Service Priorities and Programmes

Electronic Presentations

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"Enhancing the consistency on criteria for request of investigation report with cluster hospitals upon notification of clinical mishap"

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Introduction

Staffs of hospitals under the Hospital Authority in Hong Kong report incidents through a robust electronic platform (Advance Incident Reporting System (AIRS)). This system allows officers of the Quality & Safety (Q&S) department of each hospital to perform incidents trending and patterns recognition. Many incidents have significant learning value and worth to have in-depth investigations for identifying the root cause, contributory factors, preventability, and impact of the incidents. Cases within the categories of Sentinel Event/Serious Untoward Event would mandate Root Cause Analysis (RCA) while the other cases have less stringent criteria for further deep look. Excessive investigations, however, would create unnecessary workload and stress to the frontline. Patient safety officers therefore need justification for requesting such an inquiry. However, among hospitals in New Territories East Cluster (NTEC), marked variations on the reasons of such requests existed.

Objectives

To improve consistency across the criteria chosen previously by cluster hospitals which are through the perspectives of patient management.
To search for a set of agreed criteria in NTEC hospitals.

Methodology

A retrospective case series (n=977) of all reported clinical incidents were retrieved from AIRS between May and August in 2017, of which 846 cases had not been further investigated while the remaining 131 cases had. Six criteria were preliminary chosen as the most appropriate reasons for requesting reports. Based on the set criteria, these 131 cases were further analyzed. Patient safety officers had taken in charge on the details of the incidents and the circumstances when the decision was made for request of the report.

Result

131 reported clinical incidents with investigation reports were reviewed. The reasons of requesting reports were categorized as: (A) Severity Index ? 4 (12%), (B) Incident with potential harm or impact on patient (98%), (C) Incident due to the lack of manual calibration mechanism (5%), (D) Incident with learning point to department (100%), (E)

Incident relating to medication (53%) and (F) Other reasons (2%).
Apart from the criteria of Severity index ? 4, those remaining 5 agreed criteria among the NTEC hospitals were too subjective to personal bias. Therefore, qualitative study on new criteria, for example, consensus of experts in individual hospitals and standardization of requesting criteria to minimize possible delay or overuse of investigation should provide better scientific evaluation of this process, making it more systematic and efficient.