Patient Safety - Building a Reliable Culture for a Sustainable Outcome

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Aim: To share KKH's experience in working beyond system, processes and designs, optimising outcomes of intervention through building coalition, partnership in nurturing a culture of patient safety and clinical quality.

Introduction

While individual accountability for safe patient care is essential, the complexity of healthcare requires a highly reliable system that addresses the challenge of nurturing a culture of continuous improvement that enhance the quality and safe care delivery outcomes. The exploration for novel ideas that provide hospital with practical approach in garnering the effort of staff at all level is critical to effecting change and the sustenance of quality outcomes.

Methodology

Three critical elements were identified as focus to influence the improvement of safety:

1. Safety is compliance driven - targeted platforms were created for sharing safety and risk to increase awareness.

- Making Patient Safety as a compulsory agenda in monthly CEO-CMB Forum, Medical Board and various departmental meetings.
- Senior Leadership and Clinical Walkabout were carried out every month created the opportunity for frontline staff to discuss safety issues and concerns.

Patient Safety is the 1st Agenda in monthly CE)-CMB Forum

Monthly Patient Safety Newsletter -Sharing Patient Safety Lesson

ERM Talks- share on the methodology/benefits to proactive risk mitigation

2. Drive safety performance through co-creation of partnership across all functional departments to enhance clinical and operational effectiveness.

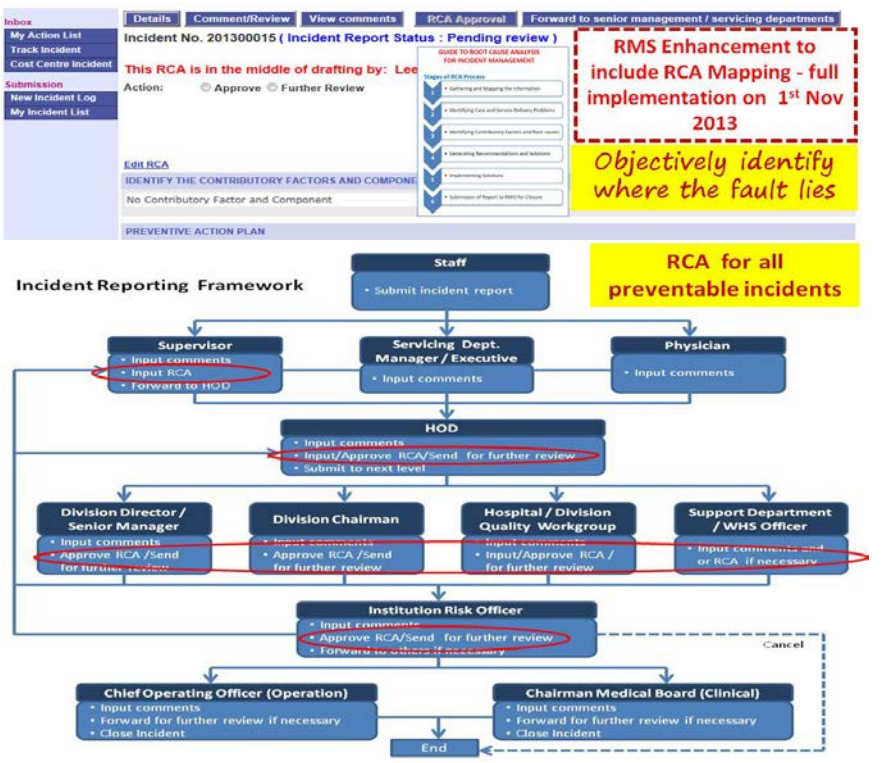
- Patient Safety and Risk Management (PSRM) Network Program was launched with the designation of 60 Patient Safety Leads (PSLs) from clinical and non-clinical departments to initiate and drive patient safety activities in their respective areas.
- The PSRM Network aimed to provide a collaborative platform for PSLs to exchange ideas, share good practices and raise patient safety issues that require support. The platform was open to all clinical and non-clinical staff of the different department in KKH and the HODs providing support .

3. Promote safety as process of improvement to which everyone can contribute and incorporate risk management training as a strategic initiative to equip staff with appropriate analysis and system thinking skills to improve work.

- Sustain a culture of continuous improvement by equipping the staff with knowledge in the use of process improvement tools and risk management concept. Therefore to date, KKH has trained more than 20% of exempted staff in the use ERM tools to co-lead projects. The initiation of project teams with multi-stakeholders and participation in ERM work plans and process improvement projects has become part of corporate goals to encourage collaboration.
- KKH has generated 50 Risk Mitigation Work Plans within 2.5 years of implementation of which 45 related to Patient Safety and 96% with multidisciplinary staff involvement.

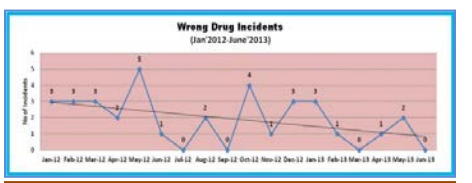
ERM project done to mitigate the risk of vacuum and medical gas shut-down in critical units

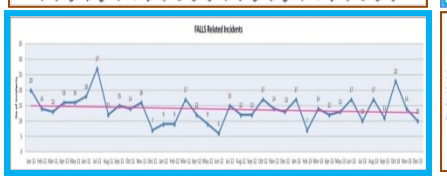
- Electronic RCA (eRCA) platform was created in Nov 2013 in Risk Management System to allow staff to systematically identify root issue.

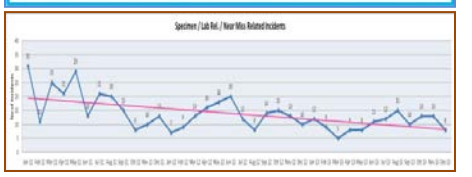


Result -

- From 2010 to 2013 - a reduction in Cat D and above medication errors from 15 to 9.
- KKH was invited to share best medication management practices in HPO Forum 2014
- Serious Reportable Events (2011-2013) has the lowest among all Public/Restructured Hospitals
- Achieved zero nosocomial Aspergillosis infection rate in Oncology ward in 2013 after initiated Key Risk Mitigation Plan using ERM approach.
- Increase in the number of RCA review for reported incidents- Pre-implementation of eRCA (May-Jul 2013) - 246 incidents were reported and only 25 % has RCA review. 56% of the incidents were preventable. However, post-implementation eRCA (Jan-Mar 2014) - 211 incidents were reported and out of which 77% has RCA review. 68% were preventable incidents.
- Others incidents that achieved a significant reduction are as shown:







Conclusion

Patient Safety Management depends upon effective strategies for preventing errors in health-care services. A good error prevention program would require the establishment of a reliable system with human integration of belief and value in which the organization serve.

Acknowledgement

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