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Panel on Health Services

Background brief prepared by the Legislative Council Secretariat for the meeting on 16 February 2015

Sentinel and serious untoward event management in the Hospital Authority

Purpose

This paper summarizes the concerns of the members of the Panel on Health Services ("the Panel") on issues relating to sentinel and serious untoward event management in the Hospital Authority ("HA").

Background

2. In October 2007, 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 improved 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 nine types of sentinel events and the two types of serious untoward events for reporting under the Policy are in **Appendix I**.

3. Under the Policy, clusters or hospitals are required to report to HA Head Office through the Advance Incident Report System any medical incidents classified as sentinel events or serious untoward events within 24 hours of their identification. The clusters or hospitals concerned should at the same time handle the incident in accordance with established procedures so as to minimize any harm caused to the patient concerned and provide support to the staff involved in the incident. For sentinel events, HA Head Office will appoint a

Root Cause Analysis Panel ("RCA Panel"), comprising members from the root cause analysis team of the hospital concerned, respective Coordinating Committees, external senior clinicians, HA Head Office coordinator and/or lay persons from Hospital Governing Committee, to investigate the root causes of the events for risk identification and implementation of improvement measures. As regards serious untoward events, the hospital concerned will form an RCA Panel. The RCA Panel shall submit the final investigation report to the HA Head Office within eight weeks' time.

4. Each year, the HA Head Office will submit to the HA Board a report on sentinel and serious untoward events for release to the public. Internally, HA facilitates the healthcare professionals to share among themselves the experience of handling medical incidents through staff training and the quarterly "Risk Alert" newsletter. A breakdown of the number of sentinel and serious untoward events reported to HA Head Office from October 2010 to September 2014 by category is in **Appendix II**.

Deliberations of the Panel

5. The Panel discussed issues relating to the sentinel and serious untoward event management in HA at a number of meetings between 2007 and 2012. The deliberations and concerns of members are summarized below.

Reporting of sentinel events

6. Members noted with concern the discrepancies in the types and the descriptions of reportable sentinel events between the public and private hospitals, as well as their different criteria for disclosing sentinel events. They urged the Administration to remove such discrepancies.

7. According to the Administration, while two reporting systems were being put in place, both public and private hospitals were required to report sentinel events within 24 hours upon occurrence of the event and conduct investigations into the event for root cause identification and implementation of improvement measures. The Administration further advised that a pilot scheme of hospital accreditation was launched 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 various aspects covering, among others, the management of medical incidents and complaints. Five public hospitals[1] and three private hospitals[2] had participated in the pilot scheme.

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

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

8. Question was raised as to whether there was any international standard classification of sentinel events. HA advised that there was no international standard classification of sentinel events. The categories and definitions of sentinel events under the Policy were modelled largely on the sentinel event reporting mechanism of Western Australia.

Implementation of the Policy

9. In response to members' concern about possible 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 all medical incidents were reported through the internal Advance Incident Reporting System. While the implementation of the Policy might generate psychological pressure on staff, the aim of the Policy was to enable healthcare professionals to learn from and share experiences on the incidents, so as to enhance safety and quality of service and avoid recurrence of similar medical incidents.

10. Members noted that the public hospital concerned had to report a sentinel or untoward event to the HA Head Office within 24 hours. There was a view that HA should at the same time inform patient's family members of the details of the incident.

Contributing factors of medical incidents

11. Members were gravely concerned that the number of sentinel and serious untoward events in public hospitals had not been significantly reduced after the implementation of the Sentinel Event Policy in 2007 and the Policy in 2010. Question was raised as to whether human error or system factor was the key contributing factor of the medical incidents concerned. Members also cast doubt on the effectiveness of the existing mechanism for sentinel and serious untoward event management in HA.

12. HA advised that similar to overseas experience, local medical incidents were mainly caused by system and process factors rather than mere human errors. Given the complex healthcare settings, it would be difficult for hospitals to attain zero medical incidents. HA had put in place a clinical governance structure to safeguard the standard of care and improve service quality. Initiatives were also implemented to further improve the mechanism for handling medical incidents in public hospitals. These included extension of the reporting criteria to cover all serious untoward events relating to medication error and patient misidentification, adoption of the patient safety round to enable direct communication between management and frontline staff to identify risks and explore improvement measures so as to reduce adverse medical events and enhance patient safety, and enhancement of patient identification by the use of 2D barcode and radiofrequency.

13. Members generally considered that the high turnover rate of senior doctors and insufficient healthcare manpower were the underlying factors contributing to the occurrence of medical incidents in public hospitals. Given that medical manpower resources could not be made available overnight, members urged HA to recruit more part-time doctors and non-local doctors by way of limited registration. HA should also take steps to alleviate the work pressure on frontline doctors in public hospitals.

14. According to the Administration, HA had implemented a series of measures to improve staff retention and strengthen medical manpower. These included, among others, enhancement of promotional prospects and training opportunities, adopting a more flexible approach in employment of part-time doctors, and improving working conditions. Measures such as re-engineering or streamlining work processes and recruiting additional supporting staff had also been put in place in order to relieve the workload of frontline healthcare personnel. It should be noted that the number of first-year first-degree places in medicine had been increased by 100 starting from 2012.

15. On the performance of public hospitals in Hong Kong as compared with other developed countries in terms of the ratio of sentinel events to service volume, members did not subscribe to the Administration's view that it was difficult to make a direct comparison between local medical incidents statistics with those in other countries because of the differences in the mechanisms and culture of reporting medical incidents. In their views, HA should conduct a comparison on an item-by-item basis with a view to measuring the performance of public hospitals on each category of the sentinel and serious untoward events. HA, however, considered it more appropriate to study the general trend, rather than the absolute figure, of each category of medical incidents so as to identify improvement measures to avoid the recurrence of the incidents.

Investigations of sentinel events

16. Members noted 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 families 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. Measures would be taken to ensure that the identity of the patients would be protected. There was a concern about whether information disclosed by the frontline staff to the investigation panel was subject to legal privilege under the Policy.

17. HA advised that appropriate level of confidentiality would be applied to the root cause analysis report to protect the identity of the 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.

18. Members considered it important to maintain the independence of the investigation panels. Some members expressed disappointment that the Administration had failed to respond to the repeated call from Members of the Legislative Council ("LegCo") 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.

19. The Administration pointed out that a two-tier 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 and the Office of The Ombudsman. The Administration held the view that the existing mechanisms were effective in handling complaints of medical nature.

20. The Administration expressed reservations about the establishment of an Office of Health Service Ombudsman. It pointed out that 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. It should be noted that the United Kingdom had decided not to pursue with the establishment of an independent medical ombudsman after taking into account the response of the pubic and the profession towards the relevant pilot scheme.

Recent developments

21. On 22 January 2015, HA released the seventh Annual Report on Sentinel and Serious Untoward Events covering the period from October 2013 to September 2014 which was endorsed by the HA Board. According to the Report, a total of 49 sentinel events and 94 serious untoward events were reported during the period. Comparing with the reporting period of October 2012 to September 2013, there was a rise in sentinel events from 26 to 49 and a decrease in serious untoward events from 104 to 94. According to HA, improvement in the areas of procedures performed outside operating theatre and

checking of the completeness of instruments on removal was required in view of the increase in the number of sentinel events, in particular events relating to "retained instruments or other material after surgery / interventional procedure".

Relevant papers

22. A list of the relevant papers on the LegCo website is in **Appendix III**.

Council Business Division 2
Legislative Council Secretariat
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Appendix I

Types of events for reporting under the Hospital Authority'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
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
2. Patient misidentification which could have led to death or permanent harm

Source: Extract from the Administration's paper entitled "Handling of medical incidents in public hospitals" (LC Paper No. CB(2)712/11-12(03))

Appendix II

The number of sentinel and serious untoward events in the Hospital Authority from October 2010 to September 2014

(A) Sentinel events

		1 October 2010 to 30 September 2011	1 October 2011 to 30 September 2012	1 October 2012 to 30 September 2013	1 October 2013 to 30 September 2014
1.	Surgery/interventional procedure involving the wrong patient or body part	3	5	4	3
2.	Retained instruments or other material after surgery/interventional procedure	18	14	10	20
3.	ABO incompatibility blood transfusion	1	0	0	0
4.	Medication error resulting in major permanent loss of function or death	1	0	0	5
5.	Intravascular gas embolism resulting in death or neurological damage	0	0	0	0
6.	Death of an in-patient from suicide (including home leave)	20	10	9	19
7.	Maternal death or serious morbidity associated with labour or delivery	1	2	1	1
8.	Infant discharged to wrong family or infant abduction	0	0	1	0
9.	Other adverse events resulting in permanent loss of function or death (excluding complications)	0	3	1	1
	Total	**44**	**34**	**26**	**49**

(B) Serious untoward events

		1 October 2010 to 30 September 2011	1 October 2011 to 30 September 2012	1 October 2012 to 30 September 2013	1 October 2013 to 30 September 2014
1.	Medication error which could have led to death or permanent harm	88	92	96	85
2.	Patient misidentification which could have led to death or permanent harm	9	10	8	9
	Total	**97**	**102**	**104**	**94**

Source: Annual Report on Sentinel and Serious Untoward Events (1 October 2013 - 30 September 2014) issued by the Hospital Authority in January 2015

Appendix III

Relevant papers on the sentinel and serious untoward event management in the Hospital Authority

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	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)
Panel on Health Services	9.1.2012 (Item IV)	Agenda Minutes CB(2)1764/11-12(01)

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