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Panel on Health Services

Background brief prepared by the Legislative Council Secretariat for the meeting on 11 May 2010

Mechanism for handling medical incidents in public and private hospitals

Purpose

This paper gives an account of the past discussions by the Panel on Health Services ("the Panel") on the mechanism for handling medical incidents in public and private hospitals.

Background

Mechanism for handling medical incidents in public hospitals

2. The Hospital Authority ("HA") has implemented in October 2007 a Sentinel Event Policy ("the Policy") to standardise the practice and procedures for handling sentinel events in all hospital clusters. A sentinel event is defined as an "unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof". Under the Policy, clusters/hospitals are required to report to HA Head Office through the internal Advance Incident Reporting System any medical incidents classified as sentinel events within 24 hours. They should at the same time handle the incident appropriately in accordance with the established procedures so as to minimise the harm caused to the patient and provide support to the staff involved in the incident. According the Administration, HA will consider disclosing the event to the public for cases with immediate major impact to the public or involving patient's death.

3. 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. The HA Head Office compiles, every six months, a report on sentinel events for submission to the HA Board and release to the public.

Mechanism for handling medical incidents in private hospitals

4. 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.

5. 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. Under the Code, private hospitals should comply with the requirements on the management of medical incidents. 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.

6. 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.

7. With effect from 1 February 2007, DH requires all private hospitals to report sentinel events within 24 hours upon occurrence of the event. 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.

8. Upon receipt of the notification, DH will gather preliminary information from the hospital and ensure that it will conduct investigation 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 risk.

9. In addition to timely notification, the private hospital concerned is also required to submit to DH a full investigation report within four weeks of the occurrence of the event.

Past discussions

10. On 9 November 2009, the Administration briefed the Panel on the measures that would be implemented to improve the mechanism for handling medical incidents in public and private hospitals. Members were advised that HA was planning to put in place the following improvement initiatives on handling of medical incidents in public hospitals -

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

Starting from 1 January 2010, in addition to the medical incidents currently classified as sentinel events in public hospitals, HA would require clusters/hospitals to report all serious untoward events (which were unexpected events possibly leading to death or serious physical or psychological injury) relating to medication error and patient misidentification;

(b) Patient safety round

Senior management of hospitals, clusters and HA Head Office would lead the rounds and listen to the frontline staff on their concerns and suggestions regarding protocols and procedures in their daily work settings which concerned patient safety. The initiative aimed to encourage frontline staff to provide feedback to the management for identification of safety issues, formulation of improvement measures and simplification of work process; and

(c) 2D barcode and radiofrequency

HA would 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.

Apart from the above, HA would 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 would also 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.

11. Members were further advised that to further enhance patient safety and the quality of healthcare institutions in Hong Kong, HA had engaged an Australian consultant to launch a pilot scheme for accreditation of public hospitals in Hong Kong in April 2009. One of the key objectives of the pilot scheme was 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 would include standards with regard to the management of medical incidents and complaints, and the commitment to continuous quality improvement. It was expected that the accreditation survey for the hospitals participating in the pilot

scheme would be conducted in 2010, followed by the award of accreditation status to the hospitals in 2010-2011.

12. Question was raised as to whether any comparison had been made on the occurrence rate of medical incidents between hospitals.

13. The Administration advised that it was difficult to compare the occurrence rate of medical incidents between private hospitals, given variations in their policies and mechanisms to identify, report and manage sentinel events. Nevertheless, private hospitals should comply with the requirements on the management of medical incidents set out in the Code issued by DH. It was expected that the introduction of hospital accreditation in the future would enhance transparency and accountability of private hospitals, including their standards with regard to the management of medical incidents. As regards public hospitals, the Administration said that the complexity of, and hence the risk associated with, operations taken at different public hospitals were different. That said, no single hospital presently stood out as having a much higher rate of sentinel events.

14. The Administration further advised that public hospitals in Hong Kong had a much lower rate of sentinel events than that of other countries. According to a report published by the World Health Organization some three years ago, the percentage of adverse events in hospital admissions was about 10% in western countries.

15. Hon CHEUNG Man-kwong was of the view that apart from requiring private hospitals to report sentinel events within 24 hours, DH should also require private hospitals to make public all sentinel events without compromising the privacy of the patients concerned.

16. On whether private hospitals would be penalised for not complying with the Code, the Administration advised that although no penalty would be imposed, compliance with the Code was a condition for the registration of private hospitals. Under Cap. 165, DH might at any time cancel the registration of a private hospital in the event of a contravention of the specified conditions relating to the accommodation, staffing or equipment.

17. Hon Cyd HO urged the Administration to review Cap. 165 to increase the deterrent effect against non-compliance with the Ordinance.

18. The Administration considered that putting in place comprehensive legislation might not be able to flexibly cater for the advancement of medical technology and rising community aspiration for quality services due to the considerable time required to amend the legislation. It was against this background that the Code was developed and implemented in 2003 to set out the standards of good practice for healthcare institutions to adopt in order to provide quality care to patients.

19. On the establishment of an independent statutory office of the health service ombudsman, the Administration expressed reservation about the proposal. Overseas

experience revealed that the setting up of such an office would not effectively reduce the number of medical incidents and might even prolong the investigation process.

Recent development

20. The Administration informed the Panel in writing on 30 December 2009 that from 1 October 2007 to 30 September 2009, HA has taken disciplinary actions against 13 staff involved in eight sentinel events. Amongst them, one was given written warning, five were given verbal warnings and seven were given counselling and advice. As regards private hospitals, from 1 February 2007 to 30 November 2009, the number of sentinel events totalled 119, amongst which 34 were caused by system factors. 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 senior management of the hospitals concerned during inspections and the annual reports on sentinel events issued to all private hospitals.

Relevant papers

21. 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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