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聖保祿醫院
St. Paul's Hospital

NewsLetter 院訊

Surgical Management of Sleep Disordered Breathing (SDB)

CME Presentation Recap:

- Osteoporosis
- Audit Review

MESSAGE
FROM THE MEDICAL SUPERINTENDENT

Dr. William Ho
Medical Superintendent

On Hospital Accreditation

St. Paul's Hospital has gone through the Consultancy Survey (Gap Analysis) exercise by ACHS (Australian Council on Healthcare Standards) in May. Although theoretically hospitals are not expected to prepare much for this initial stage, like everybody else we nevertheless put in effort to tidy up in some areas. We are glad that the surveyors complimented us on particularly two points. Firstly, they detected a genuine support for the pursuit of continuous quality improvement among top management and staff. This was evidenced from both the improvement effort as well as the fact that we were very open in acknowledging weaknesses so as to benefit from their advice. Secondly, they appreciated we were not forcing too much on frontline staff in order to "look good", because that could be counter-productive.

Indeed, we took great care to inculcate the right attitude and mindset towards accreditation. When I first joined SPH in 2012, the question of ACHS accreditation was broached in a Department Heads Meeting. The response was almost unanimous – a resounding No! The climate was not ripe at that time, as other internal management and staffing issues occupied centre stage in everybody's mind. Fast forward one year, and the opposition largely vanished. Once committed, we in fact spent more time promoting the understanding and showing staff members the way to tackle such a daunting exercise, than scrambling to write policies, guidelines and documentation. After the Commitment Ceremony in January 2013, we organized not only internal learning and briefing sessions, but also a total of four sharing sessions by guests from other hospitals on their experiences. We are most grateful to Sr. Lucy Choy of Canossa Hospital, Dr. Joseph Lui from United Christian Hospital, Dr. YK Chan and Ms. Betty Au Yeung from Caritas Medical Centre, and Dr. Raymond Yung and Ms. Queenie Chan from Hong Kong Sanatorium and Hospital. Their generous sharing and tips allayed much anxiety and helped hospital staff appreciate a more realistic picture of the exercise.

The four days of survey on May 13-16 were indeed very solid, with a large number of observations and recommendations from the surveyors. Although they were quick to point out that many were common to Hong Kong hospitals, we did get a sense of the vast amount of work that needs to be done leading up to the Organization Wide Survey stage. Many recommendations are not hard to comply. But there are still significant number of tough ones that will demand time, effort and determination to overcome anticipated resistance. Seen another way, the exercise may actually be giving us ammunition to tackle these issues. The key to success lies in Engagement – engaging our in-house staff, visiting doctors, hospital governance, patients and the community, so as to bring our performance on quality and safety to new heights.

Quality improvement is both a culture and a never-ending pursuit. It is the essence of our professional calling, and our duty to patients who entrust their lives to us. We are glad to embark on this new journey.

MEDICAL ARTICLE

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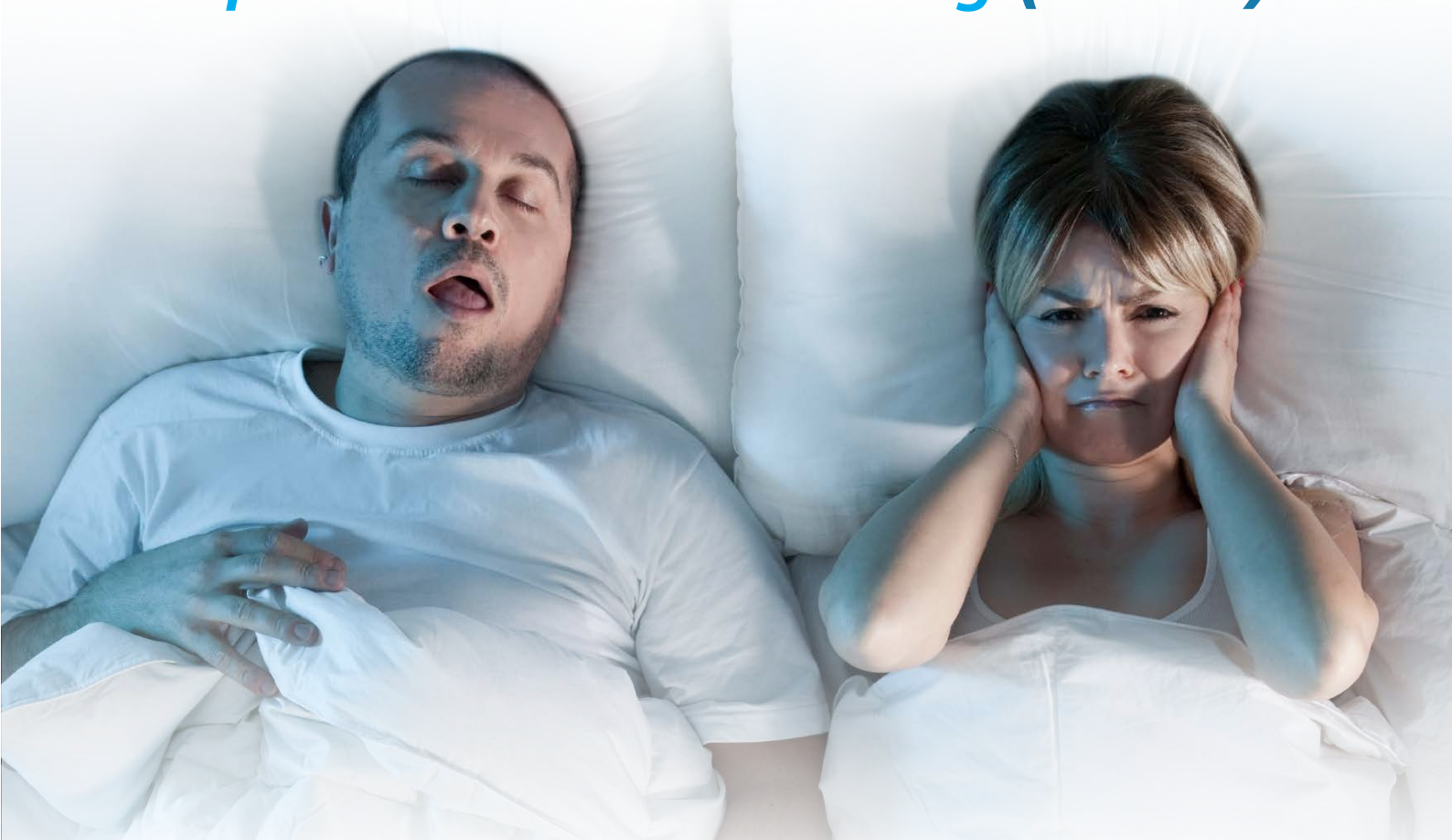
Surgical Management of *Sleep Disordered Breathing (SDB)*



Sleep Disordered Breathing (SDB) is a spectrum of diseases that include snoring, upper airway resistance syndrome (UARS), and obstructive sleep apnea (OSA). Obstructive sleep apnea syndrome (OSAS) is characterized by repetitive episodes of obstruction of the upper airway during sleep, which affects 2-4% of the population. It is associated with increased risk of cerebral and coronary vascular disease, congestive heart failure, metabolic dysfunction, cognitive dysfunction, motor traffic accidents, and disturbed quality of life. The gold standard first line treatment of OSA is Continuous Positive Airway Pressure (CPAP). Although it is a safe and effective therapy together with demonstrable technological equipment advances, adherence to CPAP treatment is insufficient in 17-54% of the patients. Reasons for poor compliance include mask discomfort and irritation, dry and blocked nose, and eye irritation. We cannot leave OSAS untreated if patient cannot tolerate CPAP therapy. Therefore, patients with OSAS who cannot tolerate or refuse CPAP therapy may be considered for surgical management.

Surgery for OSAS is not a substitute for CPAP, and the goal of surgical management is to reduce the number and severity of obstructive events. Moreover, it may improve CPAP compliance or reduced the pressure required in CPAP therapy. Surgery for OSAS has been evolving in the years since Uvulopalatopharyngoplasty (UPPP) was first described by Fujita et al in 1981. However, a meta-analysis by Sher et al in 1996 indicated an overall success rate of UPPP was only 40.7% in unselected group of OSAS patients. When subdividing patients into different level of obstruction, the success rate was increased up to 80% in those highly selected patients with mainly retropalatal obstruction. Therefore, patient selection is of paramount importance in surgical treatment of patients with OSAS instead of performing UPPP universally for all OSAS patients. With more understanding of the upper airway pathophysiology of patients with OSAS, we now understand that there are up to 90% with multilevel obstruction including nasal and retrolingual obstructions. Surgical modalities should be tailored individually to different patients with

different upper airway anatomy. It could be assessed by detailed ENT examination with Friedman staging and drug-induced sleep endoscopy (DISE), which offer the advantages of direct visualization of the upper airway dynamics, no radiation and assessment of multiple sites of obstruction.

Over the last three decades, various operations on upper airway have been developed from nasal valve down to hypopharynx and neck all aiming at upper airway patency by either actively opening the airway, removing anatomical obstructions, stiffening the pharyngeal wall, increasing its muscle tone. Given the fact that up to 90% of patients with OSA has multilevel obstruction, unilevel surgery is often disappointing. The most commonly performed multilevel surgical approach includes a palatal surgery e.g. UPPP, expansion sphincter pharyngoplasty, combined with hypopharyngeal surgery e.g. tongue base volumetric reduction either radiofrequency (RF) or midline glossectomy, tongue base suspension or hyoid suspension depends on the individual anatomical assessment with modalities mentioned above. In view of the aggressiveness of these combined procedures, close monitoring of the upper airway is required postoperatively and ICU care may be required for major hypopharyngeal surgery. With the advances in medical technology, emerging surgical techniques and more emphasis on patient comfort and satisfaction, minimally invasive surgical approaches for mild/moderate OSA patients by performing radiofrequency ablation of nasal turbinates, soft palate and tongue base was proposed. Soft palate pillar implants aiming at stiffening the soft palate by inserting a woven polyester yarns is another option. A meta-analysis of 1640 patients with multilevel surgery for OSAS revealed a reduction in AHI from 43.9 to 20.3 and an overall success rate of 53.8%. Also, the value of adding RF tongue base to UPPP with multilevel obstruction was confirmed by Friedman et al showing an increase in objective success rate by 13.2% (from 37.9 to 51.1%) and 24.9% (from 8.1 to 33%) for Friedman stage II and stage III disease respectively. Besides being an option for OSA patients who cannot tolerate CPAP therapy, surgical management can also be used as an adjunct to CPAP therapy. Nasal surgery is very often performed in OSA patients in order to improve adherence to nasal CPAP. Nasal surgery was shown to reduce nasal resistance and reduced CPAP pressure used. Although there was no significant change in postoperative AHI values, decreased nasal resistance improved CPAP titration pressures, which enabled more patients to be successfully managed with CPAP. Improvement in disease specific and generic quality of life (QOL) to some extent in OSA patients after correction of an obstructed nasal airway has been reported.

Upper airway surgery may be a feasible treatment option in selected group of patients with OSAS who cannot tolerate CPAP therapy. Therefore, for those non-compliant CPAP patients, the possibility of employing surgical management as a viable option shall be discussed. However, the possibility of offering a cure (AHI less than 5) by surgery alone for unselected patients is low. Therefore, a proper detailed patient selection for good surgical candidate is of utmost importance.

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Osteoporosis

19th February 2013

Anti-resorptive Therapy in the Management of Osteoporosis: A 2013 Update

Dr. Annie Kung
Specialist in Endocrinology, Diabetes & Metabolism

Currently available therapy for osteoporosis includes a variety of pharmacological agents, most of which are inhibitors of bone resorption, and are classified as anti-resorptive agents. These include the bisphosphonates, selective estrogen receptor modulators, calcitonin and the recently introduced RANKL inhibitors.

Bisphosphonates have been used widely in the past 17 years. Despite the proven efficacy in reducing fracture rates in patients with post-menopausal osteoporosis, this class of compound has several limitations. These include lack of effect on cortical bone mass and structure and peripheral skeleton; poor compliance with oral agents; low bioavailability; association with gastrointestinal disorder; level off of bone mineral density (BMD) increase upon prolong treatment; potential safety issues related to bone quality (as expressed by atypical fractures) with long term suppression of bone turnover by high affinity bisphosphonates.

Identification of the essential function of the RANK ligand (RANKL)-RANK pathway in the differentiation and activation of osteoclasts, as well as the natural RANKL antagonist osteoprotegerin (OPG), led to the development of a human monoclonal antibody that is capable of binding specifically to RANKL and inhibiting osteoclastogenesis and bone resorption. Clinical studies on this antibody, namely Denosumab, have confirmed that this agent improves BMD and reducesthe risks of vertebral, non-vertebral and hip fractures significantly in post-menopausal women with osteoporosis and older men with low BMD.Studies comparing the efficacy of denosumab with other alendronate, ibandronate, or risedronate showed that denosumab could increase the BMD to a larger extent than these bisphosphonates in various sites.The subcutaneous route of administration once every 6 month is very well tolerated and helps patients better comply with the treatment.It has been reported in clinical trials that patients treated with denosumab had a higher rate of eczema and cellulitis. Recent data also reported atypical femoral fractures, avascular necrosis of jaw and anaphylaxis in denosumab-treated patients. However, as these are classified as very rare side-effects, the overall benefits of denosumab treatment outweigh the risk of these very rare side-effects.

Another novel anti-resorptive target is cathepsin K, one of the major osteoclastic enzymes responsible for the digestion of collagen bone matrix. Cathepsin K inhibitors are currently undergoing phase III clinical trials and their efficacies in reducing bone fractures is pending.

Altogether, different kinds of anti-resorptive treatment are emerging for post-menopausal osteoporosis. With their proven efficacies on fracture risk reduction, it can be foreseen that the quality of life of patients with osteoporosis could be increased by choosing the treatment suitable for them.

Osteoporosis: When to Start Treatment?

Dr. Tai-Pang IP
Specialist in Endocrinology

Osteoporosis is defined as a skeletal disorder characterised by compromised bone strength predisposing a person to an increased risk of fracture. Bone strength reflects the integration of two main features: bone density and bone quality. As methods of measuring bone quality are not available for general clinical use, the diagnosis of osteoporosis has to rely on bone mineral density (BMD) measurement. Dual energy X-ray absorptiometry (DXA) is currently the gold standard for a BMD-based diagnosis of osteoporosis according to the World Health Organisation (WHO) T-score criteria (≤ -2.5).

However, epidemiology studies have shown that >50% of all hip fractures occurred in subjects without a BMD diagnosis of osteoporosis at baseline such that BMD has a low sensitivity for fracture prediction. A significant proportion of fractures occurs in individuals with low bone mass or even normal BMD. The BMD T-score of ≤-2.5 can only serve as a diagnostic threshold but not treatment threshold. The decision to treat should take into consideration other important clinical risk factors.

Clinical risk factors that have been identified as independent fracture risk predictors include age, low body weight, prior fragility fracture, a parental history of hip fracture, smoking, use of systemic corticosteroids, excess alcohol consumption, and rheumatoid arthritis. WHO has developed a Facture Risk Assessment Tool, the "FRAX" (www.shef.ac.uk/FRAX/) which is a simple ethnic-specific web-based tool that integrates clinical information in a quantitative manner to predict a 10-year probability of major osteoporotic fracture and hip fracture for both women and men. The level of absolute fracture probability above which pharmacological treatment should be indicated would depend on the availability and priority of local health care resources.

In principle, patients at high risk for fracture should be treated with specific anti-osteoporosis drugs. The treatment guidelines recommended by the United States National Osteoporosis Foundation (NOF) can serve as a guide for indications for treatment i.e. (1) prior low-energy hip or vertebral fractures; (ii) BMD T-score ≤ -2.5 at the lumbar spine or proximal femur on DXA scan and (iii) low bone mass (T-score between -1 and -2.5) and one of followings: 10-year probability of any major osteoporotic fracture ≥20% or 10-year probability of hip fracture ≥3% by the FRAX algorithm. All treatment decisions however require clinical judgement and consideration of individual patient factors, including patient preferences, co-morbidities, quality of life, life expectancy, and other risk factors not captured in the FRAX model such as frailty and falls. The decision to treat must be made on a case-by-case basis.

Audit Review

19th March 2013

Colorectal Cancer Screening

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St. Paul's Hospital

Introduction

Consensus recommends colonoscopy screening and surveillance for individuals over the age of 50. St. Paul's Hospital collaborated with Hong Kong Cancer Fund to offer discounted price for individuals to undergo colonoscopy screening in order to encourage colonoscopy screening and increase population awareness of colorectal carcinoma.

An audit was conducted to evaluate all the participates in the programme effectiveness and efficacy of the programme were to be evaluated in term of individuals fulfilled criteria of population screening and incidence of colonic polyps, significant polyps, colorectal cancer, complication rates were to compared with world benchmarks.

Methodology

All individual underwent the programme of colonoscopy screening were included, data were collected prospectively. Demographic data, symptomatology, previous history of colonoscopy, colorectal carcinoma, significant family history etc. were collected. Incidence of colonic polyps, significant polyps, incidence of colorectal carcinoma, complications rate were collected for subsequent analysis.

Results:

There were 250 individuals invited for colonoscopy screening between Dec, 2009 to Dec, 2012, total 236 (96%) individuals' data were available for analysis, 14 invitee were either considered not suitable for colonoscopy screening or data have been lost.

Cecal intubation (successful colonoscopy) was achieved in 234 cases, success rate was 99%. Colonic polyps were identified and removed in 118 individuals (50%), out of these 118 individuals, 21 participants (8.9%) harbored so called significant polyps (polyps >1 cm, polyps with severe dysplasia, carcinoma- in situ changes, villous adenoma or serrated flat polyp). There was one case of colorectal cancer identified. (0.4%)

There was no major complication, 4 participants suffered from minor post polypectomy bleeding required haemoclips application or adrenalin injection for hemostasis, but none of them required blood transfusion. There was neither perforation due to colonoscopy nor any post polypectomy syndrome, no participant required re-admission due to delayed complication. In term of colonoscopy success rate, complication, incidence of colonic polyps, significant polyps and colorectal carcinoma, we aligned with the worldwide benchmarks. Among all the screening cases, 134 (56.8%) of them fulfilled criteria of the guidelines. Comparison of demographic data revealed non-eligible cases were relative younger than eligible ones, many of the non-eligible individuals has colonoscopy screening done within the last 10 years or were symptomatic patients rather asymptomatic individuals.

Conclusion and recommendation

Our performance in colonoscopy screening aligned with worldwide benchmarks, however more refined screening strategy should be designed in order to make the programme more readily available to genuinely needed screening, eligible population.

Audit on a New Surgery for Hallux Valgus: Scarf Osteotomy and Distal Soft Tissue Release

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Introduction

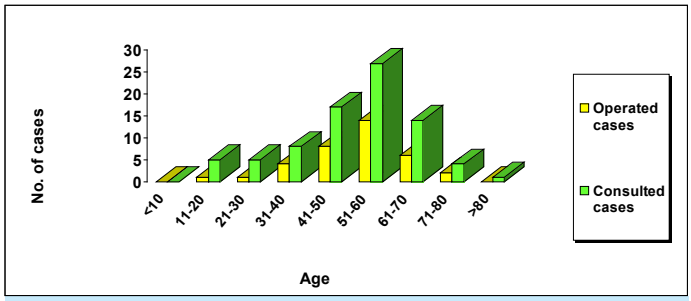
Hallux Valgus (HV) is a deformity characterized by lateral deviation of the great toe, is one of the most common chronic foot complaints presented to orthopedic surgeons. Systematic review on prevalence of hallux valgus concluded, around 23% of adults aged 18-65 years (95% CI 16.3, 29.6%) suffered from HV with prevalence increased with age and was higher among female

Osteotomy has been recommended by the Clinical Practice Guidelines of the American College of Foot and Ankle Surgeons for treatment of HV. Scarf osteotomy has been widely used in US, Japan and France for treatment of moderate to severe HV. Inherent stability and rigid compression of Scarf osteotomy at the osteotomy site allows for immediate weight bearing and possibility of bilateral surgery. Previous attempts have been made to evaluate the effectiveness of Scarf Osteotomy. The results and complications varied across studies with complication rate: 6% -15.6% and patient satisfaction rate: 46.9% - 90.0%

St. Paul's Hospital introduced this surgery on 25 July 2011. A prospective audit on all hallux valgus diagnosed in between 25 July 2011 and 25 July 2012 with Scarf Osteotomy + distal soft tissue release +/- lessor toe reconstruction were included.

Methodology

Clinical notes and x-ray records were reviewed. An audit form and a questionnaire with information including demographic data (Age, Sex), severity of Hallus Valgus , pre and post-surgery Intermetatarsal Angle (IMA) and Hallux Valgus Angle (HVA), pre and post-surgery VAS score, duration of hospitalization, period of wearing sandals, complication of operation. To avoid bias, questionnaire was conducted by Rehabilitation staffs by telephone interview.



AGE	<10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	>81
Operated cases	0	1	1	4	9	14	6	2	0
Consulted cases	0	5	5	8	17	27	14	4	1

Table 1

Results

81 Hallux Valgus cases were diagnosed during the audit period, with 37 (45.6%) of these cases received Scarf Osteotomy with a totally of 60 feet under operation. The operated patient's age ranged from 19 to 77 years old with majority of them were female. See Table 1 and 2

Patients Demographics (n=37)		
	Mean	Range
Age	53.3	(19-77)
	No. of Patients	(% of Cases)
Gender		
Male	4	(10.8%)
Female	33	(89.2%)
Nationality		
Hong Kong	34	(91.9%)
Macauese	2	(5.4%)
Japanese	1	(2.7%)

Table 2

Over sixty percent of cases received bilateral simultaneous bilateral feet surgery. See Table 3.

Side Operated	No. of Patients	(% of Cases)
Left	5	(13.5%)
Right	9	(24.3%)
Bilateral	23	(62.2%)

Table 3

Based on Clinical Practice Guidelines of the American College of Foot and Ankle Surgeons, 60% of operated feet were classified as severe, 38.3% were classified as moderate and 1.7% were classified as mild. The HVA improved significantly, from 34.5° preoperatively to 10.4°, while IMA improved from 15.7 ° to 6.4 ° at 3 months after operation. The mean pain score were also found to be significantly reduced, from 7 to 1.5 after operation. Overall patient satisfactory rate was 92%. Only 1.3% of the operations were unsatisfactory. See table 4

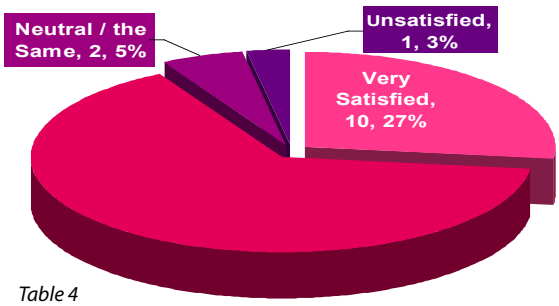


Table 4

Complications

Two cases (5.4%) of patients and (3.3%) out of operations were found to have post-operation complication. One of them suffered from hallux varus while the other suffered from delayed wound infection Table 4.

Centre	Our Sample	PYNEH	Slotervaart Hospital (n=72)
No. of patients	37 (1 year)	32 (3.5 year)	72
No. of operations	60	45	72
Patient with satisfaction	34 (92%)	46.9% (15/32)	NA
Pain relief	59 (98%)	56.3% (25)	NA
Complication Rate (per operation)			
Stress fracture	0 (0%)	0 (0%)	1 (1.4%)
Revision surgery	1 (1.7%)	NA	2 (2.8%)
Hallux valgus	0 (0%)	4 (8.9%)	NA
Hallux varus	1 (1.7%)	1 (2.2%)	2 (2.8%)
Non union	0 (0%)	1 (2.2%)	0 (0%)
Infection	1 (1.7%)	1 (2.2%)	0 (0%)

The hallux varus case was a Schizophrenia patient, he also suffered from post-operative bowel obstruction. The delayed wound infection occurred about fours weeks post-operatively. The infected wound responses poorly to simple dressing and the wound swab found to be Runyon group 4 mycobacterium.

Discussion

For the hallux varus case, Schizophrenia patient compliant to post-operative bandage dressing poorly. He prefers wearing his own open sandal from second week. Unsatisfactory foot oedema control was recorded.

Investigations had been jointly conducted by OT nurse and infection control nurse. No suspicious thoraxic case or bronchoscopy were performed in the theatre on the operation day. The source of Mycobacterium infection remains unknown.

Conclusion

The Scarf osteotomy has proven to be a versatile and powerful procedure to correct various degrees of hallux valgus deformity. Our performance reached the standard. However, as only one surgeon's performance was evaluated, the generalization of the performance was limited. It is better to assess all surgeons in the hospital to review.

It is better to set exclusion criteria for patient selection in order to ensure effectiveness of operation and safeguard patients from undesired outcome. The list of exclusion criteria includes, severe systemic disease, cardiovascular disease, SLE, severe osteoporosis, psychiatric patient.

Apart from that, patient education may reinforce post-operation care and hence may increase the success rate of Scarf osteotomy. We have produced patient education pamphlet to improve peri-operative patient care.

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聖保祿主保瞻禮

(28-29/06/2013)

28 JUNE

聖保祿宗徒為沙爾德聖保祿修會及本院之主保，每年本院會以他的瞻禮日作為院慶。

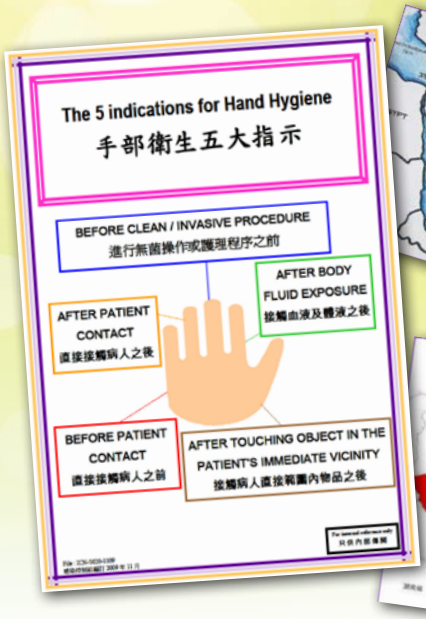
為慶祝這個特別日子，本院於六月二十八日於基督君王小堂舉行了感恩聖祭，由閻德龍神父主祭。一眾嘉賓、修女及同事誠心祈禱，同頌主恩。彌撒後，各來賓更歡聚一起，享用茶點。當日，本院更為全院員工提供免費膳食，大家聚首一堂，感謝上主的恩典。

此外，修會於六月二十九日(主保瞻禮日)舉行了感恩彌撒，並邀請得陳日君樞機主祭及多位神父共祭，有多達數百人出席，令基督君王小堂坐無虛席。

當日亦同時為沙爾德聖保祿女修會修女舉行進會週年感恩禮，慶祝莫德修女進會金禧及張柱見修女進會銀禧，隨後更舉行聖保祿之友收錄禮。禮儀後，眾來賓與進會修女一同切蛋糕慶祝，並享用修會款待之自助美食，場面溫馨愉快。

29 JUNE

HOSPITAL UPDATES



感染控制　齊來抗疫

中東呼吸綜合症候群(MERS-CoV)及甲型流感病毒H7N9病例正在持續上升，其中MERS-CoV的死亡率更高達50%。本院感染控制部已實施一連串防疫措施，以對抗這2種高危疾病。

為確保能做好前線的把關，本部門已加強門診部及住院登記部員工對禽流感/新型流行病分流評估的審查，為員工提供即時協助，加強溝通。而衛生防護中心亦建議各私家醫院/醫生：一旦遇上附合呈報準則的懷疑個案，應盡早把患者隔離及通知衛生防護中心，並根據指引把懷疑個案轉介往醫管局轄下醫院繼續治療。

此外，為提高員工對這2種疾病的認識及相關抗疫措施，本部門於4月中舉辦了3次員工講座，員工也積極參與，出席人數達到211人。本部門更會定期更新疫情最新資料於內聯網上，方便各員工查閱。本院亦已配備足夠3個月使用的個人防護裝備，以確保員工在工作期間有足夠的保護。

抗疫須要大家參與，緊記3個E: Early notification;Early isolation; Early detection（早通報、早隔離、早檢測）、時刻洗手及5個重要潔手時刻。並在臨床範圍工作期間戴上外科口罩。齊心抗疫，由你我做起。

感染控制聯系護士羅寶儀
感染控制部

聖保祿醫院物業(設施)管理部技術員榮獲第五屆全港傑出職安健員工嘉許計劃2013前線員工組優異獎

(03/05/2013)

本院物業(設施)管理部技術員莫壯敏先生，榮獲本年度職業安全健康局舉辦的『全港傑出職安健員工嘉許計劃』前線員工組優異獎，對本院推廣員工職安健方面有很大的鼓舞。作為本院參賽代表，莫先生認識職安健的重要性，身體力行遵守本院的安全指引，關心同事和病人的安全健康，並為改善工作環境方面提出很多寶貴建議，有效加強職業安全健康及提升服務水平，以發揮最佳團隊工作表現。

ACCREDITATION UPDATES

醫院認證顧問調查

(13-16/05/2013)

評審員於發佈會上，向各部門主管及醫院認證統籌員簡報調查結果。

聖保祿醫院參與澳洲醫療服務標準委員會(ACHS)的醫院認證計劃，首階段於2013年5月13至16日順利完成「醫院認證顧問調查」。在一連四天的調查中，五名來自澳洲及本地的評審員走訪四十多個臨床及行政部門，實地審視醫院的制度、醫療作業及服務流程，與醫院管理層、各部門主管及前線同事會面，分享了眾多實際及寶貴的專業意見。本院將根據評審員的建議，精益求精，循序漸進，按部就班地執行改善措施，並持之以恆，持續提升服務質素，保障病人及員工的安全。

五名評審員在臨床、支援及機構行政方面提供不少寶貴意見，令我們獲益良多。

本院於顧問調查首天，發表四項質素改善計劃，成效獲評審員認同。

本院醫務總監何兆煒醫生(左)衷心感激以Mr. Graeme Houghton為首的五名評審員。

此外，本院在此感謝嘉諾撒醫院護理總監蔡植沛修女，及養和醫院副院長翁維雄醫生和質素經理陳惠玲女士，分別於2013年4月24日及5月7日前來本院分享私家醫院參與ACHS認證的寶貴經驗。

嘉諾撒醫院護理總監蔡植沛修女(左)

養和醫院質素經理陳惠玲女士(右)

養和醫院副院長翁維雄醫生(右)

管理層於顧問調查前，到各部門打氣，鼓勵同事以輕鬆心情面對評審。

參觀明愛醫院內鏡中心 (23/04/2013)

參與澳洲醫療服務標準委員會(ACHS)醫院認證計劃，有助推動本院各個部門不斷自我檢討，凝聚團隊力量，從而提升服務質素及病人安全。為了向業界取經及加強公私營醫院的合作交流，本院的內鏡中心與感染控制組，在質素及風險管理部的統籌下，於今年4月23日前往明愛醫院內鏡中心參觀，在該中心的主管熱情款待及用心指導下，彷彿帶領我們進行了一次模擬醫院認證，令我們獲益良多。此外，該中心在實踐職安健方面不遺餘力，成效顯著，值得我們借鏡。本院在此衷心感激明愛醫院的款待。

部門使命

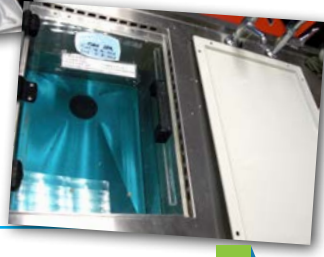
檢查流程明確清晰：

指示明確，分流有序，減低門診病人的院內感染風險。

感染控制

- 分隔清潔及污穢區域

自動清洗消毒內鏡機



- Cidex OPA 儲存及水平線抽風系統

CME Announcement

Topic	Chairman	Speakers
16/07/2013 ***Minimally Invasive Surgery*** 1. The Development of SILS and My Hidden Scar Surgery 2. Minimal Invasive Surgery: from Robotic to Endoscopic	*Dr. Chan Kuen Ting* Specialist in Obstetrics & Gynaecology	1. *Dr Wong Wu Shun, Felix* Specialist in Obstetrics & Gynaecology 2. *Professor Chiu Wai Yan, Philip* Specialist in General Surgery

Time: 7:30pm - 9:00pm (Light Refreshment Provided at 7:00pm)
Venue: Conference Room, 2/F, St. Paul's Convent
Registration: Ms. Sally Pun, Tel: 2830 3905, Fax: 2837 5271, Email: sph.sdd@mail.stpaul.org.hk
CME/ CPD Accreditation for all colleges (Pending approval). CNE Point: 1 Point

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To ensure you receive important updates from St. Paul's Hospital, please complete and return the following form to us if you have updated or changed any of your previous information. Information collected will be used for Hospital communications only. Please note that it takes about ten working days to update your contact information in our system.

Personal Particulars

Name of Physician: (IN FULL NAME)

English: _____ Chinese: _____ Physician Code: _____

Correspondence (Please write down changed items only)

Address: _____

Phone: _____ Pager: _____ Mobile: _____

Fax: _____ Email: _____ Effective Date: _____

Others: _____

Signature: _____

Please return the completed form by

1) Fax: 2837 5291 2) Email: vmo@stpaul.org.hk

3) Post: 2 Eastern Hospital Road, Causeway Bay, Hong Kong (Attn: HR Manager)

Thank you!