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SAFE Patient Transport

Background

KKH ambulance transport services has experienced an average of 1.25 incidents per year relating to falls and use of stretchers over the past 4 years. Staff and patients sustained injuries from some of these incidents. Providing safe transport to our patients is our top priority. The department recognised the need to improve the safety of our transport services, and target zero harm for both our staff and patients.

Aim

To provide safe patient transport and target zero KKH ambulance transport service incidents due to falls and use of stretchers.

Methodology

The team was formed to identify the root causes and determine the solutions to the 3 most recent incidents.

Case 1:

A hefty inpatient was ferried from KKH to NHCS for an appointment. On arrival at NHCS, the driver went to look for a wheelchair while the nurse helped the patient down from the ambulance. The patient missed a step and fell while getting down from the ambulance. (March 2016).

Root Causes	Solutions
i. Failure to assess patient's build and ferry patient via wheelchair.	<ul style="list-style-type: none"> Nurses to review the comprehensive nursing assessment for patients. The appropriate mode of transport (wheelchair or stretcher) will be arranged for the patient.
ii. Communication breakdown between driver and nurse.	<ul style="list-style-type: none"> Incident was shared with nurses from Ward 43, Drivers and Patient Transport Assistants (PTAs). Drivers were informed the importance of communicating their next course of action to the nurses. Nurses were informed to be more proactive and assertive in asking for help to move patient in and out of the ambulance.
iii. No provision of grab bar at the passenger's door in the ambulance.	<ul style="list-style-type: none"> A grab bar was installed near the passenger's door for patients to hold on to and maintain their balance while boarding or alighting the ambulance.

Case 2:

A patient was ferried from TMC in an incubator mounted on a stretcher trolley to SGH for treatment. During unloading of the incubator from the ambulance, the driver did not notice that the trolley legs were not fully extended to a locked position and the stretcher collapsed. (March 2016)

Root Causes	Solutions
i. The transport team consisting of a Doctor, two Nurses and a PTA were unaware of their roles to assist the driver during the unloading of the incubator by ensuring that the trolley legs were fully extended and locked.	<ul style="list-style-type: none"> A video instruction demonstrating the correct techniques of loading and unloading stretcher from the ambulance, and the role of each transport team member was produced. The video was uploaded into Infopedia for users' reference and training purposes (for all inpatient and critical area ward nurses).

Case 3:

A patient was transferred from KKH to Dover Park Hospice. On arrival at Dover Park Hospice, PTA unloaded the patient strapped to the stretcher from the ambulance. Although the wheels extended simultaneously, the stretcher collapsed as the lock failed to engage to keep the stretcher frame in place. (February 2017)

Root Causes	Solutions
i. Driver was busy moving the portable oxygen tank instead of unloading the patient from the ambulance. He was not aware that the nurse could assist to receive the portable oxygen tank.	<ul style="list-style-type: none"> The video instruction was shown to all Drivers. Compulsory for all new Drivers to view the video instruction and undergo hands-on training using a comprehensive training checklist as part of their training program.
ii. Driver was new and did not inform PTA to wait for him to unload the patient.	
iii. PTA noticed that the driver was busy and went ahead to unload the patient from the ambulance. He was eager to assist the patient and had forgotten that it was the driver's responsibility to load and unload patient from the ambulance.	<ul style="list-style-type: none"> The video instruction was shown to PTAs during the PTS department meeting. Compulsory for PTAs identified to assist in ambulance cases to view the video instruction and undergo hands-on training using a comprehensive training checklist.

Results

The last incident related to falls and use of stretchers happened in February 2017.

Since then, there are no reports of new incidents.

Conclusion

Several measures have been taken to mitigate the occurrence of incidents relating to falls or use of stretchers. These include the production and sharing of training videos, hands-on training sessions for staff involved in the transport of patients, as well as enhancement to the ambulance facility. With these measures in place, we had effectively reduced the number of incidents relating to falls and use of stretchers to zero and achieved zero harm.

