SingHealth Polyclinics Patient Safety Collaborative

Ms Cai Jiaxin, Dr Wong Wei Teen,
Dr Lim Hwee Boon, Dr Chow Mun Hong
SingHealth Polyclinics

Introduction

The SingHealth Polyclinics (SHP) Patient Safety Collaborative was set up in September 2017 as part of SHP's "Target Zero Harm" Patient Safety Programme.

The aims of the Patient Safety Collaborative are:

- To have a platform for sharing of updates and initiatives from SingHealth cluster, SHP committees & workgroups
- To facilitate cross-learning of patient safety concerns and improvement works
- To have a centralized platform for coordinating patient safety related activities and improvement across clinics
- To build capacity and strengthen patient safety culture

Methodology

i. Structure of the Patient Safety Collaborative

The Patient Safety Collaborative is led by the Patient Safety Group of the Quality Improvement Committee (QIC) and supported by the SHP Quality Management Department. Patient Safety Collaborative members includes multi-disciplinary Patient Safety teams from each Polyclinic (Figure 1: Patient Safety Collaborative Structure).

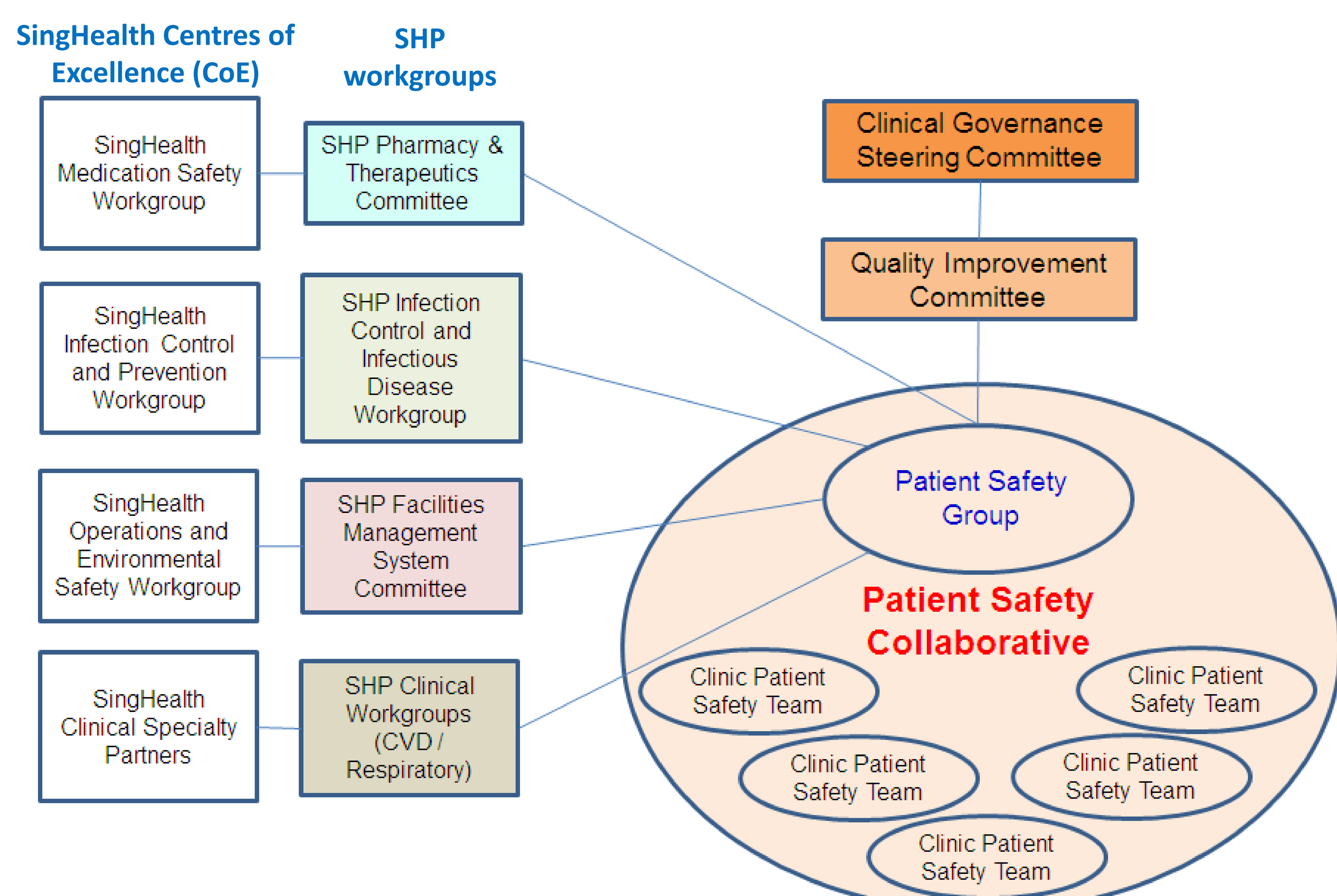


Figure 1: Patient Safety Collaborative Structure

The QIC Patient Safety Group works with different Patient Safety related workgroups to coordinate and facilitate the activities of the Patient Safety Collaborative. As the individual Patient Safety related workgroups are also linked to the SingHealth cluster level workgroups, this also facilitates the updating of ongoing initiatives that may have impact at SHP (Figure 1: Patient Safety Collaborative Structure).

ii. Format of the Patient Safety Collaborative

Patient Safety Collaborative meetings are held every quarter where there is open sharing of patient safety concerns and initiatives at cluster, SHP and clinic levels. Patient Safety indicators are included for learning and improvement at the Patient Safety Collaborative meeting. These include the indicators on medication error, falls, hand hygiene and environmental hygiene.

iii. Activities in building capacity and strengthening patient safety culture

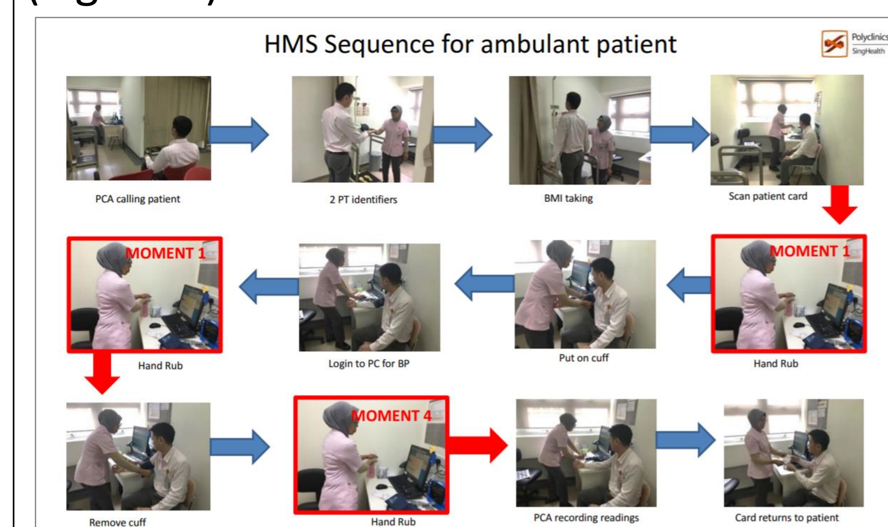
Clinic-based activities are coordinated by the Patient Safety Collaborative in the effort to build the capacity and strengthen patient safety culture. The activities include:

- Patient Safety week (Oct 2017) - Target Zero Harm presentation by the clinics' Patient Safety teams at each clinic
- Patient Safety Walkround conducted by the clinics' Patient Safety teams and clinics' management teams

iv. Activities in facilitating cross learning of patient safety concerns and improvement works

Examples of the improvement efforts that were coordinated through the Patient Safety Collaborative were improving hand hygiene compliance rate and reducing prescription error rate. Table 1 shows the improvement project summary where structured quality improvement approaches were adopted.

Table 1: Improvement project summary on improving hand hygiene rate and reducing prescription error rate

Hand hygiene	Prescription error
Stretch goal	**Stretch goal**
Hand hygiene compliance rate of 100%	Prescription error rate of <0.07%
Building knowledge	**Building knowledge**
Observation and survey conducted on ancillary staff at health monitoring station (HMS) by ICID workgroup	Qualitative information of clinic's prescription errors and clarifications were analysed
Develop a change	**Develop a change**
Intervention : Development of fixed sequence steps by ICID workgroup for training of HMS staff (Figure 2)  *Figure 2: Hand hygiene fixed sequence steps for HMS staff*	Intervention : • Information on medication errors ("Top areas of commonly occurring medication errors") was analyzed, consolidated and aggregated for sharing by the doctors and pharmacists . • This was translated into presentation slides for sharing by the Patient Safety teams with the clinic doctors
Test a change	**Test a change**
• Focused hand hygiene audit for HMS staff was conducted • Feedback on the training was obtained from the HMS staff	Feedback on the content and the use of the presentation slides was obtained from the clinics' Patient Safety teams

Results

i. Coordination of improvement across clinics
(Hand hygiene compliance rate and Prescription error rate)

Improvement can be observed for both the hand hygiene compliance rate (Figure 3) and prescription error rate (Figure 4). The set up of the Patient Safety Collaborative has provided the opportunity for the polyclinics to have more awareness and ownership on Patient Safety related matters. We are early in our journey and more effort by the Patient Safety Collaborative is required for more significant improvement.

Hand Hygiene Compliance Audit – HMS Staff

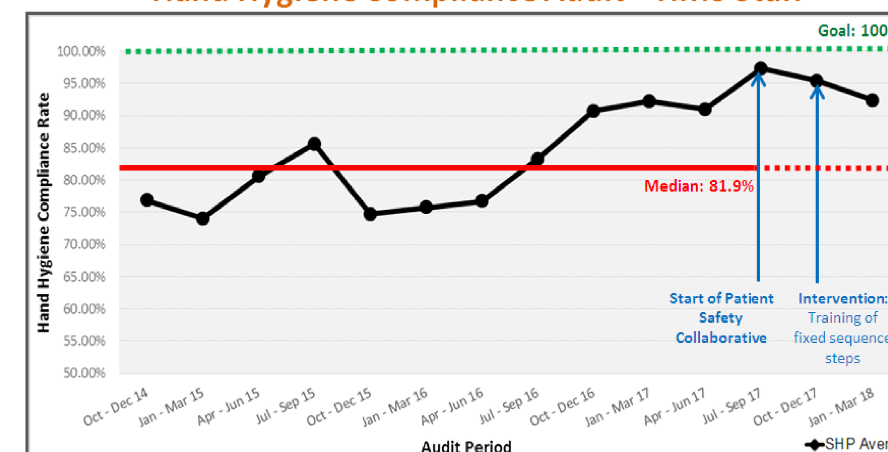


Figure 3: Hand Hygiene Compliance rate for HMS staff (the higher the better)

Prescription Error Rate (Near Misses)

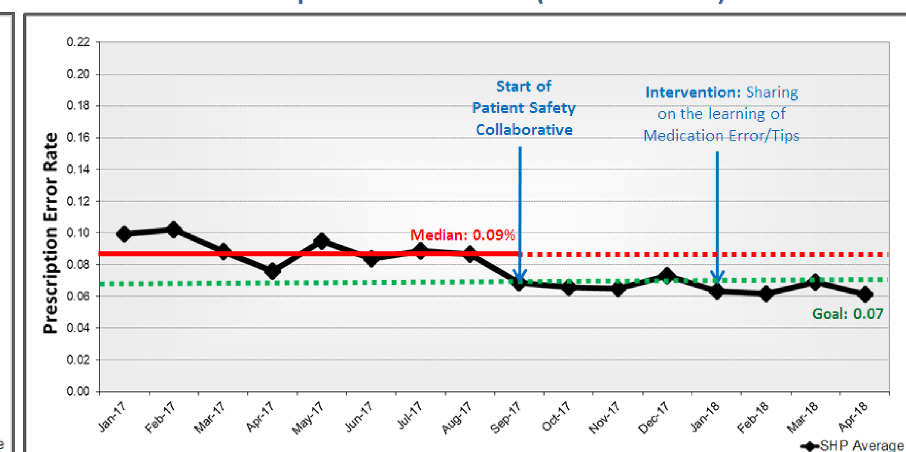


Figure 4: Prescription Error Rate (the lower the better)

ii. Building capacity and strengthening patient safety culture

Qualitative feedback on the Patient Safety Collaborative were obtained. Examples are:

- Opportunities to hear and learn from other clinics and disciplines
- Learning points shared at the collaborative can be brought back to the clinic to address potential gaps
- Materials provided to facilitate the interventions/initiatives were helpful to the clinics' teams in their communication to the targeted group
- Concerted effort by all polyclinics makes it easier to get the buy-in from staff on interventions/ initiatives

Conclusion

The Patient Safety Collaborative has been an important platform in SHP for learning and sharing of patient safety related matters across the different stakeholders. It has also enabled better coordination and facilitation of the patient safety effort that is required to be rolled out in the polyclinics.

Continuous improvement efforts and culture building are important aspects in our journey towards "Target Zero Harm".