Performance Monitoring

Power of Information

Hospital Authority Convention
6 May 2008

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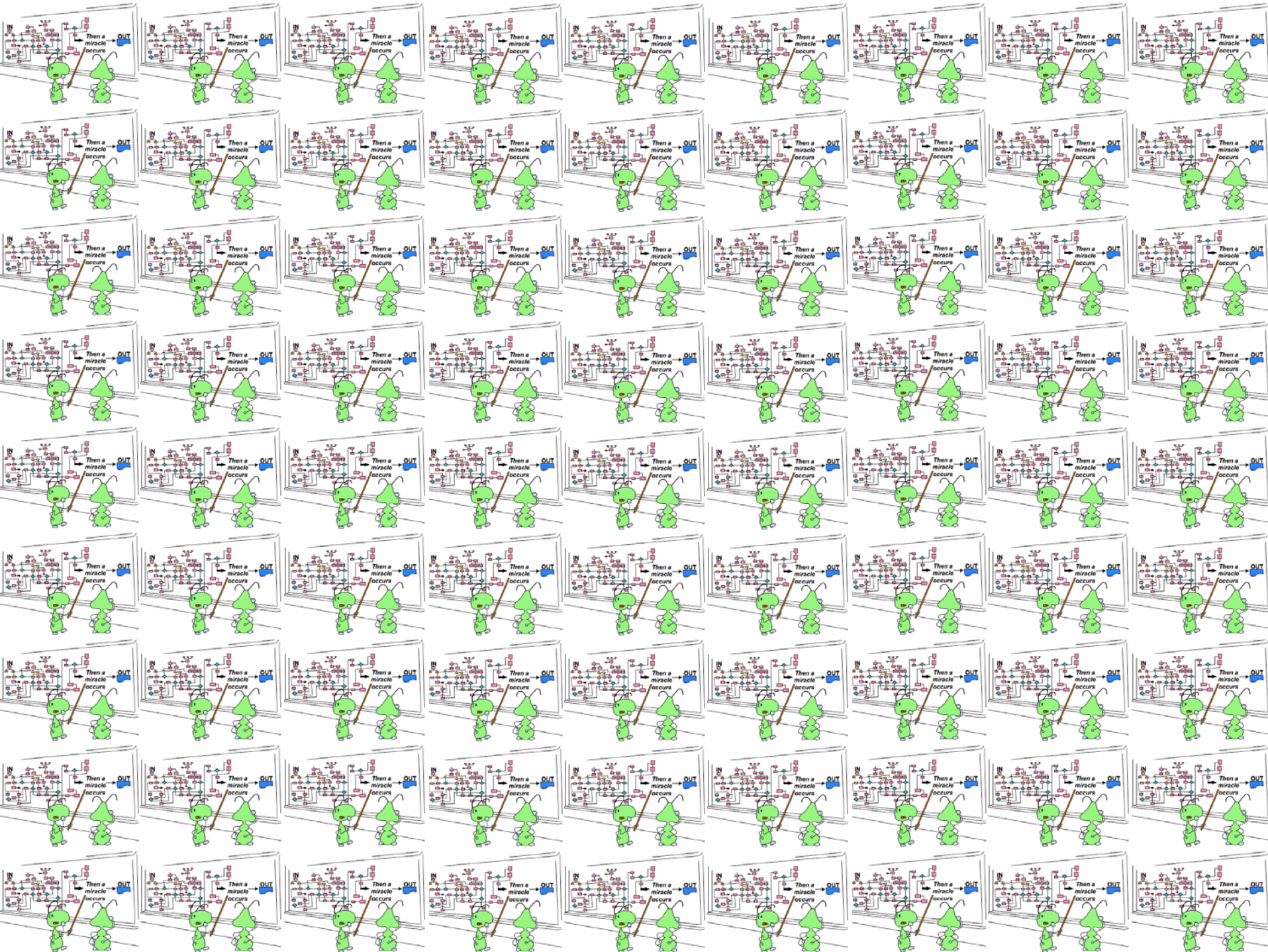
Quality & Safety Division

醫院管理局
HOSPITAL AUTHORITY


IN
Then a miracle occurs
OUT

Silence Kills

- 84% of physicians, 62% of nurses & other clinical-care providers have seen coworkers taking shortcuts that could be dangerous to patients
- 88% of physicians, 48% of nurses & other clinical-care providers worked with people who show poor clinical judgment
- <10% ...directly confronted their colleagues about their concerns, & 1 in 5 physicians said they have seen harm come to patients as a result

A survey by American Association of Critical-Care Nurses & VitalSmarts, 2005

Attend to causes...

(Factors that shape outcome)

菩薩畏因，眾生畏果

iff you are aware

1. Can I decide wisely on things that I understand only vaguely?
2. Will others agree with me if only I understand?

HEROES AND MARTYRS OF QUALITY AND SAFETY

Ernest Amory Codman MD

- The first to institute M&M meetings in surgery
- Lost his staff privileges in 1914 (plan to evaluate surgeons' competence)
- Resigned, set up his own hospital, & published 'end results' – including errors – publicly

Unlike others he made a lifelong systematic effort to follow up each of his patients years after treatment and recorded the end results of their care. He recorded diagnostic and treatment errors and linked these errors to outcome in order to make improvements. He was sufficiently disgusted with the lack of such outcomes evaluation of care at the Massachusetts General Hospital where he was on the staff that he resigned to start his own private hospital which he called the "End Result Hospital".

From 1911 to 1916 there were 337 patients discharged from Codman's hospital. He recorded 123 errors and measured the end results for all these patients. He grouped errors by type. There were errors due to lack of knowledge or skill, surgical judgment, lack of care or equipment, and lack of diagnostic

"Every doctor cares more for his reputation than his efficiency and is tempted to spend his time in
than increa

"It's not about good or bad people, it's just people." *Freakonomics*

outcome of care. He sent

hospitals throughout the country challenging them to do the same. If he were alive and with you today, he would ask in a

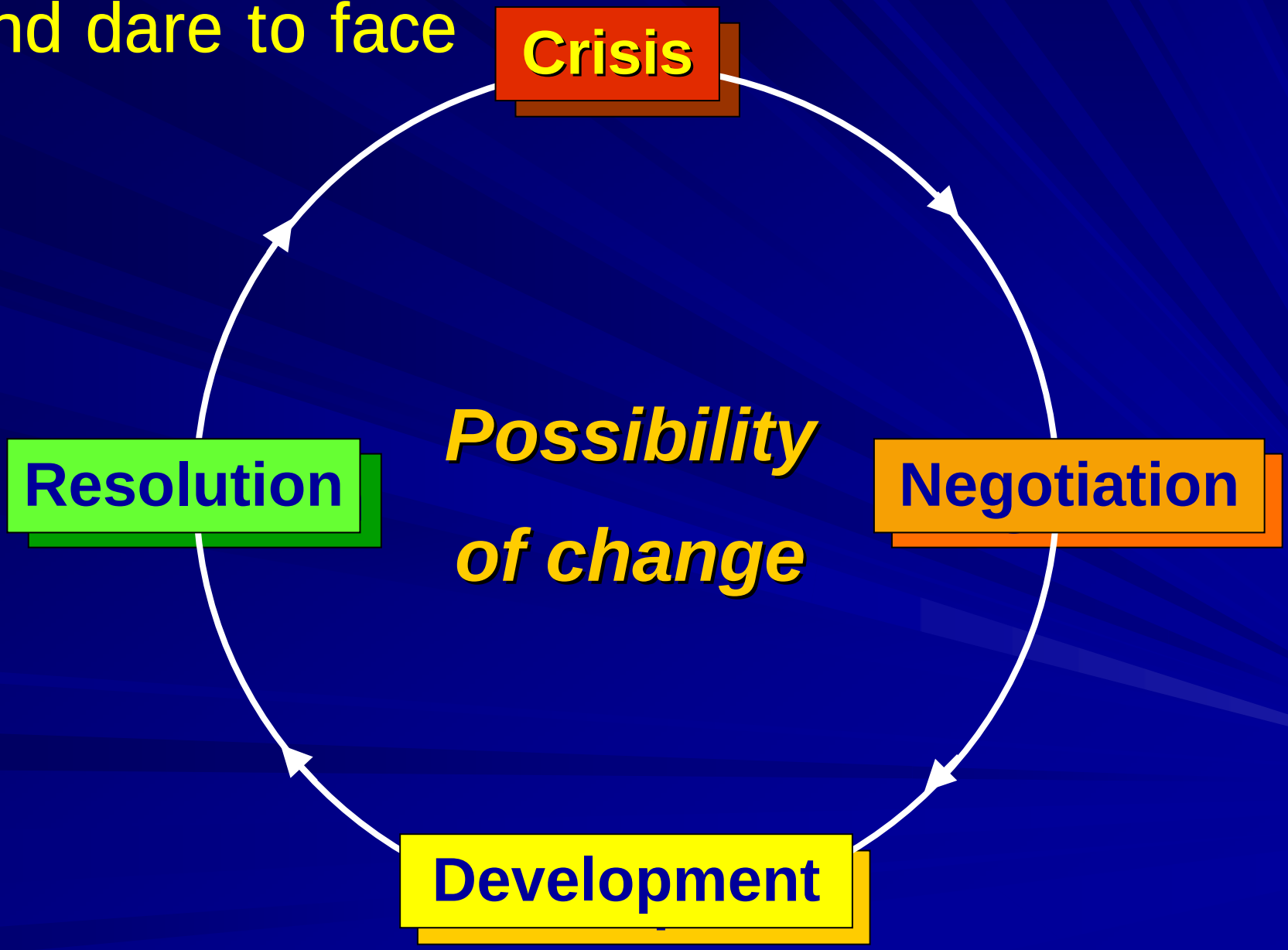
self-deception, hypocrisy, smugness, cupidity and injustice"

Performance Monitoring is...

Transparency

Ideas must be done to exist

To grow, be willing to be surprised, and dare to face



1. Crisis

前列腺炎折騰 政府削資源靠害

專科等三年病翁服鼠藥

◆本報訊 食環署外判清潔男工，疑被前列腺炎折騰，生無可戀，被迫提早退休醫病，惟公立醫院排期三年才可睇專科，他難堪長期受痛苦，昨日第二度企圖自殺，在元朗寓所服食老鼠藥，幸兒子及時發現報警獲救。

遭政府削資源所累的姓張老翁（六十二歲）與妻及三子（七至十七歲）同住大棠村。昨晨十一時許，張吞服老鼠藥後躺在床上，因身旁放有老鼠藥，長子發現報警，將父親送院搶救，警方調查後相信張因病厭世。

張妻稱，丈夫住大棠村數十年，曾靠耕種及養鴿維生，其後轉職食環署外判清潔工，本應六十五歲退休，惟數年前患前列腺炎，痛得無法工作，被迫提早退休。張曾到公立醫院求診，惟須排期三年才能到泌尿專科覆診，他因痛苦難耐，遂向朋友借錢到內地做手術，每次約一千元，但療效不理想。

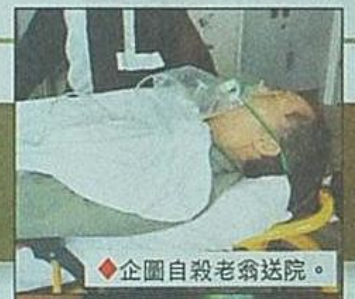
前列腺炎服藥可治愈

去年，張企圖服殺蟲水自殺，但不忍丟下妻兒而放棄死念，由於經濟拮据，一家近月領取綜援金維生。

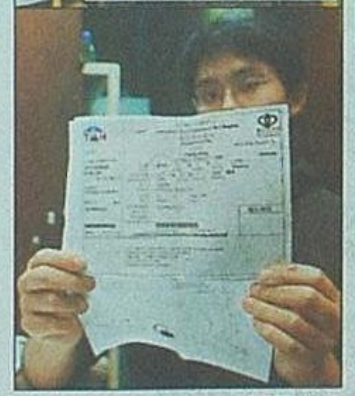
泌尿科醫生郭家麒稱，前列腺炎毋須動手術，病人只需服用藥物或抗生素及妥善治療便會康復。至於要動手術切除的，通常是前列腺肥大，病人小便會有困難，但不會痛楚。

前列腺炎是男士常見泌尿疾病，疼痛範圍不單在陰莖部分，有機會擴散至下腹、大腿內側，甚至影響性生活，堪稱男人最痛，病人情緒亦會大受困擾。

病人因前列腺肥大在公立醫院排期進行切除手術，輪候時間長達六至十二個月，醫管局正考慮透過招標方式外判前列腺手術，縮短病人輪候時間，病人日後可能獲資助到私家醫院做手術。



◆企圖自殺老翁送院。



◆張的兒子展示父親需排期三年的覆診紙。

→ HA Flagship Project “SOPC Waiting Time”

2007 –

2. Negotiation

- Write off debts/sunk cost
- Explore
- Unravel assumptions & ideologies behind interpretations

Seek to understand...
not to be understood

- Observe human psychology... mustn't antagonize or scare people off

3. Development

To open up possibilities

→ Explore weak links*... that define quality*

→ To make possible change, track system, process, accountabilities

→ Reveal  & debunk myths 

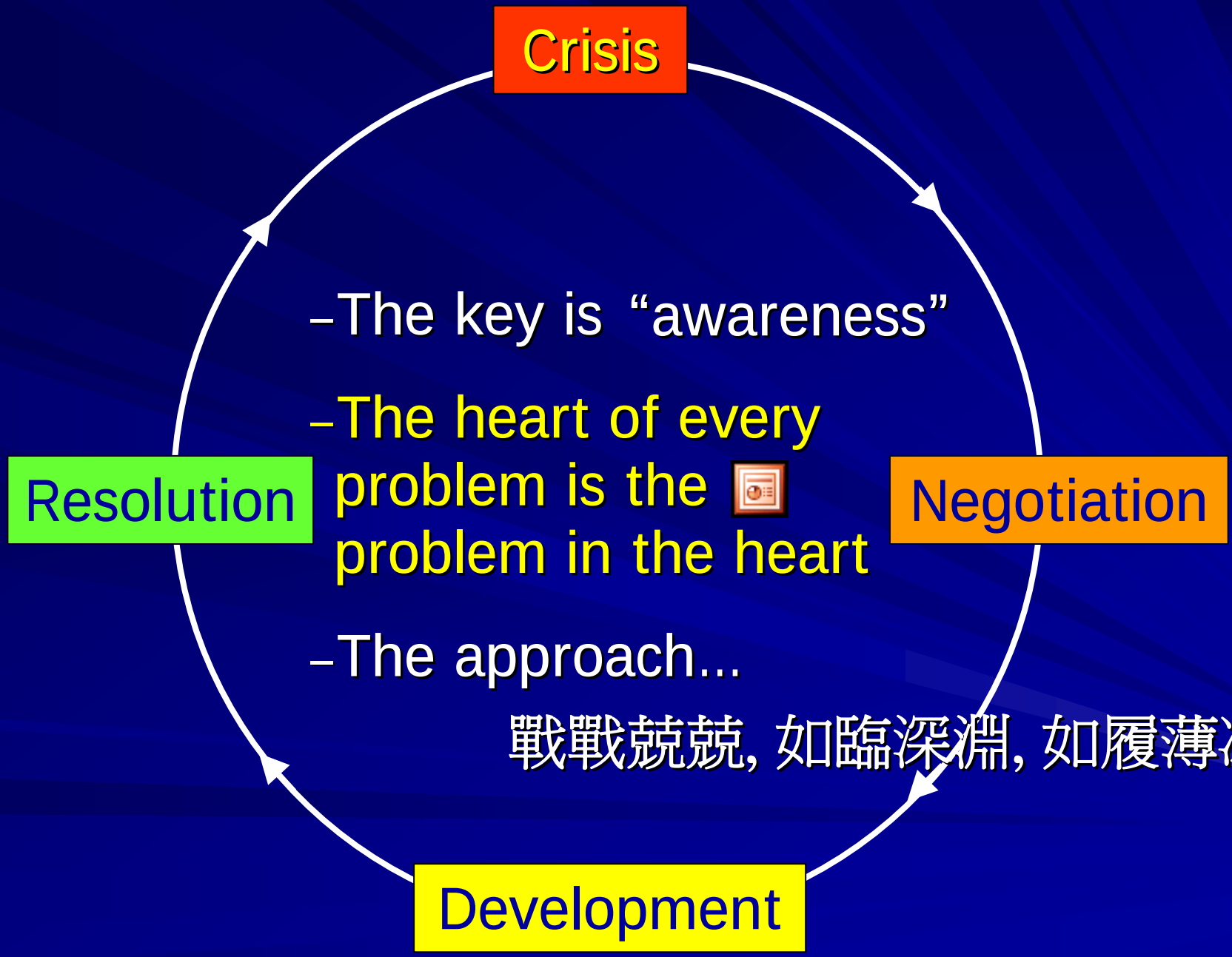
4. Resolution

- Exposing a condition and...

  the underlying belief / misbelief

  could make us aware of what it entails, and hence, open up insights of possible resolution

一即一切 一切即一


Crisis
Negotiation
Development
Resolution
–The key is “awareness”
–The heart of every problem is the problem in the heart
–The approach…
戰戰兢兢, 如臨深淵, 如履薄冰

The Way Forward...

- Leverage the power of information
- Sustain it

$\rightarrow$ habit $\rightarrow$ culture

- Ride on I T (data mining )
  - Engineer work process → carers document data as part of routine patient care
  - Align policy, structure & process

    ...down to operation
  - Monitor, analyze & report (watchdog)

    ...up to top management

Let people own what they owe:
Carers care, managers manage

In Summary

1. An objective basis to engage...
2. Understand through benchmarking
3. Debunk myths
4. Reveal signs of trouble
5. Stimulate innovation to overcome perceived inadequacy of data & indicator design
6. Enable learning
7. Drive change
8. Evidence of commitment

Caution

1. Let not the perfect be the enemy of the good
2. “It takes two to speak the truth: one to speak, and another to listen.” HD Thoreau
3. All would mean nothing unless new understanding brings forth different actions

More Examples

1. ‘Timeliness of Rx’ of malignant conditions, *08/09 –*
2. Surgical outcome monitoring & improvement program (SOMIP), *07/08 –*
3. DM care (process & outcome) monitoring program, *06/07 –*
4. Blood utilization, *08/09 –*

Acknowledgment

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