Briefing on Patient Safety Incident Reporting and Learning System for Day Procedure Centres - Frequently Asked Questions

Q.1.

What is the aim of the patient safety incident reporting and learning system ('PSI System')?

A.1.

The PSI System aims to enhance patient safety through the identification and reduction of risks. It is not for fault finding, but rather to:

- facilitate the understanding of underlying causes of an event;
- reduce the probability of recurrence of the event in the future by changing the organisation's systems and processes; and
- learn from experience and disseminate the lessons learnt to other Day Procedure Centres ('DPCs').

Q.2.

When should DPCs report patient safety incidents?

A.2.

As stipulated in the *Code of Practice for Day Procedure Centres*, with effect from 1 July 2023, sentinel events and serious untoward events must be reported to the Director of Health ('DoH') within 24 hours upon identification. DPCs are also required to report other reportable events to DoH upon identification. The chief medical executive ('CME') has to ensure that the relevant requirements, including the reporting timeframe, are complied with.

Q.3.

Who can report patient safety incidents?

A.3.

The CME, staff of the DPCs or anyone as appropriate and appointed by the licensee can report patient safety incidents.

Q.4.

Who should investigate the reported incident if there is only one doctor or dentist operating a DPC?

A.4.

Staff involved in the reported event should avoid participating in the investigation as far as possible to maintain impartiality.

DPCs should appoint designated personnel to investigate the incident and to implement measures to prevent recurrence. Designated personnel could be the CME, a staff member or staff members in a panel composition, who are preferably appointed from different services of a DPC or from the same service but not directly involved in the reportable event.

For DPCs operated by a single doctor or dentist, the investigation may be considered to be conducted by other personnel appointed by the licensee.

The investigation report (PHF214) should be reviewed and endorsed by the CME of the DPC, who is responsible for the daily operation of the DPC.

Q.5.

What events are reportable under the category of 'unplanned transfer' of other reportable events ('OE1')?

A.5.

As stipulated in the *Guidance Notes for Reportable Sentinel Events and Serious Untoward Events of Day Procedure Centres*, a patient safety incident is reportable under OE1 if it fulfills all three inclusion criteria as follows:

(i) Unplanned transfer of a patient from a DPC to a hospital directly; and
(ii) The patient was receiving or had received a planned procedure at the DPC; and
(iii) The patient required emergency management at the hospital.

OE1 is not intended to capture the following:

- The return of a patient to a hospital after receiving service at a DPC.
- The transfer of a patient with condition that is not related to the planned procedure received at the DPC.
- The transfer of other persons who are not patients of a DPC.

The following examples fulfil the inclusion criteria of OE1 and are reportable:

- A patient had cardiac arrest during haemodialysis at a DPC and was transferred to a hospital for resuscitation.
- A known complication such as perforation (the patient was aware and had signed the consent form) occurred during an endoscopy procedure at a DPC and the patient was transferred to a hospital for emergency operation.
- A patient without any known drug allergy developed anaphylaxis after receiving medication during chemotherapy procedure at a DPC and was transferred to a hospital for emergency management.

Please refer to the *Guidance Notes for Reportable Sentinel Events and Serious Untoward Events of Day Procedure Centres* for further details.

Q.6.

If there is an incident of wrong tooth removal from a patient, should DPC notify DH about the event?

A.6.

Category 1 under the sentinel events ('SE1'), surgery / interventional procedure involving a wrong patient or body part, is intended to capture any surgery / interventional procedure performed on a patient or a body part that is not consistent with the informed consent.

In general, wrong tooth removal involves an interventional procedure in a wrong body part. If the scenario meets the inclusion criteria of the reportable event, the DPC will be required to notify DH as 'SE1'. This is also applied even if the wrongly removed tooth is being replanted immediately.

Please refer to the *Guidance Notes for Reportable Sentinel Events and Serious Untoward Events of Day Procedure Centres* for further details.

Q.7.

If there is an incident of patient swallowing or aspirating dental instrument (e.g. dental bur, scaling tip ... etc) or extracted tooth during dental procedures, should DPC notify the DH about the event?

A.7.

Category 2 under the sentinel events ('SE2'), retained instruments or other material after surgery/interventional procedure, is intended to capture:

- unintended retention of foreign objects after the surgery / procedure ends, regardless of
    - size of the object;
    - severity of potential harm of such retention; or
    - whether the object is to be removed after discovery.
- foreign objects inserted into a patient's body in surgery / interventional procedure but not removed as planned.

In general, the swallowed or aspirated dental instrument or extracted tooth is considered an unintentionally retained foreign object. If the scenario meets the inclusion criteria of the reportable event, the DPC will be required to notify DH as SE2.

Please refer to the *Guidance Notes for Reportable Sentinel Events and Serious Untoward Events of Day Procedure Centres* for further details.

Q.8.

If there is an incident of retention of fractured endodontic instrument inside a patient's root canal during Root Canal Treatment ('RCT'), should DPC notify the DH about the event?

A.8.

Category 2 under the sentinel events ('SE2'), retained instruments or other material after surgery/interventional procedure, is intended to capture:

- unintended retention of foreign objects after the surgery / procedure ends, regardless of –
  - size of the object;
  - severity of potential harm of such retention; or
  - whether the object is to be removed after discovery.
- foreign objects inserted into a patient's body in surgery / interventional procedure but not removed as planned.

This category is not intended to capture:

- objects that are intentionally left in place during the surgery or interventional procedure; or
- objects that are known to be missing prior to the completion of the surgery or interventional procedure and may be within the patient (e.g. screw fragments, drill bits) but further action to locate and/or retrieve the object would not be possible or may carry greater risk than retention.

In general, a fractured instrument retained inside a root canal is considered an unintentionally retained foreign object. To determine the retention of a fractured instrument inside a root canal is a reportable incident or not, DPC should consider the inclusion and exclusion criteria listed above such as whether the fractured instrument is known prior to the completion of the procedure but further action to locate and/or retrieve the object would not be possible or may carry greater risk than retention. If the criteria of the reportable event is not met, it is not required to notify the event to DH.

Please refer to the *Guidance Notes for Reportable Sentinel Events and Serious Untoward Events of Day Procedure Centres* for further details.