

HOSPITAL AUTHORITY QUALITY AND RISK MANAGEMENT ANNUAL REPORT 2013-2014 (APR 13 - MAR 14)



Acknowledgement

This report has comprised the quality and risk management initiatives implemented in the Hospital Authority Head Office (HAHO) and seven clusters in 2013/14. Throughout the years, the HAHO Quality and Safety Division have been working closely with the seven clusters, making relentless effort in key areas under the HA's strategic direction and service priorities to continuously improve quality and patient safety. We would like to take this opportunity to express our sincere gratitude to all clusters and individuals for their wholehearted dedication and unfailing support to enhance our services.

Quality and Safety Division

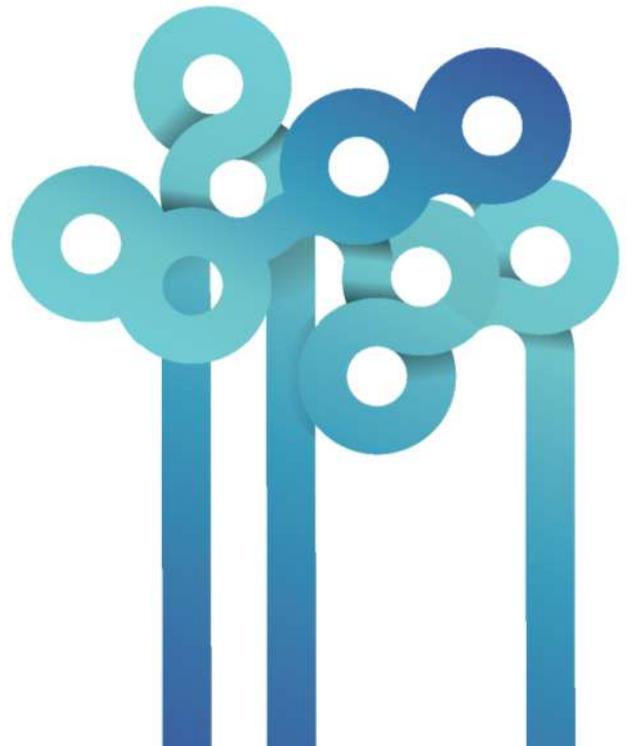




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Opening Message

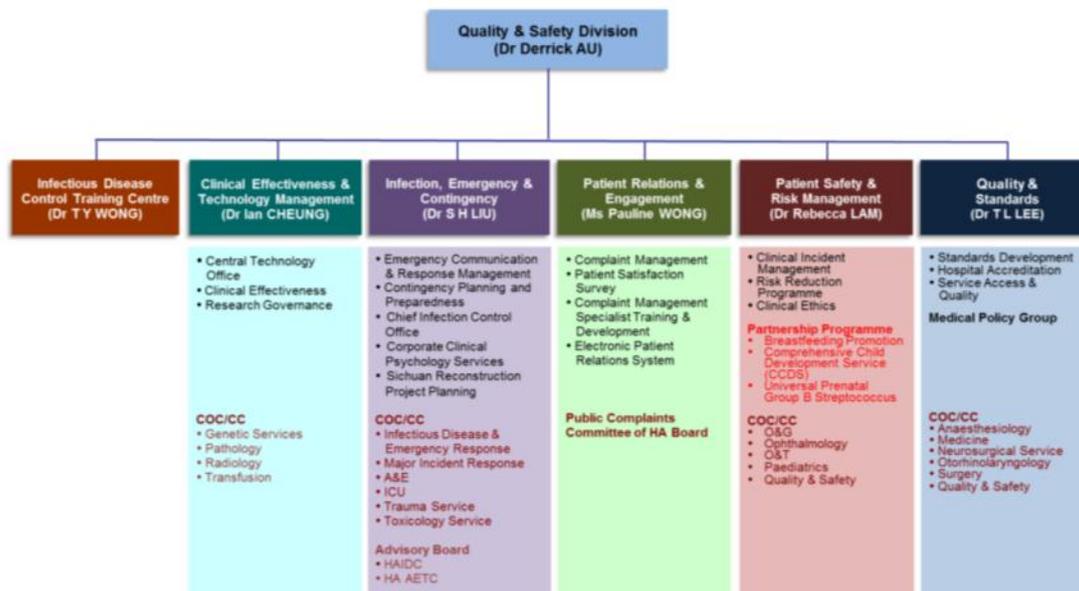


Another year past quickly, and now we have another report. Sometimes I doubt whether we need this yearly report, but as I mentioned last year it is a useful way for us to learn from each other. More recently, I have been asked by the Chairman of the Quality & Safety Subcommittee under the Hospital Governing Committee of Prince of Wales Hospital to provide a summary of what we have done in the last five years and evaluate the impact of those on patient safety. I think that may be another reason to prepare a report. Sometimes we just keep doing things within a moment to reflect. By reflecting on what we have done and their effectiveness, we may be able to identify which areas require more efforts and what should be stopped. We may even find gaps we need to bridge.

Dr SO Hing Yu
Chairperson, Committee on Quality and Safety, HAHO

Hospital Authority Head Office

1. Structure & Initiative



1.1 Hospital Accreditation

HA launched its Phase II hospital accreditation programme in 2011. In 2013/14, six hospitals, Pok Oi Hospital, Prince of Wales Hospital, North District Hospital, Tung Wah Hospital, Kowloon Hospital and United Christian Hospital, had their Organisation-Wide Survey conducted and awarded full accreditation status. Five Phase II hospitals had their gap analysis conducted during the year. As at Mar 2014, 12 HA hospitals (five pilot hospitals and seven Phase II hospitals) were accredited.

Following the theme of peers sharing and local experience, HA had invited local surveyors and quality managers from public and private hospitals to share the local perspectives through 11 monthly training workshops. About 1,800 staff from HA, private hospitals and Department of Health had attended with positive feedbacks.

To collect staff views systematically, staff were invited to complete an evaluation questionnaire after their hospitals had gone through accreditation. Over 656 returns were received from 6 hospitals in 2013/14. The overall response was encouraging. About 70% of

20TH MONTHLY TOPIC WORKSHOP
ON HOSPITAL ACCREDITATION

CONTINUITY OF CARE (I)
CRITERIA 1.1, 1.2 & 1.4

Date: 3 January 2014 (Friday)
Time: 2:00 – 5:00pm
Venue: Lecture Theatre, M/F,
Hospital Authority Building

Program Details:

2:00 – 2:45pm
Sharing from Canossa Hospital (Caritas)
Sr Lucy CHOY
Nursing Director & ACHS(HK) Surveyor

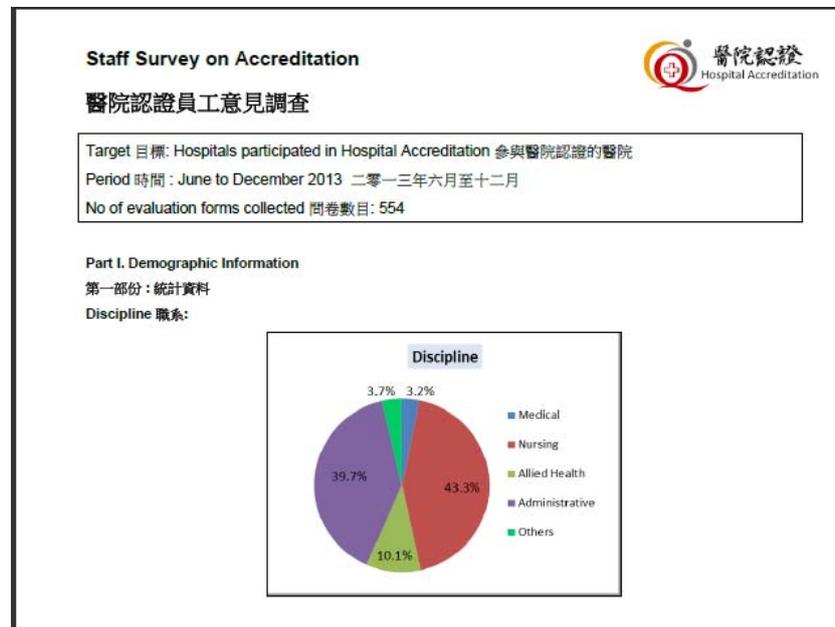
2:45 – 3:45pm
Sharing from OLMH
Ms Grace YEUNG
KWC FM&PHC GM(N) / OLMH GM(N) & ACHS(HK) Surveyor

3:45 – 4:00pm
Break

4:00 – 4:45pm
Sharing from KH
Ms Olga MA
KH Deputy GM(N) / DOM(RM&E) & ACHS(HK) Surveyor

4:45 – 5:00pm
Q&A

respondents understood the continuous quality improvement purpose of accreditation which had helped identify gaps for further improvement. About 65% of respondents expressed having support from senior level, and mutual help from other colleagues in the course of preparation.



To minimize duplication of work and relieve anxiety among staff, HA has also developed a knowledge sharing platform for survey recommendations and good practices. HA at corporate level is co-ordinating follow up of recommendations with HA-wide implications to enhance efficiency and effectiveness.



1.2 Communication and Sharing



1.2.1 Quality Times

Quality Times is published quarterly in collaboration with clusters' Quality and Safety Departments and representatives from Nursing and Allied Health as a platform to share good practices and experience on quality initiatives in HA. In addition to corporate topics, clusters were invited to share their efforts on quality improvements.

1.3 Quality Initiatives

1.3.1 Sterilization Enhancement

The corporate “Guidelines on Disinfection and Sterilization of Reusable Medical Devices for Operating Theatre (OT)” underwent the final stage of reality check and was planned to release in 2Q 2014. Development and pilot of the corporate Surgical Instrument Tracking System (SITS) for reusable medical devices used in OT was completed. A system evaluation process was performed in 2Q 2013, where the majority of users agreed that the SITS is user-friendly and effective in the enhancement of patient safety. The SITS has been carried out in five additional hospitals in two rollouts, namely The Duchess of Kent Children’s Hospital and Pamela Youde Nethersole Eastern Hospital in Dec 2013 and North District Hospital, Pok Oi Hospital and Tseung Kwan O Hospital in Mar 2014. Further rollouts to other hospitals were planned.

1.3.2 Document Control and Management

The purpose of document control and management was to ensure the controlled documents, such as policies, guidelines and protocol, are kept up-to-day, revised regular and accessible to relevant staff. To facilitate staff in the document management process, an electronic document management system (e-DMS) were piloted in Caritas Medical Centre, Queen Mary Hospital and departments in HAHO since 2012. In 13/14, 7 more hospitals had started to implement the e-DMS. Roll out of the e-DMS would be continued in more hospitals and HAHO Committees/departments.

1.3.3 Credentialing and Defining Scope of Practice

Credentialing and defining scope of practice aim to improve patient safety and enhance professional competence of clinical staff. Understanding the complexity and wider implications of the development, HA had undertaken preparatory works to improve communication and information sharing with strategic partners and enhance clinical specialty led competency standards. A Sharing Forum was held in Nov 2013 to share the experiences and practices with overseas and local speakers and also to deliberate on the way forward. It was planned to submit the proposal on the development framework, two-tier structure and prudent approach to the management and the Board for deliberation and endorsement in 2Q 2014.

1.3.4 Access Management

In 2013/14, the HA has posted the specialist outpatient (SOP) waiting time, with quarterly update, for four of the eight major specialties, namely Ear, Nose and Throat, Gynaecology, Ophthalmology and Paediatrics, on the HA Internet for public reference. The HA plans to upload the SOP waiting time for the remaining four major specialties, namely Medicine, Orthopaedics and Traumatology, Psychiatry and Surgery, on its website in 2014/15.

To better manage the waiting time variations between clusters within the routine category, a centrally coordinated mechanism for cross-cluster referral has been piloted in the specialty of ENT since Aug 2012, and extended to the specialties of Gynaecology and Ophthalmology in 2013/14.

The automatic release of quota by deceased cases was applied to all SOP clinics with effect from 1 May 2013. Over 36,000 quota (including new and follow-up cases of SOP) had been released for re-allocation in 2013/14.

A specialty-based specialist outpatient waiting time chart was formulated for each of the major specialties to facilitate specialty specific analysis and service planning. The first set of the charts was sent to CCEs and COC Chairmen of 8 major specialties in 3Q 2013 and the charts would be updated annually.

The SOP Booking Patterns of different clusters and specialties had been available at the Management Information Portal since Sep 2013 to facilitate monitoring and review.

In 2013/14, the electronic referral system was extended from all Family Medicine clinics and Accident & Emergency Departments to all specialties in all HA hospitals and launched the cross-specialty referral in order to further facilitate the referral and triage process and enhance the quality of referrals.

For elective surgery waiting list / waiting time management, computerized electronic reports for 6 common types of elective surgery such as Gallstone, Varicose Vein, Hernia, Ureteral Stone and Renal Stone were launched in the Clinical Data Analysis and Reporting System in Dec 2013 to capture real-time information on waiting list and waiting time. These waiting time reports will be discussed in various platforms such as Coordinating Committees meetings to review the situation regularly.

Since Apr 2013, HA has uploaded waiting time for cataract surgeries on HA's website. The HA plans to upload the waiting time for total joint replacement surgeries on its website in 2014/15. The waiting time information of SOP and elective surgeries would help patients understand the waiting time situation in the HA, so as to facilitate their consideration for treatment plans and choices; as well as to enhance the HA's commitment to transparency and public accountability.

1.3.5 Operating Theater Utilization

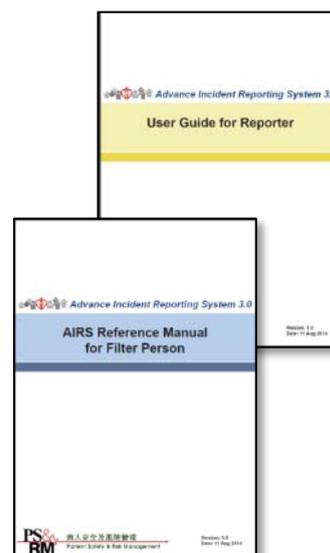
In 2013/14, the pilot operating theatre office at Hong Kong West Cluster has implemented the consultancy recommendations and used data to create management tools in order to improve the OT efficiency and utilization. The HA will continue the development of the OT management tools and implement in other clusters.

1.4 Advance Incident Reporting System 3

The Advance Incident Reporting System 早期事故通報系統 Version 3 (AIRS 3) in HA had been implemented in 6 clusters, including Hong Kong East Cluster, Hong Kong West Cluster, Kowloon Central Cluster, Kowloon East Cluster, Kowloon West Cluster and New Territories West Cluster, as well as HAHO since from 1 Jul 2013. New Territories East Cluster started using AIRS 3 on 1 Jan 2014.

To prepare for the full implementation, the HA AIRS project team had conducted a total of 38 rounds of hospital on site briefing to frontline colleagues and filter persons. A briefing session of AIRS 3 for HAHO staff was held on 22 Oct 2013 at Lecture Theatre, HA Building. The briefing session was focused on the design features of AIRS 3 and the reporting functions with demonstrations on Injury-On-Duty reporting.

A post-implementation evaluation of AIRS 3 was awarded to Hong Kong Productivity Council (HKPC) in Mar 2014. A total of 9 functional focus groups involving reporters, filter persons and executives from 7 clusters and HAHO would be interviewed. The evaluation was aimed to collect feedback from user groups as a basis for enhancing the system. The interviews were targeted to be completed by 2Q 2014.



1.5 Unique Patient Identification

HA had committed to implement the Information Standard for Blood and Transplantation (ISBT) using 128 character barcode label standard. Hence, the Patient Safety and Risk Management Department (PS&RM) had jointly organized a seminar with Hong Kong Red Cross Blood Transfusion Service in Dec 2013 to introduce staff on the background and requirements of the standard for blood transfusion. Also, the department had reviewed in the working group the current blood transfusion processes and barcode technology for the required changes to ensure safety and facilitate surveillance.

1.6 Surgical Safety

PS&RM had continuing her effort to work collaboratively with clusters in improving system and processes in safety checks so as to ensure the correct patient received the correct procedure. The improvements were made from the lessons learnt through incident reporting. These included the enhancement of specialty based checklists in counting of surgical items and checking of integrity of instrument. Also, hospitals had built cohesive surgical teams with briefing and debriefing activities to achieve patient safety.

1.7 Procedural Sedation Safety

Since its establishment in Jul 2011, the Task Force on Procedural Sedation Safety (the Task Force) has been advising on the collaborative planning and implementation of action to strengthen the knowledge and provision of safe procedural sedation in the HA.

In 2013/14, the Task Force had set up the Framework of Procedural Sedation Safety Training, which included web-based learning and simulation / interactive learning, for specialties' / disciplines' reference when devising procedural sedation safety training. Regarding simulation training, the "Curriculum Framework for Procedural Sedation Safety Simulation Training" was developed. This curriculum framework listed out the recommended requirements (e.g. topics to be covered, formats and trainer requirement, etc.) for procedural sedation safety simulation training in HA.

With the support from Institute of Health Care (IHC) and COC (Anaesthesiology), a corporate procedural sedation safety eLearning courseware would be developed in 2014/15. On the other hand, three procedural sedation safety training courses, namely (a) Enhancement of Safety of Children in Diagnostic and Therapeutic Procedure (COC(Paediatrics)); (b) Procedural Sedation Safety Simulation Training Course (Institute of Advanced Nursing); and (c) Enhancing Safety in Sedation Workshop (Institute of Clinical Simulation), were supported by the Simulation Training Committee to be provided by respective provider in 2014/15.

1.8 Prevention of Inpatient Suicide

In Aug 2013, the "Guidelines on the Prevention and Handling of Suicidal Behavior in Non-psychiatric Inpatient Setting" were released with the objectives to guide early identification of patients at risk of suicidal behavior; handling of patients with suicidal behavior; and appropriate referrals to professionals for further assessment and intervention. In addition, the "Facility-related Provision for Prevention of Inpatient Suicide in Non-psychiatric Ward Setting" (the List) was incorporated into the Guidelines on Hospital Security Design Planning (Version 3) in Dec 2014. The List served as a reference in designing new wards or at major renovation / refurbishment of existing wards other than psychiatric wards.

Inpatient suicide (including home leave) had accounted for a significant proportion of sentinel events in HA since the Sentinel Event Policy was in place in 2007. The Subcommittee of Prevention of Inpatient Suicide would continue to monitor and review the trend and nature of inpatient suicide, identify areas for enhancement and make recommendations on corporate strategies and programs which could be implemented in HA hospitals for prevention of inpatient suicide accordingly.

Hong Kong East Cluster

1. Structure

Committee Structure of Cluster Quality and Safety



2. Overview of Quality and Risk Management Issues

2.1 Engaging Clinical Leaders

To foster our strategic direction of “Building Clinical Leadership and Knowledge to Sustain Quality and Safety Improvement”, Dr K Y Pang has been appointed as the new Deputising Service Director of Quality & Safety (Q&S) and a total of six clinicians have been appointed as Deputy Directors (Q&S). They are Dr C H Ho, Dr Rex Lam, Dr C M Leung, Dr Yvonne Li, Dr K L Tsui and Dr S H Wan, from different clinical streams in the Cluster.



2.2 Hospital Accreditation

In preparation of the Organization-Wide Survey, Tung Wah Eastern Hospital (TWEH) has its gap analysis exercise done from 3 to 5 Jun 2013.



2.3 Near Miss Learning and Sharing

HKEC appreciates that reporting near-miss cases for sharing and learning is regarded efficient tools in risk management. To enhance the culture of reporting near-miss in the staff, the HKEC Working Group on Near-miss Reporting took the following initiatives in 2013/14:

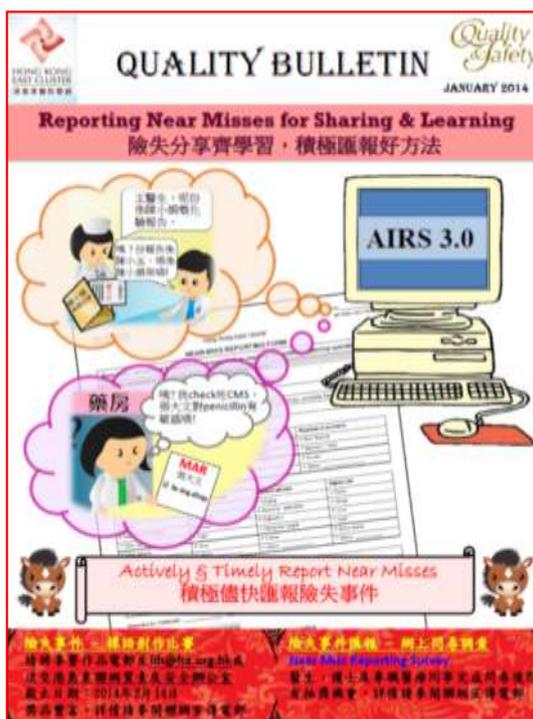
- i. An awareness forum on Near-miss Reporting has been organized for staff to share their vision and experience in near-miss reporting;
- ii. A paper form has been designed to provide a convenient means for staff to report near-miss;
- iii. Electronic near-miss reporting is also made possible with the implementation of the Advance Incident Reporting System 3 (AIRS 3);
- iv. Three issues of electronic Near-miss Digest have been published for cultural building and case sharing; and
- v. Two issues of electronic Quality Bulletin have been produced to encourage near-miss reporting;
- vi. A slogan competition on near-misses has been organized to promote learning and sharing through near-miss reporting.

HKEC also conducted two surveys in Jun 2013 and Jan 2014 to study changes in the reporting culture among the clinical staff. Compared with the results of Jun 2013, the survey in Jan 2014 shows significant improvements in the staff’s perception to the importance in reporting near-miss, the likelihood they will report near-miss, and the user-friendliness and effectiveness of the current reporting channels.

2.4 Informed Consent

To mitigate the risk associated with using abbreviations in the patient consent process, the Cluster Informed Consent Committee has initiated a review on the actively used abbreviations in clinical departments. Out of 359 abbreviations commonly being used in the Cluster, 45 have been accepted for official use in consent forms.

險失匯報互提點 病人安全齊實踐



3. Risk Prioritization

3.1 Identified Risks for 2013-2014

Clinical Risks	
1	Medication Safety
2	Infection Control
3	Fall
4	Patient Identification
5	Staff Competence
6	Pressure Ulcer Prevention and Management
7	Surgical Safety / Invasive Procedure Safety
8	Suicide
9	Clinical Handover & Communication
10	Radiation Safety
Non-clinical / Operation Risks (not in order of priority)	
1	Manpower
2	Supplies
3	Patient Transfer
4	Occupational Safety and Health (OSH)
5	Facilities Defects
6	Data Security & Confidentiality
7	Equipment Failure
8	Hospital Security
9	Fire Safety
10	Financial

3.2 Identified Risks for 2014-2015

Clinical Risks	
1	Infection Control
2	Medication Safety
3	Fall
4	Staff Competence
5	Patient Identification
6	Pressure Ulcer
7	Clinical Handover & Communication
8	Surgical Safety / Invasive Procedure Safety
9	Radiation Safety
10	Suicide
Non-clinical / Operational Risks (not in order of priority)	
1	Failure of Critical Information Technology (IT) System
2	Workplace Violence
3	Manual Handling Operations
4	Data Security and Confidentiality
5	Facilities Breakdown
6	Fire Safety
7	Shortage of Manpower in Particular Ranks
8	Cash Handling

4. Risk Reduction and Quality Programmes

4.1 Identified Clinical Risks for 2013 -2014

Programme		Action Taken / Outcome
1	Medication Safety	
a	Revise “Common Dilutions for Adult IV drugs” to include common brand names	<ul style="list-style-type: none"> ■ Pocket-sized version of the revised “Common Dilutions for Adult IV drugs” was distributed to HKEC medical, nursing and pharmacy staff while A4-sized version was distributed to clinical areas and wards in Jun 2013.
b	Standardize MAR order interpretation - “On-call to OT”	<ul style="list-style-type: none"> ■ The interpretation of medication orders including “On-call to OT” and “Bring to OT” was deliberated for standardization and endorsed in the Cluster Drug & Therapeutics Committee on 26 May 2014 for implementation.
c	Revise the list of “Drugs Commonly Causing Allergy or Allergic-like Reactions” to include Chinese drug names	<ul style="list-style-type: none"> ■ Pocket-sized version of the revised “Drugs Commonly Causing Allergy or Allergic-like Reactions” to enhance accessibility to reference of Chinese drug names was distributed to HKEC medical, nursing and pharmacy staff in Mar 2014. ■ Medication incidents related to known drug allergy have shown a downward trend.
d	Enhance safety and communication on the MAR for drug discontinuation	<ul style="list-style-type: none"> ■ Added the phrase - “For DRUG DISCONTINUATION, please also write next to the (intended) last dose with a double stroke “//” in MAR forms”.
e	Medication Safety Rounds to enhance staff awareness on medication safety and reduce risks.	<ul style="list-style-type: none"> ■ Conducted monthly Integrated Medication Safety Rounds in Pamela Youde Nethersole Eastern Hospital (PYNEH) clinical areas by nursing and pharmacy representatives since Dec 2012 to identify unrecognized risks, review staff knowledge and compliance to relevant guidelines and share good practices.
f	Medication Safety Roadshows to promote medication safety and share lessons learnt	<ul style="list-style-type: none"> ■ Medication Safety Roadshows were conducted biannually on 29 Aug 2013 and 19 Mar 2014. ■ HKEC Attendance was 348.
g	Standardize drug administration schedule and procedures to avoid misunderstanding	<ul style="list-style-type: none"> ■ Aligned IV medication schedule to line up with oral Antibiotic schedule. ■ Revisited the work division and work flow to involve supporting staff to assist patients to take drugs with the presence of nurse at the cubicle.
h	Ensure compliance on checking patient identity	<ul style="list-style-type: none"> ■ Half yearly Observation Survey on Administration of Medication to maintain staff alertness and enhance staff compliance, focused on checking wristband for identification and not leaving drug unattended at bedside. ■ 96% of in-patient wards nurses were observed in 1Q14. Compliance rate of checking patient’s wristband and not leaving drug unattended was 98% and 90% respectively. 100% compliance rate was achieved during the repeated observation on non-compliant staff.
2	Infection Control	
a	Upgrade the Electro-Medical Diagnostic Unit in Ruttonjee Hospital & Tang Shiu Kin Hospital (RHTSK)	<ul style="list-style-type: none"> ■ Renovation work to separate the clean and dirty area for Endoscopy Services was completed on 19 Aug 2013 and 3 additional endoscopy sessions per week were provided with effect from Oct 2013.
b	Quality enhancement of operating theatre (OT) sterilization by 100% replacement of OT set wrapper and pilot	<ul style="list-style-type: none"> ■ Replaced all wrappers with non-woven wrappers in Mar 2014. ■ Implemented corporate Electronic Surgical Instrument Tracking System (SITs) in Dec 2013. SITs provides a means to track and trace the operation, surgical instruments and patient information in re-processing cycle timely, facilitating tracking and tracing

	Tracking & Tracing System in PYNEH	function in case of product recall and/or when a patient with a contagious disease has been identified.
c	Implement Vancomycin Resistant Enterococci (VRE) control strategies to prevent the occurrence of inter-cluster and inter-hospital spread	<ul style="list-style-type: none"> ■ Strengthened environmental hygiene through environmental cleansing with 2-in-1 disinfectant disposable wipes twice daily. ■ Strengthened staff hand hygiene with a 3-tier hand hygiene observational survey in PYNEH; hand hygiene dance in RHTSK and reinforcing hand hygiene before meals and after toileting among patients. ■ Implemented admission screening for patient admitted to hospitals outside Hong Kong in past 6 months and sentinel screening for VRE on stool sample sent for C Difficile PCR test. ■ Conducted “Targeted Screening on Admission for VRE” with positive rate of 1% in HKEC which was comparable to the HA overall rate of 1.4%.
d	Implement HA Guideline on Prevention and Control of Nosocomial Legionnaires’ disease	<ul style="list-style-type: none"> ■ Incorporated HA recommendations into Hospital Prevention and Maintenance program of HAI Legionnaire’s Disease with monitoring mechanism in place. ■ Participated in Group Internal Audit on Compliance with Guidance on Legionnaires’ disease in HKEC in Jan 2014 with no major non-compliance identified.
e	Enhance hospital environmental hygiene by revising the existing color coding system to be in line with the HA Environmental Decontamination in Clinical Areas	<ul style="list-style-type: none"> ■ Collaborated with Housekeeping and Procurement Teams to define the application of HA color coding system in hospitals and conducted rounds to address concerns from frontline colleagues. ■ Developed pictorial information sheet on the color coding system. ■ Produced training video to facilitate training to newcomers. ■ Developed a slogan “綠茶紅廁黃隔離·藍色處處白即棄” to facilitate familiarization with the new coding. ■ Conducted 17 training sessions with around 1,200 attendees.
f	Product enhancement to facilitate infection control practices	<ul style="list-style-type: none"> ■ Collaborated with Cluster Procurement Centre to explore appropriate equipment for infection control. ■ Increased use of disposable items to minimize cross transmission. ■ Equipped with Trophon machines and Tristel wipes to facilitate high level disinfection of semi-critical equipment. ■ Installed gloves dispensers in clinical areas outside each cubicle to facilitate easy access. ■ Designated yellow colored receivers for sharps transfer during operation.
g	Regular visits / surveys to review infection control practices and compliance monitoring	<ul style="list-style-type: none"> ■ 83% compliance rate during Hand Hygiene Observation was noted indicating a year-on-year improvement ■ 99.2% compliance rate of Clinical Waste Management Audit in 2013 was achieved
h	Implement source control measures to improve 48 hours apportioned Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia rate	<ul style="list-style-type: none"> ■ Implemented evidence-based source control measures: <ul style="list-style-type: none"> ● Body cleansing with 2% Chlorhexidine Gluconate (CHG) impregnated cloths to bed ridden patients upon admission ● Universal decolonization to bed ridden patients with changing the daily bath agent from plain soap to 2% CHG bath gel. ■ The 48 hours apportioned MRSA bacteremia rate per 1000 acute bed days decreased from 0.1166 in 2008 to 0.0606 in 2013 and achieved the lowest record in 3Q & 4Q 2013.
i	Review and standardize vaccine cold chain management in clinical areas	<ul style="list-style-type: none"> ■ Developed a work instruction on managing vaccine cold chain. ■ Reviewed and standardized the drug fridge maintenance, i.e. temperature record form and checking instruction ■ Promoted the vaccine management method through trainings and newsletters. ■ Redefined logistics on vaccine transportation. ■ 99.3% overall compliance on cold chain management (handling and storage) and 100% compliance rate in criteria on vaccine storage and administration recorded in the Hospital-wide

		evaluation in Feb 2014.
3	Fall	
a	Guidelines on Fall Prevention	<ul style="list-style-type: none"> ■ Implemented Cluster Guidelines on Fall Prevention and Fall Risk Assessment & Prevention Record with multi-disciplinary input on 18 Aug 2014. ■ Conducted Q&S Forum on 7 Aug 2014 to brief staff on the updated Guidelines and Assessment & Prevention Record prior to implementation.
b	Explore alignment of cut-off score of Morse Fall Scale	<ul style="list-style-type: none"> ■ Reviewed and aligned cut-off score of Morse Fall Scale for acute and non-acute settings in HKEC.
4	Patient Identification	
a	Enhance positive identification of bone marrow specimens by using barcode system	<ul style="list-style-type: none"> ■ Implemented PathOS labelling system for specimen identification, processing slides and forms since Feb 2014.
b	Implementation review on 2D barcode scanning for blood and non-blood specimen collection	<ul style="list-style-type: none"> ■ Implemented 2D barcode scanning for blood and non-blood specimen collection in Mar 2013. ■ No incident of wrong patient identification on blood and non-blood specimens up to 31 Mar 2014.
5	Staff Competence	
a	Organize seminar / education forums to heighten staff awareness and competence	<ul style="list-style-type: none"> ■ 4 Quality & Safety Forums were held with topics including “Prevention of Patient Suicide”, “Medication Safety”, “Use of Physical Restraint” and “Take Patients’ Nutritional Status Seriously”.
b	Enhance facilities to improve training effectiveness	<ul style="list-style-type: none"> ■ Installation of 2 multi-purpose 84” 3D TVs for training and conference in Minimal Access Surgery Training Centre (MASTC). Depth perceptions during surgery were enhanced and learning curve of junior doctors was shortened.
c	Organize mandatory specialty specific training for doctors	<ul style="list-style-type: none"> ■ Basic Laparoscopic Surgery Course on 10-11 Apr 2013. ■ Advanced Laparoscopic Surgery Course on 17-18 Oct 2013. ■ Basic Laparoscopic and Endoscopic Urology Course for Higher Urology Trainees on two half-days (16 Mar & 20 Apr 2013). ■ Advanced Laparoscopic and Endoscopic Urology Course for Higher Urology Trainees on 19 Oct & 23 Nov 2013. ■ 2 Introductory Gynaecological Endoscopic Surgery workshops on 13 Sep 2013 & 14 Mar 2014. ■ 2 HA Intermediate Level (Level III) Gynaecological Endoscopic Surgery workshops on 20-21 Jun & 5-6 Dec 2013. ■ Course evaluation showed all programs received rating of ‘Good’ or above.
d	Promote good management and leadership through management and departmental training programs; and tailor-made training to widen vision and enhance management skills of the executives at different levels	<ul style="list-style-type: none"> ■ Executive Management Programmes for senior management of HKEC with topics of “Meeting Public Expectations”, “From Adversity to Success”, “Risk Awareness and Management”, “Making Changes” and “Grooming Talents under People-based & Caring Culture”. ■ 2 classes of Advanced Management Programme for middle management of HKEC with topics of “Crisis Management”, “Creative Problem Solving with Blue Ocean Strategy”, “Staff Engagement & Team Development” and “Negotiation and Influencing Skills”. ■ 2 classes of Junior Managers Development Programme with topics of “Self-Empowerment”, “Task Excellence” and “Team Synergy”. ■ A series of HKEC Edward De Bono Workshop for Senior Executives and Frontline Supervisors. ■ 2 classes of HKEC Think On Your Feet Workshop for Senior Executives.

		<ul style="list-style-type: none"> ■ 2 classes of HKEC 7 Habits for Highly Effective People for Frontline Supervisors and Professionals. ■ 3 classes of HKEC XQ Management Workshop for Frontline Supervisors. ■ HKEC Compliance Training Series for all staff of HKEC with topics including “Anti-discrimination Ordinances of Hong Kong”, “Patient Data Privacy” and “Understanding and Preventing Sexual Harassment”.
e	Build positive practice environment for nurses	<ul style="list-style-type: none"> ■ 4 classes of Service Culture Training Programme for Frontline and Newly Recruited staff. ■ 11 classes of tailor-made departmental training for Department of Community & Patient Resource of PYNEH, Medicine of PYNEH, Radiology of PYNEH, Nursing Services Division of RHTSK, and Wong Chuk Hang Hospital (WCHH). ■ Promotion of Recognition and Appreciation Campaign among nurses from Aug 2013 to Jan 2014 in all Cluster hospitals and General Out-Patient Clinics (GOPCs) with positive feedback.
6	Pressure Ulcer Prevention and Management	
a	Provide pressure ulcer training for nurses and enhancement course for PCA / HCA with the aim of pressure ulcer prevention	<ul style="list-style-type: none"> ■ Reviewed the Multi-disciplinary Pressure Ulcer Prevention & Management Workshop (Train-the-Trainers). ■ Provided Pressure Ulcer Training for Nurses on an ongoing basis ■ Provided enhancement course for Patient Care Assistant (PCA) / Health Care Assistant (HCA) on pressure ulcer prevention since 3Q13.
b	Compliance check on pressure ulcer and wound management	<ul style="list-style-type: none"> ■ Conducted inter-hospital wound rounds. ■ Piloted quarterly multi-disciplinary pressure ulcer rounds in PYNEH with effect from 3Q12.
7	Surgical Safety / Invasive Procedures Safety	
a	Compliance Audit on Interventional / Bedside Procedures Safety Policies	<ul style="list-style-type: none"> ■ Conducted Compliance audit (phase I) on Interventional Procedures Safety in PYNEH on 19 Mar 2014. The scope included 43 patients who underwent interventional procedures in respective interventional suites from Oct to Dec 2013. No discrepancy in side / site procedure and patient identification was noted. ■ Compliance audit (phase II) on Bedside Procedures Safety will be conducted in PYNEH in 2Q14.
8	Suicide Prevention	
a	Evaluation on Suicide Prevention Program	<ul style="list-style-type: none"> ■ Conducted a survey to collect feedback from PYNEH Ward Managers on the Cluster SOP on “Prevention of Patient Suicide in General Wards” and “Suicide Risk Screening and Suicide Precaution Observation Record (General Ward)”. ■ Evaluated the feedback to identify areas for improvement.
b	Patient Safety Rounds (PSRs)	<ul style="list-style-type: none"> ■ Conducted PSR on Prevention of Patient Suicide in RHTSK (18 Dec 12), TWEH (22 Feb 13) and PYNEH (18 Apr 13) ■ Identified facilities with safety and security concerns for improvement. ■ Collected feedback for suggested modification of “Suicide Risk Screening and Suicide Precaution Observation Record (General Ward)”.
c	Provide training / training kits to update staff on skills and knowledge on prevention of patient suicide	<ul style="list-style-type: none"> ■ Conducted Lunch Forum on Prevention of Patient Suicide on 23 May 2013 with a total attendance of 472. ■ Rolled out the following documents in HKEC on 2 Sep 2013: <ul style="list-style-type: none"> ● the revised “Suicide Risk Screening and Suicide Precaution Observation Record (General Ward)” ● “Advice for Relatives on Caring Patients in Hospital” leaflets (Chinese & English version). ■ Produced “Technique on Breaking Bad News” video for uploading onto the HKEC Q&S website to enhance staff’s knowledge and awareness on effective suicide prevention.

9	Clinical Handover & Communication	
a	Conduct Crew Resource Management (CRM) Training Program	<ul style="list-style-type: none"> ■ As at 31 Mar 2014, 2,467 HKEC staff joined the CRM classroom training program since it was piloted in 2010. ■ Conducted 35 workshops of scenario-based simulation training since the opening of Nethersole Clinical Simulation Training Centre in Dec 2012. 431 clinical staff from Obstetrics & Gynaecology, Psychiatry, Accident & Emergency, Intensive Care, Orthopaedics & Traumatology, Paediatrics & Adolescent Medicine and multi-disciplinary teams of staff participated. ■ Scheduled HA funded programs of simulation training, Intern Orientation and Book Camp in 2014/15.
10	Radiation Safety	
a	Compliance with Radiation Ordinance (Radiation License & Dose Monitoring)	<ul style="list-style-type: none"> ■ Regular updating of Operator License <ul style="list-style-type: none"> ● PYNEH: Sent renewal reminders to the users 6 months (and 3 months as well if necessary) prior to the expiry date for each individual license ● HKEC (non-PYNEH): Synchronized the irradiating apparatus (IA) operator list and license status with the user departments every 6 months ● All IA users possess valid licenses. ■ Personal Radiation dose monitoring (TLD badge) <ul style="list-style-type: none"> ● Refined the workflow of exchanging Thermoluminescent Dosimeter (TLD) badge with users. 50% reduction in loss / un-readable TLD badges from Jan to Dec 2013.
b	Radiation Safety Audit 2013	<ul style="list-style-type: none"> ■ Conducted cross-departmental audit during Sep – Nov 2013 involving 15 departments/sites with no non-conformance identified.

4.2 Identified Non-clinical (Operational) Risks for 2013-2014

	Programme	Action Taken / Outcome
1	Manpower	
a	Enhance career development for doctors, nurses and allied health professionals	<ul style="list-style-type: none"> ■ Created promotional posts in 2013/14 for healthcare professionals
b	Offer flexibility and choices in employment	<ul style="list-style-type: none"> ■ Conducted Contract to Permanent Conversion Exercise for staff retention and recognition.
c	Further reach out recruitment activities for supporting staff	<ul style="list-style-type: none"> ■ Expanded recruitment channels to career fairs, recruitment day, promotional / postal leaflets, and training organizations. ■ Increased the number of walk-in selection boards.
2	Supplies	
a	Conduct physical count on HA's PPE stock	<ul style="list-style-type: none"> ■ Satisfactory results in both Hong Kong and Shanghai warehouses in terms of quantity, physical condition and storage environment.
b	Tighten quality control on incoming supplies	<ul style="list-style-type: none"> ■ Guaranteed goods quality especially for those with safety alert / product recall issued before sending to wards for clinical use.
c	Standardize procedures for handling product quality complaint	<ul style="list-style-type: none"> ■ Strengthened monitoring of product quality. ■ Enhanced the information sharing with the Quality Assurance Team of Hospital Authority Head Office.
3	Patient Transfer	
a	Enhance patient's access to medical service by further expanding NEATS	<ul style="list-style-type: none"> ■ Expanded Non-Emergency Ambulance Transfer Services (NEATS) ambulance fleet by recruiting additional drivers and attendants to shorten patients' waiting time. All HA specified Key Performance Indexes (KPIs) are complied with. ■ 22 staff attended the structured training for NEATS crew in 2013/14.
b	Alerts system for safe mobilization of fragile	<ul style="list-style-type: none"> ■ Further trial of revised alerts system at selected wards in RHTSK and TWEH.

	patients	<ul style="list-style-type: none"> ■ Rolled out refined version to St. John Hospital (SJH) since 2 Jan 2014. ■ Planned to roll out to elective wards in PYNEH, RHTSK, TWEH, WCHH and Cheshire Home, Chung Hom Kok (CCH) in 3Q14.
4	Occupational Safety and Health (OSH)	
a	Staff Health Promotion Program	<ul style="list-style-type: none"> ■ Organized a series of seminars/workshops/game booths on various health topics, e.g. physical fitness, psychological well-being. ■ Conducted staff health (work & well-being) survey–工作健康調查 in Mar 2014, with “Work Ability Index” as assessment tool with a return rate of over 65% (around 5200 returns). ■ Promotion of health and wellbeing through a series of functions, OSH link person meetings and newsletters.
b	Hazard Control Enhancement Program	<ul style="list-style-type: none"> ■ Implemented assessment checklist for prevention of “Slip, Trip & Fall” in 1Q14. ■ Procured safety foot wear for protecting toes of transport teams. ■ Achieved mercury-free environment by replacing with all non-mercury contained sphygmomanometers & thermometers. ■ Provided proper & effective removal of residual formaldehyde vapor by using external formaldehyde neutralizer. ■ Purchased safety footwear, handy tube, and forearm protector for pilot run.
c	Continuous Quality Improvement (CQI) Program for OSH Awareness & Culture Development	<ul style="list-style-type: none"> ■ Conducted 3 OSH sharing sessions, 2 classes of link person training and professional leadership training for OSH Link Persons. ■ Published 3 issues of cluster-wide OSH newsletters.
5	Facilities Defects	
a	Upgrade hospital infrastructure to ensure safe and efficient delivery of clinical services	<ul style="list-style-type: none"> ■ Implemented a total of 29 projects to eradicate risks and enhance safety of hospital services in 2013/14. ■ Regular servicing of relevant plant including replacement of spare parts by Electrical & Mechanical Services Trading Fund (EMSTF)
b	Strengthen control over poor service quality of works agent	<ul style="list-style-type: none"> ■ Increased frequency of onsite supervision and conducting quality check on finished works. ■ Arranged weekly meetings at working level followed by joint site inspection with Term Maintenance Surveying (TMS) and Term Maintenance Contractor (TMC) for work project. ■ Enhanced monitoring of facilities conditions through regular ward-based inspections and common area inspections by in-house Day-to-day (DTD) team and EMSTF.
6	Data Security & Confidentiality	
a	Enhance access control to patient data	<ul style="list-style-type: none"> ■ Completed the review on Clinical Management System (CMS) accounts of HKEC not being used for over 1 year (based on last login date) and 213 inactive CMS accounts were thus inactivated
b	CMS Clinical Data Access Audit	<ul style="list-style-type: none"> ■ Conducted CMS Clinical Data Access Audit in Dec 2013 with no potential access violation reported.
c	Department Self-compliance Check / Audit	<ul style="list-style-type: none"> ■ Conducted Department Self-compliance Check using HA Checklist in Mar 2013. ■ 100% compliance rate after completion of improvement actions.
d	Privacy Walkaround	<ul style="list-style-type: none"> ■ Conducted Privacy Walkaround in SJH, Peng-Chau GOPC in Apr 2013 and in PYNEH on 4 & 11 Oct 2013.
e	Heighten staff awareness on importance of information security and data privacy	<ul style="list-style-type: none"> ■ Issued Information Security and Privacy (ISP) email reminder and alert on HA recent incidents to all HKEC staff. ■ Shared HA-wide common pitfalls in cluster publications, e.g. Eastlink. ■ 100% of all new recruits and colleagues applied for CMS received mandatory training. ■ All medical Staff, nursing staff, allied health and Management

		staff received Briefing on Data Privacy Issues in orientation programs.
7	Equipment Failure	
a	Maintenance of high-risk equipment	<ul style="list-style-type: none"> ■ Regular meetings with Electrical and Mechanical Services Department (EMSD) to closely monitor the maintenance service of high-risk equipment. ■ Continued Zero-tolerance of high risk equipment in Schedule I hospitals. ■ Joined with HA in bidding resources for upgrading maintenance service for high risk equipment in Schedule II hospitals. ■ Allocated a budget for acquisition of equipment for HKEC in 2013/14. Rejuvenated medical equipment of HKEC in the last 5 years: <10 years increased from 41% to 74% >10 years decreased from 59% to 26%.
8	Hospital Security	
a	Strengthen security installations	<ul style="list-style-type: none"> ■ Installed CCTV, Access Control System (ACS) and Burglar Alarm at various departments, panic alarms at strategic locations, and additional emergency call bells in public toilets. Related drills were arranged ■ Developed and implemented ACS guidelines on 1 Nov 13.
b	Security risk assessment	<ul style="list-style-type: none"> ■ Conducted regular security risk assessment to identify areas for security improvement. ■ Secured lightning conductors with property marking, application of sealants to fixing points and shortening the interval between each fixing point. ■ Continued to improve the adequacy of hospital's security systems with reference to the 2013 Guidelines on Hospital Security Design Planning.
9	Fire Safety	
a	Review fire safety contingency plans and evacuation plans	<ul style="list-style-type: none"> ■ Established a review period (at least once in a cycle of 4 years) of fire safety contingency plans and evacuation plans. ■ Common standard signage for "Designated Assembly Point" and "Quick User Guide for Fire Response" adopted for HKEC hospitals.
b	Develop checklist and review mechanism for routine monitoring	<ul style="list-style-type: none"> ■ Cluster hospitals used the developed cluster-based compliance checklist in periodic inspections on workplace fire safety and mitigation of fire hazards.
c	Step up smoking control	<ul style="list-style-type: none"> ■ Stationed security guards at smoking black spots; increased the number of anti-smoking patrols daily; increased visibility of smoking control with security guards wearing "Smoking Control" vest even during normal duties.
d	Staff Training	<ul style="list-style-type: none"> ■ Identified the training needs of staff such as fire ambassador refresher courses in addition to scenario drills. ■ Held Fire Safety Ambassador training in PYNEH in Feb 14 with a total attendance of 51 staff.
10	Financial	
a	Develop a new payment details report in Oracle AP System with key checkpoints to facilitate payment checking	<ul style="list-style-type: none"> ■ Since the use of the new feature in Dec 2013, 35,996 vouchers have reviewed with 30 irregular / possible wrong payment cases were detected and actioned up to 31 Mar 2014. There was no payment incident in 2013/14.
b	Enhance existing manual database on T&D payment reimbursement method	<ul style="list-style-type: none"> ■ No duplicated T&D reimbursement was reported in 2013/14.

4.3 Other Quality Initiatives

4.3.1 Medication Safety

The HKEC Medication Incident Review Panel has been closely monitoring the medication incident trend in three aspects namely prescribing, dispensing and administering. Upon analysis, the majority of cases happened in 2013/14 are related to known drug allergy which is in tandem with the HA-wide trend.

The Serious Untoward Events cases on medication errors had been reduced after taking the following measures:

- i. Near-miss reporting is established and promoted for more effective learning and sharing;
- ii. Cluster-based sharing forums on medication safety are organized biannually;
- iii. Monthly integrated medication safety round is conducted by nursing and pharmacy representatives in clinical areas to identify potential risks and review staff knowledge & compliance;
- iv. The drug allergy alert mechanism have been revisited; and
- v. The information tool entitled “Drugs Commonly Causing Allergic or Allergic-like Reactions” has been enhanced to include Chinese drug names and print it in a pocket-sized version, distributing to doctors, nurses and pharmacy staff.

4.3.2 Fall Prevention

HKEC strives to prevent patient fall and minimize fall injury with a multidisciplinary approach as well as a framework in place facilitating effective collaborative efforts. With this, the following are made possible:

Evidence-based cut-off scores of Morse Fall Scale are aligned for acute and non-acute hospitals in HKEC for consistent alert.

Workshops on Fall Risk Assessment for senior nursing staff with a train-the-trainers approach are conducted. The content involves multidisciplinary input on education about gait and ambulatory aid assessment and practical sessions with real cases demonstration. After attending the workshops, participants become departmental trainers to educate clinical nurses with formal assessment of competency.



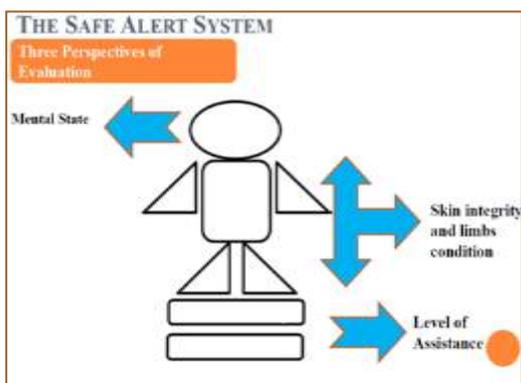
Fall Risk Assessment Workshop has been integrated into the HKEC Induction Program for nurse graduates since 2013. An updated training kit can be accessed on HKEC intranet for

staff training and review.

Department-specific Red Flag System on patients at risk of fall has been implemented in Department of Orthopaedics & Traumatology, Clinical Oncology and Medicine.

To provide all-round support, care-related supporting staff has also attended Enhancement Program on Fall Prevention and Physical Restraint.

Fall prevention will shift to a total approach that incorporates the minimization of physical restraint, nutritional management and the appropriateness of indwelling urethral catheters, which all pose risks on a patient to fall.



4.3.3 Safe Mobilization of Fragile Patients

To complement the efforts on fall prevention, an alert and communication system has been designed to facilitate both clinical and non-clinical staff in managing safe caring, mobilization and transfer of fragile patients. Piloted in St. John Hospital since Jan 2014, the System uses comprehensive representation of the risk profile of a fragile patient. Trial run

would be further rolled out to other cluster hospitals in 2014.

4.3.4 Physical Restraint

Physical restraint is sometimes applied on patients who are violent or confused in order to protect their safety. However, it is important to ensure the restraint does not harm the patient and therefore a HKEC Working Group on Physical Restraint has been set up and made the following initiatives in 2013/14 to ensure appropriate and minimal use of physical restraint:

- i. A prevalence survey on use of physical restraint has been conducted according to the scope provided by the Head Office;
- ii. “Guidelines for Use of Physical Restraint”, “Assessment & Observation Chart” and “Restraint Reminder for Doctors” have been promulgated as tools;
- iii. Briefing sessions and a lunch forum have been organized to promote the use of the tools and clear queries from staff; and
- iv. An electronic Quality Bulletin has been issued to promote the useful tips on application of physical restraint to all staff.



4.3.5 Wound Care Management

HKEC maintains the lowest GOPC wound dressing attendance / headcount ratio among seven HA clusters in 2012/13 and 2013/14. HKEC also reduced the average length of stay from 26 days in 2005-2010 to 16 days in 2010-2013 for inpatients with complicated diabetic foot ulcer by using negative pressure wound therapy device.



HKEC attains significant improvements in wound management in both hospital and community settings by having a 3-tier wound management model. This model allows prompt access to wound expertise, therapeutic intervention and care coordination so as to achieve early identification of complications, treatment plan and input from specialist when required.

To complement the infrastructure, prevalence survey, clinical audit, regular training and multi-disciplinary led wound rounds are also regularly conducted. These are further supplemented by the Home Empowerment Programme Workshop – Wound Care by Home Carers, decreasing unplanned admission and wound dressing attendance in the community.

4.3.6 Patient Suicide Prevention

The HKEC Working Group on Patient Suicide Prevention initiated the following measures in 2013/14 to evaluate the effectiveness of the existing patient suicide prevention program in general wards and to identify tools for filling gaps for continuous improvement:

- i. Patient Safety Rounds have been conducted to identify facilities with safety and security concerns for further improvement;
- ii. The Cluster “Suicide Risk Screening and Suicide Precaution Observation Record (General Ward)” has been revised;
- iii. A bilingual leaflet entitled “Advice for Relatives on Caring Patients in Hospital” has been developed for patient relatives; and
- iv. A cluster-based lunch forum on “Prevention of Patient Suicide” has been organized to highlight to staff the dos and don’ts in breaking bad news to patients with the ultimate aim of patient suicide prevention.



4.3.7 Occupational Safety and Health (OSH)

The OSH Committee implements the following programmes to enhance staff safety and wellness:

Hazard Management Program

- **Mercury-free environment** - mercury-contained equipment has been substituted by non-mercury contained equipment after cluster-wide stocktaking exercise.
- **Formaldehyde-minimizing program** - special neutralizers have been identified and procured for effective removal of residual formaldehyde vapor.
- **Selection and control of hazardous chemicals** - stocktaking of common hazardous chemicals are made with quantitative survey and onsite verification under a newly established centralized inventory; procurement policy has been reviewed; and department specific chemical risk assessment has been made in place.



Manual Handling Operation (MHO)

- Handy Tube is used in clinical areas for turning, moving patients higher up in beds, and transferring patients between beds.
- Risk assessment has been standardized on high-risk MHO tasks, e.g. high dusting, floor mopping, bed cleansing with recommendations made on proper work procedures and appropriate equipment for risk control.

5. Learning and Sharing Information

5.1 Extracorporeal Membrane Oxygenation (ECMO) Training

Extracorporeal Membrane Oxygenation (ECMO) support is provided to patients with respiratory failure with no alternative treatment. The Intensive Care Unit of PYNEH, one of 5 ECMO centres in HA, won an EXCELLENCE Award in the Hospital Management Asia 2013 held in Bangkok, Thailand with the abstract entitled *“Safe Implementation of ECMO Service through High Fidelity Simulation Training”*.



5.2 Learning and Development

HKEC colleagues have been actively participated in local and international conferences by submitting abstracts for sharing studies and related results for enhancing healthcare services.

In 2013/14, two abstract submissions entitled *“Evidence-Based Nursing Development: A Way From Novice To Expert”* and *“Review On Patients Who Had Completed Suicide Whilst Under The Care Of The Elderly Suicide Prevention Programme In Hong Kong”* from HKEC have been admitted for presentation at ISQua International Conference 2013 in Edinburgh, United Kingdom.

There were also 33 abstract submissions accepted for either oral or poster presentation in the HA Convention 2013.

5.3 Community Engagement

HKEC Symposium on Community Engagement VIII

港島東醫院聯網 醫社合作研討會(八)

This Annual Symposium with the theme of “Mental Wellness Without Boundary - A New Focus In Community Engagement 身心健康無界限 醫社合作新里程” was successfully held on 6 Jul 2013.

More than 400 participants from clinical and community partners joined for fruitful sharing and discussion on medical-social collaboration. In the same month, an annual newsletter - 醫社合作通訊 (第六期 2013年7月) was issued to share the progress of community engagement / medical-social collaboration in HKEC and promote the current services.



5.4 Procedural Sedation Safety

To enhance clinical procedural sedation safety, the HKEC Working Group on Procedural Sedation Safety conducted two identical sessions of “Train-the-Trainers Course on Procedural Sedation Safety” in Jun 2013 for doctors who perform procedural sedation. In order to equip the participants with hands-on experience, each session is composed of a half-day lecture followed by a half-day simulation workshop. Participants will then become trainers on procedural sedation in their respective departments.



This aims to facilitate the arrangement of necessary adjustments to suit departmental needs.

5.5 Forums for Continuous Quality Improvement

Tung Wah Eastern Hospital conducted its annual Quality Improvement and Experience Sharing Forum on 14 Mar 2014 with the theme of “Quality Recognition: The key to Safety Improvement”. Dr So Hing Yu, Service Director (Quality & Safety), New Territories East Cluster, was invited as the keynote speaker of the Forum. There were 7 oral presentations and 18 poster presentations at the Forum. The total number of attendance was 132.





Ruttonjee & Tang Shiu Kin Hospital organized its Continuous Quality Improvement Forum cum Award Presentation Ceremony on 8 Nov 2013. The theme is “Changing Paradigm in Quality of Healthcare”. Captain Michael C W Ng from Government Flying Service was invited as the keynote speaker of the Forum. There were 6 oral presentations at the Forum. A total of 117 colleagues attended the Forum.

5.6 Occupational Safety & Health (OSH)

The HKEC OSH Committee continues its efforts in sharing good practices for a safe work environment. Apart from the regular issuance of HKEC OSH Newsletter and gatherings of the OSH Link Persons, a total of eight classes of Health Qigong Baduanjin to promote staff physical well-being and a “Feel Good” Month with a series of talks and workshops to promote psychological well-being have been organized in 2013/14.



5.7 Quality Bulletins

Monthly electronic Quality Bulletins have been proven to be a success and welcomed by all HKEC staff. This one-page Bulletin has been enhanced as a cartoon-based and bilingual communication means with staff. It brings concise message on hot issues to staff via emails as well as electronic display panels in some key locations.



6. The Way Forward

2013/14 is another fruitful year in terms of Cluster’s achievements in fulfilling various targets through collaborative efforts among different disciplines and divisions. With the new appointment of the clinical leaders from different clinical streams to the HKEC Quality and Safety Office, we aim to achieve another new height in our quality and safety journey.

Hong Kong West Cluster

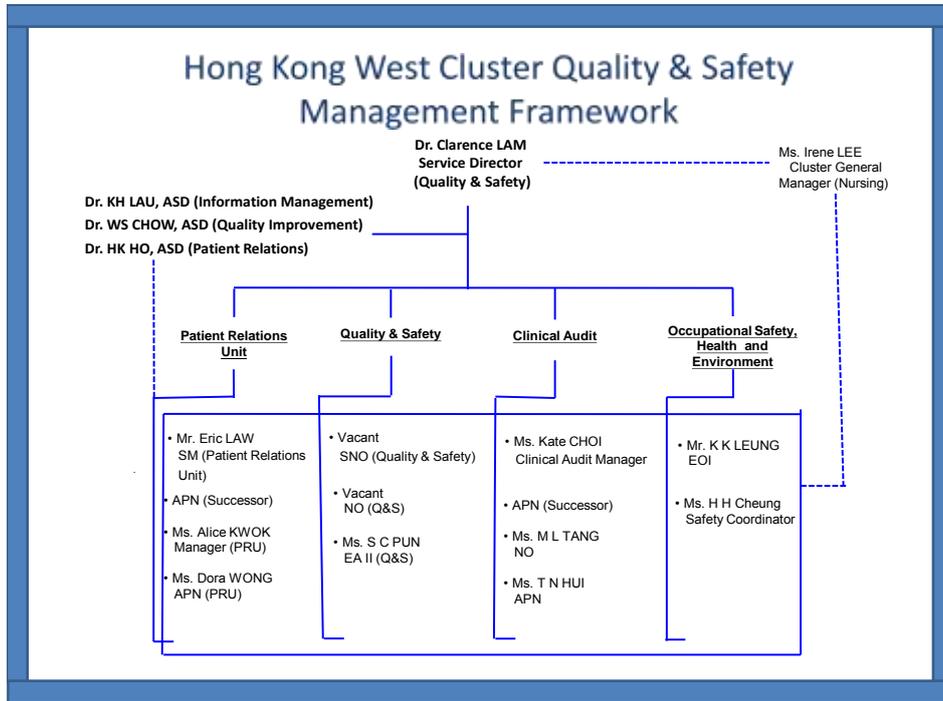
1. Structure

The Quality and Safety Department (Q&SD) is the executive arm of the HKW Cluster Quality and Safety Committee incorporating the clinical audit team, quality improvement support unit, and accreditation office and Patient Relations Unit. The department is responsible for identifying and reviewing risk via different channels including the Advance Incident Reporting system (AIRS), complaints system and reported Sentinel Events of other hospitals. Based on the systematic risk reviews including Root Cause Analysis, case review and Systematic Evaluation of Reported Adverse Events (SERAE), appropriate measures utilizing quality improvement framework are employed to mitigate the risk so identified. Q&SD takes the lead in disseminate and communicate quality and safety information within the cluster through newsletter, sharing sessions, forums and conferences. Q&SD also prepares reports to the Cluster central administration and Hospital Authority Head Office (HAHO) Committee on Quality & Safety (Q&S) on quality and risk management issues as appropriate, and share information/experience with other clusters through HAHO.

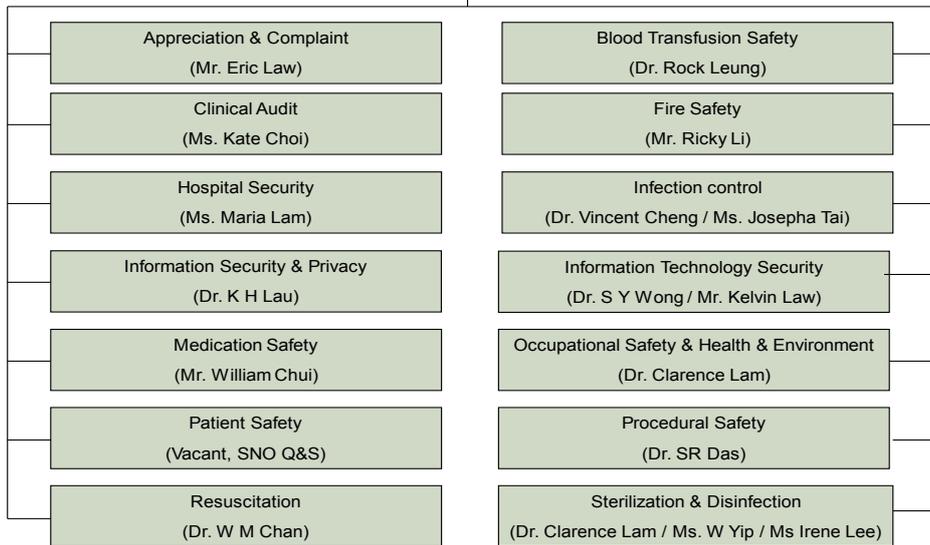


Dr. Clarence Lam and staff of Quality and Safety Department, Queen Mary Hospital

Cluster Quality & Safety Organization Chart



Cluster Quality & Safety Structure



2. Overview of Quality and Risk Management Issues

2.1 Hong Kong West Cluster hospitals have incorporated the cluster Q&S structures and functions in the HKWC Quality and Safety policy aiming to strengthen the governance of quality and risk management in the Hong Kong West Cluster.

2.2 The Standing Instructions for Major Incidents and Disasters in Queen Mary Hospital (QMH) was promulgated in 2011; The Disaster Group Call and the Major Incident Group Call list were reviewed and revised. A WhatsApp group was formed to enhance real time communication among major incident group members. Upon the stand down of a major incident call, debriefing form will be sent to members to collect their feedback for future improvement.

2.3 Four System Evaluation of Reported Adverse Events (SERAE) were conducted with three continuous quality improvement projects achieved.

2.4 Established a cluster approach in Hospital Accreditation, e.g. grouped the Subject Officers of each criterion in each HKWC hospital, shared and collated update evidences, aligned practices, identified opportunities for improvement, etc.

2.5 Integrated Walk Rounds continued. 66 walk rounds were conducted in 24 afternoons in 13 clinical and 53 non-clinical areas in 2013. 620 issues identified.

2.6 Tung Wah Hospital (TWH) underwent the Organization Wide Survey (OWS) of Australian Council on Healthcare Standards in Oct 2013 and has achieved full accreditation status. Out of the 47 criteria assessed, attained two extensive achievements (EA).

2.7 Preparation for QMH's second OWS in Oct 2014 has already commenced. Quality and Safety colleagues from our cluster hospitals were invited to sit in working group meetings, join in related activities and participate in walk rounds.

Integrated team consisting of Infection Control Nurse, Occupational Safety & Health nurse and Quality and Safety Department members undertook a safety walkround to the Pathology Department



3. Risk Prioritization

3.1 Identified Risks for 2013-2014

Clinical Risks	
1	Risk of ineffective care due to medication error
2	Potential shortcoming during resuscitation
3	Infection control risk caused by substandard sterilization and disinfection
4	Fragmented and inefficient care delivery provided to patients
5	Hazard of failure to identify nutritional at risk patients
6	Abbreviation other than official abbreviation list used in health record
7	Lack of uniform criteria for defining and identifying high risk procedures
Non-clinical / Operational Risks	
1	Potential hazard of medical record loss in the clinical setting
2	Potential risk of disclosure of personal information from workstations facing public areas
3	Potential financial risk related to coding inaccuracies for ultra-major and major operations causing reduced reimbursement, increased use of Special Honorarium Scheme, unmet annual leave clearance and medication expenditure rise
4	Fragmented business continuity plan for the whole hospital
5	Insufficient dissemination of quality and safety framework to front line staff

3.2 Identified Risks for 2014-2015

Clinical Risks	
1	Fragmented Quality and Safety policies among cluster hospitals
2	Potential shortcoming in reporting culture
3	Potential patient safety risks in: 3.1 Clinical handover during inter-hospital transfer; 3.2 Dangerous drug management; 3.3 Suicide
4	Lack of robust framework in Credentialing
5	Lack of robust framework in document management
Non-clinical / Operational Risks	
N/A	

4. Risk Reduction and Quality Programmes

4.1 Review of 2013 Risk Reduction Programs

Quality Initiatives		Action and Progress
1	<p>Implementing 2D barcode system for unique patient identification for:</p> <p>(i) Stillbirth</p> <p>(ii) Portable Radiological examination</p>	<p>Completed implementation in Department of Radiology in 2Q 2013.</p> <p>Implementation of stillbirth in labour ward is still pending.</p>
2	Implementing electronic Document Management System	Sites created for 25 departments, 5 divisions, and 18 committees. Five briefing and hands-on sessions were conducted.
3	Improving “Floor-in Time” and “Theatre-in Time”	Achieved more than 80% of “Floor-in Time” at 8:15am and more than 70% of “Theatre-in Time” at 8:30am.
4	Implementing of Malnutrition Universal Screening Tool in all in-patients who have high risks of malnutrition	Nurses conduct initial nutrition screening within 24 hours on patient admission. They consult dietitian (through GCRS) if score is ≥ 2 .
5	Implementing the proper sterilization and disinfection practices and to maintain an up-to-date and evidence-based sterilization and disinfection standard in HKWC	The HKWC Cluster Sterile Services Committee has been set up in Jan 2013. The Service Director (Quality & Safety) works according to the HA direction. Cluster General Manager (Administrative Services) monitors the Central Sterile Supplies Department (CSSD) renovation work progress.
6	Credentialing and privileging	<p>A robust framework has been set up.</p> <p>Chiefs of Service were informed to submit 3-5 high risk procedures and eligible practitioners of their respective departments.</p> <p>50 high risk procedures in 18 departments were uploaded to the HKWC website.</p>

Quality Initiatives		Action and Progress
7	Instituting clinical pathway	Three more clinical pathways have been developed: Coronary artery bypass graft, neonatal nutritional pathway for very low birth weight infant and Acute Retention of Urine.
8	Strengthening Incident Management	A Whatsapp group was set. A drill chat was conducted on real incident on 6 Apr 2013. An evaluation on its effectiveness showed general welcome as a mean to communicate. Debriefing evaluation is conducted after each major incident.
9	Implementing Risk Register	Risk register briefings were conducted for 45 departments. They were requested to submit their risk registers by the end of the year.
10	Implementing paediatric assessment tool	The Department of Accident & Emergency paediatric assessment tool was piloted in Sep 2013. Paediatric assessment tool for day patients was developing.
11	Enhancing medication safety	The guidelines on Dangerous Drug Management have been established. Audit was conducted with overall compliance rate of 96.89%.

4.2 Quality Initiatives, including Accreditation

Fencing was erected at podium of Block K and S of Queen Mary Hospital to reduce the risk of patient suicide. The fencing is not completed yet. Additional fencing is subject to the annual plan 2014-15 on the recommendation of environmental scanning for prevention of inpatient suicide.



Poster displayed on Hospital notice boards and Clinical Management System (CMS) workstations Screen Saver are one of the means to increase the awareness of surgical / procedural safety.



5. Learning and Sharing Information

5.1 Quality and Safety Forum

29 May 2013

1. PDPO Direct Marketing

Mr. Dickson WONG, CISPO, HAHO

2. Patient/Data Privacy related issues

Dr. K H LAU, ASD IT S&PO, HKWC

10 Jul 2013 (Wednesday)

1. Surgical & Procedural Safety

Dr. S.R. DAS, COS,
Dept of Cardiothoracic Anaesthesia

2. Blood Transfusion Safety

Dr. Rock LEUNG, AC,
Division of Haematology

11 Sep 2013 (Wednesday)

1. Hospital Security

Ms. Maria Lam, SHM, GH

2. Fire Safety

Mr. Ricky Li, HM, QMH

13 Nov 2013

Theme: Patient Journey

Keynote speech by Dr. KS Tang, SD (Q&S), NTWC

Dr. TL Lee, Deputy HCE III, QMH

Dr. Clarence Lam, SD (Q&S), HKWC

21 Jan 2014 (Tuesday)

Incident Reporting and Management

Dr. Rebecca Lam, CM, PS&RM HAHO

Mr. Eric LAW, SM (PRU), QMH

1 Apr 2014 (Tuesday)

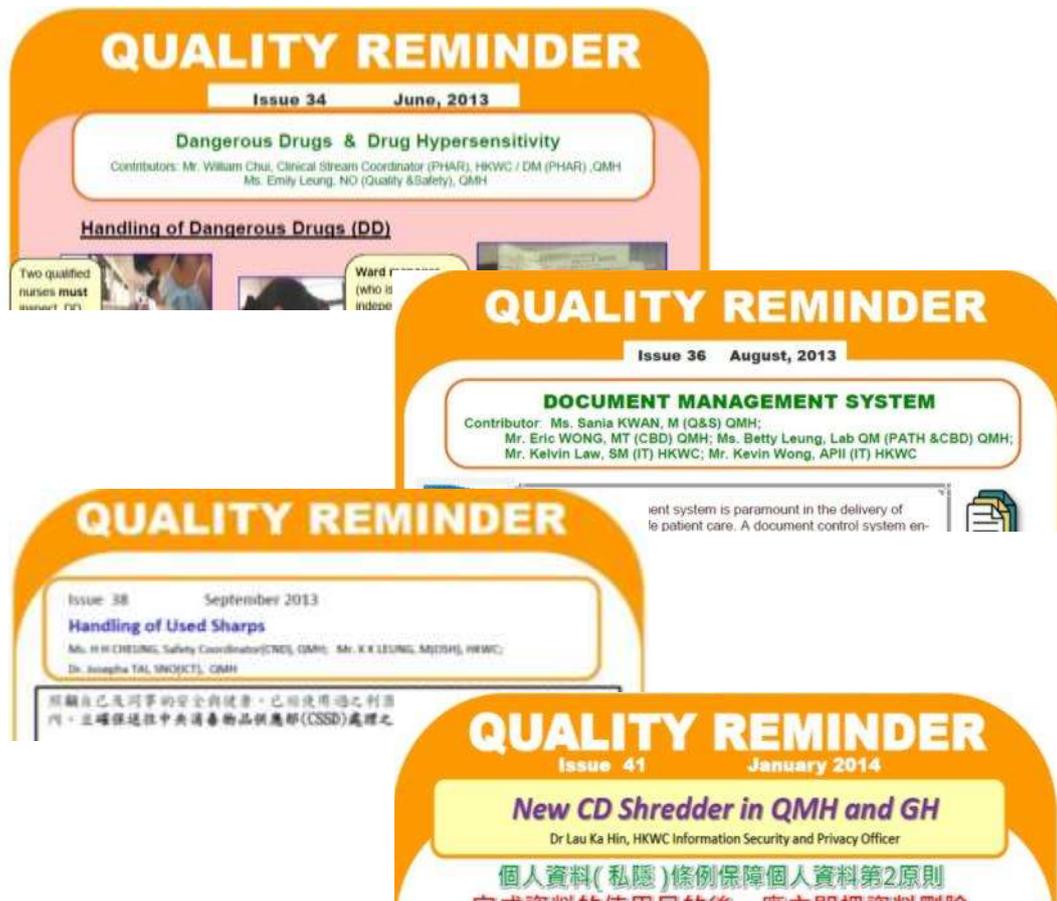
Electrical Safety in Hospital

Mr. Thomas Lai, SM (FMS), QMH

Representative from EMSD, QMH

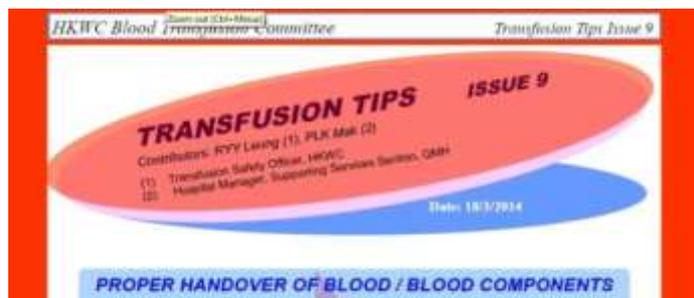
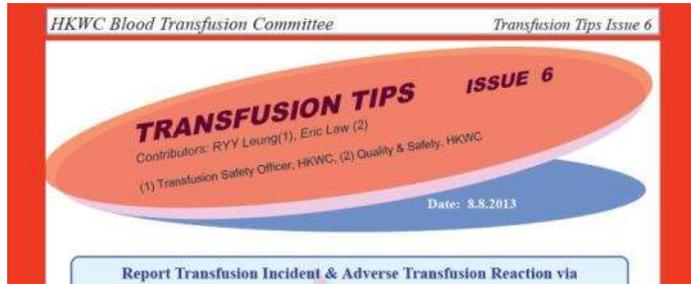


5.2 Quality Reminders



Date	Issue	Topics
Apr 13	Issue 32	Appreciations
Jun 13	Issue 34	Dangerous Drug and Drug Hypersensitivity
Jul 13	Issue 35	Prudent Use of Linen
Aug 13	Issue 36	Document Management System
Sep 13	Issue 37	Hand Hygiene – Critical Moments to Protect Patients
Oct 13	Issue 38	Handling of Used Sharps
Nov 13	Issue 39	Administration of Dangerous Drug
Dec 13	Issue 40	Handling of Cabinet with Drawers and Trolley
Jan 14	Issue 41	New CD Shredder in QMH and GH
Feb 14	Issue 42	Common Issues Identified during Integrated WalkRounds
Mar 14	Issue 43	Physiotherapists in HKWC

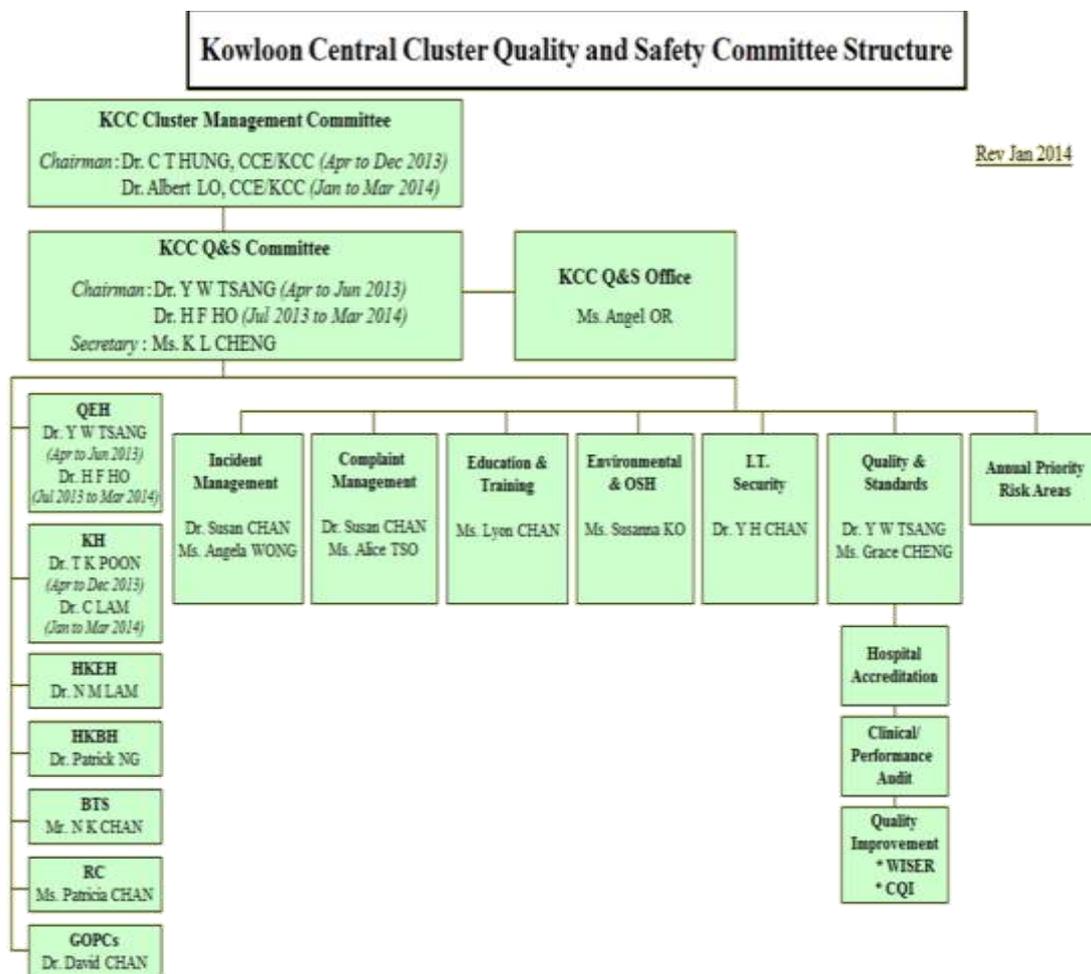
5.3 Transfusion Tips



Date	Issue	Topics
Aug 13	Issue 6	Reporting Transfusion Incident and Adverse Transfusion Reaction via AIR 3.0
Sep 13	Issue 7	Upkeeping Cleanliness of the Transfusion Chain to prevent Bacterial Contamination of Blood Components
Sep 13	Issue 8	Suspected Septic Reaction due to Bacterial Contamination of Blood / Components
Mar 14	Issue 9	Proper Handling of Blood and Components

Kowloon Central Cluster

1. Structure



2. Overview of Quality and Risk Management Issues

2.1 Advance Incident Reporting System 3 (AIRS 3)

KCC was one of the 2 clusters to roll out AIRS 3 second pilot and successfully implemented in Apr 2013. Collected feedback and reported error from KCC have been channeled to the HAHO AIRS 3 implementation team for system enhancement. At the roll out phase, 5 briefing sessions were delivered by HAHO AIRS 3 implementation team. After then, Queen Elizabeth Hospital (QE) Quality & Safety Department (Q&S) have conducted 5 seminars with video conferencing to Kowloon Hospital (KH), Hong Kong Buddhist Hospital (BH) & Hong Kong Eye Hospital (HKEH) to familiarize staff with AIRS 3 enhancement



AIRS 3 – A tool to Risk Management

function. Cluster also took this opportunity to strengthen AIRS filtering quality by adopting a 2-tier system which involved experts to act as second filter persons for respective report templates e.g. Pharmacists (Medication), Facility Managers (Facility & Environment), Physicists (Radiology & Imaging), IOD Committee members (IOD) and Nursing Quality Managers (Fall). With full implementation of AIRS 3 in all HA hospitals, 38 cluster staff

including reporters, filter persons and executives from clinical, supporting and administrative departments were nominated to participate AIRS 3 Evaluation Study held by HAHO and Hong Kong Productivity Council.

A “Near Miss Reporting Recognition Scheme” to foster a Near Miss reporting culture via AIRS Reporting System had been started in KH since Sep 2013. Staff would receive certificate from hospital management as appreciation.



2.2 Document Control

The integration of QEH, KH and BH Document Centre had been completed and the new KCC Document Centre was formally launched in Nov 2013. All QEH, KH and BH Document Control Officers have access right to maintain the document centers of respective departments. As an enhancement of the Document Centre, the search function has been upgraded with the installation of keywords search in “pdf” files. Upon the completion of document migration from ERMS to QEH Document Centre by end of Mar 2014, all clinical forms have been relocated to respective QEH departmental document centre at the same time. A pictorial icon “Chimney” with direct “form searching” function was created to facilitate staff with easy retrieval of the clinical forms.

Welcome to ...
QEH Document Control Centre

You can search all the public controlled documents from this webpage. For user guide please click "here"

Forms

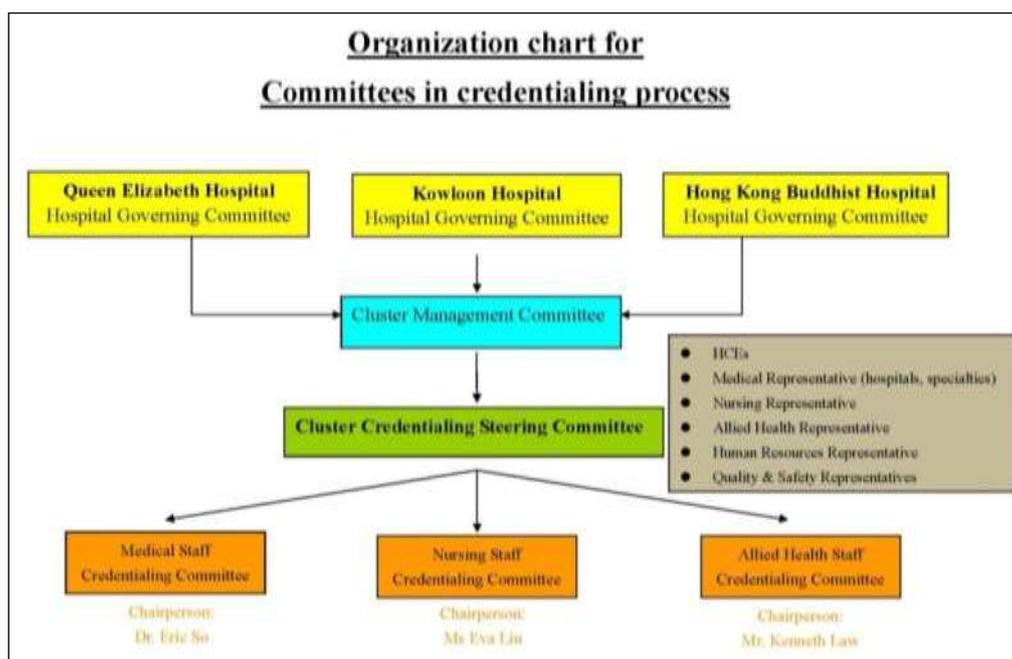
Controlled Document Centre

Clinical					Others	Nursing	Allied Health		Administrative Services	
ENT	MED	ACC & L Blk	AED	CEU	Q&S	CND	Pharm	Diet	Finance	MRO
Anaes & OTS	CTS	Clin Onc	Neuro-surg	EDU		Sch. of Nursing	Occ. Therapy	Speech	HR	Library
O&G	O&T	Paed	DR&I				Physio	Audio	Public Affairs	AS/SS
Surg	FM & GOPC	ICT	Custodial				Clin Psy		ITD	Facility Mgt
ICU	Path	Private	Oph				P&O		CP&D	E&OSH

QEH Document Centre

2.3 Credentialing

The KCC Credentialing Steering Committee and the Credentialing Committees for Medical, Nursing and Allied Health have been formed as the overarching governance framework in Credentialing. The KCC Credentialing Steering Committee steers and sets up system of credentialing in the Cluster and reviews regularly. The decisions on the scope of clinical practice of different disciplines are regularly reported to the Cluster Credentialing Steering Committee.



2.4 Clinical Handover

A KCC Policy on Clinical Handover for Medical Staff was developed in Dec 2013 and incorporated in the policy as the “iSAFE” – a framework for effective communication of handover patient condition. Departments identified the key criteria for medical clinical handover. A set of basic conditions was defined as “high risk” and clinical handover should be performed in any department or location. The CMS-eHandover system was considered as a choice of documentation tool and was piloted in Department of Paediatrics of QEH, Department of Rehabilitation and Department of Respiratory Medicine of KH. Further implementation of “iSAFE” in various departments would be continued and appropriate documentation format would be explored.



Promulgation of “iSAFE” framework

2.5 Risk Registry 2013-2014

The annual Cluster Risk Registry Workshop was conducted by the QEH Senior Manager (Quality and Standard) on 26th Nov 2013 prior to the formulation of the risk registry for 2014. Seventy-four colleagues from various departments of the KCC institutes attended this annual exercise for risk identification and prioritization. Risk Registries then developed were action and outcome-focused with risk mitigation plans laid down. To upkeep risk management, the suggestion on linking up KCC Risk Registry with the annual resources bidding exercise to provide departments with a certain degree of incentive had been supported by hospital management and would be initiated in the next annual plan exercise.



Risk Registry Workshop – Hands- on practice on risk registry formulation



Risk Registry Workshop – Introduction on risk identification and prioritization



Risk Registry Workshop – Presentation on risk registry by participants

3. Risk Prioritization

3.1 Identified Risks for 2013 - 2014

Clinical Risks	
1	Medication Safety – a. Infusion Device Safety & b. Safe Use of High Alert IV Medications
2	Medication Prescription Safety
3	Congestion in Clinical Areas
4	High Staff Turnover and Competency Training of New Recruit
5	Hand Hygiene Compliance
Non-clinical / Operational Risks	
1	Clinical Documentation
2	Renovation / Construction Site Safety
3	Windows 7 Migration

3.2 Identified Risks for 2014 - 2015

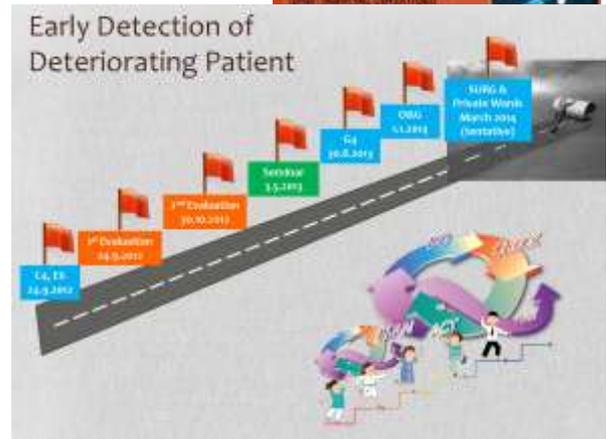
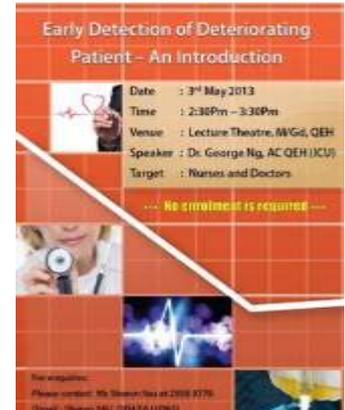
Clinical Risks	
1	Care Safety - Medication Prescription
2	Care Access - Congestion in Clinical Areas
3	Infection Control - Environmental Hygiene
4	Patient Care & Safety - Ventilated Patients in General Wards
Non-clinical / Operational Risks	
N/A	

4. Risk Reduction and Quality Programs

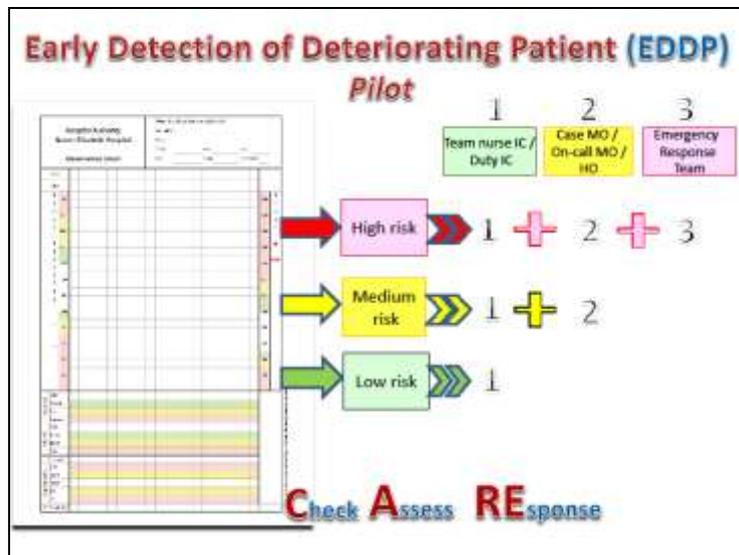
4.1 Review of 2013 Risk Reduction Programs

4.1.1 Early Detection of Deteriorating Patient (EDDP)

The Task Group on EDDP coordinates and reviews the implementation of the Guideline on Early Detection of Deteriorating Patients which includes a set of early warning physiological parameters, a graded response system and an observation chart. After the initial pilot in 2 wards (Surgical and Medical), the implementation gradually extended to include more wards and clinical departments. The staff engagement seminar “An Introduction to Early Detection of Deteriorating Patients” was held on 3rd May 2013. The 3-level escalation of Check, Assess and Response was promulgated via Clinical Management System (CMS) screen saver. Compliance review and staff evaluation were performed. It is planned to roll out in all Surgical, Medical and Private wards in 2014.



Progress of EDDP Implementation as at Mar 2014



CMS Screen Saver on the 3-level escalation

In KH, six wards completed the pilot of using the Integrated Observation Chart (MEWS) system for the detection of early deteriorating patients in Mar 14. Evaluation was done and it was planned to have full implementation of MEWS to all wards after training sessions.

In HKBH, MEWS will be piloted for use in early detection of deteriorating patient. Full implementation is expected to be in 4Q 2014.

4.1.2 Medication Safety

i. 2013 KCC Medication Safety Symposium

The KCC Medication Safety Symposium was held on 8th Nov 2013 with the theme “MEdication Safety Starts with ME”. The Symposium aimed to engage staff awareness on importance of medication safety with particular focus on Known Drug Allergy via sharing and learning among different disciplines. Expertise from KCC and other clusters were invited to share views and experiences on various aspects which included prescription code of conduct, patient drug allergy management, traps of administration of medication, and pharmacy perspectives on medication safety. Interactive real-time quiz and enlightening story-telling videos were employed to stimulate learning. More than 160 KCC staff attended the Symposium and the program evaluation revealed that over 99% respondents found the symposium useful and perceived better understanding on respective medication safety topics after the symposium.



KCC Medication Safety Symposium 2013
MEdication Safety starts with **ME**

Date: 8 November 2013 (Friday)
Time: 12:00N to 2:00Pm
Venue: Lecture Theatre, M/Gd, QEH
 Video-Conferencing to BH (A4 Seminar Room), KH (Conference Room, 2/F), HKEH (Lecture Hall)
Target Participant: Medical, Pharmacy and Nursing staff

TIME	TOPIC	SPEAKER
11:45 Am	Registration	
12:00 N	Opening Speech	Dr. H F HO KCC Q&S Dep. SD / QEH DHCE
12:05 Pm	Stories & Quiz	
12:10 Pm	Can we afford to miss?	Dr. C K LEE BTS Consultant
12:25 Pm	Stories & Quiz	
12:30 Pm	Management Approach to Patients with Drug Allergies	Dr. S M WONG PWH CON (MED)
13:00 Pm	Stories & Quiz	
13:05 Pm	Medication Safety from Pharmacy Perspectives	Ms. Amy CHU QEH Pharmacist
13:20 Pm	Stories & Quiz	
13:25 Pm	Gallery of Allergy	Dr. M H LEUNG KCC MSC Co-chair
13:45 Pm	Q&A	
13:55 Pm	Closing Speech	Dr. C T HUNG KCC CCE

* 2 CNE points is approved. CME and CPD points are pending.
 * Light lunch would be provided at QEH on first come first served basis.

For enrolment, please complete the enrolment form and return via fax at 2958-8325 or email to L N HO, QEH EAII(Q&S) on or before 4 November 2013 (Monday). For enquiry, please contact Ms. Anita HO at 2958-8328



ii. Safety Initiatives in Handling Known Drug Allergy

KCC SOP on Drug Allergy Check and Alert was endorsed and promulgated via various channels. KCC Allergy Reference Tables have been updated as according to the HA Guideline on Known Allergy Checking. In addition, a list in alphabetical orders of drug names and a “How to use” guide was prepared to facilitate staff understanding.

All ward stocks belonging to the three drug groups which are commonly associated with drug allergy (i.e. penicillin related, aspirin / NSAID, and Sulphonamide) are prepacked / labeled with coloured allergy alert label as visual aid.

Antibiotics, in particular penicillin group, are continued to be removed from ward stock with agreement from clinical departments by phases.

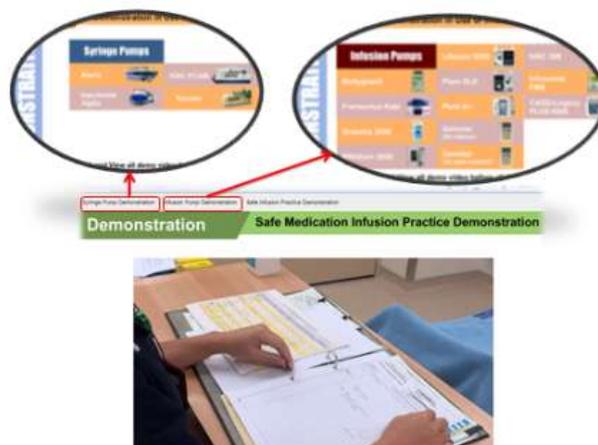


iii. Infusion Device Safety

A communication flowchart between Procurement Department and the Infusion Device Workgroup aiming to secure adequate vendor support before new infusion device model put into use in clinical areas has become effective in Jul 2013.

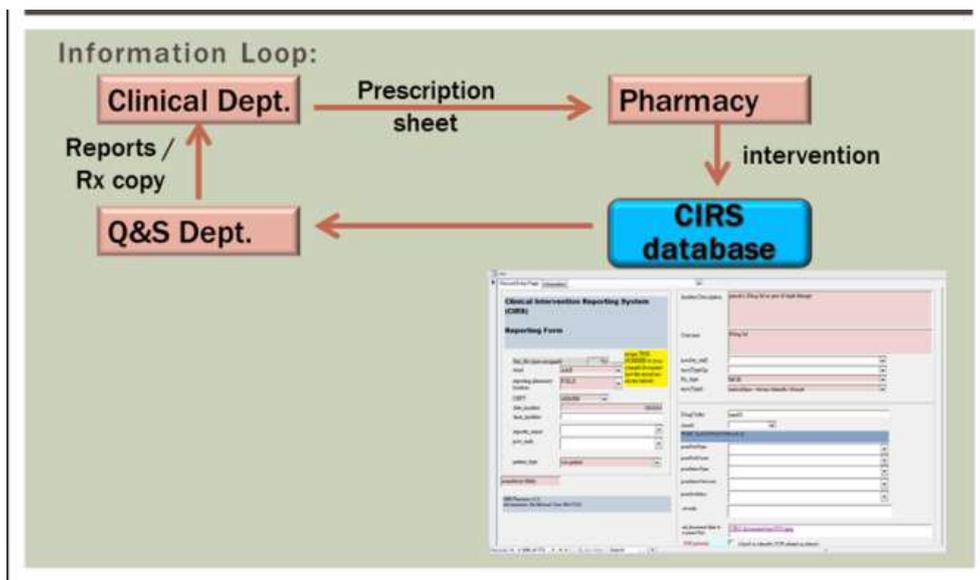
Configuration has been standardized for “Garseby” infusion pumps used in paediatric setting and “IVAC-PCAM” syringe pumps used for epidural infusion to enhance infusion safety after agreement obtained from user departments.

To complement launching of the eLearning program on Safe Infusion Practice, demonstration videos of safe medication infusion practice together with the use of all currently in-use infusion devices has been produced and uploaded to hospital intranet for staff easy reference.



iv. Prescription Safety

Since Apr 2013, Pharmacy in collaboration with the Quality & Safety Department has initiated a proactive approach to enhance prescription safety. Clinical Intervention Reporting System (CIRS) is used to record prescription interventions by Pharmacy. Captured quantitative and qualitative (image of prescription sheet) data are then used for sharing and learning and formulation of risk reduction strategies.



v. Standardization of Medication Management

Storage of adrenaline preparations is standardized unless with exemptions approved by Drug & Therapeutic Committee.

- 1mg per 10ml ampoule in Emergency kit
- 1mg per 1ml ampoule in Emergency trolley
- 30mg per 30ml vial as ward stock

Concentration of Heparin lock is standardized for central venous catheter to 1,000 units/ml unless with exemptions approved by Drug & Therapeutic Committee.

In-use storage time of all insulin preparations is standardized to 4 weeks after opening in the in-patient setting.

4.2 Quality Initiatives, Including Accreditation

4.2.1 Annual Plan Section 3 Quality Standards

Full compliance to the HA Annual Plan Section 3 Quality Standards was observed as at 31st Mar 2014 except Standard 1 for which partial compliance was reported in QEH because the target of triage category III could not be complied.

4.2.2 The Australian Council on Healthcare Standards (ACHS) Hospital Accreditation

After the first Organisation-Wide Survey (OWS) in 2010 and the Periodic Review in 2012, QEH was entering the 2nd cycle of EQUiP in ACHS hospital accreditation. To trigger off the preparation for OWS 2014, staff engagement programs and seminars were held in 1Q14:



Evaluation on the staff engagement programs showed that over 95% of participants were satisfied with the programs. Due to overwhelming responses, additional staff engagement seminars would be scheduled in 2Q2014 before OWS.

Preparation for OWS 2014			
◆ Staff Engagement Program -			
Program	Date	Staff participated	Evaluation on the program
How to prepare One-page Summary and Submissions in CQIs	15/1/2014	141	97% agreed "You are satisfied with the program as a whole"
		Admin 15	
		Nursing 109	
		Medical 3	
		Clinical 4	
"An Introduction on Hospital Accreditation" - Supporting & Clerical	7/3/2014	116	<ul style="list-style-type: none"> > 96% agreed "加強員工對醫院認證的瞭解" > 98% agreed "增加員工對醫院認證的瞭解和支援" > 98% agreed "讓員工更加注意持續質素改善重要"
"An Introduction on Hospital Accreditation" - Professional & Admin	20/3/2014	114	<ul style="list-style-type: none"> > 100% agreed "加強員工對醫院認證的瞭解" > 93% agreed "增加員工對醫院認證的瞭解和支援" > 100% agreed "讓員工更加注意持續質素改善重要"
		Medical 9	
		Nursing 79	
		Admin 18	
		AH 6	

For KH, “Organization-Wide Survey” was held from 18 to 22 Nov 2013. It was completed smoothly with good results achieved. The certificate presentation ceremony was held on 5 Mar 2014. The five hospital accreditation certificates would be posted up at the main entrances of KH buildings. A new structure for KH Hospital Accreditation was endorsed and the KH Hospital Accreditation Steering Committee was set up.



In HKBH, Newsletter with focus on Hospital Accreditation and Continuous Quality Improvement (CQI) matters, CQI Forum and Hospital Safety Round were continued. The Gap analysis by five ACHS Surveyors will be held between 4th to 6th Aug 2014.

4.2.3 Safety Round (SR)

To support risk reduction, bi-weekly Safety Round visits were conducted with participation by senior cluster / hospital executives providing support in areas of supporting service, staffing, medical record, medication, incident and complaint management and quality standards. A total of 18 SRs were held focusing on both clinical and non-clinical areas, including visits to Blood Transfusion Services and Rehabilitation Center. Through the visits, 25 best practices were recognized and 139 improvement areas were also identified for continuous improvement.

In order to promote the Safety Culture in KH, quarterly Patient Safety Round was scheduled in 2014. Q&S office will follow up the identified areas for improvement and monitor the progress made.

4.2.4 Research Statistics

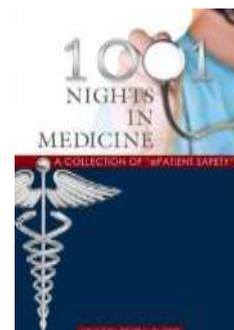
The QEH Research Statistics Support Group was established in Sep 2012 with the objectives to provide consultative services and training on research statistics. For consultative services, advices on statistical methodology are provided by Statistical Officers. Regular Hospital Research Rounds and Statistics Training Seminars are conducted to enhance research statistics knowledge. Till Mar 2014, a total of 7 Hospital Research Rounds and 5 Statistical Training Seminars were conducted with 529 and 709 participants respectively. The numbers of research publications searched from PubMed are on the increasing trend – from 34 in 2013 to 62 in 2014 (as at 30th Jun 2014).

Departments	No. of Publications in 2012	No. of Publications in 2013	No. of Publications in 2014 (as at 30 Jun 2014)
Accident and Emergency	/	1	2
Anaesthesia	1	/	1
Clinical Oncology	8	6	16
Clinical Psychology	/	1	/
Family Medicine	/	2	/
Intensive Care Unit	1	2	3
Medicine	7	5	12
Neurosurgery	1	2	2
Obstetrics and Gynaecology	/	5	3
Orthopaedics and Traumatology	/	2	2
Paediatrics	1	2	3
Pathology	6	4	6
Physiotherapy	1	1	/
Prosthetics & Orthotics	1	/	/
Radiology and Imaging	1	1	5
Surgery	6	8	7
Total	34	42	62

Research Publications of “QEH” – Searched from PubMed

4.2.5 Electronic Patient Safety (ePS)

To commemorate the 50th anniversary of Queen Elizabeth Hospital, booklet of “1001 Nights in Medicine” comprising 100 ePS stories was published to increase awareness of the health care professional towards salient pitfalls in daily patient care. More than 1000 copies were distributed to KCC staff while some were provided to other clusters and external organizations.



4.2.6 HKBH Staff Satisfactory Survey 2014

The compilation of the results of the Staff Satisfactory Survey 2014 in HKBH was completed. Totally 141 questionnaires were received with return rate of 60%. 90.8% return was satisfied with the service rendered by Hospital. The findings will be communicated to Hospital Management and improvement plan as indicated.

4.2.7 Q&S Website and Communication

The HKBH Q&S website has been launched and the construction process is in progress.

4.2.8 Informed Consent

A Forum of Informed Consent had been delivered to Nursing and Supporting Staff in HKBH to enhance understanding of its essence.

5. Learning and Sharing Information

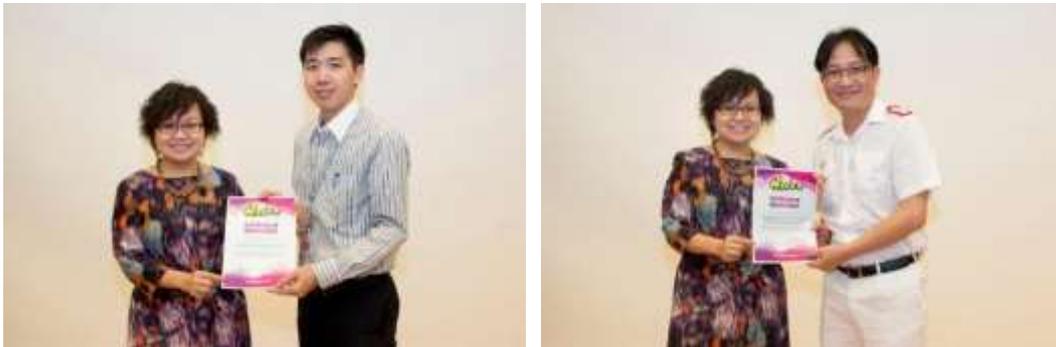
5.1 Cluster Quality and Safety Learning Activities

- i. KCC Q&S Officers Sharing Forums
(6 Nov 2013 with 84 participants)
- ii. Seminar on Incident & Near Miss management
(18 Dec 2013 with 68 QEH participants and video conferencing to other hospitals)
- iii. HAHO ‘Pre-80s Meet Post-80s: Lose Out? It's Worth It’
(Aug 2013)
- iv. Intern Simulation Training Programmes
(Quarterly Programme)
- v. “Mastering Your Risk” Workshop
(May 2013)
- vi. Mediation Skills Training Programme
(Dec 2013)

5.2 WISER Activities

To support KCC WISER Movement, the 3-pillar education & development training model has been continued to focus on Corporate Awareness Program, Project-based learning and sharing and recognition for KCC staff members.

- i. 2 ‘Come and be WISER Sharing Forums’ covering QEH and HKEH hospitals.
- ii. 5 ‘5S in Action Programs’ were completed with 45 5S projects initiated.
- iii. 3 Newsletters were published promoting staff’s achievements in 5S learning.
- iv. 21 Green Belts and 5 Black Belts were trained and 13 WISER projects initiated.
- v. 3 ‘WISER Awareness Workshops’ were conducted with 96 participants out of a total of 2290 participants joining the workshop since 2009.



“Come and be WISER” Sharing Forum

30 Sep 2013



“Come and be WISER” Sharing Forum

13 Dec 2013

The following WISER-driven training activities were awarded:

- i. ‘WISER 5-tier Project Based Learning Model’ was accepted by ISQua for an oral presentation in the 30th ISQua International Conference in Geneva 2014.
- ii. The ‘5S in Action’ journey for service improvement in the Respiratory Medical and Extended Cares at KH was accepted by KCC Convention 2014 for poster presentation.
- iii. ‘5S in Action rolling to equip, empower and enchant frontline employees in service improvement and staff engagement’ was accepted by HA Convention 2014 for poster presentation.



WISER Tools Series

“5S in Action” Program

To support Corporate Social Responsibility, the following visit was arranged for an external organization in order to share the success story of KCC WISER Movement:

- Quality Improvement Best Practice Visit in Nov, 2013.



QIBP Guests and KCC Speakers

25 Nov 2013

For WISER Movement in KH, an Opening Ceremony for WISER Board was held on 8th Nov 2013. It serves as a platform to share wiser projects in KH. In 2013-14, twenty-five 5S and wiser projects were initiated by different clinical and non-clinical departments in KH.



For WISER Movement in BH, 5S in action/practices had been organized with 11 5S improvement projects completed. One administrative staff had completed Black Belt Training with the project now underway. Four staff had completed the theoretic part of Green Belt training with the projects pending.

5.3 Crew Resource Management (CRM)

HAHO has selected QEH/KCC and another hospital in HA to pilot the CRM Training in 2013/14 with a corporate target to develop CRM culture and skill sets. Among our clinical staff in 4 high risk areas, namely, Accident & Emergency Department, Intensive Care Unit, Anaesthesia & Operating Theatre Services and Obstetrics & Gynaecology Department. For 2013/14, our overall target of training 280 medical and nursing staff was achieved with details as follows:

- i. 42 CRM trainers were developed
- ii. An open sharing forum on CRM by an external CRM expert of Cathay Pacific was held in May 2013.
- iii. ‘CRM Visit at the Cathay Pacific CRM Training Centre’ was held in Aug 2013.
- iv. ‘24 Front-line CRM Training programs’ were conducted with 291 participants attended.

Kowloon East Cluster

1. Structure

1.1 Reporting Structure



1.2 Revamp of Quality & Risk Management Governing Framework

To upkeep the robustness of quality and risk management in the cluster, the Quality and Safety (Q&S) Office had coordinated the review of its governance framework. The aim was to develop an explicit governance structure in order to delineate overtly accountability in quality and risk management. The roles and responsibilities of respective managers and committees pertaining to quality and risk management were spelt out in the form of an overarching policy framework for both the Kowloon East Cluster (KEC) and United Christian Hospital (UCH). The documents would be timely reviewed to ensure anchorage of a full-fledged quality and safety system.

Scope of the UCH Quality & Safety Committee

The diagram shows the UCH Q&S Committee (UCH Q&S Director, UCH Q&S Co-ordinator) at the center. It oversees several areas:

- File Safety and Security Management
- Emergency & Contingency: Patient Evacuation & Equipment
- Organizational Safety & Health
- Quality and Standards: Health, ITC programs, Document management, Hospital Accreditation, Infection control & control
- Patient Safety and Risk Management: Incident management, Risk register, Risk reduction program
- Medical Incident Support Team: Staff support, Following up
- Infection Control
- Hospital Environmental/Infection Service
- Patient Care: Staffing
- Medicine Safety

Supporting committees include:

- Cluster: UCH Fire Safety and Security Management Committee
- Cluster: Emergency Preparedness Committee & Contingency, Review Committee
- Cluster: UCH Occupational Health and Safety Committee
- Cluster: UCH Q&S (Idea - Q&S Manager, LIA)
- Cluster: Psychology
- Cluster: Hospital Infection Control Committee
- Cluster: Co-ordinating Committee on Hospital Accreditation & Hospital Transformation Committee
- Cluster: UCH P&T Co-ordinating Committee
- Agreement: UCH Eng & Therapeutic Committee, SDC CMC (Pharm, KEC, CD&P/Pharm)

[Legend] Core work areas of the UCH Q&S Office
 * UCH Accreditation Project Steering Committee also reports to the Hospital Management Committee
 * UCH Eng & Therapeutic Committee also reports to the Medical Committee
 [Legend] * Support: UCH Q&S Office of the special committees are responsible also to their respective line management

Document No.	KEC-QMC-PO-QSC-002-1/01
Issue Date	12-12-2013
Review Date	12-12-2018
Approved By	Cluster Management Committee
Page	1 of 11

Policy Framework of Quality and Risk Management in the Kowloon East Cluster

Version	Effective Date
1	12-12-2013

Document number	KEC-QMC-PO-QSC-002-1/01
Author	Dr. T. Y. (Dora) Dy, A.E. Sai
Co-ordinator	EDC of KEC Quality & Safety Committee
Approved by	Cluster Management Committee
Approval date	20-11-2013
Distribution	KEC AM Staff

CCE (KEC)

The organizational chart shows CCE (KEC) at the top, with four main branches:

- HCES (UCH, TKOH, HHH)
- Cluster Service Directors (Quality & Safety, Mental Health, Occupational Medicine Care Service, Pathology, Primary and Community Health Care)
- Cluster Clinical Stream Coordinators (Allied Health, Medicine, Pharmacy, Radiology, Surgery)
- Cluster General Managers (Administrative Services, Financial Services, Human Resources and Nursing)

2. Overview of Quality and Risk Management Issues

2.1 Hospital Accreditation

2.1.1 United Christian Hospital (UCH)

The launching of accreditation program in UCH heralded in a new era. Despite being a novice in the exercise, the ultimate gains were enormous and evident. The hospital was provided with a unique opportunity to revisit the practice, refresh the thinking and, most of all, consolidate partnership and teamwork at all ends in reach of a common goal.

The program and its inherent continuous quality improvement (CQI) process is no easy journey. However, with the commitment and dedication of hospital staff to quality healthcare services, the journey will certainly be a most rewarding one.

i. Preparation for Organization-Wide Survey (OWS)

The hospital had developed a multi-disciplinary “Accreditation Project Steering Committee” to oversee and steer the overall direction of the accreditation program. Among others, the Q&S Office had coordinated a series of forums and activities in buttressing knowledge, capacity and engagement of staff.

■ UCH Accreditation Staff Engagement Ceremony (Jan 2014)

The event served to boost up readiness and morale of staff in their final preparation for OWS. Apart from the reassuring support from the hospital chief executive, there was also sharing by management from the perspective of an Australian Council on Healthcare Standards (ACHS) surveyor and on focused areas for staff attention. Over 200 colleagues participated in the ceremony.

■ A hospital accreditation / OWS website was also developed, which served as a direct communication link to keep all staff abreast of the latest development on accreditation related matters.

■ A series of sharing forums and workshops were organized for staff:

Sharing Forums:

- Electronic Platform for Staff Training Records Forum (Dec 2013)
- Sharing Forum on Detecting & Responding to Deteriorating Patients by PYNEH (Oct 2013)
- Staff Forum: Risk Register (Sep 2013)
- Document Control Management Forum (Jun 2013)
- Hospital Accreditation Seminars on Priority Action Items (PAIs) with sharing by different departments

Workshops:

- Accreditation Preparation Workshop (Sep 2013)
- Workshop for ACHS Criteria Coordinators: electronic platform for submitting pre-assessment form (Aug 2013)
- Document Control Management Training Workshops (Jun to Jul 2013)



ii. UCH OWS (3-7 Mar 2014)

The UCH OWS was conducted during 3 to 7 Mar 2014. There were a total of 12 experienced ACHS surveyors reviewing across the 47 EQUIP5 criteria. 62 discussion sessions were held coupled with visits to 77 departments / units. The findings were shared with all staff at the summation conference on 7 Mar. With the concerted effort, UCH had attained ‘marked achievement’ (MA) for all the criteria, 9 of which were able to reach an ‘extensive achievement’ (EA) standard:

- 1.1.4 Outcomes of clinical care are evaluated by healthcare providers and where appropriate are communicated to the consumer / patient and carer.
- 1.2.1 The community has information on health services appropriate to its needs.
- 1.5.4 The incidence of falls and fall injuries, is minimised through a falls management program.
- 1.5.5 The system to manage sample collection, blood, blood components / blood products and patient blood management ensures safe and appropriate practice.
- 1.5.6 The organisation ensures that the correct consumer / patient receives the correct procedure on the correct site.
- 2.2.5 Employee support systems and workplace relations assist the organisation to achieve its goals.
- 2.5.1 The organisation’s research program develops the body of knowledge, protects staff and consumers / patients and has processes to appropriately manage the organisational risk associated with research.
- 3.1.1 The organisation provides quality, safe health care and services through strategic and operational planning and development.
- 3.2.5 Security management supports safe practice and a safe environment.

The Q&S Office would further coordinate with stakeholders to address recommendations of the ACHS OWS report with a view to sustaining the CQI spirit.



2.1.2 Tseung Kwan O Hospital (TKOH)

The Hospital Accreditation Steering Committee was set up with its first meeting held on 22 Apr 2013. The committee would provide direction throughout the hospital accreditation journey and monitor progress of preparation on each criterion.

Meetings with sponsors of individual criterion were conducted from Apr 2013 to Mar 2014. The objectives were to report to sponsors the progress of hospital accreditation, discuss on preparation plan for criteria under their charge, and provide support as appropriate in the preparation and promulgation.



Staff Engagement Forums on
25, 26 & 27 Feb 2014

19 buddies were nominated and had the 1st meeting held on 27 Aug 2013. Background of ACHS hospital accreditation and role of buddies were introduced. A UCH buddy also shared his experience on the UCH gap analysis. Preparation and training of buddies were in progress.

To familiarize staff with the mandatory criteria, 16 safety walkrounds and briefing sessions were conducted by the sponsor team and Q&S Office. 3 staff engagement forums were held on 25, 26 & 27 Feb 2014 to promote the 15 mandatory criteria. A total of 387 colleagues attended these forums. A KEC Quality and Safety Seminar entitled “Sharing on Related Priority Action Items (PAIs) on Medication Safety” with video-conferencing to TKOH was arranged on 18 Sep 2013.

2.2 Pioneer Clinical Partnership Program

The Q&S Office had pioneered the clinical partnership program for doctors since Jan 2013. The initiative aimed to promote cross fertilization of quality and patient safety knowledge in order to reinforce Q&S culture at the department level. Aspiring frontline doctors from different specialties were engaged in Q&S activities & management meetings, and they in turn acted as catalyst to drive the change process locally. The program was also conducive to grooming the future Q&S leaders.

This quality initiative had been extended to the nursing grade in 2013 / 14 in the form of “executive partnership” program. It was envisaged that the program could implant the Q&S concept perpetually on frontline professionals in their day-to-day patient care.



2.3 Development of Documents on Quality and Standards

To safeguard quality standard and working principles on the key Q&S related spectrums, the Q&S Office had undertaken to coordinate the review of relevant cluster & hospital policies, guidelines and procedures. These documents had gone through the requisite consultation, endorsement and promulgation processes for staff reference.

UCH Quality & Safety Committee (Custodian)

- UCH Safety Policy on Bedside Procedures (Phase One)
- Policy on In-patient Granting Home Leave
- Guideline for Patient Accommodated Outside their Specialty Area
- Policy on Mandatory Training in UCH
- Policy Framework of Quality and Risk Management in UCH
- Policy on Open Disclosure in UCH
- Policy on Signing of Consent Form in the UCH
- UCH Guideline on Urgent Inter-Departmental Consultations
- Policy on Assessment of Patients Admitted Through AED
- Procedure on Early Identification and Notification of Critical Incidents in UCH

UCH Credentialing Committee (Custodian)

- Policy on Credentialing and Defining Scope of Clinical Practice in the United Christian Hospital

UCH Document Control Committee (Custodian)

- Document Control Procedure in United Christian Hospital
- Hierarchy and Standard Codes for United Christian Hospital Committees and Departments

KEC Quality & Safety Committee (Custodian)

- Policy Framework of Quality and Risk Management in the Kowloon East Cluster

KEC Document Control Steering Committee (Custodian)

- Document Control Procedure for Kowloon East Cluster Committees
- Hierarchy and Standard Codes for Kowloon East Cluster Committees

KEC Information Security & Privacy Committee (Custodian)

- Information Security Requirements on Transmission of Document with Personal Identifiable Information (PII) by Facsimile Machine
- Testing of Facsimile Number before Programming into Facsimile Machine



2.4 Enhancement of Professional Competence – Medical Protection Society (MPS) Workshop

To equip the frontline doctors with necessary knowledge and professional competence in managing potential issues arising from clinical practice, the Q&S Office had collaborated with MPS in organizing a series of workshops. The training was conducted in interactive mode with role play and case sharing on strategies in managing the different scenarios under practical situations. Positive feedback was received from the participants.

Themes:

- Mastering Your Risk
- Mastering Adverse Outcomes
- Mastering Professional Interactions
- Mastering Difficult Interactions with Patients

2.5 Patient Safety Enhancement

2.5.1 Executive Safety Walkround

The executive safety walkround is an ongoing initiative for enhancement of patient and staff safety. Through the platform of UCH Quality & Safety Committee, a mechanism was put in place in UCH in 2013 / 14 to facilitate discussion on improvement board items requiring further deliberation on direction and / or funding requirement. For the latter, a checklist was formulated to facilitate channeling of prioritized items with funding implication to top management for necessary decision. This could secure robustness of resources injection to meet with requirement of improvement items in a timely manner.

Progress Report of the "UCH Executive Patient Safety Walkround" on Ward 6A / 6B MRG Dept held on 31 Jan 13

No.	Action Item Description	Subject Party	Action Timeframe			Improvement Attained		
			Immediate (Less than 1 week)	Short Term (1 to 3 mths)	Medium Term (3 to 6 mths)	Progress Status	Target Completed (✓ / In progress / ✗)	If the target is still not completed by due date, pls indicate the expected Completion Date
1	6A: Ensure cords of X ray viewing panel would not protrude out to the corridor	Admin		30 Apr 13			✓	
2	6A: Explore feasibility of using disposable medication vials to replace the existing plastic ones.	Admin		30 Apr 13		Requirements of each ward has been confirmed. Budget approved. Orders would be raised with MRG under trial	✓	

Checklist on ESWR Follow-up Items Requiring Funding Support

Item: Standardize patient activity information board across hospital

Description	Progress Status	Target Completed (✓ / In progress / ✗)
Re. the previous suggestion of standardizing the patient activity information board across hospital, further review would be looked at.	- Standardizing the patient activity information board across hospital has been launched since 17 August 2012 & 30 November 2012 & funding supported by NSD(A&O) for the 5 pilot wards namely A&E, 4D, 5B, 7A & 12A. - The installation is ongoing & 10 wards (5D, 6A, 6B, 9B, 11A, 11B, 12B, 9E, 9A & 5A) are pending for installation if hospital budget is viable.	Partially completed

Part I (by Q&S Office with User Dept and UCH Q&S Committee)

Categories	Minor (1 point)	Moderate (2 points)	Major (3 points)
Operational Need	<input checked="" type="checkbox"/> No specific impact on operation is foreseen for non-provision e.g. without interrupting service operations or only negligible service disruption	<input type="checkbox"/> Impact on department / ward operation for non-provision e.g. loss of ability to provide service with adverse impact on patient care, client disruption / dissatisfaction	<input type="checkbox"/> Impact on hospital-wide operation for non-provision e.g. loss of ability to provide service within hospital, restriction of service within cluster
Potential Risk	<input type="checkbox"/> Insignificant health impact on patients for non-provision e.g. no / minimal injury, no increase in LOS, no complication / disability	<input checked="" type="checkbox"/> Moderate health impact on patients for non-provision e.g. moderate increase in required level of care / LOS, recovery without significant complication / permanent disability, impact on usual no. of patients	<input type="checkbox"/> Significant health impact on patients for non-provision e.g. significant increase in required level of care / LOS, significant complication / permanent disability, impact on large no. of patients
	<input checked="" type="checkbox"/> No / minimal injury on staff is foreseen for non-provision	<input type="checkbox"/> Moderate injury on staff is foreseen for non-provision e.g. injury requiring professional intervention, no significant permanent disability, job leave for small no. of staff	<input type="checkbox"/> Major injury on staff is foreseen for non-provision e.g. injury leading to long-term incapacity / disability, significant permanent disability, job leave for larger group of staff
Public health implications	<input checked="" type="checkbox"/> No impact on public health for non-provision	<input type="checkbox"/> Cross infections with minimal public health impact for non-provision	<input type="checkbox"/> Outbreaks cross infection affecting hospital service for non-provision
Quality Improvement	<input type="checkbox"/> No / minimal impact on improving patient & staff safety for non-provision e.g. good-to-have improvement on peripheral element of treatment or sub-optimal service	<input checked="" type="checkbox"/> Moderate impact on improving patient & staff safety for non-provision e.g. treatment / service has significantly reduced effectiveness, moderate implications for patient and/or staff safety if not acted on	<input type="checkbox"/> Significant impact on improving patient & staff safety for non-provision e.g. non-compliance with regulations / standards, major patient and/or staff safety implications if not acted on, unacceptable level of quality of treatment / service

Through the hospital and cross-hospital walkrounds, relevant improvement items were devised with timeline for progress defined and reported.

Summary of improvement items due for completion within 2013 / 14

Due for completion within 2013 / 14						Percentage of completion (the remaining item had ongoing development)		
No. of action items		No. of items completed				Cross Hosp	UCH	TKOH
Cross Hosp	UCH	TKOH	Cross Hosp	UCH	TKOH	Cross Hosp	UCH	TKOH
15	43	19	15	42	19	100%	97.7%	100%

2.5.2 Roll out of new Advance Incident Reporting System (AIRS3)

The new version AIRS3 was fully rolled out to KEC hospitals in Apr 2013. The enhanced system had facilitated and encouraged the reporting of near-miss incidents. The reporting template was also streamlined to facilitate staff in reporting incidents that might involve multiple “categories”. Workshops were organized for staff to familiarize with the new system features.

2.5.3 Medication Safety - Medication Reconciliation by Pharmacists



The program aimed to enhance patient safety by the provision of a complete and accurate list of medications that the patient was currently taking. Pharmacists reviewed medications from the electronic Patient Record, interviewed patients or their care-givers, and compared the medication lists with the first prescriptions for newly admitted patients.

Their medication profiles would be reviewed again upon discharge to ensure any change of regimen during hospital stay would not be missed. Pharmacists would clarify with the prescriber when drug-related problems were found. This program had been piloted in one surgical ward since May 2013. Until May 2014, 3,159 and 988 patients were reviewed on admission and discharge respectively, with 577 drug-related problems identified and resolved.

2.5.4 Infection Control

The Infection Control Team took lead to enhance the infection control culture and improve compliance with related measures. A summary of the major programs conducted in 2013 / 14 included:

- Hand hygiene and environmental hygiene: staff hand hygiene compliance was raised by 33%, promotion of patient hand hygiene via education and provision of cleansing wipes for bed-bound patients; use of 2-in-1 cleansing and disinfection wipes for high risk areas.



Hand hygiene promotion

- Vancomycin-resistant Enterococci (VRE) control: implementation of targeted admission and environmental screening for early identification and follow up.

- Piloted trial of chlorhexidine bath in Intensive Care Unit (ICU): preliminary analysis revealed a 70% reduction of hospital-acquired Methicillin-resistant Staphylococcus aureus (MRSA) when compared to the same period (3Q to 1Q) of the past 5 years.

- Enhanced staff influenza vaccination via provision of mobile service: The uptake rate was increased from 15.65% (2012 / 13) to 19.43% (2013 / 14).

A total of 97 infection control classroom training sessions (5,599 attendance) and 17 drills were performed. Other Q&S related infection control programs included the review of sharp box safety, replacement of satellite disinfection by central reprocessing where possible, use of disposable or single patient use items and improvement of tracking system for used instrument and endoscopes.



Infectious disease drill



Environmental hygiene training

2.6 Occupational Safety and Health (OSH)



The OSH team had organized and coordinated various continuous quality improvement programs - management of major work injuries through promotion of 5S, manual handling operations training, road show for prevention of sharps and fire safety, provision & demonstration of safety devices and organization of trans-departmental drill for physical restraining.

Apart from coordinating 84 proactive OSH rounds in UCH, the OSH Team also supported departments with high number of Injury-On-Duty (IOD) cases to implement OSH improvement plans; and an average of 35% reduction in the number of IOD cases per 100 staff (IOD Rate) in 10 departments was observed. To sustain the momentum in promoting OSH, the OSH Recognition Program 2013 / 14 was held to recognize various types of OSH Improvement Projects and Best OSH Employees.



KEC had attained the following achievements and recognition through the conjoint efforts:

- IOD Rate was decreased by 17.7% in 2013/14 in comparison to 2012 / 13.
- Winner of the 6th Best OSH Employees Award Scheme, organized by the Occupational Safety and Health Council (OSHC) and the Labour Department.

Award	Name	Rank	Department	Hospital
Gold Award (Management)	Ms SIU Kwai Fung	Department Operation Manager	Department of Orthopaedics and Traumatology / Department of Obstetrics and Gynaecology	TKOH
Bronze Award (Frontlines)	Mr NG Wai Ming	Artisan	Physiotherapy Department	UCH

- Submission of 4 OSH projects from the OSH team were accepted by the HA Convention for poster display, one of which was invited for speed presentation.



3. Risk Prioritization

3.1 Identified Risks for 2013-2014 (KEC)

Clinical Risks (in order of priority)	
1	Escort of critically-ill patients during transfer
2	Surgical safety for operative, interventional and bedside procedures
Non-clinical / Operational Risks	
1	Fire hazard

3.2 Identified Risks for 2014-2015 (KEC)

Clinical Risks (in order of priority)	
1	Patient fall
2	Medication safety
Non-clinical / Operational Risks	
1	Service interruption due to utility failure and safety concerns to staff, visitors, patients & vehicles due to increased traffic and commencement of onsite construction works for the expansion project.

3.3 Identified Risks for 2013-2014 (UCH)

	Clinical Risks (in order of priority)	Non-clinical / Operational Risks (not necessary in order of priority)
1	Medication errors <ul style="list-style-type: none"> Administration errors involving intravenous medications or wrong infusion rate Dispensing errors related to wrong drugs 	Risk of staff injury from manual handling or fall
2	Winter surge has large admission number of emergency patients to medical wards. Uncontrolled workload can cause staff fatigue.	Risk of staff having percutaneous injuries by sharps from procedures
3	Injurious patient fall as a result of clinical condition or over-estimation of ability by patients	Risk of near miss or real fire
4	Risk of surgical site infection on patients undergoing colorectal surgery	Retention risk of supporting staff

3.4 Identified Risks for 2014-2015 (UCH)

Clinical Risks (in order of priority)		Non-clinical / Operational Risks (not necessary in order of priority)
1	To minimize number of medication error on known drug allergy due to non-compliance to policy and procedure and knowledge deficit	Service interruption due to utility failure caused by decanting works and the demolition of Blocks F, G, H and P (low)
2	Patient fall	Safety concerns to staff, visitors, patients & vehicles for the construction of temporary building at Block P carpark and demolition works due to increased traffic and commencement of onsite construction works
3	Long Specialist Out-patient Department (SOPD) waiting time	
4	Patient exposed to and acquiring multi-drug resistant organisms (MDRO)	

3.5 Identified Risks for 2013-2014 (TKOH)

Clinical Risks (in order of priority)		Non-clinical / Operational Risks (not necessary in order of priority)
1	Dispensing of medications to patients upon discharge from SOPD / ward (medication reconciliation)	Fire hazard
2	Escort of patients during transfer	Disposal of medical records
3	Surgical safety for operative, interventional and before procedures	
4	Preventing mentally incapacitated patient from missing	

3.6 Identified Risks for 2014-2015 (TKOH)

Clinical Risks (in order of priority)		Non-clinical / Operational Risks
1	Risks associating with the change of practice with the implementation of In-Patient Medication Order Entry (IPMOE)	Staff injury during manual handling operation
2	Cold chain management of medications	

3.7 Identified Risks for 2013-2014 (HHH)

Clinical Risks (in order of priority)		Non-clinical / Operational Risks (not necessary in order of priority)
1	Risk of decontamination of respiratory devices	Theft or unauthorized access to roof top area
2	Risk of suboptimal nursing service due to high proportion of new nursing graduates	Tree Falling Risk
3		Access and safety risk of contractor workers' activities

3.8 Identified Risks for 2014-2015 (HHH)

	Clinical Risks (in order of priority)	Non-clinical / Operational Risks (not necessary in order of priority)
1	Patient Fall	Missed collection / delivery of specimen
2	Medication incident related to ward stock	Tree Falling Risk

4. Risk Reduction and Quality Programs

In line with the development of 2013 / 14 KEC Risk Register for both clinical and operational risks, the corresponding risk reduction / quality programs were identified and monitored. The results are summarized below:

4.1 KEC

Programs	Actions and Results
Clinical Risks	
1	Escort of critically-ill patients during transfer
Develop guideline and checklist to be followed by audit	<ul style="list-style-type: none"> ■ A work group with members from 3 cluster hospitals was formed. The KEC Guideline on Inter-hospital transport of critically-ill adult patients was developed through consultation and feedback from 3 hospitals ■ The guideline was endorsed by KEC Q&S Committee to be followed by promulgation ■ A compliance audit would be conducted, aiming to achieve over 90% compliance to the guideline
2	Surgical safety for operative, interventional and bedside procedures
Introduce a robust system of gauze counting method for tenckhoff catheter insertion	<ul style="list-style-type: none"> ■ A gauze counting protocol for eliminating the risk of leaving behind gauze inside wound un-noticed had been developed
Use of raytec gauze for tenckhoff catheter insertion	<ul style="list-style-type: none"> ■ Starting from Mar 2013, all newly prepared tenckhoff insertion set had used raytec gauze
Renal nursing staff training by Nursing Consultant (peri-op) on technique of proper counting	<ul style="list-style-type: none"> ■ Training for improving the technique of gauze counting was completed
Audit on compliance of safety checklist	<ul style="list-style-type: none"> ■ The audit was completed with an overall compliance rate of 99.44%

Programs		Actions and Results	
Non-Clinical / Operational Risks			
1	Fire hazard		
	Roll out Mandatory Fire Safety Training (UCH)	<ul style="list-style-type: none"> ■ Training had been rolled out since Jun 2013 ■ Up to 7 Mar 2014, the completion rate had reached 97% ■ The training had enhanced staff awareness and participation in upholding the requirement of fire safety 	
	Conduct at least 1 Fire Ambassador Training	<ul style="list-style-type: none"> ■ Fire Ambassador Training for 2013 / 14 for KEC was arranged on 24 Feb 2014 	
	Conduct bi-monthly fire drill (UCH)	<ul style="list-style-type: none"> ■ 15 drills had been conducted at various locations since Mar 2013 ■ The drills had equipped staff members with necessary fire safety knowledge 	
	Conduct quarterly inspection to fire exits and fire-fighting facilities (UCH)	<ul style="list-style-type: none"> ■ Inspections were conducted in Jun and Oct respectively, with reports uploaded to the Fire Safety Website ■ The Electrical & Mechanical Services Department had completed visual inspection on UCH and report was submitted. Relevant observations were being followed upon ■ The inspection and monitoring had minimized potential risk of violating against the prevailing rules and regulations 	
	Provide at least 1 fire extinguisher to individual wards / departments (UCH)	<ul style="list-style-type: none"> ■ Fire extinguishers had been distributed to wards / departments to ensure the fire-fighting equipment was sufficient and in good order 	

5. Learning and Sharing Information

5.1 Risk Management / Patient Safety

- KEC Annual Information Security and Privacy (ISP) Audit Day 2013 – ISP Compliance Audit (3 Jul 2013)
- ISP Walkround 2013 (26 Sep 2013)
- Monthly Q&S Sharing by Pharmacy Department in KEC Q&S Bulletin
- Mandatory ISP trainings to all non-clerical supporting staff with video-conferencing (TKOH: 27 Jan, 5 & 19 Feb 2014)
- Quality & Safety Forums on “Safe Escort” (TKOH: 6 & 7 Mar 2014)
- Quality and Safety Forum on “Medication Safety” (TKOH: 20 Mar 2014)
- Quality and Safety Forum on “Nursing & Safety” conducted jointly with the Nursing Services Division (TKOH: 3 Dec 2013)



“Better Communication, Less Complaints” Seminar (TKOH)

5.2 Hospital Accreditation / CQI

- Workshop on Electronic Platform for Pre-assessment Form (14 Jun 2013)
- Workshop for ACHS criteria coordinator: Electronic Platform for Submitting Pre-assessment Form (26 Aug 2013)
- Seminar entitled “Occupational Safety & Health: Sharing on Priority Action Items (PAIs)” (30 Aug 2013)
- Accreditation Preparation Workshop (2 Sep 2013)
- Seminar entitled “Administrative Services: Sharing on Priority Action Items (PAIs)” (4 Dec 2013)
- Forum on Electronic Platform for Staff Training Records (6 Dec 2013)
- Seminar entitled “Infection Control: Sharing on Priority Action Items (PAIs)” (20 Dec 2013)
- UCH Accreditation Staff Engagement Ceremony (22 Jan 2014)
- UCH accreditation Website as a communication and resources platform
- Ongoing hospital accreditation update in the KEC Quality & Safety Bulletin
- Introduction of Quality and Safety to Guangdong Nurse Visit (TKOH: 17 Jul 2013). Three topics on “Hospital Accreditation”, “Sentinel Events and Root Cause Analysis” and “Building Culture on Continuous Quality Improvement” were briefed and discussed
- Seminar on Complaint Management: “Better Communication, Less Complaints” (TKOH: 17 Jan 2014)

5.3 Incident Management

- Learning from Patient Safety Incidents (27 Jun 2013)
- Annual ISP Incident Sharing 2013 (22 Nov 2013)
- ISP Seminar (27 Nov 2013)
- Seminar on “Sharing of Sentinel (SE) and Serious Untoward Events (SUE) Incidents” (28 Mar 2014)
- Sharing of SE / SUE through KEC Quality & Safety Bulletin
- Quality and Safety Forum entitled “Critical Incident Reporting and Management” (TKOH: 19 Jun 2013)

5.4 Executive Safety Walkround

5.4.1 Cross-hospital Round

- Ear, Nose & Throat (ENT) / Eye / Dental Department, UCH (26 Aug 2013)
- Health Information and Record Department, TKOH (29 Oct 2013)
- Physiotherapy Department, Occupational Therapy Department and Geriatric Day Hospital, Haven of Hope Hospital (HHH) (29 Nov 2013)

5.4.2 UCH

- Obstetric & Gynaecology (O&G) Department (17 Apr 2013)
- Orthopaedic & Traumatology Department (22 May 2013)
- Podiatry (19 Jun 2013)
- Security & Property Management (24 Jul 2013)
- ENT/ Eye/ Dental Department (26 Aug 2013)
- Speech Therapy (11 Sep 2013)
- Non-Emergency Ambulance Transfer Service Department (9 Oct 2013)
- Ngau Tau Kok Community Nursing Service Centre (13 Nov 2013)
- Accident & Emergency Department (2 Dec 2013)
- Health Information and Record Department (29 Jan 2014)
- Surgical Clinic & O&G Clinic (12 Feb 2014)
- Psychiatric Day Hospital (18 Mar 2014)

5.4.3 TKOH

- Hospital Kitchen (23 Apr 2013)
- Blood Bank & Histopathology Lab (26 Jun 2013)
- Mortuary (20 Aug 2013)



Safety walkround
to hospital kitchen (TKOH)

5.5 Document Management

5.5.1 KEC

- KEC Document Control Steering Committee Meeting (6 May 2013)
- Document Control Officer (DCO) Training Workshop (13 Jun, 19 Jun & 9 Jul 2013)
- Document Control Management Forum (20 Jun 2013)

5.5.2 UCH

- UCH Document Control Committee Meeting (8 May 2013)
- DCO Training Workshop (13 Jun, 19 Jun & 9 Jul 2013)
- Document Control Management Forum (20 Jun 2013)
- DCO Follow-up Training Workshop (8 Jan 2014)

5.5.3 TKOH

- Meeting with DCOs from departments & committees (8 & 9 Apr 2014)
- Document Control Committee to consolidate metadata (29 Apr 2013)
- Train-the-trainer workshops (26 Jul & 2 Sep 2013)
- Workshops for DCOs & technical support staff (11 & 15 Oct 2013)
- Training on electronic Document Management System (eDMS)



Training on eDMS (TKOH)

5.6 Infection Control

The Infection Control Team had performed a total of 97 classroom infection control training sessions (5,599 attendance) and 17 drills. Refresher trainings were also conducted via video supplemented by Q&A session or via online training.

- Refresher training (classroom sessions only) (36 sessions, 3139 attendance)
- H7N9 & Middle East Respiratory Syndrome (MERS) related training (28 sessions, 1480 attendance)
- VRE training (8 sessions, 599 attendance)

TKOH also introduced the following infection control initiatives:

Promotion of hand hygiene

- Hand hygiene compliance rate aimed at over 85%
- Introduced web-based hand hygiene audit in infection control link nurse (ICLN) meeting on 19 Dec 2013 (28 ICLNs). Quick reference guide for web-based hand hygiene audit was formulated.

VRE prevention and control

- Staff Forum on Vancomycin-resistant Enterococcus (VRE) (30 Oct 2013, 57 attendees)
- Briefing session for Targeted Screening on Admission for VRE (8 Nov 2013, 36 attendees)

Avian Influenza A (H7N9) management

- Right-On-Time education on H7N9 & S2 activation (Feb 2014, 116 attendees)

Needle-stick injuries reduction

- Prevention of Needle Stick Injury - 2013: NSI Case Review & Sharing (20 Dec 2013)

Drills & Audits

- Clinical Waste Management Audit (28 Jan 2014)
- Clinical Spillage Drill (14 Feb 2014)
- Designated Fever Clinic (14 Mar 2014)

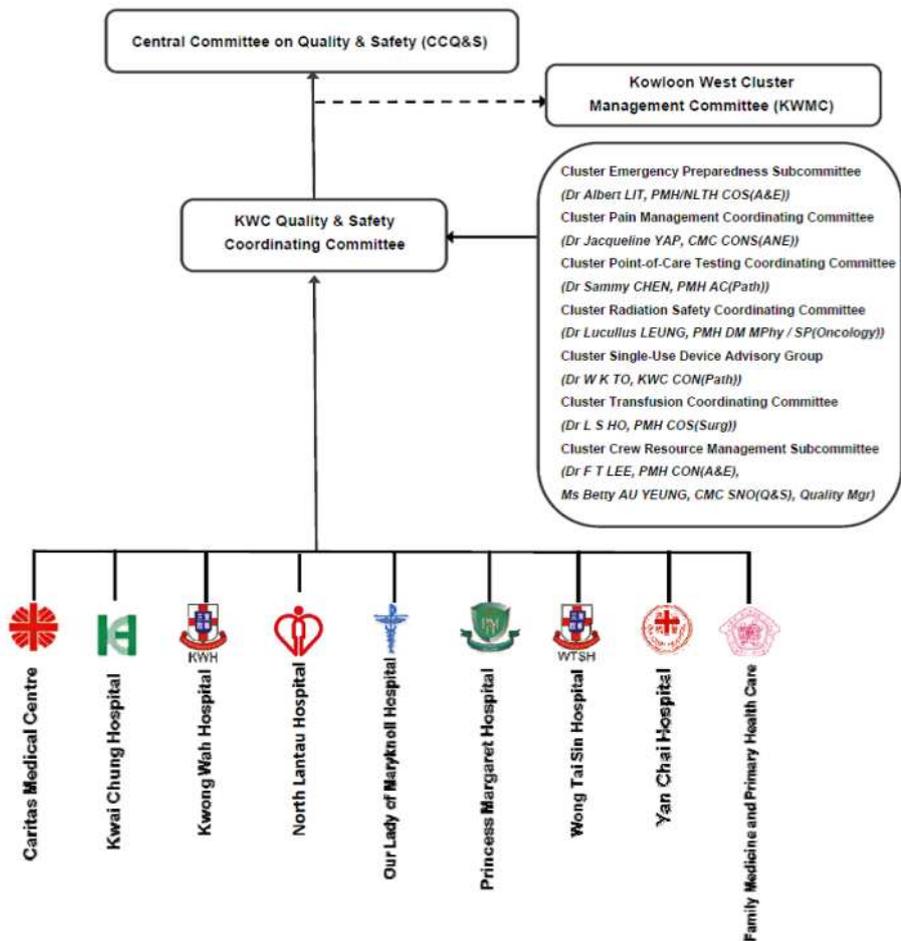
5.7 Occupational Safety & Health

The KEC OSH Team conducted a total of 32 OSH events and training programs with 4,123 staff attendance.

Kowloon West Cluster

1. Structure

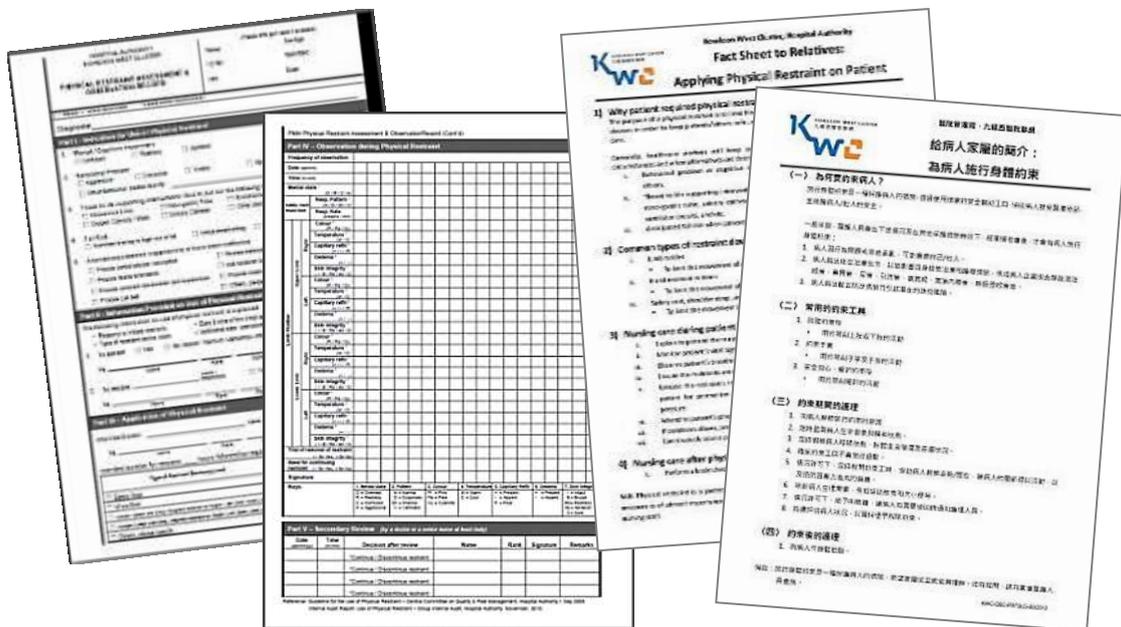
Governance Structure of KWC Quality & Safety



2. Overview of Quality and Risk Management Issues

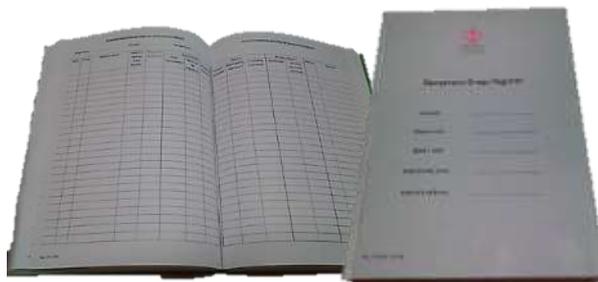
2.1 Physical Restraint

To minimize the risks imposed on patients when applying physical restraint, KWC hospitals reviewed their current practice of management of physical restraint. Related documentations on physical restraint of patient were also reexamined. After the review, alignment on the practice was made among the KWC hospitals to enhance patient safety. Physical restraint assessment and observation record were revised for better documentation and compliance with the ‘Guideline for the use of Physical Restraint’. Fact Sheets on Physical Restraint both in English and Chinese were developed to facilitate and improve the communication with patient’s relatives. Briefing sessions were conducted for staff promulgation on the change in practice. The enhanced practice was implemented in KWC hospitals in 1Q 2014.



2.2 Documentation of unused Dangerous Drug

A new Dangerous Drug Ledger was designed and printed by the Work Group of HAHO Nursing Quality and Safety Subcommittee. KWC had aligned to adopt the new Dangerous Drug Ledger to uplift the practice in documentation of unused Dangerous Drug. The practice was implemented in KWC on 1st Apr 2014 with which standardized templates for documentation was devised and endorsed for staff to follow.



2.3 Rollout of Advance Incident Reporting System 3 (AIRS 3) in KWC

Following the rollout plan of AIRS revamp project by HAHO, KWC hospitals had successfully implemented AIRS 3 at mid-night of 1st Jul 2013. To prepare for the rollout, a total of 5 briefing sessions for reporters and 2 briefing sessions for filtering person were conducted. The major breakthrough of AIRS 3 are the “One Form Concept” for all natures of incidents and creation of a new reporting form for Near Miss cases.



2.4 World Wide STOP Pressure Ulcer Day in PMH

To support and promote prevention of pressure ulcer and to echo the World-wide's activities, PMH had organized the “World Wide STOP Pressure Ulcer Day in PMH” on 29th Oct 2013 which was the pioneer in Hong Kong.

It was a one-day program including learning forum, game booths and pressure ulcer prevention devices exhibition with multidisciplinary contributions. Presentation of award to the winner of the “Logo Design Competition” for the Pressure Ulcer and Wound Management Subcommittee was taken on the same occasion.

The key message of the activity is to boost staff awareness on skin & wound care and cultivate pressure ulcer prevention atmosphere in Princess Margaret Hospital (PMH).

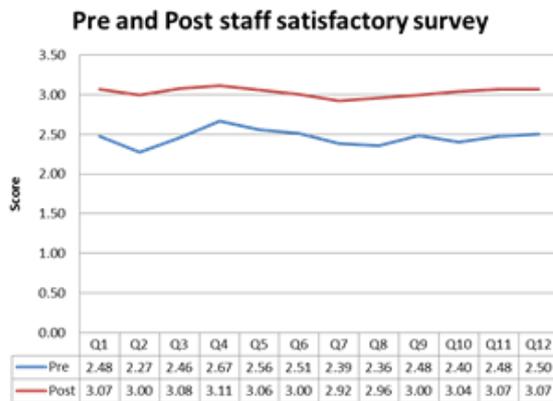


2.5 Smart Lift Policy in KWC

KWC promoted the Smart Lift Policy (SLP) as highlighted in the 2013/14 “Enhancement of Quality of Care on In-Patient Wards Project (QOCP)”. The objectives of the Project were to adopt the concepts of Smart Lift Policy, to promote Occupational Safety and Health and a Healthy Work Environment and to enhance quality of in-patient care in order to create a Positive Practice Environment.

The program of the project were to introduce to staff with additional lifting and transfer aids and how to improve staff work behavior through teaching and coaching skills so as to enhance manual handling safety and efficiency on lifting patients and transferring equipment.

The program received positive feedbacks from 208 staff who had participated in the Pre and Post Staff Satisfaction Survey. To compare the short and long-term effectiveness of SLP, monitoring and evaluation of patient fall rates and incidence of Manual Handling Operations (MHO) related Injury-On-Duty (IOD) cases would be continued.



Risk Prioritization

2.6 Identified Risks for 2013-2014

Clinical Risks	
1	Medication (Administration, Discharge Medication, Dispensing, Handling & Storage)
2	Infection control (Non-compliance, Surveillance, Environmental Cleansing & Disinfection)
3	Patient Fall
4	Occupational Safety and Health (MHO)
Non-clinical / Operation Risk	
1	Fire Safety

2.7 Identified Risks for 2014-2015

Clinical Risks	
1	Medication (Administration, Dispensing)
2	Infection Control
3	Patient Falls
4	Occupational Safety and Health (MHO)
5	Patient Identification
Non-clinical / Operation Risk	
1	Fire Incident
2	Workplace Violence
3	Loss of Property

3. Risk Reduction and Quality Programs

3.1 Review of 2013 Risk Reduction Programs

3.1.1 Medication Safety

KWC hospitals conducted various projects in promoting medication safety. Audits on administration of medication and MAR documentation were conducted.

Drug talks for KWC nursing staff were organized on a regular basis to strengthen their knowledge on medication safety and management.

The HAHO Medication Safety Committee paid a visit to Kwong Wah Hospital (KWH) and Kwai Chung Hospital (KCH) in Jul 2013 and Mar 2014 respectively. Good practices were shared and the recommended improvement areas were attended accordingly.

Hospitals had reviewed medication incidents and followed up with preventive strategies. Sharing forums on medication incidents were arranged to share the lessons learnt and to strengthen the awareness of staff.

In-Patient Medication Order Entry (IPMOE) is continued to roll out in PMH by phases. Up to 1Q 2014, total 704 nos. of hospital beds (in Lai King Building, Infectious Disease Centre, Medicine and Geriatrics Department & Surgery Department) had been rolled out.

Drug Allergy Reference Card (2013 version) were distributed to all new recruited nurses of KWH in early 2014. KWH also revised the Medication Administration Record (MAR) with “doctor’s code” added.

PMH Drug Alert card was revised with both Generic name and Trade name added. The new card was distributed to wards in Feb 2014.



To minimize the risk of medication error, a checklist was developed in Our Lady of Maryknoll Hospital (OLMH) for taking verbal medication orders. Guideline on Procedures for Verbal Medication Orders was endorsed by Medicine and Geriatrics (M&G) department in OLMH. The compliance to verbal medication orders by doctors and nurses was enhanced.

To protect electricity source to medication fridge so as to safeguard the medication stored inside the fridge, PMH had installed power plug covers and warning signage on all medication fridge power sockets to reduce the risks of being switched off accidentally.



3.1.2 Patient Identification

KWC hospitals had conducted audits on procedures of transfusion / type & screen to ensure the compliance of patient identity checking.

Family Medicine had reviewed and updated standard guideline on patient identification in May 2013. They had also conducted a department-wide annual audit in Jul 2013 in all General Out-Patient Clinics (GOPCs) with all ranks of staff involved in any procedures dealing with patient identification with 98.4% compliance rate.

3.1.3 Fall

Fall prevention seminars and sharing of fall incidents were organized at individual hospitals for nurses and supporting staff. Caritas Medical Centre (CMC) also conducted an aggregate review of fall incidents. For better identification of patients with the risk of fall, CMC piloted the Johns Hopkins Hospital Fall Risk Assessment Tool and Yan Chai Hospital (YCH) conducted briefing sessions for nurses on fall risk assessment.

Risk identification at GOPCs were done regularly and communicated with Department of Health for any improvement work on building structure. Wireless bedside fall alarms were installed at OLMH to reduce the fall rate.

3.1.4 Infection Control

A Targeted Screening on Admission aiming at identification of VRE gut carriers to prevent the occurrence of inter-cluster and inter-hospital spread of Vancomycin-Resistant Enterococci (VRE) was conducted in KWC hospitals. Epidemiological data was also collated to direct long term control strategy of VRE.



Clinical waste spillage drill and infection control drill on 'Middle East Respiratory Syndrome' were conducted at KCH and OLMH respectively.

Audits on hand hygiene, infection control practice, and infection control & isolation precaution were conducted.

To prevent nosocomial infection, training and audit on basic patient care practice were conducted for care-related supporting staff in YCH. Besides, training for preparedness of emergency situation and infectious diseases outbreak was conducted. Infection control training on Novel Coronavirus and Avian Influenza (H7N9) was also held in OLMH in Apr 2013.

At YCH, a bathing team was set up to reduce the bioload of high risk patient by performing bed bath using 2% Chlorhexidine Gluconate. An Infection Control Enhancement Cubicle was set up in acute medicine at YCH to cohort high risk patients.

3.1.5 Occupational Safety and Health (OSH)

Promotional activities on OSH such as OSH Fun Day, OSH Forum, Pre-work Stretching and Health Promotion, and 「你有營、我有盈」九龍西醫院聯網「健營生活」推廣 were organized in KWC hospitals in 2013/14.

In order to reduce staff incidents by enhancing staff awareness and knowledge on Occupational Safety and Health, KWC had



organized and conducted Chemical and Radiation Safety Training, OSH audits, workplace audits and work safety inspections in relevant workplaces.

i. Manual Handling Operations (MHO)

MHO trainings were provided for nurses and supporting staff in KWC hospitals on a regular basis. An OSH Day with the theme of MHO and Prevention of Needle Stick Injury was also conducted in Dec 2013 at OLMH to raise staff awareness on OSH.

ii. Chemical Safety

Safety inspections on chemical spillage kits at various units and surprise checking of Dangerous Goods Stores were conducted at YCH. A formalin exposure monitor test at the YCH Pathology Laboratory, mortuary & Operation Theatre was performed. A stocktaking exercise of fume hoods and Bio safety cabinets at YCH were performed to ensure proper preventive maintenance and periodic monitoring. Besides, a master chemical inventory list was also developed in YCH.

The Family Medicine Department implemented a chemical safety and housekeeping project, in which review of chemical stocks, chemical housekeeping audits, staff training on chemical safety and chemical safety slogan competition were conducted. Chemical safety assessment was also conducted in all GOPCs by the OSH Team in May 2013. To raise staff awareness on safe handling of chemicals, an OSH Fun Day was organized for GOPC staff.



iii. Display, Screen, Equipment (DSE)

The KWC DSE Train the trainer program was conducted in May 2013.

A mock DSE consultation station was set up at the YCH Specialist Out-Patient Department (SOPD) Clinic. The mock station served as a prototype for other consultation stations.

iv. Workplace Violence

The KWC Anti-workplace Violence Forum was conducted in Sep 2013 and workplace violence cases were shared with staff. Besides, workplace violence trainings were conducted at KWH, TWGHs Wong Tai Sin Hospital (WTSH) and North Lantau Hospital (NLTH) to educate staff on the handling of workplace violence.

Monthly drills on enhancing the skills of nurses and ward supporting staff in handling workplace violence was conducted at KCH. Safety alerts were also distributed to staff of KCH to raise their alertness on workplace violence.

3.1.6 Resuscitation

PMH had reviewed and revised the existing standardized layout of emergency trolley. A compliance audit was conducted in Oct 2013. Meanwhile, YCH had implemented standardization of emergency trolley in wards with audit conducted in Dec 2013.

To enhance the standard of ventilator care and monitoring, PMH had procured 40 sets of end-tidal CO₂ detectors (in addition to the existing 40 sets of devices purchased in the last year exercise) and delivered to wards. Two briefing sessions were conducted in Mar 2014 with a total of 100 participants.

3.1.7 Emergency Contingency

An Information Technology (IT) contingency drill, 'Massacro' was conducted in PMH on 11 Apr 2013 with debriefing session held. The Guideline on PMH Clinical Systems (IT) Contingency Plan was further refined and endorsed with effective in Jul 2013.

Family Medicine Department had endorsed guideline of Outpatient Appointment System (OPAS) / Clinical Management System (CMS) Contingency Plan in May 2013 after consultation from clinical frontline staff. An IT breakdown drill in all clinics was conducted in Feb 2014.

The Mental Health Direct Service of KCH formulated an IT contingency plan in May 2013 to minimize the interruption to the services when there are breakdowns in network, system and electricity. KCH also conducted drills on medical emergencies and CPR to upkeep the readiness of emergency response.

A drill on handling request for management of person found collapsed in NLTH was conducted on 5 Mar 2014.

3.1.8 Other Audits

In addition to the audits conducted with mentioned improvement programs above, audits and surveys such as informed consent, wound dressing, pain management, oxygen therapy, physical restraint prevalence survey, point-of-care testing, management of patient luggage on Non-Emergency Ambulance Transfer Service (NEATS) vehicles, radiation safety were performed. KCH also conducted a number of audits in related to psychiatric services.

3.1.9 Health Information and Record Management Services

Review on filing practices was done in KWC hospitals to reduce the risk of misidentification of patients and lower the volume of medical records folders. Cluster workflow and standard were promulgated to ensure compliance of requirement of medical report to the Coroner.

3.1.10 Business Support Services

i. Domestic & Portering Services

To ensure the stability and adequacy of manpower for domestic and portering services, the in-house and contract staff ratio was continuously monitored at individual hospitals and benchmarked. Risk assessment on outsourced manpower shortage due to sudden increase in demand from emergency situations (such as infectious diseases pandemic, staff on strike, etc.) was conducted and contingency plan was formulated.

In enhancing the environmental hygiene at clinical areas, random environmental sampling for culture test was performed for better monitoring of hygiene conditions. The cleansing workflow by domestic services staff and the materials used for cleansing were reviewed. The workflow of high touch area cleansing was standardized. Good practices on domestic cleansing were shared among KWC hospitals.

ii. Linen and Laundry Service

The use of a standardized tag for identifying infected linen was introduced to facilitate safer handling of infected linen.

iii. Non-emergency Ambulance Transfer Service (NEATS)

Checking was performed to ensure staff compliance on safety measures. Training in the form of role play was arranged for staff to enhance their understanding and empathy to patients. In addition, training on the use of stair climbers, site assessment for difficult cases and skill assessment for staff were conducted to reduce staff injury and enhance patient safety.

Posters were posted on NEATS vehicles to raise patients' awareness on safety measures.

iv. Confidential Waste

Measures for handling of confidential waste were step up to ensure compliance with recommendations by the Privacy Commissioner for Personal Data (PCPD). These included strengthening of the enforcement to separate the collection of confidential waste papers and used thermal ribbons at source. Compliance check was performed to monitor the in-house handling and storage of confidential wastes, and contractors' performance on confidential waste collection and destruction services.

v. Telecommunication

KWC hospitals conducted an annual drill to test the efficacy of the Private Automatic Branch Exchange (PABX) battery and the Uninterruptible Power Supply (UPS). Contingency plans on PABX system failure was reviewed regularly to keep the contingency measures update.

To ensure that the PABX was under strong protection, all KWC hospitals upgraded their anti-virus software in PABX.

For service enhancement, a survey was conducted to collect staff feedbacks and comments on the telecommunication system.

vi. Fire Safety

An annual liaison meeting was held with Fire Services Department (FSD) to discuss on fire safety issues. FSD was invited to participate in the review of the Hospital Fire Safety Guidelines / Evacuation Plan.

Fire safety inspections and audits were conducted in KWC hospitals. Fire Prevention Talk, Fire Evacuation Drill and Fire Safety Ambassador Trainings were also conducted to enhance staff awareness on fire safety. To reduce the occurrence of fire incidents related to the misuse of microwave, posters were displayed to remind staff on the proper use of microwave.

vii. Security

KWC hospitals had strengthened the security measures for prevention of incidents related to loss of property.

In order to ensure in-house and outsourced security guards hold a valid security guard permit, a continuous bring-up system was established between Cluster Human Resource Department and Security Section. A two tier checking mechanism on the validity of the permits was set up.

Additional security hardware which included CCTV cameras, door contact alarms, panic alarms, convex mirrors, access control system, and additional lighting facilities was installed in high risk areas of KWC hospitals.

To reduce the risks of criminal damage, thieving and patient suicide at roofs of hospital buildings, KCH had enhanced the security measures in Apr 2013. Measures included additional closed-circuit television cameras, enhanced lighting, barbed wire at walls and drain, frequent security patrol and enhanced surveillance of patients and visitors entering the premises.

To increase the collaboration between hospital and the Police, representatives of KCH and Cheung Sha Wan Police Station met in May 2013 to exchange views on common issues between the Police and the hospital on crime prevention as well as hospital safety and other operational issues. The communication system with the Police was also enhanced and streamlined.

viii. Environmental Risk Assessment

Annual tree risk assessment and patrol by arborists / contractors have been conducted in all hospitals. Recommendations such as tree pruning were followed up by hospitals and about 220 trees were pruned. Regular surveillance on the conditions of trees and monitoring on the risks associated has reduced the risk of injuries and property damage.

ix. Facility Management

Risks were identified based on the latest risk assessment and management approach of Capital Planning Department of HAHO since Oct 2013. Plans were developed and carried out to minimize the occurrence and impact. For instance, the risk of bursting of an aging salt water pipe at CMC was reviewed. Water Supplies Department was then liaised for diversion of the pipe to mitigate the risk.

Facility Condition Assessment was carried out in all hospital buildings in KWC by Term Maintenance Surveyor (TMS) and Electrical and Mechanical Service Department (EMSD) to assess the overall condition of facilities on building elements and electrical & mechanical items. Corresponding projects were planned to minimize the identified risks from the assessment.

3.2 Quality Initiatives, including Accreditation

3.2.1 Hospital Accreditation

In preparation for the Gap Analysis of PMH held in Nov 2013, PMH had conducted learning forums, accreditation rounds, department visits, meetings with criteria owners and department coordinators, and helpers training. Staff were also engaged through Promotion Days and experience sharing by other hospital.

PMH had smoothly completed the Gap Analysis in Nov 2013 and received the Consultancy Report from The Australian Council on Healthcare Standards (ACHS) in Jan 2014. ‘Priority action items’ (PAI) and ‘Suggested opportunities for improvement’ (SOI) were given in the report for preparation of the Organisation Wide Survey (OWS) in Nov 2014.

Briefing sessions for hospital staff to understand the PAIs and action plans to fill the deficiencies were conducted. Representatives from ACHS and Head Office Quality & Safety also visited PMH in Feb 2014 to know the hospital’s readiness for the OWS. The overall comment from ACHS on the action plans was positive. It was also confirmed by Head Office in Mar 2014 that the schedule for the OWS in PMH would be from 17 to 21 Nov 2014.



The Gap Analysis of YCH would be conducted in Nov 2014. A Hospital Accreditation Kick-off Ceremony was held on 3 Jan 2014. Roadshows to brief Board of Directors, medical and allied health staff on Hospital Accreditation was underway from Apr 2013 to Feb 2014. Besides, six preparatory rounds on ACHS criteria were also completed. A Clinician Sub-workgroup was also established to discuss the clinical-related outstanding issues.

CMC would conduct the OWS in Jul 2014 and the preparation work was underway.

The ACHS Accreditation Certificate Presentation Ceremony was held on 7 Jun 2013 for awarding the accreditation status for OLMH. OLMH had also conducted the Self-assessment in Mar 2014.



3.2.2 Other Quality Initiatives

i. Hospital Safety Rounds

KWC Hospital Management conducted Hospital Safety Rounds regularly in their hospitals and GOPCs focusing on environmental scanning, safe practices and staff concerns. Improvement plans and risk reduction strategies would be followed for all identified loopholes by respective hospitals.

ii. Quality & Safety Publications

To nourish safety culture in KWC hospitals, each hospital would publish newsletter, bulletins and safety gist to raise staff awareness on patient safety regularly. It also serves as a means to share the good practices among staff.

iii. Business Support Services

a. Domestic & Portering Services

In order to increase the cleaning effectiveness and mitigate the risk of cross transmission of infectious diseases, the color coding system in cleansing practices was piloted / implemented at clinical areas in KWC hospitals.

The service workload projection and benchmarking on cleansing and portering services was conducted with reference to the hospital Key Performance Indexs (KPIs) (e.g. average portering time) to improve quality standards. A standard formula for workload analysis in cleansing services was formulated.

b. Linen and Laundry Service

The linen stock-taking procedures were shared among KWC hospitals. The key steps for stock-taking were highlighted for staff attention. Besides, the feasibility of aligning the stock-taking methods among KWC hospitals was explored.

c. Waste Management

In reduction of food waste, staff were promulgated on ‘food wise’ and annual food waste audit was conducted. A liquefying decomposer was installed in KWH to handle food waste from wards. The food waste can then be decomposed and discharged to the sewage system. With the implementation of this project, the volume of food waste was reduced substantially by 240kg per day.

KWH also collaborated with the Hong Kong Baptist University, Tung Wah Group of Hospitals and the Environmental Protection Department in a research project in converting food waste from staff canteen and Chinese herbal residues to fertilizer through decomposition.

d. Environmental Management

The Cluster Green Week, with ‘food wise’ as the theme was held in Oct 2013. Experts were invited to share their experiences on food waste reduction and tips on green cooking. An exhibition was also held to display ‘green’ drawings by patients of Kwai Chung Hospital.

KWC hospitals also participated in other green activities, such as ‘Earth Hour’, ‘No Air-Con Night’, ‘Lai See Pocket Recycling’, ‘Mooncake Boxes Recycling’, ‘Used Clothes Recycling’, ‘Secondhand Goods Sales Activity’, ‘Green Tours’, ‘Gardening at roof garden’, ‘Smoke-free Singing Contest’ and ‘Take a Brake’.

4. Learning and Sharing Information

4.1 KWC Orientation & Induction Program for New Residents

The KWC Orientation & Induction (O&I) Program for New Residents was held on 6 and 12 Aug 2013 in KWC. 96% of the new Residents had attended the 2 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 practices, and to strengthen their skills in managing incidents at the beginning of their career. Evaluation from participants reflected that the overall program was useful to their daily practices in wards.



4.2 KWC Quality & Safety Forum

The KWC Q&S Forum was conducted on 3 Mar 2014 at PMH. The forum focused on the communication with the public, patients and relatives. Mr. Chi Sum NG (吳志森先生), a renowned veteran in the mass media field was invited to share on how to communicate with the public. Besides, PMH Patient Services Department also shared on the communication techniques when managing complaints and Open Disclosure. A total of 218 KWC colleagues attended the forum and positive feedback was received.



4.3 Incident Management Training

To enhance the knowledge of healthcare practitioners on incident management and to provide them with the skills required for open disclosure and conducting Root Cause Analysis (RCA), four identical training sessions were conducted in Dec 2013. There are a total of 136 staff attended the training.



4.4 Drug Talks for KWC Nursing Staff

Five training sessions on drug management on the following topics were conducted for nursing staff to enhance medication safety:

- Alzheimer's Disease
- Pharmacology and Therapeutics in Cardiovascular Disease
- Medication Safety
- Pharmacological Management of Migraine
- An Overview on Idiopathic Thrombocytopenic Purpura (ITP) Management

4.5 Sharing on Reuse of Single Use Device (SUD)

A sharing on the reuse of SUD was conducted in Dec 2013 to share the good practice on the management of reuse of SUD.

4.6 Document Control Trainings

To prepare for the rollout of the Electronic Document Management System (eDMS) in KWC hospitals, eDMS briefing sessions and 'Train the trainer' programme were conducted in PMH, YCH, OLMH and KCH.

Moreover, aiming to reinforce staff on document control concept, a 'KWC Document Control Seminar: Tips for Writing Guidelines, Protocols and Work Instructions' was held on 31 May 2013 for all KWC hospitals. Tips for writing documents were also shared in the seminar. There were a total of 623 participants attended the seminar with positive feedbacks.

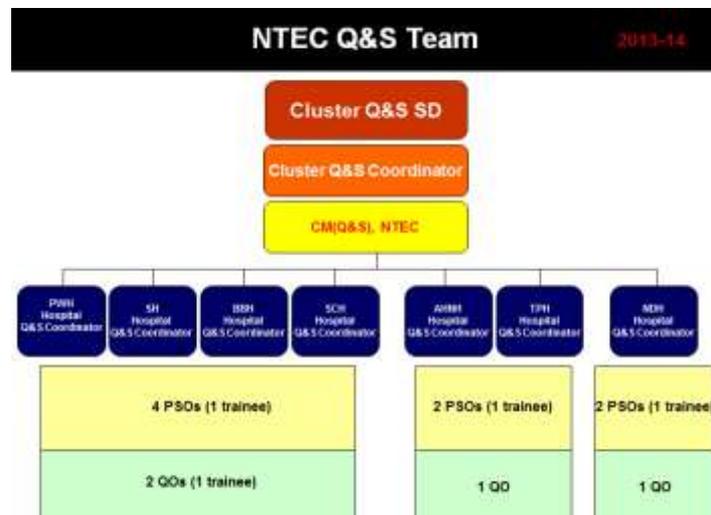


New Territories East Cluster

1. Structure



The governance structure of the NTEC Quality & Safety (Q&S) was reviewed and revised during the reporting period. In addition to the Subcommittees of Consent, Nutrition, Medication Safety, Q&S Research, Q&S Training, Procedural Safety and Nursing Q&S (collaboration), Subcommittees of Document Control and Resuscitation were established to enhance governance and align services. Efforts of frontline staff and management at the department and hospital levels were concerted to bring safe and quality services in the cluster.



2. Overview of Quality and Risk Management Issues

2.1 Risk Management

2.1.1 Medication Safety

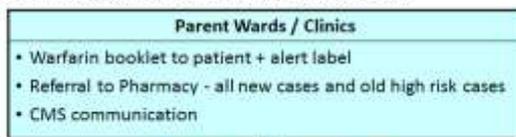
i. Policies, Procedures and Guidelines

Four protocols and guidelines on infusion safety, handling of private patients, handling of dangerous drugs and handling of medications requiring refrigeration were implemented.

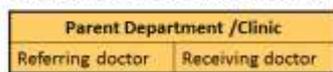


Integrated - multidisciplinary Warfarin Workflow (Apr 2012)

I. Patient Management by Parent Department /Clinic



II. Clinical handover on Patient Transfer between Clinics



ii. Safe Warfarin Therapy

A system for the evaluation of pharmacy counselling service to patients on warfarin therapy was established. The evaluation of patients' knowledge of warfarin therapy and their satisfaction over a year cluster-wide showed the service was useful and effective, especially in Prince of Wales Hospital (PWH).

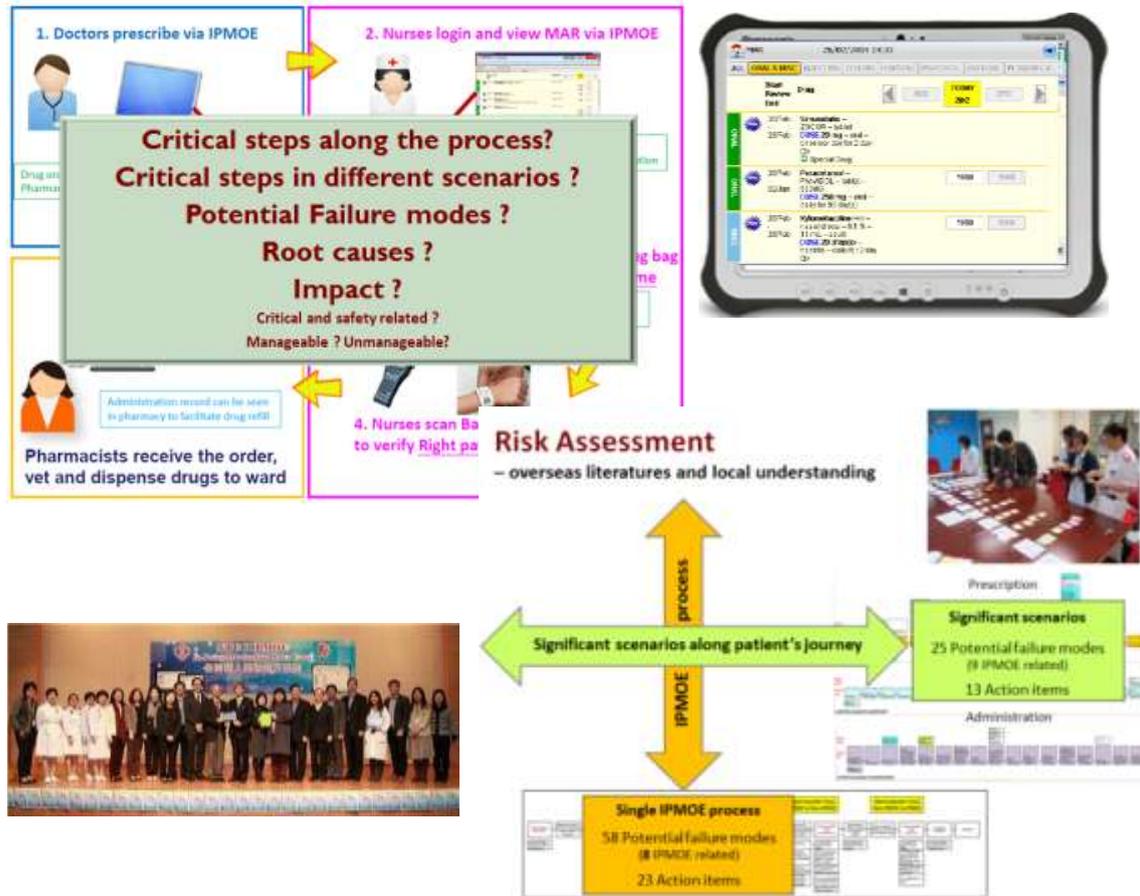
iii. Reducing Transcription Errors

A Taskforce on Transcription Errors was formed to review transcription incidents and develop risk reduction strategies for transcription errors and to recommend risk reduction strategies. First phase of trial implementation of risk reduction strategies including medical officers' direct prescription, barcode scanning to access correct patient profiles in Clinical Management System (CMS) and protected time for routine transcription in a ward of 7 participating departments cluster-wide was satisfactory. Pre-trial and post-trial surveys in interns and first year medical officer (MO); and nursing staff and On-site observation were conducted. Risk reduction strategies were refined and the second phase would be rolled out in 2014/15.



iv. Risk Management of In-patient Medication Order (IPMOE)

IPMOE was planned to be pilot run in PWH in 3Q2014 and a workgroup of IPMOE Risk was formed to proactively identify and prioritize risk for action. The workgroup reported primarily to PWH IPMOE Implementation Task Force. Risk reduction strategies included feature enhancement, workflow management, downtime procedures, staff training and technical/information support. Measures were followed up in collaboration with HAHO and multidisciplinary teams in hospital.



2.1.2 Clinical Handover and Handling of Deteriorating Patients

Clinical Handover & Detecting Deteriorating Patient (CH&DDP) Task Force

- To facilitate the formation of a structure for managing (probable) deteriorating patients:



The taskforce on Clinical Handover & Detect Deteriorating Patients continued to look into the identification and management of deteriorating patients and the system of clinical handover. Departments were encouraged to try detection tool suitable for them and handover systems were explored.

2.1.3 Equipment Safety: Standardization of Infusion Device

In order to reduce staff confusion and to minimize infusion device related incidents, Q&S collaborated with NTEC Technology Advisory Committee to develop strategies on standardization of infusion device. Target on not more than 4 models of infusion pump and syringe pump in each ward, an electronic platform for mutual sharing and monitoring was developed. The compliance with the target number of models was 100%. Strategy on sustaining the target was under discussion.

Common models of pumps used in NTEC	
Syringe Pumps	Volumetric Infusion Pumps

Monitor and Report

Develop a monitoring system in web

- Annual inventory stock-take: on 15th October every year
- Reminder/ action will be taken

NTEC Technology Advisory Committee

Quick Link

Standardization of Infusion Pump

	Date issued	Date passed
Process Details	28 Oct 2012	28 Oct 2012
Annual Inventory (app use at 15 Oct 2012)	28 Oct 2012	28 Oct 2012

2.1.4 Staff Engagement on Medication Safety and Clinical Handover

i. Quality and Safety Forum

The annual cluster Q&S Forum themed “Medication Safety – Continuity 藥物安傳” was held on 21 Aug 2013. It highlighted medication safety as a continuous and collaborative effort among multidisciplinary teams and even patients. Ir. Prof. Peter Mok, Chairman of Hong Kong Quality Assurance Agency (HKQAA), was invited to be the plenary speaker to share his experience in construction industry. 6 outstanding medication safety Continuous Quality Improvement (CQI) projects in NTEC were shared in the Forum. Totally 383 attendants participated in the forum.

A micro-movie “SafeActually” was premiered in the Q&S forum to promote medication safety. NTEC was later invited to present it at the HAHO Medication Safety Forum 2013. The film was very well received.



ii. Medication Safety Student Ambassador Program

The Medication Safety Student Ambassador Program was launched in 3Q 2013. It aimed at promoting the awareness and attitudes of participants in medication safety through a series of didactic session, workshop, forum and site visit. Total 40 medical, nursing and pharmacy undergraduates of The Chinese University of Hong Kong (CUHK) were invited to join the pilot program. A kick-off ceremony as officiated by HA Chief Executive Dr. PY Leung and Dean of Faculty of Medicine of CUHK Prof. Francis Chan was launched in the Quality & Safety Forum. Participants' feedback of the program was very good.



2.2 Incident Management

2.2.1 Trend of Incidents

There were more than 2000 incidents reported through the Advance Incident Reporting System (AIRS). In comparison with the data in 2012/13, the situation was similar. Of the total reported cases, 7.2% was near miss incidents (3.7% in 2012/13). Overall, patient injury/fall was the most reported patient incident (37%), followed by medication incident (10%) and missing patient (3%).

2.2.2 Launch of AIRS 3

AIRS version 3 was implemented in NTEC since 1 Jan 2014 smoothly. Briefing sessions by HO Q&S and HO Information Technology (IT) Team for users and for filtering persons in Nov 2013 were held. The teaching material of AIRS 3 was uploaded to iQ&S for staff reference afterwards.



2.2.3 Review of Root Cause Analysis

A Root Cause Analysis (RCA) Review Workshop was organized to review the system and quality of conducting RCA on 18 Jan 2014, with the participation of about 40 staff with



experience in RCA. Follow-up discussions were in progress.

2.3 Quality Management

2.3.1 The Australian Council on Healthcare Standards (ACHS) Hospital Accreditation

The concept of Cluster Shared Services was defined and tried out in the PWH Organization Wide Survey (OWS) with success. This contributed to ACHS' development of a system for surveying cluster shared services.

Alice Ho Miu Ling Nethersole Hospital (AHNH) / Tai Po Hospital (TPH) completed the Gap Analysis in May 2013 in preparation for the OWS. It was evident to the consultants that the staff were very caring and working together to prepare for OWS and in their daily work to provide care and service to their community.



The OWS was successfully conducted in Princes of Wales Hospital (PWH) on 9 – 13 Sep 2013. Full accreditation with 6 Extensive Achievements was awarded by ACHS. The Certificate Presentation Ceremony was held on 4 Mar 2014, with the participation of more than 200 participants. The certificate was presented by Adjunct Professor Karen Linegar, president of ACHS.



The OWS in North District Hospital (NDH) was conducted on 16-19 Sep 2013. NDH full accreditation with 7 Extensive Achievements was awarded by ACHS. The Certificate Presentation Ceremony was held on 4 Mar 2014. Over 100 frontline staff, volunteers and HGC members participated in the event.



2.3.2 Review of Risk Registry

A taskforce was formed to revisit the concept and framework of risk registry. A cluster survey was conducted. The risk registry template was revised to highlight both safety and quality concerns. Departments were encouraged to link their registries to continuous quality improvement programs and incorporate it into their annual plans.

Quality workshops titled “Beyond Incident, Beyond Safety and Beyond Head of Department” and “Risk registry” were organized to promote the concept and practice.

Current Condition

Risk Registry and Beyond

- Annual Risk assessment
 - Identification
 - Prioritisation
- Annual plan – Develop Action program and Do
 - Service development
 - CQI project plan
- Outcome Evaluation
- Hospital Accreditation

Target

三個超越

Risk Identification: **Beyond Incidents**

Quality Improvement: **Beyond Safety**

Party Involved: **Beyond HOD**

Not in Effect of Similarity on Objectives – Patient-centered, Safe, Effective, Timely, Efficient, Equitable.

NTEC Survey on Risk Registry Process

- Departmental survey to find out the existing processes in working out Risk Registry
- To facilitate a structured risk registry process
- To enhance the quality elements in risk registry

Data Collection: 7/6/13 – 19/6/13

Risk Registry in NTEC

做好基本功
融入生活中

2.3.3 Quality and Safety Walkrounds

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; and promote the safety culture.

3. Risk Prioritization

3.1 Identified Risks for 2013-2014

Clinical Risks	
1	Medication - Transcription
2	Medication - High Risk Med
3	Procedural safety
4	Fall with severe injury
5	Clinical Handover
6	Handling of deteriorating patients
7	Infection Control
8	Identification
9	Medication - known Drug Allergy
10	Suicide
Non-clinical / Operation Risks	
1	Manpower shortage of doctor
2	Workplace Violence
3	Manpower shortage of supporting staff
4	Poor Staff morale
5	Handling of serious complaints and incidents
6	Injury from manual handling
7	Fire hazard
8	Succession for senior staff at retirement peak
9	Network Power Failure
10	Injury from handling Chemical substance

3.2 Identified Risks for 2014-2015

Clinical Risks	
1	Clinical handover
2	Fall with hip fractures
3	Handling of deteriorating patients
4	Infection control (MDRO)
5	Medication - IPMOE, Transcription, Known drug allergy, High risk medications (anticoagulant /insulin)
6	Misidentification
7	Procedural safety
8	Suicide
9	Waiting time
Non-clinical / Operation Risks	
1	Manpower shortage
2	Aging facilities and facilities failure
3	Staff expectation and morale
4	Performance of domestic service contractor
5	Occupational Safety & Health hazard (Manual Handling)
6	Workplace violence
7	Fire hazard
8	Budget monitoring
9	Downtime impact/ procedures
10	Unauthorized access to personal data

4. Risk Reduction and Quality Programs

4.1 Review of 2013 Risk Reduction Programs

4.1.1 Medication Safety

i. Medication Safety Policies, Procedures and Guidelines

To further enhance medication safety and staff knowledge four medication safety guidelines, procedures and policies were endorsed and rolled out during the reporting period in PWH and NTEC:

- Procedure for Intravenous Infusion Drugs
- Guidelines for the Handling of Patients’ Private Medications in Wards
- Procedures for the Handling of Dangerous Drugs
- Procedures for the Handling of Medications Requiring Refrigeration

ii. Safe Warfarin Therapy

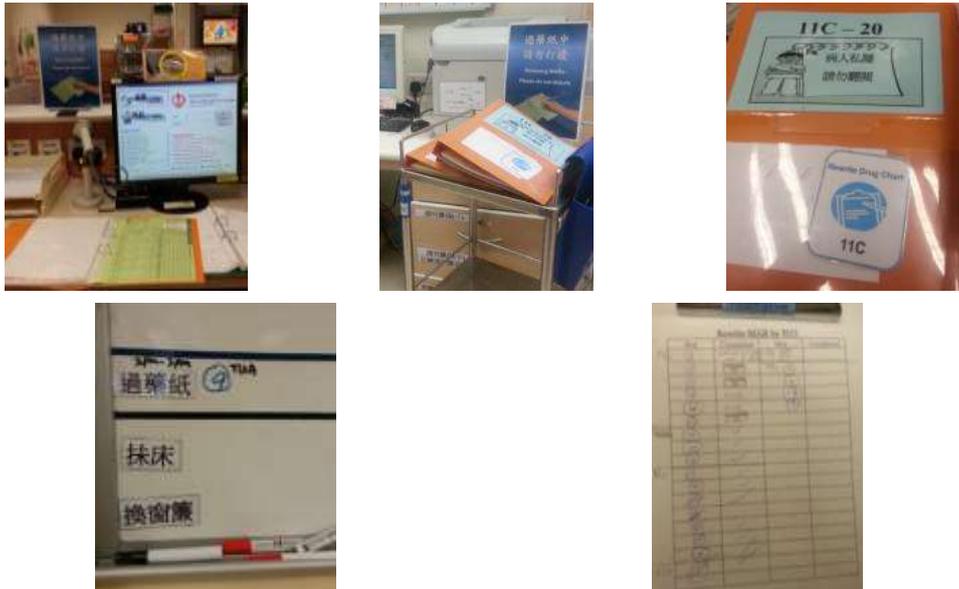
The integrated multidisciplinary workflow for safe warfarin therapy was introduced in 2012/13. A system for the evaluation of pharmacy counselling service to patients on warfarin therapy was established in 2013/14. Significant improvement in knowledge after class in all pharmacies and patients’ satisfaction with the service were evidenced, especially in PWH.

Assessment of patient's knowledge	
Q1. Warfarin uses (您知道華法林有何作用?)	
Q2. Warfarin administration method (您知道華法林正常的服食方法嗎?)	
Q3. Colors of different warfarin preparations (請將華法林的顏色與劑量連結)	
Q4. Information of latest regimen (您知道在那裡可以得知華法林最新的服用劑量?)	
Q5. Missed dose management (如果忘記服藥，您應該...)	
Q6. Warfarin-herb/supplement interaction (您是否可以隨意服用中藥材，中成藥或其他中西保健產品?)	
Q7. Warfarin-food interaction (您是否可以任意進食大量蔬菜?)	
Q8. Importance of blood taking and FU (您知道定時覆診抽血有何重要?)	
Q9. Information retrieval for the most updated anticoagulation control (您知道在那裡可以得知自己目前的抗凝血指數? → 《藥物記錄及病人須知》手冊中)	
Q10. Other precautions of warfarin therapy (您知道在服用華法林期間，有下列那些注意事項?(可選:《藥物記錄及病人須知》手冊，並告知醫生、牙醫或中醫)	

Satisfaction of Warfarin Education	
Q1. Helps to improve knowledge on warfarin uses	
Q2. Helps to improve knowledge on warfarin administration	
Q3. Helps to improve awareness on importance of drug compliance	
Q4. Helps to improve knowledge on management of bleeding episodes	
Q5. Helps to improve knowledge on precautions about drug-herb or drug-supplement interactions	
Q6. Helps to improve knowledge on drug-food interactions	
Q7. Appropriate length of education	
Q8. Helps to improve knowledge of warfarin therapy overall	

iii. Reducing Transcription Error

First phase of trial implementation of strategies to reduce transcription errors included medical officers' direct prescription, barcode scanning to access correct patient profiles in CMS and protected time for routine transcription in a ward of 7 participating departments in PWH, AHNH, NDH and Shatin Hospital (SH). Results of pre-trial and post-trial surveys in interns and first year MO; and nursing staff and on-site observation were satisfactory. Strategies were refined for phase II pilot in 2014/15.



iv. iLEARN on Medication Safety

Educational packages on medication safety procedures and policies were uploaded to iLearn unlimited 學海無涯 platform in Dec 13. Each package includes a video, PDF and quiz to facilitate self-learning of staff as well as reference record for their supervisor.

"iLearn unlimited" for all, 學海無涯

(Production date : 28 Nov 2013 as date endorsed by NTEC MSC)

Topics	Training materials	Topics	Training materials
Handling Patients' Private Medications in Wards Related PPG	 Video PDF Quiz	Use of Standardized Cluster MARS Related PPG	 Video PDF Quiz
Handling Medications Requiring Refrigeration Related PPG	 Video PDF Quiz	Verbal Medication Orders Related PPG	 Video PDF Quiz
Intravenous Infusion of Drugs Related PPG	 Video PDF Quiz	Known drug allergy Related PPG	 Video PDF Quiz

v. Medication Safety Audits

Audits on Known Drug Allergy Measures, Use of Cluster MARs, and Infusion Safety and Use of High Risk Medications were conducted cluster-wide during 17 Mar – 21 Mar 2014. Results were satisfactory. Improvement actions mainly were of local concerns.

Key areas		2014	2013	
1.	Procedures for intravenous infusion with drug additives	86.1%	NA	
2.	Use of standardized cluster MARs	93.0%	95.3%	
3.	Allergy alert procedures	94.6%	94.0%	
4.	Use of checklist for first time use of antibiotics of penicillin group	Checklist used	100%	80.6%
		Checklist entries	92.2%	88.0%
5.	Use of high risk medication	99.9%	NA	

4.1.2 Clinical Handover and Handling of Deteriorating Patients

As motivated by the Taskforce Clinical Handover & Detect Deteriorating Patients, pilot programs of Detecting Deteriorating Patients by means of Modified Early Warning Score (MEWS) and Paediatric Early Warning System (PEWS) were held at NDH (MED, SURG, O&T); PWH (PAED/SURG, Med, NEURO-SURG, ONCO, A&E); AHNH & THP (O&T). Pilot programs of Clinical Handover were held at NDH (MED, SUR, O&T, ICU); PWH (NEURO-SUR), AHNH (PAED, ENT); TPH (O&T). NTEC Quality Workshop of Clinical Handover and Early Detection of patients at risk of Deterioration was held in Mar 2013. Sharing of related information at iHosp was set up.

4.2 Quality Initiatives, including Accreditation

4.2.1 ACHS Hospital Accreditation

Coaching workshops, staff engagement forums and pre-meetings were held to help staff prepare for the Gap Analysis in AHNH & TPH and OWS in PWH and NDH. “做好基本功、融入生活中” was emphasized. Departments and committees continued to refine their policies, procedures, guidelines and CQIs; and uploaded them to iHosp on NTEC intranet.

The concept of Cluster Shared Services was defined and tried out in the PWH OWS with success. This contributed to ACHS’ development of a system for surveying cluster shared services.

Gap Analysis and OWS included presentations, visits to each of the clinical and other departments, group and individual interviews and provision of some documentary evidence for review and evaluation by the consultants.

i. **Gap Analysis in AHNH**

The gap analysis was conducted on 27-31 May 2013.



ii. **Organization Wide Survey in PWH**

PWH attained full accreditation with six Extensive Achievement in the following areas in the OWS in Sep 2013:

- Information on, and access to care and services
- Effective care and services
- Inputs from consumer
- Employee support systems and workplace relations
- Information and communication technology
- Research



iii. Organization Wide Survey in NDH

NDH attained full accreditation with seven Extensive Achievements in the following areas in the OWS in Sep 2013:

- Evaluation of outcomes of clinical care
- Systems for managing of the patient after discharge and back into the community
- Providing appropriate information of our health services to our community
- Infection control system
- Prevention and management of pressure ulcers
- Engaging patients, carers and the community in planning, delivery and evaluation of health service
- Promotion of health and wellbeing to patients and local community.



4.2.2 Quality and Safety Walkrounds

The Q&S team in individual hospitals conducted patient safety walkrounds to promote safety culture, to identify good practices and opportunities for improving safety. Surveyors were invited to join in individual hospitals.



4.2.3 Review of Risk Registry

The concept and framework of risk registry were revisited. The template was revised to highlight both safety and quality concerns. Workshops were organized.

A common risk language

Environment risk Government funding / policy, Laws and Regulations, Economy, Demographics, Technology, Market share, Other providers, Customer needs and expectations, Public awareness, Suppliers, External funders, External relations, Labour market.

Process risk Purpose, Structure, Leadership, Accountability, Authority, Boundary, Compliance, Resource allocation, Communication, Rate of change, Performance measurement.

Empowerment risk Purpose, Structure, Leadership, Accountability, Authority, Boundary, Compliance, Resource allocation, Communication, Rate of change, Performance measurement.

Integrity risk Fraud, Corruption, Unauthorised use, Unethical practice, Illegal acts, Reputation, Conflict of interest.

Legal risk Regulatory compliance, Litigation, Contractual.

Financial risk Cash flow, Budget control, Cash collection, Bad debts, Payment, Investment, Insurance, Currency, Misappropriation, Value for money.

IT risk Systems failure / Availability, To use, On, Off.

Patient Care and Safety Risk

Patient and family rights
Information & Consent
Confidentiality
Security
Substitution/consent
Privacy
Participation
Dignity / Convivance

Access and continuity
Availability / Access
Appropriateness
Timeliness / delay
Continuity
Ours / under utilisation
Values / capacity
Inequities

Assessment of patients
Adequacy of assessment
Cost (diagnostic / reporting / interpretation)
Appropriateness

Physical resource risk
Facilities / equipment
Quality
Availability
Reliability / Resilience / Redundancy
Performance
Efficiency / Economy
Compliance
Waste / Emissions
Use
Vendor
Technology

Quality and safety
Infectious products
Patient temperature
Sterility
Isolation
Hand-hygiene
Hand-hygiene (alcohol)
Health and safety
Fall of staff
Storage / Equipment / Insects
Fire, Explosion / Poisoning

Human resource risk

Staff capabilities and education
Qualifications / registration
Proficiency
Professional development.

Maintaining a quality workforce
Loss of key staff
Turnover
Recruitment
Remuneration
Industrial relations
Workforce planning

Performance
Productivity
Efficiency
Teamwork
Performance incentives
Coverage / skills
Absence / attendance
Staff morale

Occupational health and safety
Safe systems of work
Instructions / training / supervision
Ergonomics / Workload

Risk Registry - Clinical

Risk in increasing order of significance	Hospital	Department/ Committee	Unit/ Team	Nature of Quality / Safety concerns ^a	Description of Quality / Safety concerns ^a	a	b	c	Risk Ranking (Table 1)	Any link with CQI programs?	Any link with Annual Plan?
						Estimated consequences (Table 1)	Estimated likelihood (Table 2)	Risk (d) = (a x b)			
1									d		
2									d		
3									d		
4									d		
5									d		

5. Learning and Sharing Information

Cluster Quality Workshop
Six Quality Workshops were held in this period with a total of 1435 colleagues attended. The topics ranged from Document Control, Near-miss Reporting, CQI and Risk Registry, etc.



Cluster EQUALsafe Course
Incident management EQUALsafe course was conducted monthly in NTEC. Over 300 staff had attended the course in 2013/14.



Cluster Workshop on Advanced Document Control (and Document Control Workshop)

Further to the previous 15 sessions of elementary Document Control Workshop conducted since 2009, an Advanced Document Control Workshop was organized with 21 invited participants attended. The teaching material for Document Control had uploaded to iLearn platform for easy access.



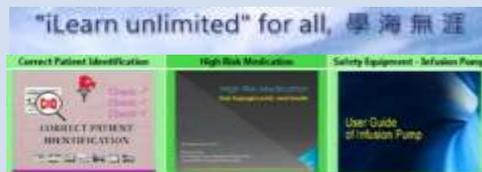
Cluster Root Analysis Workshop

On 18 Jan 2014, a RCA review workshop was organized. 38 participants including Cluster Chief Executive, Hospital Q&S coordinators, department senior staff and previous RCA Team leader and members were invited to join in the workshop in order to review the RCA process, to look for the hierarchy of effectiveness of recommendations and to identify areas to be improved. The input and feedbacks from participants were very fruitful for future RCA.



Cluster Quality & Safety learning material @ iLearn

A series of teaching materials on patient safety were prepared and uploaded to iLearn to facilitate self-learning.



Cluster Incident Sharing Flyer - iSMART

NTEC safety alert flyer, iSMART, was issued monthly. Topics covered recent sentinel events and serious untoward events of high risk medications, patient suicide, wrong surgery and retained devices, and general knowledge including root cause analysis and new reporting template of AIRS 3.



Cluster Quality Flyer and Newsletter

In AHNH/TPH, NDH and PWH, flyers or newsletter were designed by individual hospitals for local purposes.



Cluster Risk Management and Patient Safety for training development for nursing staff

NTEC Q&S team was invited to conduct risk management and patient safety courses in One Nurse One Plan nursing training, development program as well as orientation program for new graduated nurses.



Hospitals Incident Sharing Forum – Risk Watch

Incident sharing forums, Risk Watch, were conducted locally in most of the hospitals bi-monthly or quarterly.



Hospitals Intern orientation and sharing sessions

In addition to the cluster-wide intern orientation in Jun, individual hospital Q&S held regular incident sharing sessions with interns. Over 80 interns had participated in sharing sessions in PWH. Most of them commented that the sharing was very useful to their work.



NDH Topic talks, forums or educational game booths on medication safety, patient suicide, fall prevention, reporting culture and patient safety for supervisors and frontline staff ; clinical governance, etc.



PWH Department Sharing

To provide individual clinical departments with more in-depth and specific information on quality and safety issues, on-site sharing were offered to 9 clinical areas by means of incorporating the sessions into their department meetings.

New Territories West Cluster

1. Structure



w.e.f.: 12 May 2014

Organisation Chart of NTWC Quality & Safety Division



2. Overview of Quality and Risk Management Issues

2.1 Medication and Chemotherapy Safety

To promote medication safety awareness and knowledge, a Medication Safety Campaign was launched by the Drug Administration Safety Committee (DASC) in 4Q 2013. A series of activities was introduced to raise the staff awareness in medication safety, which included the invitation of Medication Safety Quiz for training, the production of a half-hour interactive medication safety video and a Cluster-wide Medication Safety Forum in Mar 2014. Furthermore, DASC continued to review medication incidents and worked closely with clinical departments to minimise medication risks.





On the other hand, the Chemotherapy Advisory Committee also produced a handbook of cytotoxic drug extravasations and a commonly used cytotoxic drug list. In addition, Occupational Safety and Health (OSH) enhancement programs on chemotherapy drug handling implemented in the wards of Clinical Oncology Department, Paediatrics Oncology team and Medicine Haematology team were shared with the committee members. Recommendations made by the Labour Department after inspecting the Integrated Chemotherapy and Day Care Centre were also shared. Furthermore, the format of delivery label for all chemotherapy and target agents was modified to safeguard patient privacy.

2.2 Serious Clinical Deterioration (SCD) in TMH Acute General Wards

Four clinical indicators for SCD were introduced with regular monitoring. A validated tool was developed with adjustment done per local situations. The rates of Tuen Mun Hospital (TMH) and individual departments were monitored and reported quarterly to the Cluster Clinical Governance Committee, respective Chiefs of Service, Service Director of Quality and Safety Division, and Cluster Chief Executive through encrypted emails and presentations using graphs and tables. The SCD indicators under monitoring included the rate of death without Do Not Attempt Cardiopulmonary Resuscitation (DNACPR), the rate of cardiac arrest without DNACPR, the rate of unscheduled Intensive Care Unit (ICU) consultation, and the composite rate of the above. The project would go on by adding control limits for quality control when more data were available.

2.3 Informed Consent

In order to minimise the use of acronyms and abbreviations in informed consent, customised printing system for informed consent was developed and piloted in several clinical areas. With collaboration of Information Technology Unit, Quality and Safety Division and several clinical department representatives (i.e., Ear, Nose & Throat, Ophthalmology, Intensive Care Unit, Medicine & Geriatrics), a working group for custom-printed informed consent was formed. The workgroup support the design of customise the printing of important data fields included name of procedure, risks, side, name of doctor, date of signing, and associated fact sheets in the informed consent form. An intranet based webpage for consent form printing was also developed. Hyperlink would be uploaded at cluster website and/or committee/ department website for easy reach by users. Extra procedures including common risks/complications i.e. blood transfusion; procedural

sedation would be edited by request. The programme was piloted in late Oct 2013.

Positive feedback was received from users and the workgroup was enthusiastic in further promoting the usage of

custom-printed forms. Some subspecialties were advised to explore the need to add more consent templates. As at 31 Mar 2014, over 4800 copies of custom-printed consent forms were viewed and/or printed by pilot departments.

2.4 Nutrition Care Management

Following the recommendations made in the TMH hospital accreditation Periodic Review report in 2012, a consultant was invited to provide a consultancy on nutritional care management in the cluster. She and her team visited four hospitals in the cluster in Jun 2013. Areas such as clinical wards, kitchen and department of dietetics were visited. The consultancy team also talked with frontline staff in understanding the nutrition care management system in the cluster. Reports and comments for individual hospital in enhancing nutritional care were provided and followed up by the cluster Nutrition Care Management Committee.



Furthermore, the consultancy team was also invited to conduct a seminar, lectures and workshops in the cluster. Nearly five hundred attendees had joined the seminar. Staff awareness on nutritional care was aroused.

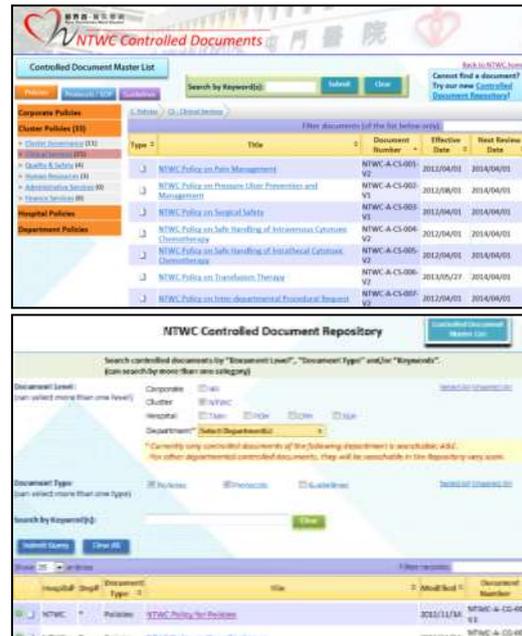
2.5 Mixed Gender Ward Management

To follow the HA Guidance for Mixed Gender Wards, a NTWC Mixed Gender Ward Management Committee was formed in 2013. The register of mixed-gender wards in the NTWC was updated in 3Q 2013 to effectively manage mixed gender issues. Notices of mixed-gender wards were posted up at all mixed-gender wards' entrance in 4Q 2013, a standard signage for toilet/shower room and cubicle was also installed in 1Q 2014. Further, a NTWC Policy on Management of Mixed-gender Wards was being drafted.

2.6 Document Control

To strengthen the document control system in the NTWC, the Policy on Document Control (version 4) was updated in Jan 2014.

Further, to allow frontline colleagues search controlled documents easily in the Intranet, the NTWC Controlled Documents Website with new layout and user-friendly search function was launched in Nov 2013. New features included the provision of a Controlled Document Master List and a Controlled Document Repository to facilitate keyword/category searching and the inclusion of departmental controlled documents in the Repository. To allow more departmental controlled documents to be searchable, clinical departments were invited to include their documents in the Repository by phases.



3. Risk Prioritization

3.1 Identified Risks for 2013-2014

Clinical Risks	
1	Patient Misidentification
2	Medication Error (Administration)
3	Patient Fall
4	Acute Deterioration (including difficult airway)
5	Medication Error (Dispensing)
6	Unanticipated Surgical Outcomes
7	Nosocomial Infection
8	Choking and aspiration
9	Transfer of critically ill patients
10	Team Communication
Non-clinical / Operational Risks	
1	Staff Turnover
2	Ward Congestion
3	Occupational Safety & Health (excluding Workplace Violence & Hospital Acquired Infection of Staff)
4	Long Waiting Time / Delay in Service
5	Equipment Breakdown
6	Workplace Violence
7	Alleged Indecent Assault
8	Unfavourable media reporting
9	Building Services Failure
10a	Security
10b	Insufficient Training & Supervision

3.2 Identified Risks for 2014-2015

Clinical Risks	
1	Falls
2	Nosocomial and Other Infection (Patient)
3	Medication Error (Administration)
4	Patient Misidentification
5	Clinical Deterioration & Choking
6	Suicide
7	Unanticipated Surgical / Procedural Outcomes
8	Specimen Handling
9	Awareness of important investigation reports
10	Patient Transfer
Non-clinical / Operational Risks	
1	Workforce planning / Staff turnover
2	Ward congestion & Inadequate physical space
3	Waiting time at Accident & Emergency (AED) / Specialist Out-patient Department (SOPD)/ Surgery
4	Occupational Safety & Health (exclude Workplace Violence)
5	Building service / facility failure
6	Workplace violence
7	Information security & privacy
8	Equipment failure
9	Project slippage & deliverable failure
10	Unfavourable Media Reporting

4. Risk Reduction and Quality Programmes

4.1 Review of 2013 Risk Reduction Programmes

Committees	Risk Reduction Programs
Clinical Audit Committee	<ul style="list-style-type: none"> ■ Developed Clinical Audit Bulletin at committee webpage ■ Conducted Clinical Audit Sharing meeting ■ Conducted Cluster Clinical Audit Programmes ■ Converted the disease specific data system (Dendrite System) into a cluster system
Correct Patient Identification Committee	<ul style="list-style-type: none"> ■ Organised sharing sessions to share good practices in preventing patient misidentification ■ Performed walk rounds in areas with high risk of patient misidentification by committee members ■ Presented certificates of achievement to wards /units achieving “Zero incident rate” or “Significant improvement”
Credentiailling Committee	<ul style="list-style-type: none"> ■ Developed the credentialing system in NTWC
Crew Resource Management Committee	<ul style="list-style-type: none"> ■ Conducted trainings on Crew Resource Management (CRM)
Decontamination Safety Committee	<ul style="list-style-type: none"> ■ Stopped using high strength alcohol for cleansing of metal surfaces in clinical areas ■ Documented environmental cidex-OPA vapour levels in clinical areas using semi-closed compact vapour control systems

Drug Administration Safety Committee	<ul style="list-style-type: none"> ■ Organised a Medication Safety MC Questions Submission Competition in Nov 2013 ■ Organised a Medication Safety Forum in Mar 2014 ■ Produced a Medication Safety Video and uploaded to the NTWC Intranet
Chemotherapy Advisory Committee	<ul style="list-style-type: none"> ■ Uploaded a handbook of cytotoxic drug extravasations, a list of commonly used cytotoxic drug and MSDS (material safety data sheet) for commonly used cytotoxic drug to NTWC intranet ■ Shared the Occupational Safety and Health (OSH) enhancement programmes on chemotherapy drug handling implemented in the wards of Clinical Oncology Department, Paediatric Oncology team and Medicine Haematology team ■ Shared the recommendations given by Labour Department after the OSH inspection in the Integrated Chemotherapy and Day Care Centre ■ Revised the format of delivery label for all chemotherapy and target agents to enhance patient privacy protection
Fall Prevention and Management Committee	<ul style="list-style-type: none"> ■ Organised a workshop with a renowned scholar in fall management in exchanging ideas in fall prevention ■ Educated staff on the correct use of Morse Fall Scale and Implemented prevention strategies according to patients' risks ■ Continue to promote the implementation of yellow-coloured vest for easy identification of high fall risk patients
Infection Control Committee	<ul style="list-style-type: none"> ■ Enhanced ward environment by using an one-step disinfectant in a general ward of Pok Oi Hospital (POH) ■ Conducted a wristwatch study to study the colonization of hospital bacteria on watches and stethoscope ■ Conducted an environmental cleansing study to evaluate the cleansing effectiveness of ward by measuring the ATP level pre- and post-cleansing in Medical & Geriatric (M&G) unit of Tuen Mun Hospital (TMH)
Informed Consent Committee	<ul style="list-style-type: none"> ■ Conducted informed consent process audit ■ Developed custom-printed Informed Consent ■ Revised a list of procedures not requiring consent
Nutrition Management Committee	<ul style="list-style-type: none"> ■ Invited an external consultant to conduct a consultancy service on nutrition care in NTWC ■ Educated staff on nutrition care ■ Educated staff on using of The Chinese Malnutrition Universal Screening Tool (HKC-MUST)
Pain Management Committee	<ul style="list-style-type: none"> ■ Introduced the sedation score for strong opioid usage ■ Enhanced pain management and assessment ■ Launched the pain resource recognition program for nurses and paramedical ■ Enhanced the pain team service in POH ■ Conducted a nursing audit on pain assessment and pain management ■ Enhanced pain management in Obstetrics unit ■ Conducted a training workshop on Understanding Psychological Issues in Pain Management & Basic Communicative & Counseling Skills in Pain Management

Patient Pacification Committee	<ul style="list-style-type: none"> ■ Conducted a pilot programme in introducing a new physical restraint decision making tool in 5 general wards. New limb holders for upper limb restraint were also trialed ■ A workgroup was formed to review the physical restraint policy, guideline and observation chart ■ Performed an audit on physical restraint in POH
Point of Care Testing (POCT) Coordinating Committee	<ul style="list-style-type: none"> ■ Conducted a train-the-trainer training of Drug of Abuse and Breath Alcolmeter
Pressure Ulcer Prevention and Management Committee	<ul style="list-style-type: none"> ■ Conducted certificate courses on pressure ulcer care ■ Developed a Central Inventory Management System of pressure relieving devices ■ Developed pressure ulcer resource kits ■ Provided video clips on turning and positioning of bed ridden patient and put it on Intranet
Procedural Sedation Safety Committee	<ul style="list-style-type: none"> ■ Enhanced the training programme for medical and nursing staff ■ Monitored the complication rate of sedation practice and benchmark with local and international standards ■ Enhanced the 'Train the trainer' course on procedural sedation ■ Used etCO2 monitoring for high risk patients ■ Conducted an audit on procedural sedation checklist
Resuscitation Committee	<ul style="list-style-type: none"> ■ Conducted training on Basic Life Support (BLS) by Clinical Skills Training Centre ■ Replaced conventional laryngoscopes by a disposable model
Single Use Devices (SUDs) Risk Management Committee	<ul style="list-style-type: none"> ■ Assured NTWC compliance with the corporate SUD policy ■ Faded out high risk Class II SUD based on the HAHO allocated budget and direction ■ Faded out 2 more high risk SUD as recommended by the HA Group Internal Audit Report 2012
Transfusion Committee	<ul style="list-style-type: none"> ■ Implemented the Blood Bank Compatibility Labelling to all blood components to include Fresh Frozen Plasma (FFP), Platelet concentrate, Cryoprecipitates and Cryo-reduced plasma ■ Implemented an Automated Blood Bank Analyser for blood grouping, antibody screening and identification ■ Established a Nurse Led Transfusion Service for thalassemia patient ■ Extended the protocol in management of Obstetrics & Gynaecology patients with massive bleeding
Trauma Advisory Committee	<ul style="list-style-type: none"> ■ Organised trauma management workshops and trauma rounds ■ Conducted a trauma audit

4.2 Quality Initiatives, including Accreditation

4.2.1 Clinical Governance

The Cluster Clinical Governance Committee (CCGC), formed in 2009, was responsible for the promotion of patient safety initiatives and clinical effectiveness, as well as advising the cluster management on actions which would improve patient safety and clinical

outcomes. Since Jan 2013, the CCGC had strengthened its membership from 16 to 20. Frontline colleagues, including associate consultants and a pharmacist, were invited to join as members to provide more precious feedback. The CCGC also enhanced its governance by introducing the review of clinical indicators, e.g. clinical indicator in monitoring of serious clinical deterioration in general wards.

On the other hand, the CCGC continued its roles in reviewing Root Cause Analysis (RCA) reports of serious incidents, monitoring the work of clinical risk-related committees, reviewing Mortality and Morbidity (M&M) cases, endorsing clinical risk-related controlled documents, reviewing reports of Patient Safety Walk Rounds and disseminating safe clinical practices through publication of bulletins.

4.2.2 Surgical Quality and Safety Circle (SQSC)

The SQSC was established to maintain Continuous Quality Improvement and ensure safety in the care of surgical patients. The care pathways of complicated surgical patients usually involve multi-interactions between different specialties and teams. Consequently, seven SQSC meetings were organized in 2013/14. The key performance indicators were reviewed and complex cases were selected for discussion by members from the Departments of Anaesthesia and Intensive Care, Surgery, and Quality and Safety Division according to a set of predefined criteria to ensure efficient and effective collaborative efforts and communication between parties.

4.2.3 Patient Safety Walkrounds (PSWs)



Building on favorable responses from onsite discussion with frontline staff and ward management on patient safety concerns, weekly Patient Safety Walk Rounds in TMH were conducted. In 2013/14, a total of 39 walkrounds in 86 clinical and non-clinical areas were carried out in TMH. On the other hand, 13 PSWs and over 40 PSWs were conducted for various departments of POH and Castle Peak Hospital (CPH) respectively in 2013/14.

To disseminate the good practices observed during PSWs, two sharing sessions were conducted in TMH and POH in Feb and Mar 2014 respectively with about 140 colleagues attended.

Further, the programme of Patient Safety Walk Rounds was highly recognized by external party. The programme had won the Excellence Award in the Asian Hospital Management Award (Patient Safety Category) which was held in Thailand in Sep 2013.

4.2.4 Development of NTWC Risk Registers

In 2013/14, the NTWC had developed the “NTWC Common Risks” which facilitated frontline departments in using standardized risk categories for identifying their departmental top risks.

On the other hand, the NTWC had adopted a more structured approach in establishing the risk registers in cluster, hospital and departmental levels. The risks were identified in a bottom-up approach which individual department provided their departmental risk register. The risks were consolidated and divided into clinical and non-clinical risks, which were rated, prioritized and endorsed by responsible committees, e.g. Cluster Management Committee, Cluster Clinical Governance Committee or Hospital Management Committee, to compile the cluster/hospital level clinical and risk registers. Risk custodians, i.e. subject officers or committees, of the top risks were then identified for risk mitigation action planning.



In order to let departments understand the development of departmental risk registers, two workshops were held in Jan 2014 with active participation by managers and frontline staff.

Risk Category	Code	Related To	Risk Category	Code	Related To
A Accessibility	A 1	High bed occupancy / rate	Q Medication	Q 1	Administration error
	A 2	Long waiting time (For 1st SOPD consultation)		Q 2	Dispensation error
	A 3	Long waiting time (For A&E consultation)		Q 3	Errors related to known drug allergy
	A 4	Long waiting time (For elective surgeries)		Q 4	Errors related to use of infusion pump / syringe pump
	A 5	Long waiting time (For emergent surgeries)		Q 5	Inappropriate storage of drugs
	A 6	Long waiting time (From registration to consultation)		Q 6	Prescription error
	A 7	Long waiting time (Others)	R Missing / Walk Away / Security	R 1	Access / Security control
	A 8	Patient overflowed to other specialties		R 2	Baby / Infant abduction
	A 9	Unplanned readmission		R 3	Disturbance / Nuisance
	A 10	Inappropriate use of hospital beds		R 4	Failure to return from home leave
B Blood Transfusion / Blood Product	B 1	Adverse transfusion reaction		R 5	Indecent Assault
	B 2	Blood / Component administration		R 6	Missing
	B 3	Blood / Component storage		R 7	Patient care in mixed gender ward
	B 4	Blood / Component transportation		R 8	Walk away / Absconder
	B 5	Blood taking related risk		R 9	Unauthorised video / photo taking / media interview
	B 6	Wrong ABO compatibility	S Occupational Health & Safety (Staff)	S 1	Exposure to dangerous/hazardous substances (e.g. chemical / electricity / explosives)
C Choking / Aspiration	C 1	Aspiration		S 2	Infection of staff at work
	C 2	Choking during feeding		S 3	Manual handling operations
D Communication	D 1	Failure in INTRA- / INTER-departmental communication		S 4	Poor air quality / ventilation
	D 2	Failure to communicate with patient / relatives		S 5	Radiation leakage
E Consent	E 1	Incomplete / Inappropriate consent form obtained		S 6	Sharps injury
	E 2	Illegible consent form		S 7	Theft / Burglary
F Corporate Related	F 1	Unfavourable media reporting	S 8	Unauthorized access	
	F 2	Poor reputation of hospital	S 9	Workplace violence	
	F 3	Non-compliance to legislative requirement	T 1	Accidental disposal of patient's property	

4.2.5 Clinical Audits

In 2013/14, archives of Clinical Audit Sharing Meeting were developed and publicized via the committee website. Also, clinical audit sharing meetings were re-scheduled at lunch hour from May 2013 onwards. A total of 258 participants had joined the sharing meetings in 2013/14.

On the other hand, nursing audits on pain management wound dressing and oxygen therapy, an audit on procedural sedation checklist and policy, and an audit on bedside procedures in NTWC were conducted in 2013/14.

Further, the Upper Gastrointestinal Cancer Management Program and Colorectal Cancer Management System were revamped and incorporated as a NTWC-wide system in 4Q 2013. Data were entered into the new system for program review. Real time clinical data monitoring was continued; such as

- 30-day post-op mortality case of Surgery will be retrieved monthly. The trend of event will be reported timely.
- Data on Serious Clinical Deterioration of TMH in-patients will be monitored monthly and sent to department heads for their information quarterly.
- OT performance indicators would be reported to committee chair quarterly and data will be benchmarked with other clusters.
- Records of cardiac pulmonary resuscitation (CPR) will be reviewed monthly included no. of CPR performed per 1000 Bed days, immediate survival rate after CPR, 28-day survival rate after resuscitation, rate of CPR performed with support from resuscitation team, doctor's response time, discrepancy of reported CPR episodes between Clinical Data Analysis and Reporting System (CDARS) and hospital records.

4.2.6 Correct Patient Identification (CPI)



The CPI Committee continued to review incidents related to patient misidentification. Site visits were conducted by core members of the committee to locations which were identified with potential environmental risks leading to the occurrence of past incidents. In addition, patient-caring units which had achieved a “Zero Incident Rate” or a “Significant Improvement” were given certificates to recognize staff efforts in ensuring correct patient identification.

4.2.7 Fall Prevention and Management

i. Education on Fall Prevention

In Jun 2013, the fall prevention and management committee had organised a half-day workshop with Professor Jacqueline Close, a renowned scholar in fall management. The workshop led to fermentation of novel ideas in fall prevention, such as recruiting sitters for specific groups of fall-prone patients. The idea would be piloted in a rehabilitation ward in collaboration with the community services centre.



ii. Education on Morse Fall Scale

A training workshop on the use of Morse Fall Scale (MFS) was conducted in collaboration with the Clinical Skills Training Centre in Aug 2013. Forty frontline nurses had participated in the one-hour workshop. An education session on fall management had also been included as one of the topics in the orientation for house officers.

iii. Fall Prevention in Castle Peak Hospital (CPH) and Siu Lam Hospital (SLH)

The Fall Risk Assessment and Intervention Record (MR102517/NTWC) was revised in Apr 2013 with choice of ‘determined by clinical judgment’ added. Also, a fall audit in CPH and SLH was conducted on 16 Dec 2013. Non-slippery footwears were also provided and alarm mats were used for elderly patients in Department of Old Age Psychiatry. Two educational talks on Fall Prevention to supporting staff and nurse learners were also conducted on 21 Feb 2014 with total attendance 114. In SLH, a physical visit would be paid after each fall incident by the hospital fall coordinator to review the incident and offer advice when necessary. The revised version of the NTWC Fall Prevention and Management Guideline was also promoted to all the SLH nursing staff.

4.2.8 Physical Restraint

In order to trial the effectiveness of a new physical restraint decision tool, a pilot programme was run in 5 general wards in TMH from May to Sep 2013. The results were reviewed and the observations were reported to the Patient Pacification Committee in 1Q 2014.

Further, a register for physical restraint had been set up for CPH wards, with access rights granted to all ward managers for better learning and sharing. Analysis on the register would be conducted regularly with results reported to the hospital clinical governance committee.

4.2.9 Pain Management

Sedation score during the use of strong opioid by editing sedation scale into the Pain Assessment form was introduced in various departments. The sedation score would be assessed during the use of strong opioid according to the department guideline. Also, 1376 attendants underwent the Unit 1 and Unit 2 pain management training in Jun 2013 while 17 nursing staff had attended the certificate course in Unit 3.

Also, cross audit on Pain Assessment & Management in TMH was conducted in 3Q 2013. Training workshops on Understanding Psychological Issues in Pain Management, and Basic Communicative and Counseling Skills in Pain Management were also held in Sep and Nov 2013 respectively, and an ongoing workshop of Understanding Psychological Issues in Pain Management was conducted since Feb 2014.

4.2.10 Pressure Ulcer Prevention and Management



The cluster Pressure Ulcer Prevention and Management (PUPM) Committee had organized four training courses on pressure ulcer management for healthcare professional and supporting staff in 2013/14, with sixty-six professional staff and forty supporting staff joining.

On the other hand, pressure ulcer preventive devices including cushions, foot blocks and adjustable wheelchair were purchased and distributed to clinical areas. To enhance frontline staff's knowledge on applying the devices, briefing sessions were conducted to receiving sites by experienced Occupational Therapists. In addition, a central inventory management system of pressure ulcer preventive devices was formulated and managed by a member of the cluster PUPM Committee.

In CPH and SLH, an e-reporting system of pressure ulcer was launched to all CPH and SLH wards in Feb 2013. Also, all pressure ulcer data of the previous month would be reported online to Nursing Services Division within the first seven days at the beginning of each month. The first Pressure ulcer prevalence survey was conducted on 12 Dec 2013 at 12 noon with return from all SLH Wards with prevalence rate of 1.04%.

4.2.11 Procedural Sedation Safety

To enhance staff knowledge and skill in procedural sedation safety, two colleagues had attended the Enhancing Safety in Sedation (ESS) Workshop 2013-2014, while two colleagues had attended the Hong Kong Simulation Instructors' Course.

On the other hand, the use of end-tidal CO₂ monitoring for high risk patients was used to enhance patient safety with accessories purchased for the pilot run. In addition, an audit on procedural sedation safety checklist and sedation policy was completed in 4Q 2013. A custom printed informed consent for procedural sedation was also implemented since Jan 2014.

4.2.12 Radiation Safety

To enhance staff's knowledge and awareness in radiation safety, Radiation Safety Forums were conducted in POH and TMH in Jun 2013 and Mar 2014 respectively. Clinical departments were also encouraged to produce their local rules in coordination with the Cluster Radiation Protection Advisor, which would uphold radiation surveillance and protection measures.

4.2.13 Patient Focus Groups

In 2013/14, patient focus groups for Physiotherapy Department and ethnic minority patients in POH were organized. A health talk on common musculoskeletal pain with mini health check for ethnic minority patients was also held in CPH. Through a face-to-face meeting between department management and participants, patient needs and service concerns were identified. Feedbacks which included the provision of patient charter and health information in different languages were followed up.

In CPH, three discussion and debriefing meetings of Patient Focus Group were held on 24 Apr 2013, 19 Aug 2013 and 6 Nov 2013 respectively.

4.2.14 Patient Satisfaction Survey in NTWC

The Hospital Authority had launched a hospital-based Patient Satisfaction Survey in 2013. For the NTWC, Tuen Mun Hospital was selected for the survey and the sample size of discharged inpatients was 530. The survey, with an aim to better understand the needs of patients, as well as their experience, feeling and satisfaction level in receiving services of hospital for the purpose of continuous service improvement, was conducted by the School of Public Health and Primary Care of the Chinese University of Hong Kong during Nov 2013 to Jan 2014.

4.2.15 Hospital Accreditation Scheme

i. Tuen Mun Hospital (TMH)

Within Year-3 of the Evaluation and Quality Improvement Programme (EQuIP) cycle, the annual Self-Assessment Support Services (SASS) review report was completed and submitted to the Australian Council on Healthcare Standards (ACHS) in Sep 2013, 10 out of



13 recommendations from the Periodic Review (PR) in 2012 were completed. With the 2nd Organization-wide Survey (OWS) of TMH scheduled on 15-19 Sep 2014, the TMH Hospital Accreditation Taskforce held monthly meetings to formulate preparatory work since Oct 2013. The Hospital Accreditation Website of TMH was revamped to provide more information with easier access. Starting from Jan 2013, subject criteria team meetings were held to prepare for the Self-assessment reports (SAR). For staff engagement before the OWS, 14 monthly staff communication forums were scheduled in 2014 with experts from different disciplines to share topics in their related areas.

ii. Pok Oi Hospital (POH)

Before the Organization-wide survey (OWS) was conducted during 24-27 Jun 2013, the POH Hospital Accreditation Resource Centre coordinated with subject criteria teams within the hospital, as well as members of the POH Accreditation Taskforce in the preparatory work.



Improvement plans were completed with respect to the Priority Action Items put forward in the consultancy report of the Gap Analysis which was completed in Aug 2012. Eight communication forums were organized in 2013 for staff information and engagement. Twelve sessions of department visits were being organized to 32 units in POH before the OWS in Jun 2013, to support various clinical departments and service units in quality improvement and enhancing safety. In Sep 2013, Pok Oi Hospital received a 4-year full accreditation status from the surveying team of the ACHS, with Extensive Level Achievements in six areas of the EQuIP standards.

iii. Castle Peak Hospital (CPH)

The gap analysis exercise of the CPH accreditation programme was conducted on 20-23 May 2013. A number of improvement works had been made in addressing the priority action items suggested by the consultants. To count a few notable



examples, a number of guidelines were formulated to set out clear standards in managing the risks and needs in areas such as end-of-life care and physical pain of psychiatric in-patients. Quality and risk management systems were augmented through building a structured workflow for incident and complaint management, and setting up platforms for learning and sharing. Besides closing the gaps identified during gap analysis, the CPH accreditation team focused on the engagement with frontline staff in the preparation for the organisation wide survey, which would be conducted in May 2014.

4.2.16 Other Quality Improvement Programmes in Psychiatric Services

i. Choking Prevention in CPH

Two briefing sessions on “Prevention of Choking” were conducted to supporting staff of CPH and SLH with 91 attendants. Also, choking incidents, collected from Advanced Incident Reporting System (AIRS), were monitored for trend analysis. Furthermore, an audit on management of choking was conducted in Jan 2014.

ii. Excessive Water Drinking Behaviour in CPH

Data was collected for analysis to check the effectiveness of the guideline. A comprehensive behavior modification program with education package was formulated in ward A001 for caring of patients with excessive water drinking habit. Significant reduction of incidence of body weight increased 5% or above as compared with the baseline body weight was observed from these patients. Also, an audit on the implementation of the guideline would be conducted by Nursing Audit Committee in mid of 2014.

iii. Management of Patient Violence in CPH

Guidelines on physical restraint and chemical tranquilization were developed and implemented. Also, a structured violence assessment tool, Dynamic Appraisal of Situational Aggression, was implemented to assess the imminent violent risk of patient since 1 Feb 2014 after the pilot use in 10 admission wards in Nov 2013.

Furthermore, the restraint and seclusion registers were kept in the Central File System by Nursing Services Division. Access rights were granted to ward managers for analysis and evaluation. Training package for Management of Violence was revised since 1 Apr 2013. Level I & II Management of Violence Training which were mandatory for staff with direct contact with patients were conducted. On the other hand, level III Control & Restraint

Training which was recommended for staff with designated duty of Control and Restraint was conducted. Moreover, an operation guideline on Nursing Management System on Violence in Psychiatric Settings would complete its revision in Apr 2014.

iv. Psychiatric Nursing Discharge Summary (PNDS) in CPH

Psychiatric Nursing Discharge Summary (PNDS) utilization rate was well monitored and maintained at 100% compliance rate. Figures on PNDS utilization rate in the NTWC were collected from HAHO Information Technology Department and disseminated to wards regularly.

v. Departmental Patient Safety Round in CPH

Over 40 patient safety rounds were conducted by various teams in CPH in the past year. Different issues were identified and the related follow-up actions were implemented accordingly.

vi. Hospital Inspection and Safety Round in CPH and SLH

Monthly Inspection and Safety Round had been conducted by the hospital senior management. The communication with frontline was fruitful. Valuable feedback on workflow and hardware had brought about enhancement of service provision. For CPH, important issues like infection control, resuscitation safety, suicide risk, etc. were always amongst our major concerns. For SLH, important issues like infection control, medication safety, pressure ulcer, choking, nursing documentation, data privacy and fall etc. were brought to the concerns. The management would share with respective units the good practices and recommendations for improvement through various channels.

vii. Hospital Resuscitation Drill in SLH

33 resuscitation drills included 1 conducted in the hospital vicinity with 223 nurse participation to enhance nurses' knowledge and skill.

5. Learning and Sharing Information

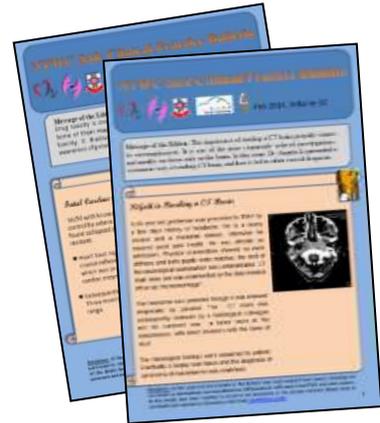


5.1 Patient Safety Newsletter

To promote learning and sharing of patient safety issues to the frontline staff, the Q&S Division started to published a patient safety newsletter named “Patient Safety Tips” to remind staff on the importance and salient points of different patient safety topics, e.g. correct patient identification, septic management in transfusion and medication safety.

5.2 Safe Clinical Practice Bulletin

To promote safe clinical practice and arouse junior doctors' interest and discussion of various clinical risks, the Editorial Board invited Chiefs of Service and Chairpersons of clinical risk-related committees to submit practical cases, expert opinions and take home messages for sharing among frontline doctors via the Safe Clinical Practice Bulletin. A total of 12 issues of the 2-page bulletin were published and uploaded to NTWC intranet in 2013/14.



5.3 Breakfast Gathering with Interns

Four breakfast gatherings were conducted for TMH interns in 2013/14 to build up friendship and a sense of belongings in the NTWC. During the gatherings, intern supervisors of individual departments provided brief introduction to their departments while representative of Quality and Safety Division shared safety concerns in clinical practices with interns.



5.4 Internal Trainings in Q&S Division

Fifteen sessions of Q&S internal trainings were conducted in 2014 to enhance staff competency and knowledge related to quality and safety. Senior staff in different teams took turn in giving lectures to all staff in Quality & Safety Division. Awards were presented to the top three active participants at the end of each training series. Lecture notes were also uploaded to Q&S website for sharing.

Besides, to enhance staff competency through sharing of contemporary knowledge in quality and risk management and to cultivate a continuous learning culture in Q&S Division, the Q&S Weekly Academic Meeting was commenced since Mar 2014. Journal and Topic presentations were conducted in alternate week.

Journal presentations were led by Executive Officer (EO) II grade staff while Topic presentations were led by EO I grade staff or above. Awards were presented to the top 3 active participants at the end of each quarter, best presenter of journal presentation and topic presentation. Participants and supervisors' evaluations would each contribute 50%.





5.5 Crew Resource Management Training Programme



It is well known that many medical errors are caused by poor teamwork and communication breakdown. Crew Resource Management (CRM) training encompasses a wide range of knowledge, attitudes and skills on teamwork, communications, situation awareness, problem solving and decision making. In the early of 2013, a multidisciplinary team including physicians and nurses was formed with the assistance of CRM expert from consultancy. A Train-The-Trainer workshop with special emphasis on debriefing skills was held and a group of healthcare professionals were equipped to become simulation-based CRM instructors. Subsequently, a locally adopted simulation-based CRM curriculum for healthcare professionals was formulated, which involved high-fidelity

simulators and moulage. In the simulation session, participants are required to practice CRM principles through communication and decision making under a clinical crisis, after which they were debriefed by facilitators in team approach. Fourteen workshops with over 200 professional staff participated in the CRM workshops in 2013-14. Positive feedback was received.

5.6 Intra-hospital Transport of Critically Ill Adult Patients

The Working Group on Cluster Intra-hospital Transport of Critically Ill Adult Patients was formed in 2011 with members from Departments of Accident and Emergency, Intensive Care Unit, Medicine and Geriatrics, Surgery and Quality and Safety Division. In 2013/14, four Intra-hospital Transport of Critically Ill Adult Patients workshops were organised for NTWC staff and over 50 staff had completed the training. In POH, in alignment with the Cluster policy on Intra-hospital Transport of Critically Ill Adult Patients, the Checklist for Intra-hospital Transport and Escort of Critically Ill Adult Patient was updated and applied as official hospital record.

5.7 Clinical Skills Training Centre (CSTC)

Clinical Skills Training Centre (CSTC) is one of the training sites in NTWC. It was established in 2009 and was continuously providing trainings to NTWC staff. CSTC is providing four theme of training. The first theme is Emergency training such as Adult Resuscitation workshop and Neonatal Resuscitation workshop. The second theme is Ward procedures training such as Chest Drain workshop and Suture workshop. The third theme is Suite procedures such as Endoscopy workshop and Laparoscopy workshop. The fourth theme is Communication workshop such as Acute Brief Support workshop.

In 2013/14, CSTC had organized 184 workshops, including 52 types of courses.

Over 3000 colleagues had attended these courses. In the future, CSTC would plan to organize more diversification training such as work-life balance training, ultrasound interpretation workshop and PEG workshop to NTWC staff.

5.8 Basic Life Support Training

In view of the changes associated with the new guidelines 2010 from American Heart Association and European Resuscitation Council and to get in line with the Australian Council on Healthcare Standards (ACHS) recommendations in hospital accreditation, Clinical Skills Training Centre (CSTC) had launched an in-house training of Basic Life Support in Jul 2011. The objective of which was to convert such training for all healthcare providers (doctors, nurses and allied health professionals) in the cluster. As a result, 44 in-house BLS practicum workshops were conducted and 2 in-house BLS train the trainer workshops in 2013/14.



5.9 MTR Visit

Staff of the Mass Transit Railway (MTR) Corporation paid visits to TMH on 25 and 27 Nov 2013. It was part of the Integrated Staff Development Programme (ISDP) of the company. A total of 32 participants joined the visits. Representatives from TMH, POH and CPH were invited to share good practices to MTR staff. In addition, a visit to the CSTC was arranged after the sharing. Participants had a chance of understanding how our professional staff were being trained. They were impressed by the effort of TMH in engaging staff in continuous quality improvement.

5.10 Staff Training on Quality Journey

A session named “Introduction of NTWC Quality Journey” was included in the Orientation and Induction Programme to all newly joined staff. In addition, two 2-day training workshops on “Process Improvement” were provided to clinical and administrative staff. During the workshop, identification of values and application of quality tools in healthcare were illustrated to trainees, with hands-on exercises. Up to 31 candidates had participated in the training over the year.

5.11 Quality Sharing Forums

Thirteen Continuous Quality Improvement (CQI) forums were held in 2013/14, which the forums served as a platform for colleagues from different departments to share their suggestions and ideas. Starting from 2013/14, extra CQI forums were allocated for POH CQI projects to encourage POH staff’s participation and recognize their



efforts in continuous quality improvement. Within this year, a total of thirty-seven departments have presented their projects in the forums, attracting an audience of over 1,100 staffs. Kaizen coordinators and alumni were invited as judges in the forums to provide feedback on the projects.

5.12 Communicating Workshops for Junior Doctors

In response to the results of HA-wide Patient Satisfaction Survey (PSS) conducted in 2010, NTWC had organized 4 intensive simulation training workshop since Nov 2012 to enhance the communication skills of junior doctors with less than 2 years of clinical experiences. The objectives of the workshop are to highlight the importance and benefits of effective doctor-patient communication, to improve the communication skills of the doctors and to help cultivate a caring culture in the NTWC hospitals. The half-day workshop comprised lectures, role-plays and group discussions. The workshops were held quarterly with 8 doctors participated in each workshop. As at Mar 2014, 32 doctors had attended the workshops and the feedback showed that the training would definitely help them in daily work.

5.13 Department Visits

11 visits to various departments in NTWC had been conducted from Apr 2013 to Mar 2014. The issues on quality and safety as well as the scope of Patient Relations Officers (PRO) services were discussed. The visits were well-received and the feedback from the participants was good.

5.14 Complaint and Incident Sharing Sessions

Complaint and Incident Sharing Sessions were held at TMH, POH and CPH regularly. Doctors, nurses, allied health professionals and frontline supporting staff from various departments were our target audience. The sharing session was a treasurable opportunity for PRO 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 Patient Safety Officer (PSO) with staff of different departments. Seven sharing sessions were held in NTWC from Apr 2013 to Mar 2014.

5.15 HA Annual Seminar on Complaint Management

HA Annual Seminar on Complaint Management – “Patient-centered Care – Why?” organized by the Central Committee (Complaints Management & Patient Engagement) of HAHO was held on 20 Nov 2013. One of the programmes called ‘Mediation Skills Training Programme’ introduced the essential mediation skills for day-to-day communication with the public, patients and co-workers. Dr Y C WUN, Cluster Coordinator (Q&S) and Dr K S YEUNG, Executive Partner(Q&S) were the NTWC representatives of the working group. The PRO team and M&G of NTWC also took part in the filming on 1 Nov 2013.

5.16 Mediation Skills Training Programme

After the overwhelming responses in the annual seminar, the level 1 mediation skills training programme was organized quarterly in different clusters. Dr Y C WUN, Cluster Coordinator (Q&S), Dr K S YEUNG, Executive Partner (Q&S), Senior Manager (PR&E) and PRO were invited as the facilitators. Additional session has been held in HAHO on 20 Dec 2013.

5.17 Medication Conference

Department of Justice of The Hong Kong Special Administrative Region (HKSAR) in collaboration with Hong Kong Trade Development Council, a mediation conference on 20 and 21 Mar 2014 (as part of the Mediation Week held in the fourth week of Mar) at Hong Kong Conference and Exhibition Centre. 4 Chief of Services, 4 General Managers/Department Operation Managers and 2 allied health colleagues of NTWC had attended the conference.

5.18 Visit and Meeting with Thailand Patients' Delegation

The visit with Thailand patients' delegation was led by Mr Charlie YIP, a Hospital Governing Committee member of TMH, as well as an executive committee member of Hong Kong Alliance of Patients' Organization (HKAPO, 病人互助組織聯盟). It was actually part of the Twinning Programme (香港與泰國病人組織配對計劃) collaborated between HKAPO and the Heart to Heart Foundation (HHF) in Thailand. Fifteen Thailand Patients' delegate and 5 members of HKAPO had joined the meeting at CPH on 5 Dec 2013 for the main purpose to understand the public hospital services in Hong Kong. Cluster Manager (Q&S) and Patient Relations Officer had also participated and presented in the meeting.

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Published by the Quality and Safety Division
Hospital Authority
Hong Kong

February 2015

Available from www.ha.org.hk/visitor

