward and will contribute to the strengthening of safety culture. The HA will continue to accord the highest priority to patient safety.

7 THE WAY FORWARD

36. Based on the valuable experience in the past six months, a series of improvement activities will be undertaken to further enhance patient safety:

(a) clarify and refine some of the reporting criteria for the Policy;

(b) enhance some of the supporting processes, such as the methodology of conducting effective root cause analysis and application of open disclosure;

(c) prevent recurrence of similar sentinel events through implementation of effective risk reduction measures; and

(d) further enhance safety culture through strengthening proactive, sharing and learning, and 'Just' culture. A HA-wide survey on patient safety culture will also be conducted to enhance the understanding of the organizational factors that have an impact on patient safety.

APPENDIX 1

SUMMARY OF INDIVIDUAL SENTINEL EVENTS AND RECOMMENDATIONS FOR IMPROVEMENT

Category 1: Surgery / interventional procedure involving the wrong patient or body part

MIX-UP OF BLOOD SPECIMENS

Manual laboratory test request forms were used during Clinical Management System (CMS) / Generic Clinical Request System (GCRS) downtime.

During delivery of specimens from ward to laboratory, in some wards, request forms and specimens from different patients were put into the same (one) bag. A batch of specimens and forms including that of patient A and patient B were delivered to the laboratory.

At the reception area of laboratory, an error occurred in pairing up the request forms and specimens from patient A and patient B, as the serial numbers appeared similar. Pre-printed "paired labels" were stuck onto the 2 sets of specimen and request form. As the request forms and specimens were wrongly paired up, the laboratory number affixed to patient A's specimen was wrongly paired with the laboratory number of patient B's request form and vice-versa.

The Haemoglobin (Hb) results of specimens A and B were released to the relevant wards and wrongly taken as that for patient B and A respectively. Patient A's Hb result was reported as 6.2 g/dl (the result of patient B). Two units of blood were given. The Hb was re-checked on the next day and found to be 16.0 g/dl. This triggered off the delta check mechanism and the error was discovered. Patient B had her Hb re-checked which was found to be low. Blood was then transfused. This event resulted in delay in blood transfusion for one patient while another patient had unnecessary blood transfusion.

Key contributing factors

System factors

a) The Clinical Management System (CMS) / Generic Clinical Request System (GCRS) was down for maintenance and staff had to revert to using the manual laboratory request system.
b) The specimen was labeled with *a serial no*. torn from a corner of the manual request form and a handwritten *ID no.* affixed to the specimen for identification purpose during GCRS downtime. Checking of patient identity using two "standard" identifiers (name and ID Number) was not adopted.
c) Specimens and request forms from different patients were placed together in the same bag.
d) Computer checking (delta check system) could not spot the discrepancy to raise alert of a possible specimen error.

Human factors

e) Specimens from different patients were handled at the same time.
f) Specimens and forms were wrongly paired up resulting in wrongly labeled specimen tubes.
g) Failure to note the discrepancy between the laboratory result and the patient's clinical signs and symptoms to trigger a re-check of the test.

Risk reduction strategies

For ward staff

a) To adopt the policy of "one bag for one specimen and form" when manual request form is used during GCRS downtime.
b) To label specimen with pre-printed label with patient's name and ID number (rather than using the serial number of manual form).

For laboratory staff

c) To handle one specimen at a time.
d) To verify vigilantly the patient's identifiers on the label of the specimen against the request form.

IT system

e) To minimize the frequency and duration of CMS / GCRS downtime by better coordination of all the IT maintenance activities.

MIX-UP OF BIOPSY SPECIMENS

Patient A attended a Day Centre for prostate biopsy twice nine months apart. Surgery for prostate cancer was suggested based on the second histopathology report. When the surgeon reviewed the medical record before operation, he found great discrepancies between the two histopathology reports and initiated further investigation. Subsequent DNA tests confirmed that the prostate biopsy taken from the first attendance belonged to Patient B who attended the same Day Centre on the same day. The mix-up resulted in delayed diagnosis of prostate cancer for Patient A and unnecessary radiotherapy for Patient B.

In preparation for biopsy sessions, a sheet of gum labels was collected from each patient's record and clipped together in sequence according to the appointment time on a clipboard. Identities of Patient A and B were verified when they arrived at the reception counter and before they entered the procedure room. Patients were called into the procedure room according to the order of their medical records laid out according to the appointment time. However, there was a change in the order of attendance of the two patients. The order of the medical records was altered accordingly, but without a corresponding adjustment in the sequence of the collected label sheets. Verification of patient identity prior to the labelling of specimens was not performed.

Key contributing factors

a) Change in the sequence of biopsy session for the two patients.

b) Biopsy specimens were labeled according to the sequence of label sheets laid out beforehand without further confirmation of the patient's identity.

Risk reduction strategies

a) To check patient identity before taking and labeling any specimens.
b) To avoid putting label sheets of different patients onto the same clipboard for subsequent use.

WRONG RADIATION THERAPY REGIMEN GIVEN

A patient received a prostate radiation therapy regimen which was meant for another patient. The former patient attended the clinic and presented his follow-up card. Radiotherapist A confirmed the patient's identity in the follow-up card, treatment record and prescription. Radiotherapist B intended to retrieve this patient's treatment data from the computer system but made the mistake of clicking the name of another patient on the list for prostate radiotherapy, which resulted in the wrong treatment regimen (wrong dosage) being uploaded into the machine. Radiotherapist C called the patient into the room according to the follow-up card. Radiotherapist A confirmed the patient identity again with the treatment record. After helping the patient to the couch, they checked the setup of the treatment parameters with the computer data but without further checking the name of patient on the retrieved computer data. As a result, wrong dosage of radiation was given.

Key contributing factors

a) Failure to check the patient's identity against the data retrieved from the computer system.
b) No explicit duty description for individual team members.
c) Error-prone design of computer screen, e.g. information (patient's name) displayed on the computer monitor was in small font.

Risk reduction strategies

a) To ensure the checking procedure is adequate to verify patient identification and the treatment to be given, including verification of the patient's identity with the uploaded treatment regimen. To adopt "Time Out" for the checking procedure.
b) To define the duty and responsibility of individual team members.
c) To explore safety measures to prevent picking the wrong patient from the patient list on a selection panel.

Category 2: Retained instruments or other material after surgery / interventional procedure requiring re-operation or further surgical procedure

RETAINED GUIDEWIRES AFTER CENTRAL VENOUS CATHETERIZATION

Case 1
Femoral venous catheterization was performed for a patient receiving an elective surgery by an experienced staff member. The femoral artery was accidentally punctured. A Cavafix was subsequently inserted into the antecubital fossa. The patient was discharged uneventfully. An out-patient PET-CT scan revealed a retained guidewire in the abdominal area.

Case 2
Femoral venous catheterization was performed for a critically ill patient in Intensive care Unit (ICU) by a trainee intensivist. The procedure was performed smoothly. Two days later, a retained guidewire was noted on a routine chest X-ray during a senior round.

Case 3
A central line was inserted in a patient in ICU with the use of guidewire. Resistance was noted during saline flushing and blood aspiration. Another catheter set was opened and a new guidewire was used to guide the removal of original and insertion of the new central venous catheter. Upon completion of the insertion procedure, a scheduled CT scan examination revealed a retained guidewire. It was likely that the first guidewire was left in-situ during the insertion process and the second guidewire had further advanced the first guidewire into the venous system.

Key contributing factors

System factor
a) No protocol to confirm the removal / counting of the guidewire after procedure.

Human factor
b) Staff might not be aware of the potential mishap of retaining a guidewire.

Risk reduction strategies
a) To increase staff awareness of such potential mishap during training and supervision of the procedure.
b) To allow only certified competent staff to perform central venous catheterization with the use of guidewire.
c) To document the checking procedure in case notes / electronic record system:
   i. Counting of guidewire must be performed at the end of the procedure;
   ii. Counterchecking of the number and integrity of used guidewire(s) by another staff member.

RETAINED GAUZE IN PATIENT AFTER SURGERY

A patient underwent low anterior resection for rectal cancer. After operation, a curvilinear shadow was noted in X-ray imaging and retained raytec gauze was suspected. A CT scan was performed and retained gauze was confirmed.

Key contributing factors

a) Multiple handovers for scrub nurses and circulating nurses (e.g. for meal breaks)
b) Time constraint for thorough gauze counting.
c) Ineffective communication between different disciplines and teams in the Operating Theatre – assumptions made without confirmation.

Risk reduction strategies

Communication

a) To "speak up" when uncertainty of correct count occurs.
b) To seek confirmation whenever there is doubt over the procedures.

Documentation

c) To clearly document the "in and out" of used gauze / abdominal pads and the record should be traceable.
d) To clearly document the number of gauze / abdominal pads used for packing throughout OT and other clinical units.

Equipment

e) To use different raytec gauze for OT and other clinical units. One example is using double Raytec for hospital areas outside OT.

Rules and Procedures

f) To start the counting procedures again from the beginning after having been disturbed or interrupted.
g) To allow adequate time to carry out the gauze counting procedures.
h) To follow the rules of placing the used gauze/ abdominal pads in designated place.
i) To undertake a final wound exploration before closure.

RETAINED COATING OF LAPAROSCOPIC INSTRUMENT

A segment (2cm x 0.4cm) of plastic insulated sheath of a laparoscopic instrument, used in a gynaecological laparoscopic surgery, was found retained inside a patient. During specimen retrieval, the surgeon transferred the specimen held by the instrument at the left side 5mm port, to a grasper forceps at the 10mm umbilical port. Difficulties were encountered during this manipulation. It was suspected that this manipulation caused a peeling off of the instrument coating by the 10 mm umbilical port trocar. The instrument integrity was not thoroughly checked before the end of operation. The peeling was noticed during cleansing of the instrument.

Key contributing factors

a) Difficult specimen retrieval in laparoscopic operation contributed to the peeling off of a piece of instrument coating.
b) Failure to check the integrity of instruments before wound closure resulted in the retention of coating in the patient.

Key recommendations

a) To consider using instrument with non-insulated metal outer tube for specimen retrieval.
b) To enforce the checking of instrument integrity before closure of laparoscopic wound(s).

Category 6: Death of an inpatient from suicide (including suicide committed during home leave)

Twelve sentinel events on patient suicide were reported.

One patient committed suicide in hospital, another found missing and committed suicide outside hospital while 10 committed suicide during home leave. Half of these patients suffered from psychiatric illnesses while the other patients were suffering from malignancies, chronic illnesses or permanent disability.

Key contributing factors

Root Cause Analysis was conducted for all these cases but it was difficult to ascertain definite contributory factors. While the underlying conditions were certainly predisposing factors for depressive moods and negative feelings, none of these patients had shown any suicidal thoughts during their hospital stay or before home leave. On the other hand, it was quite possible that unpredictable changes had happened during their home leave periods.

Key recommendations

Home leave is important in preparing our patients for integration back into the society and beneficial for their psychosocial well being. This practice should be supported.
To further enhance the safety of our patients, review could be made and improvement measures implemented regarding patient assessment, communication amongst staff members and with patients' families, as well as assessment of the ward environment for suicide risk.

<u>During hospitalization</u>

a) To enhance the tools for assessing psychological and emotional status of oncology / chronically ill patients.
b) To enhance communication among multidisciplinary teams.

<u>Before home leave / trial discharge</u>

c) To assess and document suicidal risk of patient before home leave.
d) To enhance communication between patients' relatives and hospital staff on care and management of patients during home leave / trial discharge.

Category 7: Maternal death or serious morbidity associated with labour or delivery

One rare event of maternal death associated with delivery was reported.

> A patient presented with drop in blood pressure, uterine atony and bleeding half an hour after delivery. An emergency operation was immediately arranged in view of the uncontrolled bleeding. The patient was transferred to the ICU for post-operative management. She remained stable with no significant continual bleeding. A few days later, the patient presented with a sudden drop of blood pressure and succumbed despite active resuscitation.

The hospital had set up an investigation panel to look into the case. It was concluded that this was a very rare and unexpected situation and the cause was uncertain. The case was referred to the Coroners for investigation of the cause of death.

Category 8: Infant discharged to wrong family or infant abduction

A 1-year-old baby girl was admitted for suspected child abuse. She was brought to hospital by her grandmother and a detention order was sought. On admission, an identification wristband with security tag was applied to the patient's ankle. Three hours after admission, ward staff found the child missing. Hospital search was conducted but without success. The intact security tag of the patient was found in an empty cot near the ward exit.

Neither the grandmother nor the mother could be reached by phone. The situation was reported to the police. The CCTV recording could not be reviewed because of technical problems. There was no clue to the identity of the abductor. The case medical social worker (MSW) could not be contacted after office hours.

Eighteen hours after the reporting, the child was found in her grandmother's home by the Police. The grandmother subsequently brought the child back to hospital for further assessment, as advised by the Police.

Key contributing factors

Personal Factor

a) Grandmother's fear of being blamed for causing the detention order and separating the child from her mother.

Equipment/ Environment Factors

b) The wristband holding the security tag was detachable.
c) Malfunctioning of the CCTV system caused failure in identifying the abductor.
d) Ward design did not facilitate access and exit control of visitors.

Team Factor

e) Failure to reach the case MSW urgently after office hours

Risk reduction strategies

Equipment

a) To install alarm system in ward area, including the rear exit.
b) To explore the use of a more advanced security tagging system.
c) To check the functioning of CCTV systems regularly.

Parent education

d) To remind parents or guardians of the consequences of taking patients away from hospital without permission.

Process

e) To implement preventive measures according to the HA Guidelines on Prevention of and Response to Infant/Child Abduction.

Communication

f) To develop effective communication channels among the Social Welfare Department, the Police and other relevant parties.

Category 9: Unexpected death or serious disability reasonably believed to be preventable

A disinfection incident in operating theatre was reported under this category.

Suspected contaminated instruments had been used on several patients in the Operating Theatre (OT) of a public hospital.

CIDEX has long been used to disinfect OT instruments. In order to enhance staff occupational safety, Cidex-OPA was introduced one month prior to the incident in Hospital X. However, the use of Cidex-OPA is contraindicated for bladder malignancy cases. CIDEX would still be used for disinfection of urological instruments.

Cidex-OPA at Hospital X was prepared in the preparation room of individual OT when required. CIDEX was prepared only in the Central Preparation Room of the 4/F in OT. A tray of sterile water was placed next to it for rinsing purpose. Hospital X used the same kind but different shaped trays (marked "CIDEX") as containers for CIDEX, sterile water, and Cidex-OPA. No other labeling was used to differentiate the solution in these trays.

The hospital had provided training on the use of Cidex-OPA for all OT staff. Briefing on the "new practice" of using CIDEX for disinfecting urological instruments and rinsing in a tray of sterile water was only conducted for staff working at the 4/F.

On the day of the incident, nursing staff disinfected the urological instruments from 4 trans-urethral retrograde prostatectomy cases in the Central Preparation Room by placing them firstly in the tray of CIDEX, then in the tray of sterile water placed next to the CIDEX.

In between, a nurse had to sterilize an ultrasound (USG) probe before and after its use for a brain abscess case. She came from the 2/F OT to assist a neurosurgical case at the 4/F OT and had no knowledge of the special disinfection arrangement in the Central Preparation Room. As no Cidex-OPA had been prepared in the preparation room of her theatre on that day, she went to the Central Preparation Room and placed the probe into the tray of transparent liquid next to the tray of CIDEX which she assumed to be Cidex-OPA (which actually was sterile water).

The tray of sterile water was potentially contaminated by the probe. Hence other urological instruments subsequently placed into this tray of "sterile water" might have been contaminated.

Key contributing factors

System factors

a) Inadequate briefing / communication to ensure all staff were aware of the change of practice.
b) No established system to go through a proper consultation and endorsement procedure before introducing a new practice. Inability to identify the inadequacy before implementation.

Task design

c) The use of the same type of trays to hold both CIDEX and sterilized water,

without labeling, or written standard procedural guideline.

Human factors

d) The introduction of Cidex-OPA led the nurse to the assumption that the tray sitting next to the one holding CIDEX solution was Cidex-OPA.
e) The nurse who immersed the USG probe had no knowledge of the new practice and with a wrong assumption, resulted in the incident.

Risk reduction strategies

a) To clearly label the containers for disinfectants (the content).
b) To inform all staff concerned of the change in practice before implementation.