Patient Safety Rounds in Enhancing the Culture of Safety at KK Women's and Children's Hospital

Helen de Chavez, Pang Nguk Lan,
Ng Gaik Nai, Marionette Catahan and Alex Sia Tiong Heng

KK Women's and Children's Hospital
SingHealth

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INTRODUCTION

- Creating a culture of safety remains to be an enormous task. Leadership, teamwork, evidence-based healthcare and effective communication are the key elements in developing and fostering a culture of safety.
- Patient Safety Round (PSR) was started on 2010 on a quarterly basis but since 2013, it is held every month.
- The round is led by Chairman Medical Board (CMB), Chief Nurse (CN)and Institution Risk Officer (IRO) while secretariat support is provided by patient safety officers (PSOs).
- The aim of the patient safety rounds are:
  1. To provide an avenue for staff to share, elevate and discuss safety concerns and identify opportunities for improving safety.
  2. To demonstrate leadership commitment to patient safety.
  3. To establish lines of communication about patient safety among frontline staff.

METHODOLOGY

- PSR is conducted in a pre-determined clinical areas by the 3 representatives from Allied Health, Clinic and Nursing. During the rounds, discussions are held in a room near the clinical areas lasting for 1 hour.
- For 2015, the identified patient safety issues were categorised using Charles Vincent Framework of Factors that Influence Clinical Practice. All information are input in an Excel® worksheet to reflect the progress.

Preparation Phase
- **4th quarter of the current year**
  - Confirm date, time, departments/ units to be visited for the next calendar year
  - Booked Senior leaders calendar
- **4 weeks prior to the month of PSR**
  - HODs/ HOS or equivalent & Nurse Managers are informed of the date & time via email
  - Unit to be visited to arrange the venue
  - 1-2 nominees from medical, nursing and pharmacy & other professions if applicable
  - Explain the purpose of visit
  - If applicable, the previous minutes is attached to check the progress of issues raised
- **2 weeks & 3 days prior to the date of the PSR**
  - Email reminder to all attendees

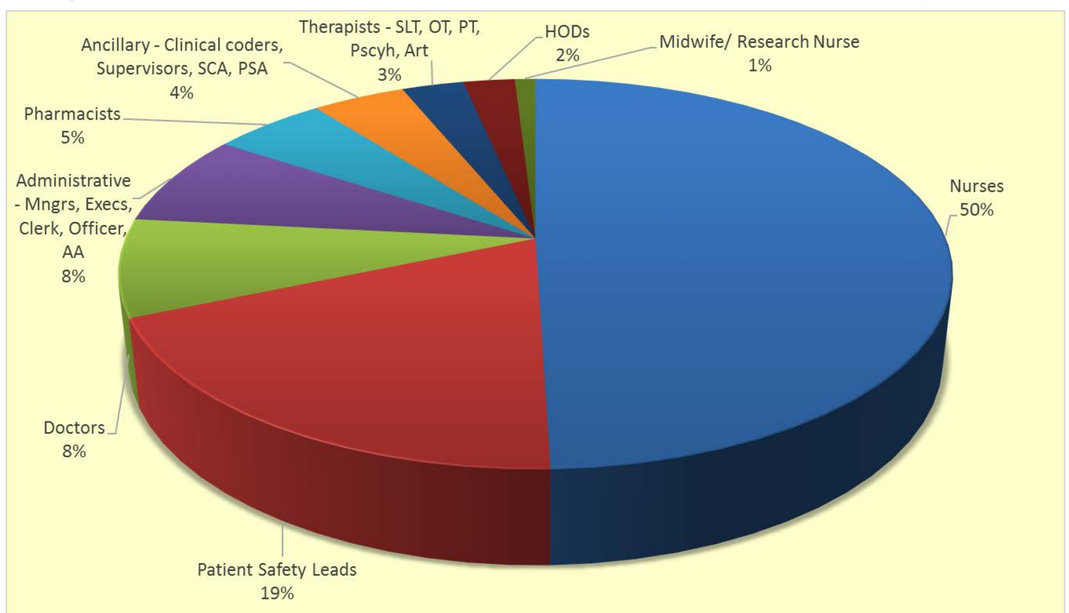
During the Patient Safety Rounds
- Opening statement by CMB, CN & IRO
- Introduction of all attendees
- Discussion of safety issues raised by staff
- PSOs record and document all the issues raised
- Closing statement by CMB

Post-Patient Safety Round Activities
- PSOs summarize the issues raised
- Approval of minutes by IRO and CN
- Release the minutes within 1 week
- Follow up actions taken by the unit/ stakeholders

RESULTS

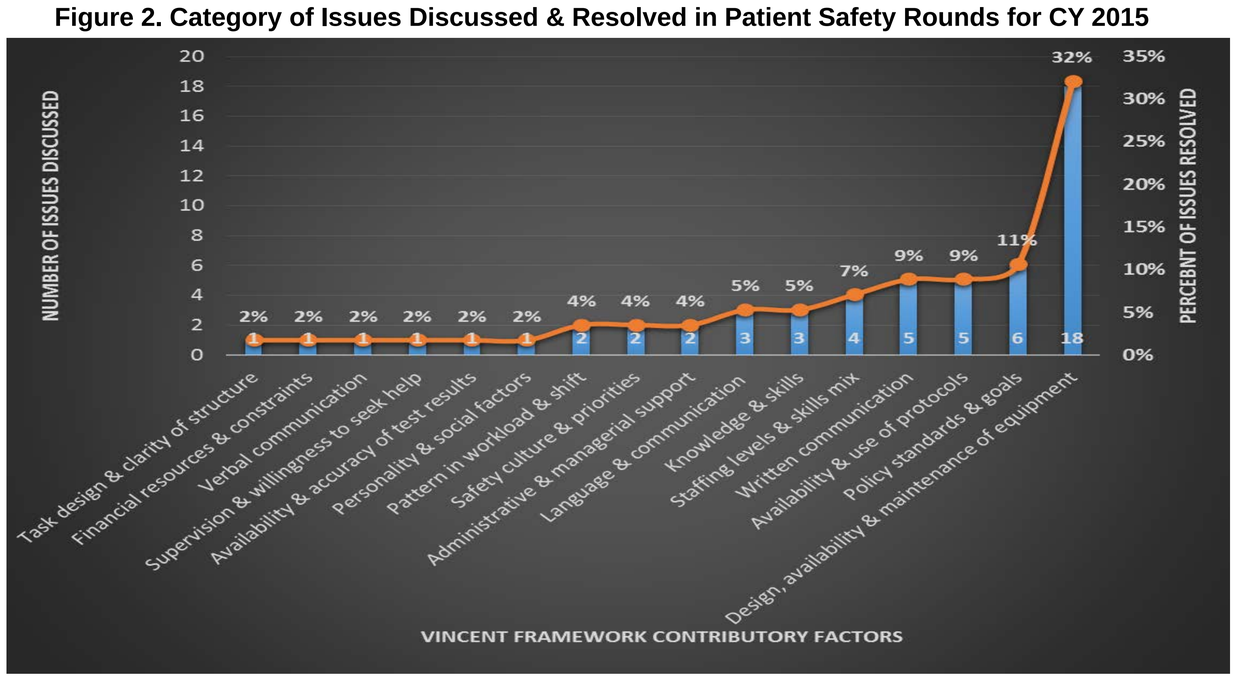
- Patient safety rounds occurred 12 times between January to December 2015 in 8 nursing wards, 2 allied health, 1 clinic and upon request ,1 non-clinical unit.
- Figure 1 showed 210 staff of varying professions and seniority participated in the patient safety round.

Figure 1. Staff Participation in Patient Safety Rounds for calendar year (CY) 2015



- Fifty-six patient safety issues were identified in 2015 as reflected in Figure 2 and Table 1.
- Of these, 48 (86%) issues are resolved while 8 (14%) remains to be in progress due to complexity.
- Using the Vincent framework, most of the issues raised during the rounds were related to work environment (46%), followed by organization and management (16%), team (13%), task (13%), patient (7%) and lastly the individual staff member (5%).

Figure 2. Category of Issues Discussed & Resolved in Patient Safety Rounds for CY 2015



CONCLUSION

- Patient safety rounds is an effective way to engage leadership and staff in an open discussion about patient safety and collaborative approaches for solutions suggesting an enhanced patient safety culture.
- Participants in the rounds are, hopefully, able to gain new insights into patient safety by understanding what encompasses good teamwork and effective communication and developed strategies for understanding and preventing errors.

Table 1. Examples of the Issues Discussed in Patient Safety Rounds for CY 2015

Vincent Framework	Description of Issues Raised	Actions Taken
Patient – Language & Communication	When parents brought another sibling during the therapy session, the sibling would be running around the gym which might cause a possible accident such as falls.	A caregiver pamphlet had been devised containing the preparation for a Rehabilitation appointment.
Task – Availability & accuracy of test results	Long Waiting Time of Adult Neutropaenic Patients at Obstetrics & Gynaecology (24-hour) Clinic	Febrile neutropaenia workflow for gynaecology oncology patient was implemented effective October 2015.
Individual staff member – Knowledge & skills	Some ward nurses are not confident in managing chronic patients requiring oxygen support and tracheostomy.	Chronic cases such as those with discharge and home care issues will be admitted to Ward 31. The training of Ward 31 nurses had already started through the help of Home Care Nurses.
Work Environment – Design, availability & maintenance of equipment	Patients' complaints the lack of available wheelchairs in taxi stand, car park & podium at Level 1 whenever they come to clinic for follow up.	Additional purchase of 10 wheelchairs on June 2015
Team – Written Communication	Some of the diet ordered by Speech and Language therapists such as addition of thickener are missed out in the wards.	Speech therapists together with Catering and Dietetics created a new diet name called "Easy Chew". Speech therapists conducted 2 nursing in-service in 2 wards with respect to Easy Chew diet menu.

REFERENCES

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