From Board to Ward:

NTWC Rapid Incident Management Team (RIMT)

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HA Convention 2026

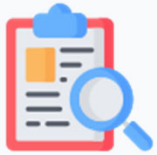
Background

- Incidents require timely management and implementation of effective preventive measures

Problems

- Unclear understanding of reported incidents based on incident reports
  - Most cases only had remote inquiries (emails / phone calls)
  - Site visits only in selected cases
- Lack of understanding of real situation (environment and patient records) in clinical units
- Lack of face-to-face communication with and support to clinical units
- Leading to superficial root causes & ineffective recommendations
- Chance of recurrence was high

What Do We Want to Change?



Prompt Investigations

- Visit the incident sites by a designated team
- Promptly review incidents
- Review records, understand the environment
- Talk with staff and patients

Direct Communication

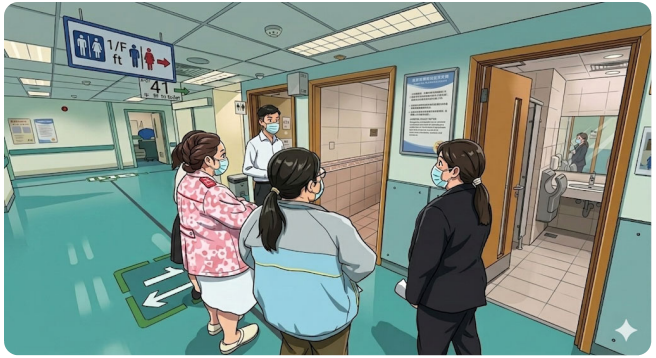
- To allow immediate, two-way communication between management and frontline staff
- Discuss improvement actions
- Listen to clinical staff's concerns

Hospital-wide Improvements

- Quick reporting to cluster/hospital management
- Identify common problems
- Introduce hospital-wide improvements with senior support

NTWC Rapid Incident Management Team (RIMT)
快速事故管理小隊

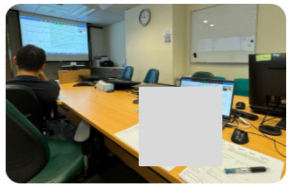
- Established in Aug 2023
- Members from
  Quality & Safety (Q&S) Division &
  Nursing Services Division (NSD)
- Work collaboratively to improve patient safety



What RIMT Do

Managed >1,200 cases/year

09:00 – Case Screening




- Review reported AIRS on every working day
- Identify cases requiring site visits
- Review electronic patient records

10:00 – On-site Visits

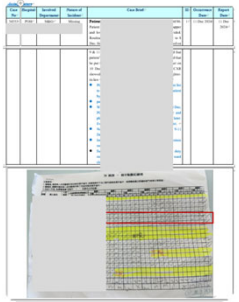


- Direct visits to involved wards/units
- Face-to-face communication with frontline staff
- Interview patients
- Review patient records and inspect environment
- Identify preliminary root causes and discuss improvement actions
- Listen to frontline's concerns

12:00 – Report to Cluster Management

- Cluster Daily Brief meeting chaired by Cluster Chief Executive
- Allows the "Board" to provide immediate directions and resource allocation to resolve systemic issues,
- Effectively shorten response time and optimise decision-making

11:30 – Summarise Findings



- Consolidate investigation findings
- Analyse commonalities and recurrent incidents across departments to identify systemic patterns in the cluster

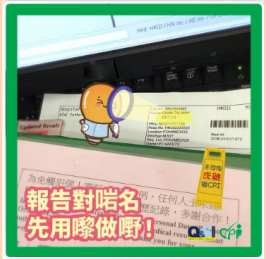
Our Actions and Achievements

Quality & Safety Messages

💡病人運送 - 氧氣3-2-1篇💡

近日有醫院發生病人於運送時氧氣供應不足個案😱，現特別提醒各同事，運送相關病人時一定要遵從以下要點，免生意外🙏

1️⃣ 緊記同做足 安全使用氧氣樽3-2-1❤️(另看附件)
2️⃣ 轉關病房前一刻 才將鼻氧管接駁去氧氣樽🔄
3️⃣ 病人如用呼吸機 (如BiPAP、Optiflow)，當中氧氣消耗速度可能比估算更快，如此類病人的運送距離較長時(如宅院特別座去主座或去不同樓層)，一定最少要帶多一支後備氧氣樽及裝上鏡頭 ，以備不時之需👍
4️⃣ 如運送途中出現問題， 盡快運送病人到 最近嘅臨床單位 尋求協助🙏



💡確認病人身份 - Investigation Report篇💡

化驗同放射報告🩻🧠📋對病人治療好重要。如果睇錯第二個病人嘅報告嚟做診斷或開藥可以好大件事😱

記住以下重點，可以避免同investigation report有關嘅CPI事件發生！
1️⃣ Filing前📁 對清楚病人全名同**ID/HN**⭕，淨係睇病床號碼唔係正確做法❌！
2️⃣ 同事都有機會file錯😢，記住每張report嘅病人身份都要核對， 後面嘅張未必屬於同一個病人！
3️⃣ 用**barcode槍** scan病人label嚟打開CMS profile，避免用Patient Selection Panel揀patient。

#CorrectPatientIdentification
#CPI

17:35

- Promote important safety messages to frontline staff
- Promptly raise staff awareness to reinforce safe practices
- >5,000 NTWC staff joined
- >140 messages published

Redesigned the System

Patient Belongings Bag

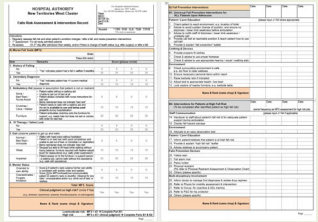
- Prevent loss of patient belongings
- Expanded to other clusters
- No incident since introduction

Safety Vest with New Design

- Prevent patient injuries and falls from escaping from the vests
- No incident since introduction

Enhanced Falls Prevention Measures

- Improved fall assessment accuracy
- Improved patient education and communication
- Installed fall-prevention facilities
- Overall reduced hospital falls



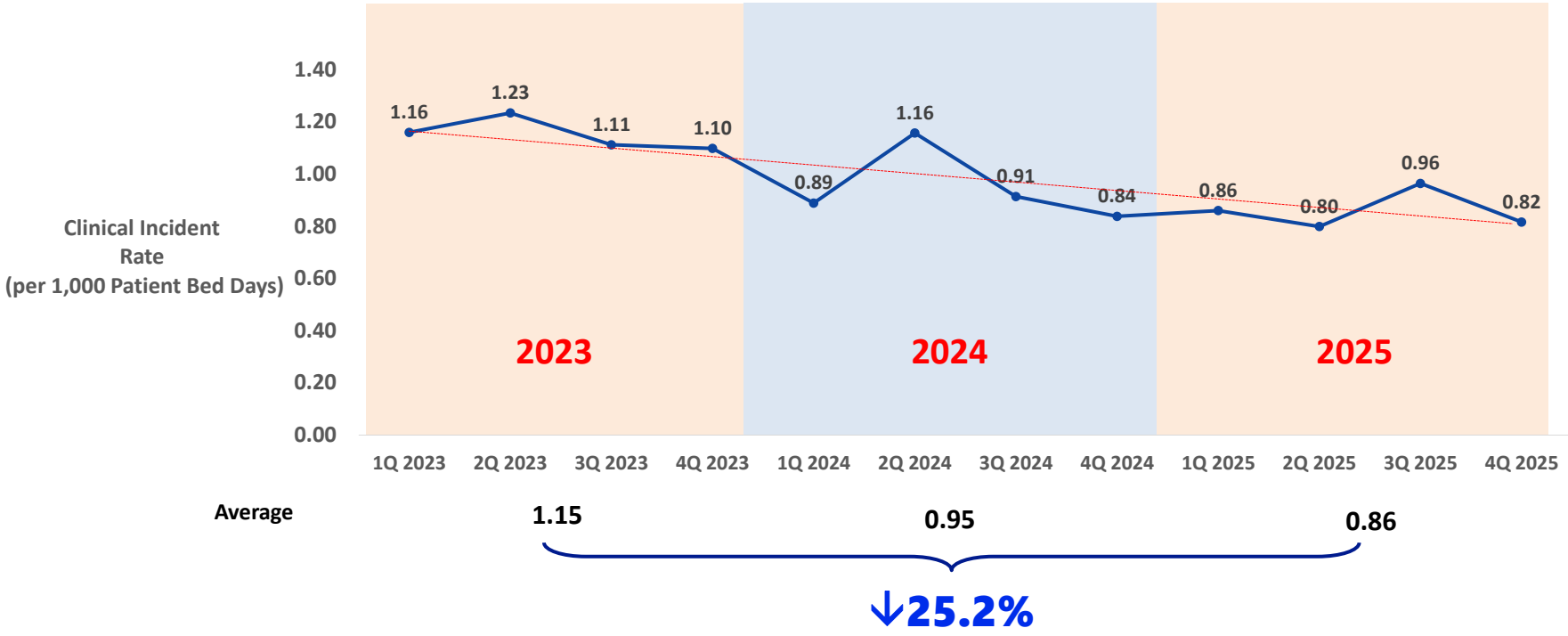
Secure Device for Monkey Pull Handle

- Prevent dropping of handle
- No incident since introduction

Designated Denture Box

- Prevent loss of dentures
- Enhanced identification & checking
- Reduced incidents

Outcomes – NTWC Clinical Incident Rates



CONCLUSIONS

Faster identification of latent risks

Corrective actions implemented promptly

Visible leadership and rapid engagement

Shift from retrospective to real-time risk reduction.

From the board to the ward ....

Through the walk, share your thoughts

THANK YOU VERY MUCH!