香港特別行政區政府
衞生署
醫護機構註冊辦事處

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THE GOVERNMENT OF THE HONG KONG
SPECIAL ADMINISTRATIVE REGION
DEPARTMENT OF HEALTH
OFFICE FOR REGISTRATION OF
HEALTHCARE INSTITUTIONS

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6 December 2012

Miss Mary SO
Clerk, Public Accounts Committee
Legislative Council Complex
1 Legislative Council Road
Central
Hong Kong

Dear Miss SO,

Public Accounts Committee (PAC)
Consideration of Chapter 3 of the Director of Audit's Report No. 59
Regulatory Control of Private Hospitals

I refer to your letters dated 3 and 4 December 2012 and would like to provide the following information and documents for the Committee's consideration –

(a) Number of referral by the Department of Health (DH) for sentinel events that involved professional misconduct occurred at private hospital

As a prevailing practice, DH will refer cases suspected of contravening the law or involving professional misconduct to the relevant authorities or statutory bodies for consideration. Some examples are provided below-

(i) Cases related to sentinel events reported by private hospitals

- In 2011, a case related to a treatment centre in a private hospital licensed under the Human Reproductive Technology Ordinance (Cap.561) was referred to the Council on Human Reproductive Technology.

- In 2012, a death case involving a neonate who died soon after birth was referred to the Coroner.

(ii) Cases related to complaints against private hospitals

- A death case occurred in 2011 was referred to the Coroner for investigation. The Coroner's findings and comments have been widely reported by the media recently (Annex 1).
- DH has also referred complaints against private hospitals to relevant authority whenever necessary, e.g. Hong Kong Police Force, Office of the Privacy Commissioner for Personal Data and Buildings Department.

(iii) Other cases handled by DH

- From January 2009 to November 2012, four cases involving registered medical practitioner, physiotherapist and chiropractor were referred to the respective statutory professional boards and councils for suspected professional misconduct (Annex 1a).

(b) Guidelines to assist private hospitals in handling sentinel events and complaints

Since the establishment of the sentinel event reporting system in 2007, DH has provided instructions, guidelines and feedbacks to private hospitals on reporting and handling sentinel events. The actions taken are summarized below –

(i) Guidelines

- From 2007 to 2011, letters were sent to all private hospitals to provide instructions and guidance on the reporting of sentinel events. A standardised notification form was designed for private hospitals to facilitate their reporting (Annexes 2, 3, 4 and 5).
- In 2010, a standardised investigation report was also introduced to guide and facilitate private hospitals to conduct investigation as well as to analyse the cause of sentinel event (Annex 6).

(ii) Feedbacks

- In 2009, an annual feedback on sentinel event reported was sent to individual private hospitals (Annex 7).
- In 2010, apart from the annual feedback, a review of sentinel events, which consists of summary of selected sentinel events and points to learn from these events, was sent to all private hospitals for sharing (Annex 8).

- Starting from 2011, the annual review has been revised and renamed as "Patient Safety Digest" with a view to foster the culture of patient safety in private hospitals. Apart from sentinel events, selected complaints and other events were also included in the Patient Safety Digest for sharing (Annexes 9 and 10).

As for the handling of complaints by private hospital, the Code of Practice for Private Hospitals, Nursing Homes and Maternity Homes ("the Code of Practice") requires that private hospitals should develop their own procedures on complaint handling and that mechanism to be in place to ensure staff are conversant with relevant procedures.

Besides, the Code of Practice also stipulates that private hospitals are required to submit complaint digest to DH regularly. A standard proforma has been designed for private hospital to report complaints received (Annex 11). All complaint digests submitted by private hospitals were screened by DH's professional staff (including doctors, nurses and hospital administrators) to look out for any potential sentinel events and cases that require further investigation and action.

(c) Criteria adopted by DH for issuing regulatory letters in relation to delay in reporting sentinel events

According to the Protocol for Sentinel Event Reporting System (March 2010) (Annex 12), DH will issue an advisory letter to the private hospital concerned if one or more of the following irregularities are noted in the course of investigation of the sentinel event:

- Non-compliance with established policies and procedural guidelines
- Repeated reporting of a similar event within a short period of time
- Lack of guidelines/protocols on essential procedures that link to patient safety
- Inadequacies that require prompt rectification/improvements

In such circumstances, if the issues concern accommodation, staffing or equipment, a warning letter will be issued instead.

Since 2011, advisory letters have also been issued to private hospitals for any sentinel events that was not reported to DH within 24 hours from its occurrence.

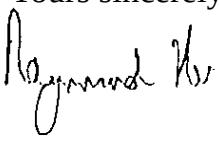
(d) Other performance measures which DH would adopt to measure the efficiency and effectiveness of its regulatory work on private hospitals

DH will take into account the audit recommendations and develop appropriate effective performance/outcome indicators in respect of the regulatory work on private hospitals (especially for providing the breakdown of inspections conducted for each type of healthcare institution) during the review of the Hospitals, Nursing Homes and Maternity Homes Registration Ordinance (Cap.165) which should complete within a year's time.

(e) Regulation made pursuant to Section 6(1) and (2) of the Ordinance

No regulation has been made pursuant to Section 6 (1) and (2) of the Ordinance. The Code of Practice was promulgated in 2003 to set out the standards of good practice and quality of healthcare services. These standards include requirements on the management of staff, management of the premises and services, protection of the rights of patients and their right to know, the setting up of a system to deal with complaints, as well as management of medical incidents, etc. Compliance with the requirements listed in the Code of Practice is required for the registration and re-registration of private hospitals under Cap 165. Subject to the outcome of the ongoing review of Cap 165, we will consider the most appropriate and effective legislative means to regulate private hospitals.

Yours sincerely,



(Dr Raymond HO)
for Director of Health

c.c.

Secretary for Food and Health	(Fax: 2102 2568)	w/o enclosure
Secretary for Financial Services and the Treasury	(Fax: 2147 5239)	
Director of Audit	(Fax: 2583 9063)	

Internal
DH CR/4-35/13C Pt.2

Note by Clerk, PAC: Annexes 1 to 12 not attached.

Annex 1a

Cases of suspected professional misconduct referred by the Department of Health to boards and councils of healthcare professionals

(January 2009 - November 2012)

DH referred four cases of suspected professional misconduct to relevant professional boards and councils after investigation of complaints lodged to various service units. These cases were not related to private hospitals.

Date of referral	Profession concerned
May 2011	Physiotherapist
June 2012	Physiotherapist
July 2012	Medical Practitioner
October 2012	Chiropractor