

**For information
on 9 November 2009**

Legislative Council Panel on Health Services

**Mechanism for handling medical incidents
in public and private hospitals**

PURPOSE

This paper briefs Members on the mechanism for handling medical incidents in public and private hospitals.

**MECHANISM FOR HANDLING MEDICAL INCIDENTS IN
PUBLIC HOSPITALS**

Background

2. The Hospital Authority (HA) is responsible for the management of the 41 public hospitals and institutions in Hong Kong. HA has all along attached great importance to the quality of its services and patient safety. An established system and guidelines have been put in place for conducting clinical audits and dealing with medical incidents. HA has also been promoting a patient-centred and learning culture among its staff, under which staff are encouraged to report a medical incident in a timely and open manner, and share their experience in handling medical incidents.

3. HA has implemented in October 2007 a Sentinel Event Policy (the Policy) to standardize the practice and procedures for handling sentinel events in all hospital clusters, thereby strengthening the reporting, management and monitoring of sentinel events in public hospitals. Under the Policy, clusters / hospitals are required to report to the HA Head Office through the internal Advance Incident Reporting System (AIRS) any medical incidents classified as sentinel events (**Annex A**) within 24 hours. They should at the same time handle the incident properly in accordance with the established procedures so as to minimize any possible harm

caused to patients and at the same time provide support to the staff involved in the incident. For cases with immediate major impact to the public or involving patient's death, HA will consider disclosing the event to the public.

4. When sentinel events occur, the hospitals concerned will investigate the causes of the sentinel events and submit a report to the HA Head Office, which is responsible for monitoring and coordinating the handling of sentinel events, as well as implementation of improvements on systems and working procedures at the corporate level. After consideration of the findings in the reports, improvements will be made to the relevant systems and work procedures where necessary with a view to avoiding recurrence of similar incidents in future.

5. The HA Head Office also compiles, every six months, a report on sentinel events for submission to the HA Board and release to the public. Appropriate level of confidentiality is applied to the report to protect the identity of patients and staff concerned. Meanwhile, through staff training and HA's bi-monthly "Risk Alert" newsletter, HA staff in different clusters could also share and learn from colleagues' experience in handling sentinel events.

Improvement initiatives on HA's handling of medical incidents

6. With an aim to improve service quality, reduce the risk to patients and prevent the recurrence of medical incidents, HA is planning to put in place further improvement initiatives. The major initiatives are set out below –

- (a) Extension of the criteria for mandatory reporting of medical incidents

Starting from 1 January 2010, in addition to the medical incidents classified as sentinel events HA in paragraph 3 above, HA will require clusters / hospitals to report all serious untoward events (which are unexpected events possibly leading to death or serious physical or psychological injury) relating to medication error and patient misidentification.

Following the same general principle for handling sentinel events, a serious untoward event will be dealt with properly so as to minimize the harm caused to the patient and provide support to the staff involved in the incident. For all sentinel and serious untoward events, the hospital involved would submit an initial report to the HA Head Office in two weeks' time. HA will appoint a panel to investigate the root causes for the events. HA will also ensure proper disclosure of these events to the public and conduct root cause analysis on the events for risk identification and implementation of improvement measures. The list of sentinel and serious untoward events to be reported under the refined sentinel event policy is at **Annex B**.

(b) Patient safety round

Patient safety round is an internationally adopted approach to provide direct communication between management and frontline staff to identify risks and explore improvement measures to reduce adverse medical events and enhance patient safety. Senior management of hospitals, clusters and HAHO will lead the rounds and listen to the frontline staff on their concerns and suggestions regarding protocols and procedures in their daily work settings which concern patient safety. The initiative aims to encourage the frontline staff to provide feedback to the management for identification of safety issues, formulation of improvement measures and simplification of work process.

(c) 2D barcode and radiofrequency

HA will adopt the use of 2D barcode and radiofrequency more extensively to enhance patient identification and reduce human errors such as mix up of blood specimen.

7. Apart from the above, HA will set up a central Staff Discipline Committee to advise the Cluster Chief Executives on the most appropriate form of disciplinary actions for the serious clinical incidents.

HA will establish a central mechanism to review all medical incidents retrospectively, to ensure consistency and alignment of disciplinary actions across different clusters / hospitals under HA's just culture.

8. HA will continue to pursue other initiatives such as the conduct of patient satisfaction survey and measures to improve working environment and workload of staff in order to further enhance patient safety and service quality.

MECHANISM FOR HANDLING MEDICAL INCIDENTS IN PRIVATE HOSPITALS

Background

9. The Department of Health (DH) is responsible for the registration of private hospitals in Hong Kong. The Hospitals, Nursing Homes and Maternity Homes Registration Ordinance (Cap. 165) empowers the Director of Health to register private hospitals subject to conditions relating to the accommodation, staffing or equipment. As the registration authority, DH monitors the performance of private hospitals by conducting routine and surprise inspections, and handling complaints lodged by the general public against private hospitals.

10. To enhance patient safety and quality of health care services provided by private hospitals, DH issued a "Code of Practice for Private Hospitals, Nursing Homes and Maternity Homes" (the Code) in August 2003. The Code sets out the standards of good practice for private hospitals to adopt in order to provide quality care to patients. These standards include the need for a private hospital to ensure that services provided are of quality and appropriate to the needs of patients, protection of the rights of patients and their right to know, requirements on the management of medical incidents, etc.

11. Under the Code, private hospitals should comply with the requirements on the management of medical incidents. The requirements include designation of a senior staff to co-ordinate the immediate response to the incident, establishment of procedures to communicate to patients

and their families the nature of incidents and follow-up actions, and investigation into the incidents.

Reporting of incidents

12. With effect from 1 February 2007, DH requires all private hospitals to report sentinel events within 24 hours upon occurrence of the event. Examples of sentinel events that should be reported to DH are at **Annex C**.

13. The primary objective of requiring the reporting of sentinel events is to identify areas for improvement in the quality and safety of healthcare services. Through the reporting system, DH monitors the operation of private hospitals and ensures that they take prompt actions in accordance to established mechanisms so as to minimise the harm caused to the patients. The hospitals concerned are also required to investigate into the root causes of the event and take remedial actions with a view to reducing the probability of recurrence of such event in the future.

14. Under the reporting system of DH, private hospitals are required to develop their own policies and mechanisms to identify, report and manage sentinel events. Upon receipt of the notification, a copy of the policies and procedural guidelines has to be submitted to DH when requested. Thereafter, DH will request the hospital to provide evidence for implementation for such policies and procedural guidelines and will conduct spot check during inspections.

Investigation Procedures

15. Upon receipt of the notification, DH will gather preliminary information from the hospital and ensure that it will conduct investigations into the event. DH will also consider disclosing details of an event to the public if it has major impact on the public health care system, or if it constitutes a persistent public health risk or involves a large number of patients. DH may also pay site visit to the hospital to gather more information relating to the event and conduct its own investigation if it is considered that the event constitutes a high public health risk.

16. In addition to timely notification, the private hospital concerned is also required to submit to DH a full investigation report within 4 weeks of the occurrence of the event. The full investigation report should indicate whether a credible root cause of the event has been identified. It should also include a remedial action plan setting out the proposed improvement measures, and tender evidence to substantiate the effectiveness of the implementation of such measures. In addition, the report should state the mechanism to be put in place for monitoring the implementation of the improvement measures.

17. All investigation reports will be studied by DH in depth, and the sentinel events and their causes will be classified upon review. To further enhance the understanding of private hospitals on the underlying problems of sentinel events, DH will analyse and collate information on these events and compile an annual report which will be issued to all private hospitals. The annual report contains relevant statistics and recommendations from DH on how the quality and safety of healthcare services should be improved in order to prevent similar incidents from happening in the future. DH will follow up on the implementation of the recommendations during subsequent inspections.

OTHER MECHANISMS

Regulation of the medical profession by the Medical Council of Hong Kong

18. Private medical practitioners are professionally responsible for their practices in private hospitals. Private hospitals will provide the necessary facilities and nursing support to assist medical practitioners in the care and management of patients. In the case of occurrence of a medical incident, the medical practitioner concerned may also be liable.

19. The Medical Council of Hong Kong (the Council) is empowered under the Medical Registration Ordinance (Cap.161) to regulate the registration, practising qualifications and disciplinary matters of all public and private medical practitioners in Hong Kong. The Council also establishes a Code of Professional Conduct on the practice and ethics for all medical practitioners. Upon receipt of complaints against medical

practitioners, the Council and its Preliminary Investigation Committee will conduct investigations into any allegations of professional misconduct and may take disciplinary actions in accordance with the procedures laid down in the Medical Registration Ordinance and the Medical Practitioners (Registration and Disciplinary Procedure) Regulations (Cap. 161E) (the Regulation).

20. If a medical practitioner is found to be in breach of the Medical Registration Ordinance or the Regulation, or the Code of Professional Conduct as a result of professional misconduct, the Council may give him a public warning or reprimand after disciplinary inquiry. In more serious cases, the Council may suspend or even revoke the professional registration of a medical practitioner.

Hospital Accreditation

21. Hospital accreditation is widely adopted internationally as a useful measure to improve the quality of healthcare services. To further enhance patient safety and the quality of healthcare institutions in Hong Kong, HA has engaged an Australian consultant to launch a pilot scheme for accreditation of public hospitals in Hong Kong in April 2009. At the same time, some private hospitals are also interested in participating in the pilot scheme by engaging the consultant as the accrediting agent.

22. One of the key objectives of the pilot scheme is to develop a set of common hospital accreditation standards for measuring the performance of both public and private hospitals in various aspects in the long run. The set of common standards will include standards with regard to the management of medical incidents and complaints, and the commitment to continuous quality improvement. Through participating in the accreditation process, it is expected that both public and private hospitals' accountability to service quality and safety will be strengthened, and that public confidence in the quality of healthcare will be enhanced. It is expected that the accreditation survey for the hospitals participating in the pilot scheme will be conducted in 2010, followed by the award of accreditation status to the hospitals in 2010 - 2011.

ADVICE SOUGHT

23. Members are invited to note the content of the paper.

Food and Health Bureau
Department of Health
Hospital Authority
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Types of sentinel events to be reported under HA's sentinel event policy (since 1 October 2007)

1. Surgery / interventional procedure involving the wrong patient or body part.
2. Retained instruments or other material after surgery / interventional procedure requiring re-operation or further surgical procedure.
3. Medication error resulting in major permanent loss of function or death of a patient.
4. Haemolytic blood transfusion reaction resulting from ABO incompatibility.
5. Intravascular gas embolism resulting in death or neurological damage.
6. Death of an inpatient from suicide (including suicide committed during home leave).
7. Maternal death or serious morbidity associated with labour or delivery.
8. Infant discharged to wrong family or infant abduction.
9. Unexpected deaths 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.

Types of sentinel events to be reported under HA's sentinel event policy (tentatively to be implemented from 1 January 2010)

1. Surgery / interventional procedure involving the wrong patient or body part.
2. Retained instruments or other material after surgery / interventional procedure.
3. ABO incompatibility blood transfusion.
4. Medication error resulting in major permanent loss of function or death.
5. Intravascular gas embolism resulting in death or neurological damage.
6. Death of an in-patient from suicide (including home leave).
7. Maternal death or serious morbidity associated with labour or delivery.
8. Infant discharged to wrong family or infant abduction.
9. Other adverse events resulting in permanent loss of function or death.

Serious Untoward Events

1. Medication error which could have led to death or permanent harm.
2. Patient misidentification which could have led to death or permanent harm.

**Types of sentinel events of private hospitals
to be reported to DH**

1. Events that have resulted in an unexpected death or permanent loss of function (not related to the natural course of the patient's illness or underlying condition).
2. Unanticipated maternal death/ serious maternal complication associated with labour, delivery or during postnatal period.
3. Unanticipated death of a full-term infant or intra-uterine stillbirth.
4. Death or serious injury that occurred during operation or interventional procedures.
5. Surgery or interventional procedure involving wrong patient or wrong body parts.
6. Serious reaction after blood or blood products transfusion.
7. Retained instruments or other material after surgery/ interventional procedure requiring re-operation or further surgical procedure.
8. Medication error resulting in major permanent loss of function of a patient.
9. Intravascular gas embolism resulting in death or neurological damage.
10. Death of an in-patient from suicide.
11. Infant discharged to wrong family or infant abduction.
12. Dispensing the same wrong medication to a number of patients.
13. Using a batch of inadequately sterilised surgical equipment.