立法會

Legislative Council

LC Paper No. CB(2)1028/08-09(22)

Ref : CB2/PL/HS

Panel on Health Services

Background brief prepared by the Legislative Council Secretariat for the meeting on 9 March 2009

The Caritas Medical Centre incident

Purpose

This paper gives an account of the past discussions by the Panel on Health Services (the Panel) on the Caritas Medical Centre (CMC) incident which happened on 20 December 2008.

Background

2. On 20 December 2008, a person tried to get help for a collapsed patient, who was outside the Wai Ming Block of CMC, from a clerk at a hospital counter of CMC. The patient subsequently passed away on the same day after resuscitation.

Deliberations of the Panel

3. The Administration and HA briefed the Panel on 12 January 2009 on a review conducted by HA on its principles for handling public requests for emergency medical needs within the vicinity of public hospitals/clinics, as well as the investigation report submitted by the Hospital Chief Executive of CMC on the incident.

4. Members were advised that HA management would follow up the following major recommendations from the investigation report as appropriate -

(a) setting up a designated contact phone number to notify the responsible person for prompt response to urgent requests for medical assistance in the vicinity of HA hospitals/clinics (HA institutions);

(b) conducting relevant training and briefing for emergency response to staff on a regular basis;

(c) providing standardised and appropriate first-aid equipment accessories, such as portable automated external defibrillators, for the emergency response team; and

(d) improving the road signage guiding to the Accident & Emergency (A&E) Departments.

5. Members were further advised that following the CMC incident, HA Head Office had reviewed immediately the existing emergency response mechanism as well as fortified the over-arching corporate-wide, patient-centred value for all hospital staff. A set of guiding principles for handling persons requiring emergency medical assistance in the vicinity of HA institutions had been drawn up for each hospital/clinic to formulate its own response plan. A special committee, chaired by the Chief Executive of HA and comprised two members of HA Board and the Chairman of CMC Hospital Governing Committee, had been set up to review the investigation report, including apportioning responsibilities between those involved and determining the human resources actions required. The special committee would complete its work in six weeks' time.

6. Members noted that there was no guideline in CMC on handling emergencies outside the hospital compound. For handling unconscious patients in non-clinical areas within the hospital, CMC's guideline required calling 999 for assistance. Hon Alan LEONG queried whether the reason why frontline staff rigidly followed the hospital guideline on handling urgent requests for assistance was because they were not sure whether the hospital management would support them in the event of adverse medical incidents.

7. HA explained that guidelines were mainly formulated to delineate responsibilities and achieve operation standards, and could never be a substitute for professional response. It was impractical for HA, being a large organisation with many specialties and departments, to produce a guideline for every circumstance. HA, however, strongly believed that all of its staff would give the best they could offer to anyone who required urgent medical assistance. HA agreed that the response to requests for urgent medical assistance should be flexible, fitting the particular situation, rather than bound by rigid guidelines.

8. Hon Albert CHAN considered it unfair that victims of adverse medical incidents had to undergo legal proceedings to obtain compensation from HA. HA should provide compensation to these victims or their family members if there was sufficient evidence that errors were made on HA side.

9. HA pointed out that being a publicly-funded body, it was incumbent upon HA to use its funds responsibly. The CMC incident was subject to inquest by the Coroner's Court. Whilst HA had stressed that the response with regard to the CMC

incident was inadequate, the Coroner's Court would ultimately decide to what extent the CMC response had contributed to the death of the deceased.

10. Concern was raised that HA staff were facing a dilemma in that if the guidelines were followed, their actions might fell short of public expectation as demonstrated in the CMC incident.

11. HA responded that there was no cause for concern about staff being unfairly treated if they simply failed to follow the guidelines. In the event of adverse medical incident, a thorough root cause of the incident would be conducted. If the investigation revealed that the staff involved 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. HA took a "Just Culture" approach in considering 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.

Recent developments

12. On 17 February 2009, the special committee announced its findings and recommendations on the CMC incident. Based on the findings, the special committee, through its Chairman, has instructed the Hospital Chief Executive of CMC and the Chief of Service of A&E Department to develop an improvement plan which will include -

(a) clear steps to improve the responsiveness within and outside the A&E Department;

(b) detailed steps for responding to all emergencies outside the A&E Department, including emergencies in the immediate vicinity of the hospital compound, and creating the capacity to respond; and

(c) training for staff in public first-contact positions in the hospital, such as A&E Department, reception counters, to include a "customer service" dimension as well as understanding of hospital procedures.

13. The Hospital Chief Executive of CMC and the Chief of Service of Accident & Emergency Department are required to present the improvement plan to the Chief Executive of HA and the Cluster Chief Executive of Kowloon West Cluster within two months and the plan will be fully implemented within 12 months with a formal direct review of progress by the Chief Executive. During this period, both staff will be barred from promotion and salary increase pending the successful implementation of the plan. This measure will stay in force beyond the 12 months if improvements are not made according to the plan. Furthermore, counselling and follow up training will be taken respectively for the concerned clerk and the nursing staff at the

A&E Department to ensure clarity of HA's expectation in relation to their role and responses.

Relevant paper

14. Members are invited to access the Legislative Council website (http://www.legco.gov.hk) for details of the relevant paper.

Council Business Division 2
Legislative Council Secretariat
6 March 2009