HA Quality & Risk Management Annual Report

(Apr 08 - Mar 09)

Patient Safety & Risk Management Department

醫院管理局
HOSPITAL AUTHORITY

ACKNOWLEDGEMENTS

Patient Safety and Risk Management Department thanks all the frontline colleagues, Hospital risk managers, hospital and cluster Quality and Risk Management Department, hospital executives for their ongoing contribution to the risk reduction strategies and programmes.

Content Page

INTRODUCTION

This HA Quality and Risk Management Annual Report, is a collection of vast efforts in improving patient safety from frontline colleagues, hospital management, hospital Quality and Risk Management Department, cluster executives and the Patient Safety and Risk Management Department.

2. To further enhance patient safety; HA will be working with the hospital management and frontline colleagues on the following measures:

(a) Risk Reduction Programs to Reduce Surgical Errors:

(i) The "Surgical Safety Policy" was implemented on 1 June 2009. By using a surgical safety checklist, it aims at ensuring correct patient receiving a right operation at the correct site. The checking processes are to be performed in three phases: (1) a pre-anaesthetic safety check to ensure the best preparation of instruments, equipments, and monitoring devices; (2) a time-out process which is a pause just before the commencement of the operation to confirm the correct patient and operation; and (3) a post-anaesthetic safety check to assure correct count and integrity of equipment and consumables, as well as correct specimen has been sent out.

(ii) An audit on compliance check is scheduled in 2010 to ensure consistent use of the checklist in the operation theatre.

(iii) The checklist could also be applied to other invasive procedures like bronchoscopy, endoscopy, radiotherapy and cardiac catheterization. These checklists will be issued and adopted in 2010 for the above procedures.

(b) Risk Mitigation by Improving Communication

Communication breakdown remains as the most important and commonest cause for a SE. It is essential to enforce the concept of team work and facilitate effective communication

amongst the team. Training on Crew Resource Management (CRM) was introduced as a pilot program to our colleagues in the Pamela Youde Nethersole Eastern Hospital. It adopts the training framework for the pilots and crew in the aviation industry. There are also positive evidences of improving patient safety in various clinical settings like in intensive care unit, operation theatre and during trauma care. It aims at developing cognitive and interpersonal skills which are essential for effective interpersonal communication, leadership, and decision making.

3. Further measures and activities will be introduced to enhancing patient safety, which includes:

(a) Implementation of the Sentinel and Serious Untoward Event Policy so as to further strengthen the reporting, management and prevention of serious adverse events.

(b) Evaluation of the implementation of "Surgical Safety Policy" to ensure sustainable reinforcement of surgical safety and communication among multiple disciplines involved in operations.

(c) Use of the checklist in interventional suite and ward for enhancing patient identification and ensuring correct procedures at correct site in different procedures.

(d) To promulgate the "Crew Resource Management" through a structured program and training for improvement of communication among healthcare professionals.

4. The report represents coordinated works and efforts of frontline colleagues, hospital management, hospital quality and risk management department and cluster executives. Their contributions to the system changes resulting in further improvement of patient safety during the care delivery processes are well acknowledged.

QUALITY AND RISK MANAGEMENT REPORT

Annual report for 12 months ending at 31 March 2009

OVERVIEW OF QUALITY AND RISK MANAGEMENT ISSUES

Clusters' Report

HKEC	HKWC	KCC	KEC	KWC	NTEC	NTWC

HKEC

OVERVIEW OF QUALITY & RISK MANAGEMENT ISSUES

1. Structure

2. Building Clinical Leadership and Knowledge

2.1 New Appointments of Panel of Nurse Specialists

A **Panel of Nurse Specialists** has been appointed in November 2008 with a view to enhancing nursing input in incident review and safety initiatives. The nurses are at the ranks of DOM/SNO, WM/APN/NO and RN.

2.2 Review of Appointments of Clinical Leaders

Following the end of the two-year term of the first **Cluster Service Director (Q&RM)**, a new Director was appointed in August 2008 to take on the leadership role with a view to achieve a diversified clinical participation and buy-in.

To offer more training opportunities for clinical staff in incident review, complaints / incident management and quality initiatives, the cluster management has reviewed the appointments of **Department Q&RM Coordinators** and **Panel of Specialists** in October 2008. Amongst the 33 Coordinators and 43 Panel Specialists, 9 and 23 will be newly appointed respectively with effect from 1 January 2009, whilst the rest will be re-appointed to continue their efforts in driving quality and safety.

3. Enhancing Capabilities in ensuring Quality System

To further enhance the capabilities of management staff in maintaining quality system, 3 clinical, nursing and administration at management level were sent for ACHS surveyor training between June and October 2008.

4. HKEC Annual Plan Program 08/09

The Annual Plan Programs 08/09 were accomplished as follows:

4.1 Correct Patient Identification Campaign

Correct Patient Identification Campaign has been launched to reinforce safety culture so that treatment and care are delivered to the right patient at all times. Apart from Campaign activities like kick-off ceremony, slogan competition and quiz, well-designed souvenirs like staff identity card holders, lapel pins and calendar posters are produced and distributed to frontline staff.

The following **system and policy** have been put in place:

(a) **Shift-over of Unique Patient Identification (UPI) from 1D to 2D barcode technology** in blood transfusion and dead body identification were completed in March 2008.

(b) **Team time-out policy** in operating theatres and procedure areas like endoscopy units, cardiac-catherization laboratories, interventional radiology unit, day wards of surgery and obstetrics & gynaecology as well as electro-convulsive treatment in psychiatry has been fully implemented in May 2008.

4.2 Clinical Handover System

To improve quality of care for patients with unstable or critical condition, PYNEH has started to roll-out by phases a standardized **clinical handover system** based on **Modified Early Warning Scores** (MEWS) with the application of **Situation-Background-Assessment-Recommendation** (SBAR) as communication tool.

Month/ Year	**Phase**	**PYNEH Specialty ward**
April 2008	1st Phase Pilot	– Surgical: one admission ward – Medicine: two acute wards
September 2008	2nd Phase Pilot	✧ Departments of Surgery, Medicine, Oncology and Orthopaedics ✧ Gynaecology wards – Emergency Medicine Ward
March 2009	Full implementation	– All wards where MEWS is applicable (i.e. excluding Obstetrics, Paediatrics)

4.3 Credentialing Framework and Scope of Practice System

To ensure **health care services are provided by competent staff**, a structured model of **clinical proctorship program** is designed for common procedures. Skills of trainees are reviewed by qualified trainers according to pre-defined skills/ techniques and specified number of cases performed.

4.4 Outcome of Care and Performance Effectiveness

A **system of monitoring on outcome of care and performance effectiveness** is established through **regular reporting on Key Performance Indicators (KPIs)** by clinical departments. The first regular report on agreed KPIs was issued for the period October 2008 to

31 March 2009.

5. HKEC Annual Plan Program 09/10

Based on the priority risks identified through a bottom-up approach and departmental input, Annual Plan for 08/09 has been drawn up as follows:

5.1 Single Use Device

Subsequent to the identification of SUD critical items, HKEC has phased out the re-use of ophthalmic knives since September 2008. Priority has been set to **regulate the reuse of at least 8% of the critical items** in 3Q09 and the rest according to resources available.

5.2 Correct Patient Identification Campaign

While the Campaign will continue in 09/10, the following systems will be further rolled-out:

(a) **Team Time-out** process for bed-side interventional procedures requiring written informed consent from patients.

(b) **2D barcode technology** in blood and non-blood sampling.

5.3 Clinical Handover System

Phased implementation of MEWS and SBAR in **clinical handover communication** will be rolled out to all HKEC hospitals in 09/10. **Evaluation** will be conducted on the effectiveness of the system. Meanwhile, **protocol-driven guidelines** will be drawn up to facilitate nursing staff in acute management response of frequently encountered clinical conditions (e.g. fever, low blood sugar).

5.4 Prevention of Patient Suicide

A **multi-disciplinary approach** will be adopted in preventing in-patient suicide. This will be facilitated through enhanced training and education of staff on **suicide assessment** and appropriate **follow-up and interventional management** by 4Q09. **Improvement works** will be done in high risk areas with a view to prevent suicide **within the hospital compound**.

5.5 Surgical Safety

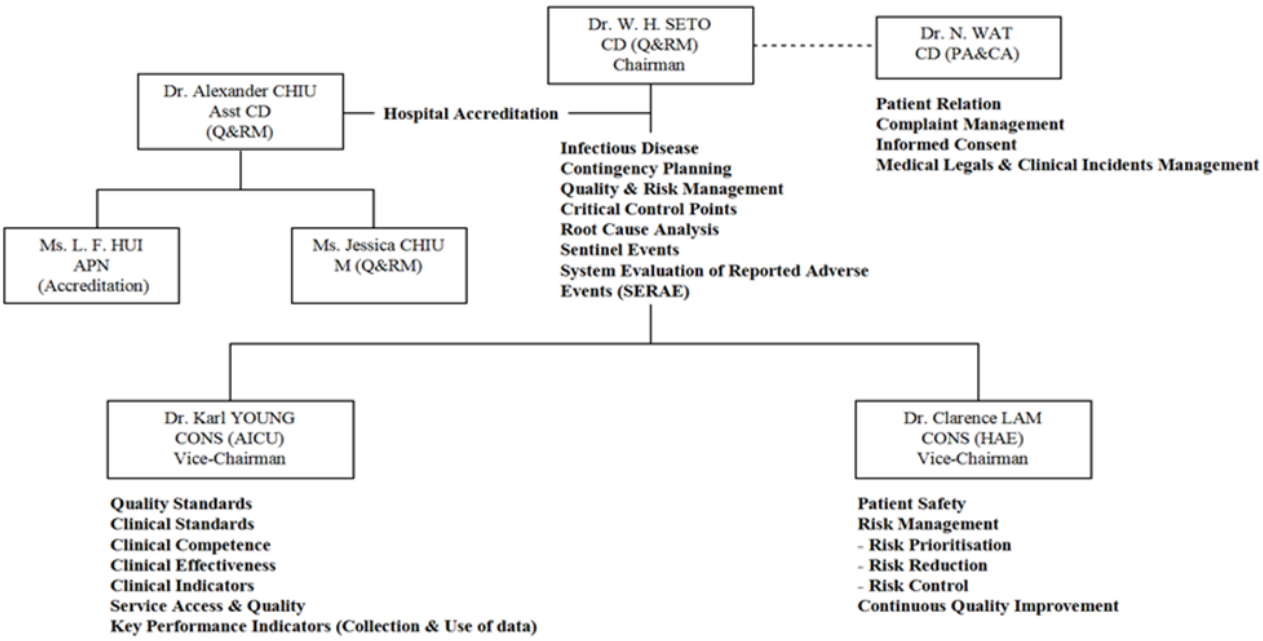
To re-enforce safety checking and better communication amongst clinical various disciplines in surgical procedures, a **system of checking before and after surgery** will be implemented to cater for operative/ interventional procedures performed in operating theatre in 09/10.

HKWC

OVERVIEW OF QUALITY & RISK MANAGEMENT ISSUES

1. Structure

Organization Structure of the Hong Kong West Cluster Quality & Risk Management (13 August 2009)



2. Ongoing Safety Projects

2.1 Data Security

(a) Survey on Clinical Management System (CMS) logged on when unattended was conducted in May 2009. 2.71% (6) of the CMS was found logging-on but leaving unattended.

(b) Bags for records were fully utilized and notice was posted at all Clinical Management Station.

(c) Audit of compliance usage of guideline would be conducted in 2Q 2010.

2.2 WHO Safe Surgery Checklist

It was successfully implemented in Operation Theatre Services, Endoscopy Unit and Department of Psychiatry for Electro-convulsive Therapy (ECT). It aimed to extend to other procedures. Continued evaluation would and conducted.

2.3 Enhancement of laboratory specimen labeling and reporting

(a) "Clinic Contact Information Update for reporting Laboratory Critical/Panic Result" was revised and updated on 20 July 2009 for ensuring the panic laboratory results prompt reporting within 24 hours. Designated reporting point had been established for all departments.

(b) 2D barcode for other specimens would be implemented in 1Q 2010.

2.4 Improve safety of High-alert, Look-alike and Sound-alike medication

(a) Examining for any stock of concentrated electrolytes in general wards – 98.53% compliance. Repeated survey of outliers – 100% compliance.

(b) Adhering to guidelines for storage in the critical and approved areas – 78.6% compliance. Repeated survey of outliers – 100% compliance.

(c) Adopting "TALLman" lettering in ward top-up cabinet for LASA drugs – 100% compliance.

2.5 Prevent Medication Errors due to inadequate Drug Reconciliation

(a) Piloted Drug Reconciliation successfully in ward B2 with more than 1400 patients in nine months.

(b) Positive feedback received from ward staff.

(c) Clinical Pharmacist to review patients' medications was implemented in 7 call wards (6 in Department of Medicine and 1 in Department of Surgery).

(d) 7174 patients' drug charts reviewed (~80% of all admitted patients).

(e) 1031 unintentional prescribing discrepancies identified.

(f) 725 pharmaceutical interventions made.

(g) All these discrepancies and interventions could lead to adverse drug events if un-attended.

(h) 1031 + 725 = 1756 ADEs prevented! (~22% of all drug charts reviewed).

2.6 Obligatory Physiological Activities Round (OPAR)

(a) Develop two hourly round job assignment for support staff.

(b) Briefing on the purpose and guidelines to all nursing and support staff.

(c) Highlight sustaining factors.

(d) Support and compliance of frontline staff.

(e) Safety culture: 巡查助起居，注意安全做得對.

(f) Review and communicate to clarify issues and solve problems.

(g) Provide clear and focus information and instructions by supervisors. Falls further decreased from 245 (2007) to 202 (2008) to 182 (2009.

2.7 Promote Hand Hygiene Program

Promoted in QMH with overall compliance rate of 70%. Department of PAM achieved

93%.

2.8 Enhance Patient Assessment

Modified Early Warning Sign (MEWS) was piloted successfully in Department of Orthopaedics and Traumatology. It would be rolled out in other departments.

2.9 Implement Clinical Pathways

(a) Clinical guideline on Acute Stroke implemented in Dec 2008.

(b) End-of-life Care pathway was piloted in Clinical Oncology Department in August 2009.

(c) Possibility of piloting clinical pathways in other diseases/ specialties would be explored.

2.10 Reduce Acute Respiratory Diseases (ARD) outbreak in hospital

ARD cubicles have been implemented in all medical call wards.

2.11 Reduce medication errors and explore use of 2D barcode for drug administration in the wards

(a) Piloted unit dose in private ward and Department of Psychiatry.

(b) Exploration the possibility of piloting in other departments, e.g., pediatric department and TWH.

3. Comment on Performance / Improvement since Last Report

3.1 A total of 8 System Evaluation of Reported Adverse Event (SERAE) and 16 Continuous Quality Improvement (CQI) Projects were conducted.

3.2 Procedures in handling of abortus fetus, stillbirth and deceased infants were reviewed.

3.3 Procedure and carrier for transporting of blood/blood components were reviewed and updated.

KCC

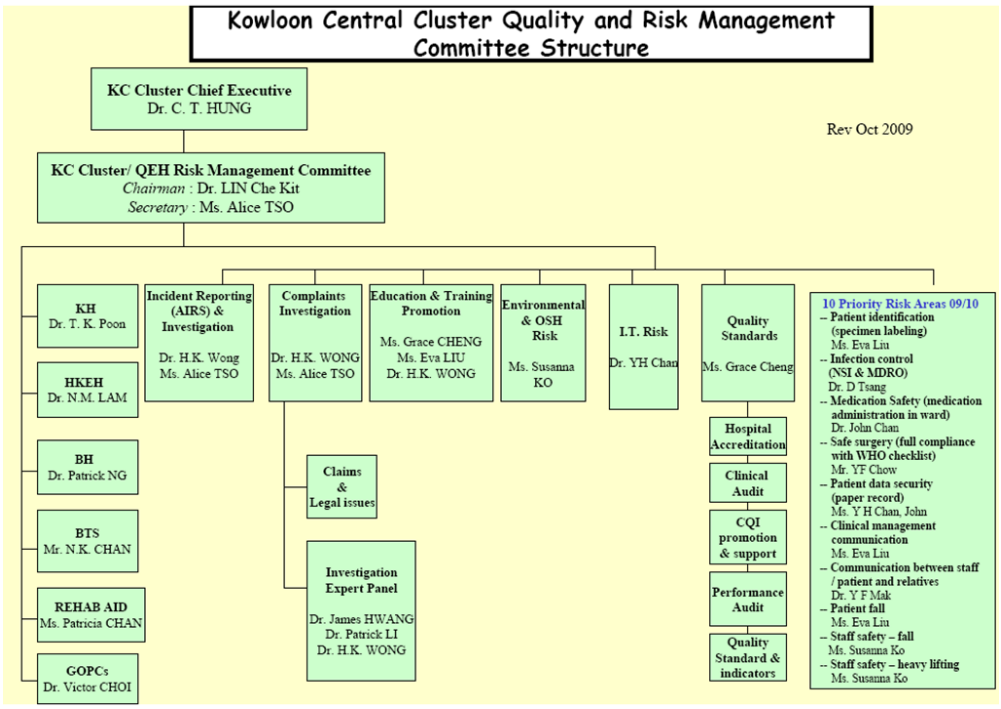
OVERVIEW OF QUALITY & RISK MANAGEMENTS ISSUES

1. Structure

In accordance with the HAHO's Quality and Risk Management structure, we have streamlined ours as follows:

1.1 QEH quality and risk management function was taken out from the KCC Quality and Risk Management Committee (Q&RM) and formed its own Hospital Quality and Risk Management Committee. Likewise, all hospitals and institutions in KCC were requested to establish its own function and regularly reported back to the KCC Q&RM Committee. In reorganizing its structure, KH had appointed a Senior Medical Officer as its Director Quality and Risk Management.

1.2 KCC Risk Officers were renamed as Quality and Safety (Q&S) Officers to reflect their expanded role to cover both quality and risk management in their workplaces. QEH had in addition appointed Departmental Q&S Coordinators who would take responsibility of all Quality and Safety matters in their respective department, with support of the Q&S Officers of their own department.



2. This report covers the period from 1 April 2008 to 31 March 2009, during which KCC had put a lot of effort to enhance service quality and patient safety. Subsequent to the KCC Quality and Risk Management Committee endorsement to designate 2008/2009 as Year of Patient Safety in May 2008, a series of program had been organized. In addition, we continued our effort in the risk reduction programs, in particular our top ten risks including patient fall, reuse of single used devices (SUD), informed consent, patient data security, patient restraint, central line insertion, use of infusion devices, and staff injury due to manual handling. Our goal was to minimize the occurrence of adverse incidents to patient and staff, whilst promoting the culture of patient and staff safety.

2.1 Asia-Pacific Business Excellence Standard award

In January 2009, QEH had decided to go for the Asia-Pacific Business Excellence Standard award with the aim to identify both the strengths and the areas for improvement through the application of criteria by self assessment. Twenty-two training sessions on the European Quality Award (EQA) criteria were planned throughout the year. The process will also help QEH to prepare for the future hospital accreditation.

2.2 Year of Patient Safety

The Year 2008/2009 has been designated as KCC Year of Patient Safety. The aims are: i) to enhance staff's awareness on patient safety; ii) to involve patients/relatives as partners in management following serious adverse events; iii) to implement risk reduction strategies to reduce clinical risks, and to minimize damage and severity of incidents; iv) to recognize staff's

effort on risk reduction by publicizing the strategies to patients and the community.

The Year of Patient Safety was officially kicked off on 10 September 2009 in a Ceremony celebrating the 45th anniversary of QEH. Summarized below are the activities organized specifically for the Patient Safety Year:

(a) KCC Patient Safety Strategic Planning Workshop

The workshop was held on 18 October 2008 with participation of senior staff of the Cluster. Strategic directions were identified at the Workshop, which encompassed management structure, communication, staff training and building a patient safety culture. A follow up meeting was held on 1 December 2009 to consolidate the action plan.

(b) Enhance communication among clinical staff and among staff and patient

A task force on Enhancement of Clinical Management Communication was formed in September 2008 for the implementation of SBAR (Situation, Background, Assessment, and Recommendation) technique for internal communication among clinical staff. In addition to the series of trainings for KCC nurses, a laminated SBAR colored chart was distributed to all clinical wards to promote SBAR practice. Moreover, QEH had revised its Patient Transfer form to improve inter-department communication in relation to patient transfer.

A working group on Communication And Relationship between Patients and Staff (CARPS) was formed in October 2008 with the objectives to: i) develop a concern, caring and respect culture; ii) create a harmonious relationship between staff and patient / relatives; iii) enhance communication between staff and patient / relatives. Since establishment, the working group had organized seminars, staff training, and a webpage. A book and video to promote better staff / patient relationship were also planned.

(c) Enhance Risk Communication

QEH had piloted 4 Clinical Incident Management Teams (CIMT) in Department of Clinical Oncology, Department of Anaesthesia and OT, Intensive Care Unit and Department of Paediatrics respectively. Each CIMT is responsible to provide systematic, comprehensive and quality assured approach to communicate with patients/relatives involved in a serious adverse incident. It aims at managing the downstream events effectively to reduce potential damages, litigation and undue publicity. Prior to launching, every CIMT member received training on open disclosure, conflict resolution, handling media and how to master adverse outcome without compromising hospital’s legal position. A one-day retreat workshop was also conducted to build

up their inner strength.

To promote sharing and learning of patient safety related information, an electronic patient safety (ePS) bulletin has been launched since November 2008. The ePS bulletin is issued via email every other Friday, aiming at providing an additional channel for the dissemination of clinical risks alerts to staff who are also invited to share their experiences and thoughts.

(d) Enhance Staff Training on Quality and Patient Safety

During the year, the following staff trainings were organized:

- risk reduction on the identified risk areas including infusion pump safety, use of oxylog portable ventilator in intra-hospital transportation of critically ill patient, patient documentation etc.,
- risk and quality management tools, communication skills for front-line staff,
- overseas surveyor training to prepare for hospital accreditation.

In addition, a structured Quality and Risk Management orientation program was also organized for the newly recruited staff.

(e) Building a Patient Safety Culture

A survey was conducted to assess the patient safety culture in the Cluster and identify areas for improvement. Results of the survey were shared with staff in QEH Hospital Operations Meeting.

Patient safety rounds were continued regularly to promote patient safety culture. During the round, the identified risks and risk reduction strategies of the concern department were reviewed and the Risk Register updated. Through this activity, staff awareness of patient safety is expected to be enhanced.

To build a patient safety culture, staff is encouraged to speak up and report not only incidents via AIRS but also near miss cases by email or phone to the Risk Manager.

The KCC Quality and Safety Bulletin has been increased from 3 to 4 issues per year. It is also available in the KCC Quality and Risk Management website.

(f) Risk Officers Projects

During the year, all Risk Officers (which now renamed as Q&S Officers) were invited to

initiate patient safety project(s) in their workplaces. More than 25 projects were received. Selected projects were shared in the quarterly Risk Officers meetings and published in the Quality and Safety Bulletin.

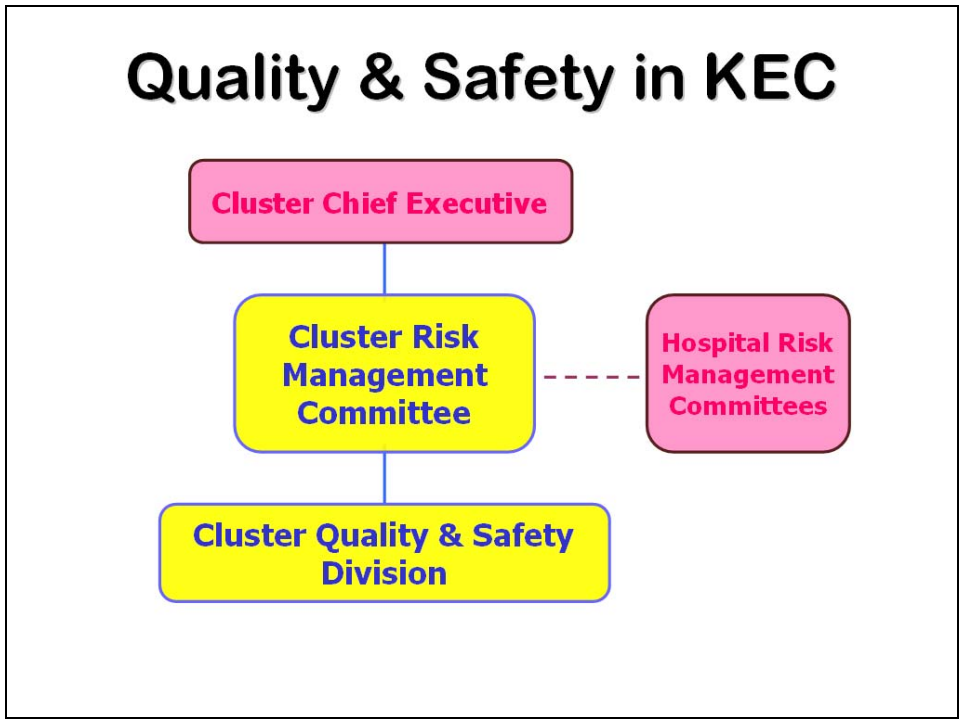
(g) Patient Safety Pledge

To manifest our commitment to protect patient safety, KCC has formulated Patient Safety Pledge (App. 1) which was formally signed by the Cluster management team including Hospital Chief Executives and Cluster General Managers, with the presence of patient group representatives and community partners, during the KCC Convention on 16 January 2009. The copies of the Pledge would be posted up at the prominent areas in all hospitals / institutions in the cluster.

KEC

OVERVIEW OF QUALITY & RISK MANAGEMENTS ISSUES

1. Structure



2. The Kowloon East Cluster has endeavored to develop a robust, interactive and transparent system in monitoring its service quality and managing various risk areas. There is an integrated structure in overseeing the risk management system. At cluster level, the Cluster Risk Management Steering Committee focuses on the following areas:-

2.1 Formulate and advise cluster management on patient safety and risk management policies.

2.2 Promote an open, just, reporting and learning culture in cluster.

2.3 Identify, assess and prioritize risks in order to develop a cluster-wide risk register.

2.4 Enhance communication and sharing among front line staff, hospital & cluster management and HAHO CCQRM.

2.5 Collaborate on activities and training related to risk management.

2.6 Align cluster practice and guidelines for improving the management of common risks.

2.7 Promote standards of the Hospital Authority as an annual planning tool.

At hospital level, the risk management committee of the cluster hospitals is charged with managing the various risk-related issues, delineating risk reduction measures and identifying room for learning and improvement. There are also various sub-committees / sub-groups in managing local or specific risk areas. These integrated efforts and structure assure the risk management activities are organized and coordinated on an effective manner.

The policy of open and just culture is also in place to encourage reporting on adverse events and medical incidents, so that risks of all kinds can be systematically identified, analyzed and managed.

Comparing the incidents trend report between 07/08 & 08/09, the total number of reported incidents had been increased from 1,884 to 1,932. On severity of the reported incidents, the ‘actual outcome’ of incidents reported under ‘major’ & ‘extreme’ categories had experienced a mild downward slope. All the reported incidents are subject to aggregate review for identifying trends and other performance information.

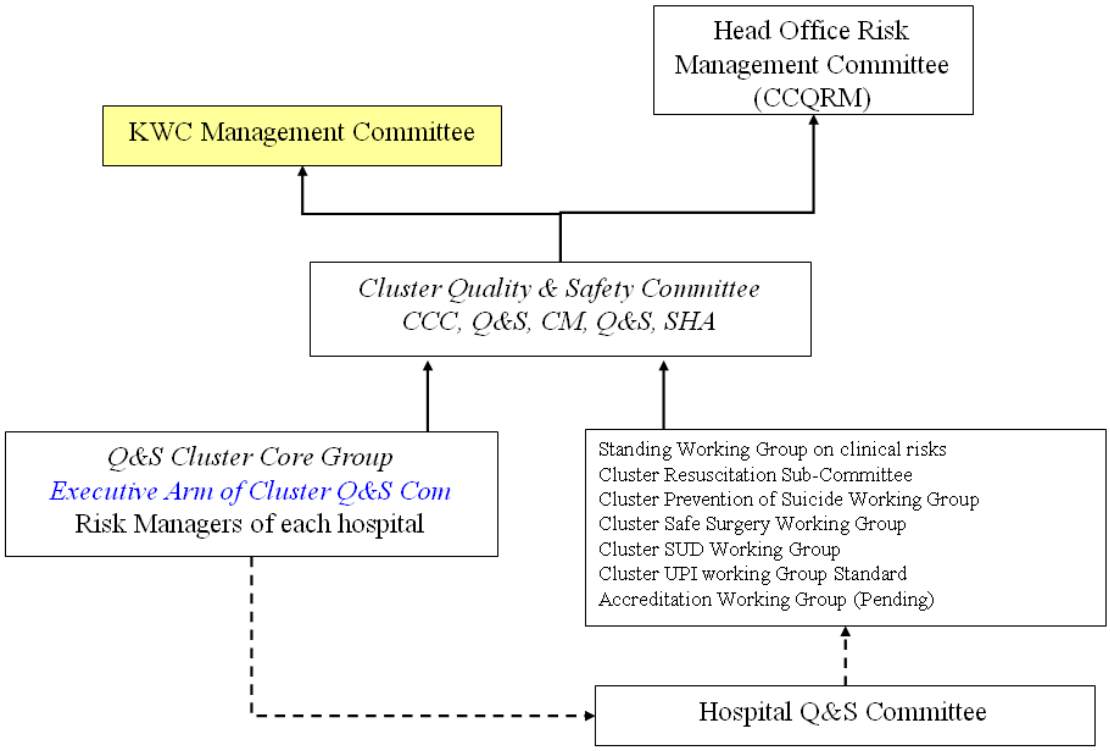
The cluster had experienced incidents of loss of USB in 08/09. Thorough investigations had been conducted. Measures to enhance staff awareness like staff forum, compliance checklist, e-learning package, sharing of latest policy manuals, guidelines & data security video were all in

place to ensure the area of data privacy and security is straightly observed.

KWC

OVERVIEW OF QUALITY & RISK MANAGEMENT ISSUES

1. Structure



2. Correct Site Surgery Policy

The Correct Site Surgery Policy was implemented in all KWC hospitals in June 2008. The policy consists of four components, namely informed consent, site marking, patient identification and time out. An agreed list of operations which site marking would be exempted was also endorsed. Staff was educated through seminars in all cluster hospitals and a poster was designed and posted in all surgical wards and Operating Theatres for the implementation.

Various departments besides Operation Theater had implemented time out policy such as Radiology.

With the introduction of HA Safe Surgery Policy, KWH was one of the pilot hospitals to implement the WHO Safe Surgery Checklist. KWC cluster had adopted the HA Safe Surgery Policy and replace the cluster policy w.e.f 1 June 2009.

3. Cluster-wide Audit on Informed Consent (Section 3 Standard 9)

An audit on Patient Informed Consent was conducted in all KWC Hospitals (except KCH & WTSH) from 1 to 13 December 2008 in the departments of Surgical, Gynae, O&T, Neurosurgery, Eye and ENT of KWC hospitals. The audit involved the following 2 aspects:

3.1 Document review to study the compliance of documentation on the consent form and explanation regarding the proposed operation to patients and/or relatives. 302 patient records were reviewed. The results also reflected that, in general, documentation was not taken on patient received information leaflet and date of signature was also not filled by doctors and patients.

3.2 Interview patients on level of understanding on the received explanation regarding the proposed operation using a standardized audit form. Out of 130 patients interviewed, all patients (100%) expressed that they understood what operation type & nature of the operation and a 67% received leaflets about operation information.

The result was shared in OT subcommittee & RM Committee at hospital and cluster level. Nevertheless, the overall compliance had been improved as compared with the audit result in 2006. The result also published in Cluster Risk Management Newsletter in March 09.

4. Transfer of Critically Patients – Standardization of Transfer Bags & Conducted Post Implementation Audit

The Cluster Resuscitation Committee had proposed a standardized transfer bag and was used in all hospitals since May 2008 in order to meet the requirements of the new guidelines. In addition, a checklist and a training video had also been developed to educate front line staff. Several cluster training sessions had been conducted to promulgate the new requirements.

An audit was conducted on September 08 for Document review and Process audit respectively. The scope of Audit had covered category I and unstable Category II patients transferred into ICU or for diagnostic tests and procedural interventions within the hospital. Observations in the audit had included:

4.1 Retrospective review on all records transferred into ICUs/HDUs from 1-15 August 2008. 50 samples were studied. Out of the 50 samples, 10% (5) were not categorized before department, 2 samples with no checklist found; no names of the escort team recorded in 6 samples & no names of the receiving team and arrival time in more than 50% of the sample.

4.2 Site visit: By convenience sampling, only 19 samples during the audit period. Areas for improvement were noted.

The result was shared in Resuscitation & RM Committee at hospital and cluster level. The result also published in Cluster Risk Management Newsletter in March 2009. This is the first time audit, in view of the small sample and overall low level of compliance noted, we shall conduct follow up audit in 09-10 to promote the awareness and compliance to the policy.

5. Management of Collapsed Persons in the Vicinity of Hospital

Guideline on management of collapsed persons in the vicinity of hospitals was updated in all hospitals with sharing sessions and forums held.

6. Early Defibrillation Program

Early Defibrillation Program was implemented in March 09. New defibrillators were delivered and refresher training on the use of new defibrillators with AED mode for nurses was completed. Along this, additional AED provided by HAHO for collapsed persons in the vicinity of hospital would be installed.

7. Medication Safety

7.1 Guideline on epidural injections had been implemented and promulgated to front line clinical staff. It was implemented in January 2009.

7.2 Do-not-use Abbreviation List was in use.

7.3 KWC Quality Forum focusing on medication safety had been conducted on 2nd December 2008 in PMH and VC to other KWC hospitals.

7.4 Guideline on DD Management reviewed and updated in PMH & WTSH.

7.5 All the new infusion pumps with free flow protection were delivered to wards. Replacement of out-dated models was completed by end of September 2008.

8. Cross Hospital Survey

Hospital survey was taken in UCH, TMH & PMH on 6, 8 & 9 April 2009 to assess the following ACHS standards: namely, informed consent; discharge and transfer of patients; clinical documentation; record management; safety management system and disaster and emergency preparedness. The overall compliance of these standards could reach the Moderate Level. Nevertheless, plenty of opportunity for improvement were noticed when preparing and during the survey process.

9. Implementation of Common Ward Language

An integrated Patient Observation Form was designed to combine the vital sign and Modified Early Warning Signs (MEWS) Score with pain score. The design of the form has been collaboration with all nurse managers in the cluster. The form was successfully launched in July 2008 and now in use in all acute care wards besides ICU. In addition, SBAR technique was also introduced for communication in various clinical departments.

10. Positive Patient Identification

A poster and video clip showing the steps of checking patient identity for GCRS label and blood pack had been sent to all wards for education. The screen idle time for CMS had been shortened from 15 mins to 3 mins to reduce the risk of using a wrong patient screen to input another patient record.

11. Implementation of Unique Patient Identification (UPI)

The HA-wide project on the use of Unique Patient Identification (UPI) for blood taking, administration of blood products and dead bodies was established in all KWC hospitals in end of March 2008. Follow up audit on the post implementation of dead body identification was conducted by all hospitals and the compliance rate was good.

Phase III UPI for all blood tests was also implemented in CMC in November 2008 and the feedback was positive. The cluster would roll out the program to all KWC hospital in 2009 - 2010.

12. E-Survey on Incident Reporting

A survey on collecting professional staff perceptions on incident reporting was completed between July and August 2008 in which 502 staff had submitted return. A cluster workgroup would be formed to follow up the concerns and valuable feedbacks. Cultivation on incident management would be strengthened through training and sharing with individual departments.

13. Promotion of Patient Safety Culture via Training & Sharing

Various programs had been implemented to enhance staff knowledge and skill related to patient safety:

13.1 Training on Risk Management & Patient safety for all new residents and nurses were conducted between July and September 2008.

13.2 Training sessions on resuscitation to new residents was held in August 2008.

13.3 Annual RCA training workshops were conducted.

13.4 Cluster Quality & Risk management Forum on Prevention of Fall was conducted in June 2008.

13.5 Cluster Q&RM Forum on Medication Safety was held in December 2008.

13.6 A two-day training workshop on Medical Legal issues was conducted in September 2008.

13.7 Audits on physical restraint, Last Offices, pain management, intra-hospital transfer of critically ill patients, patient consent would be completed within 2008 – 2009.

13.8 A Lean Six-sigma workshop for PMH staff, as a CQI project on specimen handling and delivery, was taken place in November and December 2008. It is a problem-solving methodology that uses data and statistical analyses to measure and improve an organization's operational performance, practices, and systems by eliminating defects.

13.9 A Workshop namely Failure Mode Effect Analysis (FMEA) for KWC senior nurses, Pharmacists and doctors were organized in February 2009. The total attendance was 50. FMEA is a proactive tool, technique and quality method that enables the identification and prevention of process errors before they occur.

14. Risk Communication

The latest newsletter namely Risk Watch was published in March 2009 in which risk alert and lessons learnt were heightened to bring to staff attention. Local incident alerts were issued by individual hospitals to communicate the risk reduction actions at a timely manner, such as Incident Gist in PMH, and Tips of the month in CMC.

15. Review on Incident Alerted

Review on use of laryngoscopes with detachable light bulk was completed in May 2008. Department was advised to replace all laryngoscopes with either laryngoscopes with fibrotic light source or disposable laryngoscopes (for low usage areas).

Review on handling and delivery of pathology specimen especially for breast specimen was conducted. A Time Out sheet was formulated for use in PMH.

16. International Standard Certification Achieved by The Administrative Services Division KWH

16.1 Integrated Management System (IMS) Certification.

16.2 ISO 9001:2000 Quality Management System Certification.

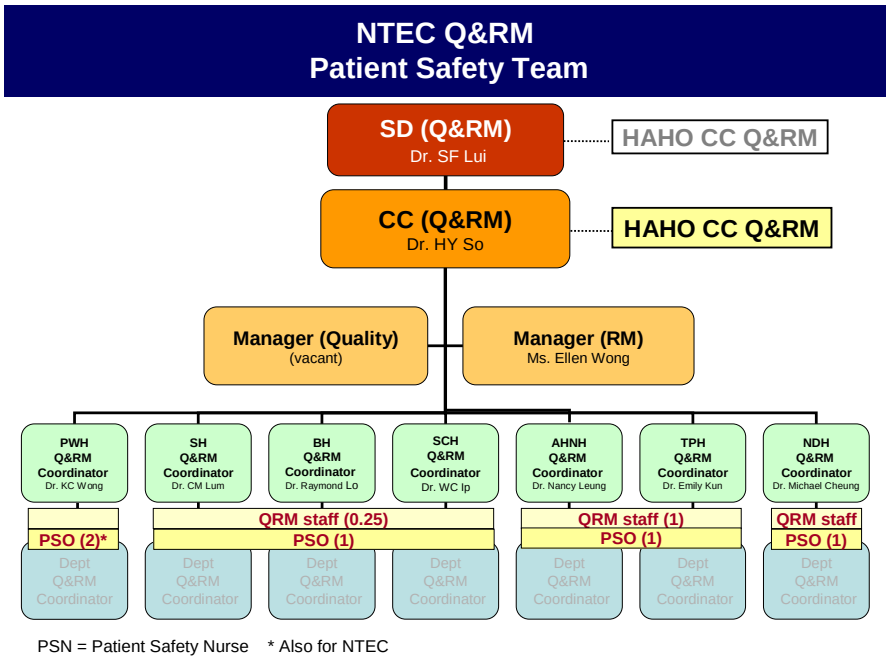
16.3 Occupational Health and Safety Assessment Series (OHSAS 18001) Certification.

NTEC

OVERVIEW OF QUALITY & RISK MANAGEMENT ISSUES

1. Structure

NTEC set up a NTEC Patient Safety Team to enhance patient safety through recruitment of full time staff to work with the frontline on Patient Safety and Risk Management Program. Five Patient Safety Officer (PSO), one Medication Safety Pharmacist and 3 clerical staff reported duty on 1 October 2008, joining the existing Q&RM staff at the NTEC hospitals. For 2008-2009, the ratio of PS/RM staff is only at 1 per 500 beds. The target is 1 PS/RM staff per 250 beds (a ratio similar to the number of ICN for each hospital).



The roles of Patient Safety Team / officer are:

1.1 Conduct Patient Safety Round

1.2 Engage / communicate with frontline staff

1.3 Collect and manage risk data (AIRS, etc)

1.4 Conduct patient safety / risk assessment

1.5 Develop patient safety solutions

1.6 Implement Risk Reduction programs

1.7 Facilitate investigation of incidents / RCA

1.8 Facilitate sharing and learning

1.9 Conduct training

1.10 Participate in annual planning

2. Patient Safety Round

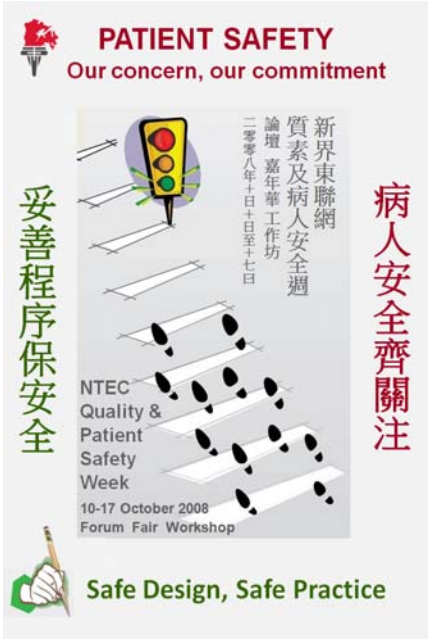
With the Patient Safety Officer (PSO) and Medication Safety Pharmacist in post, the team conducted Safety Walk Round to clinical departments since January 2009. The round is lead by senior staff / Patient Safety Officer in a systematic manner. The aim of the Safety Walk Round is to identify processes or procedures that could put patients at risk, to identify opportunities for improving safety; and facilitate staff engagement. A database was set up for recording of the PS round finding. Reports and follow-up issues were sent to related departments for review and action. The findings and area for improvement are also presented at Hospital Management meeting for follow up action. Feedback was good and positive.

3. Risk Reduction Programs – Unique patient identification

A wide range of Risk Reduction programs were initiated in NTEC. One significant achievement was the extension of the Unique Patient Identification (UPI) project Phase III (2D barcode scanning and printing of labels) to all laboratory specimen collection in in-patient wards of PWH, AHNH and NDH by phases in June 2008. The number of incidents on misidentification and mislabeling were virtually abolished with the use of the system. Feedbacks from staff were positive and supportive. The Phase III initiative will be rolled out to the AEDs and all extended care hospitals in 09/10.

4. NTEC annual Quality and Patient Safety Forum

The annual forum was held at Hospital Authority Lecture Theatre on 11 October 2008. The theme was "**Safe Design, Safe Practice**". Around 300 colleagues attended the Forum. This was followed by the NTEC Quality and Patient Safety Week. Hospitals in NTEC organized a forum in each hospital focused on different aspect of patient safety.

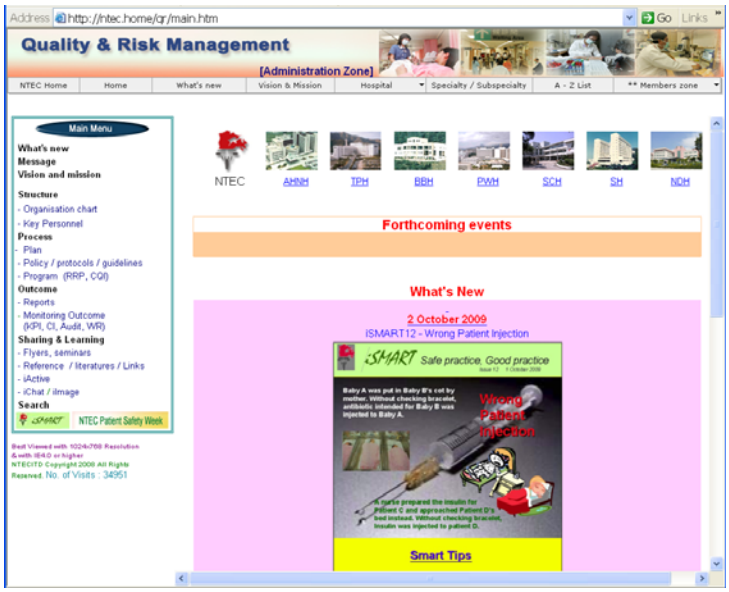


5. NTEC Patient Safety Charter

The charter was launched and adopted in October 2008. It is a milestone in establishing Patient Safety to be our major concern and top priority for quality improvement.

6. iQRM

A web base iQRM platform was launched at NTEC.Home to enhance communication with staff and team members.



7. Use of Failure Mode effect Analysis (FMEA)

Eight high risk process aiming at zero tolerance were reviewed by eight working group using FMEA (Failure Mode Effect Analysis) approach in NTEC in 08/09. The model was adopted to review the process and evaluate the protocol / guidelines.

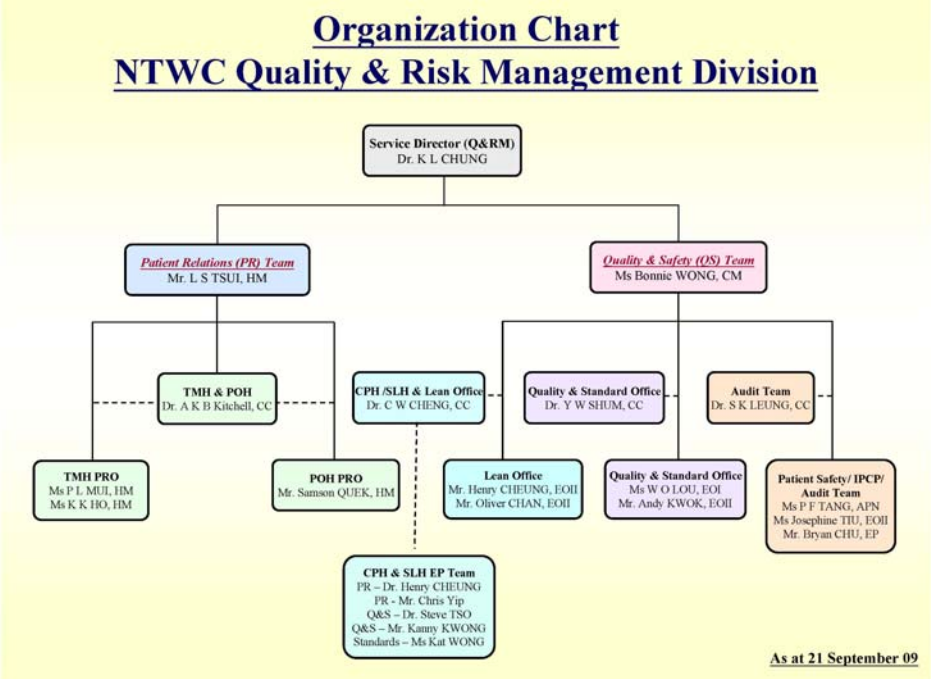
Failure Mode Effective Analysis Workshop
10 Oct 2008

Ensure correct patient and site of operation
Prevent retention of equipment / gauze
Prevent airway fire
Ensure proper position of NG tube
Administration of concentration KCl
Administration of intrathecal medication
Cross match and transfusion
Prevent patient from given known allergic drugs

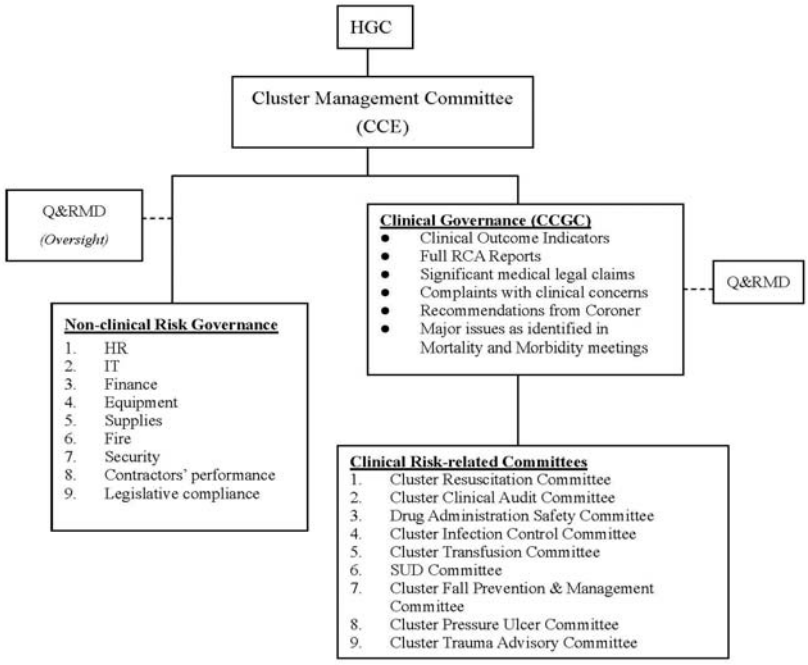
NTWC

OVERVIEW OF QUALITY & RISK MANAGEMENT ISSUES

1. Structure



The CCGE reports to Cluster Management Committee of NTWC on matters relevant to the terms of reference of the committee. The committee should submit an annual report to Cluster Management Committee.



2. Preparation of Hospital Accreditation

A new sub-team named Quality and Standard (Q&St) Team has been established under Quality & Safety Team in the Cluster Quality and Risk Management Division (CQRMD) of NTWC. The Division also works in collaboration with Kowloon East Cluster (UCH) and Kowloon West Cluster (PMH) to conduct Cross Survey for hospital standards to prepare for the hospital accreditation in near future. TMH is one of the pilot hospitals to join the pilot scheme of hospital accreditation. A project team with 10 members from different disciplinary is formed and worked closely with HAHO Q&St Team to prepare for the Hospital Accreditation.

3. Quality Improvement (QI) Movement in NTWC

Since July 08, NTWC has undertaken an active movement of Kaizen and creating a "Lean" culture throughout the Cluster. Lean Management Training Programs have been organized and many Kaizen projects have been implemented in different departments and disciplines. Kaizen in the cluster embodying elimination of waste, easing of workflow, customer-centred orientation and multidisciplinary approach. Standardization is also an important element complementary to Kaizen. The Kaizen meeting room was inaugurated in January 2009 by CE Mr. Shane Solomon. The operation of Lean Office was started in March 09, with the aims to facilitate cluster-wide Lean Management activities and coordinate training on Lean Management to NTWC staff.

4. Risk Management

Four Sentinel Events have been reported in 2008/09. They include an in-patient suicide, retention of broken suction catheter in patient's nostril, retention of varicose vein stripper tip, and Wrong-sided femoral nerve block for post-operative pain control. There were more full RCA investigation conducted for the incidents of Inappropriate handling of instruments used by patients with suspected CJD exposure, Wrong Adrenaline Dose Administration, A group of in-patient discovered fracture cases with unknown causes and The portable ventilator was turned off during patient transfer.

QUALITY AND RISK MANAGEMENT REPORT

Annual report for 12 months ending at 31 March 2009

RISK REDUCTION STRATEGIES & PROGRAMS

Clusters' report

HKEC	HKWC	KCC	KEC	KWC	NTEC	NTWC

HKEC

1. Review of 2008/09 programmes

Risk reduction strategies have been formulated based on the risks identified for 08/09 and the progress / status of work is summarized as follows:

Risk Area / Strategies		Progress / Status
Clinical Risks		
1.	**Patient Identification**	
	Enhancement of patient identification checking with the use of technology	- Unique Patient Identification checking using 2-D barcode technology has started on 26 Mar 08 in blood transfusion and test orders. - Correct Patient Identification Campaign to be launched from June 08 through a series of activities : slogan competition, kick-off ceremony, quiz on internet, sharing forums etc.
	Time-out Policy	Team time-out process has been implemented in all Endoscopy units, CCLs, Radiology Units, day wards (O&G, Surgery), minor OT (ENT, Surgery), Nuclear Medicine, Psychiatry ECT.
2.	**Medication**	
	Enhancing safety in handling high risk medications	- Pre-diluted potassium (instead of concentrated form) being used in patient care areas. - Emergency kit to be standardized on its contents as well as system and process of replenishment. - Preparation of chemotherapy and epidurals by pharmacy to be achieved. - 24-hour pharmacy service to be launched. - “Do-not-use” abbreviation list to be finalized. - “Look-Alike-Sound-Alike” drug list with strategies to be launched. - List of drugs which require patients to remain upright after administration to be launched.
	Standardization of drug concentration	Further promulgation of the standardized dilution tables (e.g. use of pocket size cards).

Risk Area / Strategies		Progress / Status
Clinical Risks		
2.	**Medication**	
	Smoothening drug administration processes and enhance communication	- Patient's weight included in paediatric drug orders. - Review of drug administration guideline.
	Enhancing safety awareness	- Drug changes and Med Safe Bulletin posted up in Intranet to give staff easy access to medication information. - Regular interactive road shows / forums. - Orientation to new staff on medication safety.
	Continuous monitoring on staff compliance to policies / procedures	Regular compliance audits.
3.	**Clinical Handover Communication & Documentation**	
	Multidisciplinary Clinical Handover System based on a generic framework to facilitate communication & handover	- Pilot program on the use of MEWS has been conducted in selected general wards and admission wards in April 08. - System to be fine-tuned based on the results of pilot program.
4.	**Staff Competency**	
	Credentialing Framework & Scope of Practice System	- To work out credentialing framework in Minimal Access Surgery for basic & advanced trainee. - A structured reviewing mechanism has been drawn-up including specified minimum no, of cases to be performed, pre-defined skills / techniques as assessment criteria & re-defined qualifications. - To review Competency Assessment Framework.
	Raising alertness of staff to change of patient condition	Continuous sharing in educational forums and medical staff orientation on lessons learnt from incidents.
	Protocol-driven guidelines	Facilitation of clinical management (e.g. prevention and management of thrombosis) with agreed checklist or guidelines.

Risk Area / Strategies		Progress / Status
Clinical Risks		
5.	**Infection Control**	
	Enhance surveillance system	- Extend SSI Surveillance in Department of Surgery and Department of O&T since July 08. - Collaborate with CHP in rolling out corporate MRSA surveillance system since Jan 08. - Implementation of surveillance on Catheter related blood Stream infection in adult ICUs of PYNEH (since July 07) and RHTSK (since Oct 08). - Roll out Surveillance on Multiple-Drug Resistant Acinetobacter since May 08.
	Enhance patient safety and staff safety	- Strengthen hand hygiene practices with reference to WHO hand hygiene promotion tools. Cluster hand hygiene survey conducted in 4Q08, the overall hand hygiene compliance rate increase from 57% (2007) to 67% (2008). - Performed Cross Hospital Infection Control rounds. - Conducted Clinical Waste Management Audit with Administrative Department. - Equipment enhancement program for prevention of needle stick injuries completed in Feb 09 with funding from HAHO.
	Emergency preparedness / response	- Regular hospital/clinic based Avian Influence drills were conducted. - Regular review of Cluster Contingency Plan of Influenza Pandemic.
	Community Partnership Project	Joined project between secondary school, Cluster ICT and Housekeeping Team to produce a training VCD on Spillage Management in Oct 2008.
	Strengthen Staff knowledge and skills on Infection Control through monthly in service training	The monthly/bimonthly Infection Control Refresher Training Program for staff is organized in PYNEH and RHTSK since 2Q08 and it is ongoing.

Risk Area / Strategies		Progress / Status
Clinical Risks		
6.	**Fall**	
	Multidisciplinary Fall Prevention Team	- Review of fall prevention guidelines and risk assessment. - Analysis of fall incidents related to treatment and medication. - Target approach focusing on newly admitted high risk patients, patient admitted due to fall etc.
	Fall reduction program	- Continuous training & education on fall risk assessment. - On-going environmental scanning for safety. - Evaluation of effectiveness of the program.
	Fall risk assessment tool	- Compare current fall risk assessment tool and Morse Fall Scale on fall incidents (in progress in PYNEH. - HAHO & Cluster WG to standardize fall risk assessment tool.
	Fall Alert Signage	- Remind the use of "need assistance" in PYNEH. - PYN WG standardized generic patient signage.
7.	**Suicide**	
	Pre-discharge Planning checklist in Psychiatric ward	- Use of suicide risk assessment form in pre-discharge planning. - Educational forum on Prevention of Patient Suicide held in April 2008 for frontline staff.
	Cluster Working Group on prevention of suicide	WG set up in Oct 07 comprising nurses, psychiatrists & psychiatry liaison nurse.
	To adopt a multi-disciplinary approach in preventing in-patient suicide	- To develop a guideline & checklist for the assessment of patients at risk of suicide in general ward. - To organize training for doctors and nurse in general stream and supporting staff to raise awareness. - To pilot in Departments of Surgery and Medicine, PYNEH.
	To identify high-risk area inside hospital (mainly popular sites for jumping from height) & planned for facility improvement works.	Started design & construction work from 2Q09.

Risk Area / Strategies		Progress / Status
Clinical Risks		
8.	**Pressure Ulcer**	
	Multidisciplinary team approach in risk reduction	- System of pressure ulcer round in place. - Collaborate with dietitian on assessment of patient's nutritional status. - Collaborate with occupational therapist to develop wedge and seat cushion for enpressure re-distribution.
	Evidence-based guidelines on care & prevention	- Review existing guidelines on care & prevention. - Identify the Incidence, prevalence of pressure ulcer in Department of Psychiatry. - Examine nurses and supporting staff's pressure ulcer knowledge in Department of Psychiatry, PYNEH. - Examine supporting staff's knowledge on pressure ulcer preventive care after refresher training.
	Enhancement on staff & carers' capabilities	Education programs for carers on pressure ulcer prevention.
	Working Group on prevention	Cluster WG to design seat & wedge cushion (pilot in Dept of Psychiatry and MED).
9.	**Blood Transfusion**	
	Improvement on workflow	- Revise workflow of responding to urgent request for blood products workflow. - Roll out of 2-D barcode technology in transfusion process in 1Q08.
	Raising risk awareness	Orientation to new staff on risk issues in transfusion.

Risk Area / Strategies		Progress / Status
Non-Clinical Risks (Administration)		
10.	**Legislative Compliance**	
	Establishing system to monitor compliance to 68 HA-related Ordinances	- Designated subject officers to work on standardized compliance checklists. - Self compliance audits as well as cross hospital audits on agreed audit plans.
11.	**Occupational Safety & Health**	
	Working group on Workplace Violence	- Study the implementation of prosecution policy on workplace violence. - On-going skill training in handling workplace violence.
	Information Management & communication	Analysis on IOD and IOD sick leave.
12.	**Equipment Failure**	
	Stepping up maintenance level of mission critical equipment	Review maintenance level for mission critical equipment.
13.	**Facilities Defect and Utilities Breakdown (Administration)**	
	Enhancement of maintenance service and monitoring system	- Step up pneumatic tube system maintenance. - Regular facilities condition assessment for prompt preventive actions. - Integration of cluster hospitals' Central Control Monitoring System (CCMS) into a single system.
	Enhancing emergency response	- Site specific emergency response plan. - Additional remote alert system (via paging, SMS) on utilities breakdown.
14.	**Contractor Management**	
	Enhancing contractor management and site monitoring work	Review protocol on contractor management.

Risk Area / Strategies		Progress / Status
Non-Clinical Risks (Administration)		
15.	**Security**	
	Enhancing Management Structure	HKEC Security Management Committee to be restructured in 3Q08 to achieve an integrated and multidisciplinary approach to facilitate alignment of standards, policies & practices, analysis of incidents, raising staff awareness and establishment of alert system within HKEC and HAHO.
	Stepping up security control	- Implementation of access control system in all wards at PYNEH. - Stepping up of security patrol to wards during visiting hours at PYNEH. - Stepping up security protection in high-risk areas, namely paediatrics & post-natal wards, pharmacy, clinical oncology, nuclear medicine, core-lab and mortuary. - Warning posters put up to remind patients/visitors of security concerns. - Provision of lockable lockers.
	Enhancement of staff conduct	Reinforce HA Code of Conduct in orientation program for new staff.
16.	**Incorrect Payroll**	
	Communication with HR staff members at different level	Staff communication forum to collect their concerns of the new change with HR staff and to manage their expectation.
	Enhancement of staff capabilities	Training to familiarize staff with the new ERP system.
17.	**Uncollectible Medical Fees**	
	Enhancement of debt recovery system	- Implementation of debt recovery procedures as promulgated by HA. - Regular monitoring and reporting of debt recovery status at CMM since 07/08.
18.	**Misuse of resources Allocated**	
	On-going monitoring on the use of resources	- Annual Audit Review by external auditors on transaction verification and system. - On-going risk assessment to identify risk areas.

2. Planning for risk reduction strategies and programs 2009/10

2.1 Top 10 clinical risks for 2009/10

Action No.	Programme name	Action Plan (Description)	Priority (high medium low)	Monitoring time scale
1.	**Patient Identification**			
1.1	Compliance audit	- Compliance audit on Dead Body identification. - Compliance audit on Blood Transfusion. - Compliance audit on Time-out policy.	Medium	6 months
1.2	To reduce incident rate related to patient misidentification in blood sampling	- To design workflow of using 2Dbarcode system in blood sampling in PYNEH as a pilot centre. - To provide training / briefing to frontline staff.	High	4 months
1.3	Cultural building to heighten staff awareness on patient identification	To extend the patient identification campaign which kicked-off in Sept 08, such as a series of activity like refresher forum, bulk distribution of 2009 calendar with practical tips of identification checking on it.	Medium	6 Months
1.4	To reduce incident rate related to wrong patient, wrong site and wrong procedure	- Roll-out "team time-out" process on bed-side invasive procedure requiring written consent. - To reinforce site marking for IR procedures. - Evaluation to be conducted.	High	Quarterly
2.	**Clinical Handover Communication & Documentation**			
2.1	To ensure a safe and effective clinical practice through a robust handover system	- To provide department "MEWS and SBAR briefing kit for medical staff. - To conduct workshop on MEWS and SBAR for nursing staff.	High	Quarterly
2.2	To roll-out MEWS / SBAR to intra-cluster hospitals	Further roll-out to Cluster hospitals by phrase and evaluation.	Medium	6 months

Action No.	Programme name	Action Plan (Description)	Priority (high medium low)	Monitoring time scale
3.	**Suicide**			
3.1	Systematic review and assessment for general patients	- Finalize the guideline on the assessment of patients at risk of suicide in general wards (3Q09). - Finalize suicide risk assessment form (3Q09). - Pilot suicide prevention in SUR & MED (3Q09).	High	6 months
3.2	Improvement projects on high risk hospital facility to prevent patient jump from height.	Design and construction works have been started since 2Q09.	High	Quarterly
4.	**Medication**			
4.1	Medication Reconciliation Services	To implement in medical ward(s) in order to reduce medication errors at patient transition point of care.	Medium	6 months
4.2	High risk medications	To review the storage of some high risk medications (e.g. muscle relaxants) as ward stock. Recommend removal from ward stock, while allowing only limited stock to be kept in some critical areas.	High	3 months
4.3	Discharge Summary	To recommended guidelines or steps for health care professionals to follow whenever discharge summary is amended upon discharging patient.	Medium	6 months
4.4	Overnight drug stock in wards	To review overnight stock items and levels in wards to enhance drug safety.	Medium	6 months
4.5	"Look-Alike-Sound-Alike" drug list with strategies	To be finalized and launched.	High	3 months
4.6	"Drugs commonly causing allergic or allergic-like reactions"	To be revised and launched.	High	3 months

Action No.	Programme name	Action Plan (Description)	Priority (high medium low)	Monitoring time scale
4.	**Medication**			
4.7	Drug Item Location Code in Pharmacy	Redesign the storage of drug items in inpatient pharmacy using drug item location code for safer dispensing.	Medium	6 months
4.8	Staff Education	Bi-yearly road shows, sharing sessions for clinical departments, interns and new clinical staff to share lessons and raise awareness.	Medium	6 months
5.	**Infection Control**			
5.1	To ensure safe and effective patient care practices through process audit	Perform compliance audit on CABSI, blood culture collection technique, isolation precautions, care of patient with urinary catheter.	Medium	6 months
5.2	Enhance surveillance system	Prevalence Survey on Infection and Antimicrobial Resistance in WCH.	Medium	6 months
		Surveillance on ESBL-positive organisms in TWEH.	Medium	6 months
5.3	Enhancement of capabilities through clinical exposure and knowledge updating	Job-rotation for ICN to clinical departments or Cluster Hospitals as a mean of professional development.	Medium	6 months
5.4	Save Lives: Clean Your Hands Program	- Hand hygiene Day. - Hand Hygiene Kick-off Ceremony in GOPC. - New posters and banners.	Medium	6 months
6.	**Fall**			
6.1	To standardize fall risk assessment tool for high risk patient of fall	Develop cluster guideline on fall prevention and care of patient with osteoporosis.	Medium	6 months
6.2	Environmental scanning on prevention of fall	Develop a checklist for environmental safety to prevent fall.	Medium	6 months

Action No.	Programme name	Action Plan (Description)	Priority (high medium low)	Monitoring time scale
7.	**Pressure Ulcer**			
7.1	Enhance staff capabilities	Identify pressure ulcer knowledge on the newly appointed APN and new graduate RN in cluster.	Medium	6 months
8.	**Staff Competence – Credentialing Framework & Scope of Practical System**			
8.1	To pilot & evaluate the credentialing scheme	To design a structured clinical proctorship program in MAS training in PYNEH.	Medium	
8.2	Crew Resources Management	To enhance skills training through Crew Resources Management (CRM) in collaboration with HKEC Training Center.		
9.	**Blood Transfusion**			
9.1	Extend the use of 2D barcode technology to other blood components (platelets, FFP & cryoprecipitate) in enhancing blood transfusion safety	Blood Bank staff would put compatibility labels on all blood components as for red cells. Clinical staff would use 2D UPI device to match the 2D barcode on patient's wristband versus 2D barcode on compatibility label to ensure that the blood components are given to the right patient.	High	Quarterly

2.2 Top non-clinical (operational) risk for 2009/10

Action No.	Programme name	Action Plan (Description)	Priority (high medium low)	Monitoring time scale
Administration				
A1.	**Fire Safety**			
A1.1	Improve Awareness of Fire Safety among Hospital Staff	Working group met to plan awareness training, training materials and network.	Medium	6 months
A1.2	Modernize Fire Services Installations	Improvement project in Chai Wan Laundry underway.	High	3 months
A1.3	Provision of Appropriate Fire Fighting Equipment	Inventory of fire fighting equipment being updated.	Medium	6 months
A1.4	Inspection of Fire Safety	Inspection and Executive Walk-around programmes being planned.	Medium	6 months
A2.	**Security**			
A2.1	Modernize Security Installations	- Improvement projects in high risk areas being planned. - Gap analysis of CCTV provision against HAHO standards being conducted.	High	3 months
A2.2	Security Risk Assessment	- Risk Assessment Checklist developed. - Assessment schedule being planned.	High	3 months
A2.3	Review of Hospital Security Manpower	Proposal for increase of Hospital Security Staff submitted.	Medium	6 months
A2.4	Inspection of Hospital Security	- Executive Walk-around on "Jump from Height" conducted, recommendations being followed up. - Inspection & further Executive Walk-around programmes being planned.	High	3 months

Action No.	Programme name	Action Plan (Description)	Priority (high medium low)	Monitoring time scale
A3.	**Transportation Service within Hospital**			
A3.1	Review Transportation Service for Specimen and Medical Records	- Working group on specimen transportation met to explore designated courier service and handing-over of specimens. - Improvement project to Pneumatic Tube System budgeted and being scheduled. - Courier service for Medical Records being reviewed.	High Medium Medium	2 months 9 months 3 months
A4.	**Medical Supplies – Product Quality**			
A4.1	Quality assurance of products received and supplied	- Procedures developed and implemented for incoming quality inspection of all medical supplies. - Expired medical consumables removed. - Periodic Quality Inspection of medical supplies stocked in warehouse and wards being scheduled. - Feedback system of product quality being planned.	High Medium Medium Medium	3 months 6 months 6 months 6 months
A5.	**Data security and confidentiality**			
A5.1	Establish a clear governance structure	- Cluster Data Privacy Committee formed. - Cluster Information Security and Privacy Officer / Health Informatics Office being explored.	High	3 months
A5.2	Improve Awareness of Data Security and Confidentiality among Hospital Staff	Liaise with HRSC to plan awareness training, orientation programme to new staff, training materials and network being planned.	High	3 months

Action No.	Programme name	Action Plan (Description)	Priority (high medium low)	Monitoring time scale
A5.	**Data security and confidentiality**			
A5.3	Conduct regular audits / walkarounds / surprise checks	- Self audit checklist developed. Compulsory annual self audit has been conducted since June 2008. - Senior Executive Walkaround was conducted in Mar 2009. - Regular small walkarounds / surprise checks being planned.	Medium	6 months
A5.4	Support frontlines to comply with the data security policy.	- A working group was formed to discuss the operational issues / difficulties and make recommendations. - Standardization on practice and required materials / facilities underway.	Medium	6 months
A5.5	Access control for corporate systems	- "Role-based" and general principles for access control has been adopted. - Review on the user profile for CMS is being conducted.	Medium	6 months
A5.6	Security measures on data export	- Installation of CMS open type workstation in PYNEH is restricted after August 2008. - Provision of advanced USB well controlled and documented.	High	3 months
Human Resources				
HR1.	**Incorrect Payroll – due to new implementation of ERP and new procedures / practices)**			
HR1.1	Parallel Testing	Compare the results generated from HRPS and ERPS.	Medium	6 months
HR1.2	Catchup Rehearsal	- Input transactions into the ERPS and try out ERPS. - Test the performance in terms of time and volume when using the ERPS.	High	3 months

Action No.	Programme name	Action Plan (Description)	Priority (high medium low)	Monitoring time scale
HR1.	**Incorrect Payroll – due to new implementation of ERP and new procedures / practices)**			
HR1.3	Enhancement of staff capabilities	End-user training to familiarize end-users with the new ERPS.	High	3 months
HR1.4	Strengthen technical support	Technical support (off-site and on-site) during initial stage of system implementation.	High	3 months
Finance				
F1.	**Payroll & Cash Handling**			
F1.1	**Payment – Payment to wrong vendor, especially for those direct invoices where there are no Purchase Order (PO) for cross-checking** Processing of "Direct Invoices" in Oracle	- Arrange refresher training to all input clerk on Oracle Accounts Payable (AP) system. - Issue internal guidelines on the selection of vendors for direct invoice settlement. - Perform cross-checking to Purchase Order (PO), where applicable, to ensure payment to the correct vendor.	Low	On-going
F1.2	**Debtors and Waivers**	Waiver checking unit.	Low	6 months
F1.3	Cash handling / patient moneys / misappropriations	Quality Assurance Programmes.	Medium	6 months
F2.	**PYNEH Charitable Trust**			
F2.1	Legislative compliance for PYNEH Charitable Trust	- Delegation of authority set up. - Bank operations procedures set up. - Financial accounting set up, including receipt donations.	Medium	6 months

HKWC

1. Review of 2008/09 programmes

Item	Program name	Progress / status
1.	Processing of Single Use Devices (SUDs)	Protocols of processing of SUDs were submitted to the Chairman of the Working Group of Reuse of SUD. No reply was received.
2.	Safe Surgeries, Safe Procedures	The modified WHO Safe Surgery Checklist was prepared and planned to be piloted.
3.	Hand Hygiene	The programme was extended to cluster hospitals.
4.	Reported Adverse Events System Evaluation (SERAE)	SERAE was continued. Fail-save measures and critical control points were identified.
5.	Prevention of adverse transfusion reaction	Procedure and carriers for transporting of blood/blood components were reviewed and updated.
6.	Prevention of missing baby body from mortuary	Procedures in handling of abortus, fetus, stillbirth and deceased infants were reviewed and reinforced.

2. Planning for risk reduction strategies and programs 2009/10

2.1 Top 10 clinical risks for 2009/10

Redistribution of medical records
Segregation between clean and dirty and enhancement of housekeeping
Enhancement of fire safety
Streamlining of ward dispensing

2.2 Top non-clinical (operational) risk for 2009/10

Enhance J-1 private clinic service excellence
Enhance biopsy prescription to processing at Diagnostic Radiology
Safety surgery checklist
Enhance potential liver transplant recipients' communication channel
Blood and blood product transport

Streamline CSSD processes and supplies
Streamline ward linen supply
Enhance biopsy prescription to processing at Diagnostic Radiology
End-of-life pathway
Streamline pharmacy ward stock
Improving in-patient dispensing system
Reducing oxygen cylinders at ward level
Implementation at acute stroke clinical pathway
Reduce queuing time in SOPD
Integrated clinical documents

2.3 Preparation for hospital accreditation

KCC

1. Review of 2008/09 program

No.	Priority Risk Area	Action Taken
1.	Workplace violence	- Reinforced violence free workplace policy. - Tightened environmental safety control. - Sped up violence prevention training to staff, public education/communication. - Set up Staff Support team. - Produced a video on Better Patient Partnership to enhance the public/patient's understanding on the hospital/clinic service. - Renamed the Workplace Violence Working Group was as Workplace Harmony Working Group.
2.	Patient suicide	- Set up Workgroup on Prevention of patient suicide. - Conducted a staff survey to identify potential clinical risk areas in workplace. - Revisited common features of inpatient suicide in hospitals. - Drawn up a report on prevention of patient suicide with recommendations. - Conducted training programs for nurses on prevention of patient suicide in hospital. - Renovated toilet facilities in high risk clinical areas to minimize risk of patient suicide.
3.	Needle stick injury	- Implemented NSI reduction program in selected department. - Reviewed NSI rate quarterly. - Maintained active communicate with staff through seminars, lectures, forums, meeting, posters and email.
4.	Infection control	- Taken prompt intervention for clustering/outbreak through on-going surveillance, risk communication and staff education. - Implemented additional controls by designing more preventive/infection reduction programs to avert infections proactively, more comprehensive surveillance system with data analysis and intensify laboratory support. - Reviewed infection rate timely. - Maintained active communicate with staff through seminars, lectures, workshops, forums, meeting, posters, banners and email.

No.	Priority Risk Area	Action Taken
5.	Medication safety	- Removed all concentrated KCl floor stock except in critical areas. - Provided premix mini-bags KCl in WFI 100ml as ward stock. - Enhanced the separation of LASA drugs and drugs with similar commercial package by providing more shelving areas and rearranging the inventory. - Shared lessons learnt from medication incidents among hospital staff, and posted lessons learnt on notice board in pharmacy. - Post new products brought in for use in pharmacy website for staff's reference. - Put up a list of LASA drugs at Risk Management Website. - Set up a working group on chemotherapy safety. - Introduce a newly designed web based drug pre-packed labeling system in BH. - Introduced enhancement measures in BH to minimize dispensing errors of LASA drugs.
6.	Patient identification	- Implemented 2D barcode technology for type and screen and blood transfusion as well as identification of deceased in KCC hospitals. - Prepared implementation of the 2D barcode technology for labeling all specimens in QEH.
7.	Communication among healthcare professionals	- Set up Taskforce on Enhancement of Clinical Management Communication. - Explored issues related to clinical management communication. - Provided training on standardized documentation among doctors. - Introduced SBAR concept to facilitate precise communication. - Revised existing patient transfer document. - Provided training for nurses on the SBAR technique. - Distributed a laminated SBAR colored chart to clinical wards of cluster hospitals to facilitate the SBAR practice.

No.	Priority Risk Area	Action Taken
8.	Communication between staff/patients and relatives	- Set up a Workgroup namely Communication and Relation between Patients and Staff (CARPS). - Organized a Kick-off Ceremony and the 1st seminar on 17 October 08 with teleconference to all KCC hospitals. - Organized 2 seminars namely "你心我心, 母說童心" for patients and staff. - Produced & distributed bookmarks and DVD of the seminars to the frontline staff. - Organized a communication workshop on end of life care and produced a DVD on the workshop. - In progress of producing a book and a DVD on better staff/patient/ carer relationship. - Set up a website for CARPS. - Organized a writing competition.
9.	Documents control	- Established a virtual "Critical and Major Incident Information Center" for timely update and dissemination of contingency plans through a web base system. - Implemented enhanced features including • a central data base of contact numbers • standard templates for all contingency plans • action checklists/command structure.
10.	Delivery of specimens	- Reviewed process and transportation mode. - Arranged designated vehicles for specimen delivery or ensure no specimen delivery through public transport. - Conducted audit on specimen packaging, transportation and handover procedure. - Assessed workers' knowledge on the related aspects.

KEC

1 Review of 2008/09 program (cluster / hospitals)

Item	Programme Name	Action Taken	Result / Risk Data
1.	Improve accuracy of patient identification	Introduction of UPI-Phase 3 program in Dec 08.	Improvement of accuracy of patient identification with result being closely monitored.
2.	Patient data security	Staff forum, compliance checklist, e-learning package, sharing of latest policy manuals, guidelines & data security video were in place to ensure the area of data privacy and security is straightly observed.	Compliance to the Personal Data (Privacy) Ordinance will be continuously monitored.
3.	Review of specimen transport project	Arrangement to differentiate colours & new collection logistics were made to streamline specimen transport.	The arrangement ensured a better system through introduction of good practice.
4.	Reduce the risk of patient fall	Refresher training to staff and audit on performance. Fall Ambassador Group was formed with training to ambassadors provided. Monitoring system was strengthened through leadership of APN/NO.	Patient fall rate and trend to be closely monitored.
5.	Eliminate wrong site surgery	'Time Out' in the Operating Theatres was implemented through checklists.	Audit conducted and compliance was assured.

Item	Programme Name	Action Taken	Result / Risk Data
6.	Missing patients and suicide prevention	The GIA report had been completed and recommendations were pending. Standard operating procedures on inpatient granting home leave was prepared.	Guidelines were available for operational use & reference.
7.	Collaboration on handling people requiring medical assistance in hospital complex	Multidisciplinary collaboration in operating system through referral mechanism. Mass CPR function and basic & advanced life support courses were conducted for all staff.	Patient safety and staff knowledge pertaining to resuscitation were enhanced.
8.	Guideline on medications with intensive monitoring & medical attention in non-critical care units	List of drugs with usual dose range/dilution, route of administration and special precautions were compiled.	Promulgation and implementation in all wards.
9.	Standardize dilution table for high risk drugs	List of high risk drugs with dilution, concentration, dosage range were compiled.	Promulgation and implementation in all wards. Post implementation audit: 100% compliance.
10.	"Do not use Abbreviations" guideline	- Collected baseline data. - Promulgated the guideline and feedback to doctors. - Implemented and conducted post implementation audit.	Compliance on individual abbreviation, namely unit, daily and microgram, were improved respectively from 15.8% to 76.2% 95.9% to 100% 0% to 100%.

Item	Programme Name	Action Taken	Result / Risk Data
11.	Drug administration	- Drug Administration Procedure and Practice Subcommittee (DAPP) continued to review and monitor the medication administration and incidents. - Increased staff alertness on Look-alike-sound-alike drugs. - Set up hospital guidelines on Safe Handling of Continuous Epidural Analgesia with reference to corporate guideline.	- Adopted “Tall Man Letter” for drug labeling. - Implemented hospital guidelines on Safe Handling of Continuous Epidural Analgesia.
12.	Single use medical devices (SUD)	- Completed SUD registry. - Mechanism had been worked out for approval of re-use of newly acquired SUD.	- SUD Registry available. - Mechanism was followed.
13.	Restrainer	- Promulgated Guidelines on Physical Restraint issued by HAHO. - Reviewed Physical Restraint Assessment Form. - Conducted a nursing audit on physical restraint.	- Implemented the captioned guidelines. - Two new assessment forms, one for medical stream and one for surgical stream were put on trial. - Nominated a WM and a MO to join the KEC Task Group on Physical Restraint. - Completed an audit with 100% compliance. - Participated in the prevalence survey on Physical Restraint conducted by HAHO on 11 Feb 09.

Item	Programme Name	Action Taken	Result / Risk Data
14.	Maintain physical security of wards, departments and entrances	Completed the installation of access control system, burglar alarm and CCTVs at the entrance of all wards and hospital lobbies.	Minimized unauthorized entry and enhanced security vigilance.
15.	Upkeep hygienic and safe environment in wards and clinics	Completed renovation in 3 medical wards and GOPCs.	Improved the environment and minimized risks due to wear and tear of facilities.
16.	Executive patient safety walkround	Bi-monthly round to ensure patient safety and reduction of potential risks.	Improvement to be continuously monitored.

2. Planning for 2009/10 programs (cluster / hospitals)

Item	Programme Name	Action Plan
1.	Patient data security	Measures to continuously enhance staff awareness towards privacy issue & compliance to the Personal Data (Privacy) Ordinance.
2.	Inter-hospital transfer	Formulate standard operating procedures in line with corporate guidelines for reference to frontline staff.
3.	Infection control	Cluster website to update & monitor the latest H1N1 flu development & continuous review of guidelines and work practice to step up infection control measures.
4.	Patient identification	Conduct post-implementation review following introduction of UPI Phase 3 program.
5.	Patient fall	Formation of fall prevention programs.
6.	Wrong site surgery	Continuous monitoring of compliance through audit.
7.	Resuscitation	Provide refresher training & forums to staff & review operational flow.
8.	Mislabeling / non-labeling of specimens	Develop staff awareness measures & workflow tracing to rectify the situation.
9.	Mortuary	Review & standardize operating procedure for handling bodies in mortuary.
10.	Deceased property documentation improvement	Formulate standard operating procedures on points & procedures to be followed.
11.	Reinforce infusion pump safety	Standardize guideline on use of infusion pumps.
12.	Clinical guidelines	Standardize practice & conduct review to ensure required clinical standards are met.
13.	NEATS	Review & streamline the current operation & management of the service.
14.	AIRS review	Conduct review, investigation or root cause analysis for selected incidents for learning & improvement.
15.	Cluster executive patient Safety walkround	Augment the program to cluster level for enhancement of patient safety.

KWC

1. Risk reduction strategies had been in place for mitigation of top risks identified for the cluster in 2008/09

1.1 Risk reduction

KWC Risk Mitigation Program on HA Top Risks for 2008 / 09	
Patient / Label Misidentification	
Pilot bar-coding technology in other blood tests	- Completed by 4Q 08. - Pilot use of 2D technology for all blood and non-blood test in CMC completed on 3 Nov 08. - PMH, KWH & YCH would implement the new technology in 09/10.
Time out policy & Misidentification	- Completed by 2Q 08. - Implement Correct patient, Correct site surgery including Time Out policy in all KWC hospital in Jun 08.
Medication Incident	
"Do not Use" Abbreviation list	- KWC Hospitals would implement the Do Not Use Abbreviation list by 1 Jan 09. - A reference reminder would be kept in patient record.
High alert medications	- KWC Hospitals implemented High Alert Med completed. - Con. KCL and other electrolytes to be kept by limited area only. - Only one strength of Heparin could be kept in each ward/ area.
Drug allergy history & drug reconciliation on admission and discharge (IT Program)	- Completed by 4Q 08. - The ePR patient summary should be printed out when doing the bed assignment by Ward Clerk or nurses. It would be placed on the front page of the patient record.
Patient Suicide	
1 Pre-discharge planning checklist in psychiatric ward 2 Suicide prevention strategies	- Cluster Working Group Formed in March 09. Chaired by CMC COS(M&G) and Cluster RM core team members and rep from each hospitals. - Conducted Environmental safety scan. - Conducted a review on incident reported on patient suicide in 08. - Plan to conduct training provide for prevention of suicide in general wards. - KCH had agreed on a protocol for assessment upon patient home leave. - Training program conducted.

Patient Assessment	
Review and explore the use of protocols and tools (e.g. MEWS) to identify ill patients	- Integrated MEWS Chart used by all KWC hospitals. - Full implementation of MEWS was commenced on 14 July 08.
Communication between Caregivers	
Review and explore communication protocol and tools amongst staff	- Briefing sessions conducted and implemented in various clinical units. - A standardized observation form using MEWS was implemented in most general wards in KWC. - Use of SBAR as communication tools for patient condition and shift handover was introduced in most hospitals.
Use of Restrainer	
Full implementation of the revised HA guideline on the use of restrainer	- The Guideline for the Use of Physical Restraint was in effective from 1 Sep 08. - Adopted HAHO guideline on the use of physical restraint. - Standardized Assessment Form and Observation Record in KWC. - Briefing sessions held on29/9 & 30/9/08. - Nursing audit was conducted in 08 in all cluster hospitals.
Infectious Disease Outbreak	
Implement WHO hand hygiene	By individual hospital ICT.
Patient Fall	
1 Review on risk assessment tools 2 Explore risk reduction program	Quality Forum on prevention of fall was conducted in between May to Jun 08 in KWC hospitals to share cases reported and the good practices to prevent further occurrence.
Prevention of Fall in PMH	- A safety round focusing on patient fall was conducted in May 08. The highlights below were given to wards for their follow-up: - Use pre-print CMS form to list the necessary nursing interventions for patients identified with risk on fall. - Provide instruction sheet to HCA in the prevention of patient fall. - Clear and more attractive signage for Fall risk to be posted at entrances of cubicle & bed head. - Review nursing workflow, especially during and soon after visiting hour as relatives may release the restrainer. - HCA handover should be made as a routine, conduct patient safety round with nursing staff. - Involve relatives and senior nurses in managing patients with poor compliance to fall prevention advices. - Open and learning culture – WM act as role model to encourage reporting of incidents including those not injured and near misses. Reinforce policies and collect feedback should be taken regularly.

Patient Fall	
Prevention of Fall in KWH	- Enforced risk management actions on prevention of patient fall in O&T. - "Prevention of Fall Workgroup" led by a Consultant with representatives from Physiotherapy, Occupational Therapy and Clinical Departments was established. - Types of new fall signage developed and in use in all wards. - Re-structuring of Prevention of Fall Workgroup in KWH & WTSH. - Fall prevention slogan competition held in the 2 hospitals to involve all hospital staff in preventing patient fall. - Audit was conducted in Private & Mixed Unit.
Prevention of Fall in CMC	Launched a "3 half-minutes exercise" poster competition for prevention of patient fall.
Personal Data (Privacy) Ordinance	
Personal Data (Privacy) Ordinance	- Review on medical records management at ward to ensure compliance with Personal Data (Privacy) Ordinance. - Organize Cluster Refresher Briefing on Personal Data (Privacy) Ordinance to refresh and update staff members the latest development.
Pressure Sore	
1 Review pressure sore assessment tools 2 Review pressure sore prevention programs	Introduction of better pressure releasing device.
Building Up Safety Culture	
Conduct survey to explore the incident reporting culture	- On line survey completed in 3Q 08. - A working group was formed in 1Q 09 for follow up.
Patient safety leadership walk around to promote safety culture in YCH & PMH	- Formulate a team that consists of all nurse executives. - Briefing on the details of the round. - Arrange walk around in wards on the regular basis. - Learn and share among good practices in ward. - Make improvement measures.
Care & treatment Enhance safety on transfer of critically ill patients	- Standardized emergency bag and accessories for transportation of critically ill patient. - Standardized inter/intra transportation of critically ill patient checklist was use.

2. Individual Hospitals RM Programme & Initiatives for the period from April 2008 – March 2009

PMH RM Programme / Initiatives	
Ensure correct specimen handling	- A Specimen Delivery Review Working Group has been formed to study the existing delivery system in May 08. A new workflow had been proposed on the mechanism of dispatching, delivery and collecting specimen with an objective to reduce the risk of missing specimen. A trial run on the new workflow was implemented in June and the result was satisfactory. Full implementation was commenced in mid-July 08. - CQI projects using 6-Sigma approach to study correct specimen flow were started in Sep 08. Five groups composed of 30 professional staff from different disciplines were formed to review the issues in depth. The project would be completed by Feb 09. .All the course participants were expected to take for the 6 Sigma Green Belt Examination.
Patient Identification	- A video clip had been filmed to reinforce front line clinical staff on the importance of checking patient identity in all procedures. Continuous education would be arranged for all nursing staff. - Old mouse pad & track ball mouse had been replaced in all CMS stations to facilitate users to select patient information correctly. - Posters and alert cards were designed for staff education.
Medication Safety	- Paediatric wards had used speakers to broadcast to patients in wards during the time of AOM. - Pre dilute Heparin had been added in the Hospital Drug Formulary. - Training on insulin administration was provided. - Inspection round on med safety and chemotherapy was conducted. - Review on Dangerous Drug management in wards was taken place. - All infusion pumps without free flow protection were replaced in end of Oct 08.

PMH RM Programme / Initiatives	
Prevention of Fall	- A safety round focusing on patient fall was conducted in May 08. - The highlights below were given to wards for their follow-up. - Use pre-print CMS form to list the necessary nursing interventions for patients identified with risk on fall. - Provide instruction sheet to HCA in the prevention of patient fall. - Clear and more attractive signage for Fall risk to be posted at entrances of cubicle & bed head. - Review nursing workflow, especially during and soon after visiting hour as relatives may release the restrainer. - HCA handover should be made as a routine, conduct patient safety round with nursing staff. - Involve relatives and senior nurses in managing patients with poor compliance to fall prevention advices. - Open and learning culture – WM act as role model to encourage reporting of incidents including those not injured and near misses. Reinforce policies and collect feedback should be taken regularly.
Early Defibrillation Program	- To implement the Chain of Survival in Hospitals as recommended by AHA. All nursing, PT and OT staff has regular re-certification on BLS provider. The early defibrillation program would be implemented in early 09. - Procurement plan for defibrillators with AED mode would be completed by 1Q 09. Refresher training on the use of AED mode for nurses was underway. - Audit program on CPR process would be conducted in 1Q 09.
Risk Alert Communication	2 publications of Incident Gist on sharing of reported incidents covering the topics of medication incident, workplace violence, patient identification and transfer of critically ill patient released in Mar & Jun 08 in PMH.

CMC RM Programme / Initiatives	
Quality improvement initiatives- Audit / Survey	
1.	Repeated audit on pain assessment and documentation.
2.	Audit on staff wearing staff ID card.
3.	Audit on lifting and transfer of DDU children in Lok Yan School.
4.	Audit on usage and handling of Cidex / Cidex OPA.
5.	Audit on the operation of FM 200 (fire extinguish system for oxygen release in central store room).
6.	Retrospective documentation review on the application of physical restraint in one acute M&G ward .
Quality improvement initiatives- Quality patient care	
1.	Launched a "3 half-minutes exercise" poster competition for prevention of patient fall.
2.	Seminar on cultural sensitivity on 9 May 08 with 90 attendances.

YCH RM Programme / Initiatives	
Resuscitation drill in wards	- Develop checklist for resuscitation process. - Implement the program on a regular basis to refresh staff skills and enhance the communication during the procedure.
Prevention of fall	- Briefing on the new fall assessment form and the preventive measure accordingly. - The new form will be implemented after 2Q 09.
Prevention of medication incident related to nurses	Survey on Administration of medication practice will be conducted after 2Q 09 for relevant nurses.
Patient safety leadership walk around to promote safety culture	- Formulate a team that consists of all nurse executives. - Briefing on the details of the round. - Arrange walk around in wards on the regular basis. - Learn and share among good practices in ward. - Make improvement measures.

KWH RM Programme / Initiatives	
Related to Data Privacy	
1.	Program by General Administration: - Review on medical records management at ward to ensure compliance with Personal Data (Privacy) Ordinance. - Organize Cluster Refresher Briefing on Personal Data (Privacy) Ordinance to refresh and update staff members the latest development.
2.	To safeguard patient privacy, request was made by M&G to the HAHO ITD to amend the active patient list printout so that Patient ID will be blanked for the last 4 digits on the daily patient round list printout.
Related to Fall Prevention	
1.	Enforced risk management actions on prevention of patient fall in O&T.
2.	"Prevention of Fall Workgroup" led by a Consultant with representatives from Physiotherapy, Occupational Therapy and Clinical Departments was established. Two types of new fall signage developed and in use in all wards.
3.	Re-structuring of Prevention of Fall Workgroup in KWH & WTSH. Fall prevention slogan competition held in the 2 hospitals to involve all hospital staff in preventing patient fall.
4.	Audit was conducted in Private & Mixed Unit.
Related to Patient Safety	
1.	Safe transfer of critically ill patient program was fully implemented in Neurosurgical Department w.e.f. Oct 2008.
2.	The content of the adult escort kit for patient transfer had been reviewed and updated in AED.
3.	Add mattress under fit ball to prevent slip when pregnant woman sitting on the fit ball for early labour pain relieved at labour ward.
4.	O&T departmental audit on pressure sore prevention.
5.	Programs in OPD: - To reduce the risk of patient injury due to unsafe practice related to the use of tourniquet for homeostasis purpose, audit on blood taking was conducted with 100% compliance. - To reduce the risk of delayed diagnosis and treatment, protocol for handling critical and abnormal investigation results received from HA hospitals and private institutions reviewed.
6.	Refresher on operating of ventilator to nurses of Private Ward.
7.	Training session on "Screening for Dysphagia by Nursing Staff" was conducted in Surgery.

KWH RM Programme / Initiatives	
Related to Patient Safety	
8.	Review on access control in wards and patient tagging systems by SSD.
Related to Infection Control	
1.	The quality and quantity of PPE stock level before winter surge was reviewed by GAD.
2.	Hand hygiene training on "Your 5 moments for hand hygiene" was held and compliance audit was conducted by AED and ICT.
Related to Medication Safety	
1.	Installation of lockable Pharmacy Refrigerator for drug storage in O&T.
2.	Reinforcement on the "read back" process in receiving verbal order in O&G.
Related to OSH	
1.	Refreshing OSH information on fire safety, chemical safety and display screen equipment through e-learning (MCQ) was carried out in Private & Mixed Unit.
2.	Proper manual handling when assisting patients to sit up in bed for assessments was reinforced in Speech Therapy Unit.

OLMH RM Programme / Initiatives	
Medication Safety Program	Still in progress, had presented the data in cluster risk sharing forum-Medication safety on Dec 08.
Fall Prevention Program (Patient)	- Monthly environmental scanning for the clinical area. - Cross ward audit of the effectiveness of the fall prevention strategies. - Installation of Excel S1 Fall Prevention Alarm (with bed or chair pad sensor).
Staff Heart Health Program	Health surveillance was done after a blood taking result, 178 staff had participated in the program.

KCH RM Programme / Initiatives
Audit on management of patient with suicide attempt tendency - Leave without completion - Primary nurse system - Pont of care glucose testing accuracy - Storage of drugs - Physical restraint - Fall prevention - Patient identification – use of wristband - Management of suicide attempt tendency

FM & PHC Programme / Initiatives
2008 Quality workplace competition – 12 entries Key note speech and prize presentation ceremony and sharing session of quality management of workplace competition.
CSSA/Dietary Allowance audit with endorsed Department Guideline - to eliminate workplace violence incidents.
Bulletin on Incidents & Complaints sharing - to eliminate workplace violence incidents.
Endorsed department guideline on Minor Operation Procedures.
Antibiotics audit.

NTEC

1. Risk Reduction Strategies & Programmes in 2009/10

1.1 Build Accountability Structure

- Recruitment of 3 new PSOs
- Involve of Department Q&RM Coordinator in incident management

1.2 Enhance Staff Engagement

- iQRM development –communication function, education, etc
- NTEC Quality and Patient Safety Week 2009 (19 – 27 October 2009)
- 5-10 Quality and Patient Safety Grand Round in NTEC
- Patient Safety Walk Round
- Quality Circles

1.3 Identification of Core Processes

- Single-use Disposable Items
- Continuous of most groups in 2008

1.4 Design and implementation

- Implementation of selected recommendation of the 8 groups (Time Out Policy, Procedure on Gauze and Instrument Counting)
- Safety handling of specimen
- Patient Care Process - MEWS ((Modified Early Warning Score) and SBAR (Situation, Background, Assessment and Recommendation) will be implemented

1.5 Document Control

- Timetable on roll out plan of document control policy
- iQRM used for document control for all hospital

1.6 Incident Management

- Improve AIRS ownership

1.7 Audits

- Dendrite model in approach
- Audit calendar
- Select 2 cluster wide audit based on 8 high risk core processes

1.8 Education and Learning

- Start EQUALsafe (Essential in Quality and Safety in Healthcare) training to Department Q&RM Coordinators – once per quarter
- Risk Watch –Learning from incidents, once per month
- iSMART (flyer on incident and smart tips) – two issue per month

1.9 Hospital Accreditation

- Set up Project Team for Shadow Accreditation in NDH
- Participate in Training and Preparation with ACHS (Australia Council of Health Care Standards) Standard Model
- Staff engagement for Hospital Accreditation

1.10 Risk Registry

- Identify top 3 risk from each clinical
- Identify one risk reduction program from each department
- Engage front line staff for risk reduction implementation

Item	TOP 10 clinical risk	Plan / progress
Risk 1	Medication incidents	- To follow up the core process on KCL and the implementation. - To reduce ward stock on muscle relaxant. - To adopt NTEC Policy on Known Drug Allergy. - To minimize the drug stock in ward by daily return of discharged patient medication. - To implement self assessment (based on drug administration guideline). - To review the medication safety at main pharmacy and GOPC.
Risk 2	Misidentification of patients	To adopt HAHO “Time Out” Policy in NTEC.
Risk 3	Fall Incidents	- To monitor the trend of incidents (Task Force under NTEC Nursing). - Re-inforce the Fall Prevention Strategies. - Video clip to alert staff on fall prevention.
Risk 4	Mislabel specimen / blood from wrong patient	- To roll out the UPI (Phase III) to TPH, SH, SCH, BBH. - To roll out the UPI with 2D barcode wristband to A&E patients.
Risk 5	Patient restraint	- Task Force under NTEC Nursing to review the Guideline. - To monitor the compliance and issue related to restrainer. - To monitor the trend of incident.
Risk 6	Infectious Disease Outbreak	- To monitor the trend of outbreak. - To continue the infection control measures.
Risk 7	Suicide	- Task Force under NTEC Nursing to review the Guideline, assessment tool, and precaution measures. - To monitor the trend of incident.
Risk 8	Positioning of naso-gastric tube	To continue the FMEA approach on safety handling and measures.
Risk 9	Missing Patient (at risk)	- Task Force under NTEC Nursing to review the Guideline. - To monitor the compliance. - To monitor the trend of incident.
Risk 10	Transfer patient	- To monitor the trend of incident. - To monitor the compliance.

NTWC

1. Follow up Action Taken to Top 10 Risks of 2008 in NTWC (As of Mar 09)

	Risk description (2008/09)	Responsible Parties	Actions Taken/ Progress to date as of Mar 2009
1.	Inadequate nursing, medical & other disciplinary manpower to meet workload demand	CGM(HR)	- Proactive recruitment processes taken, e.g. advancing recruitment action to the commencement of financial year; streamlining and speeding up recruitment process and Cluster Staffing Level Committee approval. - Re-opening of School of General Nursing. - Active use of part-time staff, temporary nurses, and leave encashment for nurses. - Enhancement of cluster attraction to new staff, e.g. opening of new staff quarters and call rooms; hospital tours for potential recruits; implementation of Nurse T&D Plan. - Outreaching recruitment exercises and walk-in interview for GSA/TSA.
2.	Medication error	DASC	- Follow the HAHO MSC directives for handling "Do not use abbreviations", handling concentrated electrolytes and high risk medications. - Advocated to use the ePR Patient Case summary to facilitate medication reconciliation. - Executive walk on assessing self medication programs in NTWC.
3.	Infection control - Hospital acquired infection	ICO	- Continuous Education (Infection control refresher course every 18 month) is mandatory to all staff to update and reinforce the Infection control standard in our cluster. - Start the pilot program of CABSI surveillance (Central venous catheter associated blood stream infection) in ICU since Aug 08 to close monitor and reduce the infection rate related to the central venous catheter. - Introduction of new safety device (safety angio-catheter) in POH (Phase I) to reduce the sharp injury rate by angio-catheter was implemented in Oct 2008.

	Risk description (2008/09)	Responsible Parties	Actions Taken/ Progress to date as of Mar 2009
4.	Staff injury - workplace violence	CGM(HR)	Reorganization of the Cluster OSH support and introduction of case management for difficult cases.
5.	Breakdown of equipment	CM(P&MM)	- Exceptional reports on preventive maintenance have been received from maintenance agents so as to maintain the quality of equipment. - Limited AMS access rights have been dispatched to clinical departments so that the equipment inventory is transparent to clinical staff and equipment shall be re-allocated if breakdowns of equipment occur.
6.	Fall	Fall Mgt Committee	- Additional height adjustable hospital beds for high risk patients (>200 as at end of July 08 by cluster NSD). - Fall Management Committee has been re-structured. - Include Fall screening as a universal item in initial nursing assessment. - Onsite ward visits and investigation for all fall incidents with SI 3 or above, and for falls with unusual causes. - Fall rate and trend in each clinical department in cluster is being monitored. - Cross survey between TMH and UCH based on ACHS fall management criteria in Oct 08. - Audits on Fall Prevention and Post Fall Management were conducted. - 40,000 copies of fall educational leaflet have been produced for distribution. - Fall seminar will be organized in 1Q 09 to enhance staff awareness on Fall prevention and management.
7.	Misidentification or mislabeling of specimens	CM(Q&RM)	- Education on importance of correct specimen labeling was highlighted in Intern Orientation Programs. - Introduction of Phase 3 Unique Patient Identification tool (2D Barcode Scanners) for general blood and non-blood specimen to facilitate patient identification process (piloted in two M&G wards in Nov 08). Roll out to all in-patient units in 1Q 09. - Survey on the factors contributing to the mislabeling is conducted.

	Risk description (2008/09)	Responsible Parties	Actions Taken/ Progress to date as of Mar 2009
8.	Training need for junior and supporting staff	CGM(HR)	- Continuous running of GSA(CR) training. - Development of new training for TSA(PC). - Implementation of Management Development Program for junior officers. - Implementation of Nurse T&D Plan to enhance the competence of junior nurses.
9.	Manual handling	CGM(HR)	- Reorganization of the Cluster OSH support and provision of more training to staff. - Organization of OSH Conference to raise staff awareness.
10.	Turnover of experienced nursing staff	CGM(HR)	- Enhancement of ward care and creation of new APN posts. - Speeding up promotion process to retain experience nurses. - Speedy implementation of the new Nurse Career Structure, advance processing of contract renewal and offering of 6-year contract to RNs.

2. Risk Reduction Strategies of Clinical Risk-related Committees for 2009 / 10

	Clinical risk-related committees under Cluster Clinical Governance Committee (CCGC), NTWC	Risk Reduction Strategies for 09/10
1.	Cluster Resuscitation Committee	- Promulgate new cluster resuscitation policy. - Set standard on resuscitation equipment including E-trolleys and defibrillators. - Training of medical, clinical and non-clinical staff.
2.	Cluster Clinical Audit Committee	Review performance of IPCP by comparing KPI with individual program.
3.	Drug Administration Safety Committee	- Parental injection dilution table. - Review intubation drug kit.
4.	Cluster Infection Control Committee	- Avian Influenza reduction. - Enhance hand hygiene practice.
5.	Cluster Transfusion Committee	- Reduce transfusion transmitted infection. - Staff education.
6.	Cluster Trauma Advisory Committee	Improve diagnostic accuracy.
7.	Cluster Single Use Device Risk Management Committee (CSUDRMC)	- Establish a committee to monitor operation of SUD. - Replace high risk SUD. - Develop Cluster policy on management of SUD.
8.	Cluster Pain Management Committee	- Purchase new drug to control pain. - Enhance staff training on pain assessment score.
9.	Cluster Fall Committee	- Reinforce reporting and follow up investigation. - Facilitate effective measures. - Enhance education of supporting staff.
10.	Cluster Pressure Ulcer Prevention and Management Committee	- Set up a new reporting system. - Use of assessment form. - Support for modernized devise.

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