Quality Improvement & Patient Safety
- Staff Nurse Cathy’s Journey

A Member of the National Healthcare Group
Staff Nurse Cathy joined the Institute of Mental Health (IMH) as a fresh graduate from the local polytechnic.
During her orientation week, she was introduced to the hospital’s Quality & Safety Framework.
In her ward, Cathy saw various indicators displayed. She also learned that the hospital benchmark against other hospitals and there were hospital data in the IMH Indicators intranet and sharepoint folders.
One day, her patient Mr Lee fell in her ward and suffered a fracture...

What can I do to prevent such incidents? The Quality & Safety Framework has a Culture of Safety Programme, let me look at it...
Cathy recalled the **Culture of Safety Programme** under the Quality & Safety Framework. She reported the incident.
She read up on the IMH’s **Code of Conduct for Safety** under the Culture of Safety Programme. The incident reinforced her commitment to the Code.
It also spurred her to do more to improve quality & patient safety. She went through the Quality & Patient Safety resource page in the intranet and NHG quality publications to improve her knowledge in these areas.
She also received information on quality & patient safety matters through various platforms.
One day, Cathy attended CEO’s Townhall and learned about the hospital’s FY2016 Quality and Patient Safety priorities.

<table>
<thead>
<tr>
<th>Priority</th>
<th>Description</th>
<th>Workgroup</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Falls</strong></td>
<td>Inpatient fall rate (number of inpatient falls per 1000 patient days)</td>
<td>Falls Prevention Workgroup</td>
<td>≤0.45</td>
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<tr>
<td><strong>Restraints</strong></td>
<td>Restraint rate (number of 4 &amp; 5 point restraint episodes per 1000 patient days)</td>
<td>Restraints Reduction Workgroup</td>
<td>≤2.38</td>
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<tr>
<td><strong>Choking with Injury</strong></td>
<td>Percentage of inpatients who were administered the water swallowing test (if they meet criteria for test)</td>
<td>Choking Prevention Workgroup</td>
<td>=100%</td>
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<tr>
<td><strong>Suicide</strong></td>
<td>Number of inpatient suicide</td>
<td>Suicide Prevention Workgroup</td>
<td>=0</td>
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<tr>
<td><strong>Clinical Documentation</strong></td>
<td>Percentage of subsidised inpatients assessed by Specialist within 24 hours of arrival in the wards, within the next 3 days, and subsequently according to the frequency specified by Specialist</td>
<td>Medical Records Audit Committee</td>
<td>≥ 80%</td>
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</tbody>
</table>
She also saw various Statistical Process Control charts on the priorities...
In the past...
Run chart
- Simple
- Incapable of showing if the process was stable and in control
- Tends to cause over- or under-reaction to data

Now...
Control chart
- Slightly more complex
- Separates process variation attributed to assignable causes from that caused by background noise
- Tells readers when actions need to be taken

...and learnt that IMH had shifted from using run charts to SPC charts. There are **mini-workshops** for staff to learn how to interpret and plot charts
From CEO’s Townhall, Cathy learnt that there were workgroups & committees working to improve the priorities and other clinical indicators. She met with the chairpersons of the Restraints and Assaults Workgroup to understand their work.

**Training**
- Restraints
  - Restraints clinic
- Assault
  - Care & Response (C&R) and soft skills / de-escalation (assault)

**Education**
- Restraints
  - Roadshows
- Assault
  - Staff Manual on Assault Reduction Training
  - Assessment tool (assault)

**Culture**
- Multi-disciplinary effort
- Assault Workgroup and Restraints Workgroup
- Safety rounding
- Early risk identification & inter-block sharing of best practices (assault)
Intrigued and inspired by CEO’s Townhall and the Workgroups’ initiatives, Cathy volunteered to take part in various quality projects and initiatives under the Quality Council.
Today, Cathy has developed a passion for quality and patient safety. She attended various training, such as the IMH patient safety training, NHG Root Cause Analysis training, etc. and sits on various quality committees & workgroups that report to the Quality Council.

She is also coaching and inspiring her colleagues on quality & patient safety.

I know how I can play an active role in quality & patient safety now. Thank you for listening to my story!
Thank You
Psychiatric Electronic Clinical Observation (PECO), Japan

- Attempted suicide
- Completed suicide
- Mean GAS (discharge – admission) for schizophrenia patients
- % tertiary patients
- Readmission rate (all acute patients)
- ALOS (all acute patients)
- Restraint hours per 1000 patient hours

UPC KU Leuven, Belgium

- Number of patient days, admissions and beds in service
- Completed suicide
- % Time-out compliance
- Hand rub consumption
- Hand hygiene compliance rate
- Fall with injury rate
- Number of reported aggression incidents

Organisation for Economic Co-operation and Development (OECD)

- Same hospital readmissions within 30 days among schizophrenia patients
- Inpatient suicide rate among patients diagnosed with mental disorder
- ALOS (mental and behavioural disorders)