Standardisation of 80 Patient Safety Practices in Clinical Wards to Enhance Patient Safety

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HA Convention 2025

Background

1 Non-standardised clinical & operational practices → Key risk factors for clinical incidents

Dangerous Drugs (DD) Storage

- **Containers: Different types of DD containers**
- **Labelling: Different formats, font sizes and colours**

Background

1 Non-standardised clinical & operational practices → Key risk factors for clinical incidents

2 Existing policies and guidelines often lack detailed operational descriptions → Challenges in local implementation and inconsistencies across clinical units

From Emergency Trolley Guideline

Observations from Patient Safety Walk Rounds

Background

1. Non-standardised clinical & operational practices → Key risk factors for clinical incidents
2. Existing policies and guidelines often lack detailed operational descriptions → Challenges in local implementation and inconsistencies across clinical units
3. Standardisation of practices is a strong intervention at organisation level to prevent incidents

	Action Category	Example
Stronger Actions (these tasks require less reliance on humans to remember to perform the task correctly)	Architectural/physical plant changes	Replace revolving doors at the main patient entrance into the building with powered sliding or swinging doors to reduce patient falls.
	New devices with usability testing	Perform heuristic tests of outpatient blood glucose meters and test strips and select the most appropriate for the patient population being served.
	Engineering control (forcing function)	Eliminate the use of universal adaptors and peripheral devices for medical equipment and use tubing/fittings that can only be connected the correct way (e.g., IV tubing and connectors that cannot physically be connected to sequential compression devices or SCDs).
	Simplify process	Remove unnecessary steps in a process.
	Standardize on equipment or process	Standardize on the make and model of medication pumps used throughout the institution. Use bar coding for medication administration.
	Tangible involvement by leadership	Participate in unit patient safety evaluations and interact with staff; support the RCA[2] process; purchase needed equipment; ensure staffing and workload are balanced.

Source: National Patient Safety Foundation. RCA[2] – Improving Root Cause Analyses and Actions to Prevent Harm. 2016.

Programme Objectives

- To provide clinical departments with a set of standardised patient safety practices
- To minimise variations across clinical units
- To enhance the ease of compliance to requirements from HA/NTWC policies/guidelines
- To minimise the occurrence of clinical incidents

HA = Hospital Authority; NTWC = New Territories West Cluster

Collaboration in NTWC

- Quality & Safety Division
- Nursing Services Division
- Administrative Services Division
- Clinical Risk Committees

NTWC = New Territories West Cluster

Identification of Standardised Practices

- Since Aug 2024, reviewed previous practices, discussed varied practices in various platforms & channels
- Identified items for standardisation and requirements/standards

Patient Safety Safety Rounds

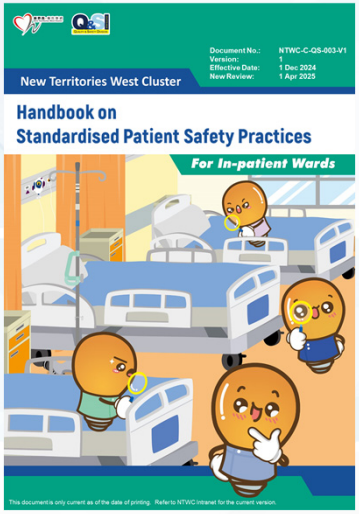
Advice from Experts

Advice from Senior Management / Committees

Discussion with Department Staff

The Standardised Practices

- Covers **13** patients safety topics with **80** standardised practices
- Applied to all in-patient wards in NTWC (except psychiatric setting)

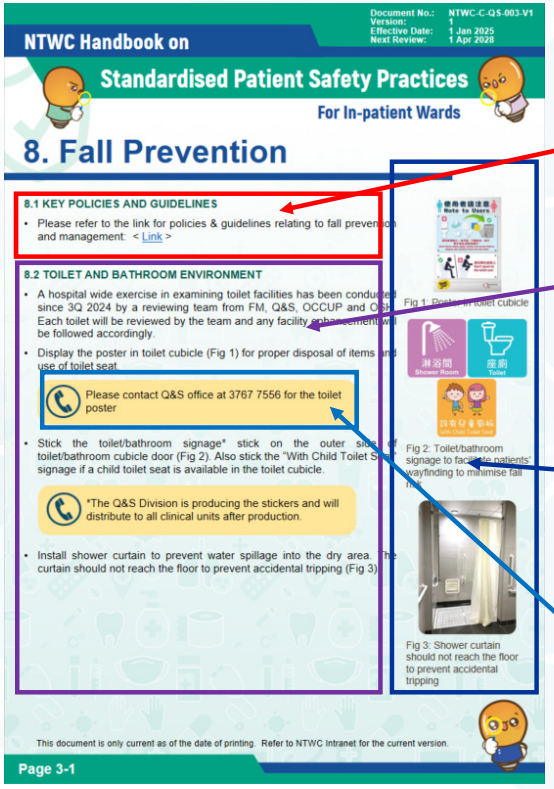


Topics Included

1. Patient Identification
2. Medication Safety
3. Fall Prevention
4. Patient Transfer
5. Suicide Prevention
6. Patient Injury/Behaviour
7. E-trolley Management
8. Patient Property/Belongings
9. Denture Handling
10. Common Signage
11. Mixed Gender Ward / Unit
12. Patient Data Privacy
13. CCTV Management

NTWC = New Territories West Cluster; CCTV = Closed Circuit Television

The Standardised Practices



Key policies / guidelines

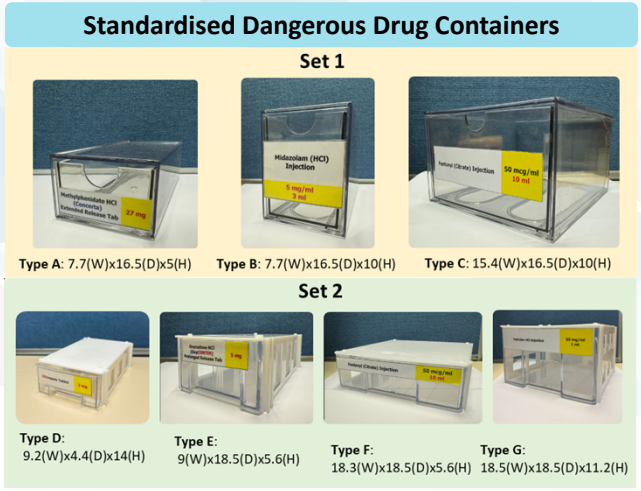
Standards and highlighted safety tips

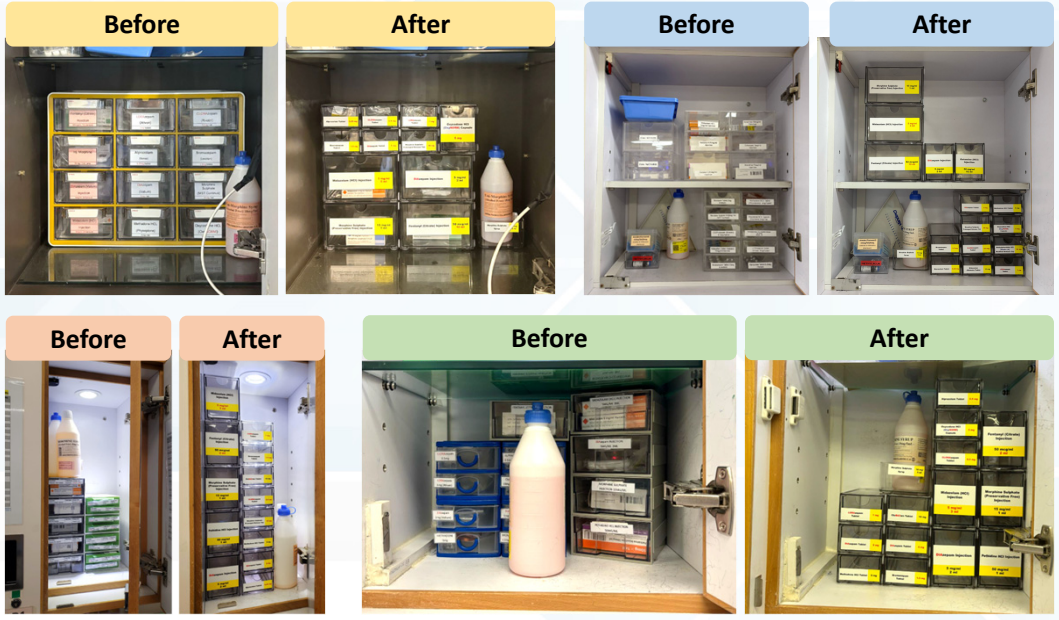
Photos / illustration

Reference / For assistance

Example

- A workgroup was formed for standardising the management of dangerous drugs in NTWC
- 2 standardised container types identified and the container drug label format was standardised





NTWC = New Territories West Cluster

Other Examples

Denture Handling Procedures

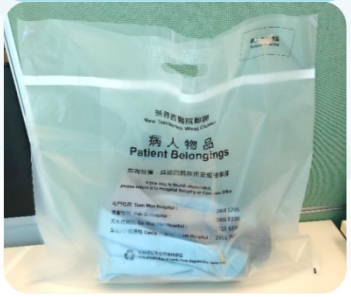
Use of Velcro Tape for Tying (replace rubber band)

Signage for Bedside Locker

Weighing BMI Scale with Handle

Child Toilet Seat for Adult Wards Admitting Children

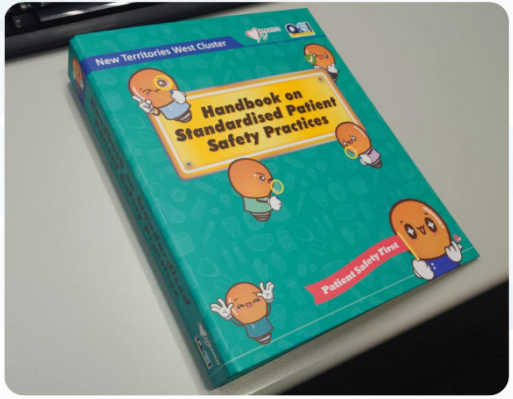
Standardised Patient Belongings Bag

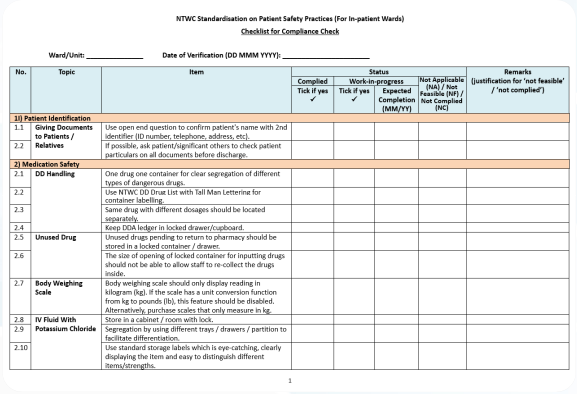


Weighing Scale with Kg Only Display (i.e. No lbs)

Implementation

- Effective since 1 Jan 2025
- Promulgated to departments
- Distributed a hardcopy folder for easy reading in wards & uploaded e-copy to Intranet
- Developed a checklist to inspect its compliance during Patient Safety Walk Rounds





NTWC Standardisation on Patient Safety Practices (For In-patient Wards)

Checklist for Compliance Check

Ward/Unit: _____ Date of Verification (DD MMM YYYY): _____

No.	Topic	Item	Status				Remarks (justification for 'not feasible' / 'not complied')
			Complied	Work-in-progress		Not Applicable (NA) / Not Feasible (NF) / Not Complied (NC)	
			Tick if yes ✓	Tick if yes ✓	Expected Completion (MM/YY)		
1) Patient Identification							
1.1	**Giving Documents to Patients / Relatives**	Use open end question to confirm patient's name with 2nd identifier (ID number, telephone, address, etc).					
2.2		If possible, ask patient/significant others to check patient particulars on all documents before discharge.					
2) Medication Safety							
2.1	**DD Handling**	One drug one container for clear segregation of different types of dangerous drugs.					
2.2		Use NTWC DD Drug List with Tall Man Letterine for container labelling.					
2.3		Same drug with different dosages should be located separately.					
2.4		Keep DDA ledger in locked drawer/cupboard.					
2.5	**Unused Drug**	Unused drugs pending to return to pharmacy should be stored in a locked container / drawer.					
2.6		The size of opening of locked container for inputting drugs should not be able to allow staff to re-collect the drugs inside.					
2.7	**Body Weighing Scale**	Body weighing scale should only display reading in kilogram (kg). If the scale has a unit conversion function from kg to pounds (lb), this feature should be disabled. Alternatively, purchase scales that only measure in kg.					
2.8	**IV Fluid With Potassium Chloride**	Store in a cabinet / room with lock.					
2.9		Segregation by using different trays / drawers / partition to facilitate differentiation.					
2.10		Use standard storage labels which is eye-catching, clearly displaying the item and easy to distinguish different items/strengths.					

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Outcome and Way Forward

- To evaluate if the standardised practices could reduce clinical incidents
  - **Loss of Denture**

Before (Jan 2022 to Jul 2024): 1.5 cases/month
After (Aug 2024 to Mar 2025): 0.6 cases/month
(↓57%)

  - **Fall Prevention**

Before (Jan 2022 to Jul 2024): 43 cases/month
After (Aug 2024 to Mar 2025): 21 cases/month
(↓51%)

Outcome and Way Forward

- To evaluate if the standardised practices could reduce clinical incidents
- To evaluate staff satisfaction on the standardised practices
- Add suitable new practices for standardisation
- To develop similar Handbook for out-patient setting

Thank you!


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