Project Title

Turning Lessons Into Knowledge: Building A Learning Repository

Project Lead and Members

Project lead: Adeline Koh Shuhan

Project members: Ng Yingshi, Dr Lim Ghee Hian, Joanna Chia, Chan Eilyn, Ang Siew Lan

Organisation(s) Involved

Ng Teng Fong General Hospital

Healthcare Family Group Involved in this Project

Healthcare Administration

Applicable Specialty or Discipline

Medical Affairs

Project Period

Start date: Jan 2017

Completed date: Jul 2019

Aims

By April 2019, the project team seeks to ensure that 100% of identified SRE, clinical, and ML cases are accessible by staff across JurongHealth Campus.

Background

See poster appended/ below

Methods

See poster appended/ below

Results

See poster appended/ below

Lessons Learnt

We learnt the importance of knowledge management in clinical governance, and sealing the knowledge gap to promote organisational learning, risk management and continuous improvement.

Conclusion

See poster appended/ below

Project Category

Care & Process Redesign, Quality Improvement, Lean Methodology

Keywords

Serious Reportable Events, Learning Repository

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TURNING LESSONS INTO KNOWLEDGE: BUILDING A LEARNING REPOSITORY

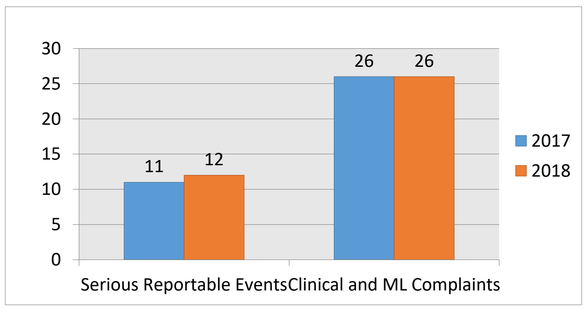
MEMBERS: :ADELINE KOH SHUHAN, NG YINGSHI, DR LIM GHEE HIAN, JOANNA CHIA, CHAN EILYN, ANG SIEW LAN

- ☑ SAFETY
- ☐ PRODUCTIVITY
- ☐ PATIENT EXPERIENCE
- ☑ QUALITY
- ☐ VALUE

Define Problem/ Set Aim

Opportunity for Improvement

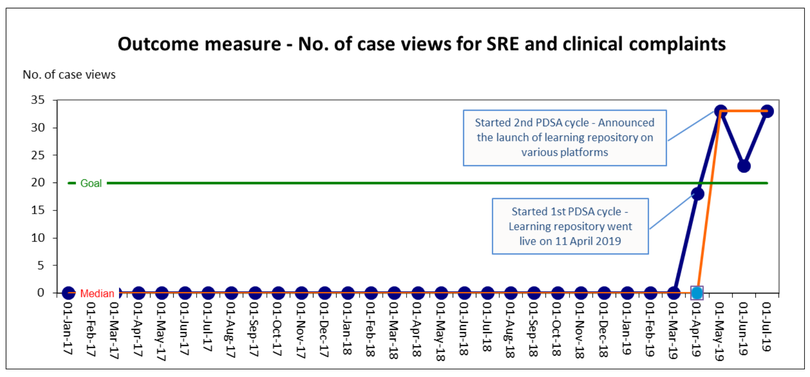
Between Jan 2017 to Dec 2018, JurongHealth Campus had 23 serious reportable events (SREs) and 52 clinical and medico-legal (ML) complaints. Staff were not aware of any of these cases. The closed feedback loop inhibits effective clinical governance, and corresponding opportunities for organizational learning and risk management.

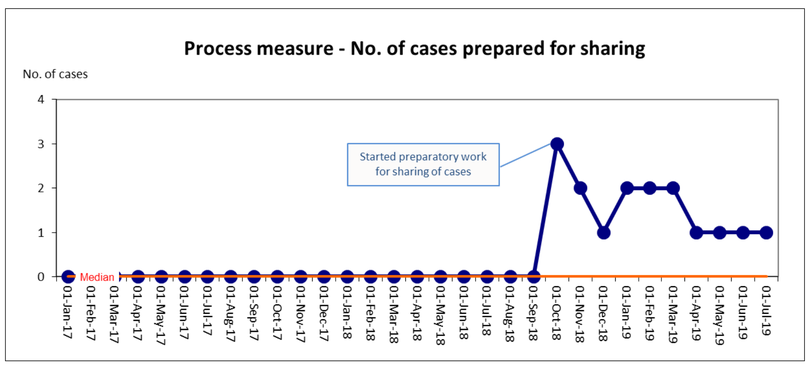


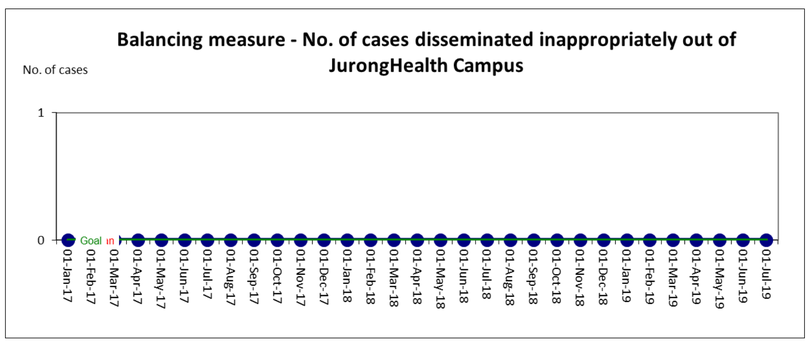
Aim

By April 2019, the project team seeks to ensure that 100% of identified SRE, clinical, and ML cases are accessible by staff across JurongHealth Campus.

Establish Measures







Analyse Problem

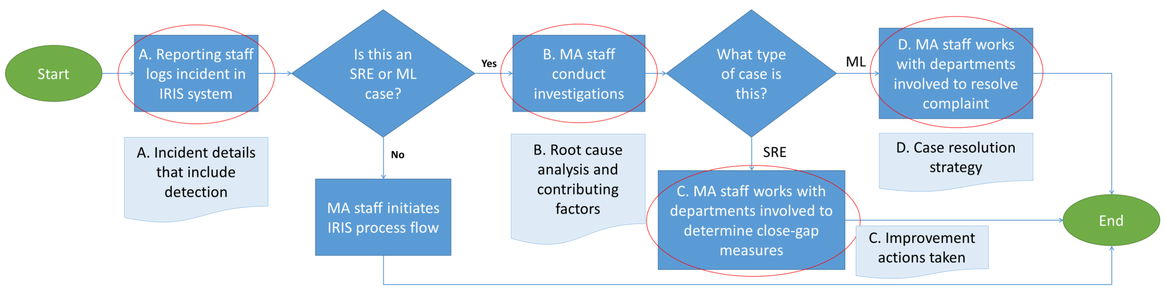
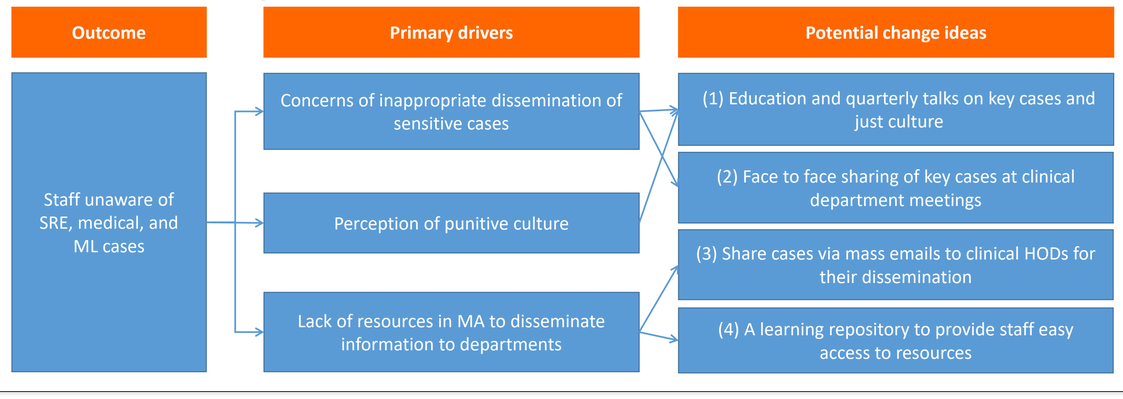


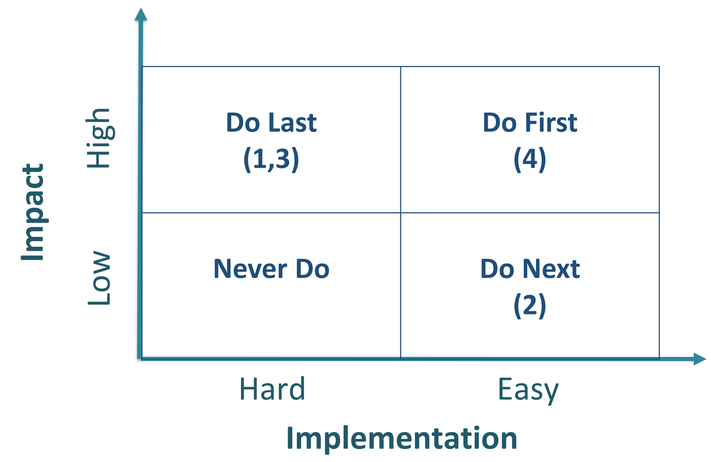
Figure 1. Incident reporting, review and resolution process map

Based on our process map, we identified waste in non-utilization of information (circled in red which were neither shared with nor accessible by staff). Further review using root cause analysis methodology, we identified constraints that contributed to our problem statement.



Select Changes

	Specific change ideas
1	Education and quarterly talks on key cases and just culture
2	Share cases via mass emails to clinical HODs for their dissemination
3	Face to face sharing of key cases at clinical department meetings
4	A learning repository to provide staff with easy access to resources



Test & Implement Changes

PLAN	DO	STUDY	ACT
In April 2019, the project team from Medical Affairs launched a learning repository on Document Management System (DMS) to test change idea #4.	Test change was carried out as planned. However, case views were relatively low (18 in total).	There was an sharp increase in our outcome measure. Nevertheless, we received feedback that the experience was not user-friendly (e.g. cases were not organized thematically).	Following the successful test change, we decided to adopt the change idea, but adapt the presentation of cases (e.g. include a "catalogue" of organized cases by themes for filtering and easy reference) and increase communication to various departments on the availability of this resource.
In May 2019, the project team worked on the previous PDSA cycle to continue to test change idea #4.	Test change was carried out as planned. Case views exceeded our target of 20 case views per month.	There was an even sharper increase in our outcome measure (i.e. from 22 to 33 case views), even though our process measure remained unchanged.	Following the successful test change, we decided to adopt the change idea. A third PDSA cycle is still being scheduled to test change ideas #1 to #3.

Spread Change/Learning Points

Every incident and complaint comes with valuable learning lessons. In fact, awareness of lapses and adverse events are critical to quality and safety in health care organizations[1], [2]. We learnt about the importance of knowledge management in clinical governance, and sealing the knowledge gap to promote organizational learning, risk management, and continuous improvement.

With a process in place to harvest and document these knowledge, our next step is to raise awareness and viewership of the repository. The study team will be looking into collaborating with clinical quality and patient safety champions to disseminate these resources and conduct case discussions within their departments, and explore organisational wide campaigns to communicate the availability of these resources.

[1] Novack DH, Suchman AL, Clark W, Epstein RM, Najberg E, Kaplan C. Calibrating the Physician: Personal Awareness and Effective Patient Care. JAMA. 1997;278(6):502–509. doi:10.1001/jama.1997.03550060078040
[2] Brady, P. W., Muething, S., Kotagal, U., Ashby, M., Gallagher, R., Hall, D., … Wheeler, D. S. (2013). Improving situation awareness to reduce unrecognized clinical deterioration and serious safety events. Pediatrics, 131(1), e298–e308. doi:10.1542/peds.2012-1364

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