For Discussion
on 14 November 2011

Legislative Council Panel on Health Services
Mechanism for Handling Medical Incidents
In Private Hospitals

PURPOSE

This paper gives an account of the mechanism for handling medical incidents in private hospitals.

MECHANISM FOR HANDLING MEDICAL INCIDENTS IN PRIVATE HOSPITALS

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

3. In August 2003, DH issued a "Code of Practice for Private Hospitals, Nursing Homes and Maternity Homes" (the Code). It sets out the standards of good practice for private hospitals to adopt with a view to enhancing patient safety and quality of health care 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. The Code also includes requirements on specific types of clinical and support services. The latest revision of the Code was issued in April 2010.

4. Private hospitals should handle medical incidents in compliance with a set of requirements stipulated in the Code, which includes designating a senior staff to co-ordinate immediate response to incidents, putting in place procedures to communicate the nature of incidents to the patients concerned and their families, investigating into the incidents and taking follow up actions such as patient care and handling enquiries.

Sentinel Event Reporting System for Private Hospitals

5. Since 1 February 2007, DH introduced a sentinel event reporting system for private hospitals. In designing the system, reference has been made to the guidelines developed by the World Health Organization, viz. that successful reporting systems should be non-punitive and confidential, and lead to constructive responses. The purpose of the reporting system is to encourage private hospitals to report sentinel events so that lessons learnt could be shared among hospitals and healthcare workers.

6. The reporting system requires all private hospitals to report to DH, within 24 hours of occurrence, medical incidents falling into specific categories of sentinel events. The list of sentinel events reportable to DH is at **Annex A**. The statistics of reported events from 2007 to 2011 are at **Annex B.**

7. Private hospitals are required to develop their own policies and mechanisms to identify, report and manage sentinel events and take prompt actions against the sentinel events in accordance with established mechanisms so that the safety and well-being of patients would be duly safeguarded. For the sake of preventing recurrence of medical incidents, private hospitals, in addition to reporting sentinel events to DH in a timely manner, are required to undertake in-depth investigation to identify underlying systems failures and to redesign their systems as necessary.

8. Upon receipt of the notification of a reportable sentinel event, DH will gather preliminary information from the hospital concerned. It will also visit the hospital and conduct its own investigation if the event

constitutes high public health risk. The private hospital concerned is required to investigate into the root causes of the events, take remedial actions with a view to reducing the likelihood of recurrence of such event in the future, submit to DH a full investigation report within 4 weeks of the occurrence of the event and put in place mechanisms for monitoring the implementation of improvement measures. DH will examine the investigation reports and follow up on the implementation of the remedial measures during subsequent inspections. DH will disseminate information on the lessons learnt and the recommended improvement measures to facilitate learning among hospitals.

9. On releasing information on sentinel events reported by private hospitals, DH will continue to strike a balance between patient privacy and the public's right to know by disseminating aggregated data on all sentinel events on a quarterly basis. Public announcement on individual events will be made by DH if the event is of significant public health impact or ongoing public health risk. Depending on the nature of the sentinel events and the significance of the risks identified, DH may alert all private hospitals to the occurrence of a particular event, and recommend precautionary measures and relevant good practices.

LATEST DEVELOPMENT

10. There have been concerns about a recent medical incident in a private hospital not being reported to DH within the required timeframe under the sentinel event reporting system. The incident involved the accidental fall of a newborn during the course of delivery. Having reviewed the case information, DH confirmed that the incident was a sentinel event which should be reported within 24 hours of occurrence. The hospital concerned was reminded to duly follow the established procedures for reporting sentinel events and to take necessary precautions to prevent recurrence of the incident.

11. Following the incident, DH issued a letter to all private hospitals, reminding them to adhere to the requirement of reporting all sentinel events in a timely manner. Hospitals are also reminded to adopt a prudent approach by reporting all suspected events in case of doubt,

including unusual medical incidents that may possibly lead to serious consequences. DH would maintain communication with the private hospitals to ensure effective operation of the reporting system.

OTHER MECHANISM

12. Hospital accreditation is widely adopted internationally as a useful measure to improve the quality of healthcare services. To pursue continuous improvement in service quality and patient safety, and develop a set of locally adapted accreditation standards for measuring the performance of both public and private hospitals, a pilot scheme of hospital accreditation (the Pilot Scheme) was launched in May 2009 in partnership with the Australian Council on Healthcare Standards (ACHS). In December 2010 and March 2011, ACHS and the International Society for Quality in Healthcare have, respectively, endorsed a set of locally developed standards as the accreditation standards for Hong Kong, which includes standards on the management of medical incidents and complaints, and measures to ensure commitment to continuous quality improvement.

13. Three private hospitals have participated and accredited in the pilot scheme. Another four private hospitals have also obtained accreditation on their own initiatives. DH will continue encouraging the other private hospitals to seek accreditation by the newly developed local standards.

Food and Health Bureau
Department of Health
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Annex A

List of Sentinel Events to be Reported by Private Hospitals

No.	Categories of Sentinel Events
Events that leads to death/ serious outcomes	
1.	Surgery or interventional procedure involving wrong patient or body part
2.	Unintended retention of instruments or other materials after surgery or interventional procedures
3.	Transfusion reaction arising from incompatibility of blood/ blood products
4.	Medication error involving death or serious injury
5.	Intravascular gas embolism resulting in death or serious injury
6.	Death of an in-patient from suicide
7.	Unanticipated maternal death or serious maternal injury associated with labour or delivery and occurring within 42 days after delivery
8.	Infant discharged to wrong family or infant abduction
9.	Unanticipated death or serious injury of a full-term infant within 7 days after birth
10.	Unanticipated death or serious injury that occurs during or within 48 hours after operation or interventional procedures
Unanticipated events that possibly lead to death or serious injury / possess significant public health risk	
11.	Medication error that carries a significant public health risk
12.	Patient misidentification which could have led to death or serious injury
Others	
13.	Any other events that have resulted in unanticipated death or serious injury, or with significant public health risk

Annex B

Breakdown of Sentinel Events in Private Hospitals

	2007	2008	2009	2010	2011 (as at 27 October)
Unanticipated death or serious injury or complications during or shortly after operation or interventional procedures	11	12	15	2	1
Maternal death/serious maternal injury*	2(2)	8(6)	12(11)	3(2)	0
Perinatal death/ serious injury**	14(9)	4(4)	19 (14)	3(1)	1(0)
Unintended retention of foreign bodies after surgery or interventional procedures	1	2	1	0	0
Wrong site surgery/interventional procedures	0	1	1	0	0
Others	11	6	4	2	1
Total	**39**	**33**	**52**	**10**	**3**

* *Include cases of non-fatal postpartum hemorrhage (as shown in brackets)*

*** Include cases of Fractured Clavicles/Humerus/Femur/Skull bone in newborns (as shown in brackets)]*