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中華人民共和國香港特別行政區政府總部食物及衞生局
Food and Health Bureau, Government Secretariat
The Government of the Hong Kong Special Administrative Region
The People's Republic of China

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30 December 2009

Ms Mary So
Clerk to Panel
Panel on Health Services
Legislative Council
8 Jackson Road
Central

Dear Ms So,

Mechanism for handling medical incidents in public and private hospitals

I refer to item 5 of LC Paper No. CB(2)494/09-10(02). At the Panel meeting held on 9 November 2009, the Administration was requested to provide the following information in writing –

(a) the number of sentinel events reported in public hospitals from 1 October 2007 to 30 September 2009, with a breakdown by category, to show the trend of reporting;

(b) a summary of the disciplinary actions taken by the Hospital Authority (HA) against the staff involved in the sentinel events since 1 October 2007; and

(c) a summary of sentinel events occurred in private hospitals since 1 February 2007 which were caused by system factor and recommendations from the Department of Health (DH) on how the related services should be improved.

Response to (a)

The number of sentinel events reported in public hospitals from 1 October 2007 to 30 September 2009 is set out in Annex.

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Response to (b)

From 1 October 2007 to 30 September 2009, HA has taken disciplinary actions against 13 staff involved in eight sentinel events; among them one were given written warning, five were given verbal warnings, and seven were given counselling and advice.

Response to (c)

The number of sentinel events caused by system factors in private hospitals since 1 February 2007 is set out in the table below -

Year	Total number of sentinel events	Number of sentinel events caused by system factors (percentage)
2007 (since 1 February)	39	17 (43.6%)
2008	33	12 (36.4%)
2009 (as at 30 November)	47	5 (10.6%)

The system factors being identified included non-compliance with procedures, the lack of credentialing procedures, and deficiency in patient assessment. DH has made recommendations to the hospitals concerned through advisory letters, meetings with the senior management of the hospitals during inspections, and the annual report on sentinel events issued to all private hospitals. Specific recommendations from DH are as follows:

(i) Sentinel events related to procedural non-compliance

DH has requested the hospitals concerned to establish or revise existing policies and procedural guidelines, and to bring them to the attention of all staff concerned. The hospitals were also requested to monitor the implementation of and to ensure compliance with such policies and procedural guidelines.

(ii) Sentinel events involving the lack of credentialing procedures

DH has advised the hospitals concerned to set up mechanisms to vet the credentials of doctors, and to ensure doctors' compliance with such procedures, e.g. submission of documentary proof of relevant qualifications and experience.

(iii) <u>Sentinel events related to deficiency in patient assessment</u>

DH has requested the hospitals concerned to develop protocols and flowcharts to cope with different scenarios in the wards, e.g. locating missing patients.

Yours sincerely,

(Kirk Yip)
for Secretary for Food and Health

c.c. Hospital Authority
Department of Health

Annex

Number of sentinel events reported in public hospitals

	1.10 2007 to 31.3.2008	1.4.2008 to 30.9.2008	1.10.2008 to 31.3.2009	1.4.2009 to 30.9.2009	**Total**
Surgery / interventional procedure involving the wrong patient or body part	3	2	5	5	**15**
Retained instruments or other material after surgery / interventional procedure requiring re-operation or further surgical procedure	5	5	7	6	**23**
Haemolytic blood transfusion reaction resulting from ABO incompatibility	0	1	0	0	**1**
Medication error resulting in major permanent loss of function or death of a patient	0	0	0	0	**0**
Intravascular gas embolism resulting in death or neurological damage	0	0	0	0	**0**
Death of an inpatient from suicide (including suicide committed during home leave)	12	13	11	4	**40**
Maternal death or serious morbidity associated with labour or delivery	1	0	2	0	**3**
Infant discharged to wrong family or infant abduction	1	0	0	0	**1**
Unexpected deaths or serious disability reasonably believed to be preventable	1	0	0	0	**1**
Total	**23**	**21**	**25**	**15**	**84**