Quality Management in Hospital Practice

Current Movement and issues of Quality and Risk Management in Hospital Authority

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Consultant (Q&RM), HAHO
Chairman, Central Committee Quality & Risk Management
For Management Seminar Workshop, Hong Kong College of Emergency Medicine
8 Jan 2008

QUALITY
“Q” issue?
What “Q”?
Why “Q”?
How “Q”?

我萬二分的憂慮
醫管局行政
總裁蘇利民

HAHO Organizational Structure
2006

CE

Group Internal Audit

Cluster Services
Quality & Safety
Strategy & Planning
Human Resources
Corporate Services
Finance

7 CCEs
A new era of Working together to achieve a safe and high quality healthcare system for our patients and staff

SF Lui, David Lau, PY Leung
Central Committee on Quality and Risk Management
10 April 2007
Does HA have a Q issue?

Incidents* reported by all clusters for 12 months
Apr 06 - Mar 07

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Description</th>
<th>No of Incidents</th>
<th>Severity Index</th>
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<tr>
<td>1</td>
<td>Patient (injury/behaviours)</td>
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<td>1</td>
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<tr>
<td>2</td>
<td>Staff (OSH)</td>
<td>2,328</td>
<td>2</td>
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<tr>
<td>3</td>
<td>Medication</td>
<td>1,994</td>
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<td>4</td>
<td>Access, Admission, Transfer, Discharge</td>
<td>822</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>Investigation</td>
<td>740</td>
<td>5, 6</td>
</tr>
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* Not all reported incidents are medical incidents or errors, include general incidents.
The Hospital Authority

41 Hospitals with inpatient service
15 Emergency Departments
49 Specialist Outpatient Clinics
23 Family / Integrated Clinics
75 General Outpatient Clinics
53,468 staff

7,000,000 Patient records
1,140,288 Inpatient admissions
2,028,569 Emergency visits
1,867,377 Allied Health consultations
4,893,528 General Outpatient consultations
5,978,021 Specialist consultations
338,161 Operation consultations
12,172 Ultra Major Operation
107,758 Intermediate Operation
134,988 Major Operation
187,904 Minor Operation
41,683,593 Prescribed Drug Items

SETTLEMENT & COST FOR MEDICAL ERRORS / NEGLIGENCE

$$, $$, $$, $$ . 00

Complaint / Feedback / Appreciation

Hospital Authority 2006
**What is Q?**

**Different views of Qs**

<table>
<thead>
<tr>
<th>Public / Patients</th>
<th>平 靚 正 (快)</th>
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<tbody>
<tr>
<td>Media</td>
<td>(可作爲頭條新聞的醫療事故)</td>
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<tr>
<td>HAHO</td>
<td>Patient-centred  以人為本</td>
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<tr>
<td>Cluster / Hospital</td>
<td>X$ → XF → XE  (Money, Food, Eat)</td>
</tr>
<tr>
<td>Department / COS</td>
<td>“Do as told / allowed / possible”</td>
</tr>
<tr>
<td>Staff</td>
<td>Fair working condition  Able to do good work</td>
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</tbody>
</table>

**Definition of quality**

- the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and [the degree to which they] are consistent with current professional knowledge
- A scale, not an end state

Institute of Medicine: Crossing the Quality Chasm

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

- Safety
- Efficiency
- Effectiveness
- Equity
- Patient-Centredness
- Timeliness (Access)
Quality Service

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

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

PROFESSIONLISM
OUR DUTY
OUR PRIDE

Our patients expect of us depend on us trust on us

Why Q?

"To cause harm to our patient"

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

The harm can be very serious, even death.
A tourniquet left on after insertion of iv catheter on a 21 years old patient, gangrene of fingers required amputation of part of all 5 fingers.

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)

How Q?
To focus on the approach
Donabedian Model

Structure
People

Process

Outcome

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 Infectious Disease 
& Emergency Response
(Dr S H Liu)

Central Committee on Clinical Specialty 
& Technology Assessment 
(Dr H W Liu)

Central Committee on Quality 
& Risk Management 
(Dr. SF Lui)

HAHO Quality & Safety Division 
(Dr P Y Leung)

CCQRM Membership

Chairperson: appointed by D(Q&S) Consultant (Q&RM) or CM(Q&RM)

Members:
- Chairperson of 7 cluster’s Q&RM Committee
- Co-Chairpersons of CCQRM Subcommittees
- 1 Medical representative (CSC)
- 1 Nursing representative
- 1 AH representative
- 1 CPO representative
- 1 BSS representative
- 1 IT representative

Ad hoc members:
- Subject officers / coordinators

In Attendance:
- Legal
- Complaint Management
- GIA
- 1 CS Division representative
- 1 S&P Division representative
- HAHO Q&S Division
- Cluster’s Q&RM Manager / deputy
To focus on the approach

Donabedian Model

**Structure**
People

**Process**

**Outcome**

**Process : Approach .....**

..... A safe and high quality healthcare system for patients and staff

..... Systematic, focused, prioritized, pragmatic

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

..... Address the needs and concerns of our staff
Avoid adding (reduce) unnecessary workload for staff

..... To establish a safety and quality culture

..... To facilitate system improvement

..... To enhance accountability (via Governance)

..... An incremental approach of rapid transformation
- basic quality: FIRST DO NO HARM to highest CQI
- From Standards to ? Accreditation

..... Everyone’s business and duty, a core part of “Professionalism”
POLICY

A commitment for Safety & Quality at all levels through a Risk Management and Quality culture, system and movement.

Quality:
Ensure basic quality
Strive for highest appropriate quality improvement

Risk management:
A proactive, reporting and learning culture
A Just culture will be adopted

Safety culture
Patient and Staff Safety - paramount importance

Proactive culture
Just culture
Reporting culture
Learning Culture

CENTRAL COMMITTEE ON QUALITY & RISK MANAGEMENT

QUALITY

RISK MANAGEMENT

3Qs QM

3Rs RM

Quality assurance
Risk Data
Quality Initiatives
Risk Reduction Programs
Quality Circle
Risk Circle
Components of 3Rs

RISK DATA

RISK REDUCTION PROGRAMMES

Learning & Sharing Knowledge Management

Risk Circle

Incidents reported by all clusters for 12 months Apr 06 - Mar 07

<table>
<thead>
<tr>
<th>TOTAL</th>
<th>Insignificant</th>
<th>Minor</th>
<th>Moderate</th>
<th>Major</th>
<th>Extreme</th>
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<td>3</td>
<td>4</td>
<td>5,6</td>
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POTENTIAL OUTCOME

<table>
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<th>Minor</th>
<th>Moderate</th>
<th>Major</th>
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<tr>
<td>Likely</td>
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<tr>
<td>Possible</td>
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<td>Unlikely</td>
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<td></td>
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<tr>
<td>Remote</td>
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</table>
### Incidents reported by all clusters for 12 months Apr 06 - Mar 07

<table>
<thead>
<tr>
<th>Category</th>
<th>Total No. of Case(s)</th>
<th>%</th>
</tr>
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<tbody>
<tr>
<td>Access, Admission, Transfer, Discharge</td>
<td>822</td>
<td>6.2%</td>
</tr>
<tr>
<td>Examination &amp; Assessment</td>
<td>27</td>
<td>0.2%</td>
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<tr>
<td>Investigation</td>
<td>740</td>
<td>5.6%</td>
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<tr>
<td>Treatment/ Care and Monitoring</td>
<td>345</td>
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<tr>
<td>Communication and Consent</td>
<td>390</td>
<td>3.0%</td>
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<tr>
<td>Medication</td>
<td>1,994</td>
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<td>Blood Transfusion</td>
<td>445</td>
<td>3.4%</td>
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<tr>
<td>Patient (injury/ Behaviours)</td>
<td>5,521</td>
<td>41.8%</td>
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<tr>
<td>Visitor (injury/ Behaviours)</td>
<td>195</td>
<td>1.5%</td>
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<tr>
<td>Staff (Occupational Safety &amp; Health)</td>
<td>2,328</td>
<td>17.6%</td>
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<tr>
<td>Staff Related issues (other than OSH)</td>
<td>83</td>
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<tr>
<td>Infection Control</td>
<td>44</td>
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<td>Environment</td>
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<tr>
<td>Food Safety &amp; Hygiene</td>
<td>30</td>
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<tr>
<td>Medical Device, Equipment &amp; Pharmaceutical Products</td>
<td>220</td>
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<td>Information System &amp; Technology</td>
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<tr>
<td>Miscellaneous</td>
<td>286</td>
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<tr>
<td>Total No. of Case(s):</td>
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### Reports by A&E Department, All HA Units

#### Outcome

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<th>Indication</th>
<th>Insignificant</th>
<th>Minor</th>
<th>Moderate</th>
<th>Major</th>
<th>Extreme</th>
<th>TOTAL</th>
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<tr>
<td>All HA</td>
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<td>201</td>
<td>23</td>
<td>10</td>
<td>6</td>
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<td></td>
<td>73.2%</td>
<td>22.5%</td>
<td>2.6%</td>
<td>1.1%</td>
<td>0.7%</td>
<td></td>
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</table>

### Reports by A&E Department, All HA Units - Actual Outcome

<table>
<thead>
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<tbody>
<tr>
<td>AllHA</td>
<td>8162</td>
<td>4147</td>
<td>583</td>
<td>269</td>
<td>58</td>
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</table>
No. of Incidents (by cluster)

No. of Incidents (total)

Components of 3Rs

RISK REDUCTION PROGRAMS
Clinical risks

- Identification: Patient identification - UPI Correct site, procedure - Timeout Information transfer – SBAR, Talk back [2008]

- Procedures: Restrainer NG Tube Patient transfer

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

- Fall - Patient missing - Suicide

- Consumables: single use devices - Devices: infusion pump

- Infection - Emergency & Contingency
Barcode scanning system
(full implemented by Q1 2008 – except A&E)

RISK REDUCTION PROGRAMS
Other risks
- Staff issues
- Manpower
- Competency
- OSH
- Information technology
- Facilities
- Property
- Finance
- Corporate
- Others

Components of 3Rs

Risk Circle
- Risk Data
- Learning & Sharing
- Knowledge Management

RISK REDUCTION PROGRAMMES
SKILLS & TOOLS:
The Self Learning Tool (SLT)

**Aims:**
- To provide a rapid and cost effective method to ensure learning and retention of practical knowledge relevant to the practice of Emergency Medicine
- To provide an open platform to share knowledge and experience.
- To enable organizational memory by passing on individual clinical experience and building corporate-wide knowledge base.

**Expected outcomes**
- Trainees learn about essential clinical knowledge and local AED guidelines
- Most importantly, retention of these knowledge
- Pass on past experience

**SKILLS & TOOLS:**
- Root cause analysis (reactive)
- Failure Mode Effect & Analysis (proactive)
- Tracer methodology
- Safety Walk Round
- Self leaning tool (SLT)
Components of 3Qs

Quality Circle

Quality Assurance

Quality Improvement

Learning & Sharing Knowledge Management

QUALITY ASSURANCE

Yardsticks
1. Clinical Practice Protocols
2. Standard Operation Protocols
3. Standards

Measurement / monitoring (data)
1. Key Performance Indicators
   (Service performance indicators)
   (Clinical outcome indicators)
2. Audits
3. Standards
   (Accreditation)

Clinical Practice Protocols
Standard Operation Protocols
HA wide vs. Local version - Standardisation
Easy reference - Day to day application

A& E Clinical Guideline

1. Management of Adult New Venue & Referral (Dec 2007)
2. Management of Adult New Venue & Referral (Jan 2007)
7. Management of Adult New Venue & Referral (Jan 2007)
8. Management of Adult New Venue & Referral (Feb 2007)
12. Management of Adult New Venue & Referral (June 2007)
15. Management of Adult New Venue & Referral (Sept 2007)
20. Management of Adult New Venue & Referral (Feb 2008)
24. Management of Adult New Venue & Referral (June 2008)
27. Management of Adult New Venue & Referral (Sept 2008)
Standards (Section 3)

SECTION 3 QUALITY IMPROVEMENT STANDARDS FOR HOSPITALS

To focus on the approach

Donabedian Model

Structure

People

Process

Outcome
QUALITY ASSURANCE

Yardsticks
1. Clinical Practice Protocols
2. Standard Operation Protocols
3. Standards

Measurement / monitoring (data)
1. Key Performance Indicators
   - Service performance indicators
   - Clinical outcome indicators
2. Audits
3. Standards (Section 3) (Accreditation)

OUTCOME

Framework: Service Performance KPIs

Access (23 KPIs)
1. Waiting Times
   • A&E WT
   • WT for SOP New Case Booking
   • WT for specific investigation / treatment
2. Safety
   • Unplanned readmission rate
   • Infection rate
3. Service Coverage
   • HbA1c test
   • VMO scheme
   • New Psy drugs
4. Responsiveness
   • (being dev)

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

Service Performance KPIs

HA wide / Cluster

(Report Period: 1.7.2006 - 30.6.2007)
KEY PERFORMANCE INDICATORS (KPIs)

Service performance KPI
Clinical outcome KPI

SATISFACTION SURVEY
Patient Satisfaction Survey
(HA wide – to be implemented 2008)
Staff Satisfaction Survey
AUDITS

- AUDITS ++
- HA wide (GIA, COCs)
  Local / Department
- Need
  - Coordination
  - Clear aims, purpose
  - Methodology
  - Sharing of learning points
  - Follow up action

AUDITS – HA GENERAL INTERNAL AUDITS

HA Internal Audit Planning Process

- Audit Committee
- Audit Committee (Chief Executive, Administration)

HAHO
Quality & Safety Division (Dr P Y Leung)

Central Committee on Infectious Disease & Emergency Response (Dr. PY Leung)

Central Committee on Quality & Risk Management (Dr. SF Lui)

Infection, Emergency & Contingency (Dr S H Liu)
Clinical Specialty Coordination (Dr M Y Cheng)
Clinical Standards & Technology Assessment (Dr H W Liu)
Quality & Risk Management (Dr David Lau)
HA surgical performance can be improved with the implementation of Surgical Outcomes Monitoring System – Conclusion from the two comparative audits on Esophagectomy

Yuen WC¹, Kwan TL¹, Andy Wai¹, Florence Lai², Deska Siu²
¹Central Surgical Audit Unit, HAHO
²Statistics and Research Section, HAHO

Mortality rates in HA

The mean in-hospital mortality rate in HA was 11%. It varied from 8% to 15%.

Hospital variation of mortality

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

Significant reduction in overall mortality

P < 0.05
Trend of hospital mortality

The reduction started in 2002 and dropped down to 2.8% in 2005

Hospital variations

- 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

Anaesthesia Related Mortality 2003-2005
Mortality within 30 days of operation*

<table>
<thead>
<tr>
<th>Hospital</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>Total</th>
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<td>15</td>
<td>27</td>
<td>70</td>
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<tr>
<td>B</td>
<td>94</td>
<td>77</td>
<td>92</td>
<td>263</td>
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<tr>
<td>C</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>D</td>
<td>41</td>
<td>39</td>
<td>28</td>
<td>108</td>
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<td>E</td>
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<td>169</td>
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<td>Overall</td>
<td>2,141</td>
<td>2,178</td>
<td>2,221</td>
<td>6,540</td>
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Table 5. Causal or contributory factors in anaesthesia-related mortality in 2003 to 2005

<table>
<thead>
<tr>
<th>Category</th>
<th>2003</th>
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<td>A PRE-OPERATIVE</td>
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<td>i. Assessment</td>
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<td>ii. Management</td>
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<td>1</td>
<td>1</td>
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<td>B ANAESTHESIA TECHNIQUE</td>
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<td>0</td>
<td>1</td>
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<td>ii. Airway management</td>
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<td>5</td>
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<td>iii. Ventilation</td>
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<td>iv. Circulatory support</td>
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<td>C ANAESTHESIA DRUGS</td>
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<td>0</td>
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<td>ii. Dosage</td>
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<td>3</td>
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<td>iii. Adverse event</td>
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<td>iv. Incomplete reversal</td>
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<td>0</td>
<td>0</td>
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<td>v. Inadequate recovery</td>
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<td>0</td>
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<td>6</td>
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<tr>
<td>i. Crisis management</td>
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<td>0</td>
<td>1</td>
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<td>ii. Inadequate monitoring</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>iii. Equipment failure</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>iv. Inadequate resuscitation</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>v. Hypothermia</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>E POST-OPERATIVE</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>i. Management</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>ii. Supervision</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>iii. Inadequate resuscitation</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>F ORGANISATIONAL</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>i. Inadequate supervision or assistance</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>ii. Poor organisation</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>iii. Poor planning</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>G NO CORRECTABLE FACTOR</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>H MEDICAL CONDITION OF PATIENT A SIGNIFICANT FACTOR</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>13</td>
</tr>
</tbody>
</table>

Number of Category 1 to 3 cases: 6, 7, 10, 23

---

**Anaesthesia Related Mortality 2003-2005**

Most likely causes of death amongst the 23 anaesthesia-related deaths

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Number of deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute coronary syndrome</td>
<td>9</td>
</tr>
<tr>
<td>Aspiration pneumonia</td>
<td>6</td>
</tr>
<tr>
<td>Hypocobalaminemia / uncontrolled bleeding</td>
<td>2</td>
</tr>
<tr>
<td>Respiratory failure</td>
<td>1</td>
</tr>
<tr>
<td>Hypokalaemia</td>
<td>1</td>
</tr>
<tr>
<td>Congestive cardiac failure</td>
<td>1</td>
</tr>
<tr>
<td>High spinal anaesthesia</td>
<td>1</td>
</tr>
<tr>
<td>Relative drug overdose</td>
<td>1</td>
</tr>
<tr>
<td>Cerebral vascular accident</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>23</strong></td>
</tr>
</tbody>
</table>

---

**Clinical Audit Report**

Waiting time of operations for benign surgical conditions

**HA Waiting times for five operations**

The following graph shows the HA median waiting times of the five operations in the year 2005 and 2006.
CSTA Report to CC(Q&RM) 12 Oct 07

- IT software for a HA-wide Clinical Audit Register
- IT software for Surgical Outcomes Monitoring and Improvement Programme
- Clinical indicators
- Clinical staff competency
QUALITY ASSURANCE

1. Clinical Practice Protocols
2. Standard Operation Protocols
3. Standards

Measurement/monitoring
1. Key Performance Indicators
   (Service performance indicators)
   (Clinical outcome indicators)
2. Audits

3. Standards - Section 3
   (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(QARM), 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 HKc
  Mr. Jimmy Wu

- In attendance
  Dr. Beatrice Cheng, HOCS CM, CS(CP) (HAHO CS representative)
  Dr. Alywin Chan, HOS&P SM(PC) (HAHO S&P representative)
  Dr. CW Liu
  Dr. HW Liu
  Dr. PY Leung
  Chairperson of HAHO NQRM

- Ad hoc members - subject officers as required.

Consultancy Report on Quality at HA & The way forward

Report from Subcommittee on Standards & Accreditation
12 October 2007

Dr. Charles Shaw and Ms. Francis Smith
with HA for 10 days in 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
Recommendations

1. Policy

HA should

• Develop explicit quality policy and strategies for improvement to reduce existing variations in perception over the scope/dimensions/principles of managing Q&S
• Engage internal and external stakeholders in formulating policy and celebrating achievements
• Reflect the recognition of quality and performance in hospital funding and anticipate future competition for resources
• Ensure best practices are shared systematically across staff in all hospitals/clinics, and disseminate accurate and positive messages to the public on service availability and performance

2. Organization and management

• HA should identify equivalent units/cells of the HA Q&S Division in other HA divisions, clusters and DH towards clarity and consistency in communication/practice.
• COCs should define clinical standards/systems, measure/demonstrate effective clinical practice/outcome improvement for objective assessment, change management and impact evaluation across clusters.
• Responsibility and authority for clinical governance and formal organisation of medical staff should be defined and documented.
• Quality is everybody’s business: Every staff should share ownership and participate in scheduled peer reviews.
• HA should issue general guidance to clusters on effective organization, methods and resources required for continuous quality improvement.

3. Methods

• The currently voluntary annual self-assessment against Section 3 Standards should be made mandatory, to ensure hospitals comply with statutory requirements and monitor progress against annual plan.
• HA should review the aggregated results of the self-assessment tool (adapted from WHO EURO) completed by clusters towards a general impression of how Q&S are institutionalised at the cluster level, and to validate and explore the gaps/variation identified.
• A system is required to pool methods/results/benchmarks and share problems/solutions/learning among clusters/hospitals.
• Hospitals should submit standard profiles of projects to a secure virtual centre moderated by the Division of Q&S.
• HA could develop a technical manual of methods and templates to support standardization/dissemination.
• All surveys/audits/reviews must feed into the management process, to ensure explicit actions locally or centrally through operational and strategic planning processes in order to change the behaviour of people and organizations.
• Standardised surveys of patients’ experience should be applied by clusters to assess compliance to the HA Charter, and the results provided to HA Board ± the public at large.
• A program should be developed to define/measure/improve organisational and clinical standards, incorporating key features for effective organisational development, including:
  • Programme governed but not dominated by stakeholders
  • Standards/system developed locally with stakeholders
  • Compliance measured by self-assessment, peer review and statistical indicators
  • Recommendations for improvement based on the standards
  • Standards, processes and headline results of hospital assessments in the public domain

Recommendations

Option 1

• Program development in HA involving frontline and stakeholders according to internationally recognized principles

Option 2

• Using external accreditation

Option 3

• Explore the feasibility of partnering with an organization which is currently offering an internationally recognized external accreditation program
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

• Can be used as the operation mode at hospital / department level to ensure quality

Components of 3Qs

QUALITY ASSURANCE

QUALITY IMPROVEMENT

Learning & Sharing Knowledge Management

QUALITY IMPROVEMENT

1. CQI

2. Technology Assessment
CONTINUOUS QUALITY IMPROVEMENTS

- Continuous improvement of basic operation
- Thrive for excellence
- Explore / apply alternative CI methods

QUALITY CIRCLE
Knowledge Management Unit

Sharing, Learning
(Communication)
Skills and tools transfer

- Forum, meetings
  (HA / cluster / hospital / department)
- iQR platform
- Circulars, flyers, posters, video clips

Components of 3Qs
QUALITY CIRCLE
QUALITY ASSURANCE
QUALITY IMPROVEMENT

Learning & Sharing Knowledge Management
Abstracts submitted by NTEC for HA Convention 2007

101 abstracts submitted many CQI projects
But so what, if front page news are …………

Useful information on the website +++
HA intranet website for Q&S will be updated

Achieve Quality Through Basics

Date: 16 June 2007 (Saturday)
Time: 9:00am – 1:00pm (Registration at 8:45am)
Venue: Shaw Auditorium, School of Public Health,
CME: CUNIC, PWH

Yóu xiǎo lín
Died 07.07.2007 aged 21
At PWH
Fought bravely to overcome acute leukemia
but succumbed to a tragic death from a medical mishap.

Died 07.07.2007 aged 21
At PWH
Fought bravely to overcome acute leukemia
but succumbed to a tragic death from a medical mishap.

Keynote speaker:
Dr Leong Pak Yin, D(QaS), HQaS,
Dr S F Lim, SBQaRM, NTEC/Const(QaRM), HQaS,
Dr Nancy Tung, SDICS, NTEC/NCE, AhNH & TPH

Other speakers:
Dr Leong Pak Yin, D(QaS), HQaS
Dr S F Lim, SBQaRM, NTEC/Const(QaRM), HQaS
Dr Nancy Tung, SDICS, NTEC/NCE, AhNH & TPH
Subject: Tragic death from a medical mishap - what have we learnt, what we must learn?

Dear All,

With great sadness and sorrow, I am writing on the death of “小琳”, aged 21, who fought bravely to overcome acute leukemia but succumbed to a tragic death from a medical mishap.

Professor Anthony Chan and I were with the family of 小琳 as they said their last goodbye to her. On behalf of the Hospital and our staff, we have once again expressed our deepest apology and condolence to the family, but ... no word can adequately express our regrets, grief and sorrow.

The relatives have requested that we must ensure 小琳’s tragic death shall not be in vain – in that her tragic death would forever remind all medical and nursing staff to be careful and vigilant at all times when giving treatment to patients.

On the afternoon of 15th June, Dr. So Hing Yu and I were working with Dr. Fung Hong on the key message for the NTEC Quality Forum to be held on 16th June, entitled “Achieve Quality through Basics”. Ironically it was on that same afternoon that this most unfortunate medical mishap took place. I would like to share with you that key message we have chosen for NTEC.

确保基本质素 - 不可引至伤害
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

The safety of our patients and staff is of paramount importance to us. It is everyone’s business to ensure “Safety”.

It is important we, senior staff, will lead by example and to take appropriate action to ensure / enhance the "Safe" operation within a department / ward. We are aware and appreciate that our staff are often working under pressure and have to handle tremendous workload. Hence especially for under these situations, we have to enhance the "Safe" provision of treatment. Extra measures which can be taken to enhance "Safety" does not necessarily require a lot of extra time.

We sincerely hope this tragic incident will draw our attention to the need to ensure Basic Quality (First do no harm), while strive for continuous quality improvement of highest appropriate quality care for our patients. We must work together to ensure this.

SF Lui NTEC SD(Q&R&M)
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.

Key steps in the Prevention of Errors

• Design safe systems / process

• Behaviors – A safety culture (managerial and staff)

A duty to avoid causing unjustifiable risk or harm

• Creating a learning culture via reporting supported by an open, fair and Just Culture

Take home message

SYSTEM & CULTURE FOR QUALITY & SAFETY

Structure / people / process / outcome

Staff engagement
Patient engagement

Risk
Data

Quality assurance

Risk Reduction Programs

Quality Initiatives

Quality & Risk Circle
Learning & Sharing
A Patient’s journey through the hospital

A safe and satisfactory journey through hospital
going home feeling better and smiling

A staff’s day to day journey through the Hospital

Wanting to come to work
Happy working environment

Do a good day’s work
Happy going home