Review Panel on
Sentinel and Serious Untoward Event Policy of
Hospital Authority

Summary of Findings and Recommendations

Definition of SE and SUE	
Certain SE and SUE categories are less clear (e.g. SE Category 4 and 9; SUE-medication error, etc.) and this might affect the timeliness of reporting.	***Recommendation 1*** Clarify and update (where appropriate) the SE and SUE definitions, with the aim to facilitate consistent interpretation, timeliness of identification and reporting.
SE and SUE Identification and Reporting	
1. When the caring of the patient involved more than one cluster as in the recent UCH SUE case, such incident reporting could be less coordinated and timely. 2. Staff are very concerned on the legal liability and the possible legal consequences when facts are reported as part of the incident information. 3. Due to the complexity of some cases that fact finding and much discussion are required among stakeholders before SE classification. 4. In the past 10 years, incident management related activities had been increasing amid the increased annual number of episodes of patient attendances / discharges and deaths from approximately 16 million in 2007 to 21 million in 2016.	***Recommendation 2*** (a) Explore measures to alleviate staff's concern regarding legal implications of the RCA process. (b) Enhance the promulgation of the essentials of SE and SUE management to staff, and strengthening staff's knowledge in (i) Objectives of SE & SUE Policy; (ii) Incident identification and management; and (iii) Independence of SE and SUE Policy from the disciplinary mechanisms of HA and the Medical Council of Hong Kong (c) Regarding SEs and SUEs that involve different clinical teams/ hospitals/ clusters, HA should: (i) Enhance the mechanism for handling such cases for better coordination, cooperation and communication of all concerned; and (ii) Clarify and strengthen the roles and responsibilities of clinical department, hospital management, hospital and Head Office PS&RM in timely reporting of incidents. ***Recommendation 3*** (a) In the event of differences in opinions among cluster, hospital Q&S and Head Office PS&RM to decide an incident as sentinel or serious untoward event, a clear line of authority should be defined. (b) Strengthen the roles and responsibilities of clinical department, hospital management, hospital Q&S and Head Office PS&RM in incident management, especially incident reporting.

	(c) Enhance AIRS to encourage early reporting and facilitate daily clinical incident management (e.g. classification of a SE, communication between hospital and Head Office PS&RM on suspected SE case, etc.). ***Recommendation 4*** Review the manpower resources for clinical incident management so as to support patient safety and risk management at various levels.
Open Disclosure	
The conduct of open disclosure in incident occurring within a hospital is generally adequate. However, when the caring of the patient involved more than one cluster as in the recent UCH SUE case, such disclosure could be less coordinated and coherent.	***Recommendation 5:*** Establish corporate policy on open disclosure to the patient and /or patient's family, while respecting patient's privacy.
Public Disclosure	
The Review Panel noted that each SE or SUE had to be individually assessed for prompt public disclosure with reference to the various factors for consideration. There is no clear and specific guidance on the timing and mode of public disclosure. Also, some patient advocates are of the view that prompt public communication should be arranged in a more timely manner.	***Recommendation 6*** (a) Enhance and promulgate the corporate SE & SUE public disclosure framework, including: (i) Timing and mode of prompt public disclosure; and (ii) Frequency and mode of publishing relevant statistics and risk alert. (b) Enhance healthcare executives' skills in prompt public disclosure through regular media and crisis management training. (c) Promulgate and enhance public understanding on the objectives of SE & SUE Policy, which is learning and sharing from a clinical incident. (d) Monitor closely the progress of the enactment of apology legislation in Hong Kong, and consider its application to HA's open and public disclosure process.
Learning and sharing	
Learning from incidents is an indispensable component of incident management. At present, learning points from SEs or SUEs	***Recommendation 7*** Explore further means to facilitate the promulgation of important learning points of SEs or SUEs and patient safety message to frontline staff effectively.

are shared on various levels by different means, e.g. departmental meeting, hospital/ cluster staff forums, Head Office staff forums, HARA, PS&RM website. The Review Panel recommends means should be further explored to promulgate the learning points to frontline staff effectively.	
Psychological support to patient and/ or patient's relatives and HA staff after medical incidents	
Various psychological support services are available to patient and/ or patient's family and HA staff after SEs or SUEs. While HA should continue to enhance the psychological support, the Review Panel comments that HA should be proactive in providing other support (e.g. assisting patient and/ or patient's family to navigate in the complex healthcare system; referring patient and/ or patient's family to Medical Social Welfare or other social support services; arrange peers or management support to the staff involved, etc.) as necessary.	***Recommendation 8*** Continue to enhance the psychological support to staff, patient and / or patient's family after a SE or SUE. (i) Enhance the accessibility of psychological services for staff, patient and/ or patient's family after a SE or SUE; and (ii) Enhance understanding of staff's possible psychological reactions after a clinical incident, and the ways to support them. (iii) Reduce the risk of incidents with pre-incident training for staff of all levels.