香港社會醫學學院
HONG KONG COLLEGE OF COMMUNITY MEDICINE
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Part II Fellowship Examination in Administrative Medicine

Case Study 1

You have just completed your RACMA/HKCCM fellowship. On return to your teaching hospital you are rewarded with an appointment as Acting Director of Medical Services. Your appointment follows the resignation of the Director of Medical Services a month ago and will conclude when a new director is appointed. You anticipate that your appointment will be for about four months.

At the first meeting with your Chief Executive, she hands you a folder of letters that are complaints about care provided by the hospital's surgical services. The file includes two letters from legal firms and one enquiry from the local newspaper. The Chief Executive tells you that not only have there been a flurry of complaints over the past couple of months but that the surgeons have been complaining to her about compromised care because of nursing staff shortages and equipment failures in theatre.

She poses the question: Is the hospital providing safe surgical patient care?

What are the steps you will take to provide an answer to the question?

For Examiner

2006 Case Study 1 Key points

Demonstrate an understanding of the measures of patient safety and be able to describe their reliability and validity. To include;

- Patient safety clinical indicators
    - Unplanned return to theatre
    - Unplanned admission to ICU
    - Unplanned readmission with 30 days
- Incident monitoring systems
- Consumer feedback including:
    - Complaints
    - Consumer feedback surveys
- Results of ad hoc and other audit activities conducted within the hospital that relate to the relevant service

Describe benchmarking processes including the choice of organisation against which to benchmark.

Consider the clinical governance arrangements that ensure patient safety. To include:

- Accountability/responsibility arrangements within the organisation
- Policies and guidelines
- Organisational processes for identifying adverse events and investigating them
- The role of peer review/clinical audit committees
- Clinical risk management arrangements such as risk rating and risk registers
- Reporting requirements

May refer to national international experience with patient safety indicators such as:

- The role of the new Safety and Quality Commission in developing a minimum data set, or of Quality Health's role in New Zealand.
- OECD benchmarking study that recommended series of indicators including sentinel events

Describe the role of benchmarking organisations such as Australian Council on Healthcare Standards and collaborations such as Health Roundtable

Mention failed services such as Bristol/UK and why they failed.