LCQ2: Medical incidents in public hospitals

Following is a question by the Hon Joephy Chan and a reply by the Secretary for Health, Professor Lo Chung-mau, in the Legislative Council today (July 17):

Question:

It has been reported that earlier a four-year-old girl developed cardiac arrest after she underwent wound suture at the Accident and Emergency Department of Yan Chai Hospital. During the suturing process, her head was positioned with the assistance of non-healthcare personnel. It took 18 minutes from the discovery of the girl's loss of consciousness and pulse to the return of spontaneous circulation after emergency treatment. There are views that, before the outcome of a formal investigation into the incident is available and before a full communication with the girl's family is made, the hospital is suspected of misleading the public by unilaterally convening a press conference and indicating that it will find out whether the girl has hidden diseases. In this connection, will the Government inform this Council:

(1) whether it knows if the Hospital Authority (HA) currently has sufficient mechanisms or guidelines covering different clinical procedures and specifying the duties of different personnel (including non-healthcare personnel) in carrying out such procedures; if HA has, of the details; whether HA will update the relevant guidelines after experiencing the incident; if so, of the details; if not, the reasons for that;

(2) whether it knows HA's mechanisms or guidelines for external reporting of medical incidents, and whether the mechanisms or guidelines specify the circumstances under which information on such incidents should be disseminated externally, as well as the form and material contents of the necessary communication with the affected patients and their families before the dissemination of information on such incidents; and

(3) of the measures put in place by the Government and HA to reduce medical incidents, so as to safeguard the healthcare quality of Hong Kong and maintain public confidence in the public healthcare system?

Reply:

President,

The Hon Joephy Chan has mentioned a truly unfortunate and very upsetting incident in her speech. I am deeply saddened by the circumstances of the girl in this case of cardiac arrest. I take this opportunity to extend my deepest sympathy to the patient and her family. The Hospital Authority (HA) is making every effort to take care of the patient, and is actively providing assistance to the patient and her family in every aspect. The Chief Executive

of the HA, Dr Tony Ko, had also visited the girl, met with and apologise to her family before meeting with the press the day before yesterday, i.e. July 15. Every medical incident involves patients' privacy. Out of respect for the patient and her family and to avoid causing "secondary harm" to them, and given that this case has entered investigation and enforcement proceedings, it is not suitable for public discussion at the Legislative Council. I therefore will not comment on the case in question, and I hope that everyone will refrain from going into details of the case in the question-and-answer process. The Health Bureau (HHB) had also reported and discussed the overall quality and safety issues of public hospital services at the meeting of the Panel on Health Services of the Legislative Council on July 12 last week.

In consultation with the HA, the reply to the question raised by the Hon Joephy Chan is as follows:

(1) The safety of patients and healthcare staff is the prime concern of hospital operations. As such, when planning and delivering patient-oriented services, the HA accords prime consideration to service quality and safety, and establishes a governance structure, systems, procedures and training covering different clinical services to ensure that these services meet stringent clinical standards.

At present, the Quality and Safety Division of the Hospital Authority Head Office (HAHO) is responsible for steering the establishment and implementation of the clinical quality and standard system. The quality and safety teams at all levels in hospital clusters as well as individual hospitals are responsible for implementing and monitoring relevant measures in various areas including credentialing, clinical audit, patients' safety and risk management as well as patients' relations, while maintaining close communication and collaboration with the HAHO to ensure that the HA provides quality and safe healthcare services.

With the rapid and ever-changing development of clinical medicine, the HA has put in place systems and guidelines for different clinical diagnoses, treatments and procedures, and they are continuously updated on evidence-based principle, so as to ensure that the service quality and standards are kept abreast of the times. The Coordinating Committees of various specialties and Central Committees under the HA are responsible for formulating various clinical standards, e.g. bedside application of cardiopulmonary resuscitation and clinical guidelines for treating diabetes and hypertension. They also play a key role in aspects such as clinical audit and implementation of best practice. There are also service guidelines on nursing care covering clinical nursing care procedures like blood transfusion and distribution of medications. Nursing audit is also conducted regularly to identify and improve potential issues. For supporting staff, the HA has also put in place guidelines and training requirements, e.g. caring skills for patients, workflow for procedures such as feeding and lifting patients, etc. Guidance and support will also be provided alongside introduction of modern technology and equipment to ensure that supporting staff can effectively and safely assist the work of healthcare staff.

(2) For reporting of medical incidents, the HA has established a full set of

medical incident reporting and investigation procedures to cope with clinical risks. At present, all public hospitals have to report sentinel events and serious untoward events to the HAHO, including surgeries involving wrong patients or body parts, or misidentification of patients that could have led to death or permanent harm.

When any incident occurs in a hospital, should report has been made to the HAHO by the relevant hospital afterwards, the corresponding hospital, hospital cluster and the HAHO will take various actions according to the nature of the incident, including follow-up investigation, risk assessment, review of the causes and formulation of improvement measures, which is particularly important, to prevent re-occurrence of similar incidents in the future. Meanwhile, the hospital will disclose the relevant incident to the patient and his or her family in an open and honest manner, and determine the timing, mode and content of the public announcement. Throughout the process of handling an incident, the Patient Relations Officer serves as a bridge of communication and will maintain contact with the patient and his or her family, and update them with the available information and situation in a timely manner. Relevant hospital departments will also provide appropriate treatment and different assistance as needed. The hospital will also inform the affected patient and his or her family of the relevant arrangement before disseminating to the public the incident information.

(3) To reduce the risk of recurrence of incidents, the HA regularly reviews, monitors and evaluates specific risk mitigation and preventive measures to ensure that they can achieve the expected outcomes. The HA is committed to building a culture of analysing and sharing the causes of medical incidents, as well as disseminating relevant information through various channels and actively introducing advanced technologies such as clinical artificial intelligence to further enhance patients' safety and risk management. The HA has also relaunched the hospital accreditation programme to objectively and systematically assess the risks and deficiencies in areas such as management of facilities and operation of hospitals through the assistance of external and independent professional organisations in hospital accreditation, with a view to continuously improving service quality and safeguarding patients' safety.

To further manifest the commitment of the Government and the HA in continuous improvement of the public healthcare system and address public concern on recent medical incidents, the HHB has instructed the HA to, apart from actively following up on recent individual incidents, reviewing their causes and adopting improvement measures, conduct a comprehensive and independent review of the systemic and structural issues involved in the overall management of public hospitals. The review covers multiple levels including the HAHO, hospital clusters, hospitals, service units/teams and staff, while involving multiple aspects including governance, appraisal, accountability, operations, risk control and compliance.

The Review Committee on the Management of the Public Hospital System (the Committee) has a membership comprising individuals of various backgrounds, and will complete the review and submit improvement recommendations to the HA Board within three months (i.e. before the end of

September). The HA Board will consider the Committee's recommendations and submit a report to the HHB.

The HHB and the HA will consider taking appropriate follow-up actions subsequently according to on the recommendations at different levels and in various aspects in the report, so as to continuously enhance the overall quality and safety of the public healthcare system, maintaining public trust in public healthcare services.

Thank you, President.