

Project Title

Learn in Order to Improve: Create an Organisational Learning Culture

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Organisation(s) Involved

KK Women's and Children's Hospital

Healthcare Family Group(s) Involved in this Project

Healthcare Administration

Applicable Specialty or Discipline

Quality, Safety & Risk Management

Aims

To learn in order to improve: Sharing KKH strategies and experience in creating a learning system and culture through embedding quality improvement work as a positive and valuable opportunity for learning.

Background

See poster appended / below

Methods

See poster appended / below

Results

See poster appended / below

Conclusion

See poster appended / below

Project Category

Organisational Leadership, Organisation Development, Change Management, Culture Building, Human Resource, Staff Development

Keywords

Organisational Learning, Culture of Quality, Risk Management System, Lean Methodology

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Change management is essential to sustain a culture of quality. Quality Improvement (QI) is about designing *system and process* changes that lead to operational improvements. An organisational culture of quality is one in which concepts of quality are ingrained in organisational values, goals, practices, and processes. Within an organisation, problem solving, incident investigation using Root Cause Analysis (RCA) is all fundamentally connected by the basic questions of what the problem is, why and how did it happen and what can be done better to improve.

To learn in order to improve: Sharing KKH strategies and experience in creating a learning system and culture through embedding quality improvement work as a positive and valuable opportunity for learning.

View Incident as learning opportunity

Adverse incidents and near-miss events are reported in the hospital's Risk Management System (RMS). An eRCA was established and incorporated in the RMS in November 2013 to support analysing and learning from reported events to promote the use of Quality Improvement Tool (QIT) in identifying problems and map control measures to reduce risks and potential harm to patients and staff.



A simple RCA step-to-step reference guide for incident management was incorporated in RMS. Completed RCA will be followed by supervisor or HOD with review by Institution Risk Officer to ensure the solutions identified have an appropriate level of effectiveness and staff benefit from making systemic change to effect a more effective outcome.



Two of the staff from the Risk Management Office (RMO) are assigned to provide support and facilitation when help is needed by any of the department or team. There is also a designated Information Service staff to assist in refining and enhancement of the program to make the system user friendly.

Equipping Staff with the ‘Know How’

RCA, HFACS and QI workshops were convened with the help of a Senior Physician, Human Factors Specialist, and two of our QI Lead Facilitators. All workshops were made available free of charge for in-house staff. The objective is to equip staff with competencies to effectively manage incident reviews and improvement projects. The training is supported by the office of Quality Safety and Risk Management (QSRM), the workshops are conducted monthly via online registration.



Use of '5 whys' technique for RCA is widely promoted by many healthcare quality and safety organisations thus, KKH leverage on process mapping and '5 whys' in analysis of incidents and improvement projects. The aim to help staff to grasp the concept of digging deeper to analyse a problem or an opportune.

Structured QI and RCA templates for incident and improvement work

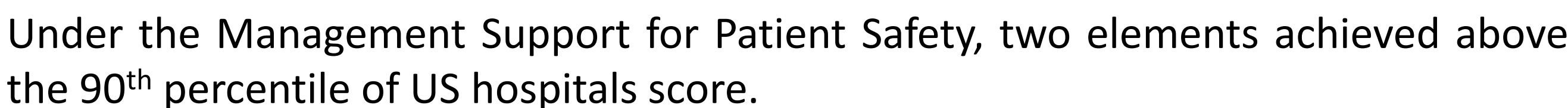
Templates were formulated to guide discussion during reviews and it also formed as a checklist to direct the process flow.

KKH Staff Training Roadmap – Courses that mapped for different level of staff

Results

Total No. staff attended the In-house Workshops and IHI Online Completed

Above was the AHRQ Patient Safety Culture Survey results, a comparison with 2010 vs 2017, KKH achieved positive improvement for all surveyed dimensions



KK Women's & Children's Hospital-2017 / AHRQ-2016:
Teamwork Within Units



Conclusion

Transforming and sustaining an evolving culture is a complex process requiring a clearly articulated strategic aim, underpinning objectives and deliberate structured programs. Promoting a culture of learning has to be embedded into every aspect of the organisation so that they will eventually become hardwired into what employees do and how they act in approaching improvement to effect a better outcome for the work does.