中華人民共和國香港特別行政區政府總部食物及衞生局
Food and Health Bureau, Government Secretariat
The Government of the Hong Kong Special Administrative Region
The People's Republic of China

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15 July 2018

Ms Maisie Lam
Clerk to Panel
Panel on Health Services
Legislative Council Complex
1 Legislative Council Road
Central

Dear Ms Lam,

**Panel on Health Services**
**Follow-up to the meeting on 19 June 2017**

During the discussion on mechanism for handling medical incidents in public and private hospitals at the meeting of the Legislative Council Panel on Health Services held on 19 June 2017, Members requested supplementary information relating to certain types of sentinel events and follow-up actions by the Hospital Authority (HA). Having consulted the HA, the requested supplementary information is provided in the ensuing paragraphs.

**(I) Whether HA had taken any disciplinary actions against its staff for delaying or omitting the reporting of medical incidents classified as sentinel events or serious untoward events to HA Head Office within 24 hours of their identification, as was required under the Sentinel and Serious Untoward Event Policy**

2. HA continues to promote the incident reporting culture for root causes analysis and implement appropriate actions to prevent recurrence of similar incident. HA has separately put in place an established mechanism to handle disciplinary matters of its staff. Disciplinary actions are considered with regard to the circumstance of each case and are not confined to medical

incidents. HA does not keep breakdown statistics on disciplinary actions taken solely for delaying or omitting the reporting of medical incidents.

**(II) The reason(s) why the sentinel events relating to "retained instruments or other material after surgery/ interventional procedure" and "death of an inpatient from suicide (including home leave)" remained as the top two categories of sentinel events reported by HA during the period of 1 October 2007 to 30 September 2016, albeit HA had implemented improvement measures identified by the relevant Root Cause Analysis Panels for these incidents, including whether healthcare manpower constraint of HA was a factor attributing to the above phenomenon**

3. The occurrence of the sentinel events relating to "retained instruments or other material after surgery/ interventional procedure" and "death of an inpatient from suicide (including home leave)" are multi-factorial, with systems, processes, human factors and latent risks, rather than manpower strength, as the main causes. HA continues to develop safer systems and work processes so as to reduce the risks of human error in the caring of patients.

4. For "retained instruments or other material after surgery/ interventional procedure", the rapid technological advances in medical care and procedures make many effective treatments possible, but in turn has increased the complexity of the surgical procedures as well as the types and variety of equipment used during the procedures. HA has been placing particular emphasis on after-surgery counting, and has extended the practice to procedures performed outside operating theatre, to check vigilantly the completeness of instruments upon removal from patients.

5. As regards "death of an inpatient from suicide (including home leave)", it should be noted that a majority of inpatient suicides occurred during patients' home leaves and were under various socio-economic situations, and HA has been raising staff awareness on this risk. Furthermore, to reduce the risk of inpatient suicide, HA has been improving communication among patients, families and staff, and mitigating the environmental risk in hospitals (e.g. minimising structures or fitting which could be used in suicide by hanging or strangulations).

**(III) Details of the support provided by the clusters or hospitals concerned for their staff who were involved in sentinel events or serious untoward events**

6. After the occurrence of a sentinel or serious untoward event, the hospital would discuss with the staff concerned for the necessary psychological support

as appropriate. Also, depending on the recommendations of the root cause analysis panel, the hospital would follow up on the necessary staff development, like clinical supervision, skills training and team management.

Yours sincerely,

( Bernard Lo )
for Secretary for Food and Health

c.c. Chief Executive, Hospital Authority
(Attn.: Ms Dorothy Lam)