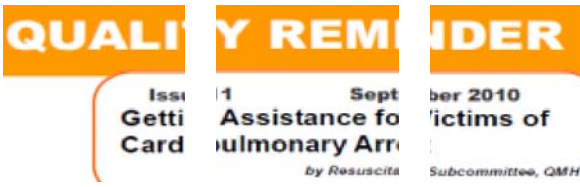

Hospital Authority Quality And Risk Management Annual Report 2010 - 2011 (Apr 10 - Mar 11)

ACKNOWLEDGEMENT

We would like to express our deepest appreciation to the support from all frontline colleagues, hospital risk managers, clinicians, executives of hospitals, and colleagues of cluster quality and risk management departments in improving patient safety. We would also like to thank them for their contributions in the risk mitigation strategies and programmes.

Patient Safety and Risk Management Department

Quality and Safety Division

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Opening Message

This is the third publication of Hospital Authority Quality and Risk Management Annual Report, compiled by Patient Safety and Risk Management Department and Quality and Standards Department, Hospital Authority. The purpose is to facilitate sharing of good quality and safety practices across Hospital Authority.

With the advancement in healthcare service - new treatment options, new technology, hospital operation is becoming even more complex. It is inevitable that adverse events (from mishap, error) will occur. It is important to ensure that our healthcare system is safe. With the increasing workload and demand on the public service, it is also essential to ensure that our healthcare system is effective and efficient.

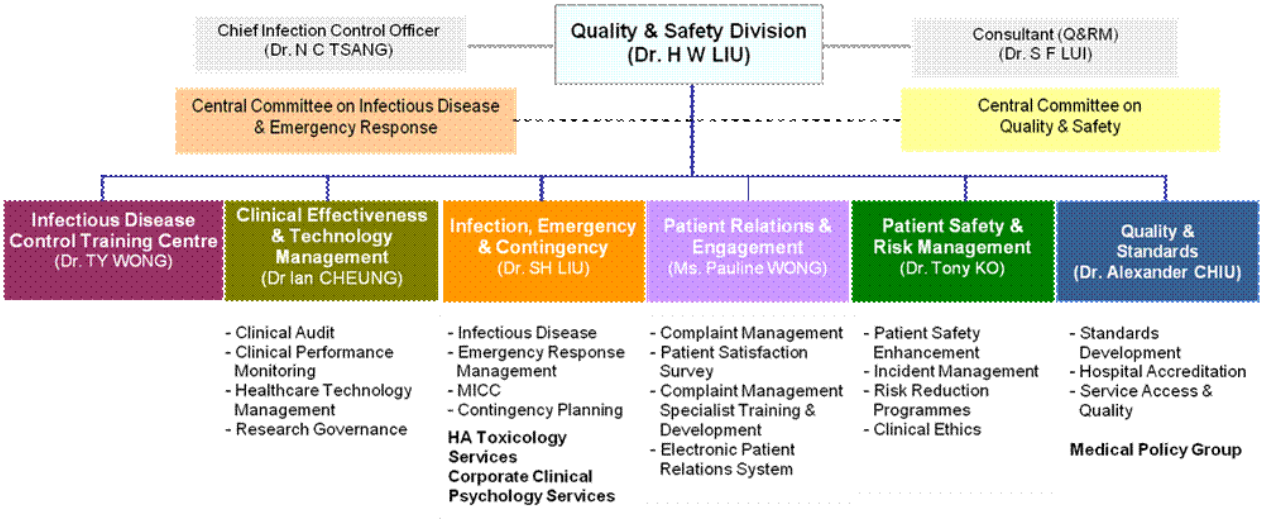
Over the past few years, the Division of Quality and Safety (Q&S), Hospital Authority Head Office (HAHO) together with the cluster's Quality and Safety team has continued to strive for a safe, effective and efficient healthcare for our patients. During the annual visit by HAHO Q&S Division to the different HA clusters, we have observed a more "structured" approach to Q&S issues at the cluster and hospital level, with the setting up of Q&S office and designated staff for Q&S. There were many innovative Q&S programs being developed and implemented across the clusters. These good Q&S practices should be shared among the clusters. We are also pleased to see that the Q&S activities are being evaluated to ensure that the purpose of the program is being achieved and led to further improvement, as part of the Continuous Quality Improvement cycle.

A safe, effective and efficient healthcare system for our patient is also a better and "happier" healthcare system for our staff to work. Keep up with the good work.

Dr. SF Lui, Consultant (Q&S), HAHO

for Q&S Division, HAHO

1. Structure & Initiatives



This report covers the quality and risk management initiatives implemented in Hospital Authority Head Office (HAHO) from 1 April 2010 – 31 March 2011. In the last year, both Quality and Standards Department and Patient Safety and Risk Management Department have made continuous effort in planning and steering strategies to ensure quality and patient safety in HA.

1.1 Hospital Accreditation

1.1.1 A Systematic Approach to Continuous Quality Improvement

Hospital accreditation program is recognized internationally as a CQI tool to help hospitals and healthcare institutions to identify gaps and opportunities for improvement. Partnering with the Australian Council on Healthcare Standards (ACHS), HA continued the Pilot Scheme of Hospital Accreditation (Pilot Scheme) in 2010/11 with support and collaboration from the Government, Private Hospitals Association (PHA) and the Department of Health (DH). Five public hospitals (namely, CMC, PYNEH, QMH, QEH and TMH) as well as three private hospitals (namely, the Baptist Hospital, Hong Kong Sanatorium & Hospital and Union Hospital) completed their Organisation Wide Survey from June to October 2010. They were all awarded 4-year full accreditation status by ACHS.

醫 院 認 證 計 劃
Hospital Accreditation

1.1.2 Achievements

(a) *Outstanding CQI Initiatives*

Participating public hospitals had planned and implemented many CQI initiatives with outstanding results. The surveyors had, during the Organization Wide Survey, duly recognized their achievements, such as pressure ulcer management, care of dying and deceased, incident, complaint and feedback management, external service provider management as well as

safe practices and environment.

(b) Successful adaptation of local ACHS Accreditation Standards

The "ACHS Evaluation and Quality Improvement Program (EQuIP) 4 Hong Kong Guide" was developed. This Hong Kong version of EQuIP 4, based on the local adaptation of the original ACHS EQuIP 4 Guide, received recognition by both the ACHS and The International Society for Quality in Health Care (ISQua). The Guide will ensure consistency in interpretation and understanding of local guidelines between overseas and local surveyors.

(c) Building up a Hong Kong Surveyor System

As of March 2011, 33 local surveyor trainees had completed their training and were appointed ACHS (HK) Surveyors. These local surveyors were given the same recognition and status as the ACHS surveyors in Australia. They are part of the Hong Kong Surveyor System with involvement in future accreditation program and contributed to the long-term vision of establishing a HK accreditation system.

(d) Enhancing Communication and Sharing

To support accreditation as a continuous improvement process, HA has developed and launched an IT platform "Continuous Quality Improvement Initiatives System" (CQIs) in December 2010. This HA-wide database on quality improvement projects was welcomed by hospital staff for learning and sharing, planning of quality improvement programmes and streamlining documentation for accreditation program. The first issue of "Quality Times, a periodic publication on quality initiatives in HA, was launched in Feb 2010. This 4-monthly publication is aimed at enhancing communication through sharing of good practices as well as lessons learnt from local and overseas experiences.

1.1.3 Common Gaps

The surveyors had identified some common gaps in pilot HA hospitals, such as sterilization practices in operating theatre, document control, credentialing and defining scope of practice. These gaps are being addressed at corporate level by setting up Task Force, Working Groups and developing a "Guideline on Disinfection and Sterilization of Reusable Medical Devices for Operating Theatre".

1.1.4 Evaluation of Pilot Scheme

The Pilot Scheme has been evaluated both by the Steering Committee and the Nethersole

Hospital Authority Head Office

School of Nursing. The Chinese University of Hong Kong (CUHK) also conducted studies on accreditation experience of the management and frontline staff of participating hospitals. The evaluation findings will help to guide HA in the journey of hospital accreditation.

1.2 Access Management

In 2010/11, different working groups on access management had taken measures in addressing the pressure areas in waiting time. For specialist outpatient service, the electronic referral system was extended to all 7 clusters to enhance quality of referrals, as well as facilitate feedback and communication between referral sources and receiving ends. The patterns of referrals were surveyed to identify pressure areas to formulate referral templates to enhance structured referrals and to develop specialty-specific programs.

For elective surgery waiting list / waiting time management, cataract, total joint replacement and BPH surgery were identified as the pressure area. Prioritization guidelines were developed to triage patients with urgent clinical needs for surgery. Key performance indicators for selected cancer types and elective surgeries were set with respective coordinating committees and monitored in the Cluster Management Meetings quarterly.

Common platforms for sharing of information were developed in HA computer systems such as Clinical Data Analysis and Reporting System (CDARS) and Management Information Portal (MIPo) to facilitate various levels of staff ranging from clinicians to senior management on real-time access of waiting time trend and information for service planning.

1.3 Clinical Measurement

A Working Group on Clinical Indicators (CI) was formed in October 2010 and laid out the principles for a "good Clinical Indicator": benchmarkable, longitudinally comparable, readily retrievable and associate with Continuous Quality Improvement (CQI) programs. Professional advices from different coordinating committees, e.g. Anaesthesiology, Internal Medicine, Intensive Care, Obstetrics & Gynaecology, Paediatrics, Radiology and Surgery were sought in the CI development.

1.4 Unique Patient Identification (UPI)

The adoption of 2D barcode system technology in ensuring correct patient identification in "Blood and Non-blood Specimen Collection" (phase 3 of UPI project) was further rolled-out to all HA Hospitals in 2011 after the trial run in PWH, TMH, CMC, UCH, QEH. Further application of 2D barcode has been introduced to Accident & Emergency Department (AED), NDH and PWH

Hospital Authority Head Office

have piloted the technology in AED in 2010. The technology was also welcomed by Diagnostic Radiography Department and was piloted in mobile radiography to reduce risk of in-patient misidentification (phase 4 of UPI project). It planned to roll-out its application to all HA hospitals gradually.

1.5 Surgical Safety

Phase II of Surgical Safety Policy, "Interventional Procedure Safety Policy", was effective on 1 October 2010 and fully implemented by 31 December 2010. The phase III of Surgical Safety Policy, "Bedside Procedure Surgical Safety" was effective since 1 March 2011. It emphasized on the development of a checklist for the bedside procedures "Chest Tapping, drainage and paracentesis" and "Insertion of intravascular catheter with the use of guide wire" to improving patient safety during bedside procedures.

1.6 Patient Safety Round

A "Patient Safety Round Training" was orgamized by Head Office in November 2010. It was conducted by Dr. Allan Frankel of Pascal Metrics. The training comprised a one day forum and on-site safety rounds at PMH, TMH, PMH, TWH and PYNEH. It had provided us with a new perspective on the application of walkrounds and the leadership skills in engaging staff in clinical units to improving patient safety.

1.7 Revamp of Advanced Incident Reporting System (AIRS)

With the recommendations from the user functional requirement study conducted by Hong

Hospital Authority Head Office

Kong Productivity Council (HKPC), the reporting methodology, system design and the screen layout will be reviewed in the revamped version. This new version would be simple, user-friendly and easy for reporting and is named as "AIRS 3". The AIRS 3 has added a new feature of reporting near miss to further promote the sharing and learning culture. Prototypes testing were conducted prior to pilot in clusters by November 2011.

1.8 Crew Resource Management (CRM)

CRM programme was first piloted in PYNEH in 2009 and received positive staff feedback. The impact on patient safety culture was also reflected in the programme evaluation. A Steering Committee was formed under the Quality and Safety Division of HA to review and looked into the future roll-out of CRM. A second phase of CRM in HA would be commenced in QEH & TMH in 2011/2012 and should focus on team-based training.

1.9 Continued efforts in phasing out reused Single Use Devices: Ensuring patient safety

Single use devices (SUD) are often reprocessed for reuse worldwide for various reasons. In this aspect, HA has established structures and processes to initiate a risk stratified approach to phase out the reuse of SUD to ensure patient safety. This includes:

- An advisory group under the Central Committee on Quality & Safety;
- Registration of SUD reused in HA;
- Requirement for hospitals to develop a reprocessing protocol; and
- Reporting of incidents relating to the reuse of SUD via HA's Advanced Incident Reporting System (AIRS).

Since 2006, HA and has stopped reusing all high risk SUD, and planned to phase out the reuse of moderately high risk SUD. The challenge is to draw together the lessons learnt and to continue implementing measures to reduce the reuse of SUD including the followings:

- Ensuring registration data of SUD is accurate, complete and consistent;
- Providing feedback to clusters to ensure consistency in the type of devices reused amongst clusters;
- Establishing guiding principles in the registration and funding of SUD;
- Aligning the central priority list to phase out reuse of SUD with policy and funding; and
- Exploring better options in improved procurement of SUD.

1. Structure & Initiatives

1.1 Engaging Clinical Leaders

To foster the strategic direction of "Building Clinical Leadership and Knowledge to Sustain Quality and Safety Improvement", two more clinicians were appointed as Deputy Director (Q&S) in April 2010, making a total of four in the team.

In order to widen the participation of doctors and nurses in quality and safety improvement, new Department Q & S Coordinators were appointed with effect from 1 January 2011 for a two-year term.

1.2 Hospital Accreditation

PYNEH was successfully awarded full accreditation for four years by the Australian Council on Healthcare Standards (ACHS) in September 2010. As the first public hospital accredited under the HA pilot scheme, PYNEH was commended by ACHS Survey Team in particular for its values

that allow and support staff to be innovative and creative in their clinical work practices for continuous quality improvement and better outcomes for patients and clients entrusted to their care; good teamwork with seamless interfacing between clinical and management teams; and a sound management structure to facilitate the corporate and clinical governance operation of the Hospital. In terms of quality and safety, the ACHS accorded the following five areas in PYNEH with Extensive Achievement (EA):

1.2.1 Systems exist to ensure that the care of dying and deceased consumers / patients is managed with dignity and comfort.

1.2.2 The incidence and impact of pressure ulcers are minimised through a pressure ulcer prevention and management strategy.

1.2.3 The system for prescription, sample collection, storage and transportation and administration of blood and blood components ensures safe and appropriate practice.

1.2.4 The Hospital ensures that the correct patient receives the correct procedure on the correct site.

1.2.5 Waste and environmental management supports safe practice and a safe environment.

1.3 Crew Resource Management (CRM)

A research in 1979 in the United States identified the majority of aviation accidents was due to human factors: failures of interpersonal communications, decision making, and leadership. CRM training was developed to eliminate errors by making better use of the human resources on the flight deck. CRM in aviation is being applied to healthcare in overseas organizations with similar objectives.

PYNEH was commissioned by the Hospital Authority to plan and organize CRM training program commencing 2009/10 as a pilot project. By March 2011, over 1,400 doctors and nurses have been trained to enhance risk awareness, communication and decision making in their clinical teams.

A CRM Campaign entitled “CRM-in-Action” has been launched to reinforce the effective

application of CRM tools in daily operations. The Campaign was kicked off in Dec 2010. Top management and all the Chiefs of Service have committed full support in promoting CRM towards building a culture of patient safety. Multiple channels and media are being used in the promulgation, including a CRM Gallery, an intranet webpage as well as distribution of useful workplace gadgets like iSBAR card and tourniquet.

1.4 Correct Patient Identification

Patient identification has been ranked the first of the Top 10 clinical risks in HKEC. To heighten staff awareness, HKEC has been organizing a series of educational & promotional programs on Correct Patient Identification. The Campaign promoted the use of at least two personal core identifiers. Game booths were concurrently set up in all cluster hospitals during 1-3 March 2011. The total number of attendance was 2,297 and the correct rate in answering quiz at booth games increased to over 90% this year. Compared with around 70% in 2009/10, this demonstrates a significant improvement in staff awareness on correct patient identification.

1.5 Prevention of Patient Suicide

Following the successful implementation of the new guideline and checklist for Suicide Risk Assessment in PYNEH, the same was rolled out to HKEC hospitals in 3Q 2010. Training sessions for medical, nursing and supporting staff were held across HKEC between April and May 2010. HKEC achieved zero patient suicide in the year of 2010/11.

"The multi-disciplinary model of staff engagement towards suicide prevention in HKEC" was presented in the HA Convention of 2010. HKEC has been invited to share the experience in various safety seminars after the HA Convention.

1.6 Surgical Safety

Implementation of a standardized surgical safety checklist has started to enhance team communication and safety checking at various critical points before and after a surgery. Compliance rate at PYNEH was 100% as revealed in an audit in March 2010.

2. Risk Prioritization

2.1 Identified clinical risks for 2010-2011

	Identified clinical risks
1	Patient Identification
2	Communication
3	Surgical Safety
4	Medication
5	Fall
6	Pressure Ulcer
7	Suicide
8	Infection Control
9	Staff Competence
10	Blood Transfusion

2.2 Identified Non-clinical (operational) risk for 2010-2011

	Identified non-clinical / operation risks (not in order of priority)
1	Fire Safety
2	Equipment Failure
3	Data Security and Confidentiality
4	Occupational Safety and Health
5	Security
6	Patient Transfer (external and internal)
7	Facility Defects
8	Medical Supplies – Product Quality
9	Incorrect Payroll (due to new implementation of ERP(HCM) and new procedures/practices)

2.3 Identified clinical risks (in order of priority) for 2011-2012

	Identified clinical risks (in order of priority)
1	Communication
2	Medication Safety
3	Patient Identification

4	Staff Competence
5	Clinical Handover and Communication
6	Surgical Safety
7	Infection Control
8	Fall
9	Pressure Ulcer
10	Suicide

2.4 Identified non-clinical / operational risks for 2011-2012 (not in order of priority)

	Identified non-clinical / operation risk (not in order of priority)
1	Fire Safety
2	Equipment Failure
3	Data Security and Confidentiality
4	Occupational Safety and Health
5	Security
6	Patient Transfer (external and internal)
7	Facility Defects
8	Medical Supplies – Product Quality

3. Risk Reduction and Quality Programs

3.1 Identified clinical risks for 2010/11

No.	Programme	Action Taken / Evaluation on Effectiveness
(a)	Patient Identification Risk	
	Correct Patient Identification Campaign reinforcing the use of at least 2 personal core identifiers.	• Total Attendance of 2,297. • Correct rate in answering quiz was over 90% (2009:70%)
(b)	Communication	
	CRM-in-Action: Promulgation in the use of tools introduced in Crew Resource Management training in improving patient safety in 4Q10.	Surveys have revealed that: • 11 out of 12 dimensions of safety culture (AHRQ) showed improvement. • Staff feel that the hospital is actively improving patient safety • Participants agree CRM has positive impact on patient safety culture • Majority of trainees had started practicing CRM at work
(c)	Surgical Safety	
	Further Promulgation of Surgical Safety.	• Extension of HA policy on procedural safety from operating theatres to interventional suites. • Practising CRM tools e.g. briefing and debriefing, SBAR and assertion in Operating Theatres and Procedure Rooms.
(d)	Medication	
	Prevention of medication incidents related to known drug allergy.	• Review of the 2008 version of Drug Allergy List. • Review of drug allergy warning mechanism and replacement of drug allergy warning sheet with a printed CMS allergy record. • Number of medication incidents related to known drug allergy was reduced to 3 in

No.	Programme	Action Taken / Evaluation on Effectiveness
		the latter half of 2010/11. (Further evaluation on the effectiveness is in progress.)
	Enhance learning and sharing of medication incident.	• Appointment of frontline staff as Medication safety Ambassadors (ward) to promote the learning and sharing.
	Safety enhancement in handling high risk medications	• No ward stock of muscle relaxants is kept in general wards except in designated areas and with a warning. • Only one strength of midazolam is used in each hospital.
(e)	Risk of Fall	
	Environmental screening against patient falls.	• Checklists for environmental safety to prevent fall designed and available at PYNEH Nursing Homepage for use of ward staff in Patient Safety Round.
	Alert Mobility System for safe mobility of patients	• System being developed as a pilot program to facilitate both clinical and non-clinical staff in managing mobility of patients.
	Forum "From Fall Prevention to Safe Mobilization of Fragile Patients" to arouse staff awareness	• Total Attendance of 293 staff. • Evaluation showed a satisfactory feedback of 4.82 average scores over 6.
(f)	Pressure Ulcer	
	Workshops on Prevention of Pressure Ulcer	• 3 workshops conducted by a multi-disciplinary team in April and May 2010 • 66 HKEC Pressure Ulcer Link Persons were appointed • The Pressure Ulcer incidents decreased from 0.40 per 1,000 in patient bed-days (n=315) in 09/10 to 0.35 (n=276) in 10/11.
(g)	Suicide	
	Elimination of environmental risks	• Improvement works to high-risk locations

No.	Programme	Action Taken / Evaluation on Effectiveness
		in PYNEH. • Executive Walkaround conducted in RHTSK and TWEH to identify potential environmental risks.
	Staff training on prevention of patient suicide	• Two rounds of training to medical, nursing and supporting staff in Dec 2010 • Zero case of patient suicide was recorded in 2010/11.
	Implementation of Suicide Prevention Program	• Systematic review and assessment for general patients in HKEC implemented in 3Q10.
(h)	Infection Control	
	Continuous audits and surveys to monitor compliance of various critical infection control measures	• Compliance audit on various KPI to ensure safe and effective patient care practices showed improvement over results in 2009/10. • Compliance on Isolation Precautions in HKEC was 87.7% in the audit in 1Q10. • Overall compliance on hand hygiene moment 1 ranged from 47.3% - 91.7% in 2Q10. • HA-wide prevalence survey on Hospital Infection conducted in 3Q10 showed improvement from 3.19% in 2007 to 2.79 in 2010. • Hand hygiene observation survey conducted in 1Q11 showed overall compliance slight improvement to 69% compared with 67.3% in 2009. • Overall compliance on initiating physical isolation to MRSA cases increased from 84.7% in 2008 to 93.3% in 2010. • Cluster-wide audit on Clinical Waste Management completed in 3Q10. Overall compliance was 98.6%.

No.	Programme	Action Taken / Evaluation on Effectiveness
	Use of needleless connector and sterile cap in PYNEH in 1Q10	• Survey showed utilization rate was 79% and 98% for needleless connector and sterile cap respectively.
	Stringent control measures against MRSA bacteraemia in Renal Unit	• No Catheter Related Blood Stream Infection (CRBSI) cases reported in renal unit for 6 months from Aug 10 to Jan 11 • Hand hygiene compliance had increased from 61.8% in 4Q09 to above 80% in 1Q10 & 1Q11
	Training to minimize blood culture contamination in PYNEH & RHTSK.	• Blood culture technique assessment among phlebotomists conducted in 4Q10 • 2 sessions on post assessment refresher trainings conducted in 4Q10 for all phlebotomists • A lunch symposium targeted for doctors held on 13 Jan 2011 • The overall compliance was around 79%
(i)	Staff Competence	
	Setting up of a hospital credentialing framework to guide, monitor and lead improvement projects on credentialing and introduction of new interventions.	• A multi-disciplinary Hospital Committee on Credentialing & Introduction of New Interventions set up. • A new Policy on Credentialing & Introduction of New Intervention developed. • Clinical competency registers of medical, nursing and allied health staff in each department drawn up and regularly reviewed. • Structured process for annual verification of medical registration by Human Resources Department continued • Peer review meetings for continuous sharing of lessons learned and identification of opportunities for improvement arranged

No.	Programme	Action Taken / Evaluation on Effectiveness
		• Credentialing system for Minimal Access Surgery (MAS) in Department of Surgery, PYNEH, piloted.
(j)	Blood Transfusion	
1.	Common platforms for staff to share and communicate change of procedures and practices in HKEC.	• Cluster Transfusion Committee meets twice annually among Blood Bank, clinical department & nursing representatives. • HKE Blood Bank staff meetings and Quality Assurance meetings held quarterly. • Incident shared, change of practice adopted and ways to improve transfusion service explored in these platforms. • Messages to frontline staff disseminated through department representatives.

3.2 Identified non-clinical (operational) risks for 2010/11

No.	Programme	Action Taken / Evaluation on Effectiveness
(a)	Fire Safety	
1.	Improve the accessibility and coverage of fire safety training.	• The fire safety training video shared to staff in hospital website. • As at the end of June 2010, over 99% of PYNEH staff attended fire safety training. 94% of PYNEH staff correctly answered all 5 questions in the e-learning fire safety module.
2.	Involving frontline participation in fire safety promotion in departments.	• Renewing appointment of 98 Fire Safety Ambassadors in PYNEH
3.	Continuous quality improvement to fire safety lectures.	• 95% of PYNEH staff attending Fire Safety Lecture agreed that it enhanced their knowledge on fire prevention, evacuation and use of fire fighting equipment.

No.	Programme	Action Taken / Evaluation on Effectiveness
4.	Fire risk assessment.	• Risk Assessment conducted at 24 PYNEH departments in 2010/11. Fire risks were identified and subsequently reduced by improvement actions.
(b)	Data security and confidentiality	
1.	Enhanced control on security of data in confidential waster paper.	• Workflow in collection, storage and disposal of confidential waste paper reviewed. • Tightened up physical security of confidential waste paper. • 100% staff of housekeeping contractor completed mandatory awareness training on data privacy within one week from the date of reporting duties.
(c)	Occupational Safety and Health	
1.	Training on Safe Handling of Chemicals	• 10 training sessions conducted for 500 supporting staff on handling of domestic chemicals • Chemical safety training kits developed & uploaded to cluster OSH website for OSH Link Persons • No related IOD incident reported.
2.	Manual Handling Operation (MHO) Risk Assessment and training	• MHO Risk Assessment tools developed & implemented in Neuro-medical wards of TWEH, Psycho-geriatric wards of PYNEH, Geriatric wards of RHTSK and SJH. • Relevant training conducted to minimize MHO risk.
(d)	Security	
1.	Sharpening skills of Hospital Security Staff.	• Completed analysis of core competence and identification of training needs of Hospital Security Guards. • Security response plans for occurrence of crimes to supplement documented

No.	Programme	Action Taken / Evaluation on Effectiveness
		procedures for Security Guards • Basic life support training provided to all Hospital Security Staff to equip them respond to emergency situation when necessary.
2.	Improve the physical security in HKEC hospitals.	Minor capital works of $2M completed in various hospitals.

3.3 Other Quality initiatives

3.3.1 Injury on Duty involving Medical Records Transfer

A Multi-disciplinary Work Group was formed to investigate the increasing trend of IOD cases in the Transportation Team involving medical records transfer. The following root causes were identified:

(a) Task – Mismatch of workload and workforce causing overloading of trolleys

(b) Tools – Specially designed trolleys meant to move along narrow aisles in Records Store turned out to be too tall and narrow to be safely moving around in the hospital.

(c) Facilities & Environment – Hazards along the route of transfer, e.g. rough floor surface, blind corners, bottleneck in some passageway

Improvement measures including workforce reinforcement, limiting trolley loads, removing facilities hazards, recalling dangerous trolleys and etc were implemented in 2010. As a result, zero incident related to medical records transfer was recorded in 2010.

3.3.2 Heat Stress Reduction Program in Chai Wan Laundry

A series of improvement measures were implemented in Chai Wan Laundry as part of the Heat Stress Reduction Program. They include:

(a) Upgrade of the ventilation system to increase the air flow rate from 9 to 18 air changes per hour.

(b) Construction of electrical skylight and replacement with larger windows to increase air circulation.

(c) Redistribution of equipment layout to remove obstruction to air flow.

(d) Replacing pressing process with tunnel finishing process so as to reduce heat generation. Linen & uniform items with fabric that fits in the new finishing process were introduced too.

As a result, the measured heat index (WBGTi) ranged from 30.4 to 31.6 °C. That means the risk of heat stroke to workers is low. Over 85% of staff were satisfied with the heat reduction.

3.3.3 Manual Handling Operation (MHO)

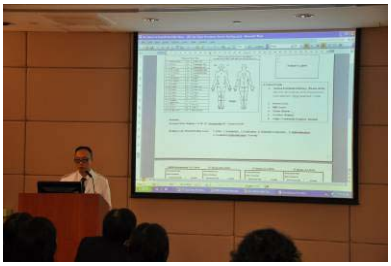
Manual handling operation (MHO) is a high risk in wards. Ceiling hoists have been installed in 13 clinical wards as of May 2010. They relieve MHO of the healthcare workers, thus significantly reducing the risk of Injury-on-Duty (IOD).

4. Learning & Sharing Information

4.1 Prevention of Pressure Ulcer

A multidisciplinary working group was formed to develop preventive measures and management guidelines on pressure ulcer in early 2010.

Train-the-trainers workshops - "Multi-dimensional Pressure Prevention and Care" were conducted in 1Q-2Q10. A total of 66 clinical staff has passed the assessment and become qualified Pressure Ulcer Link Persons to facilitate knowledge transfer within their respective departments.



4.2 Department OSH Link Persons

A total of 139 Department OSH Link Persons have been appointed in HKEC. The OSH Committee has conducted regular meetings with OSH Link Persons to maintain a communication for sharing of good practices to enhance staff safety and wellness.

A system has been established to provide mandatory OSH-related training to all staff on an on-going basis so they are continuously refreshed on the basic knowledge and skills of OSH.

To equip staff knowledge on Management of Violence Aggression (MVA), basic trainings were provided to all staff who work in high risk departments, namely Psychiatry, Security Service and Community Nursing Service. There has been a decreasing trend of workplace violence incident, particularly in Department of Psychiatry.

4.3 Community Engagement

The Fifth HKEC Symposium on Community Engagement "Family –The Key to a Healthy Community" was held on 15 May 2010 in collaboration with 14 NGOs/community partners. Over 400 participants attended. The Symposium promoted harmonious and healthy family relations with the participation of community partners.

4.4 HKEC Clinical Audit Sharing Forum

The 1st HKEC Clinical Audit Sharing Forum was held on 21 March 2011 with a total attendance of 184. Dr. Jonathan Boyce & Mr. Dick Waite, UK independent consultants, were invited to share the Review of Clinical Audit across HA hospitals. Dr. Michael Cheung, Chairman of Integrated Clinical Audit Committee from NDH, was also invited to share the local experience of NDH & NTEC.

4.5 Quality & Safety Seminar

The 3rd HKEC Quality & Safety Seminar - 'Better Health for All: Mission, Passion and Action' was held on 6 March 2010 with a total attendance of 213. Mr Cheung Tak Hai, vice chairman (external affairs) of Alliance for Patients' Mutual Help Organizations and Dr Teresa Wang were invited to deliver keynote speech on patient engagement in healthcare system. There were 8 projects competing for the best project and oral presentation award while other 29 projects competing for the best poster award.

4.6 Early Defibrillation

The Emergency Preparedness Committee has established key performance indicator (KPI) on staff's response time to major incidents. First-tier responders are expected to report duty to A&E within 15 minutes upon receipt of notification from telephone operator through Short Message Service (SMS) or pagers.

15 sets of automatic external defibrillators (AED) for emergency resuscitation had been installed in public areas of HKEC hospitals.

In addition to provision of on-going training to staff on AED since 2009, Cardio-Pulmonary Resuscitation auditing was conducted and monitored by the HKEC Resuscitation Committee.

4.7 Blood transfusion

A multi-disciplinary educational forum on Clinical Blood Transfusion Safety was held on 20 May 2010 with a total attendance of 351. The objective is to strengthen the staff in their

knowledge and alertness in the critical points of blood transfusion.

4.8 Others

Corresponding to the top clinical risks identified and incidents taken place in 2010/11, the following staff education and training were organized as well:

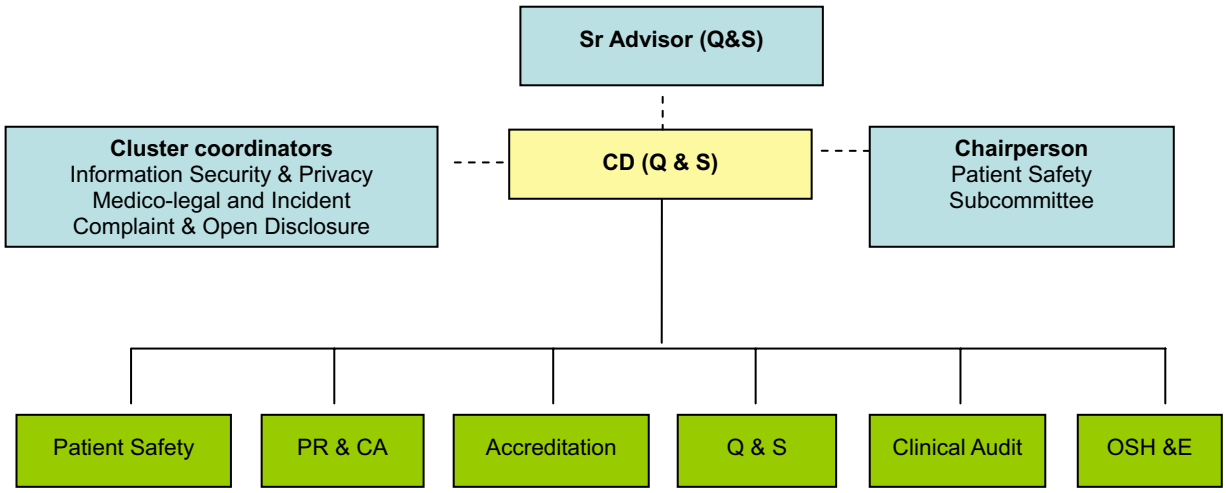
1.	An update on Care of Urinary Catheter	May 2010
2.	Seminar on updated nursing practice on naso-gastric tube placement	September 2010
3.	Q&S Forum – "From fall prevention to safe mobilization of fragile patients"	March 2011
4.	Staff Forum on Radiation Safety	March 2011
5.	18 identical sessions of Basic Life Support Refresher Course for nurses	Various dates in 2010/11

4.9 The Way Forward

The Quality and Safety Office of the HKEC will strengthen the fundamental qualities of the staff as an on-going mission. To this end, clinical leadership, culture and communication are the critical strategies we take. 4 clinical consultants will be appointed to manage public feedback; continuous training programmes will be provided to sharpen the capability of the medical and nursing Q&S coordinators in areas of feedback management. Operating units will sustain "CRM-in-Action" as a means to translate the safety culture into day-to-day practice. Q&S Office will continue to run Roadshows to support department Q&S coordinators in enhancing awareness in quality and safety among the front-line and involving them in risk identification process.

1 Structure & Initiatives

Quality & Safety Department



Subject Officers reporting to CQRMC
As of 1 July 2011 (arranged in alphabetical order)

1.1 New organizational Q&S structure

The new Q&S structure has incorporated the OSH and patient safety elements. The reporting framework of committees/ subject officers related to quality and safety has also been revised to encompass more proactive risk identification and reporting system.

1.2 Cluster approach to Quality and Safety

A cluster approach to Quality and Safety including integrated walk rounds and preparation of Accreditation has been implemented. All quality and safety related committees and functions are also revamped to be cluster based.

1.2.1 Accreditation

QMH underwent the Organization Wide Survey of Australian Council of Healthcare Accreditation scheme in October 2010 and has achieved full accreditation status. Out of the 45 criteria assessed, QMH attained 1 outstanding achievement (OA) and 10 extensive achievement

(EA) levels. The preparation for Tung Wah Hospital's accreditation commenced in Jan 2011 to enhance learning and sharing as Quality and Safety colleagues from all cluster hospitals were invited to sit in all working group meetings.

1.2.2 Integrated walk rounds

Cluster integrated quality and safety rounds commenced in January 2010. A core cluster quality and safety team was formed in 2011 to conduct quality and safety rounds in transferring knowledge on methodology to other colleagues within the cluster. In 2010/11, a total of 90 integrated quality and safety rounds were conducted in clinical and non clinical areas of Queen Mary Hospital and starting from January 2011, the integrated rounds were promulgated to other cluster hospitals with a total of 13 rounds in 1Q 2011 (Table 1).

Table 1 Integrated quality and safety rounds at HKWC

Year	QMH	TWH	GH	DKCH	FYKH	MMRC
2010	90	-	-	-	-	-
1Q 2011	3	7	1	1	-	1

1.3 Quality improvement initiatives

Through the various avenues of risk identification and gap analysis, quality improvement projects were instituted with a monthly progress update that is uploaded onto HKWC Q&S website accessible to all intranet users.

http://hkwc.home/QnS/Doc/HKWC%20Quality%20Initiatives%20Progress%20Report.doc

1.4 Hong Kong West Cluster Quality and Safety Annual Plan 2011/12

The HKWC quality and safety annual plan with strategies was developed based on a risk identification framework.

1.4.1 Risk of medication incident occurrence due to over reliance on manual confirmation and bypassing of pharmacists' verification process.

Risk reduction strategies:

(a) Enhance medication delivery to reduce ward stock;

(b) Pilot 2D Barcode System for drug administration in private wards.

1.4.2 Risk of over-sedation and airway accidents due to inadequate expertise or supervision of clinical staff in administering procedural sedation.

Risk reduction strategies:

(a) Establish procedural sedation taskforce to define strategy ;

(b) Risk stratify procedural sedations conducted outside theatres;

(c) Recruit additional manpower for administering procedural sedation outside theatres;

(d) Provide education and training for relevant staff.

1.4.3 Hazard of patients in mixed gender wards being offended by those of opposite sex.

Risk reduction strategies:

(a) Establish policy for segregation;

(b) Risk stratify patients that are unable to protect themselves into single gender ward;

(c) Enhance staff awareness and sensitivity;

(d) Educate patients and relatives.

1.4.4 Risk of patient safety hampered by bedside interventional procedures due to inadequacy or non-compliance of patient identification procedures.

Risk reduction strategies:

(a) Establish Committee for Surgical, Interventional & Procedural Safety to overlook implementation of HAHO policy;

(b) Enforce use of standardized checklists for high risk procedures conducted over bedside;

(c) Conduct regular audits to ascertain compliance.

1.4.5 Hazard of failure to identify nutritional at risk patients.

Risk reduction strategies:

(a) Apply nutritional assessment tool;

(b) Acquire necessary equipments for weighing patients;

(c) Educate staff the importance of nutritional screening;

(d) Conduct audits.

1.4.6 Infection control risk caused by substandard sterilization and disinfection.

Risk reduction strategies:

(a) Establish Cluster sterilization and disinfection committee;

(b) Streamline Central Sterile Supply Department (CSSD) services;

(c) Eliminate satellite disinfection practices;

(d) Regulate and control flash sterilization;

(e) Explore on the long term plan of establishing Theatre Supply Service Unit (TSSU).

1.4.7 Lack of robust framework to regulate scope of practice of clinicians.

Risk reduction strategies:

(a) Establish credentialing committee;

(b) Develop clinical privileging criteria for high risk high volume procedures;

(c) Conduct audits on control points in checking compliances.

1.4.8 Fragmented and inefficient care delivery model provided to patients.

Risk reduction strategies:

(a) Enforce use of nursing care plan and discharge plan;

(b) Modernize care delivery model through introduction of clinical pathways.

1.4.9 Potential shortcomings in incident management leading to staff and client discontent.

Risk reduction strategies:

(a) Revamp governance structure on incident management;

(b) Develop standing protocol for incident management.

2 Risk Prioritization

2.1 Identified clinical risk reduction strategies for 2010-2011 (as reported last year)

	Identified clinical risk reduction strategies
1	Implement WHO second challenge for safe surgery
2	Enhance medication safety through reducing ward stock
3	Enhance correct patient identification of laboratory specimen using 2D barcode system
4	Enhance nursing care quality with structured nursing care plan
5	Implement integrated quality and safety walk round
6	Incorporate integrated peri-operative nursing documentation into patient's medical record
7	Integrate clinical documentation for all clinical specialties
8	Improve in-patient dispensing system
9	Standardize instrument sterilization and tracking system through out all areas in QMH
10	Streamline CSSD processes

2.2 Identified Non-clinical (operational) risk reduction strategies for 2010-2011

	Identified operation risk reduction strategies (not necessary in order of priority)
1	Enhance private patient billing
2	Institute PACS data storage and off-site backup
3	Enhance hospital security with regular staff update
4	Systematic monitoring of compliance with statutory requirement and ordinance
5	Enhance fire safety through regular fire drill, training and mandatory paper drill
6	Reinforce personal data security through training and paper drill

2.3 Identified clinical risks (in order of priority) for 2011-2012

	Identified clinical risks (in order of priority)
1	Risk of medication incident occurrence due to over reliance on manual confirmation and bypassing of pharmacists' verification process.
2	Hazard of inadequate supervision and monitoring of clinical staff in administering procedural sedation.
3	Risk of Patient safety hampered by bedside interventional procedures
4	Risk of failure to identify nutritional at risk patients
5	Infection control risk caused by substandard sterilization and disinfection
6	Risk of substandard care due to lack of robust framework to regulate scope of practice of clinicians
7	Risk of fragmented and inefficient care delivery model provided to patients
8	Potential shortcomings in incident management leading to staff and client discontent

2.4 Identified Non-clinical (operational) risks for 2011-2012

	Identified operation risks (not necessary in order of priority)
1	Hazard of patients in mixed gender wards being offended by those of opposite sex
2	Risk of security or access lapse due to inadequate structure to oversee access control and hospital security
3	Liability related to inconsistent time documented in medical record due to unsynchronized clocks in different parts of the hospital
4	Risk of delayed treatment or getting lost in the hospital due to unclear and uncoordinated signage within the cluster
5	Risk associated with access to and use of out-dated documents due to inadequate document management system
6	Risk related to sudden mechanical failure due to outdated medical equipment

3 Risk Reduction and Quality Programs

3.1 Review of 2010 risk reduction programs

	Quality initiatives	Action and progress
1	Implement WHO second challenge for safe surgery	Implemented checklist for chest drain insertion and tapping in ward settings for the whole cluster in March 2011
2	Enhance medication safety through reducing ward stock	Ward stock of Department of Surgery, Psychiatry and Paediatric in QMH reduced by 57%
3	Enhance correct patient identification of laboratory specimen using 2D barcode system	• Implemented 2D barcode for patient identification of laboratory specimens in 2011 at QMH • For roll out to cluster hospitals in 2011/2012
4	Enhance nursing care quality with structured nursing care plan	• Nursing care plan developed after consensus • Implemented care plan by phases to whole hospital in September 2010
5	Implement integrated quality and safety walk round	• Continued integrated walk-round for all clinical and allied health areas of QMH in preparation for accreditation – a total of 90 walk rounds conducted with follow-up improvement measures • Expand cluster based integrated walk-round starting in January 2011
6	Incorporate integrated peri-operative nursing documentation into patient's medical record	Implemented integrated peri-operative nursing documentation that is filed into patient's medical record for all patients undergoing surgical procedure in the OTS
7	Integrate clinical documentation for all clinical specialties	Instituted integrated management and progress sheet for all disciplines in enhancing seamless care record
8	Improve in-patient dispensing system	• Employed 4 supporting staff for improving efficiency of dispensing turn-around-time • Pending employment of dispensers to

	Quality initiatives	Action and progress
		further enhance efficiency
9	Standardize instrument sterilization and tracking system through out all areas in QMH	• Eliminated satellite sterilization at ward level • Implemented instrument tracking system in all OTS
10	Streamline CSSD processes	Replaced utensils supply by disposable items to cater for increased demand for centralized sterilization

3.2 Accreditation

Queen Mary Hospital one of the hospitals that joined the pilot accreditation scheme underwent the OWS in October 2010. With the concerted effort by all colleagues of Queen Mary Hospital, the hospital attained 10 Extensive Achievement (EA) and 1 Outstanding Achievement (OA) out of the 45 criteria and achieved full accreditation.

Clinical		Support	Corporate
Assessment	Appropriateness	Quality improvement	Strategic planning
Care plan	Effectiveness	Risk management	Governance & delegation
Consent	Medication safety ❋	Incident management ❋	Credentialing
Care evaluation	Infection control	Work force planning	External service provider
Discharge/ transfer	Pressure ulcer ❋❋	Recruitment & selection	Safety management ❋
Ongoing care	Falls ❋	Learning & development ❋	Buildings management
Death and dying ❋	Blood transfusion	Employee support	Waste management ❋
Health record	Correct site surgery	Health record management	Emergency management
Access to information	Community participation	Data & information	Security management ❋
Access & admission	Rights & responsibilities	Information technology	
		Health promotion ❋	
		Research ❋	

Note ❋ Extensive Achievement
❋❋ Outstanding Achievement

4 Learning & Sharing Information

4.1 Staff training

	Highlights of Staff Education Activities: Topics:	Sessions
1	**Blood Transfusion related**	
	Transfusion safety & annual report	9
	OTBTS & summary of incidents	5
	Transfusion for nurses (GH)	5
	Safety in blood transfusion for care related workers/workman/drivers	4
2	**Medication related**	
	Annual Medication Safety Forum	1
3	**Fire Safety Talk**	
	Queen Mary Hospital	20
	Grantham Hospital	18
	Tung Wah Hospital	11
	Fung Yiu King Hospital	10
	Duchess of Kent Children's Hospital	8
	MacLehose Medical Rehabilitation Centre	4
4	**Infection Control Training**	
	Queen Mary Hospital	11
	Tung Wah Hospital	14
	Grantham Hospital	1
5	**Protecting Patient Data Privacy and Security**	
	HKWC	13
6	**Quality and Safety and Accreditation**	
	Briefing and preparation for hospital accreditation (QMH, GH & TWH)	18
	Preparation for hospital accreditation for nursing supervisors (TWH)	1
	Patient safety forum	8
	Open disclosure	2
	Quality & risk management (TWH)	1

4.2 Quality & Safety Publications

4.2.1 HKWC Quality of Care Report is an initiative to publicize the commendable effort and invaluable contributions of various units and departments in the pursuit of service excellence and continuous quality improvement.

4.2.2 QMH Newsletter

Oct 2010

Fire safety and fire safety again.

The importance of fire safety is indisputable and one of the most important subjects to be inspected in our coming survey.

For your own safety and the safety of our patients, may I appeal to you to spend 5 minutes to answer this 12 questions exercise if

you have not done a printed one in the last 12 months

you have forgotten about the key messages of fire safety

you have newly joined the hospital (see picture)

For the convenience of staff and improvement in handling training record, a web based exercise fire safety exercise has been formulated. Since we launched the exercise on 17th May 2010, we have already more than 2600 staff that completed it in 2 months' time. This is very encouraging but yet there is still room for improvement given we have around 5000 staff in Queen Mary Hospital. All participation will be recorded by Human Resources. We shall also promulgate the use of this exercise to our cluster hospitals in due course.

The exercise can be found in HKWC intranet > QMH website > fire safety icon > Web-based Training on Fire Safety (2010), or you can follow the link below: http://hkwc.home/webapps/FDOSS/showquestionnaire.aspx

Dr Alexander CHIU
Cluster Director, Quality and Safety, HKWC

齊來關注防火安全

Jan 2011

瑪麗醫院認證計劃及展望

QMH Accreditation and Beyond

After our successful accreditation in 2010, the forthcoming year will be a year of consolidation for Queen Mary Hospital. For the many improvement programmes we have commenced, our challenge will be to maintain the momentum and to keep up the spirit of staff. We fully embraced the fact that there will be some inevitable decay in awareness and implementation, and we shall need to fortify, refine and reassess the systems we have constructed. Some of the highlights in the year 2010 will include shortening medication delivery time, further sterilization practices enhancement and clinical privileging. These are no simple tasks, as to maintain is definitely more difficult than to build, and I shall look forward to the continued collaboration with our colleagues in achieving these targets.

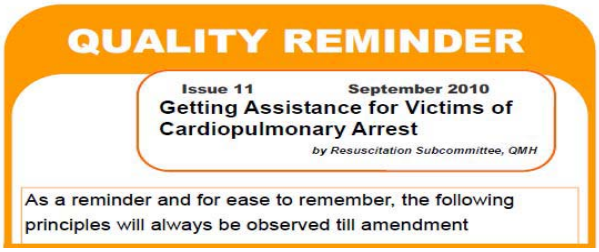
Over the cluster side, the target for 2011 is to assist our sister hospitals within the cluster to go through the same journey. Tung Wah Hospital has been nominated as the next hospital in the cluster to go through this exercise and Queen Mary Hospital shall mobilize all its resources and manpower to assist them. Grantham Hospital and the Sandy Bay Hospitals will also start their preparation in pace with TWH, so that colleagues will not feel left out and more importantly, they will be able to gather valuable experience through observing and participating in the process.

Finally, May I wish you all in having a prosperous new year.

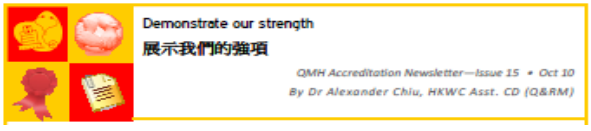
Dr Alexander CHIU
Cluster Director, Quality & Safety, HKWC

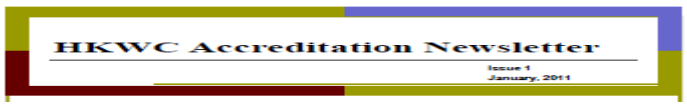
Day 1

4.2.3 Quality Reminder



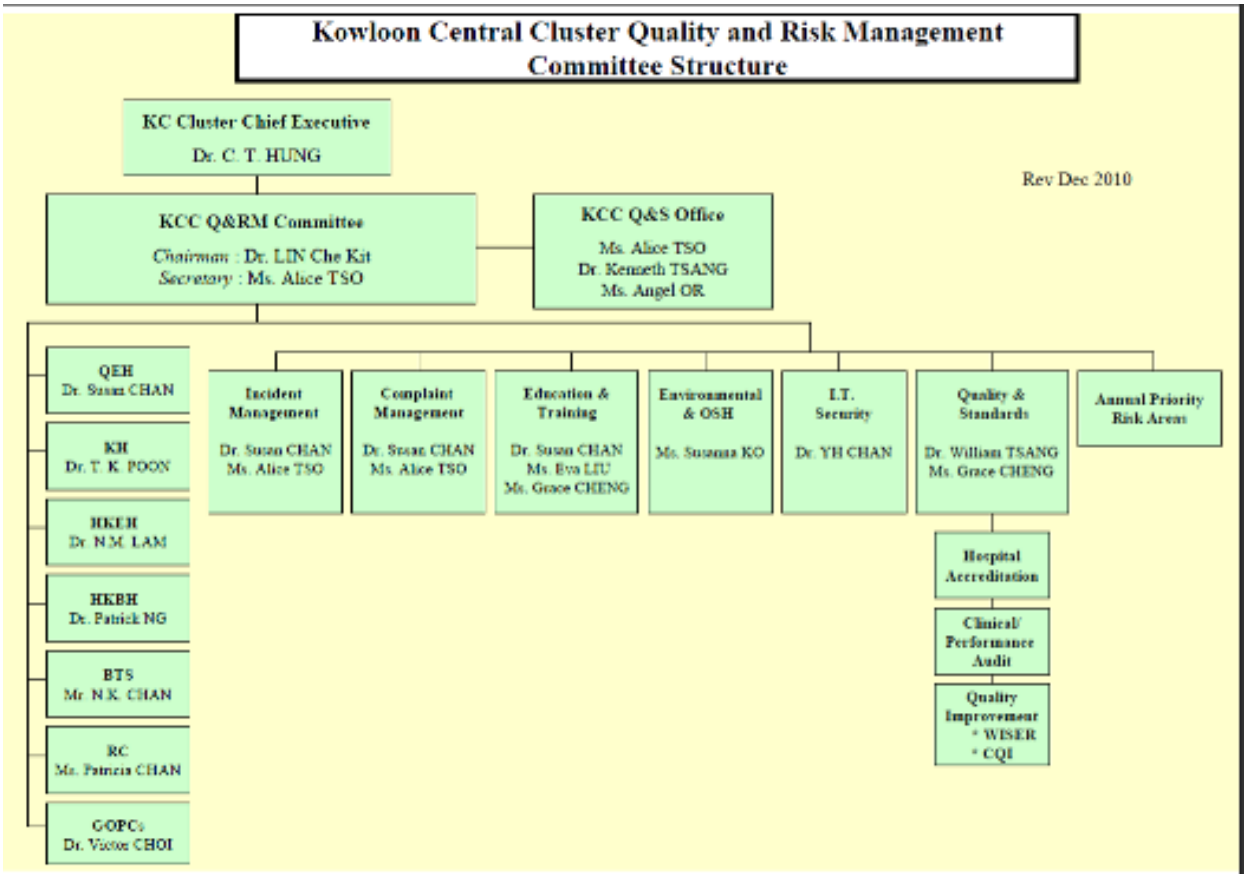
4.2.4 Accreditation Newsletter





QMH Accreditation and Beyond
Dr. Alexander Chiu, Cluster Director, Quality & Safety (HKWC)

1. Structure & Initiatives



This report covers the period from 1st April 2010 to 31st March 2011. In the past year, Kowloon Central Cluster has achieved gratifying outcomes in many aspects.

Structure

The cluster has further strengthened its structure. With the introduction of the position of Senior Hospital Manager Q&S (Education & Development), KCC consolidated the pillars for supporting the Quality & Safety Structure – namely Risk Management, Quality & Standards, Patient Services and Education & Development.

As mentioned in last year's report, KCC established a Quality and Safety Office manned by full time as well as part-time staff. The office is an executive arm of the Cluster Quality and Risk Management Committee. The role of the Quality and Safety Office is to derive, drive, support and monitor cluster priority risk areas, risk reduction programs and improvement efforts on a cluster level. This was consolidated by the expansion of the cluster office supporting staff numbers.

At the hospital level, immense effort was placed in QEH to drive the hospital accreditation process. Reinforcement of the structure of the Quality& Standards Team saw the hospital through the journey.

Process

1.1 Years of Safety

KCC has continued its effort in enhancing patient safety. This was the third of its years of safety – the Year of Quality.

This year, we rewarded by the outcomes in 2 major projects. We achieved excellent results in the APBEST award and we also achieved full accredited status by the ACHS. Detail of these will be depicted later in this report.

1.1.1 New Risk Register

Every year, a cluster-wide / organization-wide risk identification exercise will be done starting with the compilation and then collection of departmental risk registers. The Cluster Quality & Safety Office will compile the Cluster Top Ten Priority Risk Areas using these risk registers and the incident/complaints data of the previous year. This was done using the traditional way of using risk matrices, etc. This is a particularly difficult job for the clinicians as they find this tedious and the tools 'unfriendly'.

As different clinical departments might use the same words to describe different risks or different vocabularies to describe the same risk, it adds on to the complexity of developing an organization-wide risk register and thus affects the accuracy and usefulness of the Cluster Top Ten Priority Risk Areas which are supposed to benefit these clinical departments. Eventually, the Top Ten Risk Areas predominantly reflected the incidents that occurred the previous year.

In 2010, we developed a new risk register using the World Health Organization Conceptual Framework for the International Classification for Patient Safety 2009 (V1.1) as the backbone. We used the taxonomy to build an easy-to-use Excel file with multiple pull down menus and self-explanatory guides.

The results were encouraging. The percentage of returned risk registers at deadline and the completeness of the risk registers rose significantly. As the clinical departments now use the same glossary of terms, the data can be confidently pulled together and specific risks common to different departments can be identified. Thus, cluster-wide risk identification is now truly current. Hopefully, the Top Ten Priority Risk Areas can reflect the needs of the clinical departments and the work of the subgroups designated to look after these Ten Risks will be able to assist the departments in mitigating the most current problems.

Furthermore, the risk identification exercise can now with ease accommodate multiple inputs namely Patient Safety Walk-around, technological risks identified by IT departments but not at the frontline clinical areas, incident data, near-miss events data, complaints data. All these contributed to the complexity of highlighting or prioritizing risks. Using the World Health Organization Conceptual

Framework for the International Classification for Patient Safety, we can convert these risks into meaningful data and further ourselves into the work of risk mitigation.

As this data collection exercise is novice, it has yet to show its true power or weakness. A longer term monitoring of its usefulness will be required. We were glad that a paper reporting the use of this risk register tool was accepted by the 28th International Conference of The International Society for Quality in Health Care (ISQUA) to be held in September 2011.

1.1.2 WISER Movement

Since the formation of the WISER taskforce in Oct 2009, WISER has come to represent 'possibilities' in KCC. While Lean describes a thinking paradigm and a set of tools, WISER is looking at the broader scope of engaging staff for innovation and for service improvement. The cluster has now 6 Blackbelts and almost 100 Greenbelts trained in Lean Six Sigma. The KCC Q&S Office is the executive arm of this movement.

With the dedicated efforts of the Blackbelts and Greenbelts (all operating at their own time!), KCC has been running regular Awareness training for all levels of staff. In-depth tools training are also welcomed by the staff. This was exemplified by the regular over-subscription to the WISER Tools Training Series (1 lunch session per week for 3 consecutive weeks).

We have also completed a website of WISER. If someone wanted a crash course of Lean Management without the need to read through bulky textbooks or going to classes, this is the best place to go. On the website, we also shared with everyone who have access to the intranet, information regarding completed and on-going projects, timetable of our training programs as well as the training materials. We have no intention (and we don't think we can) to monopolize the material, we thus put everything on the web for everyone to freely download and read. We are also now testing a mobile website to be used on mobile phones for quick reference to basic Lean concepts and simple tools (e.g. Take time calculator).

Numerous projects sprouted from different departments. We have projects ranging from the management of formula milk stocks in wards to the improvement in the prostate biopsy specimen handling. These projects were all problems identified by frontline colleagues and end-users. As all projects need facilitation from either Black / Green belts, we have assured the quality of the results. The fact that these projects need to report their progress to the WISER taskforce ensured that they obtained the required management support (as the taskforce is well represented by all aspects of senior management).

The WISER Sharing forum was a bimonthly event where a few of the completed projects were invited to share their success stories to the rest of the cluster. The CCE was present on all occasions and gave immense support to the staff, usually frontline, and commended them on their effort and

celebrated with them their successes.

1.1.3 Building Safety Culture

Like brand-building in private corporations, culture building with regards to Quality and Safety need to be persistent. The Q&S Website provides updated information, references, standards, good articles and risk alerts for sharing. The objective is to increase staff alertness on quality and safety.

We have further enhanced our Electronic Patient Safety alert (EPS) by forming a multi-disciplinary editorial board. The editorial board comprised of doctors and nurses from different specialties and the serve to constantly supply the EPS with interesting stories as well as reviewing the contents of these alerts. Each issue of the EPS was sent to all KCC electronically via email on a bi-weekly basis.

KCC Quality and Safety Forums were also held bimonthly (intercalating with WISER Sharing Forum). Each Q&S Forum has a theme to follow. In the past year, we ran forums focusing on Incident Management and demystifying the process of Root Cause Analysis. We have invited Dr Ares Leung to give us a talk and the lecture theatre was packed with staff eager to learn. We also ran forums with in-house staff. We developed the "RCA 解密" series. This started small using data from the SE/SUE Forum held by HA Head Office colleagues. This generated a significant group of followers and we discovered that they are interested in the 'mysteries and secrecies' behind RCA processes. We thus went ahead to explain to them the process of RCA (using freely available materials from World Health Organisation). This, again, generated significant interests and we were requested to further on in this series.

2. Risk Prioritization

The KCC Q&RM Committee had identified 10 priority risk areas (Table 2 & 3). Risk reduction strategies and action plans were formulated and implemented accordingly.

2.1 Table 2: Identified Risk Areas for 2010/11

Identified Risk Areas for 2010/11	
1	Medication Safety
2	Safe Surgery (Operation Theatre and Procedural Suites)
3	Sedation protocol
4	Document Control
5	Patient falls
6	Patient Identification
7	Pressure Ulcer
8	Infection Control
9	Data Security
10	Investigation findings alert safety

2.2 Table 3: Identified Risk Areas for 2011/12

Identified Risk Areas for 2011/12	
1	Medication Reconciliation & Administration
2	Medication Dispensing
3	Procedural Safety (surgical, interventional and bedside procedure safety)
4	Patient Identification
5	Safe Handling of Abnormal Investigation Report
6	Fire Safety
7	Staff Injury

8	Workplace Violence
9	Data Security
10	Transfer of Critically Ill

3. Risk Reduction and Quality Programs

3.1 Progress on Risk Reduction Programs

1	***Medication Safety***	
	13/04/2010	• A Failure Mode Effects Analysis (FMEA) was completed in mid-March 2010 with recommendations made. A final report is being prepared and will be submitted to KCC Medication Safety Committee in mid-April as well as NQRM committee.
	08/06/2010	• A medication Reconciliation Workgroup led by Dr Kenneth Tsang had been formed. Members include pharmacist, doctors and nurses. The Workgroup is responsible to liaise with the Head Office Medication Safety Committee.
	07/12/2010	• A workgroup meeting was held on 10.9.10. It was proposed to standardize the drug allergy practice in KCC. • In a review at the recent KCC Q&RM Committee Meeting, it was endorsed that executive power should be vested in the Medication Safety Committee, accordingly the TOR of which would be revised. • RIE on Medication Reconciliation is in progress.
	15/02/2011	• RIE on Medication Reconciliation in Med/QEH is in progress with a pilot to be conducted shortly. Another RIE on the same topic will be conducted in O&T/QEH.
	11/04/2011	• The Medication Safety Committee formed two taskforces: 1) dilution table and 2) MAR standardization and time scheduling. Respective meeting will be held in April 2011. • Known Drug Allergy – Promulgation of good practice on known drug allergy management would be made via CMS screen saver.
2	***Safe Surgery***	
	13/04/2010	• The Safe Surgery Audit conducted in all operation theatres in QEH and HKEH in March includes the three phases of safety check: the pre-anaesthetic (sign-in), Time-Out process, and the post-operative safety check (sign-out). • The Workgroup is also streamlining the process using Lean Six Sigma methods. All surgical specialties had participated in the

		• exercise and a new workflow is being drafted. • Safe Surgery policy with the use of a checklist will be rolled out to all cardiac cases requiring intervention. A checklist is being drawn up by the Cardiac team with references from other HA hospitals.
	08/06/2010	• Head Office Q&S audit on Safe Surgery Policy was completed in March 2010. • The Workgroup is revising the workflow of the 3 steps of Safe Surgery Policy to streamline patient journey throughout pre-admission to completion of surgery. • A new Workgroup led by Dr YF Chow and Dr Donald Tang with Dr Kenneth Tsang serving as facilitator will be formed to steer the implementation of Phase 2 of Safe Surgery policy (all Interventional Suites). • Cardiac Catheterisation Laboratory (B7) has already adopted and fully complies with the Safe Surgery Policy.
	07/12/2010	• An integrated checklist form for Surgical Safety Process has been endorsed. A pilot scheme will be conducted. • KCC Workgroup on Intervention Procedure Safety Policy was formed and co-chaired by Dr Donald Tang, Dr KT Chan and Dr CH Kwok. This policy will be fully implemented by 3.1.11.
	15/02/2011	• The pilot of the integrated checklist form for surgical safety process in QEH O&T and Surgery Department is in progress. • The interventional procedure safety policy has been fully implemented. An audit will be conducted shortly.
	11/04/2011	• The pilot of the integrated checklist form for surgical safety process is still in progress. • The HA Safety Policy on Bedside Procedures became effective on 1 March 2011 and should be fully implemented by the end of 31 August 2011. It applies but is not limited to 1) Chest tapping, drainage & paracentesis and 2) Insertion of intravascular catheter with the use of guide wire. A meeting will be held to discuss this issue.
3	***Sedation Safety***	

	13/04/2010 08/06/2010 10/08/2011	• Policies of clinical departments are being reviewed for the purpose of preparing a standardized protocol. • Draft of departmental sedation checklists was near completion. • A draft KCC guidelines for procedural sedation had been developed and discussed. It could be implemented in principle if user departments' manpower requirement could be met.
4	***Document Control***	
	08/06/2010	• Target to comply with the standards of Australian Council on Healthcare Standards (ACHS) in July.
5	***Patient Fall***	
	07/12/2010	• A3 size "Sweet Reminders" has been designed and the patient education pamphlet has been revised. They will be distributed to clinical areas in KCC when ready.
6	***Patient Identification***	
	13/04/2010 08/06/2010	• Due to the unexpected delay in the delivery of UPI co-ordinated by HAHO, the implementation date of UPI system in HKEH would be deferred to end of May. • HKEH will implement the 2D barcode system for labeling of all in-patient specimens on 28.6.10. Related training is scheduled for 21.6.10. • To provide better quality wristbands for patients, a new wristband design has been developed. System Scanning Ltd will continue to be the supplier for the adult and paediatric patient wristbands. All existing wristband printers will require tuning to suit the new design. The proposed date of live run for KH, HKEH is August 2010; QEH October 2010 and HKBH February 2011.

	10/08/2010	• A number of incidents regarding unlabelled blood culture specimen had been reported. The causes of these incidents were still undetermined. A RCA workgroup had been formed to find out the possible reasons. • A number of mislabeling incidents had been reported recently. Most of them were due to the use of the traditional 1D barcode system (bypassing the new 2D barcode system). Measures will be made to restrict the use of GCRS (1D barcode) machines. • The UPI Phase III Training was provided for HKE staff and QEH housemen on 21.6.10 and 25.6.2010 respectively. • As the new UPI devices had not yet been programmed for KCC's specific setting, the UPI implementation in HKE had been postponed until further notice from HAHO. • A new design had been developed to improve the quality of patient wristband. The proposed dates of implementation of the new design were as follows: - KH: 3rd week of August 2010 - HKE: 3rd week of August 2010 - QEH: 1st week of October 2010 - HKBH: 5th week of January 2011
	07/12/2010	• A new design has been developed to improve the quality of patient wristband. HKE and KH had commenced using the new wristbands since 18.8.10. QEH and HKBH will start in January 2011. • UPI devices have been upgraded to mitigate misidentification. • RIE on "unlabelled blood culture" is in progress. • Adoption of 2D barcode technology in portable X-ray is under discussion.
	15/02/2011	• A new design has been developed to improve the quality of patient wristband. QEH had commenced using the new wristbands since 6.1.11. HKBH will start in May 2011. • According to HAHO, the new UPI sets will be available in 1Q 2011. UPI Phase III could be rolled out to HKE and KH when the new UPI sets are ready.

	11/04/2011	• A survey is being conducted in QEH, KH and HKE to collect feedback on the new patient wristband. • The pilot of UPI for portable X-ray will be conducted soon. Target date for implementation is 3Q 2011.
7	***Pressure Ulcers***	
		• Coordination between Geriatrics and Nursing units were organized. • Pressure ulcer charts were reviewed and implemented
8	***Infection Control***	
	08/06/2010	• A hand hygiene ceremony was held on 5.5.10. • A scheduled Education talk to Infection Control Link Nurse (ICLN) focusing on preventive measure to reduce NSI will be conducted on 10.6.10. • A programme to reduce Needle Stick Injuries (NSI) after use of needle before disposal will be implemented in July 2010. • A Cluster Environmental Hygiene Committee has recently been set up. • A protocol on the appropriate dilution of Hypochlorite has been developed. • A protocol and checklist on Infection Control Risk Assessment for Construction and Renovation work has been developed.
9	***Data Security***	
	08/06/2010	• An information security and Privacy compliance check-list was distributed to all department and operational units in KCC in May 2010. All departments are requested to complete the audit and return their return in 3Q10. • The Clinical Management System / Electronic Patient Record (CMS/ePR) access audit (non-green zone, staff, private patient) was completed in May 2010. 66 cases were audited. A total of 18 queries were raised with involvement of 12 staff. Only one case was required further follow up. • The HA Guidelines on Information Security and Privacy Incident Management relating to lost / misplaced personal records / data was issued to all KCC Senior Managers and Units Heads on

		17.4.10. • The updated guideline for handling of unclaimed USB and other data containing electronic devices found within the hospital compound was issued to all KCC Senior Manager on 13.5.10. • The new e-learning course in English and Chinese on protecting patient privacy and data security was developed and available online. Staff were reminded to participate in the course before 17.5.10.
	07/12/2010	• Most units / departments have conducted the Information Security and Privacy Compliance Check as at 12.10.10. A report will be compiled accordingly. • The Endpoint Encryption for Removable Media (EERM) was implemented at open workstations in QEH in August 2010. It will be implemented in other KCC hospitals in 4Q 2010. • The 'Patient Selection Panel' (PSP) function has been enhanced on 29.9.10. The HKID & DOB of patient would be masked from the initial screen of the patient name search function in the PSP. • Corporate Information Security and Privacy Office (CISPO), HAHO has issued and distributed 'Information Security and Privacy Training Kit for General Staff' (including a video clip of 8 mins and a quiz) to HRs of all clusters on 5.11.10 for action.
	15/02/2011	• An Executive Walk Round for Privacy Compliance was held on 13.12.10. Members involved CCE and colleagues from HA IT, KCC IT & Q&S. The report revealed that the compliance in KCC was satisfactory.
10	***Safe Handling of Abnormal Investigation Reports***	
	07/12/2010 15/02/2011 11/04/2011	• Workgroup meeting would be held bi-monthly. Individual department workflow would be brought into focus. • The workflow on investigation findings in A&E was reviewed. Recommendations were made to them. Next unit to be reviewed is Day Ward/QEH. • The workflows on investigation findings in Day Wards of HKBH and QEH were reviewed. Recommendations were made to them. Next unit to be reviewed is ACC/QEH.

Others	11/04/2011	Informed Consent • The Informed Consent SOP has been revised and adopted. • Departments are reviewing their information pamphlets to facilitate patient/carer understanding. • The QEH Audit on Informed Consent in 2010 has been completed. The finding reviewed that all operations / procedures were performed as consented. Several recommendations have been made for improvement.

3.2 APBEST AWARDS

APBEST Implementation in QEH

The Asia Pacific Business Excellence STandard (APBEST) Award programme has been commenced in January 2009. Under the guidance of an external consultant, seven hospital departments (Central Nursing Division, Administrative Services, Human Resource, Accident & Emergency, Anesthesiology & Operating Theatre Services, Pathology, Surgery) embarked on a one-year journey of learning, self-assessment, and planning using European Quality Award (EQA) criteria to identify strengths and areas for improvement. The evidence of achievements was summarized in the Award Submission Document for the scrutiny of the Board of Examiners (comprising 5 international experts on quality management), and a site verification visit was conducted by 3 international examiners on 13th August 2010.

Onsite Verification Visit for APBEST 2010 on 13th August 2010

APBEST Examiners and Department Representatives on 13th August 2010

According to the EQA scoring framework, QEH was given a score of 774 out of the total 1000 which is unprecedentedly high as compared with the Spanish hospitals where the EQA is very popular. Through examining the submission documents and during the visit and interview with staff and patients, the examiners were deeply impressed by the dedication of hospital team and the quality of service. The achievements were reflected in the examiners' conversations with patients who unanimously expressed great appreciation to staff members and the services received. As a result, QEH topped all the other commercial or non-commercial competitors in the Asia Pacific region, and received the Grand Award and four other corporate and individual awards under the ABPEST:

- Queen Elizabeth Hospital:
  - "APBEST Grand Award Winner of the Year"
  - "BEST Hospital in Asia-Pacific" and overall winner
- Dr. HUNG Chi-Tim, Hospital Chief Executive:
  - "APBEST Strategist of the Year".
- Dr. CHOW Yu-Fat, COS (A&OTS):
  - "APBEST Customer Services Driver of the Year"
- Dr HO Hiu-Fai, COS (A&E):
  - "APBEST Operations Driver of the Year"

The outstanding results in the APBEST Award symbolized an international recognition of the QEH Hospital quality management. Traveling the APBEST journey, staff members have also gained invaluable insight and impetus for the ongoing quality movements, notably the ACHS Hospital Accreditation Pilot Scheme.

Project Presentation by Dr. T C Wu, Associate Consultant (Med) QEH

Dr. C T Hung receiving the "BEST Hospital in Asia-Pacific"Award

Group Photograph with Organizer and other APBEST candidates

3.3 ACHS Hospital Accreditation

3.3.1 Organization Wide Survey 2010 in QEH

The Australian Council on Healthcare Standards (ACHS) Organization Wide Survey (OWS) was completed in QEH on 19-23.7.10. Full accreditation was granted by the Australian Council on

Healthcare Standards (ACHS) and three areas were rated with Extensive Achievements which include:

(a) Systems for ongoing care of the consumer / patient are coordinated and effective

(b) Healthcare incidents, complaints and feedback are managed to ensure improvement

(c) External service providers are managed to maximize quality of care

The ACHS Hospital Accreditation Certificate Presentation Ceremony for QEH was completed on 14th March 2011 with an attendance of about 150. Representatives for medical and nursing staff, and patient groups were invited to share experience on hospital accreditation and quality healthcare.

Experience sharing by Dr. M H Leung, Associate Consultant (Med), QEH

Experience sharing by Ms S L Leung, Ward Manager (Surg), QEH

Experience sharing by Mr. Tong Chow, Chairman of Mutual Aid Association Ltd. (Nasopharyngeal Carcinoma Patient Self-Help Group)

Dr. C T Hung receiving the ACHS Hospital Accreditation Certificate

Guests are Mr Brian Johnston, Chief Executive ACHS & ACHSI; A / Prof Peter Woodruff, President ACHS & ACHSI Board; Mr John LEE, JP, Chairman HGC / QEH; and Dr LIU Hing Wing, Director(Quality & Safety) HA

In response to the recommendations from the OWS in QEH and to prepare for phase II implementation in cluster hospitals, cluster based working groups on specific EQuIP criteria have been set up to streamline and strengthen practices on respective aspects which include: Assessment and care planning; Discharge and ongoing care; Care of dying; Information to community; Access and admission; Pressure ulcer; Patient falls; Consumer participation; Population health.

3.3.2 Self Assessment 2011 in QEH

Along the EQuIP hospital accreditation cycle, OWS is not the destination. In fact, the completion of the OWS denotes the commencement of another phase of this cyclical exercise in continuous quality improvement. It conveys expectations and new challenges to the organization every year. QEH has been undergoing the Self Assessment 2011 and the scope of review covers all criteria of the Clinical Function of EQuIP, all the mandatory criteria, and recommendations given in the OWS 2010. The Self Assessment report is being compiled via the CQI electronic system into which departments are submitting improvement projects. The report will be submitted to ACHS on 19th July 2011.

3.3.3 2nd Phase Implementation of Hospital Accreditation

The 2nd phase hospital accreditation involving 15 HA hospitals will be rolled out in 2011. In KCC, KH and BH will be participating the phase II program which will be commenced after mid-2011 and expected to be completed within 3-5 years.

3.4 Year Of Quality – Strategic Planning

KCC has moved into the third and final year of the rolling "Years of Safety" program. In the previous two years, we have been focusing specifically and rightly on improving patient and staff safety, which are arguably the most fundamental attributes of quality health care delivery. With the safety-conscious mindset firmly engraved, colleagues of KCC are ready to engage themselves upfront in the broader arena of "quality in healthcare". Encircling this frame of mind, the participants of the "2010 KCC Quality Strategic Workshop" set out to explore about healthcare quality improvement in this one day workshop held on 4th December 2010.

The workshop was held at the Breakthrough Youth Village Shatin and a total of 76 colleagues had participated. During the workshop we have adopted the more comprehensive 9- dimension healthcare quality model to start our journey. The categorization of quality dimensions is more than an academic exercise – it provides an understandable framework for the important achievable goals of quality, and put our current improvement activities into perspectives, particularly in the perspectives of our "customers" (patients, relatives, carers etc).

3.4.1 Nine-dimension healthcare quality model

During the workshop, a number of process and outcome indicators were identified which when collected and reviewed along the courses of the improvement actions, will help to complete the Plan-Do-Check-Act quality improvement cycle of Deming. In fact, the workshop had been designed and conducted with the Deming model in mind, and going through the one-day program participants have journeyed through a condensed PDCA cycle. It is foreseen that a number of the discussed projects will come to fruition by the end of this year, and be presented in the year-end KCC Quality Convention.

Butterfly Game – "… eventually, we knew that we were leading the move of each other…"

Yes! We got it!

Victory!

We work as a TEAM!

4. Learning & Sharing Information

A full-time Senior Hospital Manager has been deployed in early January 2011 to coordinate, enhance and sustain the staff education and development in initiatives relating to Q&S.

4.1 Project Learning

The year of 2009/2010 was both a consolidating and rewarding year for project learning in KCC. Based on the 'Three Pillars' model, we engaged and developed KCC staff through various WISER (We Innovate, Services excel regularly) project learning initiatives:

(a) Project coaching

(b) Corporate awareness

(c) Sharing forums

4.1.1 Project Coaching

A total of 37 projects were registered. Based on the department burning issues, various levels of front-line staff worked together, tried out the lean tools and accomplished remarkable business outcomes like reduced waiting time for daily procedures.

Six A3 coaching sessions were conducted to develop staff's competency in completing and documenting the WISER projects.

4.1.2 Corporate Awareness

To develop one common language of services innovation and enhancement, 43 WISER Awareness workshops were conducted across all cluster hospitals. A WISER Link was also established in October 2010 to educate staff on lean tools and techniques through electronic means.

4.1.3 Sharing Forums

To further engage staff in their project accomplishments, they were invited to present their completed WISER projects through structure sharing forums.

Three Come and Be WISER Forums were arranged with 8 projects shared by the front-line staff.

4.2 Recognition & Awards

Through the 'Three Pillars' approach, 'KCC WISER Movement' was accepted for poster display in HA Convention 2011. In addition, KCC WISER Movement was also related as one of the 6 finalists in the Hong Kong Management Association Award for Excellence in Training & Development 2011, which is one of the most prestigious awards in Hong Kong. The Final presentation would be held on July 15, 2011.

1 Structure & Initiatives

1.1 Quality & Safety Management Structure

On 1 Dec 2010, KEC had appointed a new Cluster Service Director (Quality & Safety), who was also appointed as Service Director (Quality & Safety) of UCH since 3 Jan 2011.

1.2 Initiatives in KEC Quality and Safety

Under the new management, the division had undertaken process re-engineering both internally and externally in driving for efficacy and effectiveness:

1.2.1 Strengthened the internal structure and process of the KEC Quality & Safety (Q&S) Division

1.2.2 Streamlined various platforms of education and communication about Q&S

1.2.3 Improved effectiveness and efficiency of cluster Q&S committee meeting

1.2.4 Enhanced accountability of Q&S division to hospital and cluster management through reporting

1.2.5 Incorporated ISPO as Q&S division member

1.2.6 Enhanced incident management at departmental level

1.2.7 Established executive partnership program to augment exposure of middle managers in Q&S

1.3 Promotion of 'Think Safe, Work Smart'

To sustain the momentum gained from 2010, the KEC Quality Week 2011 was conducted under the theme "齊心合意集大成 , 優化工序善流程 Think safe, Work smart". The main objective was to fortify quality culture in our cluster through staff participation in the various quality-related activities. The week was kicked off with the 'KEC Quality Conference 2011' at which various speakers shared with the audience their experience and expertise on areas related to risk management and quality enhancement. The conference was followed by workshops & visits under the pivot of 'workflow improvement', and also the patient safety rounds. The quality week had delivered an efficient platform for staff in consolidating and synergizing their efforts in the quest for service betterment.

1.4 KEC Convention

To enable staff to refresh on the good quality endeavours exemplified in the HA Convention, the KEC Convention was held in May 2010. Staff selected for oral presentation in the HA Convention and those outstanding staff and team receiving the HA merit award shared their good works on various patient safety and service enhancement areas.

1.5 Consolidation of CQI Concept

In order to revitalize the importance of CQI concept, there were regular Q&S forums conducted by inviting colleagues of different streams to share their CQI programs. A UCH Forum on HA CQI Initiatives was also held by inviting HA Q&S Division to coach departmental coordinators on use of the HA CQI Initiatives System. The latest 'competition for the best CQI program in KEC' under the KEC Quality Week 2011 also marked the culmination of staff engagement in quality culture building via the number of abstracts received. The thrust of driving CQI in the cluster would be sustained as one of our major initiatives.

1.6 Preparation for Hospital Accreditation

1.6.1 KEC Cross Hospital Survey

In preparing for future accreditation exercise, KEC had organized the 4th

cross hospital survey among UCH, TKOH & HHH in Oct 2010. A total of 6 ACHS criteria were selected as mock exercise for staff to go through the survey process. Summation sessions were held at the end of each survey during which good practices and services gaps were shared. Follow up actions on those identified gaps were undertaken to complete the loop in attainment of quality improvement.

1.6.2 Seminars on Hospital Accreditation and Teaching Walkround

Capacity building and knowledge sharing were two essential pillars in preparing for hospital accreditation. In Dec 2010, we had invited representative of HKWC and NTWC to share their invaluable experience on accreditation. In Feb 2011, representative of KCC and KWC were invited to conduct seminar followed by teaching walkrounds. Staff all found these activities both informative and educational.

1.7 Patient Safety Enhancement

1.7.1 Executive Patient Safety Walkround

To demonstrate top level commitment to patient safety as well as establishing direct line of communication with frontline colleagues, regular patient safety walkround at hospital and cluster levels were conducted. In Jan 2011, a cluster grand round comprising 4 teams led by invited experts as team leader was organized. Relevant good practice and areas of recommendation were shared. Follow up improvement actions were devised with progress monitored timely.

Walkrounds conducted in first half of 2010/11 (Apr to Sep 10)

Nature	No. of action items	No. of items completed within 2010/11	Percentage of completion	Remarks
Cluster	6	6	100%	-
UCH	39	31	80%	Remaining items: In progress with target completion date defined

1.7.2 Promotion of Use of Correct Specimen Bottles

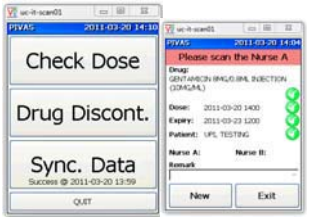
Following the introduction of new specimen labelling policy, a propaganda campaign was organized through email communication, face-to-face training with interactive exercise, poster and promotion. The main objective was for improving accuracy of labelling appropriate blood specimen containers by staff, in particular the phlebotomists and interns. Through the conjoint efforts by

various departments, the number of inappropriate blood specimen container incidents also experienced a significant drop by 66% before and after implementation of the policy.

1.7.3 Medication Safety - PIVAS (Pharmacy IntraVenous Admixture Service)

The program embraced the following features:

- Enhancement of safe and effective use of medication for NICU & PICU patients thro' clinical pharmacy service & unit dose dispensing of high risk medications, commonly used antibiotics etc
- IT support on pharmacy web application of reconstitution worksheet, unit dose preparation worksheet
- Support with handheld device for drug administration checking and discontinuation
- Other features include: Alarm for due dose, PIVAS dashboard, dose time label (Label for every 36 hours)



1.7.4 Infection Control

Key initiatives were in place pertaining to infection control areas:

<table>
<tr><th>Initiatives</th><th>Performance</th></tr>
<tr><td>Control of MRSA infection
– Review existing practices in individual units
– Target on high risk areas
– Develop rapid molecular detection method
– Develop mechanism for prompt isolation, decolonization and patient education</td><td>MRSA bacteremia for acute episodes (cases per 1000 bed days)

<table><tr><th></th><th>2008</th><th>2009</th><th>2010</th></tr><tr><td>KEC</td><td>0.1271</td><td>0.1243</td><td>0.1162</td></tr><tr><td>HA Mean</td><td>0.1718</td><td>0.1735</td><td>0.1503</td></tr></table></td></tr>
</table>

<table>
<tr><th>Initiatives</th><th>Performance</th></tr>
<tr><td>Antibiotic Stewardship Program
– Antibiograms & guidelines for empirical therapy
– Formulary restriction and pre-authorisation
– Staff education
– Antibiotic order forms
– Audit and feedback</td><td>– Compliance (%) to recommended indications of “Big gun” antibiotics
<table>
<tr><th></th><th>UCH</th><th>TKOH</th></tr>
<tr><td>2008</td><td>94</td><td>70</td></tr>
<tr><td>2009</td><td>94</td><td>85</td></tr>
<tr><td>2010</td><td>96</td><td>88</td></tr>
</table>
– Utilisation of “big gun” antibiotics in terms of DDD per 1 000 BDO
<table>
<tr><th></th><th>UCH</th><th>TKOH</th><th>HA average</th></tr>
<tr><td>ICU</td><td>298.41</td><td>292.99</td><td>274.1</td></tr>
<tr><td>Medical</td><td>34.18</td><td>24.18</td><td>45.48</td></tr>
<tr><td>Surgery</td><td>21.91</td><td>10.1</td><td>35.41</td></tr>
<tr><td>Orthopedic</td><td>6.69</td><td>8.11</td><td>12.75</td></tr>
</table></td></tr>
</table>

1.8 Process Re-engineering in Bed Booking System in KEC

To streamline patient transfer arrangement in the cluster, the Inter-hospital Patient Transfer Working Group had developed an automated intranet-based bed-booking system. The system had allayed cumbersome manual operation of the bed booking system and enhanced transparency of booking status. The project also received a silver award from the Bright Suggestion Scheme as recognition of its merit in bringing forth workflow improvement.

1.9 Occupational Safety and Health (OSH)

OSH team had organized and coordinated various CQI programs and training in development of a safety management system. These included management of major nature of injuries, 5S, manual handling operations, display screen equipment, work at height, trolleys operations and staff wellness programs. There was also coordination of multi-departmental drills on workplace violence & chemical spillage as well as regular OSH visits. Their endeavours had attained the following achievement and recognition:

1.9.1 Number of IOD per 100 staff was decreased by 7.4% and IOD sick leave day was decreased by 55% in 2010/11 (in comparison to same period of 2009/10).

1.9.2 Cluster OSH Coordinator / CGM(HR) had received a Bronze Award (Management Category) in the 2nd OSH Best Employee 2010 organized by the Occupational Safety and Health

Council (OSHC).

1.9.3 3 OSH Improvement Projects had received Merit Award in various recognition schemes organized by the OSHC.

1.9.4 1 submission from OSH team was accepted by HA Convention for oral presentation and 3 were accepted for poster display.

1.10 Information Security and Privacy (ISP)

1.10.1 Privacy Walkround

The KEC Privacy Walkround with Corporate ISP team was successfully conducted in July 2010. The main objectives of the walk round was to ascertain compliance with PD(P)O and HA ISP Policy by the frontlines and build up culture on data privacy and security. The walkround provided staff a good opportunity to reflect and refresh on current system. A lot of good practice was also acknowledged by the corporate team.

1.10.2 KEC e-Media Disposal Campaign

To uphold the data protection principle in handling of electronic personal information, KEC ISP office had organized the campaign to clear and develop a process for proper handling of unused electronic storage media. With the positive response and support from staff, KEC had sanitized over 7,000 pieces of electronic storage media. The Campaign had enriched staff knowledge on proper handling of electronic storage media and fostered the information security culture in KEC.

1.11 Quality & Safety Bulletin

To nurture the quality and safety culture in the cluster, a monthly newsletter was published to keep staff abreast of latest knowledge and operational tips related to quality and risk management issues. The newsletter was formally renamed as 'KEC Quality & Safety Bulletin' in Jan 2011. A review was also conducted to refine its scope. The bulletin under the new format encompassed a three-month cycle with the following themes:

1st Month	2nd Month	3rd Month
Sharing of quality & safety topics by subject functional officers	Quality programs sharing by cluster hospitals	Cluster SE/SUE sharing
+ / - Topical sharing		
Accreditation tips		
Translation of selected article from HA Risk Alert		

2 Risk Prioritization

2.1 Identified clinical risks for 2010-2011 (as reported last year)

	Identified clinical risk
1	Medication incident
2	Wrong site surgery
3	Retained foreign objects
4	Specimen mislabelling
5	Patient suicide
6	Inter-hospital transfer
7	Patient fall
8	Patient documentation
9	Resuscitation
10	Transfusion

2.2 Identified Non-clinical (operational) risk for 2010-2011 (as reported last year)

	Type	Identified operation risk (not necessary in order of priority)
1	Compliance / IT	Information security
2	OSH / Security	Workplace violence
3	Compliance	Mortuary
4	Corporate / Compliance	Compliance of HA related ordinances
5	Physical resources	Health and safety: Fire
6	OSH	Manual handling operations
7	Compliance / Security	Visitors requiring medical assistance
8	Physical resources	Facility breakdown / Utilization (environmental safety scanning)
9	Property / Security	Security and access to wards / departments
10	IT	Computer virus outbreak led to IT system breakdown

2.3 Identified clinical risks (in order of priority) for 2011-2012

	Identified clinical risk (in order of priority)
1	Medication Management ● *improvement of dispensing accuracy* ● *medication safety in relation to drug administration* ● *medication safety and storage of drugs in wards (ward stock) including dangerous and controlled drugs* ● *Look-Alike Sound-Alike medications* ● *medication safety (Verbal / Phone order of medications)*
2	Patient Falls (with special reference to): ● *prevention through standardization of the assessment process* ● *streamlining the process of evaluation* ● *inpatient fall assessment and intervention programme*
3	Infection Control ● *enteral feeding decontamination* ● *sluice room environment management*
4	Retained Instruments or Other Material
5	Blood Specimen Collection in Right Container
6	Correct Patient Identification for Radiology Service

2.4 Identified Non-clinical (operational) risks for 2011-2012 (not necessary in order of priority)

	Identified operation risk (not necessary in order of priority)
1	Workplace Violence ● *workplace violence in out-patient setting*
2	Information Technology ● *hospital data centre breakdown* ● *web server failure* ● *loss of data due to desk top computer failure*
3	Injury On Duty ● *staff slip, trip and fall* ● *sharps injury*
4	Telecommunication System Failure (PABX, mobile and internal paging service)
5	Loss of Records Containing Personal Identifiable Information
6	Drainage Problem
7	Theft or Damage of Hospital Property
8	Unsettled Bills

3 Risk Reduction and Quality Programs

In line with the development 2010 / 11 KEC Risk Register for both clinical and operational risks, the corresponding risk reduction / quality programs were identified and monitored. The results are summarized below:

Item	Program name	Result / Evaluation on Effectiveness
Clinical Risks		
1	*Medication incident* (a) Strategies to reduce incidents on prescribing / administering "KDA" drug to patients. (b) Minimize risks in the use of "Neuromuscular Blocking Agents"	● All ward stock penicillin group antibiotics were labelled with alert sign. ● All neuromuscular blocking agents were kept in designated container with alert label.
2	*Wrong site surgery* <u>OR of TKOH</u> Establish, implement and conduct audit on "Surgical Safety Checklist". <u>OR of UCH</u> (a) Conduct audit on "Surgical Safety Checklist". (b) Develop "Surgical Safety Checklist" in Chinese version to facilitate better verbal communication among surgical team members.	● Hospital wide training on use of "surgical safety checklist". ● Compliance Audit in 3Q11. Target: 100% compliance. ● Over 92% staff compliance. ● The Chinese version of Surgical Safety Checklist was user friendly. ● Survey on user satisfaction and audit on improvement of communication among surgical team members during surgical safety checking.

Item	Program name	Result / Evaluation on Effectiveness
3	*Retained foreign objects* OR of TKOH & UCH (a) Launch web quiz on HAHO peri-operative nursing standard of "Counting of Accountable Items used during Operative Procedures" as a self-test for every OR nurse. (b) Develop intra-operative "Count Sheet" as medical record and for hospital accreditation (c) Devise "Gauze Count Bag" to eliminate swab rack in OT room and to facilitate infection control & counting, and for hospital accreditation.	● UCH: Achieved over 97% compliance. ● TKOH: Quiz under preparation. Target: 100% compliance. ● UCH: Electronic counting program followed by user satisfaction survey. ● TKOH: Pilot completed followed by trial run. Target: 100% staff compliance. ● UCH: Final version adopted and program to be rolled out in May 2011; followed by user satisfaction survey. ● TKOH: Sourcing in progress.
4	*Specimen mislabelling* Establish clear instruction for users to adopt right specimen containers for specimen collection.	● Posted up education material in emails and as screen savers in CMS workstations. ● Change of IT set up to print colour code of bottle caps onto GCRS labels. ● Conducted campaign in promotion of using right specimen containers for blood. ● Established search function for information of specimen containers for various tests.
5	*Patient suicide* (a) Adopt HAHO initiative to further strengthen the existing systems for minimizing suicide incidence. (b) Incorporate the suicide assessment tool recommended by the "HAHO TF on Patient Suicide" for frontline staff to early detect those patients with	● The 3 suicidal screening questions had been incorporated in the initial nursing assessment forms and performed on admission in HHH, TKOH and UCH. ● Suicidal precaution measures and appropriate nursing interventions were carried out according to risk of suicide identified

Item	Program name	Result / Evaluation on Effectiveness
	high suicidal risk in general wards of HHH, TKOH & UCH.	
6	*Inter-hospital transfer* Streamline HHH Bed Booking System to facilitate patient transfer from UCH / TKOH to HHH.	Simplified and ensured an accountable system for bed booking with basic statistics on bookings available in the system.
7	*Patient fall – reduction of fall risk* (a) Assessment of fall risk to be conducted for all inpatients in 3 cluster hospitals. (b) Individual clinical unit would be requested to monitor its own fall rate and recommend improvement plans. (c) Fall rate would be monitored in individual hospital and KEC NQRM. (d) Sharing of good practices among 3 hospitals.	● Fall assessment conducted on admission and as physical condition required. ● Fall incident trend was provided to clinical unit to facilitate monitoring fall rate and recommendation on improvement plans. ● Fall rate was monitored. It was decreased by 6.76% in KEC in comparison of 09-10 statistics. ● Relevant good practices were shared.
8	*Patient documentation – Enhancement of nursing documentation* (a) Standardize the content of nursing observation chart in KEC. (b) Pilot Patient Assessment System in UCH. (c) Evaluate the audit result of "Nursing Documentation" completed in 1Q10 and recommend improvement actions.	● Nursing observation charts with standardized content had been implemented in 2Q10: UCH (modified version); TKOH/HHH version. ● Patient Assessment System was piloted in 4 wards of UCH. ● The audit result of 'Nursing Documentation' completed in 1Q10 was evaluated and practice was reinforced.

Item	Program name	Result / Evaluation on Effectiveness
9	*Resuscitation – ensure and monitor the resuscitation of patients both within the hospital complex and in the hospital vicinity* (a) Implementation : ● Staff education Scheduled training on BLS & recognition of cardiac arrest and conditions requiring resuscitation ● Staff awareness Define catchment areas and corresponding response teams; availability of resuscitation drugs and equipment; program flowchart / algorithm / telephone hotline for activating the response team; periodic program reminders by posters / seminars / website and drills (b) Program monitoring ● Capture cases and perform regular audit by reviewing the resuscitation records to ascertain compliance ● Availability of scheduled training on BLS	● Staff training commenced in Feb 2011. Target: 100 additional staff to be trained. ● Resuscitation manual was updated & published. ● Resuscitation manual was updated & published. ● Ensured all defibrillators were biphasic type. Over 90% completed. ● Adopted AHA 2010 guidelines for planning algorithm for activating response team. ● Website under construction. ● 7th resuscitation record audit was completed. ● Courses under arrangement.
10	*Transfusion* Internal audit on compliance with requirement for performing ABO on new cases by 2 independent technical staff during office hours.	100% compliance achieved.

Item	Program name	Action & Result
Operational Risks		
1	*Information security* (a) KEC (UCH, TKOH & HHH) Annual ISP Audit.	● Overall compliance: 99%.

Item	Program name	Action & Result
	(b) KEC e-media Disposal Day.	● The campaign had sanitized more than 7,000 pcs of e-media. Proper handling of e-media was standardized in KEC. ● Endorsed SOPs on Proper handling of electronic media with personal information had been promulgated to all KEC staff.
2	*Workplace violence* (a) Issue Security Newsletter to enhance awareness & experience sharing. (b) Security Seminar by Crime Prevention Bureau. (c) Security Training in collaboration with PWH. (d) Purchase of forearm cuff for security team. (e) Workplace Violence Training (level I + physical restrainer skill). (f) Consolidate recommendations made in last risk assessment at high risk departments.	● Arrangement was ongoing. The next (4th) issue Newsletter would be published in July 11. ● Annual Security Seminar was held on 25 March 11. ● Identity Counterfeit Banknotes Talks held in collaboration with PWH on 31 Jan 11. ● Purchase was done. Protective gears for security team were improved to enhance physical protection. ● Training for professional staff (Level I) and supporting staff (Level I & physical restraint) were held in Jun and Aug respectively. ● Completed in AEDs of TKOH and UCH.
3	*Mortuary* (a) Internal audit on compliance with SOP on reception and issuing of bodies. (b) Intra-cluster cross hospital audit on compliance with SOP on reception and issuing of bodies	Minor non-compliance noted due to local variation in SOP. Rectification already made.
4	*Compliance of HA related ordinances* (a) Update subject officers about the guidelines and related implementation documents of the HA ordinances under their scope	The exercise was completed in Dec 2010.

Item	Program name	Action & Result
	of operations. (b) Consolidate returns from KEC subject officers to ensure compliance with HA related ordinances on an on-going basis.	
5	*Health and safety: Fire* (a) Cluster Fire Safety Committee to align standards & practice. (b) Develop fire safety orientation checklist for induction and refresher training purpose at frontline. (c) Standardize design of fire evacuation plan. (d) Design fire inspection checklist for routine inspection. (e) Coordinate Fire Safety Ambassador Training.	● Committee was established. ● Orientation checklist and fire inspection checklist were prepared and issued by OSH team in Nov 10. ● The design of fire evacuation plan was confirmed. ● Fire inspection checklist for routine inspection was confirmed. ● Fire Safety Ambassador Training was held on 28 Feb 11.
6	*Manual handling operations* (a) Form local support network for MHO & DSE. (b) Conduct regular MHO refresher training to supporting colleagues who are at high risks. (c) Conduct annual MHO refresher training to MHO coordinator/subject officer. (d) Conduct OSH/MHO training to newly-recruited nursing	● MHO incidents were reduced by 10.6% (104 to 93) [Yr 2010 in comparison to 2009]. ● Local support network formed by ergonomic members. ● Supporting Service (Care-Related): 5 classes (June, July, Sept, Dec 2010, and Mar 2011) with duration of 2 hours each. ● Supporting Service (General):1-2 classes per dept. per year. supervisor: 2 hours front-line: 1 hour (including HSK, TRN, Catering, Security, Laundry). ● For others including nursing, AH and medical, review would be made by OSH training sub-committee for addressing training needs, evaluating progress and effectiveness. ● Training was completed on 1 Sept 2010.

Item	Program name	Action & Result
	colleagues. (e) Produce training material in MHO assisted aids/equipment.	● Production was in progress.
7	*Visitors requiring medical assistance* (a) Conduct drill on relevant incidents.	Workplace violence drill at AED in coordination with OSH team and AED was held on 19 Jan 11.
8	*Facility breakdown / Utilization (environmental safety scanning)* <u>Medical Equipment</u> (a) Annual utilization report for major and selected minor equipment. (b) Perform annual equipment breakdown analysis (on major and minor equipment) to review breakdown rate of individual equipment for management review. (c) Aged major and minor equipment (e.g, equipment aged over 10 years) with high breakdown rate and / or no maintenance support will be accorded with higher priority within KEC in the CBV 3-5 year equipment planning exercise	● Half year utilization report (Jan – Jun 2010) was endorsed at KEC CTC and CMC in Sept 10. On going utilization data was being captured and monitored. ● Replacement plan for 4 Types of mid-ranged ($150K - $1M) equipment including Endoscopic, Pathology, Physiologic and Ultrasound with age over 10 years were reviewed with due consideration of the age profile and breakdown analysis. Findings had been incorporated in the CBV planning exercise in 2011. 3-year replacement plan for the 6 types of OLV equipment (value below $150K) was in place and awaiting funding support. Batch replacement of OLV equipment and Loose F&E items were planned with due consideration of breakdown rate, safety concerns, and age profile. ● Replacement plan for other types of mid-ranged and major equipment including CT and MRI with breakdown analysis were conducted and used for CBV planning for 12-13.

Item	Program name	Action & Result
	Hospital Engineering Systems (a) Enhance planned maintenance programme. (b) Conduct drill on contingency plan regularly. (c) Review plant and facility utilization profile and backup capacity.	● The planned maintenance schedule for 2011 had been updated and uploaded in website for sharing. ● The drill for other system was scheduled in accordance with the plan. ● The utilization profile and actual condition of plant and system were reviewed and evaluated.
9	*Security and access to wards / departments* (a) Drill on contingency plan for Access Control System breakdown. (b) Review keeping and management of door keys in Security Department. (c) Review the key copying procedure (d) Develop SOP for key management and ACS card management.	● ACS drill was conducted in Dec 10. ● Review was done with different risk level of keys management adopted. ● Review was done and safe copying and record of keys was ensured. ● SOP for keys management developed with access to different risk levels being incorporated.
10	*Computer virus outbreak led to IT system breakdown* Based on the weekly PC compliance reports from HOIT, local ITs would update the virus definition files on those non-compliance computers.	● 98% of the hospital computers had the latest anti-virus software and definition files to prevent virus infection. ● 2% were those who had notebook computers and might not always get connected to HA network.

4 Learning & Sharing Information

4.1 Related to Risk Management / Patient Safety

4.1.1 Sharing on National Forum on Safety and Quality in Health Care (17 Dec 10)

4.1.2 Review of Risk Register 2011/12 (17 Nov 10)

4.1.3 Forum on Risk Register – iSAY (21 Oct 10)

4.1.4 Educational Session on Advance Directive (with illustrative cases) (6 Oct 10)

4.1.5 Complaint Management (TKOH: 4Q 10)

4.1.6 Review of Glass Door Safety and Key Management (15 Sept 10)

4.1.7 A Multi-disciplinary Model of Suicide Prevention in Hospital: Sharing on Experiences and Use of Suicide Checklist & Observation Record by HKEC (1 Sept 10)

4.1.8 DAMS Friendly Visit – Sharing of Good Practices, Opportunities for Improvement (4 Aug 10)

4.1.9 Pain Assessment in Elderly Patient (TKOH: 3Q 10)

4.1.10 SE, SUE, RCA: What have we learnt? (TKOH: 3Q 10)

4.1.11 Basic Life Support Seminar: CPR and Use of Automated External Defibrillator in Resuscitation (2 Jun 10)

4.1.12 Review of Glass Door / Window Safety and Key Management (21 Apr 10)

4.2 Related to Incident Management

4.2.1 Seminar on 'Lessons Learnt from Incidents in 2010' (5 Jan 11)

4.2.2 Open Disclosure & Just Culture (TKOH: 1Q 11)

4.2.3 Sentinel Events – Sharing by CSD(Q&S) & Colleagues (3 Nov 10)

4.2.4 Review of incident related to injection of Morphine as Midazolam (11 Aug 10)

4.2.5 Review of the incident on mislabeled specimen on 25 October 2009 (21 Jul 10)

4.2.6 Review following 3 incidents related to influenza / pneumococcal vaccination (23 Jun 10)

4.2.7 Review after the suicide incident on 22 Aug 09 (26 May 10)

4.2.8 Quarterly sharing of incident trends through KEC QSD web

4.2.9 Monthly sharing of HA incidents through KEC Quality & Safety Bulletin

4.3 Related to Hospital Accreditation

4.3.1 Preparation for Hospital Accreditation – Sharing by QEH & CMC (9 Feb 11)

4.3.2 Forum on Preparation for Hospital Accreditation - Sharing by Pilot Hospitals (21 Dec 10)

4.3.3 Forum on Document Control – ACHS Accreditation (23 Nov 10)

4.3.4 Staff Forum on Hospital Accreditation (5 Aug 10)

4.4 Related to CQI

4.4.1 UCH Forum on HA CQI Initiatives System (13 Dec 10)

4.4.2 Sharing on CQI Programs - Medical Stream (1 Dec 10)

4.4.3 Sharing on CQI Programs - Critical Care (7 Jul 10)

4.4.4 KEC Convention (19 May 10)

4.4.5 Sharing on CQI Programs - Surgical Stream (7 Apr 10)

4.5 Related to Infection Control

4.5.1 A total of 80 courses were conducted by Infection Control Team with 2,529 staff attendance

4.5.2 12 infection control drills performed

4.5.3 Infection Control Related to Q&S Issues (TKOH: 4Q 10)

4.6 Related to Occupational Safety & Health

4.6.1 Coordinated CQI programs in managing major nature of injuries including SSF (slips, trips & falls), Percutaneous Injuries, Manual Handling Operations and Workplace Violence

4.6.2 Organized recognition programs for OSH improvement in 5S, Manual Handling Operation, Staff Wellness and Others and the Best OSH Employee

4.6.3 Conducted 32 OSH training sessions/seminars, such as 5S training on environmental management, refresher and trainer courses on Manual Handling Operations, Safety Management System, Trainer courses on Display Screen Equipment, Work at Height and Trolleys Operations etc.

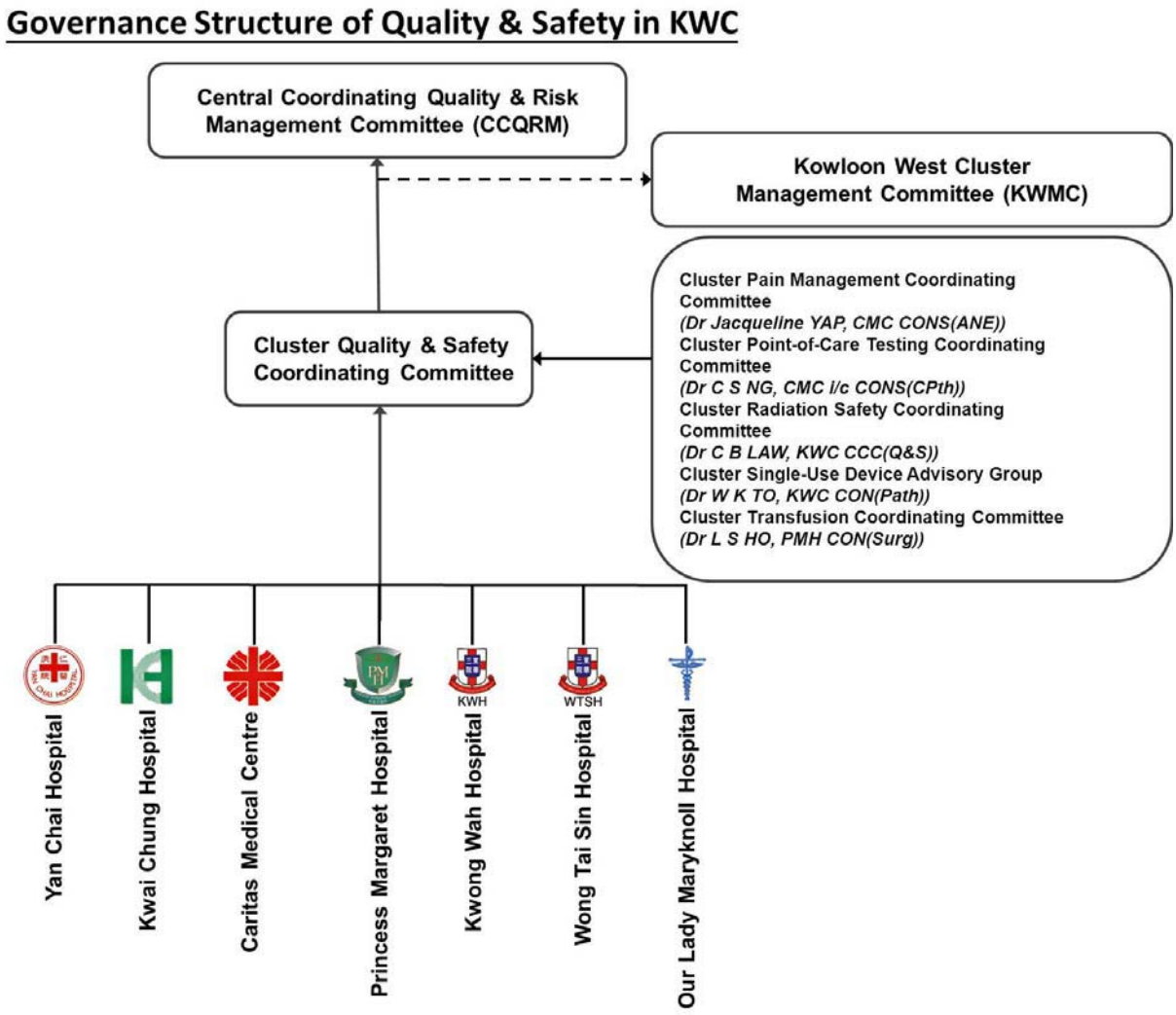
4.6.4 Organized 13 Staff Wellness Programs addressing physical, psychological, nutritional and social perspectives

4.6.5 Conducted OSH Safety Program at M&G Department of UCH and Domestic & Transportation Department of TKOH

4.6.6 Coordinated multi-departmental drills in workplace violence and chemical spillage

4.6.7 Conducted 42 OSH Visits/Consultations to help address OSH concerns

1 Structure & Initiatives



This report covered the period from 1 April 2010 to 31 March 2011 on a wide range of quality and patient safety programs in Kowloon West Cluster (KWC).

The Cluster Quality and Safety Coordinating Committee meets quarterly to oversee all the quality and patient safety issues, such as developing patient safety strategies and programs, formulating safety standards and policies at cluster and hospital levels, and cultivating a safety culture through training, sharing and monitoring. To assist the Committee to execute the KWC quality and safety annual plan and risk reduction programs, a Cluster Quality and Safety Core Group consists of representatives from Q&S departments of KWC hospitals would also meet regularly to implement and review all the activities, and to give expert advices. Regular training for staff on incident and risk management would be organized to upkeep the safety culture in KWC hospitals. Publications on safety events, such as Safety Gist and Quality Bulletin would also be issued monthly to frontline staff for their alert. Quality and safety forums would be held for staff to give their feedbacks on the practice of safety programs.

In the past 12 month, with good collaboration among representatives of KWC Q&S team, KWC hospitals had successfully launched a number of quality and patient safety initiatives with effective measures to advance patient safety.

1.1 Implementation of Interventional Procedure Safety Policy

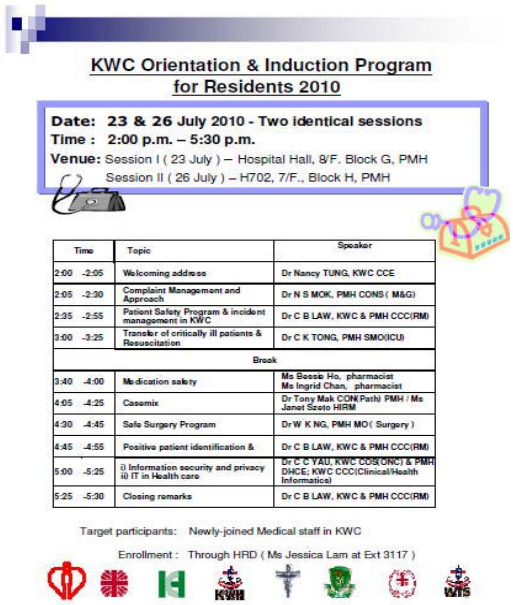
All hospitals in KWC had implemented the Interventional Procedure Safety Policy in interventional suites before end of Dec 2010. The HA Safety Policy on Bedside Procedures which covers the communication and the process during bedside procedures, would be in effect by 31.8.2011. Details of the timeline and work plan were drafted by a workgroup.

1.2 Unique Patient Identification (UPI) Phase III

The Phase III UPI system is a tool to ensure correct patient identification for all blood tests and specimens by using 2-D barcode devices. All hospitals in this cluster had implemented the system in 1Q 2011.

1.3 KWC Orientation and Induction (O&I) Programme for new Residents

86% of the new residents had attended the 3 identical half-day O&I training sessions. The scope of the program was to raise the awareness of residents to common pitfalls and risks in hospital practice, and to strengthen their skill in managing incidents at the beginning of their career.



KWC Orientation & Induction Program for Residents 2010

Date: 23 & 26 July 2010 - Two identical sessions
Time : 2:00 p.m. – 5:30 p.m.
Venue: Session I (23 July) – Hospital Hall, 8/F. Block G, PMH
Session II (26 July) – H702, 7/F., Block H, PMH

Time	Topic	Speaker
2:00 -2:05	Welcoming address	Dr Nancy TUNG, KWC CCE
2:05 -2:30	Complaint Management and Approach	Dr N S MOK, PMH CONS (M&G)
2:35 -2:55	Patient Safety Program & incident management in KWC	Dr C B LAW, KWC & PMH CCC(RM)
3:00 -3:25	Transfer of critically ill patients & Resuscitation	Dr C K TONG, PMH SMO(ICU)
Break		
3:40 -4:00	Medication safety	Ms Bessie Ho, pharmacist Ms Ingrid Chan, pharmacist
4:05 -4:25	Casemix	Dr Tony Mak CON Path/ PMH / Ms Janet Szeto HRM
4:30 -4:45	Safe Surgery Program	Dr W K NG, PMH MO (Surgery)
4:45 -4:55	Positive patient identification &	Dr C B LAW, KWC & PMH CCC(RM)
5:00 -5:25	i) Information security and privacy ii) IT in Health care	Dr C C YAU, KWC COS(ONC) & PMH DHCE; KWC CCC(Clinical/Health Informatics)
5:25 -5:30	Closing remarks	Dr C B LAW, KWC & PMH CCC(RM)

Target participants: Newly-joined Medical staff in KWC

Enrollment : Through HRD (Ms Jessica Lam at Ext 3117)

1.4 Patient Safety Walk round

Patient safety walk round had been conducted in all KWC hospitals with participation from staff of Q&S Department and Hospital Management. The key objectives were to meet frontline staff at wards or other workplaces, and to collect their views on hospital plans and other concerns related to staff and patient safety. Several issues identified during the Walk rounds in their hospitals had been reviewed and followed up, such as handover communication, SOPD booking and enquiry system, management of drug trolleys in wards, streamline of blood collection procedures at blood bank, etc.

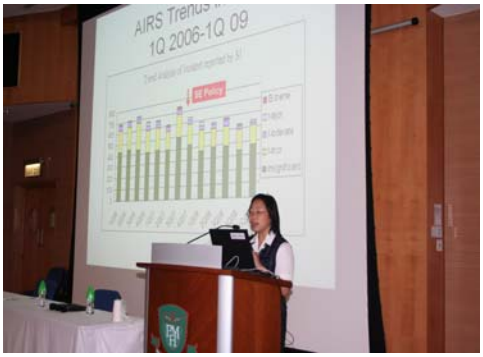
1.5 Lean project

KWC hospitals had participated on the HO Lean Management training. The lean projects below had been implemented to improve work flows and environment. These projects were also selected in the LEAN Roving Exhibition rotated among HA hospitals.

Project Name	Hospital
KWC IT Account Management System in KWC Finance Division	KWC
KWH- Surg Patient admitted for elective Surgery in KWH	KWH
PMH-AED AED workflow revamp in PMH	PMH
CMC - AED Door to needle time for AMI patient presented to A&E in CMC	CMC
KWH-O&G Universal Downs Screening in KWH	KWH

1.6 KWC Q&S Forum (Attendance: 399 staff)

A KWC quality forum was conducted on 9 June 2010 to share with staff on the topics including Accreditation Program done in CMC, Safe Surgery Audit results, Development of Document Control framework in KWC, and Incident Report through AIRS. The objective was to reinforce staff to keep on providing quality services to patients.



1.7 KWC Incident Management and Root Cause Analysis Workshop (Attendance: 291 staff)

Four identical one-day Incident Management and Root Cause Analysis Workshops were conducted. The objectives of the workshop were to enhance the knowledge of health care practitioners on incident management and provide them with the skills required to conduct RCA for serious incidents.

2 Risk Prioritization

- By Clusters

2.1 Identified clinical risks for 2010-2011 (as reported last year)

	Identified clinical risk
1	Patient care - fall with serious injury
2	Medication Safety : patient identification, Drug Allergy, high risk medication and LASA medication
3	Medication Safety : Drug reconciliation on admission / discharge
4	Staff (OSH) Injured whilst lifting or carrying
5	Infection Control: Infection control practice compliance
6	Patient Treatment, Care & Monitoring : Patient identification
7	Patient Examination & Assessment : Care of acute deterioration patients

2.2 Identified clinical risks (in order of priority) for 2011-2012

	Identified clinical risk (in order of priority)
1	Patient Fall
2	Infection Control
3	Medication / Dispensing
4	Clinical Documentation
5	Manual Handling Operation (MHO)
6	Safe surgery
7	Discharge planning

2.3 Identified Non-clinical (operational) risks for 2011-2012 (not necessary in order of priority) (Optional)

	Identified non-clinical risk
1	MHO
2	Fire Safety

3 Risk Reduction and Quality Programs

3.1 Review of 2010 risk reduction program

3.1.1 Medication safety

(a) KWH

- Sharing sessions on medication incidents was held by CND.
- Re-labeling and re-allocation of look-alike & sound-alike ward stock drugs in Private ward.
- Inclusion of patient's drug allergy status in the nursing handover checklist in M&G.
- Promulgation of "Drug prescription Safety Self-assessment guide" by forwarding the link to all M&G doctors via email.
- Hospital wide audit on administration of oral medication was conducted.
- Near miss monitoring of prescribing error by Pharmacy.
- Colour lettering approach was applied in drug labeling in AED.
- Audit on nursing staff handling patient drug allergy in M&G.
- Simplified the type and storage of Dangerous Drugs in OT rooms.

(b) OLMH

- Implementation of Oral Syringe for administer of syrup medication in May 2011.

(c) WTSH

- Changed duration of drug supply from 3 to 6 days in one infirmary ward
- Monitoring temperature of the Drug Storage by using thermometers.

(d) PMH

- Update and distribute PMH Guideline on Handling of Drug Allergy for medical, pharmacy and nursing staff (Aug 2010)
- Distribute DO NOT USE List – 2 additions- Avoid "trailing zero" and "omission of zero before decimal point" (Jul 2010)
- Updating of Discharge Summary to minimize risk of mismatch between the medications dispensed and the discharge drug information printed on the outdated discharge summary (Dec 2010)
- Promote Use of DH Website (Registered Pharmaceuticals in Hong Kong) to minimize prescribing and administration of drugs to patients with known drug allergy due to unfamiliarity with the drug ingredients contained in certain combination drugs (Dec 2010)
- Set up a link to HK registered drug was posted on the front page of PMH web (Useful links) and front page of pharmacy web to facilitate staff to check on all HK registered drugs, including combination and OTC products (Dec 2010)
- Displayed Screen-saver on drug allergy in all Clinical Management System stations to remind

staff in PMH.

(e) YCH

- A Task Force on medication safety was set up in Q2/10. Standardization of the drug administration schedule among all departments in Q3/10. A standardized MAR form for intravenous infusion fluid was implemented in Q1/11.

(f) KCH

- Communication on medication advice between PMH and KCH were reviewed with improvement on the advice of legible handwriting in prescription, marking the used row as invalid in the MAR, and seeking opportunity to double check documents before patient transferring out of the wards.

3.1.2 Patient identification

(a) KWC

- Implementation of Phase 3 of Unique Patient Identification System in all KWC hospitals.

3.1.3 Falls

(a) KWH

- Fall prevention posters was developed and distributed to clinical area.
- Sharing sessions on fall incidents was held to raise staff's awareness.
- Assessment made on safety of patients' shoes or slippers on admission. Varies sizes of non-slippery slippers are available for loan in Private Ward.

(b) OLMH

- Slogan on fall prevention for patient/relatives was designed.
- "防跌小貼士" competition was organized in Jan, 2011 to promote fall prevention.
- Trial use of non-slippery slippers after conducting survey in M &G unit from Nov 2010 onwards. 97.3 %-100% of patients agreed very much on the new slippers that the comfort, non-slippery function, and provision of appropriate size were important to prevent the fall.
- Inspection on environment and walking aids in clinical area on 24 Mar 2011 to prevent fall.

(c) WTSH

- Assessment was made in Rehab ward on patient's safety awareness within the first three days of admission. Immediate feedback and individual education were provided. Proper signage for risky patient within work team. Reinforcement in ward
- Promotion of fall prevention by using patient safety awareness questionnaire.
- Continued staff education was enhanced in WTSH.
- Identification of risky patient in Occupational Department. Placed patient at easily monitored site. Close supervision and monitoring of patient. Apply safety vest if needed

(d) PMH

May 2010 – EBP study on fall risk assessment tool.

Adoption of Morse Fall Scale for fall risk assessment tool in Jan 2011.

3.1.4 Infection control

(a) KWH

- Respiratory Protection & Fit Test Workshop was held by CND & ICT.
- Audit on Hand hygiene was conducted.
- Biological spillage drill in TB lab was conducted.
- Drill on handling suspected / confirmed infection of chickenpox by ICT, O&G and Anaes & OTS.

(b) WTSH

- Incidence of resistant microorganisms was reviewed.
- Promotion of rational therapeutics and judicious use of antibiotics through various channels.
- Audit on staff compliance in antibiotic prescription practice was conducted.
- Audit on segregation of clinical waste was conducted and feedbacks were collected.
- Reinforcement of cases report on use of IV antibiotics for longer than 7 days.
- WHO Hand Hygiene Day was organized, included proper use of gloves as one of the items in the Hand Hygiene Campaign.
- Photo guide in common procedures of Infection control was provided for supporting staff.
- Regular infection control training and revision was conducted.
- Plastic material was used for boxes so that they could be cleaned and disinfected regularly.
- WHO global observation survey on hand hygiene compliance with moment was conducted.

(c) PMH

- Hand Hygiene Ambassador Program was organized in June 2010.
- Catheter Related Blood Stream Infection Prevention Program was held in July 2010.
- An ID drill was taken in 4Q2010 by the Emergency Preparedness Sub-committee.

3.1.5 Occupation Safety and Health (OSH)

(a) KWC

- KWC DSE Working Group conducted a comprehensive DSE assessment to cluster procurement office

(b) KWH

- MHO Train-the-trainer Workshop was held.
- MHO Workshop was held for Supporting Staff and Nurses.
- MHO revision course with assessment done in Anaes & OTS.
- Proper manual handling was reinforced when assisting inpatients to sit up in bed for

assessments in Speech therapy Unit.

(c) OLMH

- Safety Climate Index (SCI) survey was performed with over 40% of staff return.
- Work Safe Behavior (WSB) was performed in CNS for protecting vulnerable staff from ergonomic risk- comprehensive staff health program for Community Nurse on 1Q11

(d) WTSH

- Proper function of panic alarm was ensured.
- OSH guidelines were reviewed.
- Continued MHO training for new recruit and existing staff.
- Reinforcement of proper MHO technique with close monitoring and supervision.
- Regular inspection of MHO task (materials) including tools.

(e) PMH

- Conducted WSB (Work Safe Behaviour) program in NEATs regarding the patient lifting inside the vehicle.
- Smart Lift Policy implemented in LKB to address the MHO problems.

3.1.6 Physical restraint

(a) WTSH

- Proper use of restrainer was promoted and reinforced to frontline.
- Audit (include surprise audit) was conducted and feedback on staff compliance of using restrainer was provided.
- Wards with good performance / great progress were encouraged and announced

3.1.7 Documents / records handling

(a) WTSH

- Conducted 10% checking of all case records by supervisor (MSW) before filing. Check all the referrals and correspondences to outside agencies by supervisor.
- Audit on nursing documentation was conducted every year and provide feedback to frontline staff. Sent reminder to staff with non-compliance on specific criteria via DOMs. Conducted sharing sessions and facilitate supervisors to debrief result to ward staff by sending presentation material to supervisors.
- Wards with good performance / great progress were encouraged and announced.

3.1.8 Audit

(a) KWC

- Individual hospital had taken some audits on various kinds programs, such as nursing documentation, oral medication, safe surgery, pressure ulcer, POCT, informed consent, SUD, NG Tube, AOM, and so on in order to check that correct procedures, code of practice and

newly implemented policies had been carried out promptly and correctly.

3.1.9 Others

(a) CMC

- Emergency patient evacuation plan was revised.
- Establish a tracking mechanism for abnormal test report.

(b) WTSH

- Accreditation on joint ISO and HACCP for catering sector was obtained in food poisoning.

(c) PMH

- Survey on SCI (Safe Climate Index) of ISWP was completed with over 46% returns.

3.2 Quality initiatives, including accreditation.

3.2.1 Hospital accreditation

(a) KWC

- A visit to PYNEH organized by the Staff Engagement Team of PMH on 4 Jan 2011. Another visit to HA & private accredited hospitals including PYNEH & TWAH was organized by YCH.
- CMC experience in Accreditation was shared with YCH, PMH, OLMH, UCH and TKOH in 4Q 2010.
- Briefing on HA e-CQI system in CMC and VC to PMH, YCH, KWH, WTSH was organized in 1Q 2011.

(b) OLMH

- Document control system was implemented in 2Q 2010.
- Newsletter "Accreditation Express" (認證快訊) are published for promulgation of Accreditation.
- Collection of Preliminary master list of document control in 1Q 2011.
- Training and briefing on document control and ACHS were conducted in 4Q 2011.

(c) PMH

- CCE forum on hospital accreditation was held on 16 Aug 2010.
- Two briefing sessions for Standard Owners and Department Coordinators was organized in 3Q 2010.
- Accreditation Forum for Heads of Departments, Standard Owners and Department Coordinators was held on 22 Oct 2010.
- Sharing session on QMH's experience in accreditation related to administration was conducted

in Dec 2010.

(d) CMC

- OWS was conducted in Jul 2010.
- A co-jointed hospital-wide study with of CMC and CUHK on "Understanding Organizational Culture and Accreditation Performance" on using self-reporting questionnaire was carried out, and 5 focus groups were formed in 4Q 2010.
- Award Ceremony on accreditation was held on 14 Dec 2010.
- Sharing of ACHS hospital accreditation projects with Master of Public Health student (HKU) was conducted in 1Q 2011.
- Experience sharing with QMH on ACHS hospital accreditation in 1Q 2011.

(e) YCH

- Formation of taskforce for standardization of pressure ulcer assessment and management in 3Q 2010. Pressure ulcer risk assessment and management records were reviewed to meet the ACHS criterion 1.5.3 in 2010-11.

3.2.2 End of life policy

The PMH Resuscitation Sub-committee had implemented the End of Life Policy with an objective to alert clinical professionals that patient's individual needs, priorities and preferences for end of life care are identified, documented, reviewed, respected and acted upon, wherever possible. The ultimate goals are:

(a) to ensure that all people are treated with dignity and respect at the end of their lives;

(b) to ensure that pain and suffering minimum with access to skillful symptom management for optimum quality of life;

(c) to ensure that all those approaching the end of life have access to physical, psychological, social and spiritual care.

3.2.3 Other quality initiatives

(a) Oxygen consumption audits jointly conducted by Pharmacist and CND of YCH to identify areas for improvement and recommended good practices on a quarterly basis.

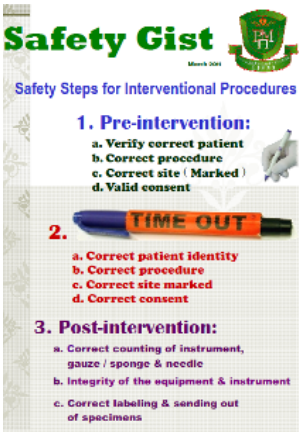
(b) A Task Force on medication safety was set up in 2Q 2010 in YCH. Standardization of the drug administration schedule among all departments in 3Q 2010. A standardized MAR form for intravenous infusion fluid was implemented in Q1/11.

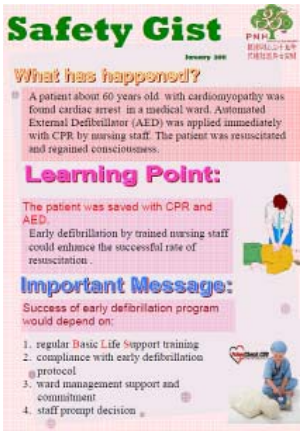
(c) Join the WHO International Safe Workplace Program (ISWP) in KWC in 2010-11 with gap analysis, road show, hospital safety plan, safe climate index and work safe behaviour conducted.

(d) Publications

Safety Gist on the topics of Early Defibrillation Program and Safety Steps for

Interventional Procedures were issued in PMH.





4 Learning and Sharing Information

Staff Education and Training on Q&S

4.1 Quality and risk management

(a) KWC

- KWC Q&S forum was organized in Jun 2010.
- 2010 HA Nurses Forum was conducted in Jul 2010.
- Crisis Management for Nurse Leaders was held in Oct 2010.
- Leadership Development Program for senior nurses was organized in Aug 2010.
- KWC pain management education program / symposium was held from 4Q 2010 to 1Q 2011.

(b) OLMH

- Fall Awareness sharing session for clinical staff was done in Jul 2010.
- One-day Incident Management (RCA) Workshops was held in Nov 2010.

(c) WTSH

- Briefing & demonstration on application of 2D barcode technology was conducted.
- Sharing session on AIRS incidents & Nursing Quality Indicators was held quarterly.

(d) PMH

- Crisis Management for Nurse Leaders was held in Jun & Jul 2010.
- Nursing research & EBP training was organized in May & Jun 2010.
- Sharing session on the OR experience was conducted in Oct 2010.

(e) YCH

- Safety Talks on Medication & Patient Identification to share the related incidents and good practices on medication safety was held on 17 Feb 2011.
- Monthly Patient Safety Leadership Walkarounds in wards was held.
- AIRS Forum was organized on a quarterly basis.

4.2 Resuscitation training

(a) PMH

- BLS provider and renewal course were held.

4.3 Clinical care quality

(a) KWC

- Chronic disease management to community was organized in Apr 2010.
- Program of Application of Psychological First Aid on Children population was held in Jun

2010.

- Refresher course of phlebotomists training was conducted in Jun & Jul 2010.
- Social & Professional Reality Integration Program for Nurse Graduates was held.
- Basic / Advanced Wound Care Courses was conducted.
- KWC Trauma Service Update was conducted in Sep 2010.
- Joint Task in Organ Donation & Transplantation was conducted in Dec 2010.
- Clinical Enhancement Programs was organized.

(b) KWH

- Education talk on "New drugs in Diabetes" was conducted on 27 Apr 2010.
- Talks on Nursing Documentation, Nursing Quality Indicators and Quality & Safety delivered to newly joined nurses were held on 15 Sep 2010.
- Professional Development Program for Nurses in PMH and KWH.

(c) OLMH

- Sharing of incident reporting and management SPRING program for new graduates on 14 Sep 2010.

(d) PMH

- Professional Development Program for Nurses in PMH and KWH.
- Briefing on Automatic Dispatch System was conducted in May 2010.
- Spring program for new nurse graduates on AIRS, DSE and medication safety was held in 2010.
- Workshop and sharing on Nursing Audit was conducted in June 2010.
- Chemotherapy & biological therapy nursing training was held in Jul & Aug 2010.
- Joint Orthopedic Traumatology Nursing Forum was held in Oct 2010.
- PMH 35th Anniversary Commemorative Scientific Conference in Nov 2010.
- Program for Introduction of HA Safety Manual was conducted in Feb 2011.
- Psychological Trauma Clinic Talk Series was organized in Feb 2011.
- ECG training session was conducted in Feb 2011.
- Training on Inter-Facility Critical Care Transport Medicine was conducted in March 2011.
- Pressure Care Liaison Nurse Sharing Session was conducted.
- Practical Skills Enhancement Workshop was held.
- Helping people facing life limiting illness was promoted.

(e) CMC

- PRCC (Respiratory nurse) on the role of nurse auditor and risk management was held in 3Q 2010.
- Orientation program to EN on AIRS and medication safety was organized in 1Q 2011.

(f) YCH

- Two workshops on prevention of fall for nurses & care-related supporting staff was conducted on 9 & 16 Nov 2010.
- Nursing Audit Training to train new auditors on Dec 2010.

4.4 OSH

(a) KWC

- DSE train-the-trainer program was conducted.
- Seminar on Anti-workplace violence was organized in Sep 2010.
- Risk Assessment for Chemical Substances was conducted in Oct 2010.
- Introduction to Nuclear Medicine and Radiation Safety in Hospital on Oct 2010.
- ISWP open ceremony was held in Oct 2010.

(b) KWH

- "醫院內電力安全展覽暨講座" was held in 6 May 2010.
- 「預防及處理工作間暴力事故」workshop was conducted on 16 & 24 Sep, 25 Nov & 2 Dec 2010.
- Talk on "Safety Management System Training in Health Care Setting" was held on 25 May 2010.

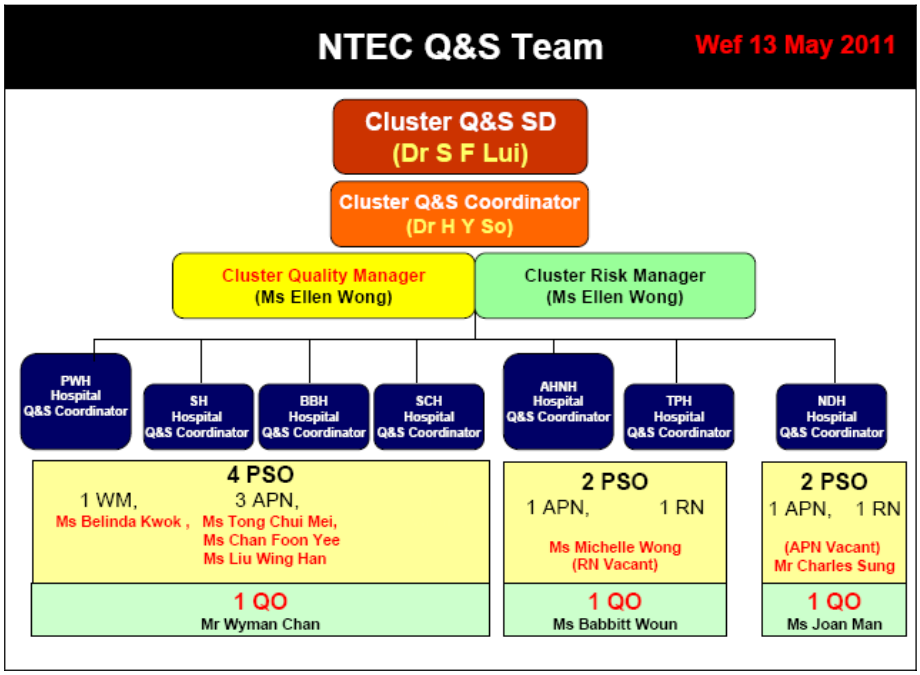
(c) PMH

- MHO training for MHO trainers was held in 2010.
- Program of safe use your computer was organized on 28 May & 30 Jun 2010.
- Workplace Violence Guideline update and Magnetic restrainer practice was held in Aug 2010.
- 靠得住單位 competition aimed to promote safety culture

(d) YCH

- Two MHO training workshops for care-related supporting staff in Dec 2010 & Mar 2011.

1. Structure & Initiatives



During the year, there were 2 PSO (Patient Safety Officer) shortage that the vacant post could not be filled due to the overall nursing manpower shortage. To prepare for Hospital Accreditation at PWH, NDH, AHNH, and TPH, three Quality Officers (QO) were appointed in February 2011 under the team of NTEC Quality & Safety. The Hospital Coordinators for Hospital Accreditation were also appointed to lead the preparation for each of the four hospitals.




1.1 Incident Management

Root Causes Analysis were conducted on each of the SE / SUE cases. Recommendations were made to hospital management and department(s). The cases were discussed with senior management every 6 months in the cluster.

After the review meeting and discussion, the major improvements were initiated including:

1.1.1 Instrument Tracking System was implemented in PWH TSSU;

1.1.2 Policy on Counting procedure for major / minor operation was reviewed;

1.1.3 Safe Surgery – Time Out for Interventional Procedure;

1.1.4 Review of MAR (Medication Administration Record) format

1.1.5 Review of Dangerous Drug Handling procedure (by Nursing)

1.1.6 Review of 3 Checks 5 Rights Procedure (extend to other discipline)

1.1.7 Review of High Risk medication in A&E, e.g. muscle relaxant

1.1.8 Policy on Nasogastric tube insertion, testing and checking of integrity

1.1.9 Strategies for Warfarin handling (prescription in MOE, dose form, and patient education booklet);

1.1.10 Review the alertness for patient with Known Drug Allergy

1.1.11 Use of protocol and checklist for patient on Chemotherapy;

1.1.12 Replacement of Syringe Driver with safe model

1.2 Safety Culture

The new slogan "有疑必問 盡我本份" for safety culture was promoted in NTEC. Staff is encouraged to ask and clarify when there is doubt in treatment / prescription / procedure, etc.

1.3 Medication Safety

Medication safety was the top priority in this reporting period. From July 2010 onward, a series of activities were organized following the CCE Forum "Medication Safety – Yes We Can".

An on-line communication platform, iChat, was launched in July 2010 to booster feedback and suggestions about medication safety cluster-wide. 229 responses were collected over 4 months. Feedback and suggestions covered broadly the structure, process and outcome of the medication process.

The Medication Safety Slogan Competition was launched cluster-wide in July - August 2010 to increase the staff awareness of medication safety. 146 slogans were received across the cluster and 2,841 votes were recorded for final selection.

The Medication Summit was organized in September 2010 with 60 clinical staff from Intern to CCE joined the discussion. Six focus areas were defined with strategies proposed.

NTEC Quality & Safety Month focusing on medication safety was held between 15/11 to 15/12/10. A series of activities were organized in NTEC, including REAL day in AHNH/TPH, a quiz game booth on medication safety, and a staff forum on patient safety culture at PWH. A true-man show was held in NDH, and paper sharing in SH/BBH, and SCH.

The Annual Quality & Safety Forum was held on 15 December 2011. Sir Liam Donaldson, Chair of World Health Organization World Alliance for Patient Safety was invited to share in the

Forum. The NTEC Safety Culture Slogan "有疑必問" was launched. 608 attendances at the Cluster Forum, including 305 staff and 303 medical/nursing students were recorded.

1.4 Surgical Safety

Safe surgery was one of the top priorities of patient safety in NTEC/PWH. The standardized NTEC 123 Safe Surgery 123 Checklist was implemented since August 2010 to improve communication between parties involved in the surgery and facilitate a one-go surgical checking procedure. 9 Safety Checklists for Minor Operations / Interventional Procedures in interventional suites were implemented in Dec 2010. The roll out was smooth. Re-evaluation audit of surgical safety in the main operation was repeated from 28/2-12/3/11 and 50 samples were taken. The overall compliance was 99.7% and showed improvement as compared to 98.4% in the same audit in 2010.

1.5 Unique Patient Identification (UPI)

All 2D barcode scanners were uploaded a new version (v.2.34b) and the function of manual input of HKID was disabled. The use of 2D barcode scanning and labeling to ensure correct patient identification and specimen labeling was extended to X-ray department, Eye / ENT clinic, and PWH Operation Theatre for all in-patient operations. The pilot in NDH A&E in 2010 was a success that no incident related to wrong labeling was reported. The finding was shared with other A&E services. There was plan to implement the system to A&E in PWH and AHNH in 2011/2012.

1.6 Patient Safety Round

The Q&S team in individual hospital conducted patient safety walkrounds to establish lines of communication about patient safety with frontline and

management staff and to identify good practices and opportunities for improving safety.

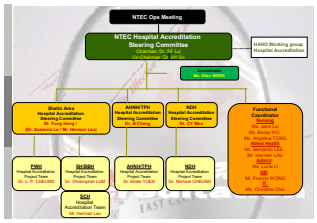
50 senior hospital staff and the Q&S team attended the commission training on “Patient Safety Walkrounds” conducted by Dr. Allen Frankel from USA in early November.

1.7 Sir Liam Donaldson Visit

In December 2010, during Sir Liam Donaldson’s stay in Hong Kong, three talks on patient safety were arranged in PWH, AHNH, and NDH respectively. The PWH session was a discussion and sharing on safety culture, the subject for AHNH was Safety Solution with a clinical visit, whereas the subject for discussion in NDH was the dilemma on patient safety and clinical efficiency. The discussion was fruitful and feedback was good.

1.8 Hospital Accreditation

Structure in NTEC, PWH, AHNH/TPH, and NDH for preparation of Hospital Accreditation were formed to coordinate quality improvement initiatives in patient care and to prepare for hospital accreditation. Three Quality Officers and clerical staff were recruited and in post in Feb 2011. A series of staff engagement, training workshops, briefings and coaching sessions to departments were held in 2010. Subject Officers for each criterion were appointed in cluster as well as in hospital. The Subject Officers are requested to review the standard and practice, and identify the gaps for improvement. The web site iHosp was used as a platform for department to upload their department’s guideline / protocols. Progress is good.



2. Risk Prioritization

2.1 Identified clinical risks for 2010-2011 (as reported last year)

	Identified clinical risk (in order of priority)
1	Medication incidents
2	Misidentification of patients
3	Fall Incidents
4	Infectious Disease Outbreak
5	Missing patient (at risk)
6	Work Place Violence
7	Patient restraint
8	Mislabel specimen / blood from wrong patient
9	Patient Transfer
10	Suicide

2.2 Identified Non-clinical (operational) risk for 2010-2011 (as reported last year) (Optional)

	Identified operation risk (not necessary in order of priority)
1	Aging hospital facilities / faulty biomedical equipment
2	OSH Manual handling Injury
3	Manpower / Workload
4	OSH Workplace violence
5	Staff morale
6	insufficient space / bed
7	Data Security
8	IT system breakdown
9	Safe custody of patients' specimen
10	Security

2.3 Identified clinical risks (in order of priority) for 2011-2012

	Identified clinical risk (in order of priority)
1	Medication incidents
2	Patient Fall
3	Patient Misidentification
4	Patient injury during procedure
5	Outbreak of infectious disease
6	Communication between staff/patient/relative
7	Risky Patient care
8	Specimens error
9	Physical restrain
10	Wrong site surgery

2.4 Identified Non-clinical (operational) risks for 2011-2012 (not necessary in order of priority) (Optional)

	Identified operation risk (not necessary in order of priority)
1	Shortage of manpower
2	Aging hospital facilities / faulty biomedical equipment
3	Workload
4	Insufficient space
5	OSH Workplace violence
6	Quality of Hot Water Supply
7	Insufficient patient beds (e.g. PICU beds)
8	OSH Manual handling Injury
9	Patient record - missing/documentation/storage
10	OSH Needle prick injury

3. Risk Reduction and Quality Programs

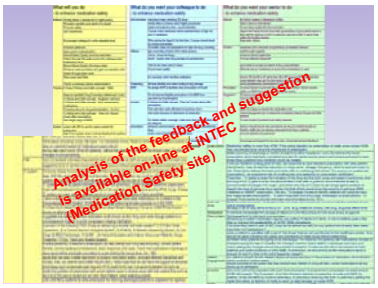
3.1 Review of 2010 risk reduction programs

3.1.1 Medication Safety

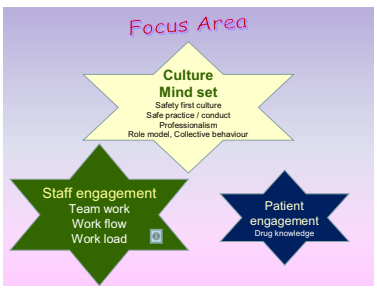
The Medication Safety was rated as top high risk area with high priority for improvement in NTEC. In 2010, a series of risk reduction program was commenced in NTEC as well as in individual hospital.

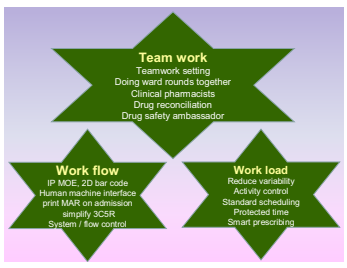
(a) July 2010 Cluster Chief Executive (CCE) Forum for clear message to staff: yes we can (improve medication safety)!

(b) July 2010 On-line discussion using iChat platform started after CCE Forum to promote participation and generate ideas. 3 questions asked: What will you do? What do you want your colleagues to do? What do you want your seniors to do? A total of 229 responses were collected from web (iChat).



(c) September 2010 Medication Safety Summit. 60 staff of all grades to discuss on possible strategies, taking into account all the ideas collected from online platform. 6 key areas that flow through the discussion at the Summit formulated the direction and strategies for action plans.



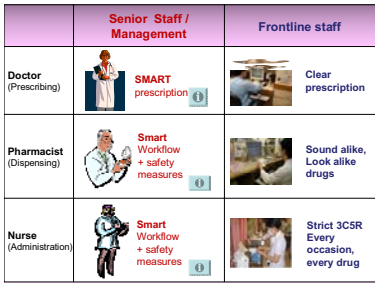


(d) October 2010 Slogan Competition.

Slogan competition was called in NTEC in October to arouse the staff's attention on medication safety. A total of 145 slogan was received. The panel selected ten slogans and put it for open voting in web. The response was encouraging as 2800 colleagues participated in the voting at web, and the winner was :

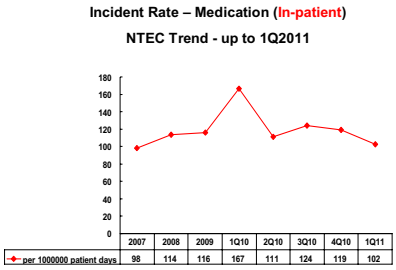
(e) December 2010 Patient Safety Forum: Sharing of successful examples from within the cluster to stimulate ideas and participation. Before the cluster Forum, individual hospital organized their Medication Safety Forum in their own hospital. On 15th December 2011, the cluster Forum on Medication Safety was organized with Sir Liam Donaldson as the guest speaker, followed by 7 presentations from individual hospital. The Forum was a success with 600 attendances (300 medical / nursing students). The main theme was promoted, i.e. Medication Safety: Yes, we will!

(f) Jan 2011 onwards Monitoring and Sharing, Quality Circles for Improvement Projects. Four Cluster wide projects and Six departments wide (Prescription / Dispensing / Drug Administration) projects.



(g) Measurement and Monitoring

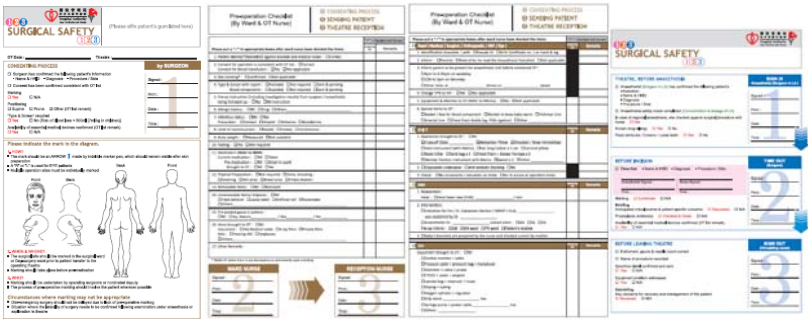
Incident rate – The medication incident in cluster per million bed days was monitored. As at end of 1Q2011, the incident rate was 102 per million bed days, which was a decreased in trend. However, the target of zero incident was still a long way to be achieved.



3.1.2 Surgical Safety

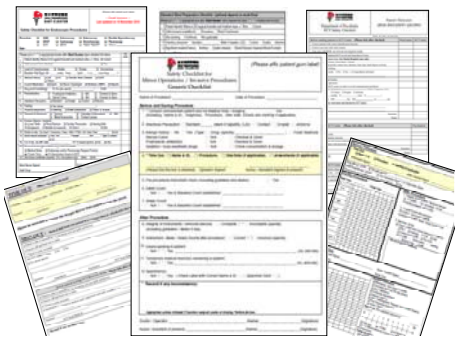
(a) Phase I – Safe Surgery in Operation Theatre

A Policy on Time-Out to ensure Correct Patient and Correct Site Surgery was developed in 2009, and a checklist "123 Surgical Safety 123" was pilot in October 2009. To further enhance the effectiveness and efficiency of the Safe Surgery policy and to improve the communications between all parties involved in surgical procedures, a combined Safe Surgery 123 and Nursing Pre-Operation Checklist was developed and implemented in August 2010. The implementation involved three major and acute Operation Theatre, and 30 wards in the NTE cluster.



(b) Phase II - Interventional Procedure Safety Procedures

In December 2010, the implementation of safe surgery was extended to outside Operating Theatres so as to reinforce interventional procedures safety in interventional suites, such as Minor Operating Suites, Interventional Procedures performed in Radiology suite, gynaecology procedures at interventional site, Endoscopy Units, venues for performing Electroconvulsive Therapy, Cardiac Intervention Centre, etc. A Generic Checklist was developed. Different specialties add extra items required for their specialty on top of the Generic Checklist. The implementation involved 22 Interventional Suite, and 130 wards in the NTE cluster.



(c) Phase III - Safety Policy on Bedside Procedures

The policy for bedside procedure was endorsed and effective on 1st March 2011. It applies but not limited to Chest tapping, drainage and paracentesis, and Insertion of intravascular catheter with the use of guide wire. The implementation involves all clinical areas (total 140 wards) where tapping and insertion of guidewire will be conducted when necessary. The full implementation will be commenced with effect from 15 August 2011.

(d) Measurement and Monitoring

Incident Track - Incident related to Wrong Site Surgery / Retained Instrument were tracked. In 2010, the incident related to wrong site surgery down to zero, and the incident related to retained instrument down to 2 in NTE cluster.

Audit on Compliance

A cluster-wide audit on compliance to surgical safety policy in Operation Theatre had been conducted in March 2010 after the pilot stage. The compliance rate was 98.8%. The same audit was repeated again in March 2011 after the implementation, the compliance rate was increased to 99%. For Phase II Checklist, the compliance rate was 99.5% as audited in April 2011. The compliance rate demonstrated an improvement in quality.

Staff Feedback

The staff's opinion / feedback on the use of Checklist and the item of Checklist were collected throughout the process at each stage. The majority of staff were happy of the simplified and unified checklist which enhance the operation / procedure safety.

3.1.3 Fall Prevention Study

The NDH Fall Prevention work group worked with Quality & Safety team formulating strategies on fall prevention. A study on the effectiveness of the fall alarm pad for the elderly in a period of 4 months was conducted and total 300 samples were recruited. A total of 10 fall cases were recorded and 9 out of 10 fall cases were from the control group without using fall alarm pad. The result showed a significant difference. The use of fall alarm pad for at risk patients would be a valuable tool in prevention of fall while in the mean time keeping the restraining rate at a minimum.

3.2 Quality initiatives, including accreditation

3.2.1 Policy developed and endorsed related to patient safety

The following policies were endorsed and put up in iHOSP:-

- Policy for Administration of Research Medication in In-patient Service
- Policy and Procedures for Use of Potassium Chloride for Adults
- Procedures to Prevent Airway Fire During Tracheostomy
- Policy for Prevention of Naso-gastric Tube Mal-position or Retention

3.2.2 Patient Safety Round

In PWH, 10 sessions of patient safety walkrounds to 3 GOPC including their pharmacies and 9 clinical areas in 4 departments including AED, M&T SOPD, Surgery and Paediatrics were conducted. Visits were withheld in Nov and Dec 2010 due to relocation to the new clinical block. The focus of the walk rounds in 2011 was the set up, patient flow and workflow related to the new clinical block after relocation. Junior doctors and frontline nurses were invited to join the discussion.

In AHNH, Safety Ward Round on Fall Prevention was conducted to all wards, recommendations will be followed up by Central Nursing Division.

In NDH, 31 sessions of Safety Walk Rounds were conducted. Total 63 departments/ units/ wards were visited during the reported period.

3 patient safety walkrounds conducted in BBH to enhancing the awareness of patient safety in operation among staff.

3.2.3 Preparation for Hospital Accreditation - Progress in NTEC

The NTE Cluster Hospital Accreditation Steering Committee was established since March 2010. In 2010, the Steering Committee conducted a series of activities focusing on promotion and training. Hospital Coordinators for individual hospital was appointed.

Hospitals in NTEC establish their own Steering Committee to prepare for the Hospital Accreditation, i.e. Shatin area (PWH / SH / BBH / SCH), NDH, and AHNH/TPH. Each hospital appointed the senior staff as Co-ordinators / Subject Officers for the different standards / criteria, whereas some of the standards / criteria will be reviewed at cluster wide approach.

In February / March 2011, three Quality Officers were appointed to assist the Hospital Coordinators in preparing the Hospital Accreditation in PWH, NDH, AHNH and TPH.

In 2010, the web site of iHospital was developed, and departments were requested to upload their department protocols / guidelines to their department web site. A stock take was done on 31

December 2010 to have a preview of protocols and guidelines in department web site.

The departments are also requested to conduct a Risk Registry and plan for the program of Continuous Quality Improvement (CQI) and the next stock take will be conducted in June 2011.

4. Learning and Sharing Information

Cluster	Commissioning Training on Patient Walk Round	50 senior hospital staff and the Q&S team attended the commission training on "Patient Safety Walkrounds" conducted by Dr. Allen Frankel from USA in early November to learn more about the effective execution of patient safety walkrounds  
Cluster	Sir Liam Donaldson Visit	While Sir Liam Donaldson was invited as speaker for Medication Safety Forum in December 2010, he was invited to hold three sessions with NTEC senior staff. The PWH session was a discussion and sharing on safety culture, the subject for AHNH was Safety Solution with a clinical visit, whereas the subject for discussion in NDH was the dilemma on patient safety and clinical efficiency. Feedback was good.
Cluster	Certificate course on Patient Safety	6 Patient Safety Officers attended the Certificate course organized jointly by CUHK and NTEC Q&S Division.
Cluster	Workshop on Basic Patient Safety	1-day training workshops on Basic Patient Safety were co-organized with CUHK and 2 workshops were held and 50 doctors and nurses in NTEC attended.
Cluster	Workshop on Documentation	Workshops on Documentation and Document Control were held the second year with 5 sessions being conducted and around 300 staff in NTEC attending.
Cluster	iSMART (alert flyer)	iSMART was issued monthly and the main emphasis was medication safety which was the theme of the year.
Cluster	Workshops on Hospital Accreditation	From May 2009 to January 2010, a total of 15 engagement sessions involving 1335 attended staff were arranged in NTEC. Pamphlets and souvenirs were made to promote the Hospital Accreditation. From April 2010 to July 2010, in-depth training sessions were arranged to managers and professional staff, including 6 sessions with clinical staff (doctors, nurses and allied health staff), 1

		session with administrative staff, and seven sessions with various committee members, a total of 503 staff attended the training. Feedback from the attendants was good. Since September 2010, individual department coaching was commenced in PWH and AHNH / TPH. The concept on CQI (Continuous Quality Improvement) was further explained and shared.
Cluster	Risk Watch	In PWH, Risk Watch (forum) for sharing and learning of incidents reported via AIRS was held monthly in 2010 and bi-monthly from 2011. A total of around 670 attendances were recorded. In NDH, SH, BBH and SCH, Risk Watch was held quarterly.
Cluster	Patient restraint	A Train-the-Trainer workshop on physical restraint was conducted at cluster wide approach. The physical assessment and observation form was revised.
PWH	Hospital Grand Round	Hospital Grand Rounds - 4 rounds was held with an emphasis on surgical safety and medication safety. Administrative Services, Physiotherapy, Pharmacy, Surgery, Paediatrics and Central Nursing Division participated in the sharing. A total of around 400 attendances were recorded.

1. Structure & Initiatives

1.1 Executive Safety Walkround (ESW)

With the positive outcome and experience on unit-based walkround when preparing for the organization-wide survey in 3Q 2010, NTWC had modified the format from theme-based (i.e. with focus on medication safety or patient restraint) to unit- or ward-based walkround, so that all areas in the hospital would be covered throughout the accreditation cycle for assuring safe practices were in place. Since November 2010, two hospital executives were invited to walk through selected patient care units, allied health or supporting service areas on a weekly basis. Frontline staff and unit managers were encouraged to discuss patient safety concerns and quality improvement programs being implemented in the unit with the executives during the walkrounds. As of 1Q 2011, the executive team had visited 19 patient care units, allied health and supporting service areas, 61 concerns were recorded and most of the action plans were in good progress. Good practices were shared at 20 different meetings included Cluster Clinical Governance Committee and

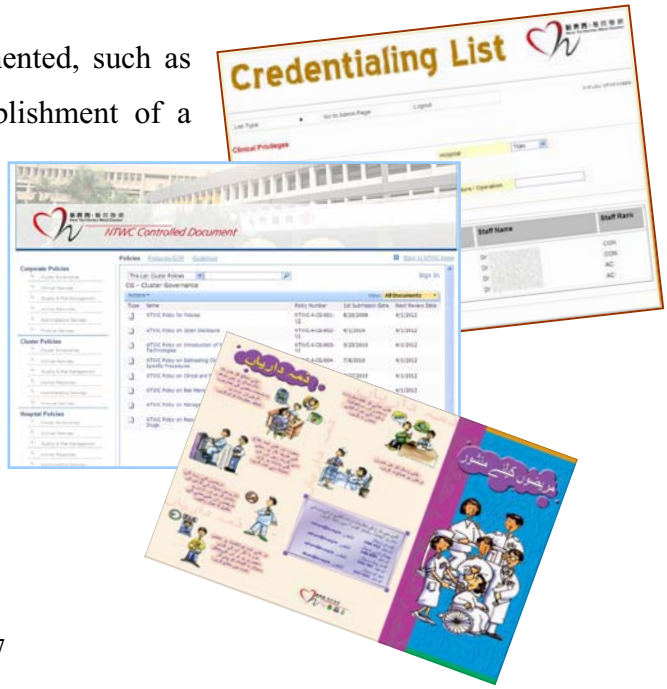
Department Operation Managers meetings. ESW not only facilitated the identification of patient safety risk, but also empowered frontline managers and clinical staff to engage in quality and safety issues.

1.2 Hospital Accreditation Scheme in TMH

Tuen Mun Hospital underwent the first Organizational-Wide Survey (OWS) in September 2010 and was awarded full accreditation for four years with 13 Extensive Achievements (EA). The criteria that rated as EA are listed in the table below:

Clinical	***Support***	***Corporate***
114 care evaluation	211 quality improvement	314 contractor management
117 death & dying	213 incidents & complaints management	321 occupational safety and health
121 info & access		
122 access prioritisation	224 staff training	323 waste management
151 medication safety	241 health promotion	325 security management

In preparation for the OWS, gaps were identified and recommendations were made by the consultancy surveyors. Committees and working groups were set up to follow up the recommendations. In order to address the surveyors' potential concern over the sterilization practice of surgical instruments, an overseas expert was invited to offer consultancy services on the decontamination services in the cluster and improvement actions were taken according to his expert advice.



Other improvement measures had been implemented, such as the development of document control system, establishment of a credentialing system with defined scope of practice for healthcare professionals and the development of electronic training platform to facilitate staff' learning. Patient Charter pamphlets were published in four different languages, including Urdu and Nepalese to enhance patients' awareness of their

rights and responsibilities.

A post-accreditation survey was jointly conducted by TMH and Nethersole School of Nursing of the Chinese University of Hong Kong. The results were analysed and discussed in HA.

1.3 NTWC Quality (Lean) Journey

Kaizen Sharing Forums

Twenty six departments had presented their Lean/ Continuous Quality Improvement (CQI) projects in the monthly sharing forum. These forums attracted a total audience of over 880. Kaizen Coordinators were invited to give suggestions on each individual project. Many outstanding project teams were recommended to submit abstracts to local and overseas conferences.

Kaizen Room Open Day

Six open days were organized during the lunch period in the Tuen Mun Hospital's Kaizen Room. The NTWC Quality Journey as well as the selected CQI projects were introduced to staff attending the visit.

Gemba Walks

Hospital management engaged in Gemba walks had visited 8 clinical areas over the past year. Many new ideas were written by frontline staff on the NTWC suggestion boards. Frontline staff have actively exchanged opinions and raised suggestions to the top management. Good practices were video-recorded and the video clips are shared in the Q&S website.

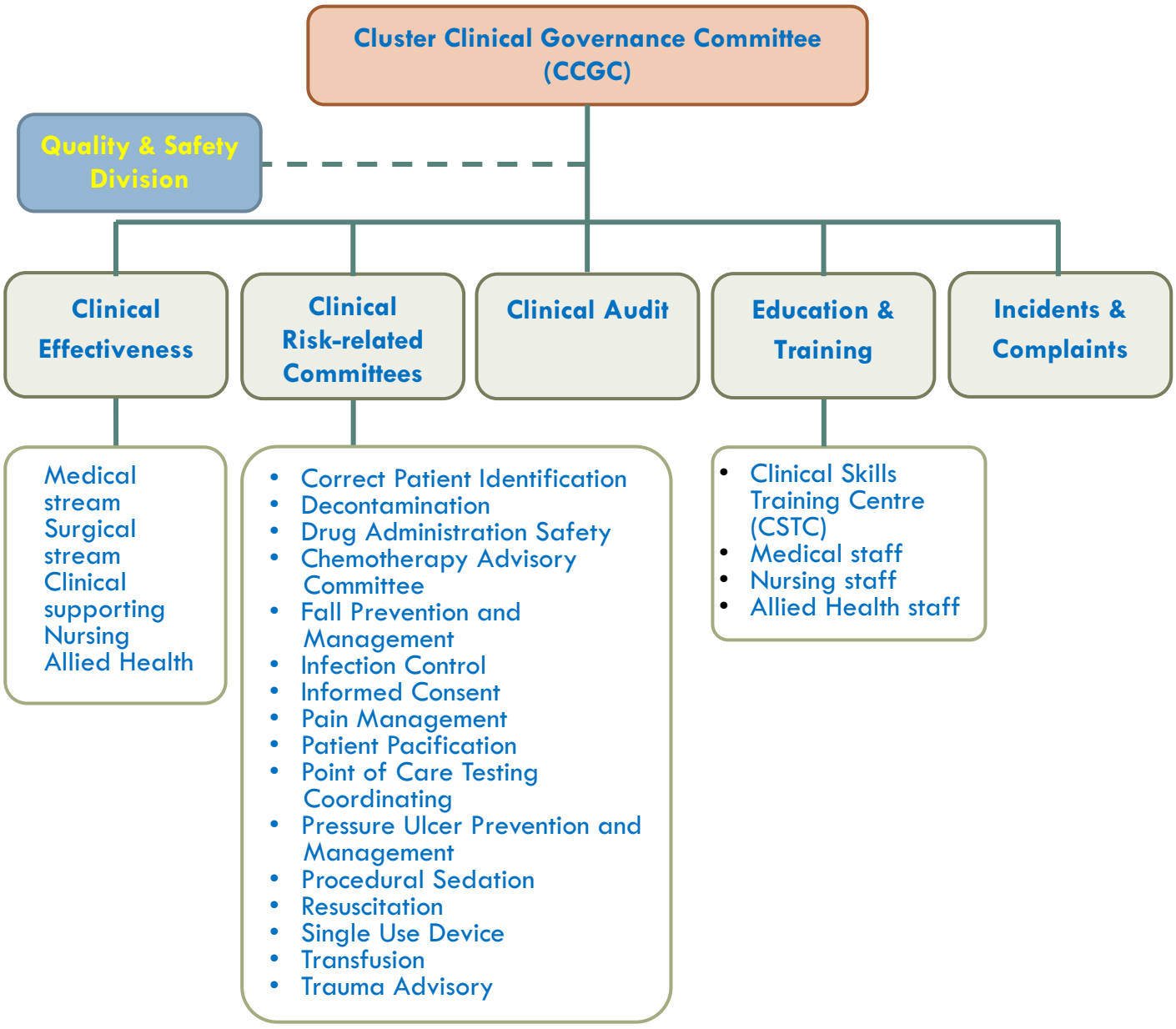
Staff Training

"Induction of NTWC Quality Journey" was provided in the Orientation and Induction Program to all newly joined staff. Experienced clinical and administrative staff were also invited to attend an advanced 2-day training on Process Improvement, focusing

on the identification of values and application of quality tools in healthcare.

1.4 Cluster Clinical Governance Committee

The committee was restructured into a 5-pillar format aiming at a wider coverage of clinical governance including clinical effectiveness, clinical risk-related, clinical audit, education and training, incident and complaint. The number of members was increased from 13 to 16 with effect from 1 January 2011. In the new format of the meeting, Mortality & Morbidity (M&M) case review sharing became a regular agenda item for multi-disciplinary discussion. The committee would also keep track of the follow up actions.



2. Risk Prioritization

2.1 Identified clinical risks for 2010-2011 (as reported last year)

	Identified clinical risk
1	Medication - administration (intrathecal + IV + oral)
2	Medication prescription - allergy + dosage
3	Mis-identification of patient (consultation)
4	Handling lab result filing error + miscommunication
5	Handling of specimen - mis-labelling
6	Care of acute deterioration patients
7	Handling of fragile patients
8	Fall
9	Patient choking + ingestion of FB
10	Suicide (in-hospital)

2.2 Identified Non-clinical (operational) risk for 2010-2011 (as reported last year) (Optional)

	Identified operation risk (not necessary in order of priority)
1	Maintaining a quality workforce (loss of key staff/ workforce planning/ recruitment)
2	Capacity of Facilities (insufficient space and equipment)
3	Budget Control
4	congestion in ward (patient overcrowded)
5	Equipment breakdown/ failure
6	Resource Allocation (Insufficient fund for rising demand)
7	Performance (Staff morale /absence)
8	IT system failure / not able to support changing needs timely
9	IT security/ unauthorized access/ use
10	Cash collection

2.3 Identified clinical risks (in order of priority) for 2011-2012

Identified Clinical Risks in NTWC (2011-12)

Ranking	Clinical Risk Description (General)
1	Medication - prescription (allergy, dosage)
2	Medication - administration
3	Care of patient with acute deterioration of condition
4	Wrong drug dispensing
5	Handling of specimen
6	Patient identification - consultation
7	Care of critically ill patients - transfer and interdepartmental consultation
8	Team communication for caring of patient
9	Patient fall
10	Retention of medical items inside patient bodies

Identified clinical risks in Psychiatric Settings in NTWC

Ranking	Clinical Risk Description (Psychiatry)
1	Patient Violence
2	Patient Suicide
3	Choking
4	Fall
5	Medication error

2.4 Risk Reduction Strategies by Clinical risk-related Committees

Committees	Risk Reduction Programs
Clinical Audit	1. Staff education through Clinical Audit Conference 2. Cluster clinical audit programs according to risk assessment and ACHS recommendations.
Pain Management	1. Nurse Recognition Program via E-learning system 2. Collaboration with HK Pain Society to organize the workshop on interventional pain management 3. Consolidate the pain assessment and pain protocols\ 4. Collaboration of Chinese Medication for chronic pain.
Procedural Sedation Safety	1. Mandatory procedural sedation training and workshops 2. Credential list is prepared 3. E- learning program 4. Establish the committee website for staff information
SUD	1. Fade out high risk Class II SUD based on the HAHO allocated budget and direction 2. Assure NTWC compliance with the corporate SUD policy
Resuscitation	1. Staff training on the latest cardiopulmonary-cerebral resuscitation 2. Pilot on using end-tidal CO_2 monitor for Advance Cardiac life support
Pressure Ulcer Prevention and Management	1. Promotion of pressure ulcer care to patients and their carers aimed to enhance pressure ulcer handling skills of patients and their carers. 2. Staff education for enhancing nursing knowledge and skills on advanced pressure ulcer care 3. Provide multidisciplinary consultation service on pressure ulcer care 4. Conduct road show on appropriate use of pressure ulcer relieving devices

Committees	Risk Reduction Programs
	5. Set up Central Inventory Management System of pressure relieving devices 6. Develop pressure ulcer electronic reporting system
Laser Safety	1. Staff training on advance medical laser safety 2. Formulate an inventory record system on Class 3 or above medical laser machines using in the cluster 3. Initiate the 1st laser safety self-audit program
Blood transfusion	1. Developed massive transfusion protocol 2. Revision of NTWC transfusion guidelines 3. Briefing and orientation of new intern and residents
Trauma	Promote preventable trauma mortality through staff education and audit
Infection Control	1. Conduct training sessions with the supplier for the use of new devices with aim to prevent sharp injury 2. Minimize the use of chemical disinfectant in general ward/unit: a) Disposal medicine cup will be used to replace the plastic medicine cup b) Drinking cup will be cleansed by central kitchen daily 3. Carry out audit on the use and placement of sharp box
Patient Pacification (Restraint)	1. Formation of the Patient Pacification Committee 2. Study on staff attitude in the use of physical restraints and assess for any knowledge gaps 3. Develop e-learning website for modern concepts in using Physical and chemical Restraints 4. Conduct NTWC forum on safe use of physical restraints

Committees	Risk Reduction Programs
Medication Safety	1. Promotion of medication safety by printing of high risk medication label for top-up cupboard, IV bottle opening and expiry label, education booklets 2. Pilot programs for introducing preset Heparinized syringes for arterial blood sampling. 3. Introduce magnifying glass to staff for reading small but important information printed on label of drug ampoule.
Decontamination Safety	1. Promotion on safe use of cidex and cidex-OPA 2. Carry out audit on the quality and completion rate of the scheduled PM and/or functional test of various sterilization and disinfection equipment
Fall	1. Staff education on Morse Fall Assessment Scale by developing an e-learning course 2. Promote patient empowerment in fall prevention by developing a video patient education program 3. Provide yellow vest to patient for easy identification of patients with high falls risk 4. Carry out audit on Falls screening

3. Risk Reduction and Quality Programs

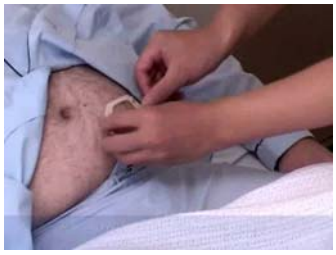
3.1 Review of 2010 risk reduction programs

3.1.1 Prevention of Patient Scald during baby bathing

In view of a serious incident related to scald of baby during bathing happened in another hospital in March 2010, TMH has taken a proactive approach for checking the temperature of all hot water outlets in the Paediatrics and Post-natal wards. After consulting the EMSD and Infection Control team, "mixers" of water tap with temperature regulators that set at below 40℃ were installed immediately to all water outlets in these two departments to prevent accidental scald by improper manual mixing of hot and cold water in ward. Besides, safe practices of water temperature testing by staff elbow or digital thermometer were also reinforced in these units.

3.1.2 RFID Wireless Body Temperature Monitoring System

In September 2010, TMH had installed an advanced body temperature monitoring system in the isolation ward system by using Radio-frequency Identification (RFID) technology. This system not only could promote patient comfort by reducing the disturbance to patient due to frequent temperature taking but also saved the time and reduced the risk of infection to nursing staff. With the introduction of this system, at least 3 minutes could be saved per temperature taking due to the elimination of bedside body temperature taking, manual charting and hand washing before and after entering the isolation rooms.



3.1.3 RFID Body Identification System in Mortuary

In March 2011, Tuen Mun Hospital has also successfully installed the body identification system by applying RFID technology in the Mortuary. This system can improve the efficiency and reliability in the processes of body identification, stock taking and tracking of body location within mortuary.

3.1.4 Innovative "Audible Drug Label" to enhance Medication Safety

Figure 1: Dimension of the "Audible Drug Label"

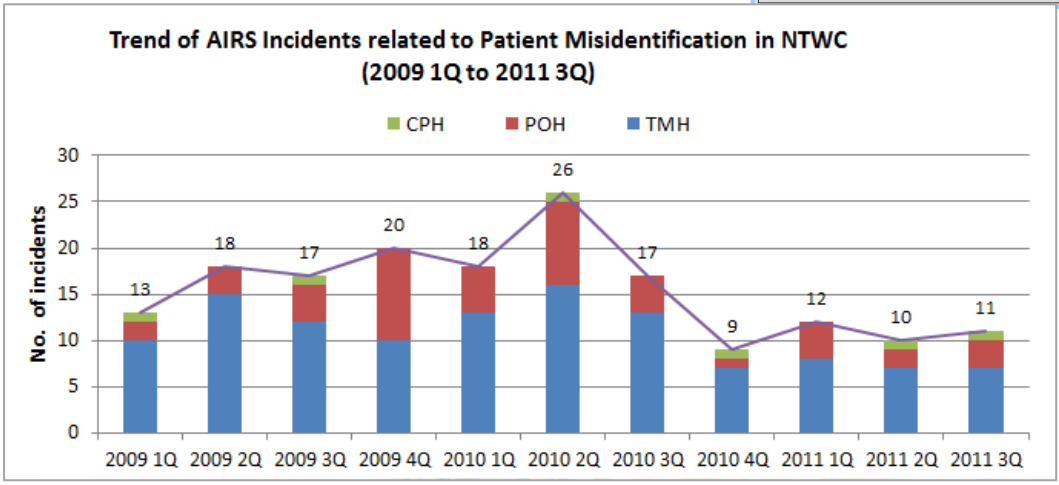
The "Audible Drug Label" was placed inside the drawer. In addition to the eye-catching design of the "Label", the 10-second alerting note would be delivered to the nurses each time when they take out the "Augmentin" from the drawer.

In view of some past medication incidents that were related to the administration of an antibiotic (Augmentin) to patients with history of allergy to penicillin, an innovative "Audible Drug Label" system is implemented in the satellite pharmacy in POH in November 2010. The "Audible Drug Label" is powered by replaceable batteries and is installed in the drawer for the storage of "Augmentin". The "light sensor" would be activated when the drawer is opened when the nurse taking out the drug, a 10-second alerting note would be played from the speaker. Three key messages are played which including the drug name (i.e. Augmentin), the antibiotic group (i.e. Penicillin) and a reminder to confirm patient's allergy history before the administration of the drug. Since the implementation of the "Audible Drug Label", the three M&G wards in POH have achieved zero medication error related to the administration of Augmentin.

3.1.5 NTWC Correct Patient Identification (CPI) Working Group

The first NTWC Correct Patient Identification Forum was held on 17 March 2011 with a hundred and fifty attendances from NTWC and other clusters. Representatives from Princess Margaret Hospital, POH and TMH presented their CPI improvement projects in the forum, which provided a platform for colleagues to share their achievements and experiences on prevention of misidentification of patients.

In 2010, the working group worked with the HAHO and local Information Technology team to implement the CMS enhancement function "Next Patient Reminder" in the AED of TMH and POH. Staff' awareness of the importance to verify patients' identity was heightened. As a result, the reported incidents of misidentification of patients due to data entry to the previous patient from CMS has dropped significantly after the rolling out of this new module.



3.1.6 NTWC Pressure Ulcer Prevention and Management Committee (PUPMC)

Electronic Pressure Ulcer Reporting System (EPURS)

The Cluster PUPMC and the Information Technology Section developed and launched the first electronic reporting system for pressure ulcer in HA. This system was implemented in most of the acute and rehabilitation wards in TMH. 8 training workshops were conducted. Over 200 nursing and clerical staff attended the workshops.

Pressure Ulcer Staging Assessment Tool

The Cluster adopted the pressure ulcer staging system from the National Pressure Ulcer Advisory Panel (NPUAP) and incorporated the staging system into the EPURS. A cue card with measurement tool was designed and distributed to every nursing staff in the cluster.

Pressure Ulcer Experts Visit

In order to enhance quality of care and provide expert advices on pressure ulcer management, the Cluster PUPMC initiated a "PU Round". A multi-disciplinary group of experts visit wards to give advices on management of patients with pressure ulcers. Clinical colleagues welcomed this initiative and expressed that their advices on managing pressure ulcers are useful.

Pressure Ulcer Certificate Courses

Two levels of certificate courses were formulated and conducted in 2Q and 4Q 2010. The aim was to enhance knowledge and skill of our professional staff in management of pressure ulcer. Over a hundred staff attended the certificate courses. Apart from providing training to professional staff, the PUPMC also worked with the Cluster HRU team to conduct a lecture on 「壓瘡的預防及護理講座」 in the program of「新界西翱翔進修增值計劃 10/11」for supporting staff.

3.1.7 Fall Prevention and Management Committee

Annual Fall Prevention and Management Seminar

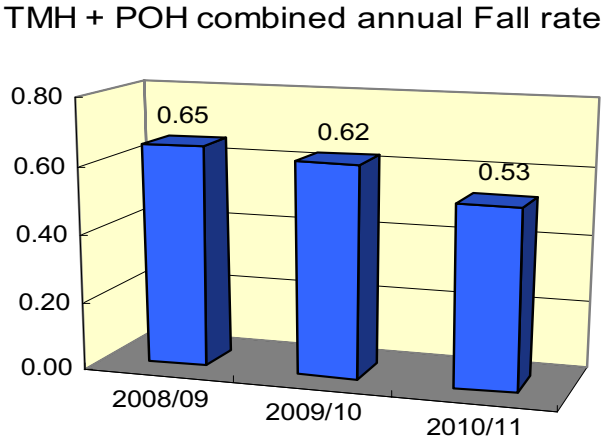
A seminar on "Effective fall screening and assessment" was organized in August 2010. Distinguished guests were invited to share their life-long expertise in their medical and nursing management in fall prevention. Over 100 NTWC colleagues came to this meaningful sharing event.

Standardization of Fall screening in TMH and POH

Morse Fall Assessment Scale has been adopted as the standardized fall screen tool in general adult wards in TMH and POH. The standardization was fully implemented in 4Q 2010. An e-learning course on the appropriate use of the Morse Fall Scale for NTWC nursing colleagues will be launched in April 2011.

Reduction of fall risk due to slippery shower trays

Being aware of a potential fall risk of the slippery rim of wet shower trays, the committee quickly enhanced the alert signage in all shower cubicles in TMH in August 2010. With the enhanced signage, no more fall cases related to wet shower trays were reported in 2010/11. In a further attempt to reduce this risk, a trial on an anti-slippery spray treatment has been performed in 1Q 2011. With the positive feedback from the trial ward, a larger scale trial will be planned in 2011/12.



3.2 Quality initiatives, including accreditation

3.2.1 Hospital Accreditation Pilot Scheme

Taking reference from the successful experience of the Hospital Accreditation Pilot Scheme, the Castle Peak Hospital would participate in the extension phase of the Hospital Accreditation Scheme. The Hospital Accreditation Taskforce, chaired by HCE, was set up under the command of the Cluster Hospital Accreditation Steering Committee. The taskforce works closely with the Hospital Clinical Governance Committee and the Hospital Management Committee to ensure smooth collaboration in the hospital's effort toward a successful accreditation. Same as any work towards quality and patient safety, hospital accreditation relies much on active support from frontline colleagues. Staff engagement started early with two introduction and sharing seminars organized in November 2010. Colleagues from Tuen Mun Hospital shared the learning points in their successful accreditation exercise. An expert from Australia also shared his experience in

accreditation in psychiatry. The seminars were warmly received by a total audience of over 200.

In preparing hospital accreditation in POH, a series of staff training activities, focusing on engagement and readiness, commenced in November 2010.

3.2.2 Surgical Safety

Study on compliance of Surgical Safety Checklist was conducted on the 2nd and 13th of July in 2010 at TMH operating theatres. Good practices were shared at the Cluster OT Committee meeting. A workgroup of Surgical Safety Checklist Programme Enhancement in Operating Theatre was formed in December 2010 to strengthen the good practices and work on the improvement initiatives.

3.2.3 Surgical Quality and Safety Circle

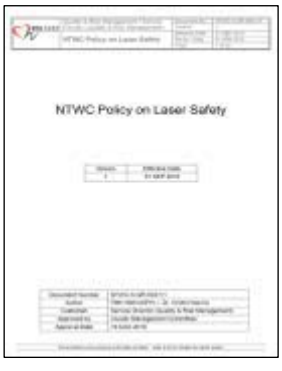
Continuous quality improvement and ensuring our patients' safety is an endeavor of NTWC. A Surgical Quality and Safety Circle was formed in February 2011, with health care professionals from different teams and specialties, to ensure clear communication between parties involved in the management of complicated surgical patients and to improve the co-ordination between various specialists involved in the care pathway.

3.2.4 Clinical Audit Committee

Clinical Audit Conference was held on 9 July 2010, 36 abstracts were collected and 8 team leaders have presented their projects. More than 200 attendants participated in the event and suggested many invaluable comments. It was followed by six regular clinical audit sharing sessions with the contribution from 11 departments including P&O, Psychiatry, Pharmacy, Surgery, A&E, Anaes &IC, Dietitian, Diagnostic Radiology, ENT, M&G and Neurosurgery. The Q&S Division has also initiated a process audit by reviewing the timeliness on performing initial patient assessment, 447 patient records across the department of GYN, NEU, ORT and SUR were studied in 3Q 2010.

3.2.5 Laser Safety Committee

In July 2010, the Cluster Laser Safety Committee was set up and the first Cluster Policy on Laser Safety was endorsed. Staff training and credentialing for users and assistants were formulated. Asset record for Laser equipments (Class 3B or above) was developed and would be updated regularly for better management. A new mechanism for purchasing class 3B or above laser equipments was developed and trial run of this mechanism was commenced in 1Q 2011.


NTWC Policy on Laser Safety

3.2.6 Patient Focus Group

The cluster also committed in providing quality patient services from the eyes of patients. In 2010, NTWC had further organized the Patient Focus Groups for the families of Paediatric patients in TMH, the ethnic minorities patients who attended POH AED regularly as well as the outpatients who attending mental health specialist clinics in CPH. Valuable opinions were solicited. Improvement measures were taken accordingly, which included the provision of comfortable chairs for parents who wished to stay overnight with the young patients, and more information about the consultation process in different languages for ethnic minority patients who were waiting for consultation.

3.2.7 Integrated Patient Care Plans

In 2010, four patient care programs have joined the ***Dendrite*** Clinical Audit Database. They include the management of breast cancer, colorectal cancer, upper GI cancer and urology disease program. Process and outcome data were retrieved and analyzed to identify gaps proactively. Care program for ST elevated myocardial infarction patients are also planned fundamentally and the structured database for data collection has been developed in cluster web. Patient education booklets for breast cancer management program were launched and distributed to the concerned clients in 2Q10.

3.2.8 Cluster Procedural Sedation Safety Committee

With an aim to ensure patient safety in receiving procedural sedation, the TOR and policy on the captioned were well developed and fully implemented in July 2010. E-learning system for nurses and credentialing workshops were formulated for

staff enhancement. The training curriculum was set up by the panel which was collaborated with Hong Kong College of Anaesthesiologists. Two identical train the trainer workshops were conducted in May and June 2010 for preparing subsequent safe sedation workshops to our medical staff. Fifty-four medical and nursing staff were trained as the trainers.

Seventeen credentialing workshops were conducted in 4Q 2010 and 1Q 2011, a total number of 252 medical staff from various departments including A&E, DR&NM, M&G, NEURO, O&T, Paed and SURG passed the sedation training and have the privilege to conduct sedation to patients who are undergoing selected procedures. The on-going credentialing workshops will be conducted in Jul and Jan yearly for the new comers or those missed the previous training.

We expected that 70% of nurses who are working in the department of A&E, DR&NM, M&G, NEURO, O&T, Paed and SURG would undergo E' learning in 2Q 2011 and achieved 90% in 3Q 2011. The complication reporting mechanism was established. The checklist for procedural sedation was used and the significant incident/complication will be reported monthly. The case study will be shared in the committee meeting. Some departmental guidelines on patient discharge and information sheet to the discharged patient will be standardized.

3.2.9 Pain Management Committee

Guidelines on Use of Opioids, Cancer Pain Management, Postoperative Pain Management in Adults were endorsed and adopt for cluster use in August 2010. E-learning system for nurses was developed and has been incorporated in HAHO's eLC in 1Q 2011. Nursing Forum for introduction of Pain Resources Nurses Recognition Program will be held in 2Q 2011 and workshop on the Interventional Pain Management would be held in 2Q 2011.

3.2.10 Patient Pacification Committee (PPC)

The PPC was established in December 2010, which was chaired by Deputy Service Director (Q&S), with members come from different specialties in the cluster. The committee would review guideline and observation chart as well as develop KPI for monitoring physical use in the cluster. Meanwhile, a survey on the changing staff attitude for physical restraint use as well as a pilot programme for new designed restrainer would be carried out.

3.2.11 Patient Opinion Survey at Tuen Mun Mental Health Centre (TMMHC)

An opinion survey was conducted at TMMHC on 10 June 2010 for obtaining feedbacks from service users on the new registration and queuing system implemented in November 2009. The survey also helped to collect our clients' opinion on their preferred time slot for registration. The overall response rate was 45%. 66% of respondents had a general impression that the new system was excellent or good with 82% respondents commented that the queue discipline was better or much better. However, improvements were required for waiting time for drug collection (only 41% reported a shortened waiting time) and time spent on direct medical consultation (only 25% reported a longer consultation session).

For the preferred time slot for consultation, the result of this survey showed that any clients may have their own reasons to prefer a specific time slot no matter they need to work or not. Actually, there was higher percentage of those not at work (91%) than those at work (83%) who had chosen a specific preferred time slot.

All comments collected would be served as a reference where further improvement programs would be based. The results had been presented to the HGC in March 2011.

3.2.12 Patient Satisfaction Survey (PSS) in CPH

The PSS was launched to better understand patients' experience and perspectives in their journey of recovery. Aiming at maintaining neutrality, the study was conducted in collaboration with the department of Sociology and Social Policies, Lingnan University for the design of the survey and analysis of data. In view of the lack of a validated and scientifically sound instrument in studying patients' satisfaction within the context of psychiatric service, a research team was set up. In December 2010 the Perception of Care, Chinese version was developed, and the result was accepted for presentation at The International Society for Quality in Health Care. After the

Hospital Clinical Governance Committee (HCGC) was formed in March 2011, the Clinical Incidence and User Experience Pillar developed a mechanism for structured collection and monitoring of patient feedback from different aspects of services using scientific methodologies. The aim was to deploy quality improvement plans by annual review of the satisfaction indices. This also allows future benchmarking between different psychiatric units.

3.2.13 Major Kaizen Initiatives in CPH

Queue Display Management System (QDMS)

The QDMS has been put into service since 17 January 2011 after a preparation of more than one and a half year, patients now know about the real time situation of the individual consultation room, so they can choose to go to other area of TMMHC instead of crowding the waiting hall. Moreover, doctors or other user of the consultation room can have more information of the condition of the queue, including the number of the patients registered and the identity of next patient.

Satellite Pharmacy Room

A pilot Satellite Pharmacy Room was established in July 2010 with a view to optimize medication inventory management, so that resources could be saved, and possibly minimize the occurrence of medication incidents.

Project Submissions

Nine projects with very good quality and high service impact were submitted to Conferences in 2010 and 2011, they included queue management in Pharmacy, QDMS, satellite pharmacy room, follow-up appointment booking and paperless medical record forms management.

4. Learning and Sharing Information

4.1 Leadership Safety Walkrounds

NTWC had engaged a Patient Safety consultant, Dr. Allan Frankel, to demonstrate the key characteristics of Leadership Safety Walkrounds in November 2010 for OT and HDU in POH. Clinical staff were more receptive to the walkrounds with the Executive Team by sharing and discussion on patient safety issues.

4.2 Annual Quality Conference

In 2010, the cluster had received more than forty quality improvement projects that joined NTWC best quality projects competition. Following the successful 2009 NTWC Quality Conference, the cluster continued to organize a two-day Annual Quality Conference in November 2010 with great accomplishment. Three pre-conference workshops and three renowned keynote speakers including the Vice-chancellor of CUHK, Chairperson of Alliance for Patients'Mutual Help Organisation, and the President of the Youth Foundation had attracted more than 500 staff to share their life experience and achieved the theme of the Conference "Enrich the Soul, Excel in Action".

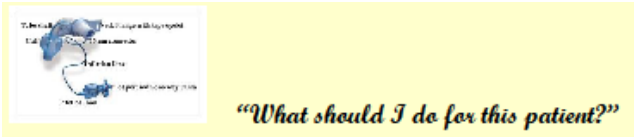
4.3 Sharing forums on Hospital Patient Safety Rounds (HPSR)

We had successfully conducted 10 HPSRs in cluster from March to July. In order to promote patient safety culture, sharing of good practices observed and work together for other observations. In Jul, two forums were organized for sharing some observations and recommendations/ improvement measures made during and after the HPSR. CCGC members had invited in Panel Discussion. Over 180 staff of TMH and POH attended the forum and exchanged their invaluable views.

Alert System on drug allergy

4.4 NTWC Safe Clinical Practice Bulletin

The monthly bulletin was launched since March 2011 to share with clinical staff on the learning points of different clinical cases locally and internationally. Senior staff of respective specialty was invited to express their comments on each case. The topics shared in the bulletin include speak-up culture, readiness of handwriting and clinical practice of tracheostomy. The bulletin was uploaded to the Q&S Division's website for wider accessibility.



Comments from Dr Koo Chi Kwan, Director of ICU, NTWC

That the patient was breathing normally did not exclude impending disaster in a pa
tracheostomy. A thorough examination is always warranted if there is any susp
problems with tracheostomy.

4.5 Radiation Safety Forum

With the aim to advise clinical departments on radiation safety matter, a Radiation Safety Forum was held on 10 August 2010 with 140 participants attended.

4.6 Complaint and Incident Sharing Sessions

In order to enhance communication and complaint management skills for our frontline staff, Complaint and Incident Sharing Sessions were held at TMH, POH and CPH. Doctors, nurses, allied health professionals and frontline supporting staff from various departments were our target audience.

The sharing session was a treasurable opportunity for Patient Relations and Safety Officers and patient safety and quality improvement team staff to meet the frontline clinical and supporting staff. This sharing session served as a chance to build up rapport for PRO and PSO with staff of different departments. There were 6 sharing sessions were held in NTWC from April 2010 to March 2011.

4.7 Practical Communication Skill Workshops

SM(PR&E) supported the Cluster Human Resources Department by introducing practical communication skill and conflict management skills in Orientation Programmes for newly recruited doctors and frontline staff. Deputy SD(Q&S) also shared with the new residents on how to communicate with patients' relatives effectively.

4.8 End-of-Life Care Symposium

A whole day End-of-Life Care Symposium was held in June 2010. The members of the organizing committee include our Patient Relations Officer and the doctor representatives from Paediatrics & Adolescent Medicine, Medicine & Geriatric and Clinical Oncology. Apart from inviting our doctors and nurses to share their valuable experience in End-of-life care, we had also invited some University professors, a social worker from St. James Settlement and a nurse-in-charge of Children's Cancer Foundation Respite Care & Rehabilitation Centre for sharing. Patient Relations Officer had presented the topic of 'Care of Relatives for the Dying Patient'.

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Safety Gist

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