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Panel on Health Services

Background brief prepared by the Legislative Council Secretariat for the meeting on 8 December 2008

Incident reporting system in the Hospital Authority

Purpose

This paper gives an account of the past discussions by the Panel on Health Services (the Panel) on the incident reporting system in the Hospital Authority (HA).

Background

2. Since March 2006, HA staff are required to immediately report all medical incidents via the Advance Incident Reporting System (AIRS) to HA Head Office. To further strengthen the reporting, management and monitoring of adverse medical incidents classified as sentinel events in public hospitals, HA has since October 2007 implemented a sentinel event policy. A sentinel event is defined as an "unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof". Under the new policy, public hospitals must report, investigate and respond to sentinel events promptly and make necessary efforts to prevent similar events from happening in the future. The sentinel policy seeks to ensure immediate and appropriate handling of sentinel events by senior management of the respective hospitals, and if necessary, HA Office.

Deliberations of the Panel

3. The Panel discussed HA's sentinel event policy on 10 December 2007. Major views/concerns expressed by members and HA's responses are summarised in the ensuing paragraphs.

4. Whilst welcoming the sentinel event reporting system for improving patient safety, concern was raised over the likelihood which its implementation would add to the already heavy workload of frontline healthcare staff and the possibility of blame which might be laid on staff.

5. HA advised that the implementation of the sentinel event reporting system would not increase the workload of frontline staff, as they were presently required to report all medical incidents via AIRS. On the contrary, staff would know how to better manage a serious medical incident in which they were involved and prevent extra pressure arising from medical incidents in the future. HA had consulted staff of all hospital clusters before implementing the new reporting system, and responses from staff were generally positive.

6. HA further advised that the policy was intended to encourage staff to report sentinel events so that lessons could be learnt from the events to prevent similar medical incidents from happening in the future. A "Just Culture" approach was adopted in considering disciplinary action which emphasised a learning approach. If investigation revealed that staff involved in a sentinel event were negligent, the case would be dealt with in accordance with the prevailing HA human resources policy and established disciplinary mechanism. Senior management would be held responsible if they were found to be negligent or if the incident was caused by system failure, such as a lack of clear protocols or guidelines.

7. Concern was also raised about under-reporting of sentinel events, having regard to the vague description of one of the nine specified types of sentinel events required to be reported, i.e. “Unexpected death or serious disability reasonably believed to be preventable (not related to the natural course of the individual's illness or underlying conditions) .

8. HA assured members that under-reporting of medical incidents would not arise because firstly, the hospital concerned was required to report medical incidents via AIRS regardless of whether the incidents fell within the nine specified types of sentinel events. Secondly, actions to be taken by the hospital cluster concerned and HA Head Office for a sentinel event would also be required for major incidents which did not fall within any of the nine categories if warranted.

9. A member was of the view that the sentinel event policy should be underpinned by the following principles: (i) ensuring the independence of the investigation panel; (ii) disclosing the event to the public within a specified time frame but only after the patient and his/her family had been informed of the incident; (iii) prompt implementation of improvement measures; and (iv) appropriate compensation to patients concerned.

10. HA pointed out that not all sentinel events would call for the appointment of an investigation panel, for instance, cases involving death of a patient from suicide did not normally warrant the setting up of such a panel. To enhance accountability to the public, HA would compile, every six months, a report on sentinel events for release to the public, and the first report covering the period from October 2007 to April 2008 was expected to be released to the public in June 2008. Furthermore, a “Risk Alert” bulletin would be issued on a bi-monthly basis to all HA staff on the learning points from the reported sentinel events. As regards compensation to patients, it would be a matter for the court to decide.

Relevant papers

11. Members are invited to access the Legislative Council's website (http://www.legco.gov.hk) for details of the relevant paper and minutes of the meeting.

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