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Panel on Health Services

Background brief prepared by the Legislative Council Secretariat for the meeting on 14 November 2011

Mechanism for handling medical incidents in private hospitals

Purpose

This paper summarizes the concerns of members of the Panel on Health Services ("the Panel") on the mechanism for handling medical incidents in private hospitals.

Background

2. 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.

3. 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. The Code sets out the standards of good practice for private hospitals to adopt in order to provide quality care to patients. 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.

4. 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.

5. 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 the event to the public if it has major impact on the public healthcare system, or if it constitutes a persistent public health risk or involves a large number of patients. DH may also pay site visits 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.

6. 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.

Deliberations of the Panel

7. The Panel held two meetings between November 2009 and June 2010 to discuss issues relating to the mechanism for handling medical incidents in private hospitals. The deliberations and concerns of members are summarized below.

Disclosure of sentinel events in hospitals

8. Members noted that the Hospital Authority ("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, while 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.

9. The Administration agreed that it was necessary to align the different descriptions of reported sentinel events between public and private hospitals. In this connection, 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. Members were advised that five public and three private hospitals had participated in the pilot scheme.

10. Members noted that under the reporting system of DH, private hospitals were required to develop their own policies and mechanisms to manage sentinel events, including whether to disclose the events to the public. There was a view that the Administration should devise a uniform mechanism for all private hospitals to follow. Apart from reporting sentinel events within 24 hours, DH should also require private hospitals to make public all sentinel events without compromising the privacy of patients concerned.

Occurrence rate of medical incidents

11. Members expressed concern on the performance of public and private hospitals. They sought information on the occurrence rate of medical incidents between public and private hospitals in Hong Kong.

12. 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. Nevertheless, the Administration considered that the introduction of hospital accreditation in Hong Kong would enhance the transparency and accountability of both public and private hospitals, including their standards with regard to the management of medical incidents.

Investigations of sentinel events in private hospitals

13. Noting that private hospitals were responsible for conducting self-investigation into the causes of sentinel events, some members queried the impartiality of private hospitals in their investigations. They urged the Administration to consider establishing an independent statutory Office of Health Service Ombudsman to handle medical incidents occurred in hospitals.

14. The Administration advised that private hospitals were encouraged to invite independent persons and specialists with fellowship in the Hong Kong Academy of Medicine to join their investigation committees to enhance independence of their investigations. Private hospitals would also submit a full investigation report within four weeks of the occurrence of the event to DH. DH would also pay site visits to the hospital to gather more information relating to the event and conduct direct investigation if necessary.

15. On the establishment of an independent statutory Office of Health Service Ombudsman, the Administration expressed reservations about the proposal. 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.

Penalty imposed on private hospitals

16. Members expressed grave concern that private hospitals would not be penalized for non-compliance with the Code. They were advised that DH would issue advice or warning letters to the private hospital concerned based on the severity of the case. Private hospitals would be requested to implement improvement measures within a specified period of time. DH would also monitor the performance of private hospitals by routine and surprise inspections. The Administration pointed out that 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. Members held the view that private hospitals should be penalized for non-compliance with the requirements on the management of medical incidents. They urged the Administration to review Cap. 165 to increase the deterrent effect against non-compliance with the Ordinance.

18. The Administration advised that it might not be a desirable approach to strengthen the regulation through amending the legislation. Instead, the implementation of the Code in 2003 was considered a more effective approach to ensure the delivery of quality care to patients.

19. Noting the increasing number of maternal deaths or serious maternal injury cases reported by private hospitals from 2007 to 2009, members explored whether consideration would be given to imposing penalty on private hospitals which had been involved in sentinel events that were repetitive in nature.

20. The Administration advised that upon identifying the root causes of the sentinel events in private hospitals after investigation, DH would follow up cases which were caused by systemic factors, such as shortage of manpower, lack of appropriate facilities or non-compliance with procedures. DH would then recommend how the related services should be improved.

Recent developments

Number of sentinel events reported by private hospitals

21. According to the website of DH, the numbers of sentinel events reported by private hospitals in 2010 and 2011 (as of 21 October 2011) were 10 cases and three cases respectively. The numbers included five and two fatal cases in 2010 and 2011 respectively (**Appendix I**).

Delivery accident reported in Hong Kong Baptist Hospital

22. A medical incident relating to the obstetric service occurred in the Hong Kong Baptist Hospital ("Baptist Hospital") on 4 October 2011. A newborn baby was accidentally dropped on the floor and suffered a head injury after birth. The parents of the baby were Mainland residents. After examination, the baby was discharged from the hospital on 10 October 2011. DH was informed of the incident through media enquiries. The Baptist Hospital failed to report the case to DH as it considered that the case did not involve severe injury or death. The Baptist Hospital would submit an investigation report to DH.

23. According to the press release issued by the Food and Health Bureau on 24 October 2011, the Secretary for Food and Health considered the case an unusual incident that should have been reported. On the regulations to monitor private hospitals, the Administration would review the licensing terms of private hospitals as well as the regulations and ordinance to empower DH to penalize private hospitals for not complying with the requirement to report sentinel events.

Relevant papers

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

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Appendix I

Statistics on Sentinel Events Reported by Private Hospitals for 2010

No.	Categories of Sentinel Events	No. of Sentinel Events (No. of fatal case)			
		Jan - Mar	Apr – Jun	Jul - Sep	Oct-Dec
I.	***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	2(1)	1(0)	-	-
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	1(0)	-	1(1)*	1(1)*
10.	Unanticipated death or serious injury that occurs during or within 48 hours after operation or interventional procedures	2(1)	-	-	-
II.	***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	-	-	-	-
III.	***Others***				
13.	Any other events that have resulted in unanticipated death or serious injury, or with significant public health risk	-	-	-	2(1)*
Other significant events		-	-	-	-

*Remark: Suspected case pending Coroner's investigation.

Source : Office for Registration of Healthcare Institutions, Department of Health

Updated as of 26 October 2011

Statistics on Sentinel Events Reported by Private Hospitals for 2011

No.	Categories of Sentinel Events	No. of Sentinel Events (No. of fatal case)			
		Jan - Mar	Apr - Jun	Jul - Sep	Oct- Dec
I.	***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	1(1)*	-	-	-
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	-	-	-	1
10.	Unanticipated death or serious injury that occurs during or within 48 hours after operation or interventional procedures	-	-	-	1(1)
II.	***Unanticipated events that possibly lead to death or serious injury / possess significant***				
11.	Medication error that carries a significant public health risk	-	-	-	-
12.	Patient misidentification which could have led to death or serious injury	-	-	-	-
III.	***Others***				
13.	Any other events that have resulted in unanticipated death or serious injury, or with significant public health risk	-	-	-	-
Other significant events		-	-	-	-

*Remark: Suspected case pending Coroner's investigation.

Source : Office for Registration of Healthcare Institutions

Updated as of 21 October 2011

Appendix II

Relevant papers on the
Mechanism for handling medical incidents in private hospitals

Committee	Date of meeting	Paper
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 CB(2)198/10-11(01)

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