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SMART TEL (Telephone Enquiry Logistic) - SOPD Communication System

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Handling patient feedback and enquiries are important issues and responsibilities in the Specialist Outpatient Department (SOPD) of United Christian Hospital. All in-coming calls had been handled by the telephone enquiry team (TET) since 2009. Telephone enquiries on health conditions/ medications are documented by clerical staff in the logbook and sent to relevant clinics for professional advice on an hourly basis. The following logistic problems have been identified in the telephone enquiry process:

1) Potential delay for two hours or to the next day in handling enquiries by nurses because of hourly round.
2) Potential patient data security risks during transportation of logbook.
3) Difficulty for staff to trace enquiry process.

Based on the SMART ideas, SOPD had created a web-based communication platform (SMART TEL) with the help from IT Department to alleviate the problems. With SMART TEL, clerical staff could input enquiry details and clinic nurses could retrieve enquiry records directly from the system without a logbook. All interventions could be documented and traced real time.

The benefits of using SMART TEL are that SOPD staff could now handle 500 enquiries daily. Response time is reduced from more than two hours or days to within minutes. Patient data is protected as the system is secured by individual login. Staff can easily trace the enquiry progress and respond timely. With proven success, SMART TEL has been extended to the Patient Relations Office to facilitate the handling of patient complaints.

SMART TEL has effectively improved both the patient experience and staff's efficiency in telephone enquiries. When presented at HA Convention 2016, this project won the "Best Oral Presentation Award". With its many benefits, it is planned to further extend SMART TEL to Pharmacy for provision of additional pharmaceutical advice to patients.

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SMART Ideas	
S	***Security on patient data handling***
M	***Multi-department collaboration***
A	***Assurance of no case missing***
R	***Responsiveness***
T	***Tracking***

In This Issue:

Editorial Comments

Right from the start, the project team was clear about its work focus - to respond to patients' enquiries in a timely and efficient manner. The team had examined the whole telephone enquiry processes in detail and had identified inefficiencies and problem areas. Putting on colleagues' SMART thinking hat, a simple web-based tool was created to improve telephone enquiry service with remarkable results. In a way, this is more than just a performance improvement program as it has also nurtured a team of happy staff who has excelled in their mission. I certainly hope that the hospital will further roll-out this project with a view to improving its health services which is developing all the time. Congratulations to the team!

Dr Rebecca Lam
Chief Manager (Clinical Effectiveness & Technology Management), HAHO

Can We Try to Reduce Food Wastage?

By ***Mr Calvin Chan, Ms Vivien Tang, Ms Flora Ng, Ms M F Fu, Ms K Y To, Ms Helen Leung, Mr W K Chau, Ms Vienn Kong, Ms Tsang Man Ling, and Ms Suen Yuen Kan***
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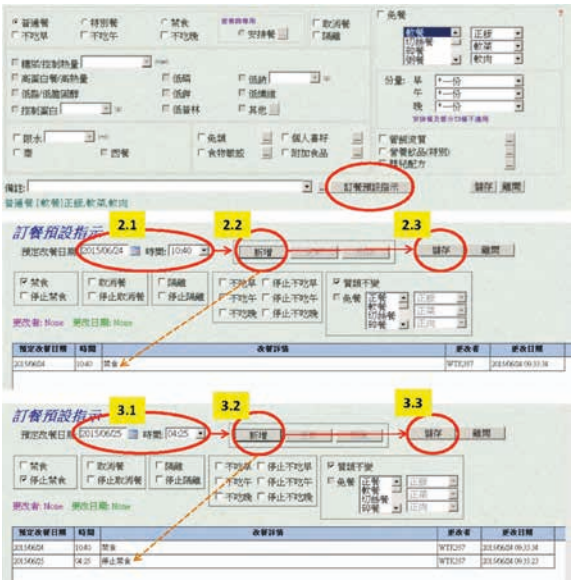
Food wastage nowadays is a global problem. According to the United Nation Environment Program (UNEP), roughly 1/3 of foods produced in the World including USA and UK get lost or wasted. In Hong Kong, around 3200 tons of food, equivalent to 120 double decker buses, is sent to landfill every day. For Day Ward (DW) and Day Surgery Unit (DSU) of Pok Oi Hospital (POH), an average of 26% of patients' food had been wasted. Hence, an improvement program for food wastage management was conducted in collaboration with our Department of Ambulatory Services Centre (ASC), Department of Operating Theater (OT) and Hospital Food Services of Administrative Service Division (HFS) with a view to minimizing food wastage and enhancing patient satisfaction.

In this improvement program, an easy-to-read "Menu" of commonly available foods in Hospital was set in DW and DSU to offer patients the choice of food according to their appetite and taste preference on admission. With the collaboration of HFS, refresher training on the use of Dietetic and Catering Management System (DCMS) was given to both nursing and clerical staff. The cut-off time for meal ordering was modified to facilitate the timely update of meal orders for patients.

Pre- and Post-program evaluation study revealed that (i) the average percentage of food wastage in Day Surgery Unit and Day Ward were sharply reduced by 92.3% (from 26% to 2%); (ii) patients' percentage of "excellent" rating for overall satisfaction was increased by 6.5% (from 31% to 33%); and (iii) staff's comments were positive as "great gain was made with little effort".



Step 1:
按訂餐預設指示

Step 2:
選擇開始禁食時段，然後按新增並儲存，指令隨即生效。

Step 3:
選擇結束禁食時段，按新增並儲存，指令隨即生效，然後重新訂餐。

Editorial Comments

Hospital Authority (HA) hospitals generate relatively high quantities of food waste. In view of this, some HA hospitals have already adopted measures such as minimizing food-waste generation and implementing food recycling strategies to reduce food wastage. POH's improvement program, which included strategies such as having menu choice for patients and a good meal ordering system, has proven to be effective in reducing food wasting and was widely accepted by both the staff and patients.

Ms Karen Mak
Senior Manager (Allied Health), HAHO

Diabetes Education by Experience to Hospitalized Patients – a Pilot Study in the Accident and Emergency Department Ward, Queen Elizabeth Hospital

*By **Ms Winnie Cheng**, Department of Medicine and **Dr Y W Tsang**, Department of Pathology, QEH*

Despite the busy and crowded environment of the general Accident and Emergency Department wards, QEH ward nurses have successfully demonstrated in this pilot project that with relevant training, education and support from diabetes specialists, they could provide timely and effective training to hospitalized diabetic patients admitted because of hypoglycemia. The project was partly inspired by the "Adult Learning Principles" which stipulated that people learn more effectively from their immediate experience. As such, training in diabetes may be more effectively delivered to patients in the ward because of their immediate past experience of hypoglycemia leading to admission.

After receiving targeted education and training from the Diabetes Nurse Consultant, 10 participating nurses in this pilot project reflected that there were significant improvements in their confidence, competence and willingness to engage in bedside diabetes patient training (mean score of an eight-item Satisfaction Survey was 3.3 out of 4). Apart from continued post training support provided by the Consultant, three face-to-face group meetings and education pamphlets were provided to participating nurses to facilitate patient training.

Post–education evaluation comprising two telephone follow-up (at day 2-4 and day 28-30 post discharge) was conducted to assess knowledge reinforcement. Out of the 309 patients (mean age 74.8 years, range 25-91 years) receiving such bedside training from April 2014 to March 2015, 180 (59%) completed the evaluation. All respondents were very satisfied with the education received (satisfaction survey mean score 8.35 out of 10).

"Providing diabetes education to hospitalized patients by ward nurses" – Project Team Members

Educational materials for ward nurses to provide diabetes education to hospitalized patients

Patient's Satisfaction Survey N=180 (59%)	**Score 0-10 0 - not satisfied 10 - very satisfied**
1. The educational **information** provided by the ward nurses was **useful** in preventing hypoglycemia	8.5
2. The ward nurses enabled me to **understand the reason** for this **hypoglycemic** attack	8.0
3. The ward nurses **explained clearly** to me on the DM treatment **before discharge** and follow up arrangement	8.5
4. The ward nurses **enhanced my confidence** in caring for my own diabetes and preventing hypoglycemia	8.4

Editorial Comments

In pursuit of competent workforce and quality service, equipping our frontline colleagues with the necessary knowledge and techniques, as in this QEH pilot project, not only help us achieve such goals, but also facilitate educating patients in self-managing their health conditions in the community. The encouraging results from this pilot study further demonstrate the significance of staff training in enhancing service quality and patient satisfaction.

Ms Susanna Lee
Manager (Nursing) and Chief Nursing Officer, HAHO

Safeguarding Unintentional Repetition of Drug in Clinical Management System Medication Order Entry (CMS MOE)

*By **Dr Joyce Chan**, Health Informatician, Information Technology and Health Informatics Division, HAHO*

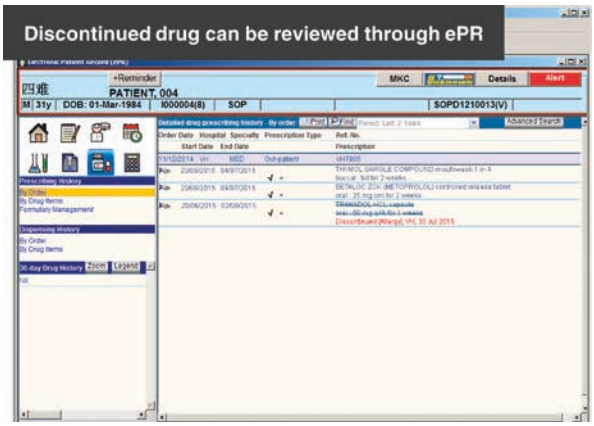
There were a number of medication incidents related to unintentional repetition of drugs during transition of care.

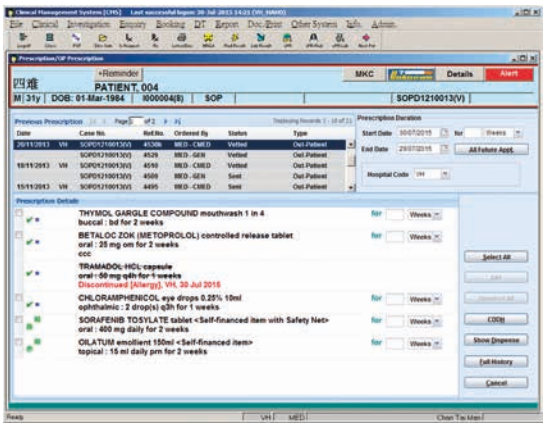
In this improvement project to safeguard against unintentional repetition of drugs, when a doctor has decided to discontinue a particular drug explicitly due to whatever clinical reason, the corresponding drug item in the previous prescription history is allowed to be marked "discontinuation" in the HA CMS MOE. The drug item with strike-through effect and reason for discontinuation would be shown in both MOE and ePR. The corresponding drug item would not be allowed to be repeated automatically in the next consultation or during transition of care. Moreover, the discontinued drug item in all CMS printout with all medications included would also be shown with strike-through effect. Since the explicit discontinuation of medication in CMS MOE was enabled in November 2015, a total of 1670 drug items was so marked as of 25 April 2016.

Cases for illustration:

1. Patient with multiple medical problems:
   Patient presented with retrosternal chest pain with cardiac catheterisation done in August 2015 was managed by family physician (FM). Elantan, which was prescribed by FM on last FM follow-up (25 June 2015), was taken off and changed to ACEi by cardiologist. The cardiologist had explicitly discontinued Elantan in the CMS MOE to safeguard against the FM from repeating Elantan during the next FM follow-up.

2. Patient with percutaneous cardiac catheterisation (PCI):
   The treatment plan was for the patient to have one-year course of Clopidogrel. Accordingly, Clopidogrel was marked "discontinued" in the CMS MOE after the course completion in order to prevent unintentional repeat prescription in subsequent follow up.





Editorial Comments

There is a wise saying: "Little drops of water can be transformed into a river or ocean". Marking "discontinuation" in MOE seems to be a "simple" measure but can significantly improve outcome. More importantly, mitigating the potential risk of unintentional repetition of drug promptly can prevent actual medication incidents from recurring. To maximize its beneficial effect, it is imperative to promulgate this improvement initiative to our frontline doctors and let it become our habit in prescribing.

Dr K H Lau
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