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Strive through Baby-friendly Hospital Designation, Support Successful Breastfeeding

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The Baby Friendly Hospital Initiative (BFHI) is a global accreditation movement aimed to remove breastfeeding barriers in health facilities. HA supports hospitals with maternity service in their strive towards BFHI designation.

In Hong Kong, BFHI includes a four-stage assessment and accreditation scheme, namely, award of Certificate of Commitment, Certificate of Level 1 Participation, Certificate of Level 2 Participation and the final Baby Friendly Hospital Award.

At present, four HA hospitals have attained different stages of BFHI:

Hospital	Level attained
Queen Elizabeth Hospital	Award of Level 2 Participation
Queen Mary Hospital	Certificate of Commitment
Kwong Wah Hospital	Certificate of Commitment
Prince of Wales Hospital	Certificate of Commitment

Highlights of BFHI Pathway in Queen Elizabeth Hospital

Staff Training

We have conducted regular training for our medical and nursing staff, dietitians, allied health colleagues, health care assistants and other hospital supporting staff to equip them with the knowledge and skill to provide professional service to supporting breastfeeding mothers. We have passed the Level 2 Participation interview where over 80% of our colleagues who were randomly selected for the interview met the requisite knowledge criteria.

Change in Practice

We have significantly improved the immediate and sustained skin-to-skin contact of newborns with their mothers both in normal delivery and caesarean section.

Hospital Breastfeeding Promotion

BFHI is a whole hospital movement. We have organized Breastfeeding Fun Day in recent years to promote BFHI to colleagues, patients and the community to build a positive and supportive culture for Breastfeeding.

Protecting, Promoting and Supporting Breastfeeding We Value

Since QMH's announcement on participation in Baby Friendly Hospital Initiative (BFHI), we have formed the QMH Steering Committee and 5 working teams to support all newborn to have a good start in life.

In This Issue:

To protect, promote and support breastfeeding in our Hospital, we have developed the Infant Feeding Policy in 2014 and a number of important guidelines in 2015.

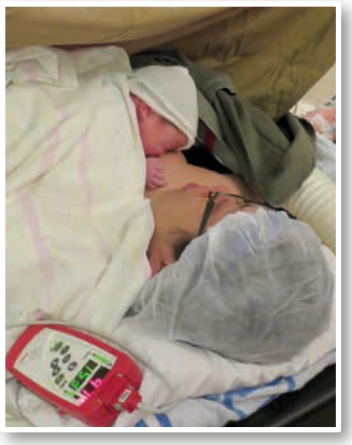
We have conducted orientation and training programs which are tailored made for all hospital staff and have arranged monthly lactation consultant sharing sessions for midwives and nurses. The training includes new client-centered approach counselling, hands off technique, bonding and relationship building as well as understanding and use of various forms for breastfeeding assessment, practicum assessment, feeding log sheet and lactation consultant referral.

Our maternity unit is now providing one to one breastfeeding counseling in antenatal period, lactation consultant clinic and phone follow up services. We have aligned common breastfeeding practices and teaching tools used by hospital and MCHC. We have also recently established the one stop tongue-tie management service by OBS, P&AM and Paediatric surgery.

Implementing skin-to-skin contact after caesarean section in operating theatre – Kwong Wah Hospital

Skin-to-skin contact (SSC) after delivery is an important intervention to facilitate early initiation of breastfeeding and mother-baby connection. Since the operation theatre (OT) settings might constrain and delay immediate SSC, we have formed a team to study the gaps and make improvements:

- Address the concerns of stakeholders (anaesthetists, obstetricians, OT staff and midwives)
- Share evidences of SSC
- Recruit only women with uncomplicated elective caesarean and uncompromised babies at this stage
- Assess physical setting of OT for easier SSC
- Adjust the placement of equipment and furniture
- Perform simulation in OT before implementing the pilot
- Develop guideline on early SSC in OT
- Revise the educational kit to women for pre-operative counselling
- Develop a checklist to collect women's feedback for further practice improvement



The SSC practice was successfully implemented in September 2015, with 93 % of all mothers highly appreciating the unique moment with their babies.

Experience of Prince of Wales Hospital

PWH has attained the Certificate of Commitment in October 2015. The process was fruitful, particularly the learning and experience gained by the teams. In the process, a comprehensive review on the existing practice of the different teams was conducted. This helped to give us an insight on our current performance levels and lay down the blue print for future actions planning. Communication and collaborations established among the multidisciplinary teams were also improved. Through engagement of the frontline colleagues, creative ideas such as the organisation of a daily 3-minute staff breastfeeding training in wards and forming of small workgroups for various promotional activities were initiated. As a result, their concepts and acceptance on breastfeeding strengthened. Though becoming a baby-friendly hospital is not an easy process, we hope that the fun and learning could ease our staff's stress in this long journey.

Editorial Comments

It is evident that babies who are breastfed exclusively for their first six months of life are less likely to suffer from gastroenteritis, eczema and asthma. Women who don't breastfeed have increased risk of developing breast cancer and ovarian cancer. To uphold the International Code of marketing of breast-milk substitutes, free or low-cost supplies of substitutes, promotional material, sample gift packs should not be permitted in hospitals. Pregnant women should not receive materials that promote artificial feeding in hospital setting. Feeding with breast-milk substitutes should only be demonstrated by healthcare professionals, and only to pregnant women, mothers, or family members who really need to use them. All the above are considered the responsibilities of hospital administrators.

Dr N C Sin
Chief Manager (Patient Safety & Risk Management), HAHO

CLUSTER SHARING

New Territories West Cluster

"If you can't measure, you can't improve" Why do we measure serious clinical deterioration (SCD) rates in an acute general hospital?

*By **Dr Jasperine HO,** Project Lead, Quality and Safety Division, New Territories West Cluster*

Timely detection and management of clinically deteriorating patients could save lives. Two-third of patients showed identifiable signs of deterioration within 6 hours of cardiac arrest (Schein, Hazday, Pena, Ruben & Sprung, 1993). Some hospital deaths could be prevented if these telltale signs are recognized early and acted upon appropriately.

Different hospitals and clinical departments have different response mechanisms to manage deteriorating patients. There is no universally accepted clinical indicator (CI) to reflect the performance of these response mechanisms. We developed four CIs that allow managers and clinicians to monitor the performance at hospital and departmental level longitudinally. When the CI goes beyond the control limits on the control charts, effort should be made to identify possible reasons for the potential special cause variation(s). Changes in the slope and mean could reflect any meaningful effects on the improvement works implemented. Moreover, the 4 CIs could be applied further and act as a trigger to initiate clinical audit cycles targeting on identified clinical problems and monitor the effectiveness of clinical improvement measures.

Four CIs were derived based on the scientific statement from the International Liaison Committee on Resuscitations with adjustment made according to local situations. (Peberdy, 2007)

Rates are reported in acute inpatient general wards per 1,000 hospital admissions. Thirty-month data has been accumulated, a downward trend in death without DNACPR is observed while the total number of death is fluctuating in phase with the winter surge pattern. This could be attributed to the effort of promulgation and staff compliance on the corporate DNACPR guideline which improves the end-of-life care of the patients. Death without DNACPR rates were above the control limits in January & February of 2014 with half of these patients died of cardiopulmonary diseases. Significant efforts have been spent on increasing the flu vaccination rate on susceptible patients as well as winter surge response strategies in our cluster. We are waiting to assess the effectiveness of these clinical improvement measures which are going to be reflected in the coming SCD rates. In summary, SCD is a new clinical governance tool to monitor the performance of clinical teams in treating acutely deteriorating patients and effectiveness of clinical improvement measures.

1. Rate of death without do not attempt cardiopulmonary resuscitation (DNACPR)
2. Rate of cardiac arrest without DNACPR
3. Rate of unscheduled ICU consultations
4. Overall CI is the composite rate of the above

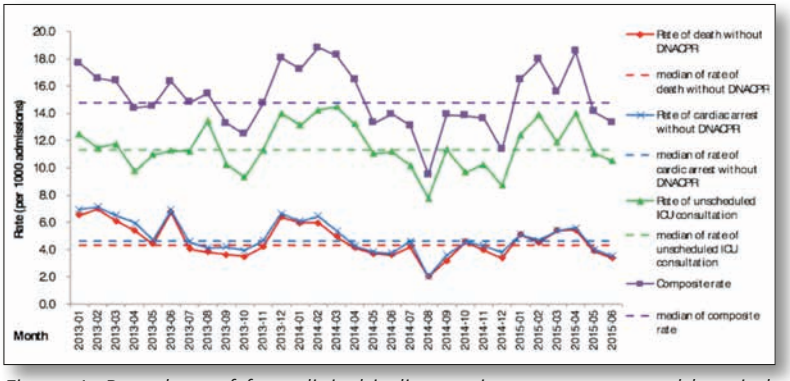


Figure 1: Run chart of four clinical indicators in an acute general hospital, Jan 2013- June 2015.

Editorial Comments

Clinical Indicator can contribute to improvement on quality of care. Yet, measurement per se is subject to debate and does not provide definitive answer for quality improvement. SCD is being employed to identify service gaps and to improve healthcare outcomes in an acute hospital. We are looking forward to seeing how the data is used and acted upon, and most importantly, how it leads to quality improvement.

Dr Rebecca Lam
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CLUSTER SHARING

Hong Kong West Cluster

System Evaluation of Reported Adverse Events – a 10-year review, from 2007 to 2016

By Quality & Safety Department, Hong Kong West Cluster

System Evaluation of Reported Adverse Events (SERAE) is a team-based, systematic, and proactive technique that is used to prevent process problems by analysing adverse events reported and described in other hospitals. The Queen Mary Hospital has been conducting SERAE since April 2007. The Hong Kong West Cluster hospitals have joined in since 2010. Up to December 2015, 79 SERAE have been conducted.

As a result of SERAE, more than 40 improvement initiatives were implemented. The five significant initiatives implemented in the past two years are:

1. Worked out the logistics for neutropenic fever or severe septic patients to receive empirical intravenous antibiotics as early as possible with door-to-antibiotic time within one hour.
2. Strengthened the practice of pre-assembling at least one resuscitator in clinical areas with emergency trolleys and conducted drills to prepare for a similar scenario.
3. Strengthened the identification of strangers and enhanced security in clinical areas.
4. Replaced the suboptimal model of cold room alarm system in Queen Mary Hospital and performed regular drill on handling of alarm activation of Tung Wah Hospital, Grantham Hospital and Duchess of Kent Children's Hospital Blood Banks.
5. Rechecked the current reference ranges in Clinical Biochemistry, Haematology, Immunology and Transplantation and Immunogenetics laboratories. Implemented checking new tests / reference ranges by two staff.

Studying other hospitals' reported adverse events has helped Queen Mary Hospital and Hong Kong West Cluster come up with SERAE, the first-of-its-kind quality system in the world, to improve health care services. SERAE has proven successful in raising staff awareness on various adverse events occurring elsewhere as well as preventing or reducing identified risks on an ongoing basis. It serves as an effective continuous quality improvement activity for any organization to mitigate unanticipated risks.

Editorial Comments

Learning from other's experience for improvement sounds sensible especially considering the fact that HA hospitals to a certain extent share "common" risks due to similarities in system set up and corporate culture. SERAE successfully weaves common sense and good habits into a good system in order to ensure such learning happens consistently and systematically. It should complement nicely with other learning and sharing initiatives such as the "HA Staff Forum for Sharing on SEs & SUEs" by building a sustainable local implementation arm.

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