



Implementing A Safer and Standardized Patient Movement Workflow for 'Out-of-Ward' Procedures and Consultations in Changi General Hospital

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Changi General Hospital

Introduction

The improvement project was launched in Changi General Hospital to streamline the process of moving patients for "out-of-ward procedure or consultation", and to enhance patient safety.

Background

There were incidences in which patients were put at safety risks during their movements for out-of-ward procedures due to lack of standardized handover process. The existing "Hand-Off" form is used mainly for inter-ward transfers of patients but not suitable for two-way movements between ward and X-ray, clinics or therapy sessions. The project was kicked-off to establish a standardised process to facilitate:

- **Optimal health and safety of patients** when moving them out of wards for procedures/consultations and back to wards.
- **Effective communication** in accordance to Joint Commission International Accreditation (JCIA) Standards and International Patient Safety Goals (ISPG) 2.2 requirement.

Methodology

A **5-day Rapid Improvement Event (RIE)** was carried out in January 2015 to review the previous processes and identify gaps. Allied Health, ancillary staff and nurses from both inpatient and outpatient areas who are directly involved in the process were identified as project core members.

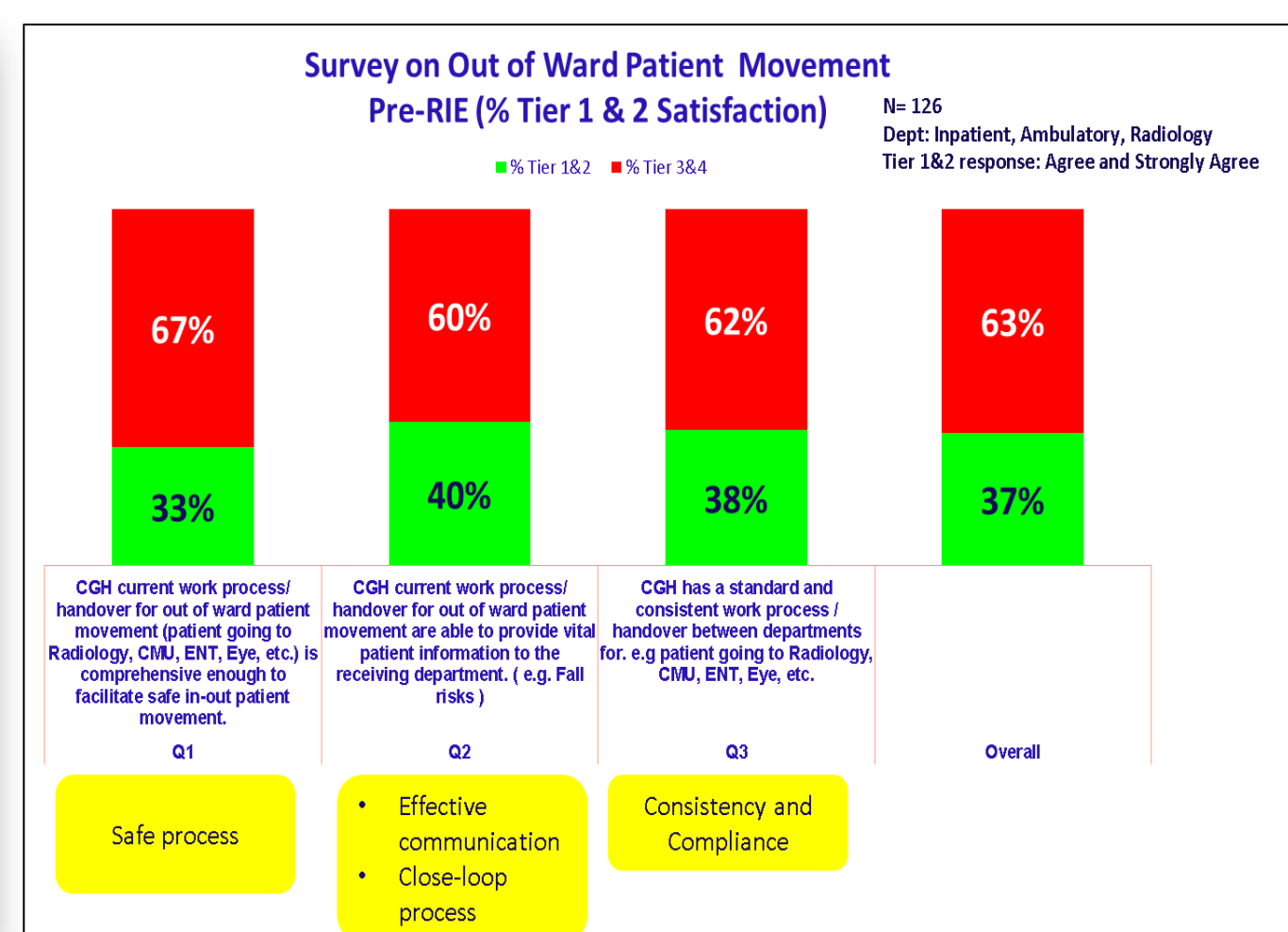


Prior to the workshop, the team reviewed the cases of missing case notes during patient movement and on the current workflow of communicating patient movements.

A pre-RIE survey was conducted in January 2015 involving nurses from inpatient, outpatient and X-ray department to assess staff satisfaction.

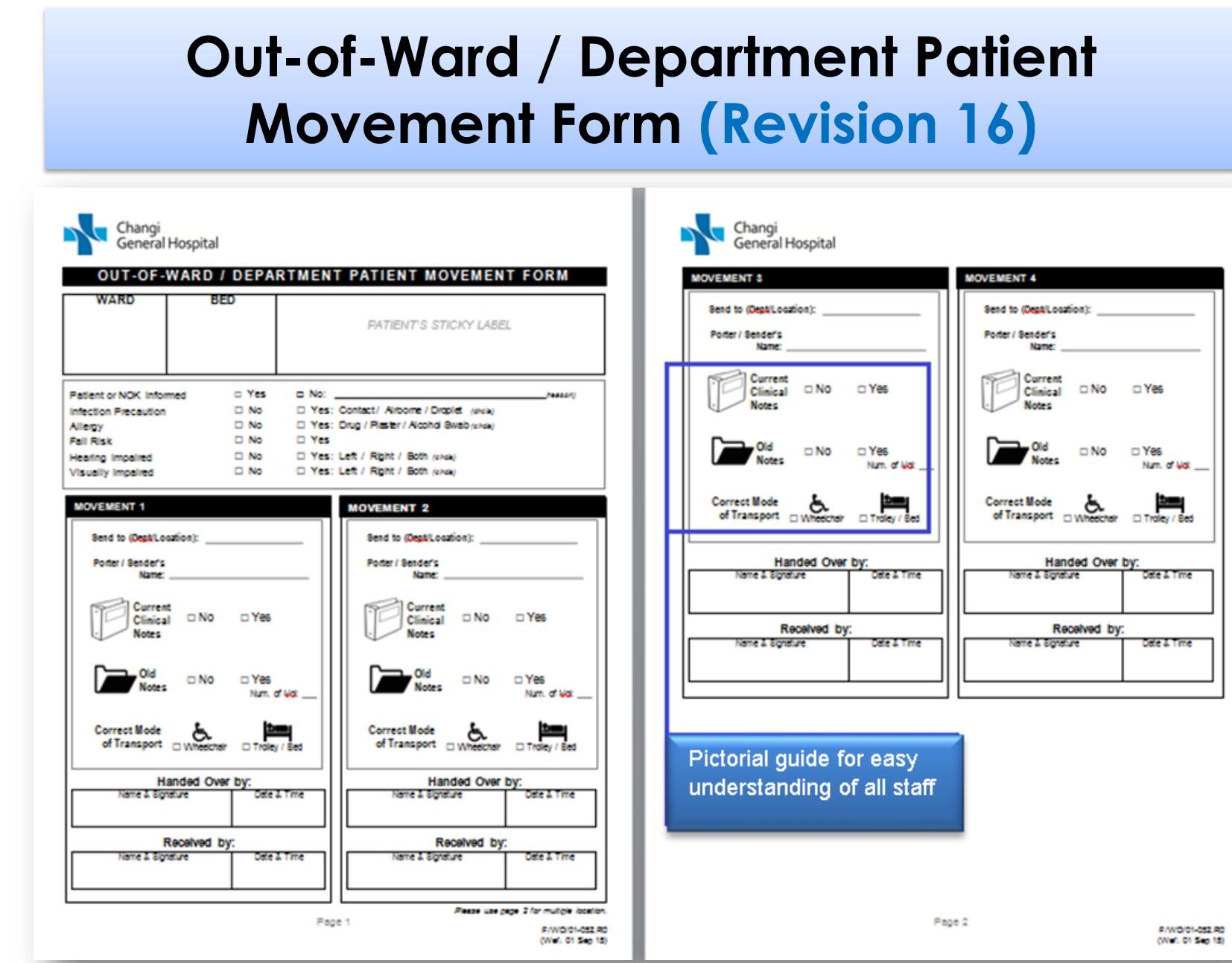
Pre Pilot Survey Questionnaire

- CGH current work process/handover for out of ward patient movement (patient going to Radiology, CMU, EYE, etc.) is **comprehensive enough** to facilitate safe patient movement.
- The current work process/handover for out of ward patient movement **are able to provide vital patient information to the receiving department** (e.g. fall risks)
- CGH has a **standard and consistent handover process between departments** for e.g. patient going to Radiology, CMU, EYE, etc.



Outcome

A **new form** facilitating a safer and standardised patient movement workflow for 'out-of-ward' procedures and consultation has been established. The form used pictorial symbols to represent items (like wheelchair) to facilitate understanding of all staff.



Improved Patient Safety

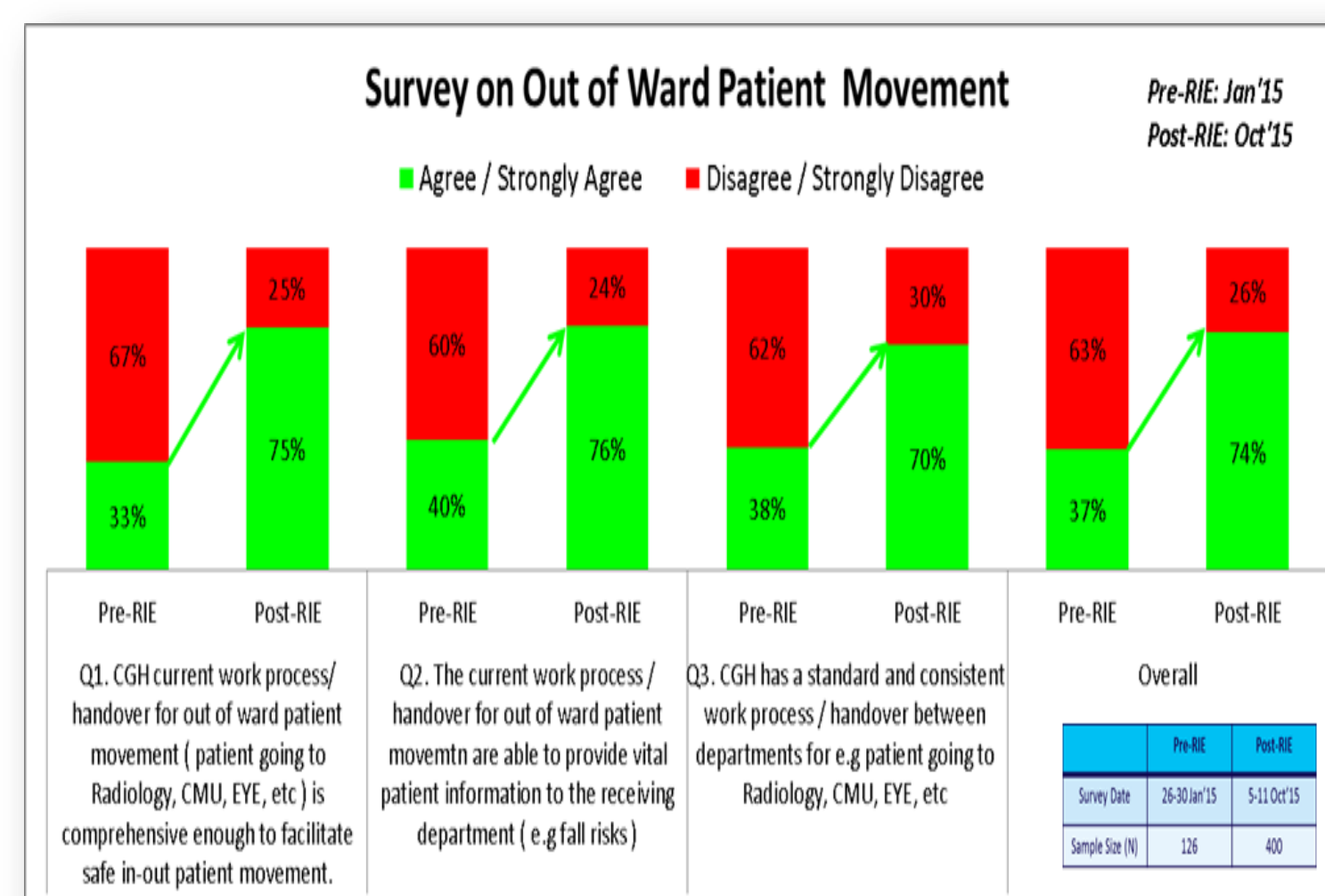
It facilitates a **fully documented patient return journey**, which includes date and time, patient whereabouts, risk information such as infection and fall precaution.

Patients / Families As Partners

The form serves as standard tool to **check patient before transfer** and **inform patient/next of kin on any impending out-of-ward procedures**.

Better Teamwork and Working Relationships

There was initial ground resistance with introduction of a new form. Continuous engagement and regular reviews with all staff enhanced ownership, increase support and improve sustainability. The form was revised **16 times** to be more user-friendly for all. It facilitates **better teamwork and communication between wards, porters and receiving departments**.



Pre and post-RIE surveys were conducted to better understand the ground challenges and to evaluate staff acceptance and satisfaction on the new form and workflow. The survey showed an encouraging improvement in satisfaction from **37% to 74%**.

Reduce Rework and Errors

This resulted in the reduction of misplaced case notes from **4 cases** in 2014 to **zero** in 2015 (**100%** improvement on rework and errors).

Conclusion

Engaging the key stakeholders from the beginning in the process of solution brainstorming and fine-tuning, ultimately allowed better buy-in and teamwork.

The success of the pilot run gave way to hospital-wide implementation of the new workflow on **01-September 2016**.

