Better Hospitals through Innovation

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UNITED CHRISTIAN HOSPITAL

醫院管理局
HOSPITAL AUTHORITY





To Cure Sometimes, To Relieve Often, To Comfort Always



Better Hospitals are…

where more diseases can be cured

Better Hospitals are….

where sufferings are often relieved.

Better Hospitals are….

where the souls are comforted, always.

Better Hospitals

- More Healing
- More safe
- Patients have more sense of control
- More individualized care
- More Fulfilling for the healthcare professionals
- Less stress for patients, families and healthcare workers
- Always being Family-centered


PRIMUM
FIRST DO
NON
NO HARM
NOCERE

■東區醫院加強對兒科病房保安，探病者須先透過對講機通報。（李子強攝）

■東區醫院昨派出職員在兒科病房外核對探病人士身份。（梁卓明攝）

醫生：男女童分房乏人手

【本報訊】東區醫院男病童涉姦女病童事件，令公立醫院讓男女病童共處一室的做法敲響警號，病人組織及立法會議員要求醫管局重新檢視現行安排。但有兒科醫生認為，現時以年齡劃分的兒科病房，若要再細分為男女病房，分薄了醫護人手，反增加其他事故風險。

攤薄資源增風險

香港兒童呼吸學會會長吳國強指，公立醫院主要以年齡來劃分兒科病房，通常會以十二歲作為「大仔」和「細仔」分界（部分醫院以十歲作分界），「大仔」房會分男女，不會將男女病童安置同一病房，病房外會上鎖；不過，病房內的不同病室卻會安置男女「細仔」，病室間不會上鎖，甚至不裝門，不同性別的「大仔」和「細仔」可在病房內不同病室四處走動。

吳國強認為要分開男女兒科病房需從詳計議，因「大仔」及「細仔」護理需求不同，有些護士專責護理「細仔」，若「細仔」房再劃分男女，便需更多人手，「依家兒科醫生同護士人手已經好緊張，病房亦不足，再分多啲病房可能會攤薄人手，急救都可能有問題。」

病人互助組織聯盟副主席張德喜直斥事件離譜，他建議醫管局考慮在足夠人手及配套下，為兒科病人分男女病房。關注病人權益的社區組織協會幹事彭鴻昌對事件感驚訝，促請當局檢討男女病童同房安排。立會醫學界議員梁家騮要求院方調查事發時病房人手是否不足。

Hospitals are Dangerous Places

- According to the US Dept. of Health and Human Services ~ 15,000 patients a month in suffer from harm done by the hospital.

- 10 years ago, The Institute of Medicine: 98,000 patients die every year from mistakes made in the hospital.

Wrong Medications kill

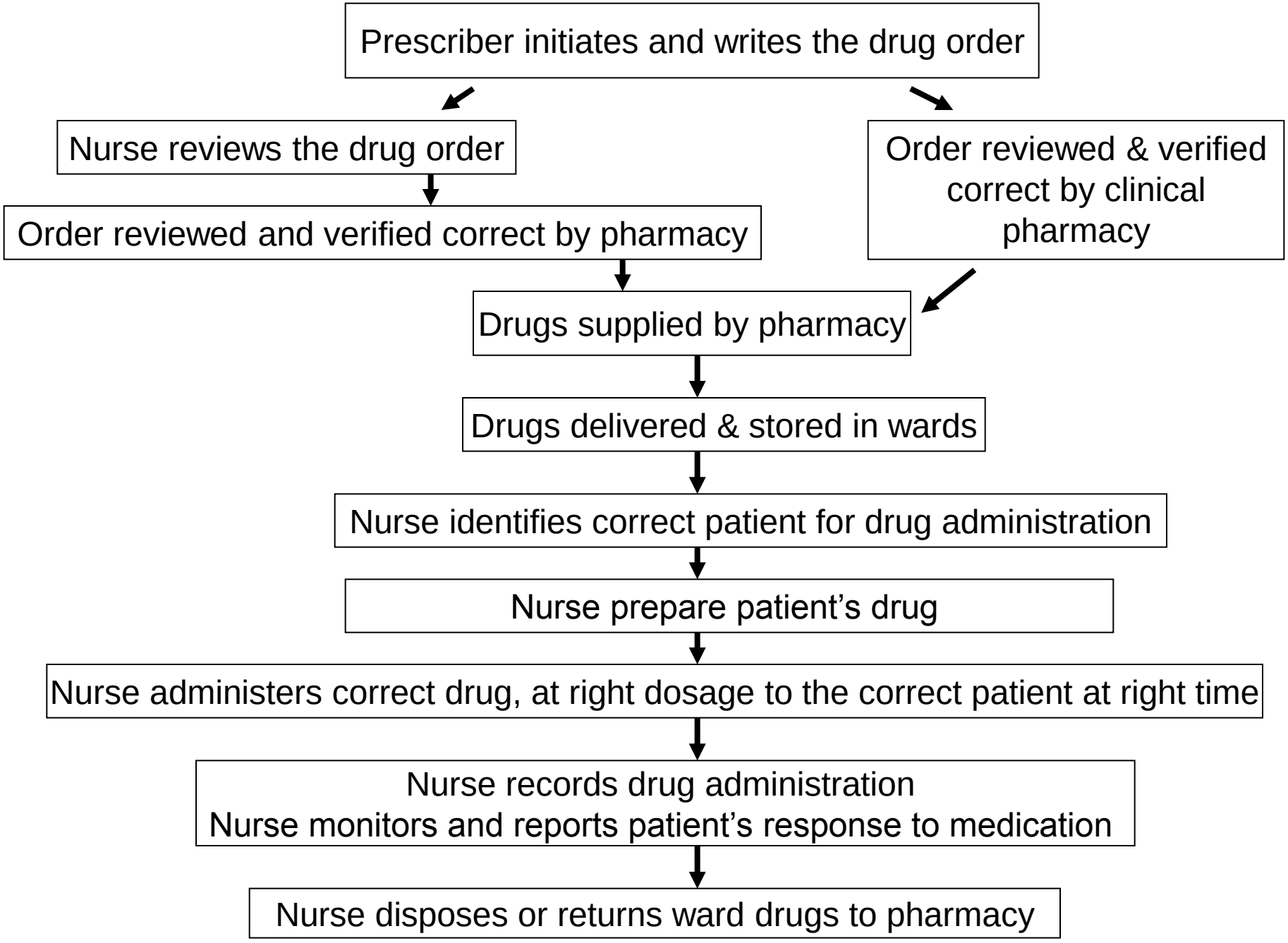
- In the Internal Medicine departments of German hospitals, 29,000 patients die each year as a result of being given the wrong medication.

Medical University of Hanover

TOP 5 REPORTED INCIDENTS* via AIRS (Jan – Dec 2007)

**** Incidents reported voluntarily for sharing and learning purposes.***
The great majority of the reported incidents were near misses or caused only minor consequence.
Fortunately, with early detection of the error and existing safety measures,
serious outcome causing permanent harm to the patient occurred in only a very small number of cases.
Nevertheless, the risk of error is high and the consequence may be severe under other circumstances.

NATURE	GROUP	1Q 2007	2Q 2007	3Q 2007	4Q 2007
Patient (Injury)					
	Patient falls	925	981	1004	974
Staff (Occupational Safety & Health)					
	Workplace violence (Physical assaults)	160	167	174	144
	Workplace violence (Threats / abuses)	183	208	203	186
Medication					
	Prescription	236	207	218	228
	Dispensing	103	88	91	109
	Administration	199	199	179	203
Access, Admission, Transfer, Discharge					
	Missing patient	138	127	126	143
Investigation					
	Mislabeling	114	63	130	96


Prescriber initiates and writes the drug order
Nurse reviews the drug order
Order reviewed & verified correct by clinical pharmacy
Order reviewed and verified correct by pharmacy
Drugs supplied by pharmacy
Drugs delivered & stored in wards
Nurse identifies correct patient for drug administration
Nurse prepare patient's drug
Nurse administers correct drug, at right dosage to the correct patient at right time
Nurse records drug administration
Nurse monitors and reports patient's response to medication
Nurse disposes or returns ward drugs to pharmacy

The Number of Incidents by Severity (Jan – Jun 2010)	
Severity Index	**Jan - Jun 2010**
0	132
1	441
2	81
3	17
4	5
5	0
6	1

Top 3 Most Common *PRESCRIBING ERROR* (Jan – Jun 2010)		
Position	In-patient	Out-patient
No. 1	Wrong Drug Wrong Strength/Dosage (15%)	Wrong Patient (51%)
No. 2	Known Drug Allergy (14%)	Wrong Strength/ Dosage (12%)
No. 3	Wrong Patient (13%)	Wrong Drug (9%)

Top 3 Most Common DISPENSING ERROR (Jan – Jun 2010)		
Position	In-patient	Out-patient
No. 1	Wrong Drug (45%)	Wrong Drug (25%)
No. 2	Wrong Strength/Dosage (15%)	Wrong Patient (21%)
No. 3	Wrong Patient (10%)	Wrong Strength/Dosage (20%)

Top 3 Most Common ADMINISTRATION ERROR (Jan – Jun 2010)		
Position	In-patient	Out-patient
No. 1	Dose Omission (23%)	Dose Omission (19%)
No. 2	Extra Dose (14%)	Extra Dose/ Wrong Drug (16%)
No. 3	Wrong Drug (10%)	Wrong Dose (12%)

The "Five Rights"

- Right drug
- Right dose
- Right time
- Right route
- Right patient

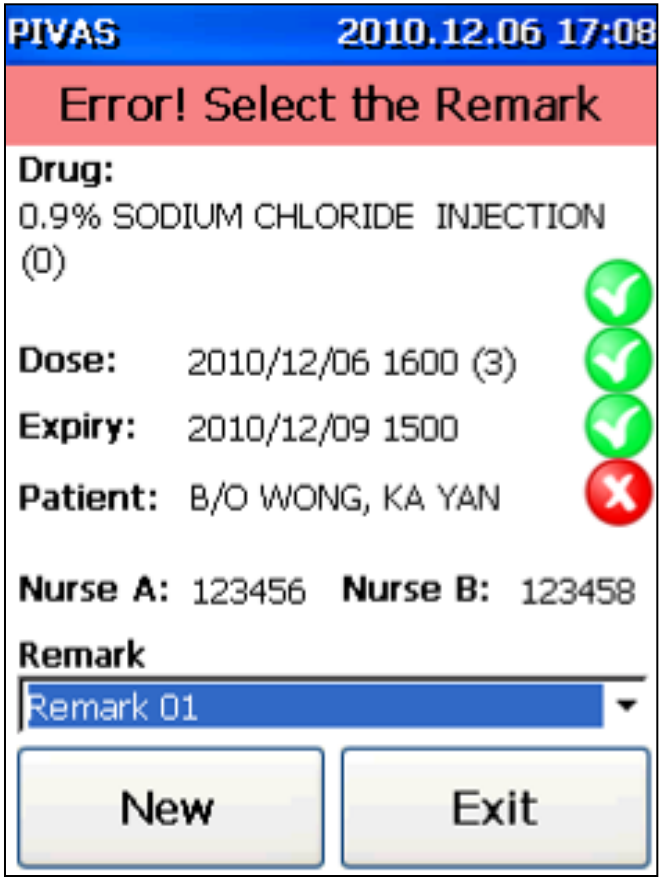

General Hospital
PATIENT ID


for
NICU / PICU
SCAN
ENT
ESC
BKSP
F1
F2
F3
F4
CTRL
FUNC
ALPHA
SP
Del
Rm 3

Handheld Application for NICU/PICU

Checking of Injection/Infusion

1. MAR, Dose and Patient
2. Injection/Infusion time
3. Dose is not expired



Dashboard for NICU/PICU

PIVAS for NICU/PICU

dashboard label printing system setting

2010/12/12 19:30

Dose for Injection / Infusion

Dose Time	Patient Name	Unit Dose	Bed No.
2010/12/12 20:00	UPI, TESTING	GENTAMICIN 15MG/1.5ML INJECTION (10MG/ML)	PICU N04
2010/12/12 20:00	UPI, TESTING	5.85% SODIUM CHLORIDE 5ML + CALCIUM GLUCONATE 10% 5ML + D5 490ML INFUSION	PICU N04

Problem Dose

Dose Time	Patient Name	Unit Dose	Bed No	Remark
2010/12/12 16:00	UPI, TESTING	GENTAMICIN 15MG/1.5ML INJECTION (10MG/ML)	PICU N04	Missing Dose

Pharmacy Intravenous Admixture Service (PIVAS) with IT Support

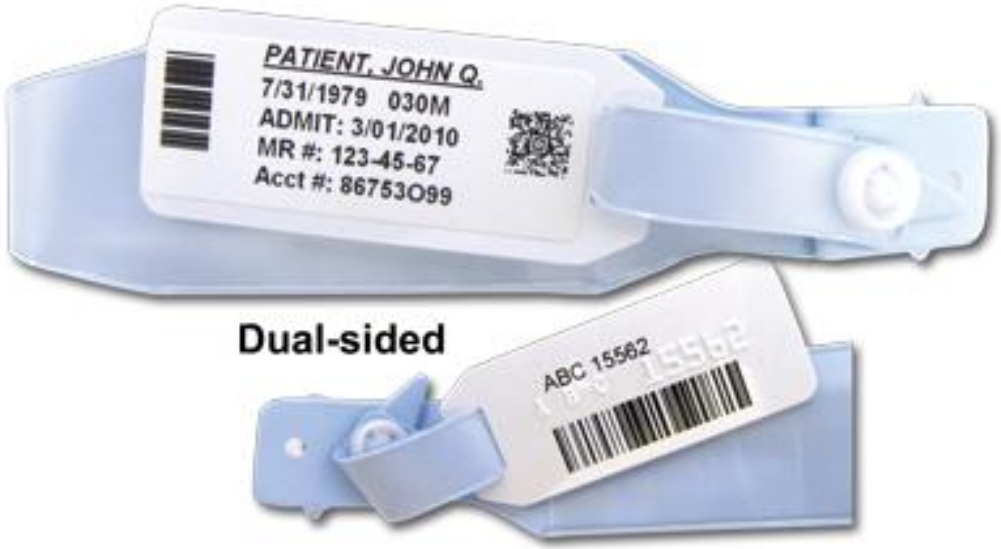
Type of error	Research & ratios of factors contributing to MAE						
	Fortescue et al (2003)	Hicks et al (2004)	Tissot et al (2003)	Wirtz et al (2003)	Headford et al (2001)	Wilson et al (1998) PIC statistics	Schneider et al (1998)
Wrong administration rates		5:100	19:100	21.6:100	8:100	7:100	8.7:100
Wrong IV push rate				88:100			
Omission of dose	8.1:100	20:100	16:100	10.6:100	50:100	5:100	1.1:100
Drug compatibility			6:100	10:100		3:100	
Wrong dose	37.1:100	24:100	12:100	10:100	7.6:100	4:100	7.7:100
Calculation errors				12:100			
Wrong drug					5.7:100	1:100	
Wrong patient		2:100			1.9:100		
Wrong time	12.5:100	3:100	26:100	18.9:100	2.7:100	9:100	8.7:100
Dose delayed > 1 hour						49:100	
Wrong route	17.7:100	1:100			1.5:100	1:100	0.7:100
Allergy related error	1.8:100				1.3:100\		
Additional/ unauthorised dose	0.7:100	14:100	13:100		9.3:100		

McBride-Henry K, Foureur M. 2006. Medication administration errors: understanding the issues. *Australian Journal of Advanced Nursing*. 23(3):33-41.

Zero Medication Error

Result for the PIVAS program until 2011/03/20	
Scanned Dose	1811
Due Dose Alert	107
Medication Error	0

Prescribing for Patient, John O

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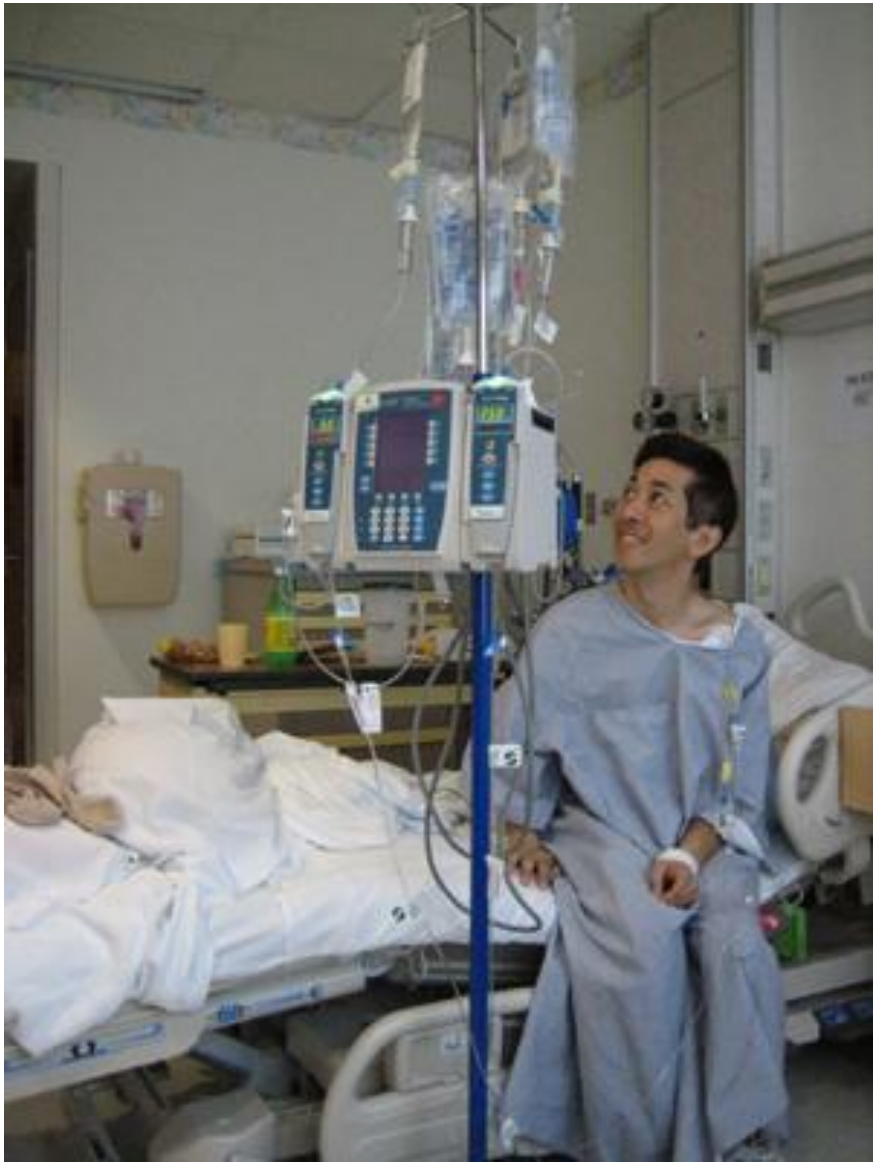


HALF YEARLY REPORT ON SENTINEL & SERIOUS UNTOWARD EVENTS

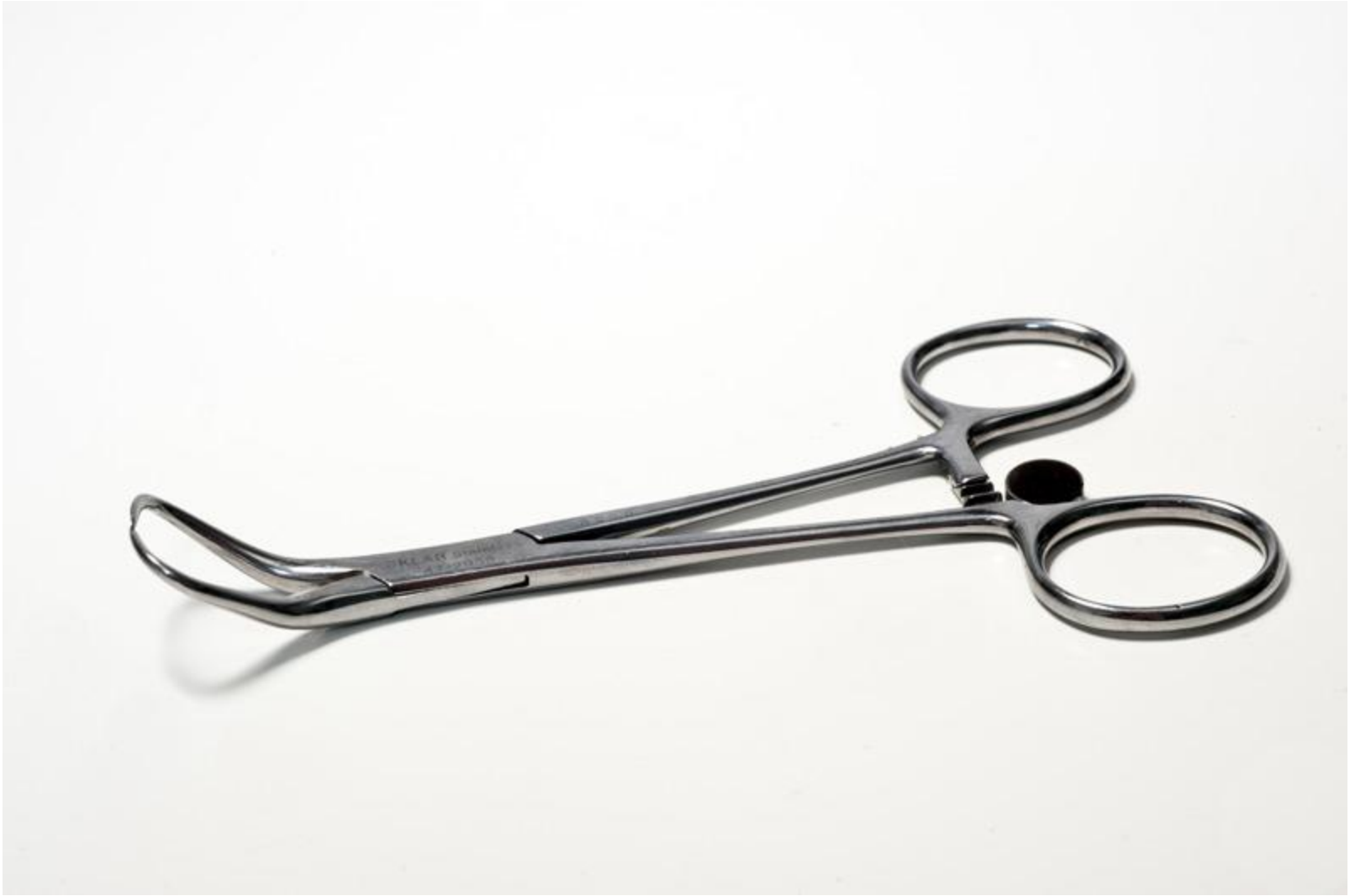
1 October 2009 – 31 March 2010

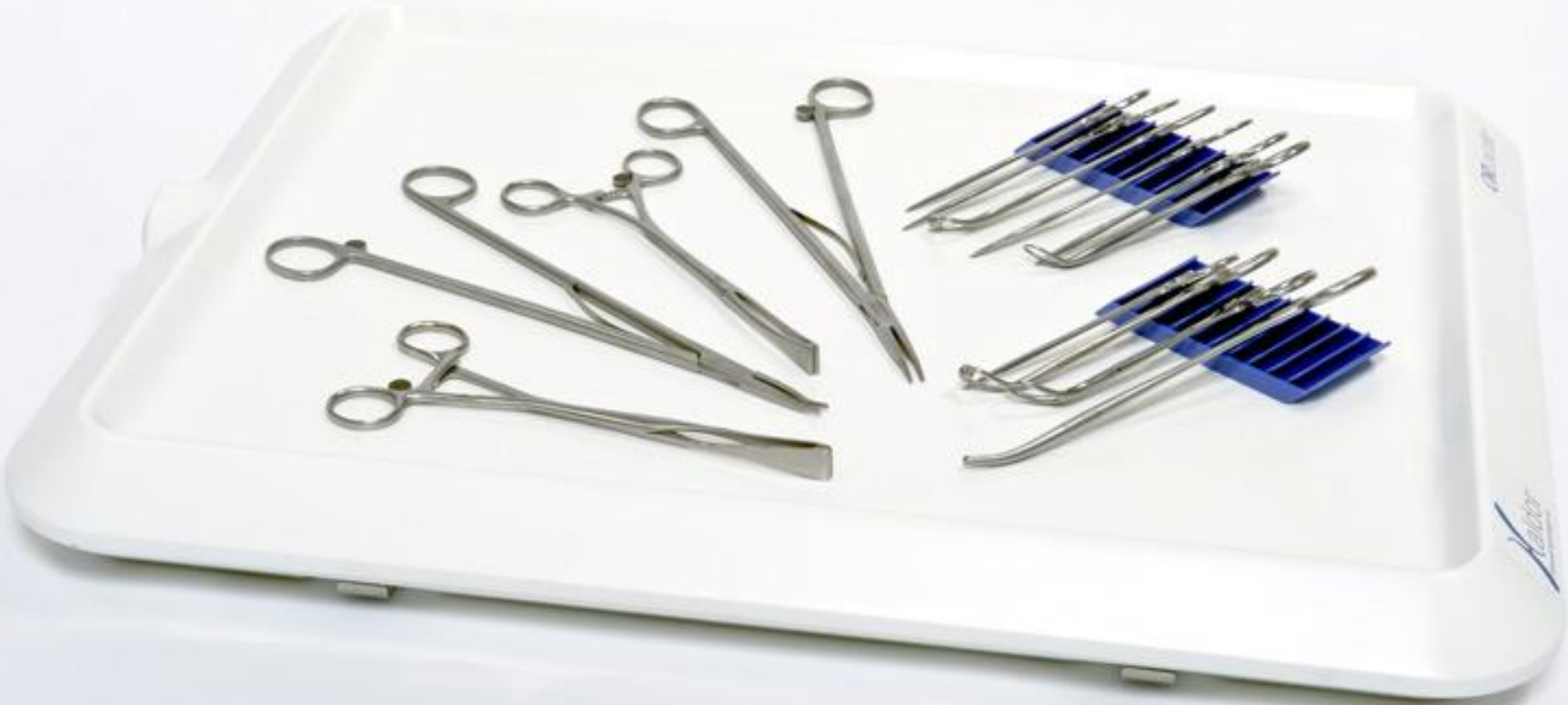
HOSPITAL AUTHORITY
HONG KONG

July 2010

醫院管理局
HOSPITAL AUTHORITY

Sentinel Events	
1	Surgery / interventional procedure involving the wrong patient or body part
2	Retained instruments or other material after surgery / interventional procedure
3	ABO incompatibility blood transfusion
4	Medication error resulting in major permanent loss of function or death
5	Intravascular gas embolism resulting in death or neurological damage
6	Death of an inpatient from suicide (including home leave)
7	Maternal death or serious morbidity associated with labour or delivery
8	Infant discharged to wrong family or infant abduction
9	Other adverse events resulting in permanent loss of function or death (excluding complications)
Serious Untoward Events	
1	Medication error which could have led to death or permanent harm
2	Patient misidentification which could have led to death or permanent harm

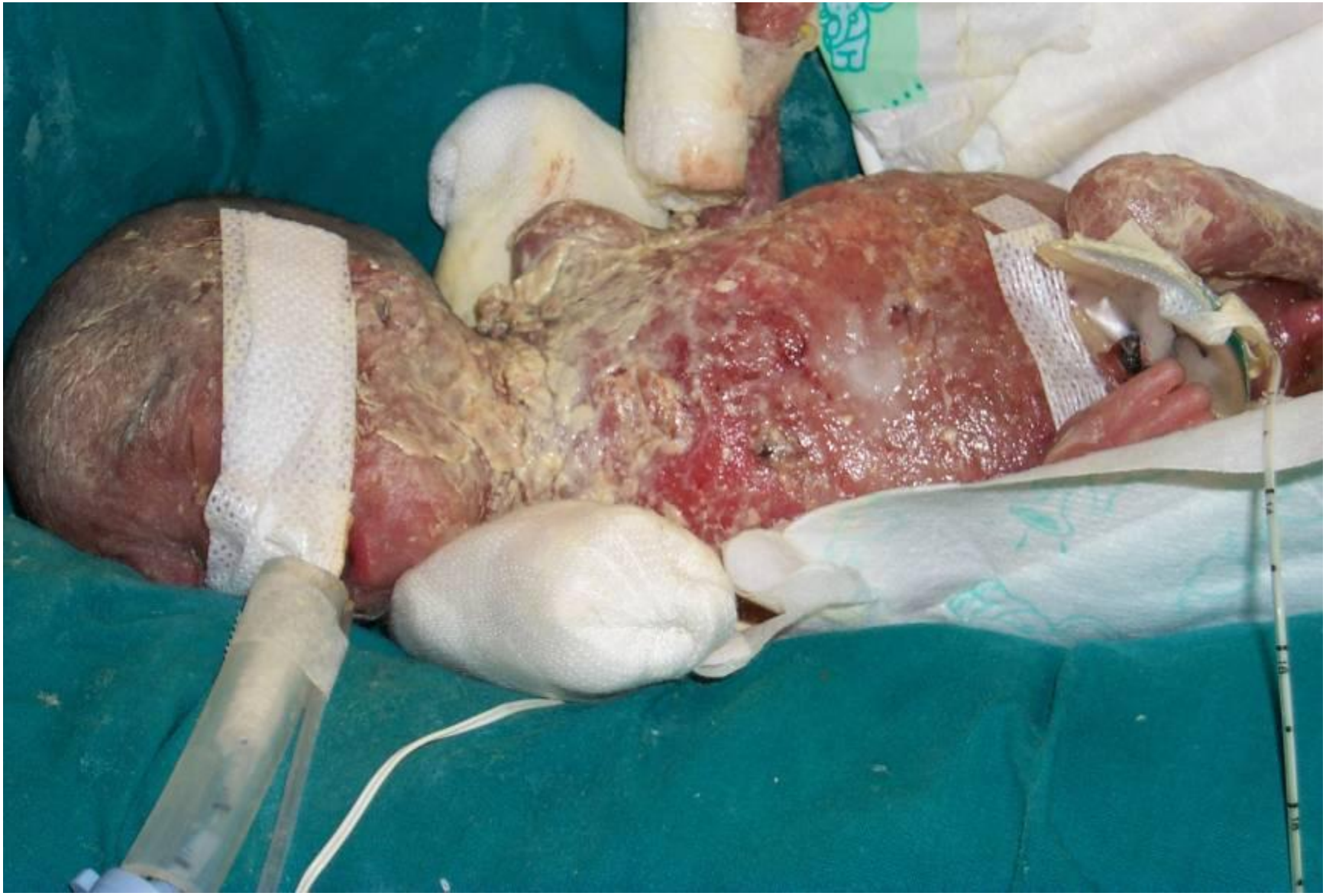





Stack Up To This Line
Xaldor
ORLocate


Haldor
advanced technologies ltd.
ORLocate™


Haldor

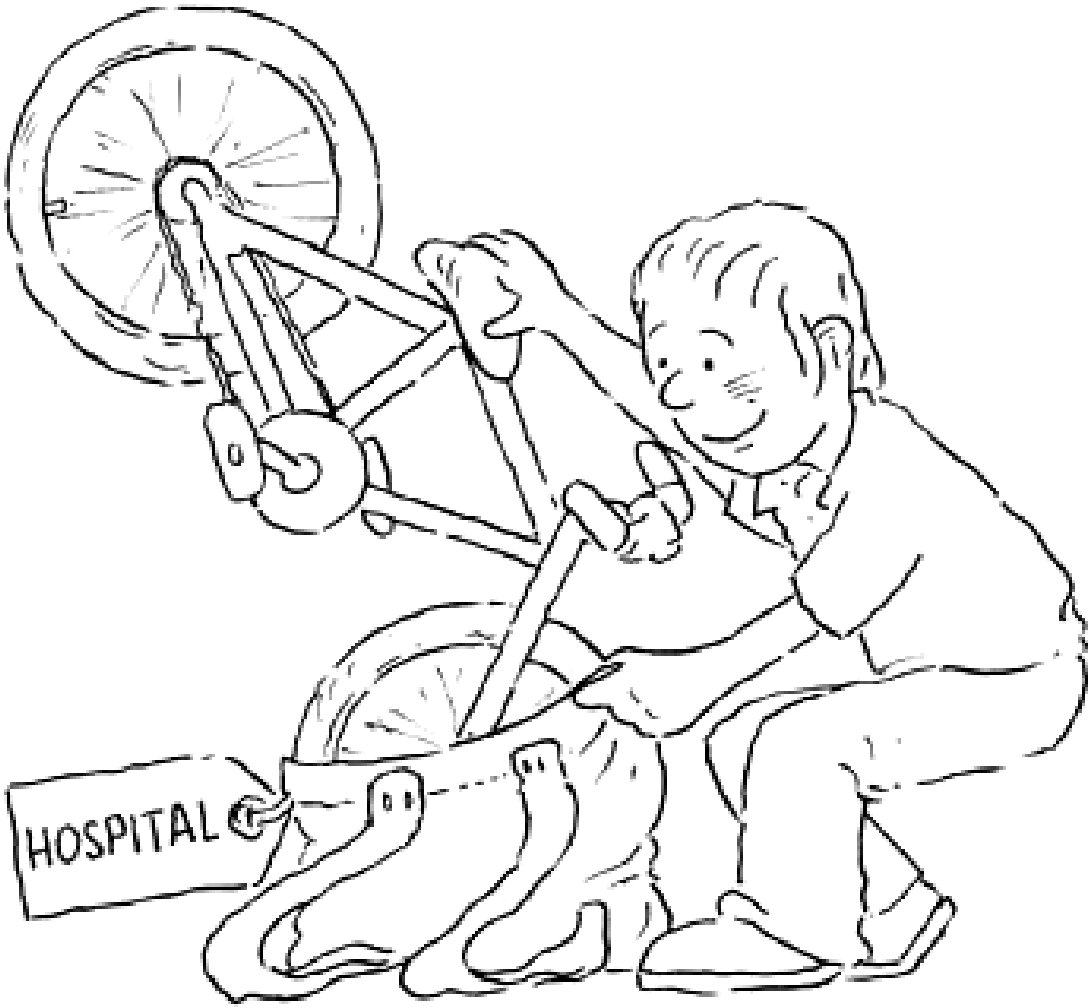


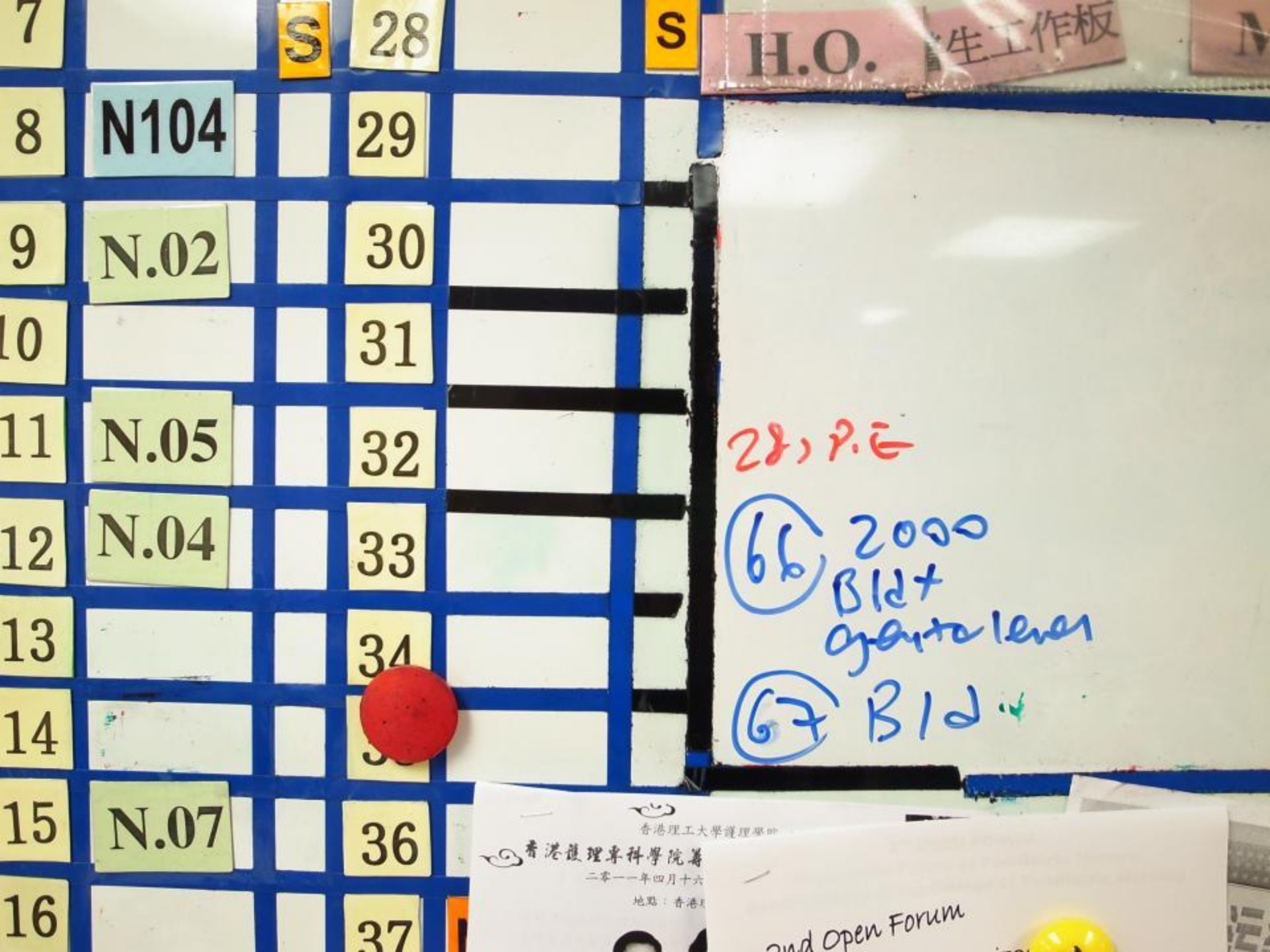

穿了個叮噹住
阿哥.快洗手.
否則害你全國
誤殺....


HyGreen
HyGreen
HyGreen
HyGreen
HyGreen
Dr. Shanna Murphy
STAFF

"The only thing we have to fear,
Is fear itself!"

Franklin D. Roosevelt


HOSPITAL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28, P.E
66 2000 Bld + ground level
67 Bld
香港理工大學護理學
香港護理專科學院籌
二零一一年四月十六
地點：香港
and Open Forum

1.陳道. 2.3 20 by 36 wks. NC. feed —
MOL 子. feed up.
2 Adoption.
文傻 cleft lone
6 文英 A/B D4.
莉. feed up. oral FW. Echo —
王時. vomit 'N' feed. stitches —
10k 蘇小 N-CPAP
X 劉用 B-CPAP 5 NC →. Laser done. RT 已排.
熊. MRSA B-CPAP 6. vomit x 2.
郭. B-CPAP 6. to cot. NC →.
GBS x②. Inguinal. HVS - E coli. Lead Box → RA.
CXR. mild streakiness. G6PD — T4 TSH —
↓PLT 98. repeat —.

28. TTN. CXR
~~24. ↑ Renal pelv~~
27. ↑ lead. R
25. B fever.
23. stridor
26. NNJ
~~72. Lod~~


THE ROY AND PATRICIA DISNEY FAMILY
CANCER CENTER
at Providence Saint Joseph Medical Center
THE ROY AND PATRICIA DISNEY FAMILY
CANCER CENTER


PHILIPS

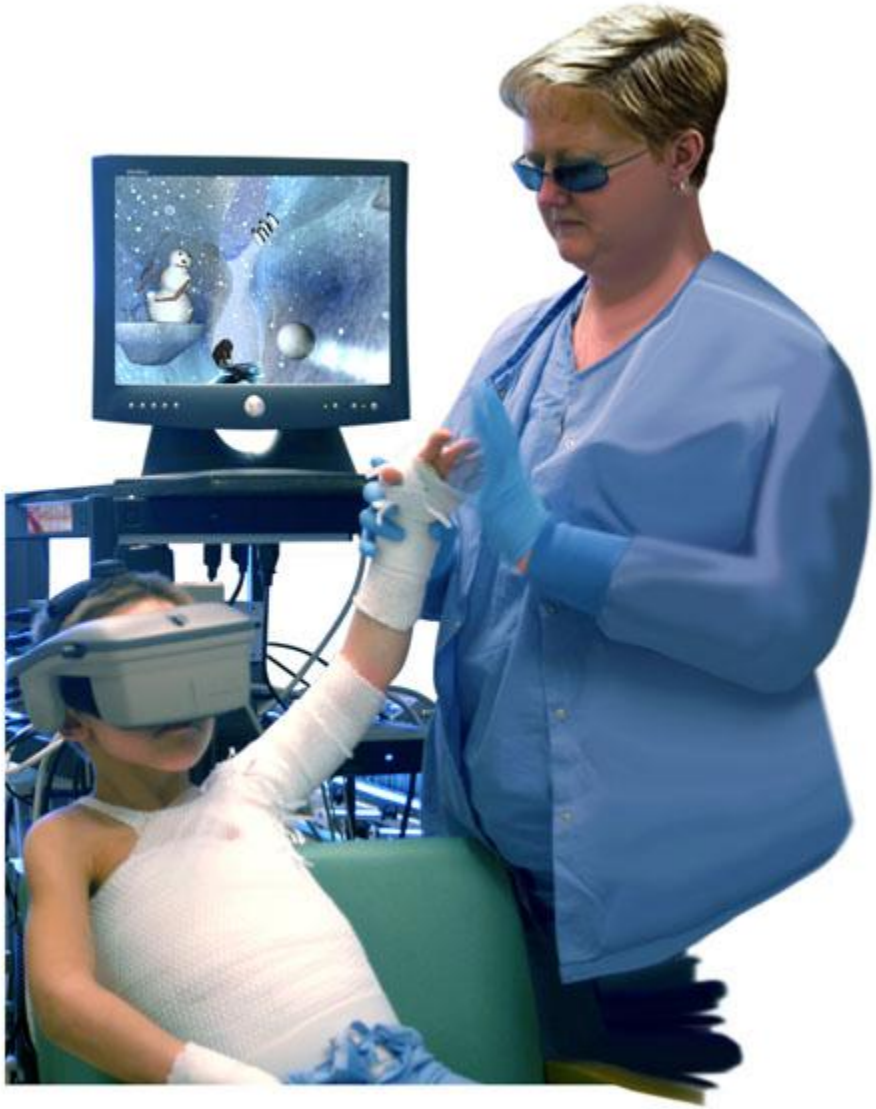

PHILIPS

Family

Children

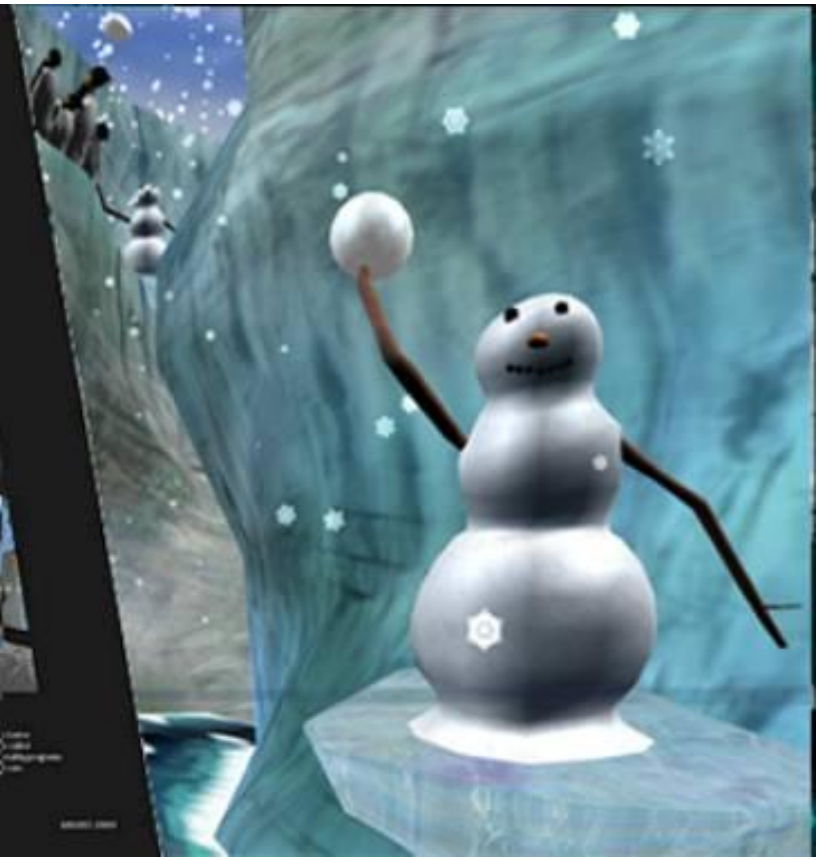
Parents

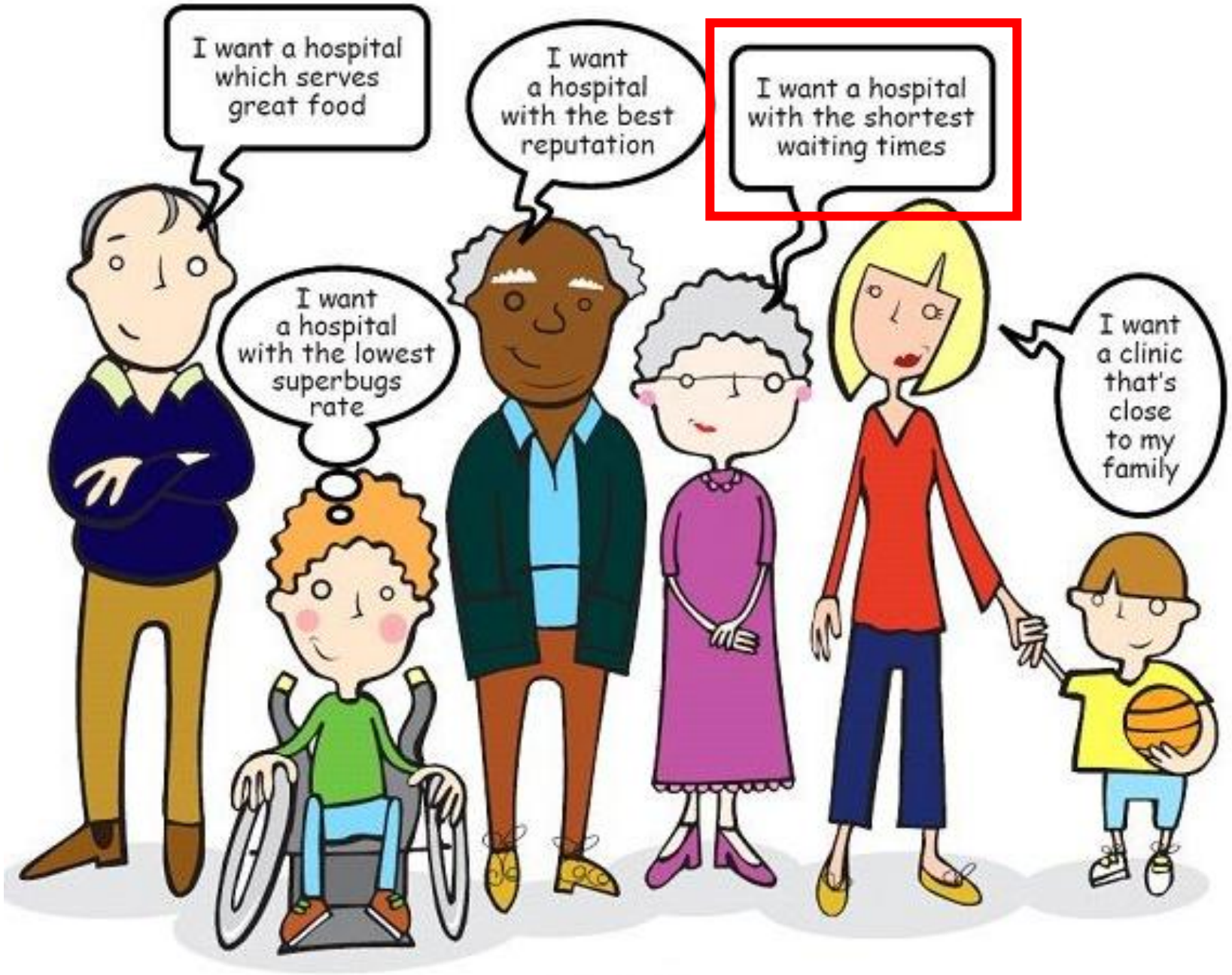
Extended Family



VIRTUAL-REALITY THERAPY

Patients can get relief from pain or overcome their phobias by immersing themselves in computer-generated worlds BY HUNTER G. HOFFMAN




I want a hospital which serves great food
I want a hospital with the lowest superbugs rate
I want a hospital with the best reputation
I want a hospital with the shortest waiting times
I want a clinic that's close to my family

"Oh, good, I can finish the article I started last year."

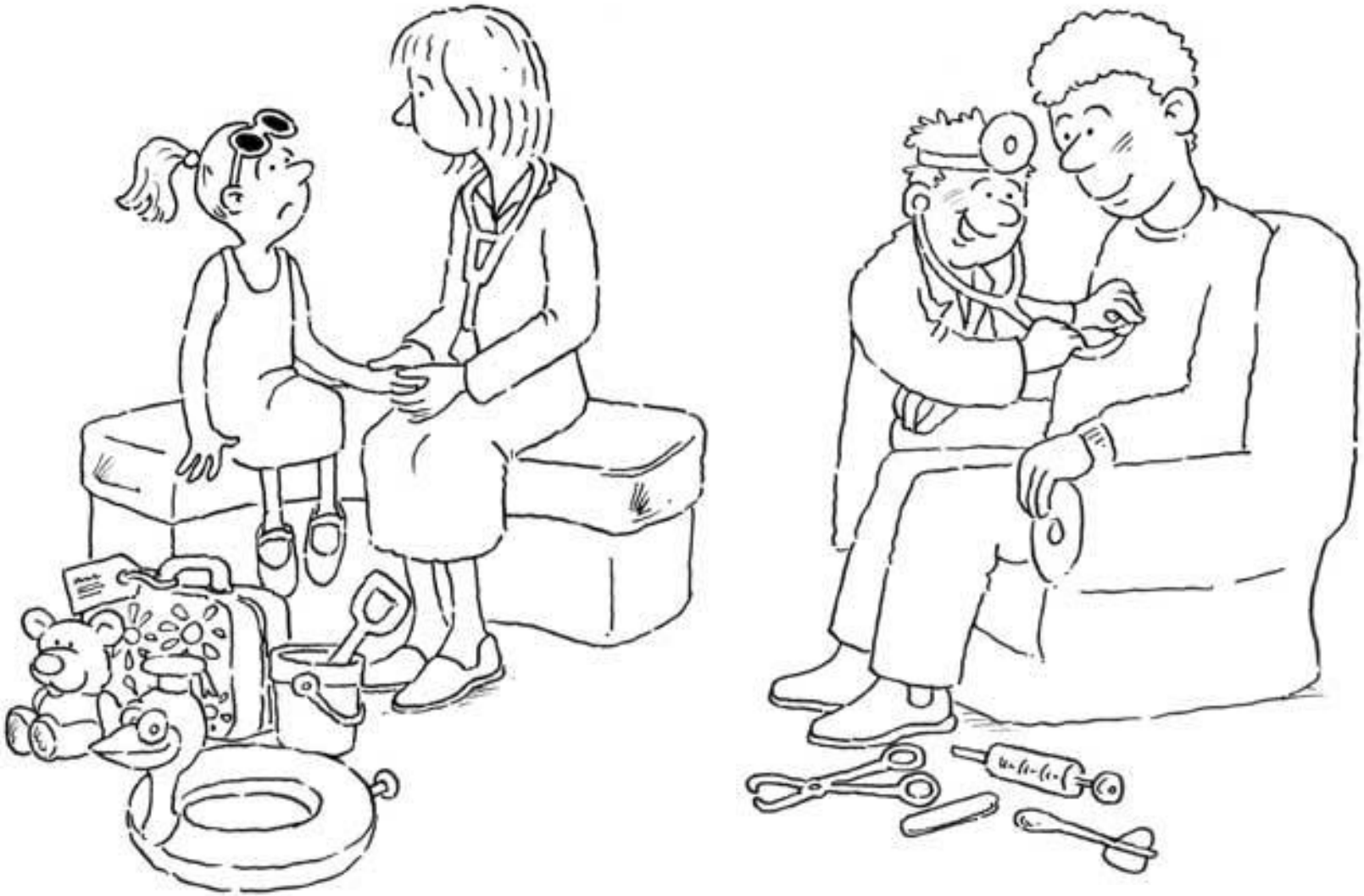

Advil
advil.com
HALLS

Patient - A waiting person is a patient person

- “Patience” means the willingness to stay where we are and live the situation out to the full in the belief that something hidden there will manifest itself to us.
- Patient people dare to stay where they are. Patient living means to live actively in the present and wait there.
- Waiting, then, is not passive. It involves nurturing the moment, as a mother nurtures the child that is growing in her womb.

Henri Nouwen, *Eternal Seasons: A Spiritual Journey Through the Church’s Year*

I don't need to know
where I'm going
as long as God gives
THE
NEXT STEP



RFID in Hospitals

1. to track objects like beds, wheelchairs and operating instruments or medical items such as infusion pumps.
2. Patients information can be accessed more quickly using the tags.
3. personalized medication, where RFID ensures safe distribution of drugs.


NAMSUNG
K LINE
DONGYOUNG


BlueCard


ALIEN


MOTOROLA

DOCTOR FUN


WE WANT TO IMPLANT THIS RFID TAG IN YOU.
THAT VIOLATES MY RIGHTS!
WE WANT TO IMPLANT THIS RFID TAG IN YOU AND IT'S ALSO A CELLPHONE, DIGITAL CAMERA, AND MP3 PLAYER.
COOL!
↖ WRONG
RIGHT →


味蔵
テレトラック
MIYAKO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Port-au-Prince

Better Cities through Better People

Better People through Better Education

Better Education through Better Access to Information

Better Access to Information & Education through Innovation


It is not technology
It is what you do with *it*