Quality & Safety

醫院管理局
HOSPITAL AUTHORITY

A new era of working together for a safer and better healthcare system for our patients and staff

Dr. Lui Siu Fai
Consultant (Q&RM), HAHO
Chairman, Central Committee Quality & Risk Management


威院打錯針－昏迷20日終拔喉

小琳玉殞家人誓究責

守候病榻半月 盼女友別牽掛

癡情男友忍淚含笑送

小琳遭打錯化療針事件簿


威院打錯針累死人

調查報告指人為錯誤

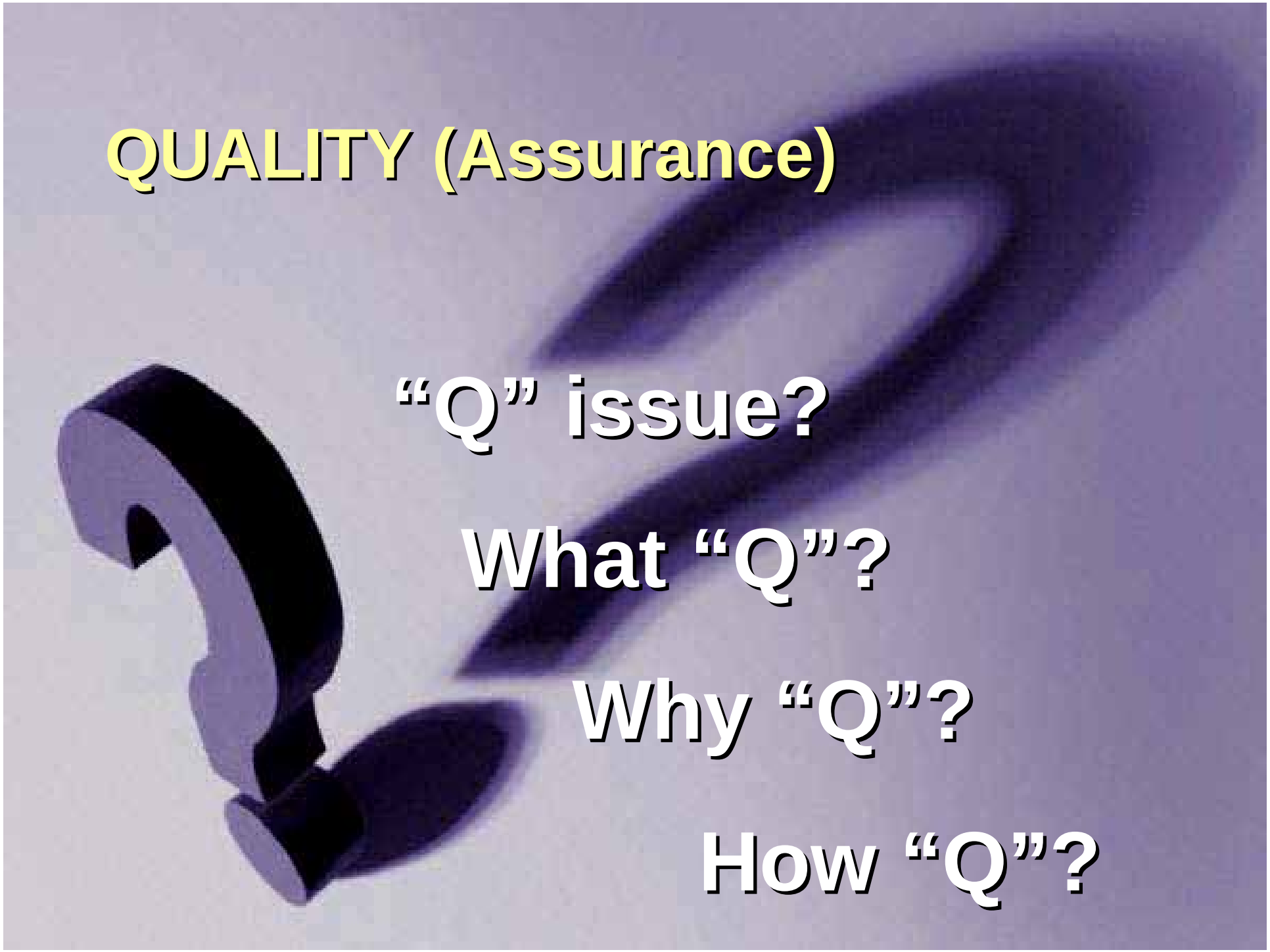
威院打錯血癌針調查報告主要建議

呂小琳

Died 07.07.2007

aged 21

Fought bravely to overcome acute leukemia
but succumbed to a tragic death
from a medical mishap.


QUALITY (Assurance)
“Q” issue?
What “Q”?
Why “Q”?
How “Q”?

41	Hospitals with inpatient service
15	Emergency Departments
49	Specialist Outpatient Clinics
23	Family / Integrated Clinics
75	General Outpatient Clinics

7.0m Patient records

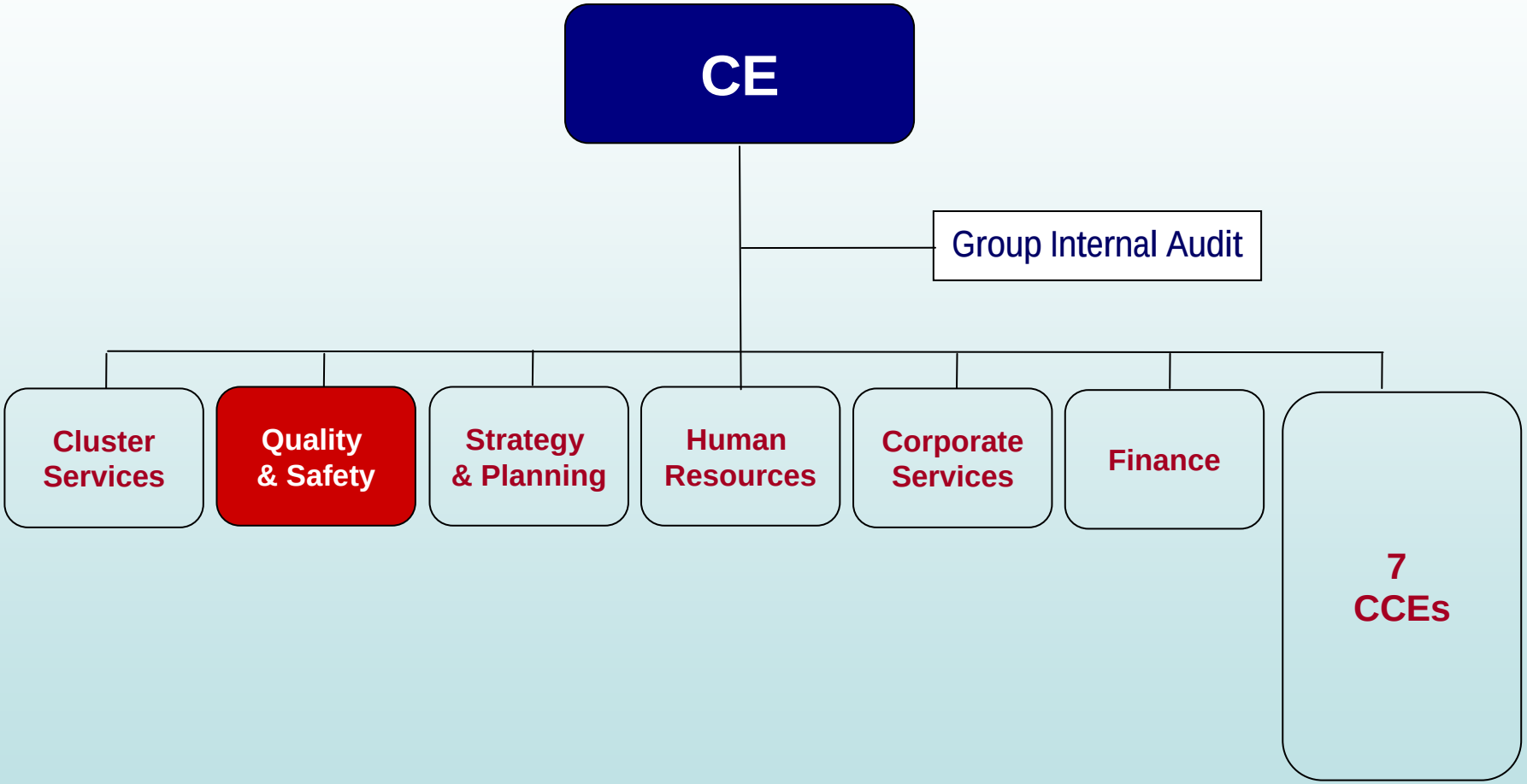
1.1m	Inpatient admissions
2.0m	Emergency visits
1.9m	Allied Health consultations
4.9m	General Outpatient consultations
6.0m	Specialist consultations
0.34m	Operation 8,865 Ultra Major Operation, 104,304 Major Operation
41.6m	Prescribed Drug Items

53,468 staff

2007 data

醫院管理局
HOSPITAL AUTHORITY

HAHO Organizational Structure
2006



Inauguration of
Central Committee on Quality and Risk Management

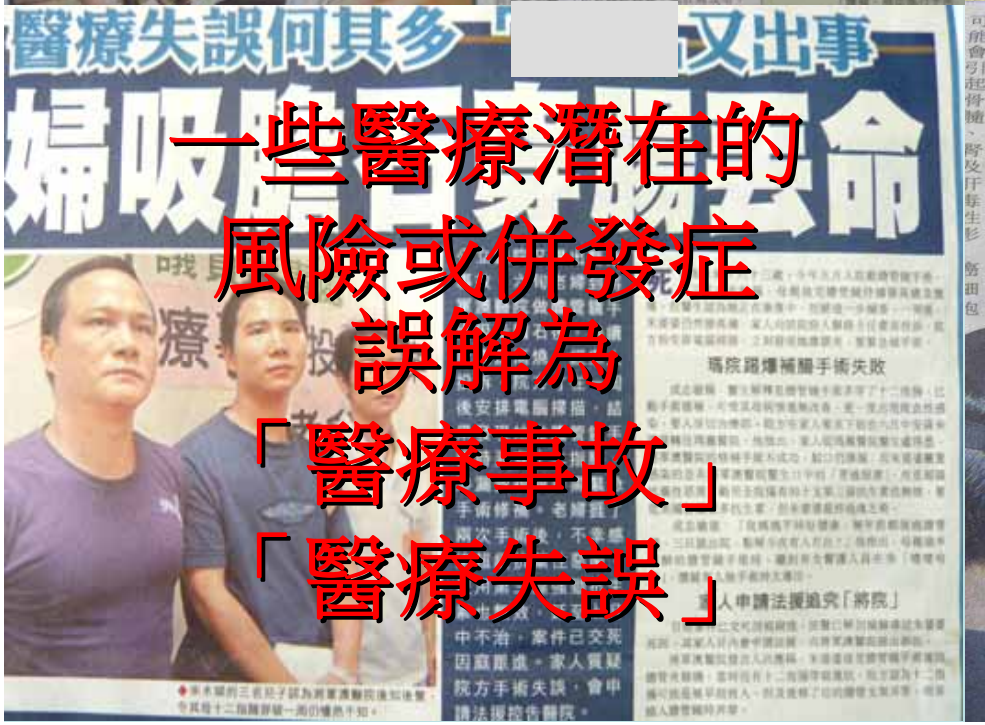
10 April 2007

A new era of working together for
a safer and high quality healthcare system
for our patients and staff


醫療失誤
Medical error
醫療制度、教育、人為 釀打錯針擲命
一條龍出錯
Medical error
死撐程序正確 卸責要自己核名
派錯藥
Medical error
體內留紗布抽痰管
再揭多宗醫療事故
醫療失誤
Medical error
公立醫院又揭3宗醫療事故
護士
醫療失誤
Medical error
夜診無藥劑師 護士誤加九倍劑量
險害死男嬰
Medical error
醫療失誤
Medical error

Known risk or complication misinterpreted as medical incident / error

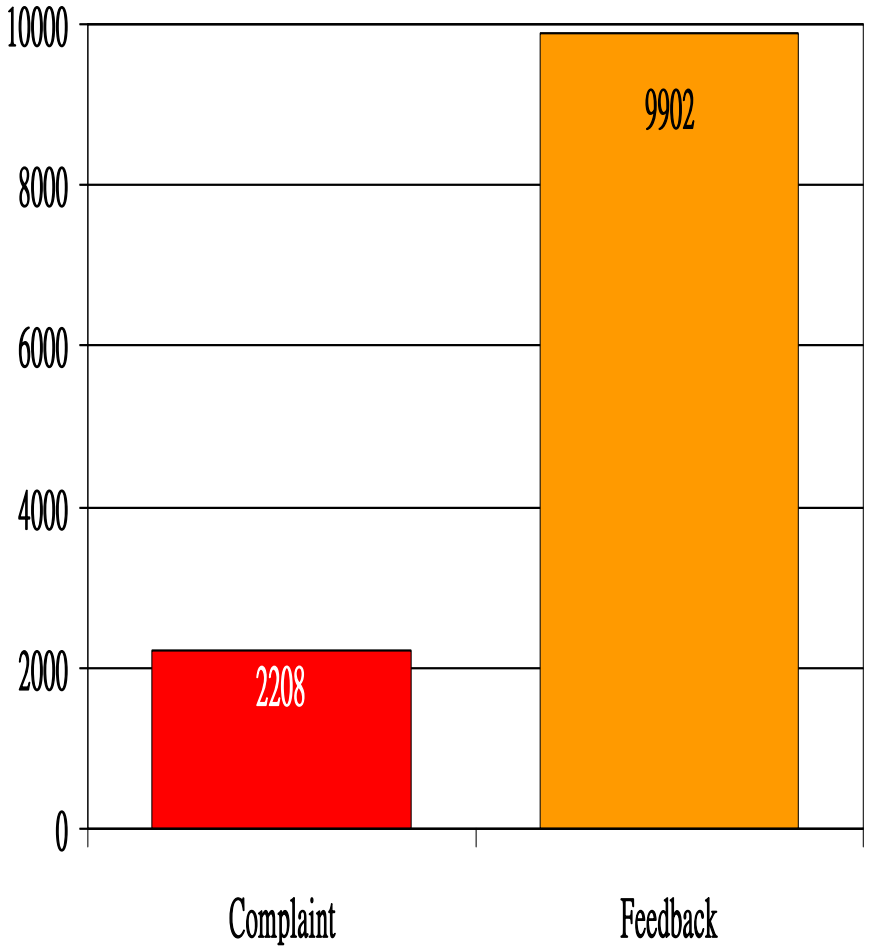
Sudden / natural death misinterpreted as medial incident / error



一些醫療潛在的風險或併發症誤解為「醫療事故」「醫療失誤」

突發或自然死亡誤解為「醫療事故」「醫療失誤」

Complaint / Feedback
HA 2006



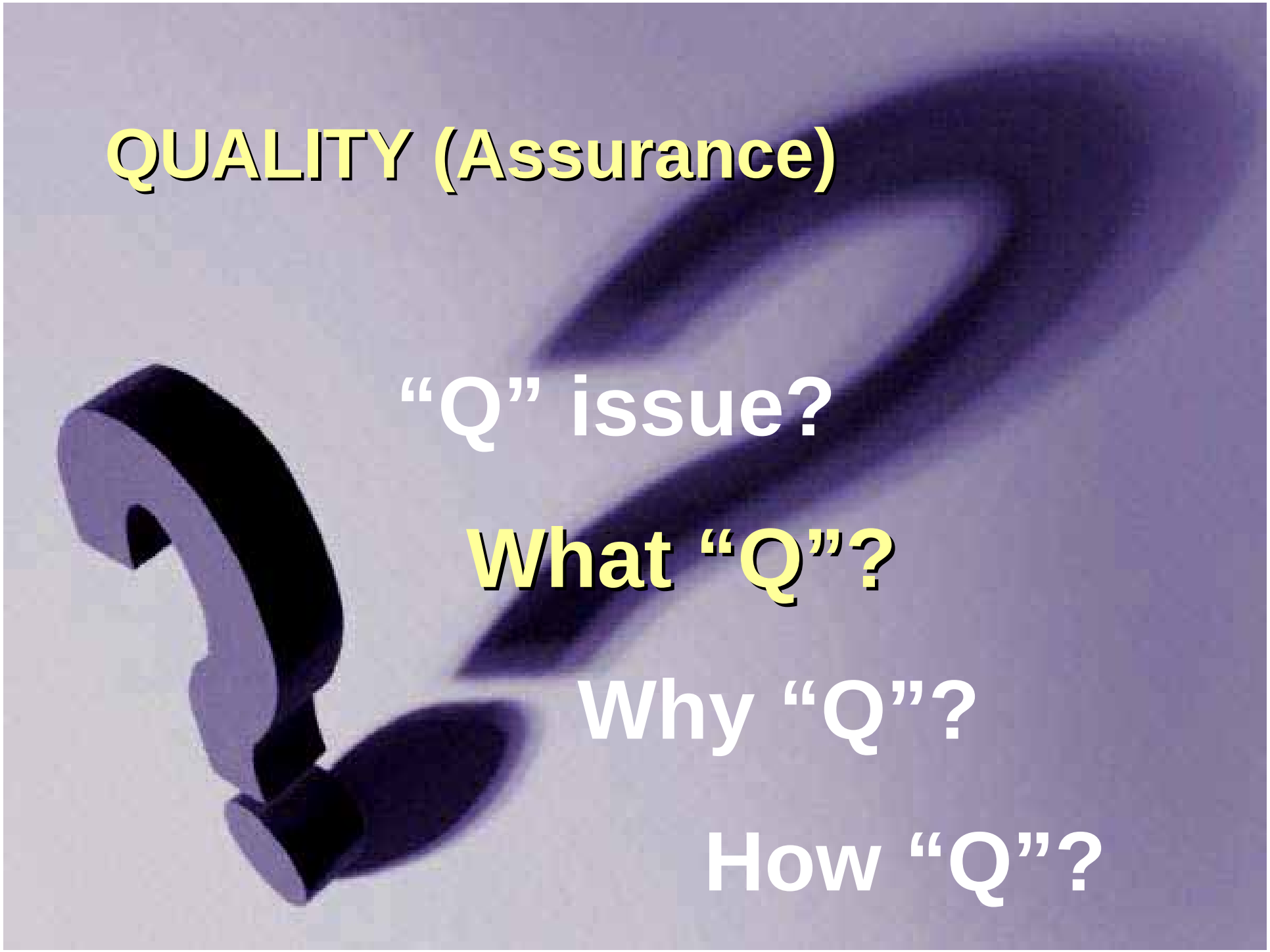
SETTLEMENT & COST FOR MEDICAL ERRORS / NEGLIGENCE

$X0,000,000

No of incidents report via AIRS (for 12 months)		13797	
1	**Patient (injury/ behaviours)**	**5,521**	**40%**
2	**Staff (OSH)**	**2,328**	**17%**
3	**Medication**	**1,994**	**14%**
4	**Access, Admission, Transfer, Discharge**	**822**	**6%**
5	**Investigation**	**740**	**5%**

Severity Index	Insignificant	Minor	Moderate	Major	Extreme
	1	2	3	4	5,6

*** Not all reported incidents are medical incidents or errors, included general incidents**


QUALITY (Assurance)
“Q” issue?
What “Q”?
Why “Q”?
How “Q”?

Perspectives of Quality

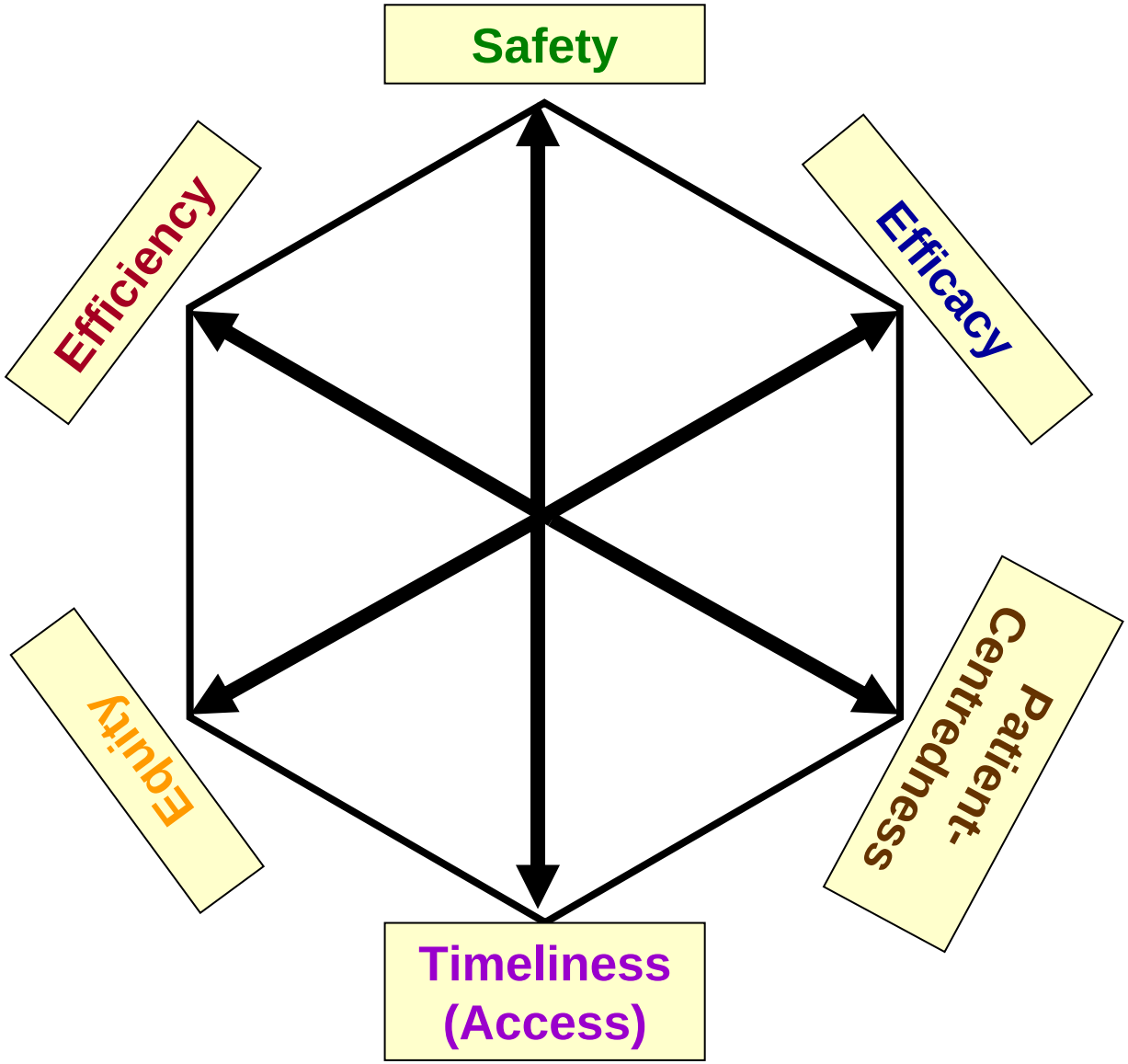
Patient	平靚正 **(快)** Cheap, Good, (fast) Get what one's want
HAHO	**Patient-centred** 以人為本
Cluster / Hospital / COS	**?** **X$** → **XS** → **XQ** Money Service Quality
Staff	**Fair working condition** **Able to do good work**

Definition of quality

The degree to which health services
for individuals and populations
increase the likelihood of
desired health outcomes
and are consistent with
current professional knowledge

Institute of Medicine: Crossing the Quality Chasm

(Institute of Medicine, Committee to Design a Strategy for Quality Review and Assurance in Medicine, 1990)



Crossing the Quality Chasm: A New Health System for the 21st Century. Institute of Medicine, 2001

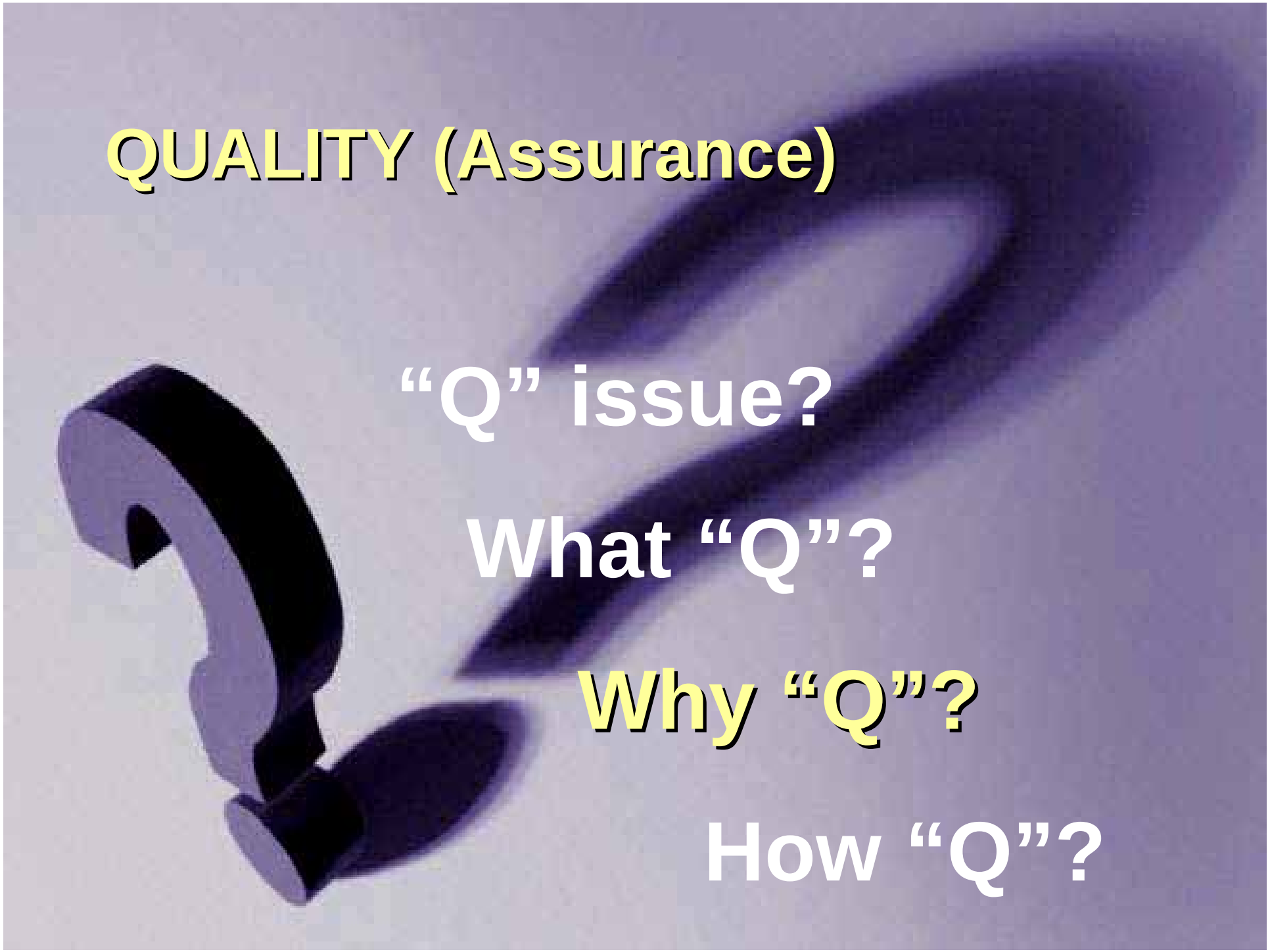
Quality Service

The right service (treatment)
for the right people
at the right time
at an right (optimum) cost.

為有需要、適合的人
在適當的時候
以適當的價錢
提供適當的服務

Meeting the expectation* of the patient
*(*appropriate / realistic expectation)*

QUALITY (Assurance)



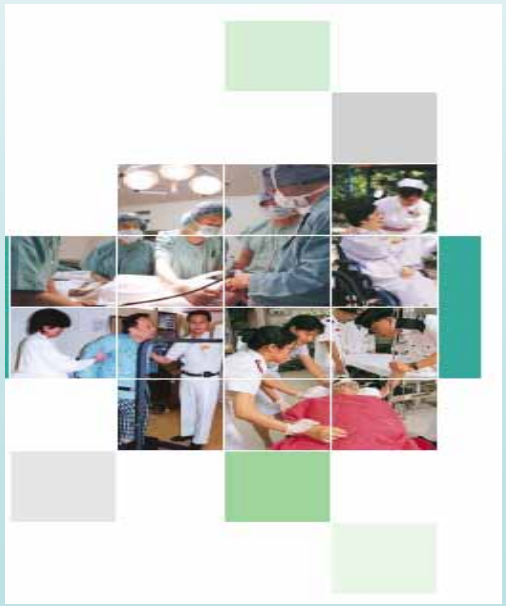
"Q" issue?

What "Q"?

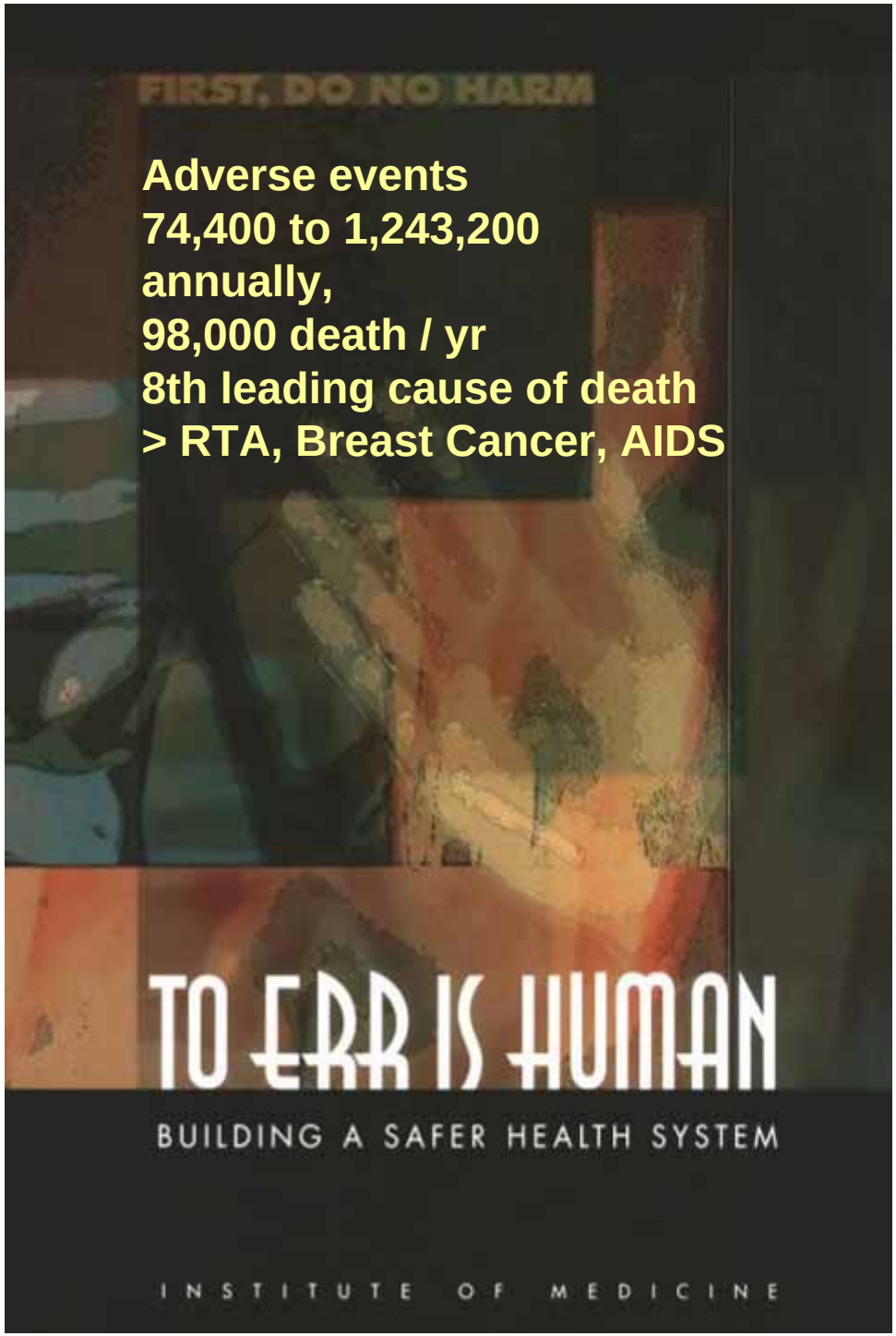
Why "Q"?

How "Q"?

Our patients
depend on us
expect of us
trust on us



OUR DUTY
OUR PRIDE
PROFESSIONLISM

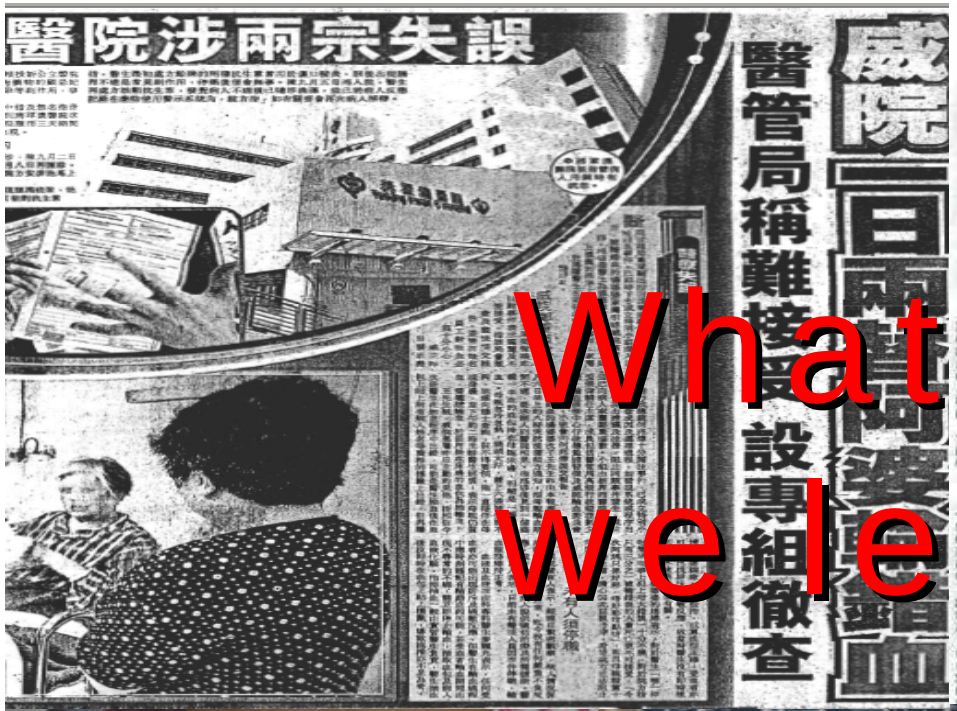


(Adverse event in 1 out of 10 in-patient)

To cause harm to any of our patients

- we, as professionals surely do not want it to happen, nor should we let it happen

*The **harm** can be very serious, even death.*

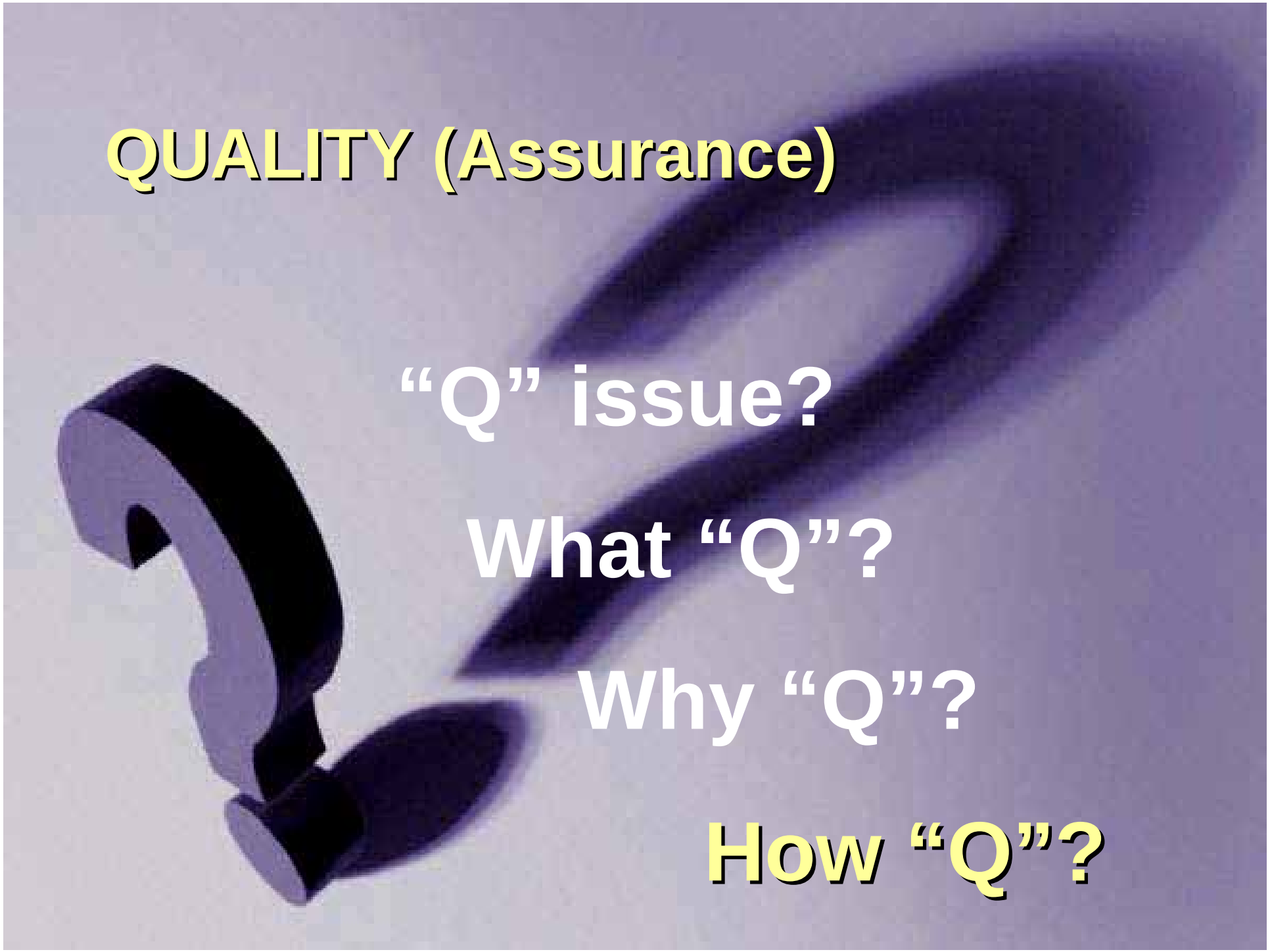


What have we learnt ?

What must we learn ?

A safe & high quality healthcare system for our patients & staff

(Staff is / can be a second victim of the adverse incident)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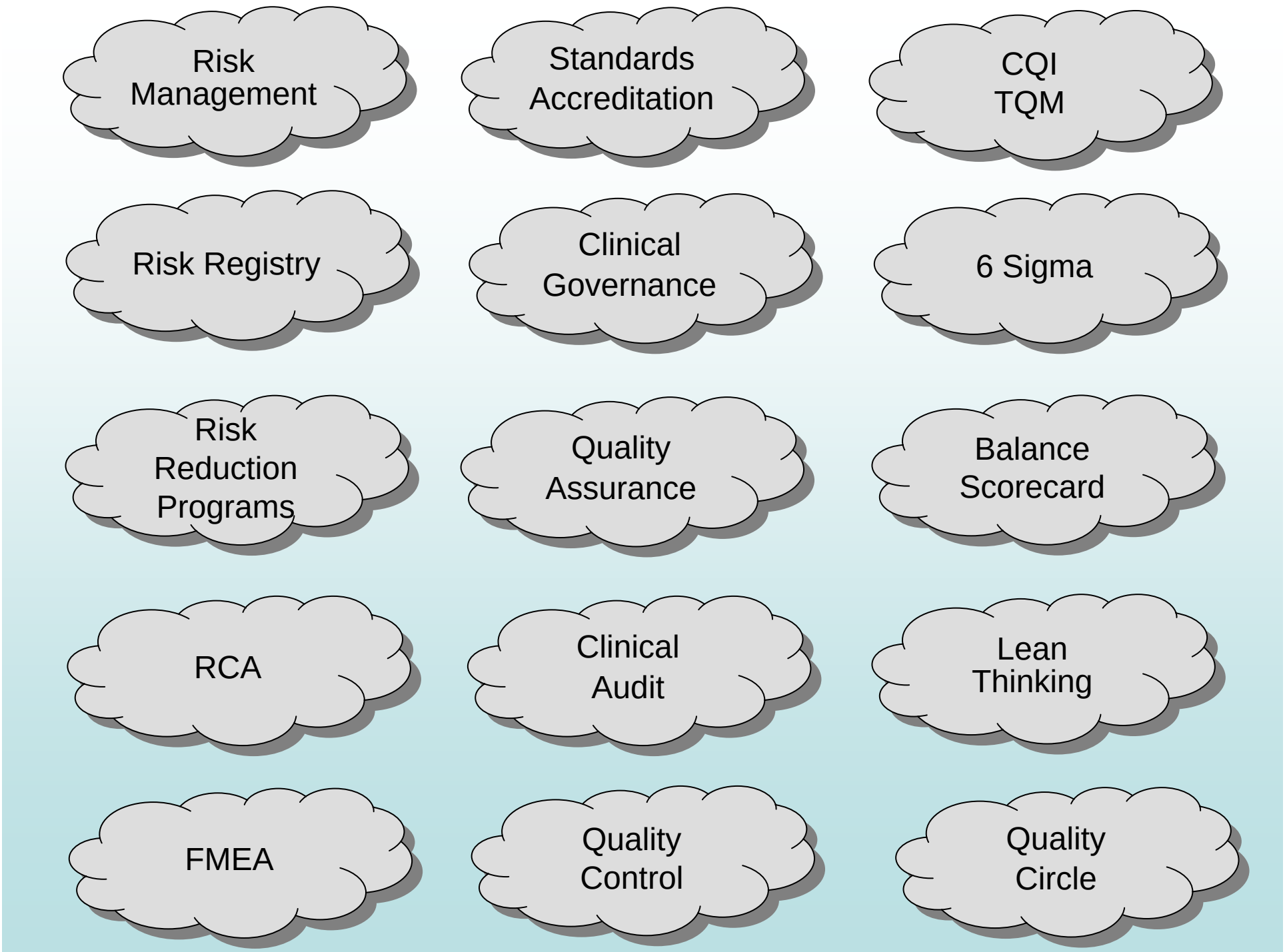

Risk Management
Standards Accreditation
CQI TQM
Risk Registry
Clinical Governance
6 Sigma
Risk Reduction Programs
Quality Assurance
Balance Scorecard
RCA
Clinical Audit
Lean Thinking
FMEA
Quality Control
Quality Circle

STRATEGY

The approach

1. Structure
People

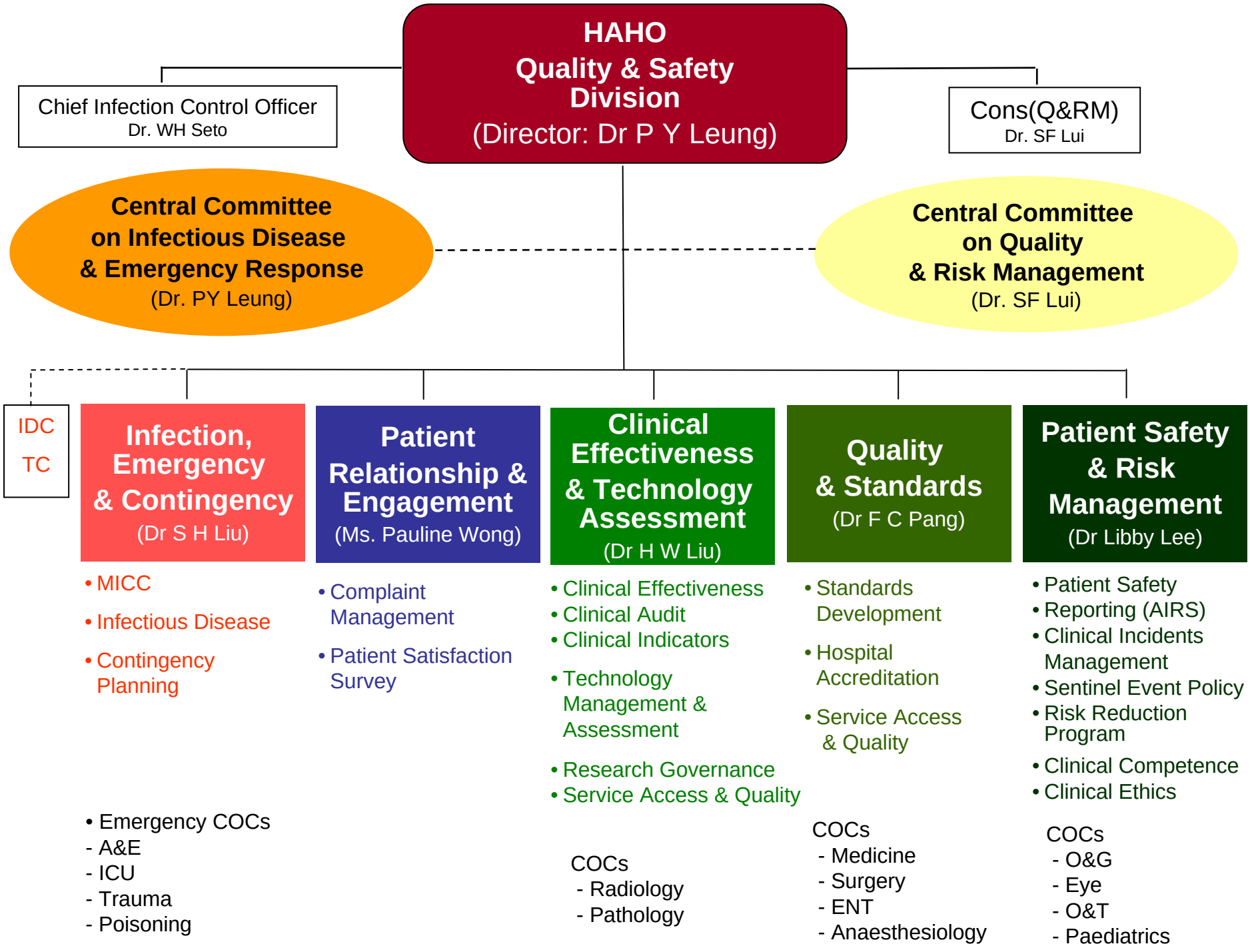
↓

2. Process

↓

3. Outcome

Avedis Donabedian
1919-2000

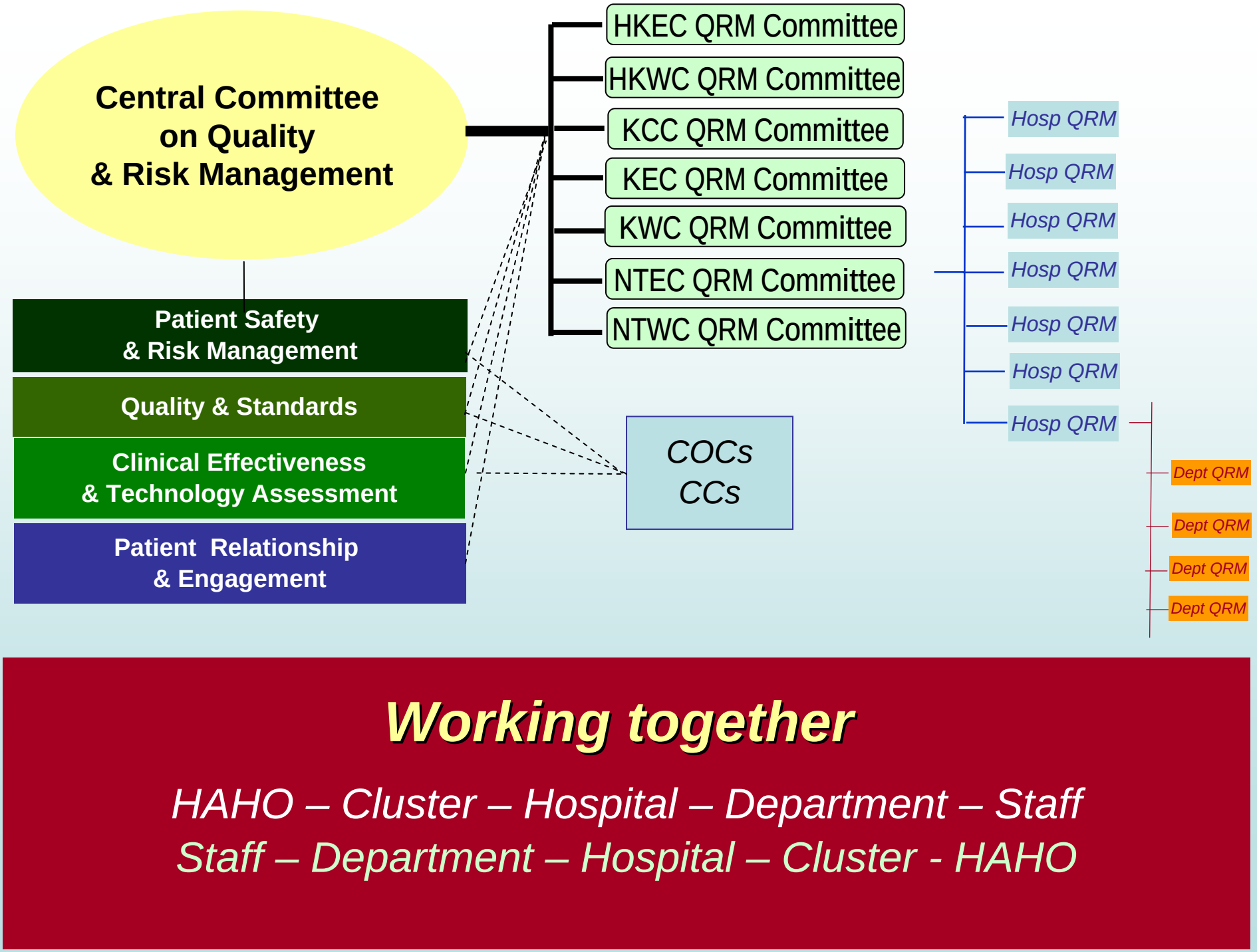

HAHO
Quality & Safety Division
(Director: Dr P Y Leung)
Chief Infection Control Officer
Dr. WH Seto
Cons(Q&RM)
Dr. SF Lui
Central Committee on Infectious Disease & Emergency Response
(Dr. PY Leung)
Central Committee on Quality & Risk Management
(Dr. SF Lui)
IDC
TC
Infection, Emergency & Contingency
(Dr S H Liu)
Patient Relationship & Engagement
(Ms. Pauline Wong)
Clinical Effectiveness & Technology Assessment
(Dr H W Liu)
Quality & Standards
(Dr F C Pang)
Patient Safety & Risk Management
(Dr Libby Lee)
• MICC
• Infectious Disease
• Contingency Planning
• Complaint Management
• Patient Satisfaction Survey
• Clinical Effectiveness
• Clinical Audit
• Clinical Indicators
• Technology Management & Assessment
• Research Governance
• Service Access & Quality
• Standards Development
• Hospital Accreditation
• Service Access & Quality
• Patient Safety
• Reporting (AIRS)
• Clinical Incidents Management
• Sentinel Event Policy
• Risk Reduction Program
• Clinical Competence
• Clinical Ethics
• Emergency COCs
- A&E
- ICU
- Trauma
- Poisoning
COCs
- Radiology
- Pathology
COCs
- Medicine
- Surgery
- ENT
- Anaesthesiology
COCs
- O&G
- Eye
- O&T
- Paediatrics

HAHO
Quality & Safety Division

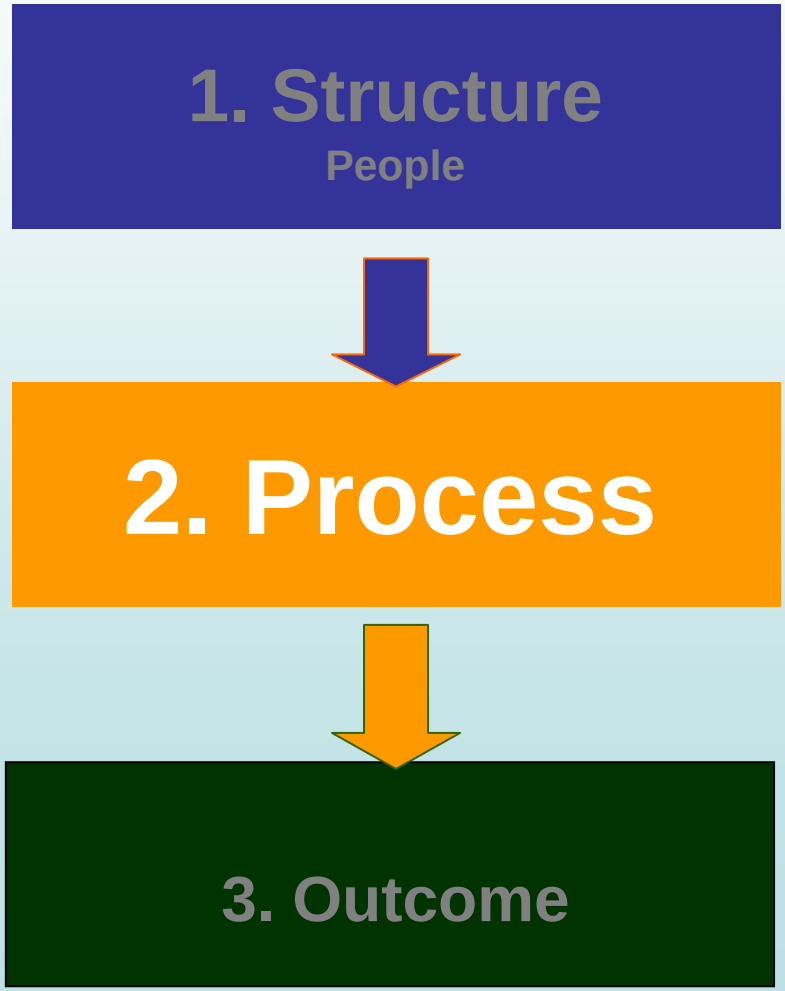
Dr. FC Pang	Dr. Libby Lee	Dr. WH Seto	Ms Pauline Wong	Dr. PY Leung	Dr. SF Lui	Dr. HW Liu	Dr. MY Cheng
Dep CM Q&S	Dep CM PS&RM	CICO	SM PR&PE	Director	Cons (Q&RM)	CM CETM	CM

Central Committee on Quality & Risk Management

- Provide **strategic advice** on best practice thinking to drive quality improvement and risk management
- **Lead and coordinate** improvements in Q&S, including standards, quality assurance, accreditation
- **Monitor and report** on Q&S
- **Disseminate knowledge for sharing, learning and advocate** for Q&S


Central Committee
on Quality
& Risk Management
HKEC QRM Committee
HKWC QRM Committee
KCC QRM Committee
KEC QRM Committee
KWC QRM Committee
NTEC QRM Committee
NTWC QRM Committee
Hosp QRM
Hosp QRM
Hosp QRM
Hosp QRM
Hosp QRM
Hosp QRM
Hosp QRM
Dept QRM
Dept QRM
Dept QRM
Dept QRM
Patient Safety
& Risk Management
Quality & Standards
Clinical Effectiveness
& Technology Assessment
Patient Relationship
& Engagement
COCs
CCs
Working together
HAHO – Cluster – Hospital – Department – Staff
Staff – Department – Hospital – Cluster - HAHO

The approach



PROCESS

to enhance / ensure a safer and higher quality healthcare …..

….. **CULTURE**: Safety and quality culture

….. **SYSTEM** : Safe design, effective and efficient

….. **ACCOUNTABILITY:** Governance

….. **Meeting the needs of our patients** (appropriately)

….. **Address the needs and concerns of our staff**

Avoid adding (reduce) unnecessary workload for staff

….. **An incremental approach of rapid transformation**

….. **From basic quality (FIRST DO NO HARM) to highest CQI**

….. **Systematic, pragmatic, focused, prioritized**

Everyone's business and duty

Senior leadership - Staff engagement - Patient engagement

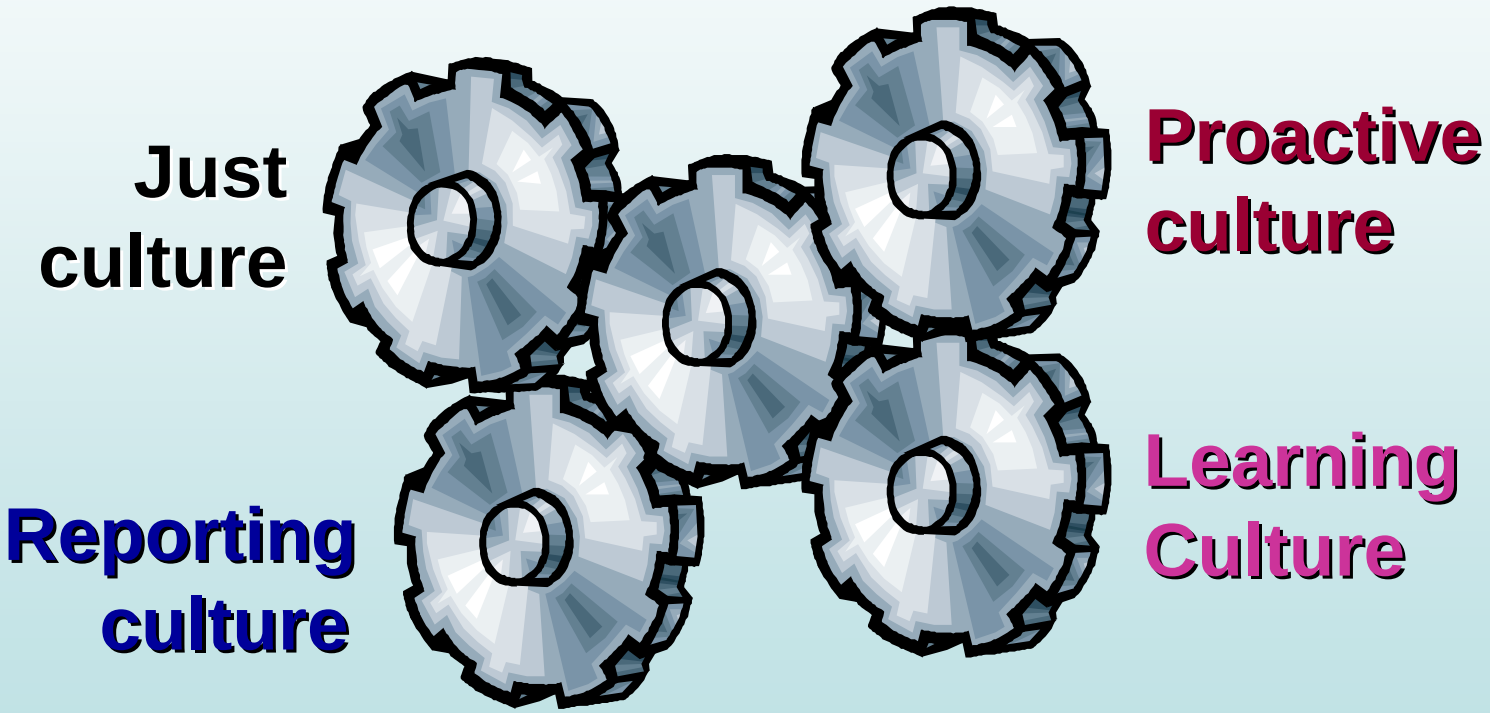
Quality & Safety

Patient Safety & Risk Management

- Safety culture
- Reporting (Risk Data)
- Clinical Incidents Management
- Investigation (RCA)
- Risk Reduction Programs
- Sharing and Learning

Safety culture

Patient and Staff Safety
- paramount importance



Open culture

RISK DATA

1a. Risk Observatory
(data source)

- Advance Incidents Reporting System (AIRS)
- Legal / public liability
- Coroner case report
- Complaints
- Safety Walkround

1b. Risk registry

Incidents reported

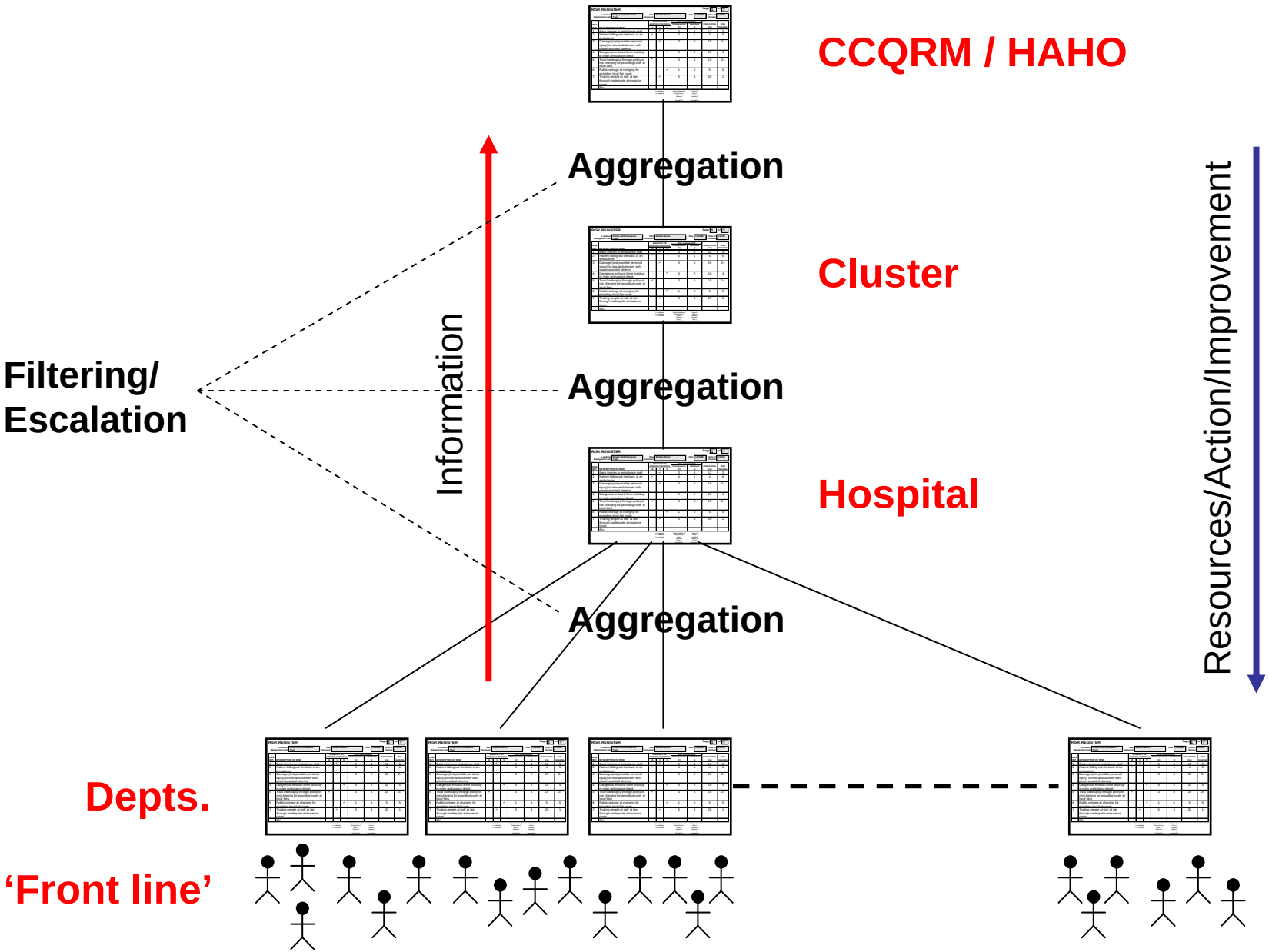
for 12 months
Apr 06 - Mar 07
(N=13,219)

	Total	%	
Access, Admission, Transfer, Discharge			
Examination & Assessment			
Investigation			
Treatment/ Care and Monitoring			
Communication and Consent			
Medication			
Blood Transfusion			
Patient (injury/ Behaviours)			
Visitor (injury/ Behaviours)			
Staff (Occupational Safety & Health)			
Staff Related Issues (other than OSH)			
Infection Control			
Environment			
Food Safety & Hygiene			
Medical Device, Equipment & Pharmaceutical Products			
Information System & Technology			
Miscellaneous			

Actual Outcome of Incidents reported by all clusters for 12 months Apr 06 - Mar 07 (n=13219)

SEVERITY	Insignificant 1	Minor 2	Moderate 3	Major 4	Extreme 5,6
Suicide					
Fall					
Medication					

*** Not all reported incidents are medical incidents or errors, Reported incidents included general operation incidents**


CCQRM / HAHO
Aggregation
Cluster
Aggregation
Filtering/
Escalation
Information
Hospital
Aggregation
Resources/Action/Improvement
Depts.
'Front line'

HA clinical risks 2007 - 2008

HKW	HKE	KC	KE	KW	NTE	NTW
Patient identification	Patient identification	Fall	Medication incident	Medication - High risk med	Fall	Medication
Correct operation site	Medication incident	Medication incident	Restrainer	Medication - on discharge	Medication	Infection control – HAI
Fall	Handover Communication & Documentation	Needle Stick Injury	Patient identification	Fall	Patient identification (specimen)	Fall
Medication - LASA	Staff Competency	Patient identification	Infection control	Patient transfer / transport	Patient identification	Patient identification (specimen)
Medication - Drug reconciliation	Infection Control	Patient Missing	Correct operation site	Patient identification (specimen)	Infectious Disease Outbreak	Patient identification
Infection Control	Fall	Infection Control	Fall	IOD-MHO	Patient Suicide	Long waiting time for new cases
Enhance patient assessment	Patient Suicide	Patient Suicide	Single use medical device	IC-SSI, MRSA	Restrainer	Delay of treatment
Medication - medication management in wards	Pressure sore	Pressure sore	Patient transfer / transport	Single use medical device	Choking	Increasing case volume of unstable patients
Establish a new clinical pathway on CA Rectum	Blood Transfusion	Communication among health care professionals	Patient documentation		Patient transfer / transport	choking
WHO Acute Respiratory Diseases IC Guideline		Communication between staff/ patient /relative	Safety of using infusion pump		Correct operation site	Error in laboratory results

HA - Patient Care Related Risks 2007-2008

Misidentification	• Patient • Specimen • Operation site
Medication	• High risk drugs in wards • Drug reconciliation on admission / discharge • Drug Allergy
Infection	• HAI- Surgical site infection • HAI- MRSA • Infectious disease outbreak
Patient's condition	• Patient suicide • Patient fall • Pressure sore
Patient Care process	• Patient assessment (identify critical ill patient) • Communication between caregivers • Use of Restrainer

Sentinel Events Policy

嚴重醫療事件

(警戒事件)

1 October 2007

1. Objectives
2. Definition
3. Immediate management
4. Reporting
5. Investigation
6. Learning and Sharing
7. Staff management

2. Reportable Sentinel Events

An “unexpected” occurrence involving death or serious physical or psychological injury, or the risk thereof.

1. **Surgery / interventional procedure involving the wrong patient or body part.**
2. **Retained instruments or other material after surgery / interventional procedure requiring re-operation or further surgical procedure.**
3. **Haemolytic blood transfusion reaction resulting from ABO incompatibility.**
4. **Medication error resulting in major permanent loss of function or death of a patient.**
5. **Intravascular gas embolism resulting in death or neurological damage.**
6. **Death of an in-patient from suicide (including home leave).**
7. **Maternal death or serious morbidity associated with labor or delivery.**
8. **Infant discharged to wrong family or infant abduction.**
9. **Unexpected death or serious disability reasonably believed to be preventable.** Assessment should be based on clinical judgment, circumstances and context of the incident.

3. Immediate management

(Department / hospital team)

- **Patient**
  - To minimise the harm to the patient
- **Staff**
  - Appropriate support / counseling
- **Patient and relative**
  - Open disclosure policy
- **Public relations / Media**
  - Protocol, standardisation

Click to show one page at a time

醫院管理局
HOSPITAL AUTHORITY

Root Cause Analysis

Application guidelines

September 2004

Stuart Emslie & Dr Maree Bellamy

To be updated

醫院管理局
HOSPITAL AUTHORITY

COMMUNIO

Introduction to Root Cause Analysis

RISK REDUCTION PROGRAMS

- **Identification:** **Patient identification** - UPI
  Correct site, procedure - Timeout
  Information transfer – SBAR, Read back

- **Medication:** **Concentrated electrolytes (KCl)**
  Allergy
  Medication reconciliation [2008]

- **Patient care / procedures:** **Suicide**
  Fall
  Restrainer
  Missing patient
  NG Tube
  Patient transfer

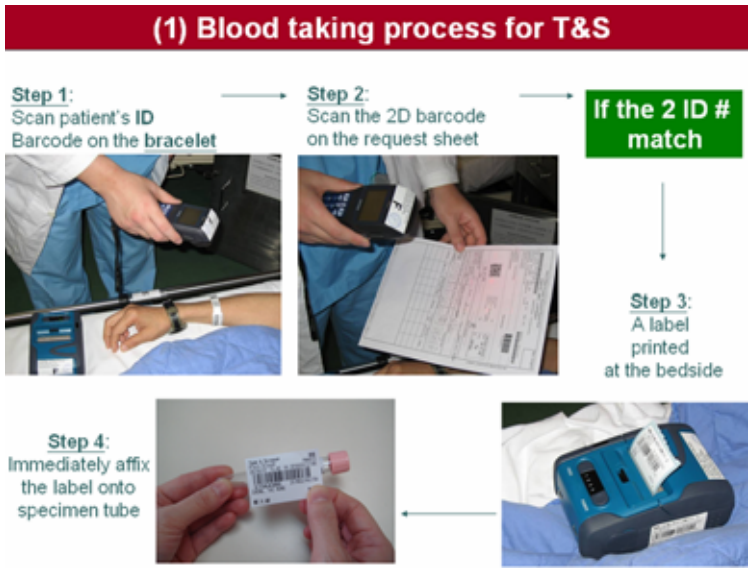
- **Consumables:** **single use devices**

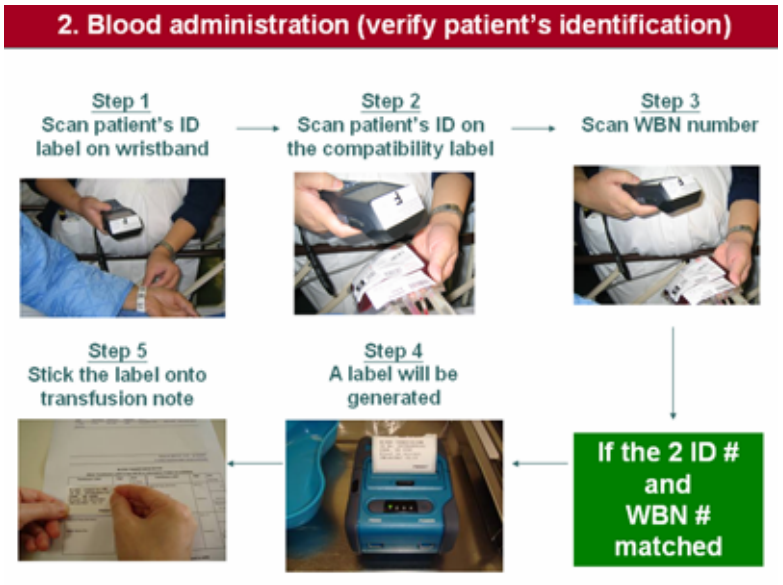
- **Devices:** **infusion pump**

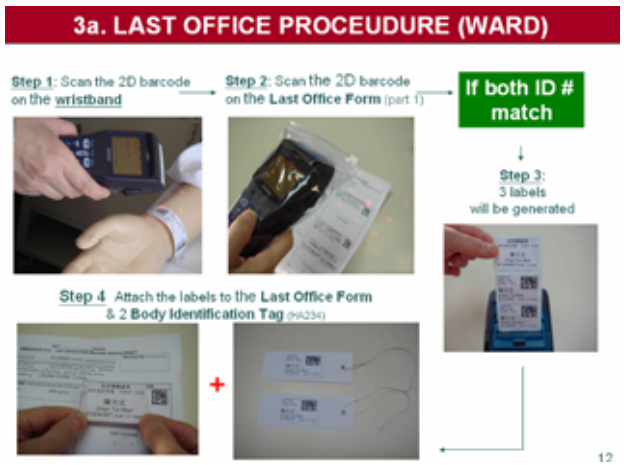
Unique Patient Identification project

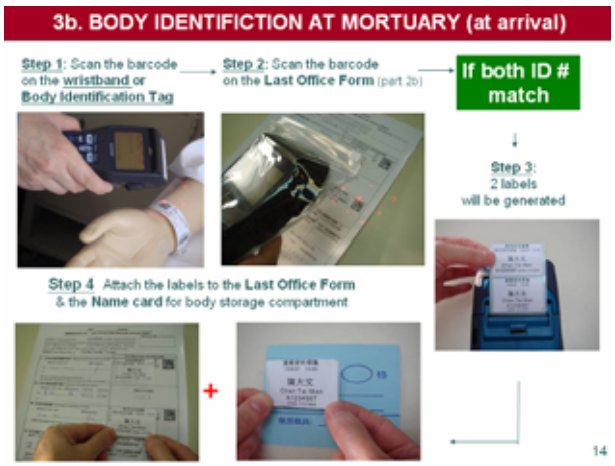
(2D Barcode scanning system)

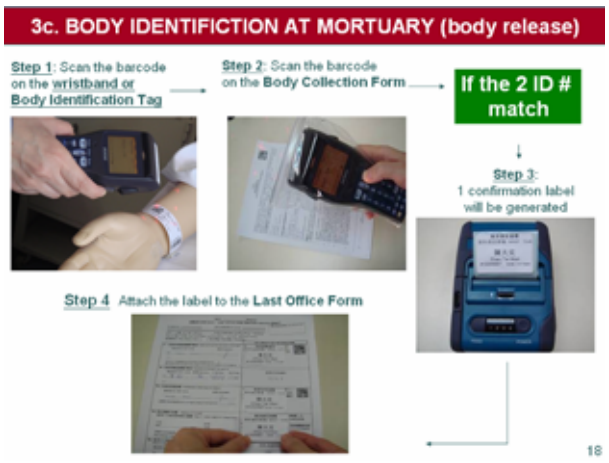
(full implemented by Q1 2008 – except A&E)









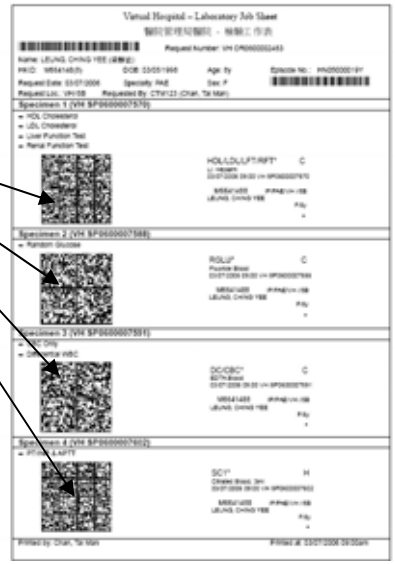


Unique Patient Identification project phase 3
- generating of labels for other investigations at bedside
– pilot at 3 hospitals 2008/2009

1 **Scan 2D barcode on patient wristband at bedside**

2 **Scan 2D barcode(s) on job sheet**
separate sheet for
- blood sample
- non-blood sample (for nursing staff)
- special sample

Sample of GCRS Job Sheet for other blood specimens



- Repeat scanning (if more than one test)
- When finished scanning all the job barcodes press [ENTER]

If IDs matched

3 **Label(s) will be generated by the printer at bedside**

RISK & QUALITY CIRCLE

Knowledge Management

Sharing, Learning

Communication

Skill and tools transfer

Tracer methodology, Root cause analysis (reactive), Failure Mode Effect & Analysis (proactive)

- Forum, seminar, meeting ***(HA / cluster / hospital / department)***

- electronic platform ***(websites, eKG)***

- Circulars, flyers, posters ***(Risk Alert, Q&S bulletin)***

醫院管理局 HOSPITAL AUTHORITY

RISK ALERT

ISSUE 1 NOV 2007

A Risk Management Newsletter for Hospital Authority Healthcare Professionals

IN THIS ISSUE

Message from CE

Dear Colleagues,

Ensuring our patients' safety is our most fundamental responsibility. I'm pleased to introduce the first issue of HA Risk Alert (HARA), a periodic publication to keep everyone updated with local & overseas risks in healthcare settings.

Sharing and learning are the cornerstones to improve patient safety. It is only by increasing our awareness and understanding of the potential risks that we can prevent medical errors from occurring. As part of the implementation of HA Sentinel Event policy, HARA serves as a communication channel for us to learn together from the sentinel events. Together we can bring in a positive change in patient safety.

In this issue, the HARA covers some medical incidents that were previously reported to HAHO which would have been classified as Sentinel Event. We have also highlighted some "Near Misses" which have occurred locally, as well as risk alerts from overseas.

We wish to provide a Safe and High Quality Healthcare Service – Let's do it together!

Shane Solomon, CE, HA

LOCAL SENTINEL EVENT (1)

Fatal error of Vincristine being given intra-thecally (wrong route)

At a busy ambulatory oncology centre, it was already 3 pm in the afternoon but many patients were still waiting for their intravenous chemotherapy treatment. A 21-year-old patient was waiting for her maintenance dose of intrathecal chemotherapy drug (c-ARA). She was also to receive her other chemotherapy drug – vincristine to be given intravenously. After receiving one treatment procedure, she went home and was readmitted with headache. What had happened?

HOW DID IT HAPPEN?

Both IV vincristine and IT cytarabine were prescribed together for this patient on the **same prescription sheet** by Doctor A in the morning

↓

Both drugs were supplied together in the **same bag**

Both drugs were put together on the **same trolley** prepared for the LP and IT chemotherapy administration
(Nurse A was not aware of the different routes for the 2 drugs)

↓

In the afternoon, this patient (for IT & IV chemotherapy) was waiting with other patients who came for IV chemotherapy. Doctor B handled her first to meet the closing time for laboratory test half an hour later.

↓

Doctor B & nurse B checked the prescription but were not aware of the two different routes prescribed

↓

Doctor B reviewed previous prescription sheet and noted the same drugs had been given previously

↓

Both vincristine and cytarabine were given INTRATHECALLY

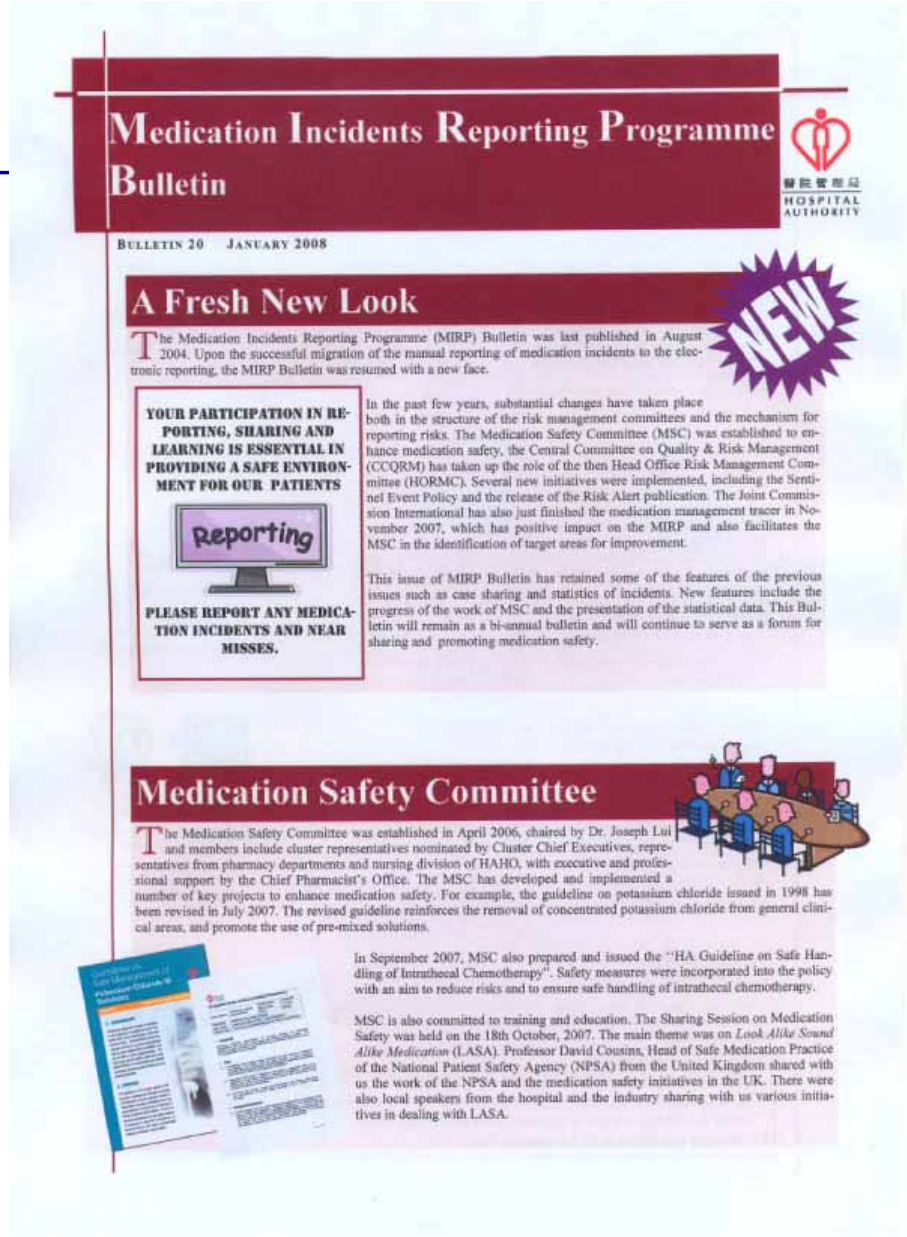
MAJOR CONTRIBUTING FACTORS

1. **"System factors"** – 2 drugs (one for IV and one for IT administration) were delivered together by pharmacy to the clinical area, the administration of the 2 drugs were at the same time and in the same location, imperfect labeling of the drugs, inadequate checking of the medication and route of administration by the staff.
2. **"Education factors"** - insufficient awareness that intrathecal administration of vincristine is fatal.
3. **"Human error"** - failure to follow existing guidelines in drug administration.

KEY RECOMMENDATIONS

1. Only specially trained and designated oncology staff should prescribe, prepare, dispense and administer cytotoxic medication.
2. **Must use a formal checking procedure to ensure the "5 RIGHTS", that is, right drug is given at the right dose, by the right route, at the right time and to the right patient**.
3. Intrathecal chemotherapy must only be administered in an area where no other cytotoxic drugs are available & at a different time from other systemically administered drugs.
4. Vincristine should be prepared in a small-volume intravenous bag (minibag).

LEARNING POINT
Vincristine can only be given intravenously



Medication Incidents Reporting Programme Bulletin

醫院管理局 HOSPITAL AUTHORITY

BULLETIN 20 JANUARY 2008

A Fresh New Look

NEW

The Medication Incidents Reporting Programme (MIRP) Bulletin was last published in August 2004. Upon the successful migration of the manual reporting of medication incidents to the electronic reporting, the MIRP Bulletin was resumed with a new face.

YOUR PARTICIPATION IN REPORTING, SHARING AND LEARNING IS ESSENTIAL IN PROVIDING A SAFE ENVIRONMENT FOR OUR PATIENTS

Reporting

PLEASE REPORT ANY MEDICATION INCIDENTS AND NEAR MISSES.

In the past few years, substantial changes have taken place both in the structure of the risk management committees and the mechanism for reporting risks. The Medication Safety Committee (MSC) was established to enhance medication safety, the Central Committee on Quality & Risk Management (CCQRM) has taken up the role of the then Head Office Risk Management Committee (HORMC). Several new initiatives were implemented, including the Sentinel Event Policy and the release of the Risk Alert publication. The Joint Commission International has also just finished the medication management tracer in November 2007, which has positive impact on the MIRP and also facilitates the MSC in the identification of target areas for improvement.

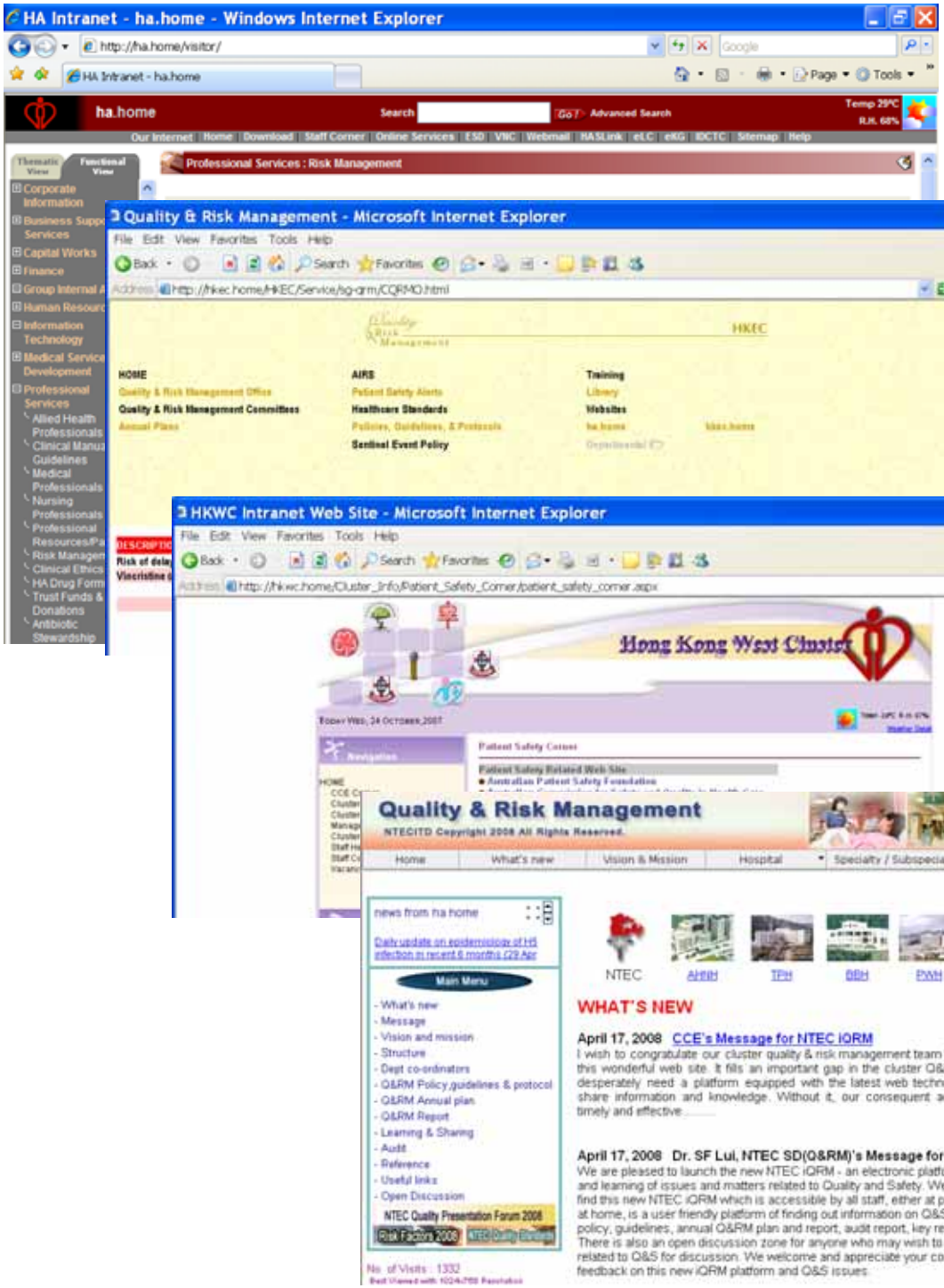
This issue of MIRP Bulletin has retained some of the features of the previous issues such as case sharing and statistics of incidents. New features include the progress of the work of MSC and the presentation of the statistical data. This Bulletin will remain as a bi-annual bulletin and will continue to serve as a forum for sharing and promoting medication safety.

Medication Safety Committee

The Medication Safety Committee was established in April 2006, chaired by Dr. Joseph Lui and members include cluster representatives nominated by Cluster Chief Executives, representatives from pharmacy departments and nursing division of HAHO, with executive and professional support by the Chief Pharmacist's Office. The MSC has developed and implemented a number of key projects to enhance medication safety. For example, the guideline on potassium chloride issued in 1998 has been revised in July 2007. The revised guideline reinforces the removal of concentrated potassium chloride from general clinical areas, and promote the use of pre-mixed solutions.

In September 2007, MSC also prepared and issued the "HA Guideline on Safe Handling of Intrathecal Chemotherapy". Safety measures were incorporated into the policy with an aim to reduce risks and to ensure safe handling of intrathecal chemotherapy.

MSC is also committed to training and education. The Sharing Session on Medication Safety was held on the 18th October, 2007. The main theme was on *Look Alike Sound Alike Medication* (LASA). Professor David Cousins, Head of Safe Medication Practice of the National Patient Safety Agency (NPSA) from the United Kingdom shared with us the work of the NPSA and the medication safety initiatives in the UK. There were also local speakers from the hospital and the industry sharing with us various initiatives in dealing with LASA.


HA Intranet - ha.home - Windows Internet Explorer
ha.home
Professional Services : Risk Management
Quality & Risk Management - Microsoft Internet Explorer
HKEC
HOME
AIRS
Training
Quality & Risk Management Committees
Healthcare Standards
Websites
Sentinel Event Policy
HKWC Intranet Web Site - Microsoft Internet Explorer
Hong Kong West Cluster
Quality & Risk Management
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Home
What's new
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A - Z List
** QRM members zone
news from ha home
Main Menu
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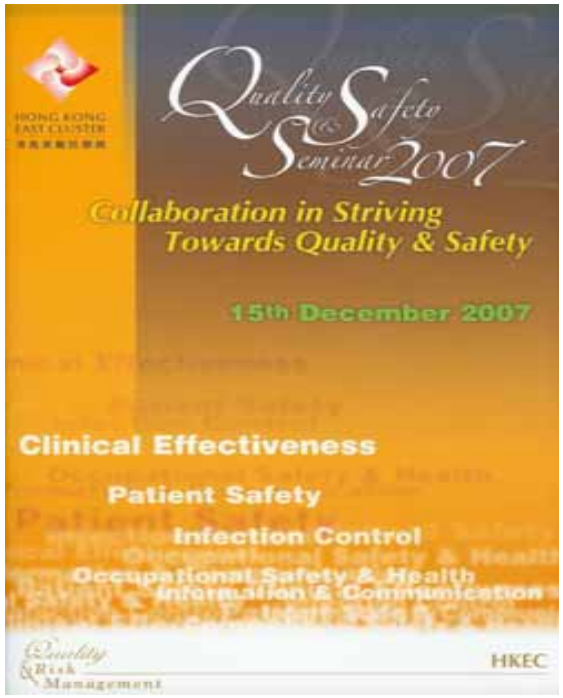
- Useful links
- Open Discussion
NTEC Quality Presentation Forum 2008
Risk Factors 2008
NTEC
AHNH
TPH
BBH
PWH
SCH
SH
NDH
WHAT'S NEW
April 17, 2008 CCE's Message for NTEC iQRM
April 17, 2008 Dr. SF Lui, NTEC SD(Q&RM)'s Message for NTEC iQRM


QUALITY & SAFETY
Contents
實施風險管理，
你我有責


Quality and Risk Management Newsletter
Vol 3 No. 3
Safe Practice Series
Issued on 25 Sept 2007
A safer workflow for specimen collection from patient:
Label first, Specimen after;
Identity check, Patient safe.
先印標籤，後取標本
確認身份，大家安心
CMS
Generate GCRS Label
Stick label to specimen container first
Check 2 identifiers on wristband
From NTWC Quality and Risk Management Division


New Territories West Cluster
新界西醫院聯網
優質服務會議
Quality Conference 2007
Pursuing Excellence – Making Everybody Win
3-4 December 2007


HONG KONG EAST CLUSTER
Quality & Safety Seminar 2007
Collaboration in Striving Towards Quality & Safety
15th December 2007
Clinical Effectiveness
Patient Safety
Infection Control
Occupational Safety & Health
Information & Communication
Quality & Risk Management
HKEC


NTEC Quality Presentation Forum 2007
Q Q
Achieve Quality Through Basics
優質醫護靠根基
確保基本質素 - 不可引至傷害
Ensure basic quality – First do no harm
堅守基本手則
Always comply with basic steps
高度專注 Attentive at all times
嚴守指引 Strictly follow protocol
絕不假設 Never assume
莫貪方便 Not to cut corners

Quality & Standards

- Standards
- Accreditation

SECTION 3 QUALITY IMPROVEMENT STANDARDS FOR HOSPITALS

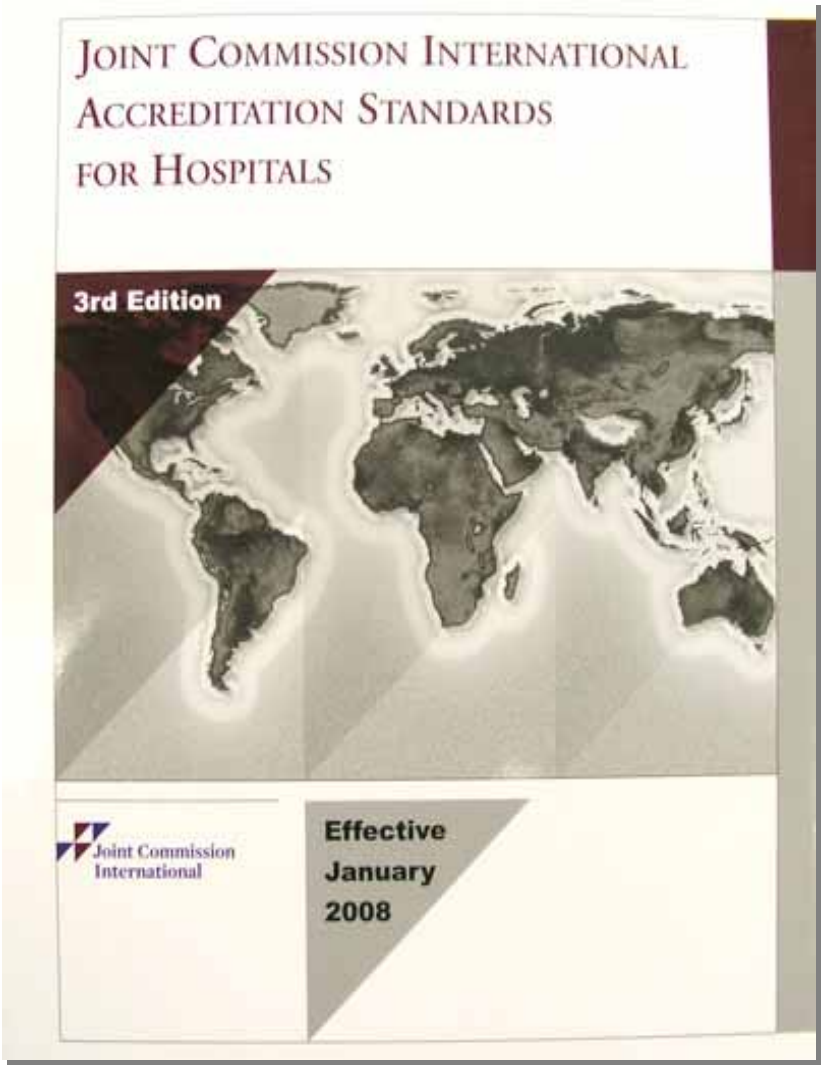
STANDARDS REPORTS 2007-2008 (As of 31 Mar 2008)

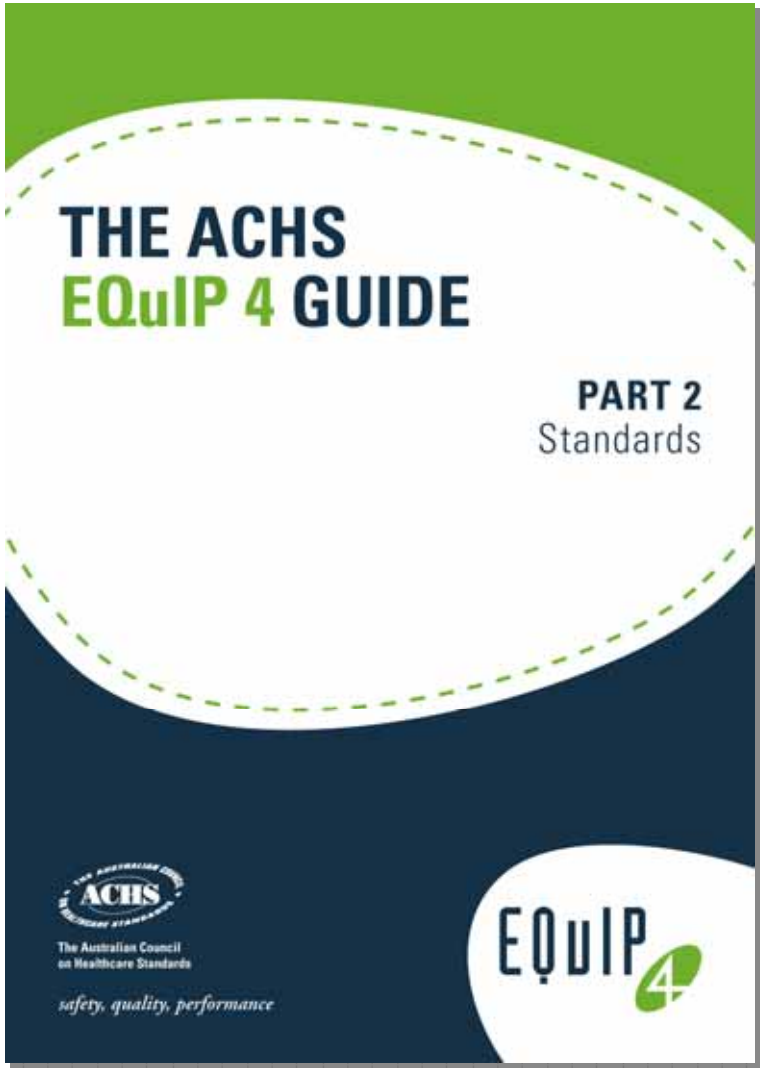
Cluster

(**Y**: yes, **P**: partial, **N**: no, **NA**: not applicable)

	Cluster X	Hosp 1			Hosp 2			Hosp 3			Hosp 4			Hosp 5			Hosp 6			Hosp 7		
	Level	L1	L2	L3	L1	L2	L3	L1	L2	L3	L1	L2	L3	L1	L2	L3	L1	L2	L3	L1	L2	L3
Standard 1	Accident and Emergency																					
Standard 2	Access																					
Standard 3	Patient assessment																					
Standard 4	Hospital bed utilization																					
Standard 5	Discharge and transfer																					
Standard 6	Patient rights and responsibilities																					
Standard 7																						
Standard 8																						
Standard 9	Informed consent																					
Standard 10																						
Standard 11	Media communication																					
Standard 12	Public and patient feedback																					
Standard 13	Assessment and documentation																					
Standard 14																						
Standard 15	Laboratory services																					
Standard 16	Point of care testing																					
Standard 17	Radiology services																					
Standard 18	Care delivery for all patients																					
Standard 19	Missing patients																					
Standard 20	Resuscitation																					
Standard 21	Blood and blood products																					
Standard 22	Dialysis																					
Standard 23	Physical restraint																					
Standard 24	Patient falls																					
Standard 25	Prevention of pressure sores																					
Standard 26	Anaesthesia care																					
Standard 27	Surgical care																					
Standard 28	Intensive care																					
Standard 29	Medication management																					
Standard 30	Food therapy and nutrition therapy																					
Standard 31	Risk management																					
Standard 32	Infection Control																					
Standard 33	Fire safety																					
Standard 34	Emergency preparedness																					
Standard 35	Clinical and radioactive waste management																					
Standard 36	Medical equipment management																					
Standard 37	Water and electricity supply																					
Standard 38	Security																					
Standard 39	Occupational safety and health																					
Standard 40	Food safety and hygiene																					
Standard 41	Procurement and materials management																					
Standard 42	Telecommunication																					
Standard 43	Patient transport (non-emergency)																					
Standard 44	Hospital Linen supply																					
Standard 45	Environmental management																					
Standard 46	Human resources																					
Standard 47																						
Standard 48																						
Standard 49																						
Standard 50																						
Standard 51	Patient clinical record																					
Standard 52	Information management																					
Standard 53	Information to suport continuous patient care																					
Standard 54	Management of information																					
Standard 55	Finance																					
Summary of Scores for all Standards																						
Yes	Y	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Partial	P	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
No	N	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Not applicabl	NA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	(Y: yes, P: partial, N: no, or NA: not applicable)																					

International Standards / Accreditation





HAHO CCQRM

Standards & Accreditation Subcommittee

- **Co-Chairpersons:**
  Dr. Loretta Yam (accreditation),
  Dr. CC Luk (standards),
  Dr. SF Lui

- **Members**
  Ms Kate Choi Clinical Audit Manager (CND) HKWC representative
  Dr. Anne Kwan CC(3), UCH, KEC representative
  Ms. Eva Liu CC(RM), KCC representative
  Dr. KL Chung SD(Q&RM), NTWC representative
  Dr. HY So CC(QM), NTEC representative

  Dr. Derrick Au KCC
  Dr. Patrick Li KCC
  Dr. Andrew Yip KCC
  Dr. Joseph Lui KWC
  Ms. Sylvia Fung KWC
  Ms Mary Wan HKEC
  Mr. Jimmy Wu

Consultancy Report on Quality at HA & The way forward

Charles Shaw and Ms. Francis Smith
June 2007

To review, in an international context, existing policies, structures, methods and resources applied to improving quality and safety in HA
To make recommendations to strengthen coordination and development of Q&S

Key Milestones

Establishment of Subcommittee on Standards and Accreditation	Apr 07
Consultancy study on Q&S coordination and development in HA	Jun 07
Decision on options at Directors' Meeting	Sep 07
Invitation to 3 accrediting bodies to present to Subcommittee and frontline staff	Nov 07 – Mar 08
Select an international accreditation agent as partner Phase 1: pilot study (18-24 months) Phase 2: To decide on long-term commitment to accreditation after evaluation of Phase 1	Q3/4 2008

Accreditation as a driver for healthcare quality improvement

OBJECTIVES

1. To provide independent assurance

The government and HA are committed to healthcare quality
HK hospitals are achieving internationally recognized standards

2. To develop relevant and essential tools to measure the quality of healthcare organizations

3. To provide leverage to drive quality change through a systematic & comprehensive approach

4. To ensure sustainability of quality improvement efforts

5. To (responsibly) respond to public expectations

External accreditation may head off further medical blunders

Hospitals need quality-control scheme: report

Ella Lee

All hospitals in Hong Kong will have their standards assessed by a common accreditation system under a proposal to improve the quality of health-care services.

A recently commissioned report for the Hospital Authority concluded that Hong Kong needs an accreditation system on hospital services.

The proposal comes amid a litany of medical blunders in public hospitals in the city.

At present, the 44 public hospitals are only subject to internal assessments, while the 12 private hospitals have joined the Trent Accreditation Scheme, developed in Britain.

Under the scheme, teams of surveyors comprising various health-care professionals visit the hospitals every two years to audit services ranging from medical equipment and hospital management to staff training and service standards for each department.

They also make recommendations for improvements.

The Hospital Authority's consultancy report said Hong Kong's public hospitals should first join an external hospitals accreditation system.

In the long run, the city should establish its own accreditation board, it said.

The authority is looking at the possibility of joining one of the major hospital accreditation bodies, including the Australian Council on Healthcare Standards (ACHS) and the Joint Commission in the United States.

'Framework for improvement'

The Australian Council on Healthcare Standards is an independent, non-profit organisation to improve the quality of health care through continual review of performance and accreditation. Established in 1974, it now has more than 800 member health-care organisations representing more than 1,000 individual organisations. In 2005, it started providing services internationally amid increasing global interest in its accreditation. The council said its accreditation programme was designed to provide a framework for continuous improvement.

A delegation led by the authority's chief executive Shane Solomon will visit Australia at the end of this month to learn more about ACHS.

The delegates, including representatives from private hospitals, will also meet officials from the government-run Australian Commission on Safety and Quality in Health Care to exchange views on patient safety and handling of medical incidents. The commission's scheme measures 300 areas of quality performance.

A senior authority source said the current practice of internal audits was "unsatisfactory".

"We need to compare with other health-care organisations using an international standard. Patients also expect a common standard for all public and private hospitals in Hong Kong," the source said.

Editorial A16

"We also agree that in the long run, Hong Kong needs its own accreditation board."

The source said the external accreditation would first be run in several public hospitals and then extended to all.

In the wake of a series of medical blunders recently, the authority has pledged to improve patient safety and clinical governance.

In August the authority introduced a new sentinel events reporting system in which public hospitals will have to report serious medical blunders within 24 hours.

The authority source said having a hospital accreditation system would further boost public confidence in health-care services.

Medical legislator Kwok Ka-ki said the public hospitals' self-examination had failed.

"An external accreditation body will be more independent and more credible. And we need a commonly agreed standard for all hospitals. A third party can also give new ideas," Dr Kwok said, adding that the body should be a non-profit-making group with fair charges.

But a public hospitals executive called on the authority to think twice. "Bringing in external accreditation will mean we have to spend perhaps millions of dollars a year on an outsider who may not know Hong Kong hospitals very well," the executive said.

28/4/2008

Assessment to ensure hospitals make the grade

Expectations that our health system be of the highest quality are inevitable given constant medical advances and rising affluence. Confidence in hospital services has been hit by a series of mistakes by public and private doctors. The Hospital Authority has rightly responded by taking the first steps towards implementing an open, internationally recognised, accreditation mechanism.

By having staff, facilities and services at our 44 public hospitals assessed regularly by a team of health professionals, standards can be assured and risk minimised. The 12 private hospitals in Hong Kong are already assessed this way, although under different foreign schemes. Ideally, once the system is in place and operating in the public sector, it should be widened to include private hospitals.

The authority has long had an internal assessment system for public hospitals. It has already improved transparency by implementing a voluntary 24-hour error-reporting mechanism for staff. But as the medical blunders and other problems – such as long waits to see doctors and short consultations – show, this does not address concerns about the safety and quality of services.

Medical staff have made mistakes, but this happens in hospitals the world over, no matter whether public or private. An element of risk always exists during treatment or surgical procedures. The aim of an independent accreditation mechanism is to keep the chances of mishaps as low as possible. Doing this by having a foreign group carry out the assessment, as the authority plans, is the way forward. With the tender process expected later this year and a pilot project completing the first accreditations within two years, a worthy start will have been made. But over time, Hong Kong should have its own assessment team attuned to local needs, as is the authority's long-term goal. To ensure that international trends are accounted for, however, some members of the team should be from overseas.

Health-care reforms will mean more residents will use the private rather than public system. Ensuring that standards in both sectors remain high is therefore important. This can only be done if all hospitals are assessed under the same system.

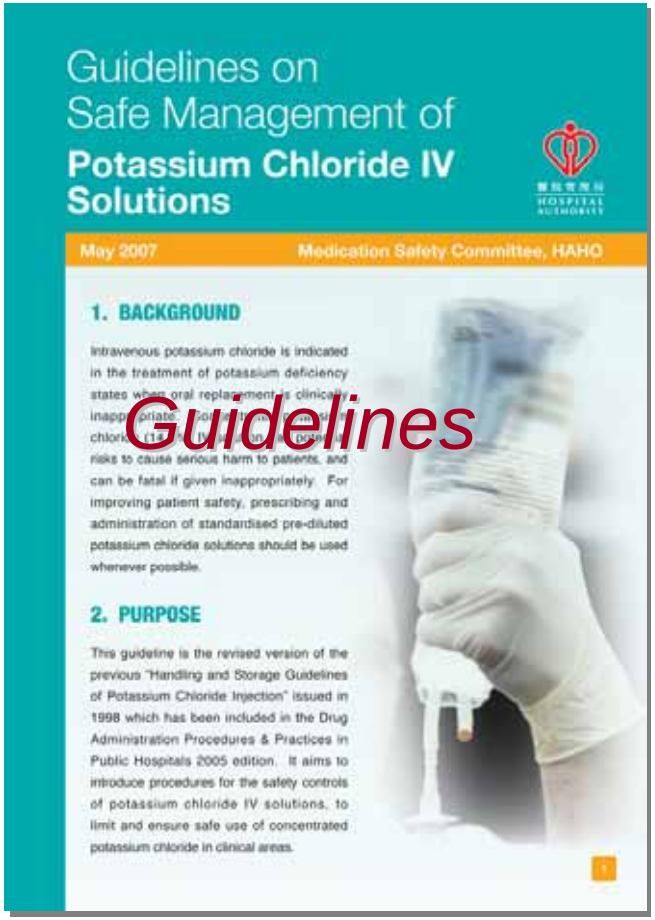
Quality & Safety

Clinical Effectiveness & Technology Assessment

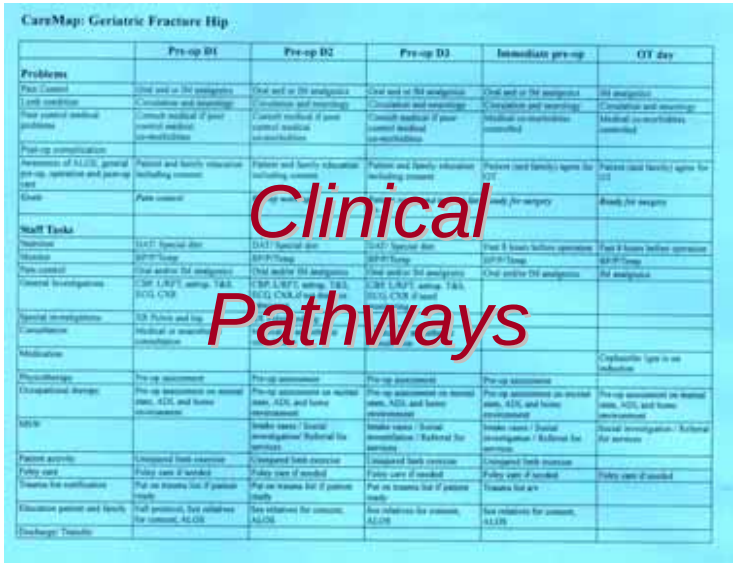
- Clinical Effectiveness
- Clinical Indicators
- Clinical Audit

- Technology Management & Assessment

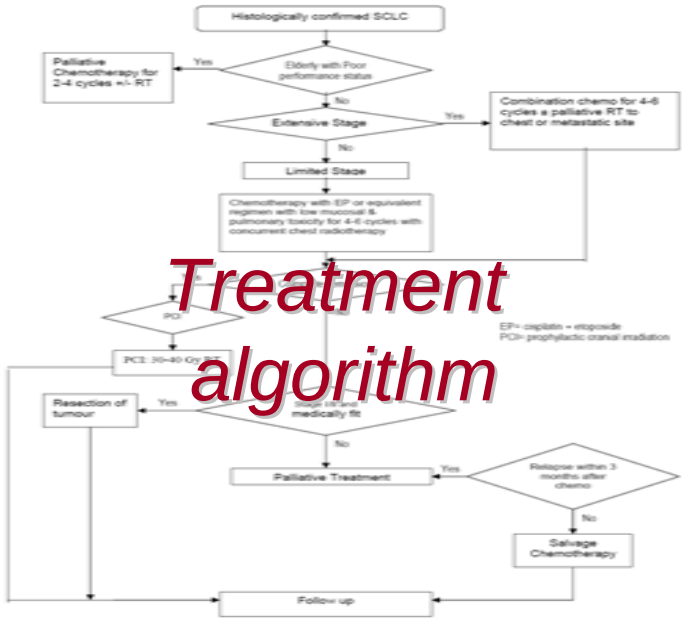
Define best practice



Guidelines



Clinical Pathways



Treatment algorithm

Management checklist

Adult patients with acute stroke

- Received treatment in an ASU
- Received CT/MRI of brain ≤12 hrs of A&E registration
- Not to give short acting antihypertensive (nifedipine) ≤3 days of admission
- 7-day case-fatality
- Screened for swallowing disorder ≤24 hrs of admission
- Received aspirin/plavix ≤48 hrs of admission
- Received warfarin for AF
- Assessed by PT ≤ 3 days of admission
- Assessed by OT ≤ 7 days of admission
- Prescribed aspirin/plavix on discharged

HAMSINP

HA Mechanism for the Safe Introduction of New Procedure/Technology

Support Doctors, Protect Patients

About HAMSINP	Application guide, MSDC Discussion Papers, Presentation Materials, Memorandum.
Quick Guide	A quick guide for applicants
	Operating Procedures Central cardiac committee memo on Introduction of New Cardiac Device into HA

Central Review Mechanism

1. New Procedure Classification

No.	Description	Classification	Records			Alert	Update Column
			Application	Review Protocol	Recommendation		
01/01	Ventricular assist device as a bridge to heart transplantation for end stage heart failure	A	12 Jan 01		12 Apr 01		Nov 02
01/02	Real-time CT fluoroscopic guided aspiration of intracerebral haematoma and biopsy of deep seated brain lesion	Significant Change	2 Mar 01		21 Mar 01		
01/03	Radiofrequency ablation for unresectable liver tumours	B	24 May 01		07 Aug 01		Nov 03
01/04	Photodynamic therapy with verteporfin for subfoveal choroidal neovasculization in: (1) age-related macular degeneration (AMD), and (2) pathologic myopia	A for 1, B for 2	19 Jun 01		10 Sep 01		Nov 02
01/05	Laparoscopic donor nephrectomy	B	23 Aug 01		5 Oct 01		

Central Review Mechanism

2. Expedited Review

No.	Description	Classification	Records	Alert	Update Column
E03/01	Paclitaxel-eluting coronary stent	B	18 Mar 03	FDA's DES Thrombosis Panel 7-8 Dec 06	FDA granted PMA on 4 Mar 04
				5 Jan 07	US Congress Committee requests sweeping information on DES 6 Mar 07
E03/02	Dexamethesone-eluting coronary stent	B	30 Aug 03		
E03/03	Biphasic waveform defibrillation	A	1 Aug 03 FDA Approval Letters		
E03/04	Cobalt-based coronary stent	B	7 Aug 03		

http://www.ekg.org.hk/html/gateway/tm/htareport.htm 移至

Healthcare Technology Assessment Reports

- Ventricular assist devices (VADs) for end stage heart failure. Hong Kong: Hospital Authority; 2001 Mar . (Hospital Authority Healthcare Technology Assessment Report; HTA TA/01/05)
- Interventions for asymptomatic carotid artery stenosis - Part I. Hong Kong: Hospital Authority; 2001 May. (Hospital Authority Healthcare Technology Assessment Report; HTA TA/01/06)
- Relative effectiveness of different cochlear implant models - CLARION®, NUCLEUS®, COMBI and DIGISONIC®. Hong Kong: Hospital Authority; 2001 Jul. (Hospital Authority Healthcare Technology Assessment Report; HTA TA/01/07)
- Asymptomatic carotid artery stenosis - Part II: Risk stratification for moderate to severe asymptomatic carotid artery stenosis. Hong Kong: Hospital Authority; 2002 Mar. (Hospital Authority Healthcare Technology Assessment Report; HTA TA/02/08)
- Surgical intervention for spontaneous supratentorial intracerebral haemorrhage. Hong Kong: Hospital Authority; 2002 Jul. (Hospital Authority Healthcare Technology Assessment Report; HTA TA/02/09)
- Hyperbaric oxygen for carbon monoxide poisoning. Hong Kong: Hospital Authority; 2003 Jul. (Hospital Authority Healthcare Technology Assessment Report; HTA TA/03/10)
- Core decompression for avascular necrosis of the femoral head. Hong Kong: Hospital Authority; 2003 Sep. (Hospital Authority Healthcare Technology Assessment Report; HTA TA/03/11)
- Bisphosphonate and avascular necrosis of bone. Hong Kong: Hospital Authority; 2003 Nov. (Hospital Authority Healthcare Technology Assessment Report; HTA TA/03/12)
- Hyperbaric oxygen and avascular necrosis of bone. Hong Kong: Hospital Authority; 2003 Nov. (Hospital Authority Healthcare Technology Assessment Report; HTA TA/03/13)
- Health Hazards of Benzyl Alcohol Preserved Parenteral Solutions and Medications. Hong Kong: Hospital Authority; 2005 Feb. (Hospital Authority Healthcare Technology Assessment Report; HTA TA/05/14)
- Endovascular coil embolization for intracranial aneurysm. Hong Kong: Hospital Authority; 2005 Jun , revised 2006 Mar. (Hospital Authority Healthcare Technology Assessment Report; HTA TA/05/15)
- Current status on medical application of hyperbaric oxygen therapy (HBOT). Hong Kong: Hospital Authority; 2006 Jun. (Hospital Authority Healthcare Technology Assessment Brief; HTA RR/06/03)
- The role of cardiac resynchronization therapy in the management of advanced chronic heart failure in adults. Hong Kong: Hospital Authority; 2006 Oct. (Hospital Authority Healthcare Technology Assessment Brief; HTAB 06/01)
- Current status of positron emission tomography (PET) in the management of lymphoma. Hong Kong: Hospital Authority; 2007 Mar. (Hospital Authority Healthcare Technology Assessment Brief; HTA RR/07/04)
- Current status of Natural Orifice Transluminal Endoscopy Surgery (NOTES). Hong Kong: Hospital Authority; 2007 Jul. (Hospital Authority Healthcare Technology Assessment Brief; HTA RR/07/05)
- Mobile computed tomography scanner for head and neck imaging. Hong Kong: Hospital Authority; 2007 Sep. (Hospital Authority Healthcare Technology Assessment Brief; HTA RR/07/06)
- new! Radiofrequency ablation for breast cancer. Hong Kong: Hospital Authority; 2007 Oct. (Hospital Authority Healthcare Technology Assessment Brief; HTA RR/07/07)

Quality & Safety

Patient Relationship & Engagement

- Complaint Management
- Patient engagement
  Patient Satisfaction Survey

Patient Engagement & Partnership

Patient group (communication)

Participation in health care governance

Facilitating patient care process

Health education

Health citizenship

Patient Satisfaction Survey (PSS)

A Quality and Organization Improvement Project through structured collection and monitoring of patient feedback

Driving forces

(1) "***Need to tap patient views, collate and analyze the results with a view for improvement of services and formulation of policies***."
HA Annual Plan Section 3 - Quality Improvement Standard No. 12

(2) Public accountability & clinical governance

(3) The growing trend / need of involving patients in the delivery of health care (WHO's paper August 2003)

NHS UK

Annual hospital survey using standard questions for national performance monitoring and benchmarking. Department of Health follow-up results at the National Performance Assessment Framework

Australia (Victoria) - Monitoring overall care index

- Access and admission including staff attitude
- General patient information giving
- Treatment information and help offered
- Complaints management
- Physical environment and food
- Discharge and follow-up arrangements

USA (Medicare and Mediaid)

Hospitals treating patients with Medicare and Mediaid plans need **to monitor patient experience and satisfaction** using the standardized approach endorsed by The Center for Medicare and Medicaid Services (a dept in the Federal government)

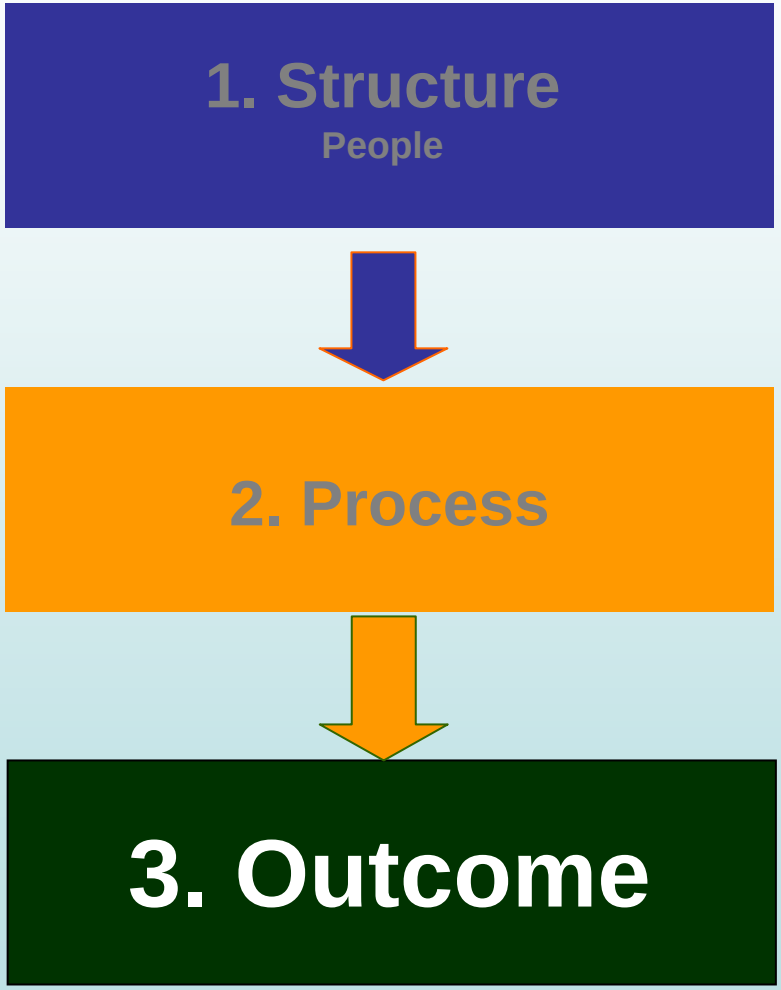
Proposal - A Structured PSS in HA

1. Standardised tools and method
2. Centrally - coordinated and led
3. Measure patients' experience (patients' journey)
   - Accessibility & convenience
   - Physical environment
   - Mechanism for handling dissatisfaction
   - Interpersonal relationship
   - Treatment co-ordination

PSS results →

- Identify areas for improvement
- Benchmark over time
- Public accountability & clinical governance

The approach



QUALITY ASSURANCE

Measurement / monitoring (data)

1. Key Performance Indicators

- Service performance indicators
- Clinical outcome indicators

2. Audits

Service Performance KPIs – HA wide

Access (23 KPIs)

1. Waiting Times

- A&E WT
- WT for SOP New Case Booking
- WT for specific investigation / treatment

Quality (12 KPIs)

1. Appropriateness

- Admission Rate for AED Pts

2. Safety

- Unplanned readmission rate
- Infection rate

3. Service Coverage

- HbA1c test
- VMO scheme
- New Psy drugs

4. Responsiveness

- (being dev)

Efficiency (16 KPIs)

1. Cost

- Drug cost

2. Efficient Use of Resources

- Day Surgery Rate
- Bed occupancy rate
- Bed Management
- ALOS
- New case ratio for SOP service
- Utilization Rate of GOP service

KPIs for Service Performance

(For reporting to Sep 2007 round of CMMs)

(Report Period : 1.7.2006 - 30.6.2007)

*** **The figures serve as comparison/reference only. They are not pledged performance/target of the Hospital Authority.** ***

Item	KPIs	Implementation	Data provided by	HKE	HKW	KC	KE	KW	NTE	NTW	HA Overall
1	% of A&E pts seen within target WT for T1	Sep CMM	Stat Unit (Mx info & clinical info)	1							100%
2	% of A&E pts seen within target WT for T2	Sep CMM	Stat Unit (Mx info & clinical info)								96%
3	% of A&E pts seen within target WT for T3	Sep CMM	Stat Unit (Mx info & clinical info)								86%
4	Average A&E WT for T4 (mins)	Sep CMM	Stat Unit (Mx info & clinical info)								75
5	Average A&E WT for T5 (mins)	Sep CMM	Stat Unit (Mx info & clinical info)								99
6	A&E WT for 90th percentile of patients of T4 (mins)	Sep CMM	Stat Unit (Mx info & clinical info)								164
7	A&E WT for 90th percentile of patients of T5 (mins)	Sep CMM	Stat Unit (Mx info & clinical info)								204
	Waiting Time for SOP New Case Booking										
8	% of pts seen within target WT for P1 SOP new cases (Med)	Sep CMM	Stat Unit (Mx info & clinical info)								95%
9	% of pts seen within target WT for P2 SOP new cases (Med)	Sep CMM	Stat Unit (Mx info & clinical info)								96%
10	% of pts seen within target WT for P1 SOP new cases (Surg)	Sep CMM	Stat Unit (Mx info & clinical info)								93%
11	% of pts seen within target WT for P2 SOP new cases (Surg)	Sep CMM	Stat Unit (Mx info & clinical info)								90%
12	% of pts seen within target WT for P1 SOP new cases (O&T)	Sep CMM	Stat Unit (Mx info & clinical info)								97%
13	% of pts seen within target WT for P2 SOP new cases (O&T)	Sep CMM	Stat Unit (Mx info & clinical info)								96%
14	% of pts seen within target WT for P1 SOP new cases (Psy)	Sep CMM	Stat Unit (Mx info & clinical info)								92%
15	% of pts seen within target WT for P2 SOP new cases (Psy)	Sep CMM	Stat Unit (Mx info & clinical info)								89%
16	WT for SOP new case booking for 75th percentile of 'R' cases for Med (weeks)	Sep CMM	Stat Unit (Mx info & clinical info)								42
17	WT for SOP new case booking for 75th percentile of 'R' cases for Surg (weeks)	Sep CMM	Stat Unit (Mx info & clinical info)								83
	WT for SOP new case booking for 75th percentile of 'R' cases		Stat Unit (Mx info &								

A&E waiting time

SOP New case waiting time

Item	KPIs	Implementation	Data provided by	HKE	HKW	KC	KE	KW	NTE	NTW	HA Overall
	Quality										
	Appropriateness										
	Admission Rate for AED Pts										
24	Standardised admission rate for AED pts	Sep CMM	Stat Unit (Mx info & clinical info)								26%
25	Standardised admission rate for AED pts presenting with medically related problems	Sep CMM	Stat Unit (Mx info & clinical info)								34%
	Safety										
	Unplanned Readmission Rate										
26	Unplanned readmission rate for fracture hip	Dec CMM	Stat Unit (Mx info & clinical info)								
27	Unplanned readmission rate for Stroke	Dec CMM	Stat Unit (Mx info & clinical info)								
	Infection Rate										
28	Surgical site infection (SSI) rate	TBA	Quality & Safety Division								
29	Catheter associated bloodstream infection (SABSI) rate in ICU per 1,000 catheter days	TBA	Quality & Safety Division								
	Service Coverage										
	HbA1c Test for DM Pts										
33	% of DM pts followed up in SOPDs with HbA1c checked in same 12 month period	Dec CMM	Stat Unit (Mx info & clinical info)								
	VMO Scheme										
34	No. of OAHs covered by VMO scheme (as at 31.3.2007)	Sep CMM	Primary & Community Services								211
35	% of OAHs covered by VMO scheme (as at 31.3.2007)	Sep CMM	Primary & Community Services								28%
	Bed Occupancy Rate										
42	Overall bed occupancy rate at midnight	Sep CMM	Stat Unit (Mx info & clinical info)								82%
43	IP bed occupancy rate at midnight for Medical specialty	Sep CMM	Stat Unit (Mx info & clinical info)								90%
	Bed Management										
44	Total no. of excess bed days in all wards	Sep CMM	Stat Unit (Mx info & clinical info)								147,662
45	Total no. of vacant bed days in all wards	Sep CMM	Stat Unit (Mx info & clinical info)								1,757,716
	Average Length of Stay										
46	ALOS for Fracture Hip (acute + convalescent)	Dec CMM	Stat Unit (Mx info & clinical info)								
47	ALOS for Stroke (acute + convalescent)	Dec CMM	Stat Unit (Mx info & clinical info)								
	New Case Ratio for SOP Service										
48	New case ratio for SOPC (Medicine)	Sep CMM	Stat Unit (Mx info & clinical info)								4%
49	New case ratio for SOPC (Surgery)	Sep CMM	Stat Unit (Mx info & clinical info)								14%
50	New case ratio for SOPC (O&T)	Sep CMM	Stat Unit (Mx info & clinical info)								12%

A&E Admission rate

Unplanned readmission rate

Infection rate

A1c test for DM

VMO

Bed occupancy rate

ALOS

New Case Ratio for SOP

KPIs for Service Performance

(For reporting to Sep 2007 round of CMMs)

(Report Period : 1.7.2006 - 30.6.2007)

*** The figures serve as comparison/reference only. They are not pledged performance/target of the Hospital Authority. ***

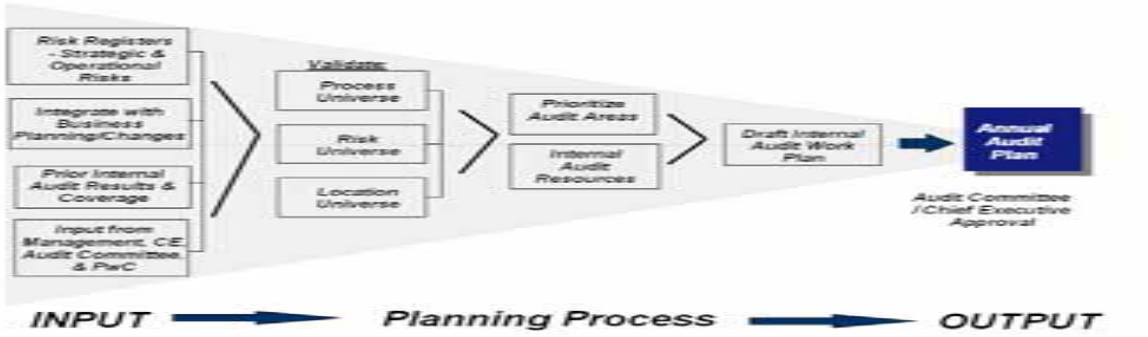
Item	KPIs	Implementation	Data provided by	HKE	HKW	KC	KE	KW	NTE	NTW	HA Overall
	Cost										
	Drug Cost										
39	Consumption expenditure of big gun antibiotics in acute general hospitals per 1,000 BDO	Sep CMM	CPO	PYN RH				PMH $11,65			
40	Consumption expenditure of overall antibiotics in acute general hospitals per 1,000 BDO	Sep CMM	CPO	PYN RH				TCH $23,92			

Antibiotic expenditure Per 1000 BDO

KEY PERFORMANCE INDICATORS
(KPIs)

Clinical outcome indicators
(being developed)

HA GENERAL INTERNAL AUDITS



Annex III

HA ANNUAL AUDIT PLAN
2007 / 2008

#	Audit Areas	Audit Scope
A	Patient Care Risks	
210	Waiting Time Information Management - 3Q 2007	• Definition - consistency • Information availability / coverage • Performance targets and monitoring • Reporting and benchmarking across clusters • Use of management information
230	Obstetric Services Booking Administration - 2Q 2007	• Risk assessment • Guidelines and standards • Compliance assurance • Patient communication • Anti-corruption measures
231	Long-Stay Patients Management - 3Q 2007	• Accountability • Policy and procedures • Patient communication • Discharge planning & co-ordination • Length of stay • Performance management • Sharing of good practices
250	Patient Identification - Pathology Services - 2Q 2007	• Risk assessment • Guidelines and standards • Compliance assurance • Awareness and training • Facilities • Incident reporting / remedial actions
251	Hospital Annual Plan Section 3Q IS • Patient clinical record #51 - 4Q 2007	• Accountability • Guidelines and standards • Quality Assurance • Safekeeping and retention
310	Hospital Annual Plan Section 3Q IS • Point of care testing #16 - 1Q 2008	• Application of code of good practice • POCT devices • Waiting time • Performance management • Training
340	Management of High Risk Medications - 1Q 2008	• Standard abbreviation chart • Standard medication dilution chart • Removal of concentrated KCL from general wards • Compliance assurance • Performance indicators / targets • Sharing of good practices
980	SARS Review Reports F/U - 2Q 2007	Provide independent assurance on the actioning of all SARS review report recommendations

B	Supporting Services Risks	
420	Medical Equipment Management F/U (including Calibration) - 4Q 2007	• Accountability • Acquisition planning • Maintenance and prevention of faults • Calibration • Utilization management • Overall management strategy
C	Financial Risks	
540	Management of Medical Fee Waivers (DOA) F/U - 4Q 2007	• Processing of applications • Approval authority • Anti-fraud and anti-abuse measures • CSSA establishment and verification • Quality assurance mechanism • Performance management • Training
541	Management of Outstanding Medical Fees (DOA) F/U - 1Q 2008	Hospitals • Telephone tfu record and time-frame • Settlement by instalments HAHO • Warning letters to defaulters • Filing claims /seeking legal advice • Collection team resources • Performance management Preventive measures • Frequent defaulters • Surcharge on overdue fees • Address proof verification
D	Human Resource Risks	
640	Payment of Doctors Work Hours Claims - 3Q 2007	• Ensuring no 'Ghost' doctors / duplication • Correct and authorized payments • Verification and reconciliation control • Compliance assurance • Budget control
641	Employee Compensation - Injury-on-Duty - 3Q 2007	• Policy and procedures • Compliance assurance • Assessment capability • Staff communication • Management information availability and use
E	Legal Risks	
280	Claims Management - 1Q 2008	• Policy and procedures • Risk assessment • Quality assurance • Capability / outsourcing • Performance monitoring and reporting
950	Doctors' Work Hours – Legal Compliance - 4Q 2007	• Typical weekly hours at each grade • Rest days, SH compensation, call frequency • Comparison with previous periods • Changes in resources and systems at

		the department level
F	Information Resource Risks	
430 542 543	Computer Assisted Audit Techniques (CAATs) - ongoing	• HBFS - Purchase • HRPS • HBFS – Accounts Payable
830	Data Centre Facilities - 4Q 2007	• Project & vendor management • Contract and power supply administration • Network and operation controls and security • Post implementation review
831	IT Network Availability - 1Q 2008	• Strategy • Planning • Monitoring • Review process
840	Enterprise Resources Planning System (ERPS) - Ongoing	• Strategy • Procurement controls • Project management controls • User requirements, testing & acceptance • Operation controls & security design • Change management
841	Patient Billing & Revenue Collection (PBRC) - Ongoing	• Strategy • Procurement controls • Project management controls • User requirements, testing & acceptance • Operation controls & security design • Change management
850	Web Application Control and Security - 3Q 2007	• Strategy • Policies & procedures • Implementation • Awareness
860	IT Continuity Planning F/U - 2Q 2007	• Strategy • Planning • Implementation
870	Public Private Interface – Auto Reply / Discharge Summary F/U - 4Q 2007	• Automation • Monitoring • Review Process

HA-wide Clinical Audit

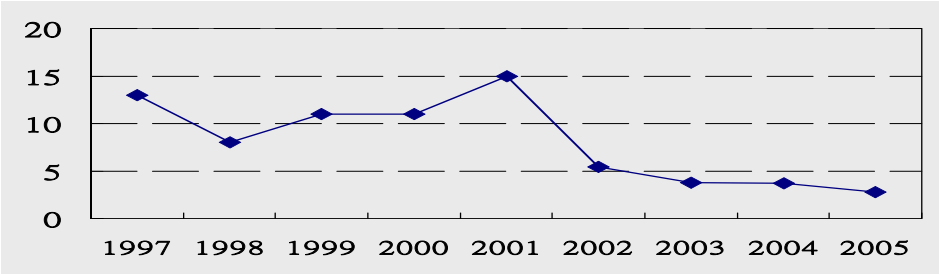
Year	Topics	Risk-adjustment	Focus of audit
2002	Hepatectomy	No	Mortality
	Esophagectomy	No	
	Liver Transplantation	No	
2003	Total cystectomy	Yes	Mortality
2004	Laparoscopic surgery	No	Trend
	Whipple's operation	Yes	Mortality
2005	Emergency colectomy	Yes	Mortality
	Thoracic surgery	Yes	Mortality and survival
2006-2007	Esophagectomy- second audit	Yes	Mortality
	Ca rectum	No	Mortality and survival
	Pre-operative length of stay	No	
2007-2008	Very Low birth weight	No	Morbidity & mortality
	Management of adult in-patients with acute stroke	No	Service review
	Management of adult diabetic patient in Specialist Out-patient Clinic	No	Service review

HA surgical performance can be improved with the implementation of Surgical Outcomes Monitoring System

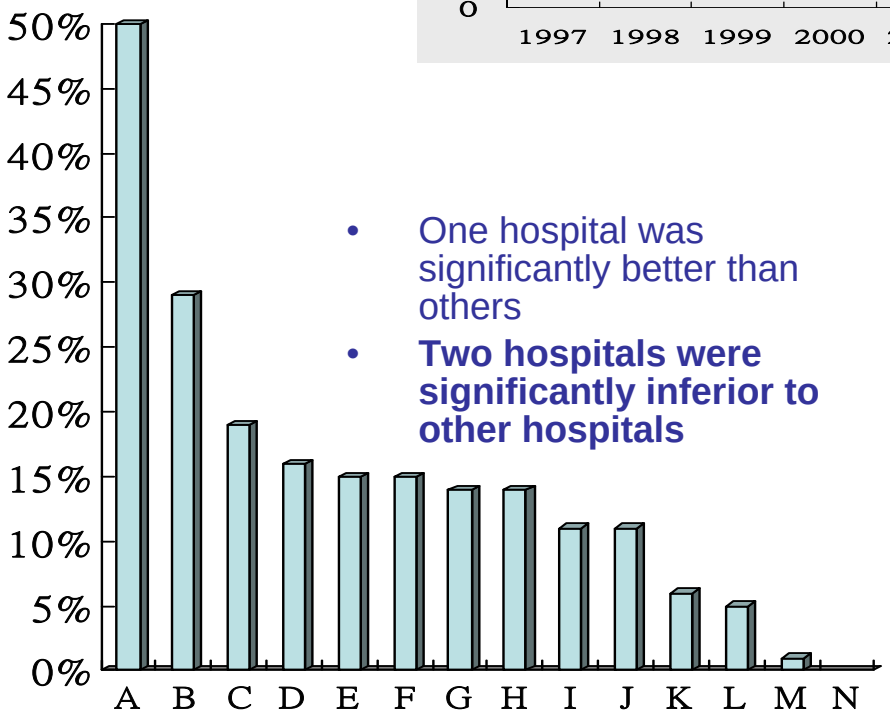
Conclusion from the two comparative audits on Esophagectomy

Yuen WC[1], Kwan TL[1], Andy Wai[1], Florence Lai[2], Deska Siu[2] [1]Central Surgical Audit Unit, HAHO [2]Statistics and Research Section, HAHO

Mortality rate dropped between 2002 - 2005



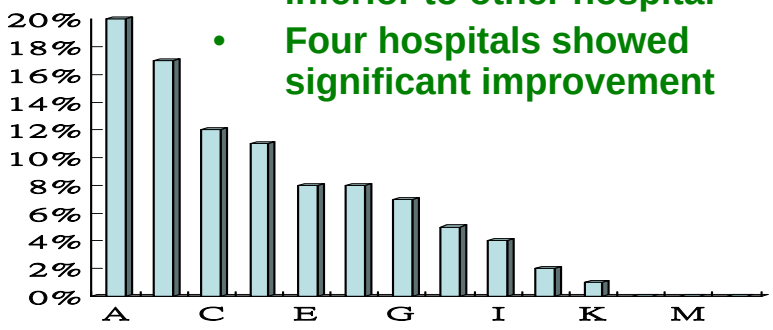
2002 AUDIT



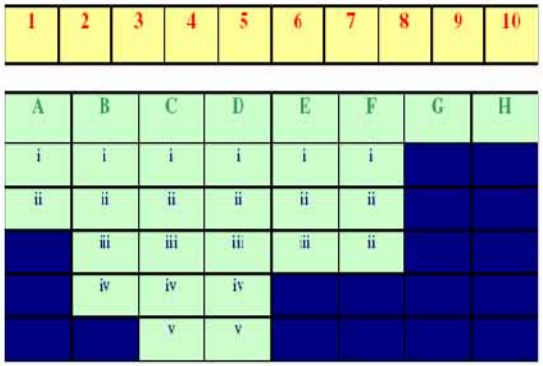
- One hospital was significantly better than others
- **Two hospitals were significantly inferior to other hospitals**

2005 AUDIT

- One hospital continued to be significantly better
- **No hospital was significantly inferior to other hospital**
- **Four hospitals showed significant improvement**



Anaesthesia Related Mortality in Hong Kong 2003 – 2005



Report prepared by the Quality Assurance Subcommittee
of the Co-ordinating Committee in Anaesthesiology of the Hospital Authority

Anaesthesia Related Mortality 2003-2005

Mortality within 30 days of operation*

Hospital	2003	2004	2005	Total
A				70
B				263
C				1
D				108
E				17
F				392
G				416
H				7
I				463
J				556
K				503
L				1,187
M				728
N				166
O				141
P				703
Q				32
R				519
S				264
T	0	0	0	0
Overall	2,141	2,171	2,221	6,533

ble 5. Causal or contributory factors in anaesthesia related mortality in 2003 to 2005

		2003	2004	2005	Total
A	PRE-OPERATIVE	2	3	6	11
	i. Assessment	1	2	5	8
	ii. Management	1	1	1	3
B	ANAESTHESIA TECHNIQUE	2	6	5	13
	i. Choice of application	0	1	0	1
	ii. Airway maintenance	2	2	1	5
	iii. Ventilation	0	0	0	0
	iv. Circulatory support	0	3	4	7
C	ANAESTHESIA DRUGS	2	0	1	3
	i. Selection	0	0	0	0
	ii. Dosage	2	0	1	3
	iii. Adverse event	0	0	0	0
	iv. Incomplete reversal	0	0	0	0
	v. Inadequate recovery	0	0	0	0
D	ANAESTHESIA MANAGEMENT	1	2	3	6
	i. Crisis management	1	0	0	1
	ii. Inadequate monitoring	0	1	3	4
	iii. Equipment failure	0	0	0	0
	iv. Inadequate resuscitation	0	1	0	1
	v. Hypothermia	0	0	0	0
E	POST-OPERATIVE	4	2	4	10
	i. Management	2	1	3	6
	ii. Supervision	0	0	0	0
	iii. Inadequate resuscitation	2	1	1	4
F	ORGANISATIONAL	1	0	3	4
	i. Inadequate supervision or assistance	0	0	1	1
	ii. Poor organisation	0	0	1	1
	iii. Poor planning	1	0	1	2
G	NO CORRECTABLE FACTOR	2	0	2	4
H	MEDICAL CONDITION OF PATIENT A SIGNIFICANT FACTOR	4	4	5	13
	Number of Category 1 to 3 cases	6	7	10	23

Anaesthesia Related Mortality 2003-2005

Table 7. Anaesthesia related mortality in other countries.

Country	Year of audit	No of anaesthetics performed	Incidents per 10,000 anaesthetics
Hong Kong	2003-2005	374,373	0.61
Australia[9]	2000-2002	7,650,000	0.18
Netherlands[6]	1995-1996	869,483	1.37
Taiwan[7]	2002	486,932	1.7
Japan[8]	1994-1998	2,363,038	0.21
Japan[14]	2001	1,284,957	0.1
Thailand[11]	2003-2004	163,403	5.75
France[10]	1999	7,756,121	0.54
England[3]	1987	485,850	7.4
Brazil[13]	1996-2005	53,718	1.12
Sweden[4]	1979-1989	262,850	0.27
Average			1.75

HK: 1 death in 16277

Clinical Audit Report

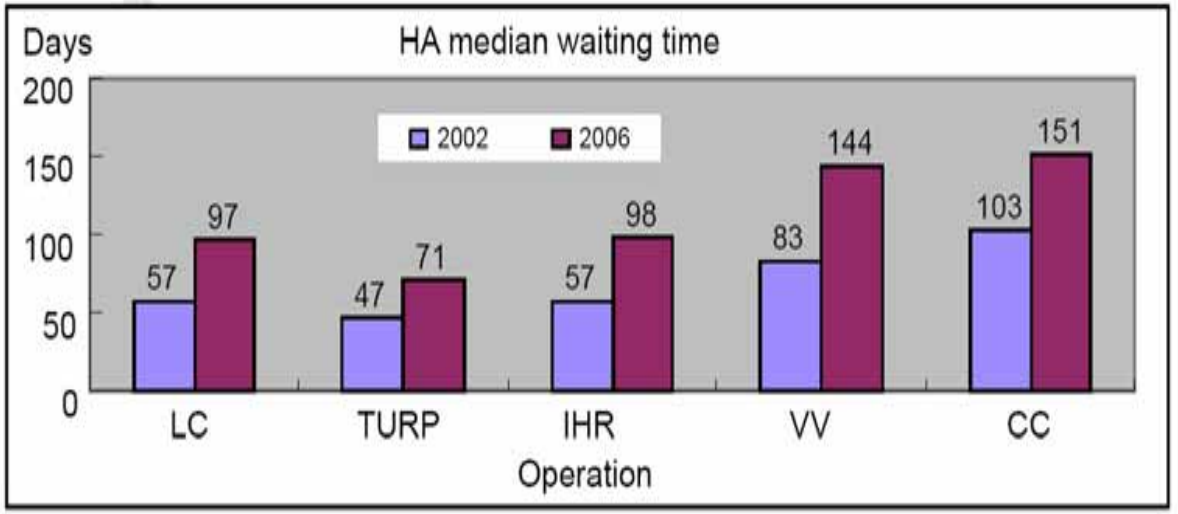
Waiting time of operations for benign surgical conditions

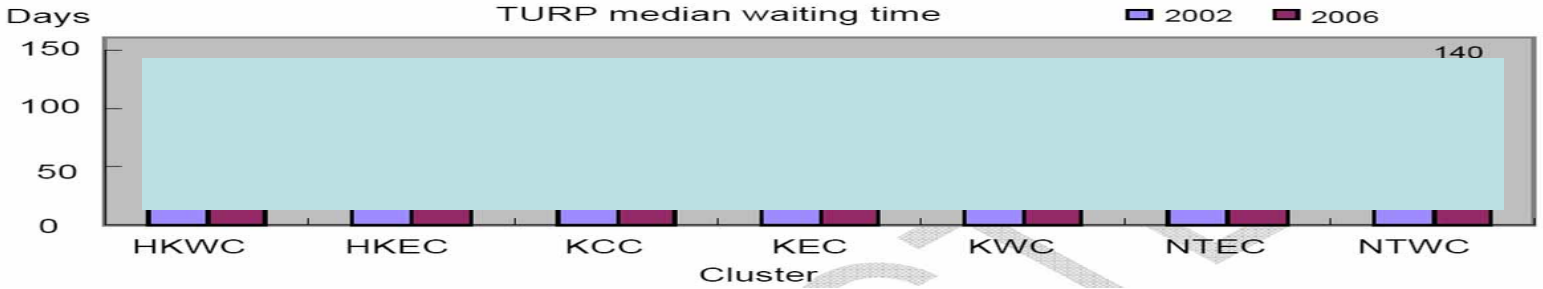
October 2007

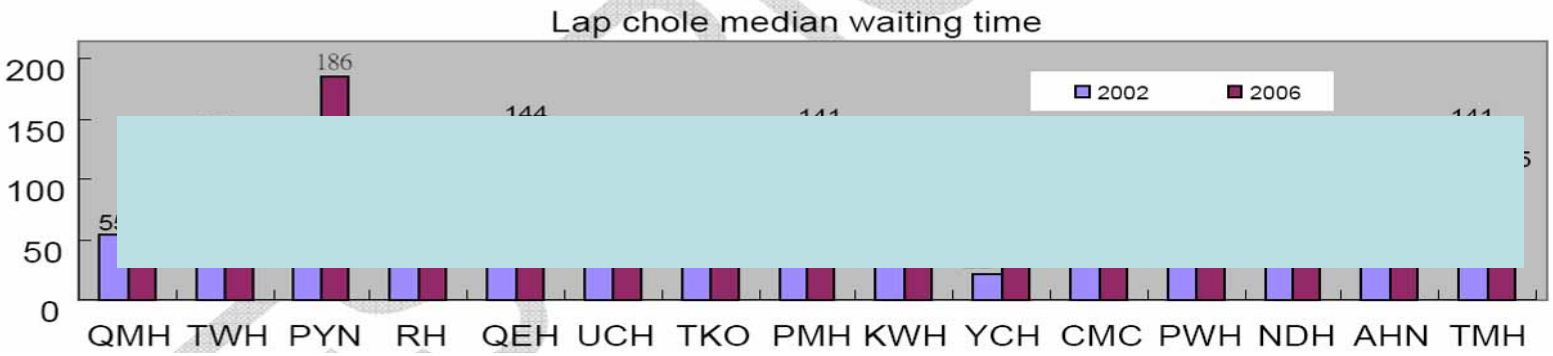
Central Surgical Audit Unit,
COC (Surgery) &
Quality & Safety Division
HAHQ

HA Waiting times for five operations

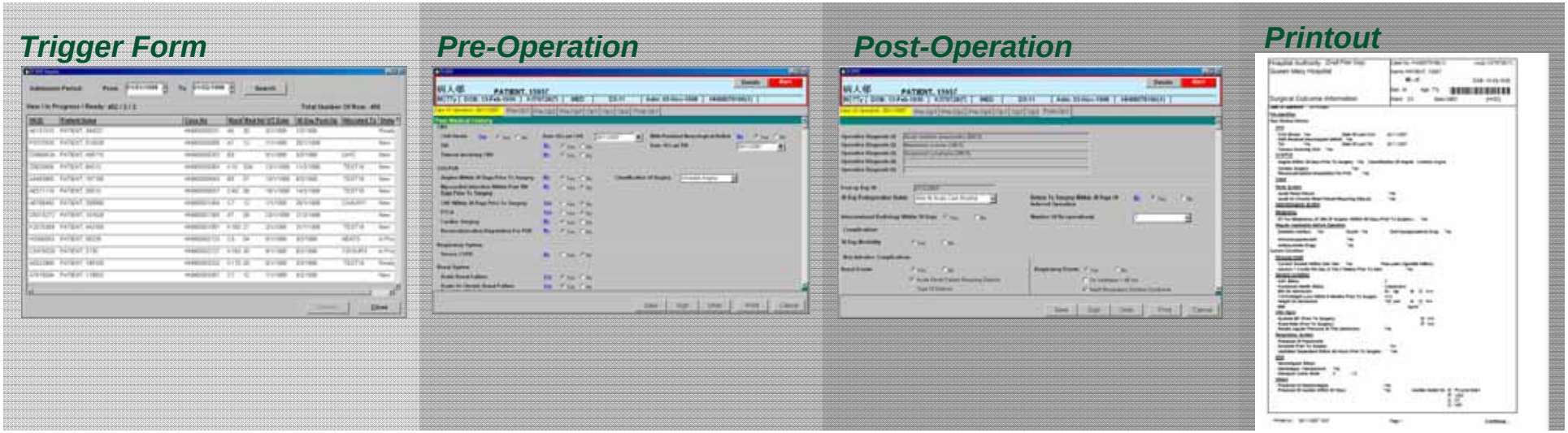
The following graph shows the HA median waiting times of the five operations in the year 2006 and 2002.







Surgical Outcomes Monitoring and Improvement Program (SOMIP)

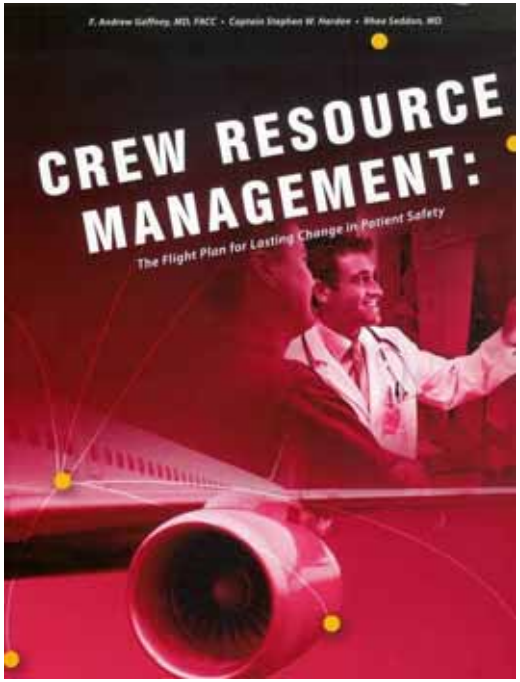


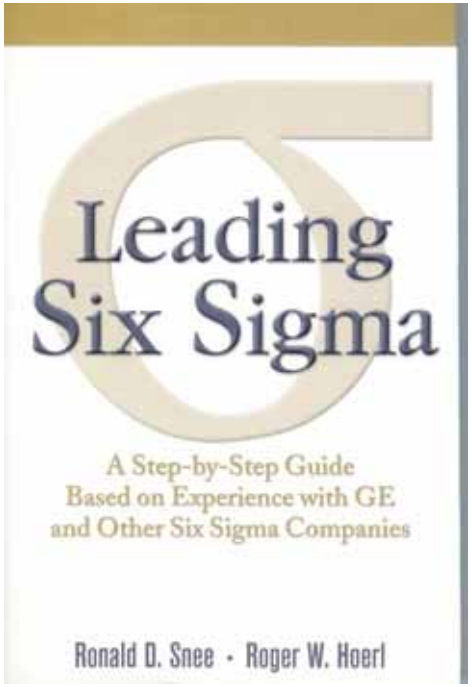
- Next phase of surgical clinical audit is 30,000 operations, using web-based data form,
  and 30 day post-operation check,
  adjusting for patient risk

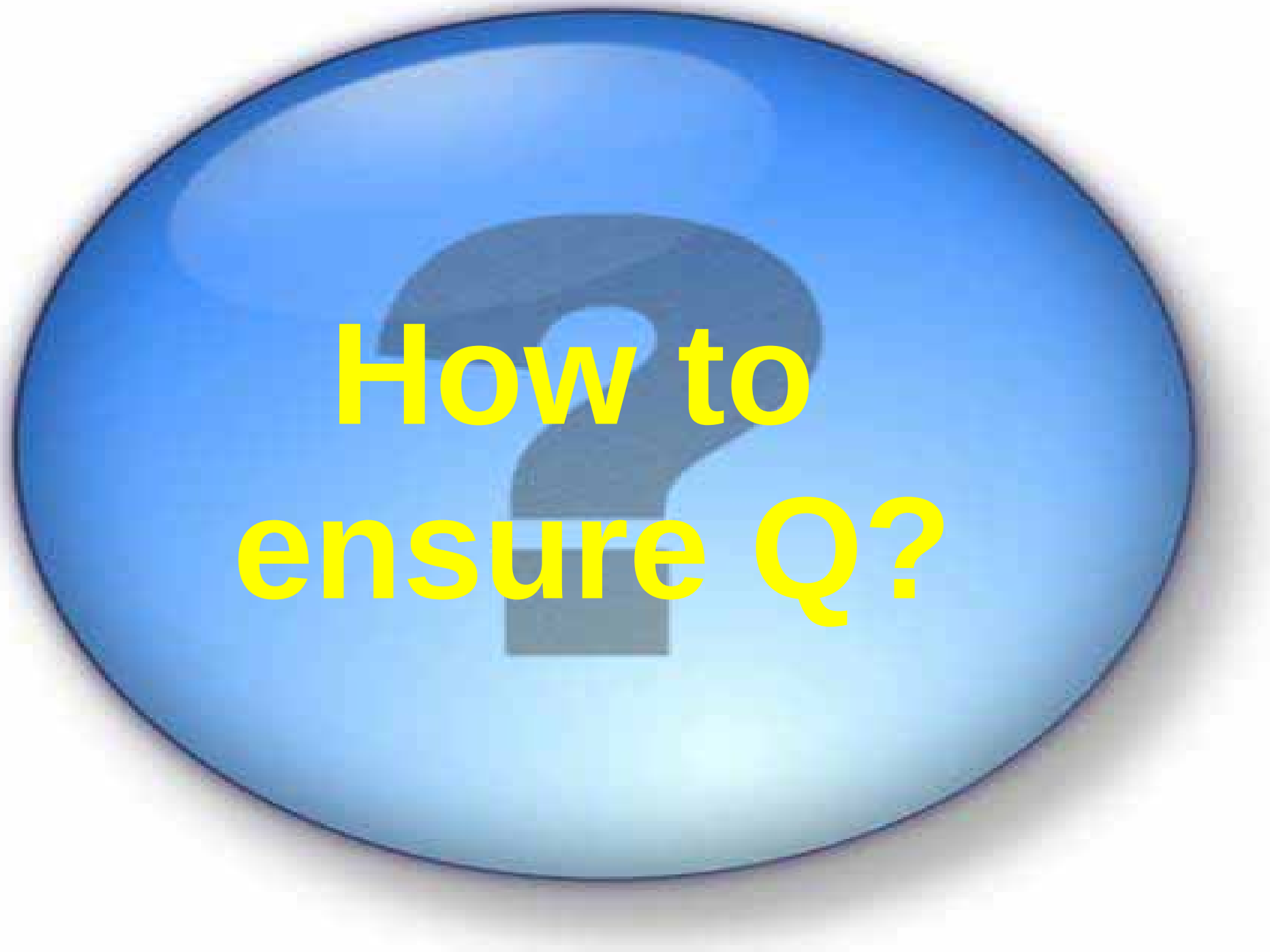

QUALITY IMPROVEMENT
1. CQI
2. Technology Assessment

CONTINUOUS QUALITY IMPROVEMENTS

- Continuous improvement of basic operation
- Thrive for excellence
- Use of technology, including IT
- Explore / apply alternative CI methods






How to
ensure Q?

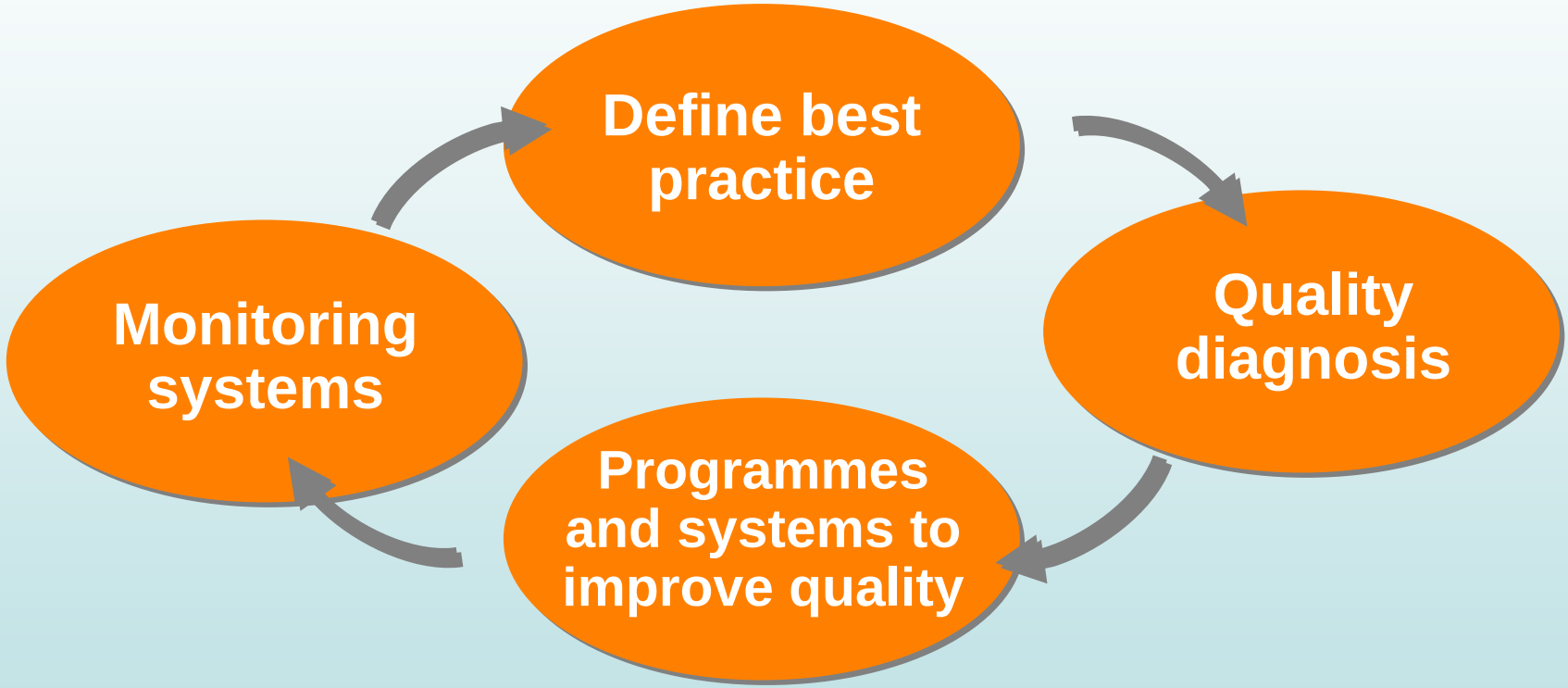
Clinical Governance

- **Clinical Governance is the system by which the governing body manages and clinicians share responsibility and are held accountable for patient care, minimizing risks to consumers and for continuously monitoring and improving the quality of clinical care.**

Australian Council on Healthcare Standards
ACHS News 2004; 12:1-2

- **Can / need to be used as the operation mode at hospital / department level to ensure quality**

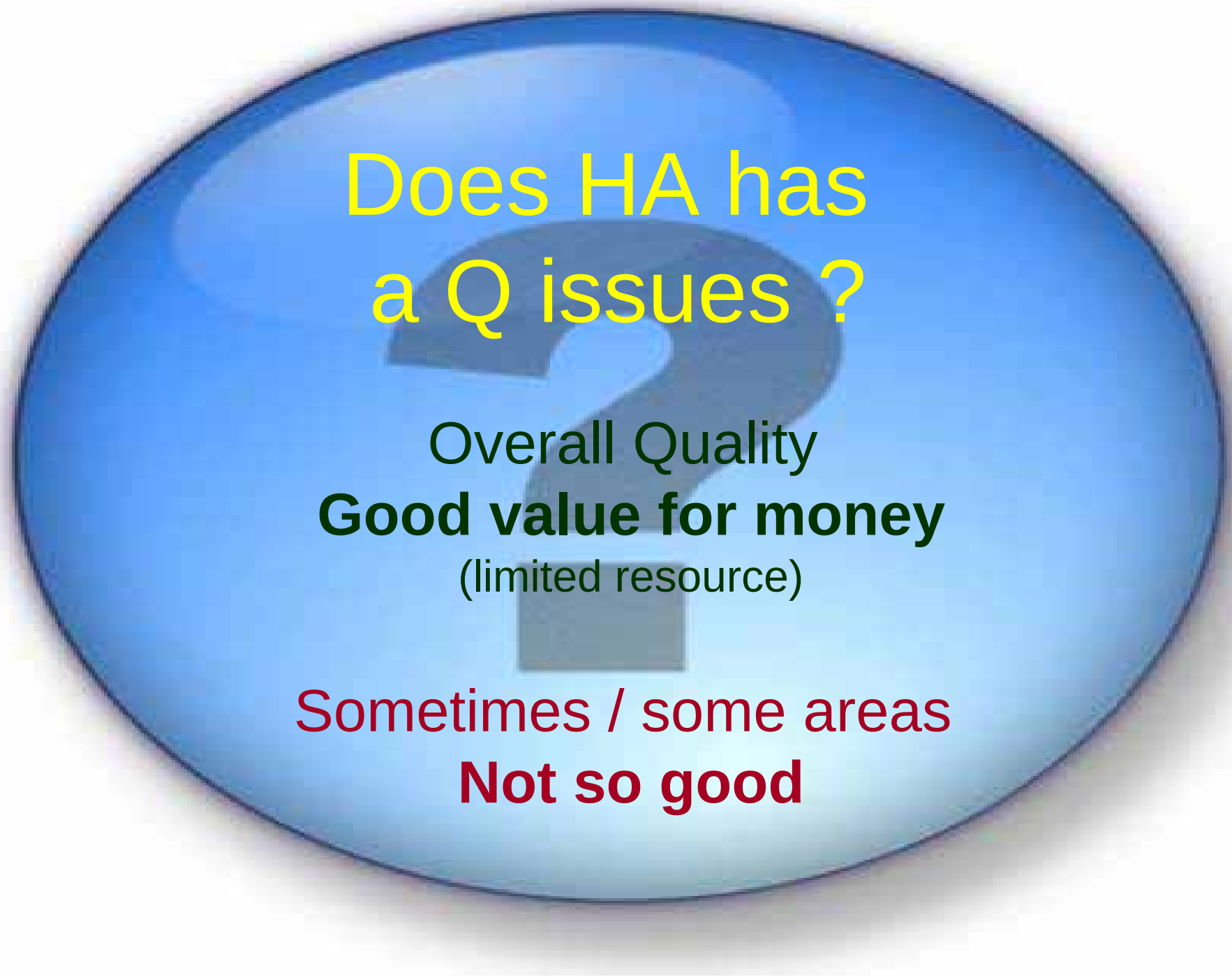
The Clinical Governance Loop



Presentation by CE, Top Management's needs and responsibilities for a Quality Program
2nd International Conference of the Asian Pacific Society for Healthcare Quality 2008

Monitor progress
Clear accountabilities

Presentation by CE, Top Management's needs and responsibilities for a Quality Program
2nd International Conference of the Asian Pacific Society for Healthcare Quality 2008


Does HA has
a Q issues ?
Overall Quality
Good value for money
(limited resource)
Sometimes / some areas
Not so good

South China Morning Post
Founded in 1903, Morning Post Centre, Dai Fat Street, Tai Po

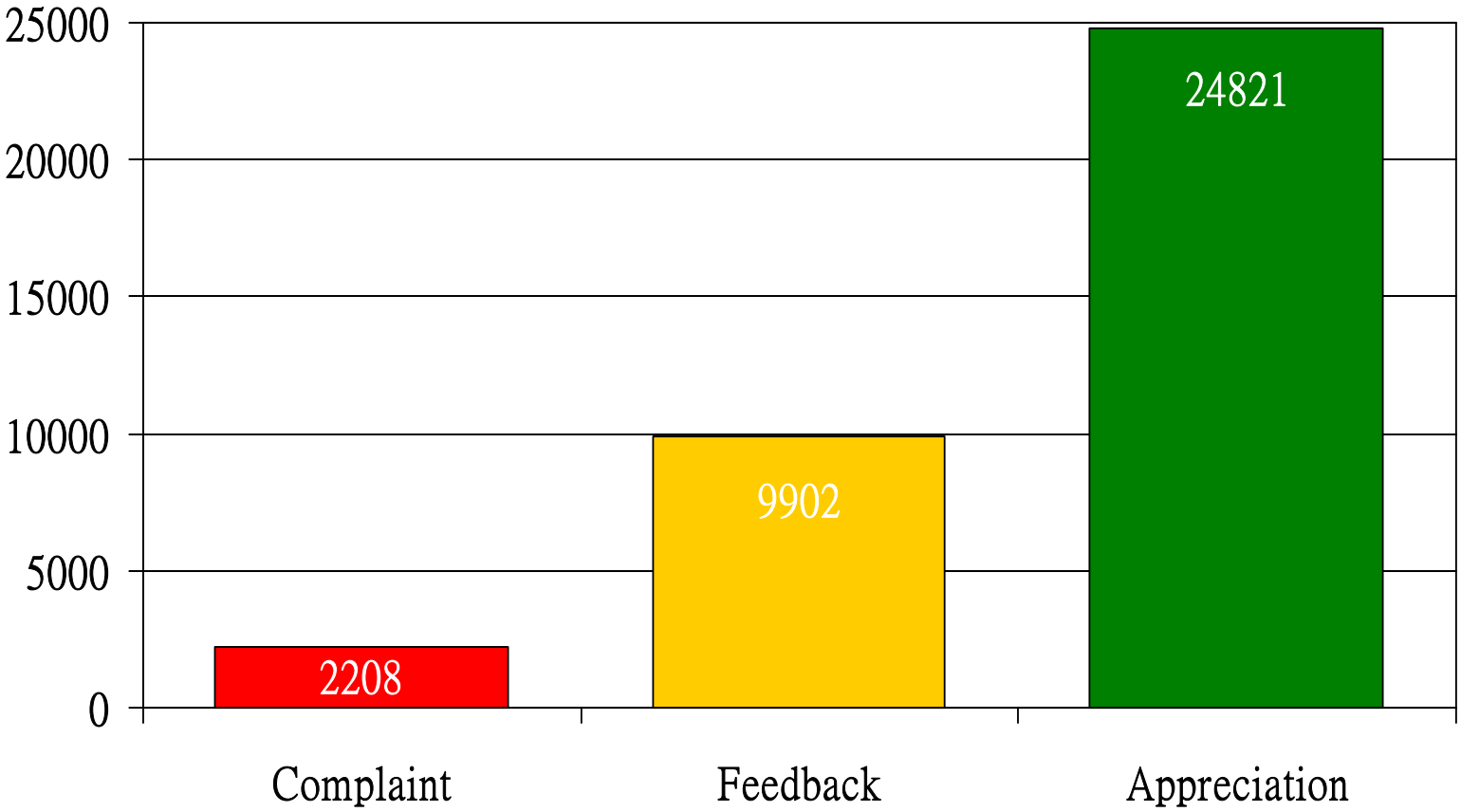
The right treatment for our hospitals

This is not to say that there are major problems with our public hospitals. The service they offer is of a high standard and is delivered to residents for minimal cost.

Medical staff have made mistakes, but this happens in hospitals the world over, no matter whether they are private or public. There is always an element of error involved with treatment or surgical procedures, while doctors with heavy work schedules are under much stress.

Some mistakes are inexcusable, of course; a patient being given the wrong blood type or a cancer treatment that is dangerous – as has happened in Hong Kong – has to be prevented. Regardless, we expect that with medicine and technology constantly improving, the risks should be nil and the quality of hospital staff, equipment and services high.

Complaint / Feedback / Appreciation
Hospital Authority 2006




Key Message

A new era of working together
for a safer and better healthcare system
for our patients and staff

Everyone's business

Leadership commitment - All staff engagement
Patient engagement

(1) Structure / people

(2) Process: Culture / System

Safety culture (reporting and learning), Open culture, Just culture
Safe systems (design), effective and efficient systems

(3) Outcome

Monitoring & Quality Assurance

World Health Organization

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- Patient safety
- World alliance
- Global challenge
- Patients for patient safety
- Taxonomy
- Research

Patient safety

Events | Links | Contact us

WHO > WHO sites > Patient safety > World alliance

World Alliance for Patient Safety

The Launch of the World Alliance for Patient Safety, Washington DC, USA — 27 October 2004

A significant event in the ongoing efforts to improve the safety of health care worldwide took place on 27 October 2004, when the World Health Organization and its key partners announced a series of important actions to reduce harm caused to patients with the launch of the World Alliance for Patient Safety. This is the first time that heads of agencies, policy-makers and patients' groups have came together from all corners of the globe to advance the patient safety goal of "First do no harm" and reduce the adverse health and social consequences of unsafe health care.