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KK Women's and Children's Hospital
SingHealth

Establishment Of Obstetric Patient Safety Champions From Ground Zero

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Background

Patient Safety Lead was formed within the hospital in February 2013 with highlights on the importance of establishing a meaningful patient safety network. Everyone is accountable for the safety of patients and to have a higher awareness of keeping the patient safe. The team comprises of managers and Heads of Unit. Then comes the birth of patient safety champions who are staffs from the ground of the obstetric ward.

Aim

To instil awareness on patient safety related issues and encourage staff nurses from the ground level to take the lead as patient safety is an important responsibility that should not always fall to the managers alone.

Methodology

The Patient Safety Lead from the obstetric wards spearheaded the formation of the group by choosing five representatives each from the four obstetric wards (Wards 32, 34, 81 and 82). Each representative was trained on conducting audits, providing constructive feedbacks to peers and provides a platform for collaboration with other departments. Monthly meetings were conducted with the aim of sharing good practices, identifying risky behaviour and gaps in processes, and standardising practices as shown in Figure 1.

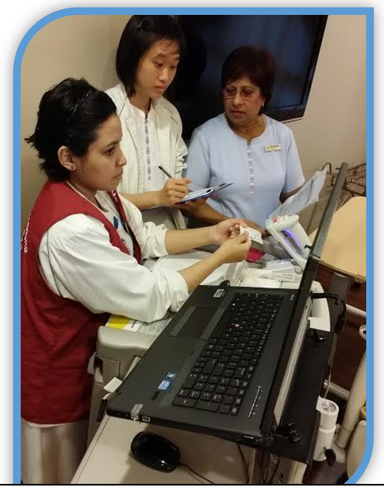
Figure 1

Patient Safety Champions had undergone training in performing audit as shown in Figure 2:

- Guidance on auditing methods, auditing within their own wards and cross-auditing.
- Constructive feedback = Improvement and encouragement for areas well done.
- Audited on:
  - ✓ Patient identification
  - ✓ Hand hygiene
  - ✓ Medication administration
  - ✓ Specimen collection

Figure 2

Training on performing audits



Member performing an actual audit

Results

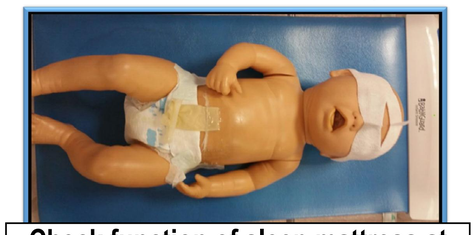
Regular peer audits on patient identification, hand hygiene, medication and specimen collection were conducted. The results obtained via audits and feedbacks shown significantly enhanced knowledge and attitudes about patient safety in most of the staffs during the sharing of patient safety meetings.

Figure 3

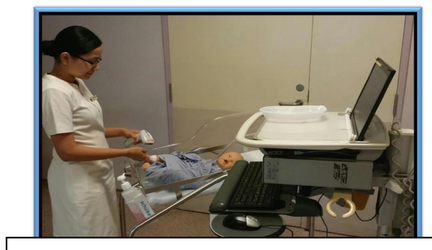
AUDITS

Workflow changes are implemented in the area include :

- ✓ Patient centred nursing that provides holistic care to patients.
- ✓ Improved workflow for transferring high risk post natal patient and baby.
- ✓ Improved and standardised the process of obtaining serum bilirubin.
- ✓ Use of blunt scissors for cutting RFID tag to prevent accidental injuries.
- ✓ Use of medication carts when serving medications at all times.
- ✓ Check on the function of sleep mattresses at the start of each shift.
- ✓ Accompanying high risk patients during ambulation.
- ✓ Frequent patient monitoring rounds.
- ✓ Share on P&P daily for 15minutes prior to hand over report.



Check function of sleep mattress at the start of each shift



Standardisation in the process of obtaining serum bilirubin via CPOE: Scan→Order→Blood Taking→Label Printing

Accompanying high risk patients during ambulation

Use of blunt scissors to cut RFID tag

IDEAS IMPLEMENTED

Conclusion

1. The establishment of patient safety champions heightens patient safety awareness and provides a platform for collaboration to deliver safe care for patients.
2. It helped to improve the compliance rate on the expected standards.
3. It also demonstrated organization's commitment to patient safety.
4. With the increase of awareness on patient safety, members morale was boosted.
5. Created a cohesive and safe working environment.

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