立法會
Legislative Council

LC Paper No. CB(2)712/11-12(04)

Ref : CB2/PL/HS

Panel on Health Services

Background brief prepared by the Legislative Council Secretariat for the meeting on 9 January 2012

Handling of medical incidents in public hospitals

Purpose

This paper highlights the major concerns of members of the Panel on Health Services ("the Panel") on the issues relating to the handling of medical incidents in public hospitals since 2007.

Background

2. In October 2007, the Hospital Authority ("HA") implemented a Sentinel Event Policy to standardize the practice and procedures for handling sentinel events in all public hospital clusters, thereby strengthening the reporting, management and monitoring of sentinel events in public hospitals. It was further revised to become the Sentinel and Serious Untoward Event Policy ("the Policy") in January 2010. The Policy defines a sentinel event as an "unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof" and a serious untoward event as an "unexpected occurrence which could have led to death or permanent harm". The list of sentinel and serious untoward events to be reported under the Policy is in **Appendix I**.

3. Under the Policy, clusters/hospitals are required to report to HA Head Office any medical incidents classified as sentinel events or serious untoward events relating to medication error and patient misidentification within 24 hours of their identification. The clusters/hospitals concerned should at the same time handle the incident properly so as to minimize the harm caused to the patient and provide support to the staff involved in the incident. HA will consider disclosing the sentinel event to the public for cases with immediate major impact on the public or involving patient's death, and ensure proper

disclosure of serious untoward events to the public.

4. The hospitals concerned will investigate the causes of the event and submit a report to the HA Head Office. An initial report should be submitted to the HA Head Office in two weeks' time and a final report in eight weeks' time. When sentinel and serious untoward events occur, HA will appoint a panel to investigate the root causes of the events for risk identification and implementation of improvement measures.

5. The HA Head Office compiles half-yearly and annual report on sentinel and serious untoward events for submission to the HA Board and release to the public. A "Risk Alert" bulletin is also issued on a bi-monthly basis to all HA staff on the learning points from the reported sentinel events. During the period from October 2009 to September 2010, there were a total of 33 sentinel events and 81 serious untoward events. From October 2010 to March 2011, a total of 23 sentinel events and 47 serious untoward events were reported.

Members' concerns

6. The Panel discussed the subject of handling of medical incidents in public hospitals at a number of meetings between 2007 and 2011. The major concerns of the Panel members are highlighted in the ensuing paragraphs.

Disclosure of sentinel events in hospitals

7. Members noted that HA would consider disclosing a sentinel event in public hospitals if it had immediate major impact on the public or involved a patient's death, whereas the Department of Health ("DH") would consider disclosing a sentinel event in private hospitals if it had major impact on the public healthcare system, or if it constituted a persistent public health risk or involved a large number of patients. There was a concern that the criteria for disclosing sentinel events and their details in private hospitals were different from those of public hospitals. Members urged the Administration to remove such discrepancies.

8. The Administration agreed that it was necessary to align the different descriptions of reported sentinel events between public and private hospitals. HA had launched a pilot scheme of hospital accreditation in May 2009 with a view to developing a set of common hospital accreditation standards for measuring the performance of both public and private hospitals in the management of medical incidents and complaints, as well as other aspects

relating to the performance of public and private hospitals. Five public[1] and three private hospitals[2] had participated in the pilot scheme.

Implementation of the Policy

9. In response to members' concern about the additional workload and pressure arising from the implementation of the Policy on HA frontline staff, HA advised that implementation of the Policy would not increase the workload of frontline staff as they were required to report all medical incidents through the internal Advance Incident Reporting System. While the implementation of the Policy might generate psychological pressure on staff, the Policy would reduce the risk of recurrence of similar medical incidents, resulting in better patient safety.

10. At the Panel meeting on 14 June 2010, members raised concern on the increase in the number of certain reportable sentinel events relating to surgery/interventional procedure from 2007-2008 to 2008-2009. They questioned the effectiveness of the existing mechanism of HA for handling medicine incidents to prevent recurrence of similar incidents in future.

11. HA advised that in line with the international trend to improve the safety of surgical care, the "Time-out" process had been fully and partially implemented in the Department of Surgery and the Department of Medicine respectively to ensure the verification of key information and process of operations. According to the Administration, initiatives would be implemented to further improve the mechanism for handling medical incidents in public hospitals. The initiatives included extension of the criteria for mandatory reporting of all serious untoward events relating to medication error and patient misidentification, adoption of the patient safety round 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, and enhancement of patient identification by the use of 2D barcode and radiofrequency.

Occurrence rate of medical incidents

12. Members expressed concern on the performance of public and private hospitals. They sought information on the occurrence rate of medical incidents

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[1] The five public hospitals are namely the Caritas Medical Centre, Pamela Youde Nethersole Eastern Hospital, Queen Elizabeth Hospital, Queen Mary Hospital and Tuen Mun Hospital.

[2] The three private hospitals include the Hong Kong Baptist Hospital, Hong Kong Sanatorium & Hospital and Union Hospital.

between public and private hospitals in Hong Kong. According to the Administration, it was difficult to compare the performance of public and private hospitals in Hong Kong given the variations in their policies and mechanisms to identify, report and manage medical incidents.

13. There was a view that the high turnover rate of senior doctors of some specialists (e.g. Surgery and Obstetrics and Gynecology) in public hospitals would increase the likelihood of medical incidents. As advised by HA, the reports of the root cause analysis of medical incidents revealed that these incidents were mainly caused by system factors. The turnover of senior doctors should have no direct negative impact on the occurrence rate of medical incidents.

Investigations of sentinel events

14. Members were advised that under the existing mechanism, staff of the hospital concerned would explain the incident and the handling of the incident to the patients as well as provide them with suitable assistance. HA would also obtain the consent of patients and their family before disclosing the incident to the public. After investigation, meetings would be arranged with patients to explain the contents of the investigation report before release to the public. A patient relation officer would assist the patients throughout the process. Measures would also be taken to ensure that the identity of the patients would be protected.

15. There was a concern on whether information disclosed by the frontline staff to the investigation panel was subject to legal privilege under the Policy. HA advised that appropriate level of confidentiality would be applied to the root cause analysis report to protect the identity of patients and staff concerned. In line with the existing practice for the investigation of all adverse medical incidents, HA would first seek legal opinion before providing any confidential information so requested.

16. Members considered it important to maintain the independence of the investigation panels. Some members urged the Administration to establish an independent statutory Office of the Health Service Ombudsman to handle medical incidents occurred in public hospitals so as to ensure the independence of investigations and better protect the interest of patients.

17. The Administration pointed out that a complaint mechanism had been put in place to handle complaints lodged by patients, who were not satisfied with the explanation provided by HA. All complaints would first be handled and responded to directly by the respective hospitals. If complainants were not

satisfied with the outcome of their complaints, they could appeal to HA's Public Complaints Committee, which comprised medical experts and lay members from different sectors of the community, for a review of their cases. Apart from resorting to legal proceedings, there were also other well-established complaint redress avenues, such as the Medical Council of Hong Kong. The Administration held the view that the existing mechanism was effective as HA had disclosed and handled the medical incidents in a transparent and impartial manner.

18. The Administration expressed reservations about the establishment of an Office of Health Service Ombudsman. The Administration explained that as revealed in overseas experience, the setting up of such an Office would not effectively reduce the number of medical incidents and might even prolong the investigation process.

Recent developments

Recent occurrence of medical incidents in public hospitals

19. A series of medical incidents have occurred in public hospitals including Caritas Medical Centre, Kowloon Hospital, the Prince of Wales Hospital and Tuen Mun Hospital[3] since the second half of 2011. The situation has caused wide public concern and called into question public confidence in the performance of the public healthcare system. Panel members expressed grave concern over the frequent occurrence of medical incidents in public hospitals. Some members held the view that the management of and the shortage and high wastage of healthcare manpower in the public hospitals were the major factors contributing to the incidents.

Measures to address shortage of healthcare manpower in public hospitals

20. At the special meeting of the Panel on 20 October 2011 to receive a briefing from the Secretary for Food and Health on the 2011-2012 Policy

[3] According to media reports, a number of medical incidents had occurred in Tuen Mun Hospital during the period from July to December 2011. These incidents included the following which had been announced by HA in its press releases -

(a) a 13-year-old boy died after undergoing a cervical spine operation in August 2011; and

(b) a 69-year-old man who had hurt his head and suffered a brain haemorrhage died after being treated with anti-clotting drugs due to misreading of brain scan images by three specialists in November 2011.

Agenda, members were advised that HA had implemented a series of measures to address manpower issues. The measures included recruitment, the creation of additional promotion posts, strengthening of professional training for medical and healthcare practitioners, as well as relieving the workload of frontline healthcare workers by re-engineering work processes, streamlining work procedures and recruiting additional supporting staff. The number of training places for doctors, nurses and healthcare disciplines would also be increased to meet the service demand.

21. In reply to an oral question relating to the recruitment of non-local registered doctors raised at the Council meeting of 9 November 2011, the Administration advised that in 2011-2012, HA would recruit about 330 doctors and 1 720 nurses to strengthen its manpower. In view of the serious manpower shortage problems faced by a number of specialty departments in public hospitals, such as Medicine, Anaesthesia and Accident and Emergency Departments, HA had extended the pilot scheme to employ part-time doctors in the Obstetric and Gynaecology Speciality to all other specialities. As at November 2011, there were some 60 senior doctors serving in the public hospitals on a part-time basis. HA had carried out recruitment of non-local doctors for limited registration to serve in the pressurized areas in the public hospitals to address the persistent shortage of doctors.

22. When the Panel discussed the issues relating to manpower and wastage of doctors in HA, members considered that the proposal to recruit non-local registered doctors could not address the manpower shortage problem which was caused by the poor management of HA and uneven distribution of resources among public hospitals. Members urged HA to improve its management in order to alleviate the work pressure on frontline doctors in HA.

23. According to the press release issued by HA on 24 November 2011, 10 applicants of non-local doctors for limited registration were considered suitable for appointment after interviews by user departments. The first batch of nine non-local doctors for limited registration had been submitted to the Medical Council for approval. These doctors were recommended for appointment in three specialities, namely Anaesthesia, Medicine and Emergency Medicine.

24. To ensure a sufficient supply of healthcare manpower in the long run, the Government would set up a high level steering committee to conduct a strategic review on healthcare manpower planning and professional development. The steering committee would put forward recommendations in the first half of 2013 with a view to ensuring the healthy and sustainable development of the healthcare system.

Members' motions

25. Two motions without legislative effect were moved and passed with amendments at the Council meetings of 14 January 2009 and 30 November 2011 respectively urging the Administration to establish an independent statutory Office of the Health Service Ombudsman.

Relevant papers

26. A list of the relevant papers on the Legislative Council website is in the **Appendix II**.

Council Business Division 2
Legislative Council Secretariat
4 January 2012

Appendix I

Types of events that are required to be reported under HA's Sentinel and Serious Untoward Event Policy

Sentinel events

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; and

9. Other adverse events resulting in permanent loss of function or death (excluding complications).

Serious untoward events

1. Medication error which could have led to death or permanent harm; and

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

Source: Extracts from the Administration's paper entitled "Mechanism for handling medical incidents in public and private hospitals" (LC Paper No. CB(2)1467/09-10(09))

Appendix II

Relevant papers on
Handling of medical incidents in public hospitals

Committee	Date of meeting	Paper
Panel on Health Services	10.12.2007 (Item V)	Agenda Minutes
Legislative Council	14.1.2009	Motion moved by Hon Andrew CHENG on "Establishing an independent statutory Office of the Health Service Ombudsman" Official Record of Proceedings (pages 191 to 264)
Panel on Health Services	9.11.2009 (Item IV)	Agenda Minutes CB(2)647/09-10(01)
Panel on Health Services	14.6.2010 (Item IV)	Agenda Minutes
Legislative Council	9.11.2011	Official Record of Proceedings (Question 3)
Legislative Council	30.11.2011	Motion moved by Hon Andrew CHENG on "Establishing an independent statutory Office of the Health Service Ombudsman" Chinese version of Official Record of Proceedings (pages 194 to 252)

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