

Patient Safety and Risk Management Network in Enhancing the Culture of Safety at KK Women's and Children's Hospital

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INTRODUCTION

Communicating information about patient safety is an important responsibility that should not only fall to senior leaders alone but to all hospital staff. However, creating a culture of safety remains to be an enormous task. Institutions should engage a high level of commitment at all levels and develop effective teams to improve the overall safety awareness.

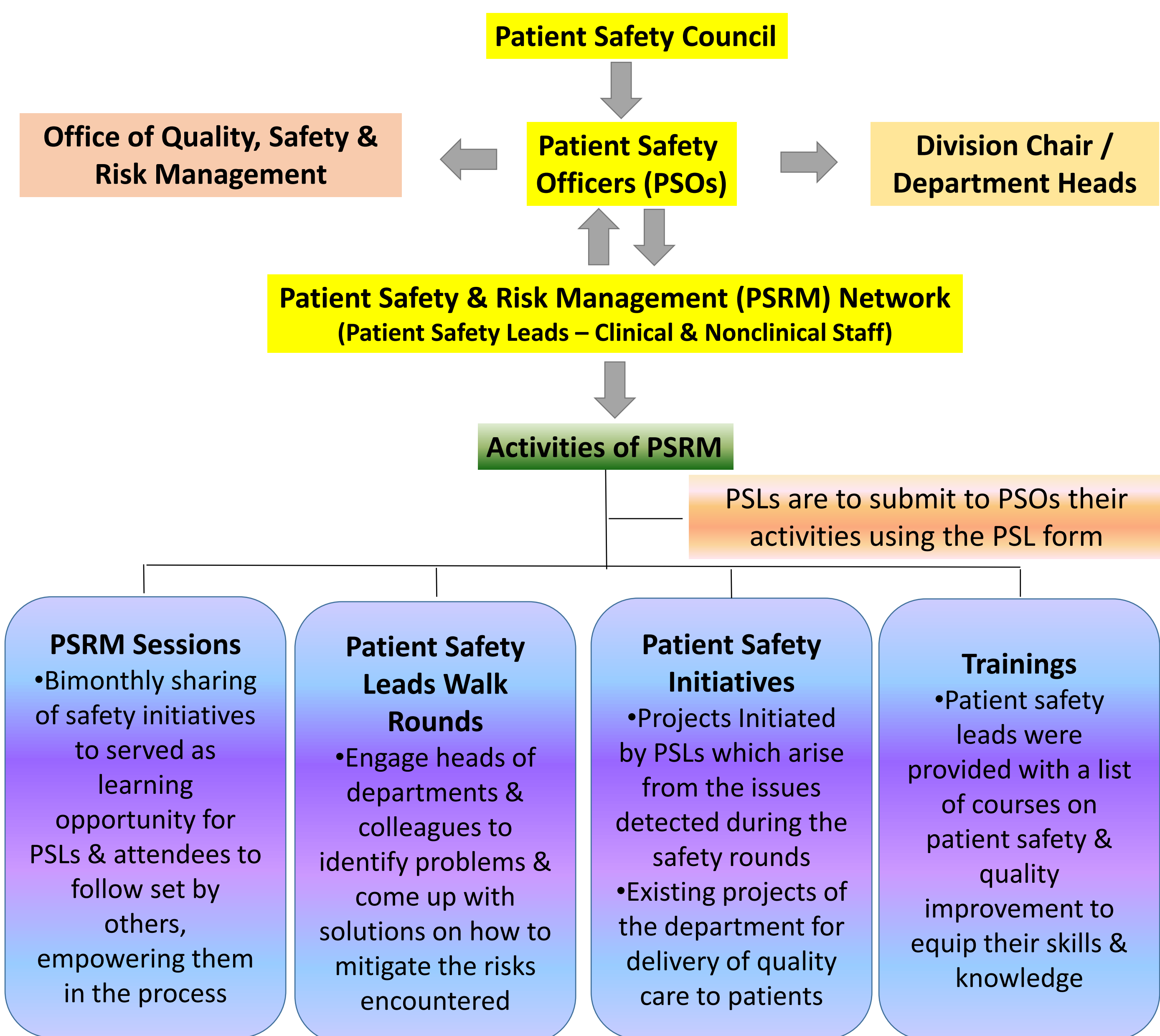
AIM

To build a multidisciplinary network of safety experts who will lead in patient safety initiatives and quality improvement activities thereby improving the culture of safety for patients and staff.

METHODOLOGY

Compelled to "bridge the gap" between hospital leadership and ground staff and to enhance the culture of safety in the hospital, patient safety leads (PSLs) were appointed for every department. As presented in Figure 1, the Patient Safety Council oversees the patient safety efforts and implementation of safety measures in the hospital while the patient safety officers coordinated the activities of the network.

Figure 1. Structure

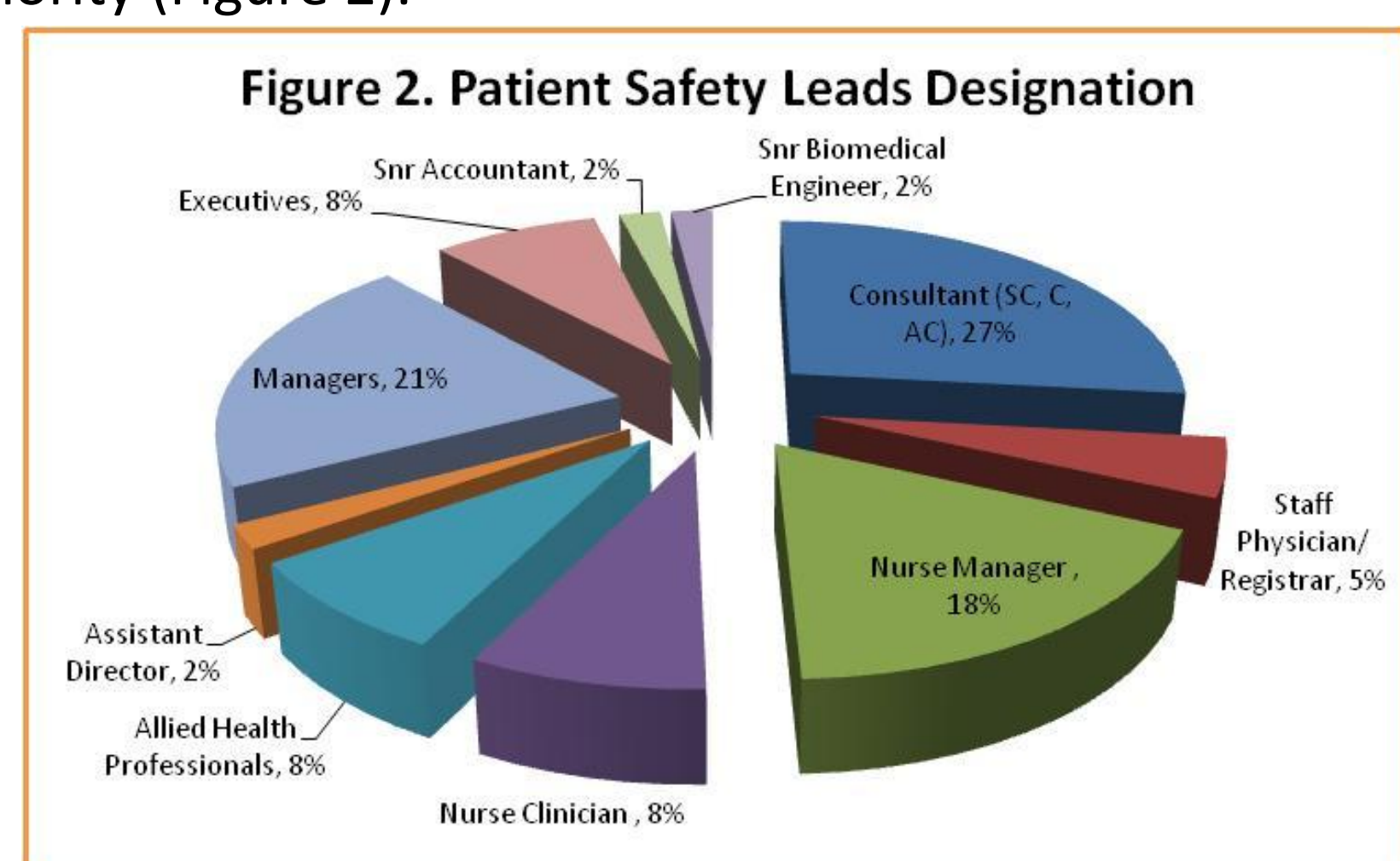


RESULTS

Patient Safety Leads formed the middle level Patient Safety and Risk Management network established on 18 February 2014 which has cross-functionality across all departments to promote collaboration. Badges were distributed for each of the PSLs to showcase their visibility.



Sixty two PSLs are currently participating in the network with a renewable term of 2 years consisting of physicians, nurses, allied health professionals, administrative and ancillary staff of varying seniority (Figure 2).

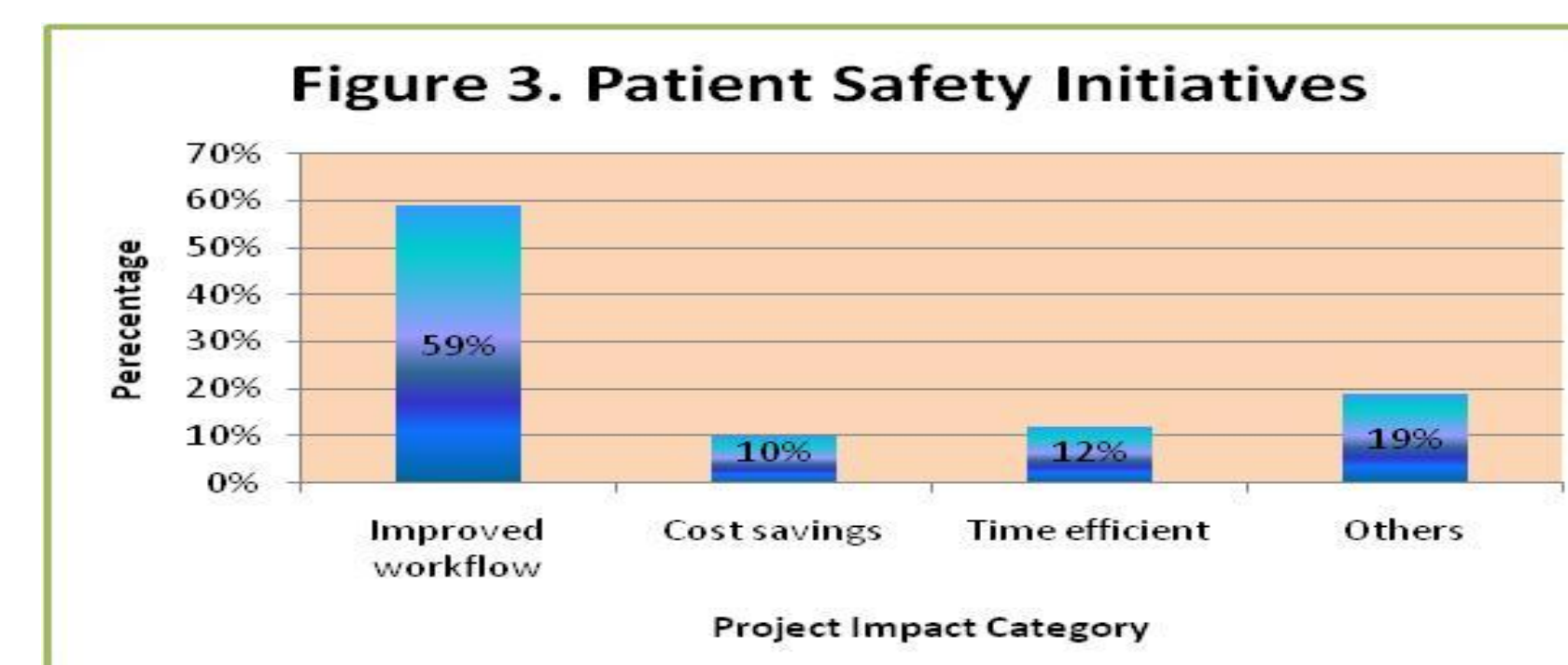


Patient Safety Leads Walk Rounds & Patient Safety Initiatives



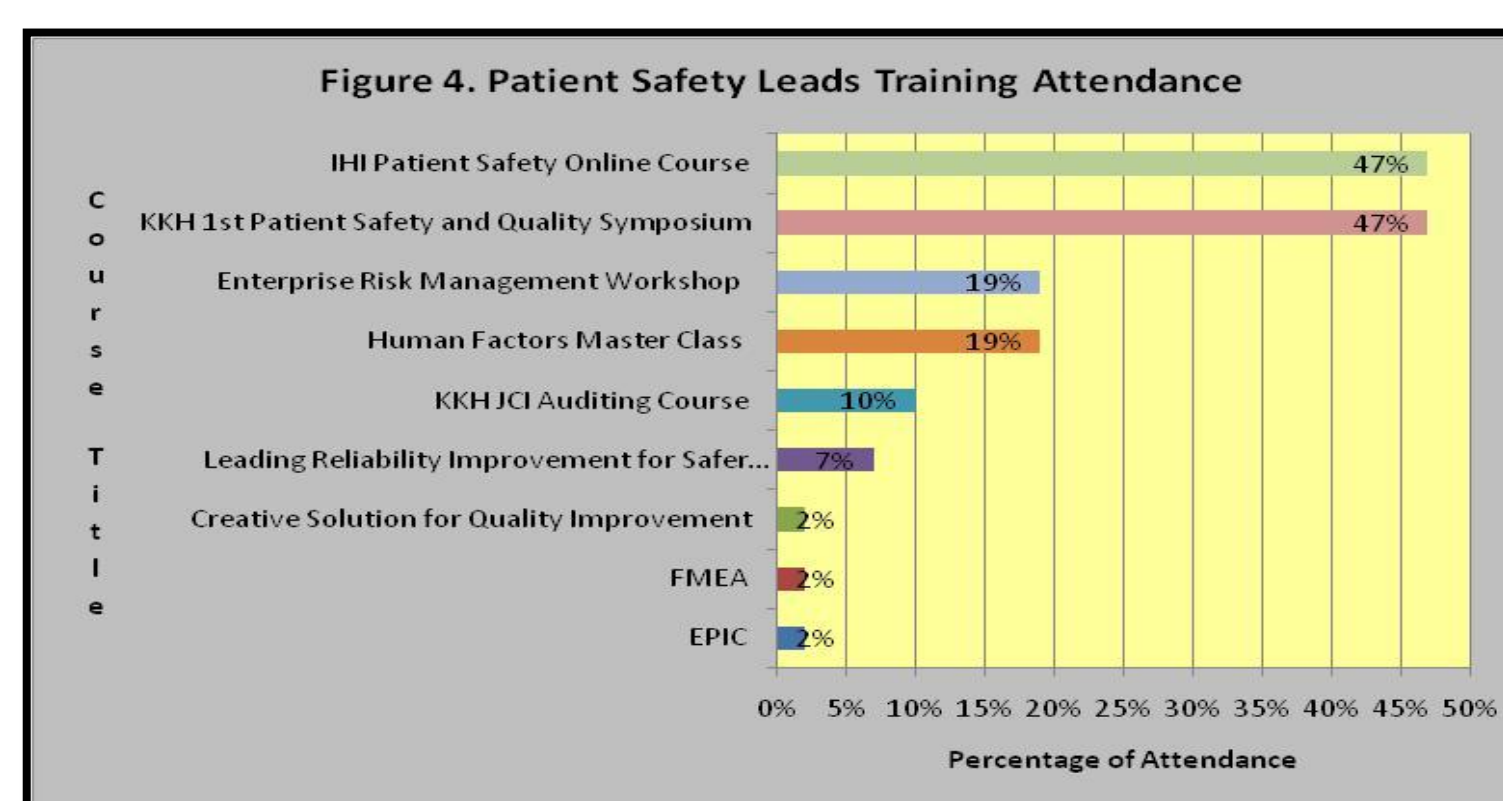
A total of 25 patient safety lead walk rounds were conducted from the period of March 2014 to January 2015 in the form of a walkabout and sit-down discussion. The walk rounds served as an excellent learning platform as more than 100 safety issues were highlighted, of which approximately 50-65% were closed.

About 58 initiatives and projects on patient safety emerged within a short span of 6 months as shown in Figure 3.



One initiative worth mentioning is the setting up of safety champion workgroup by patient safety leads in some of the departments to oversee on safety issues encountered in their areas. The 6 groups consists of 2 physicians, 58 nurses, 2 managers and 1 clinic coordinator.

PATIENT SAFETY WORKGROUPS INVOLVING PATIENT SAFETY LEADS					
Obstetric Wards Patient Safety Champions Patient Safety Lead Ward 32 SN Chan Sze Wern SN Coleman Young SN Nairah Bie Sukardi Ward 34 SSN Shen Hongyu SN Nurul Faridah Bie Mohd Ward 81 SN Kalia Chenska Baudista SN Subashree Panneer Ward 82 SSN Stacey Lim Lee Joo SSN Enka Nuryah SN Nurayda Kasim EN Judith Fernandez	Delivery Suite Patients' Safety Lead Team SNM Juay Siew Ngoh Facilitator NM Lee Bik Yik Members SSN Choo Lee Cheng SSN Nurul Faridah Bie Mohd SSN Chitra Palanivel SSN Odette Calli Rasacho EN Danielissa Adam Ward 81 SN Kalia Chenska Baudista SN Subashree Panneer Ward 82 SSN Stacey Lim Lee Joo SSN Enka Nuryah SN Nurayda Kasim EN Judith Fernandez	Safety Committee in Surgical Area Children Surgical Centre Dr Ramona Rai SSN Rangit Ward 65 MM Thirayasi SSN Fatima Begum SSN Jocelyn Ward 86 NC Phoa Hui Ping NC Suriani NM Farahatizah Ward 43 SSN Nurani	Oncology - Patient Safety Lead Team Gynaecology Cancer Centre Dr Rama Padmarathi Ward 71 MM Catherine Sandra Paul NC Jennifer Andaya SSN Rasidah Ward 75 NM Chia Lai Heng Ward 76 NC Lee Xiu Hua NC Charmaine Guek Ward 43 SSN Nurani	CE Department Patient Safety Workgroup Lead NC Lim Zi Ying Members SSN Michelle Thia SSN Zhang Rui SSN Gina SSN Menaka SN Dhurika SN Lynn	SAS RCA Workgroup Lead Mgr Celine Chow SAS Admin Mgr Goh Bee Kioe P Clinic SN Wong Mee Leng TPS NM Zaiton Soedra KKWF SSN Wendy Dai Cardiac Centre SSN Maureen Bie Gum Ali PCC SN Suryanti Bie Gum Ali Breast Centre Clinic Coordinator Jenny Chang



Trainings

Reflected in Figure 4 are the list of courses attended by patient safety leads. IHI Patient Safety Online Course & KKH 1st Patient Safety & Quality Symposium has the highest number of intake.

SUSTAINABILITY

Bimonthly sharing sessions (6x a year) became the avenue for sharing of initiatives and best practices which are attended by hospital staff. In one of the sessions, patient safety leads were recognized for their efforts and rewarded with certificates and token of appreciation.

Our model of patient safety and risk management network is cost effective and highly sustainable and is an effort that we hope other healthcare institutions can adapt since this model will be very beneficial for ensuring a robust patient safety culture in the hospital.



CONCLUSION

The Patient Safety and Risk Management Network in KK Women's and Children's hospital is the first of its kind in a healthcare institution in Singapore comprising of clinical and non-clinical members from the middle ground collaborating for the common goal of enhancing patient safety.

The Patient Safety and Risk Management network empowered the patient safety leads and paved the way for improving the hospital's culture of safety and quality of patient care.