

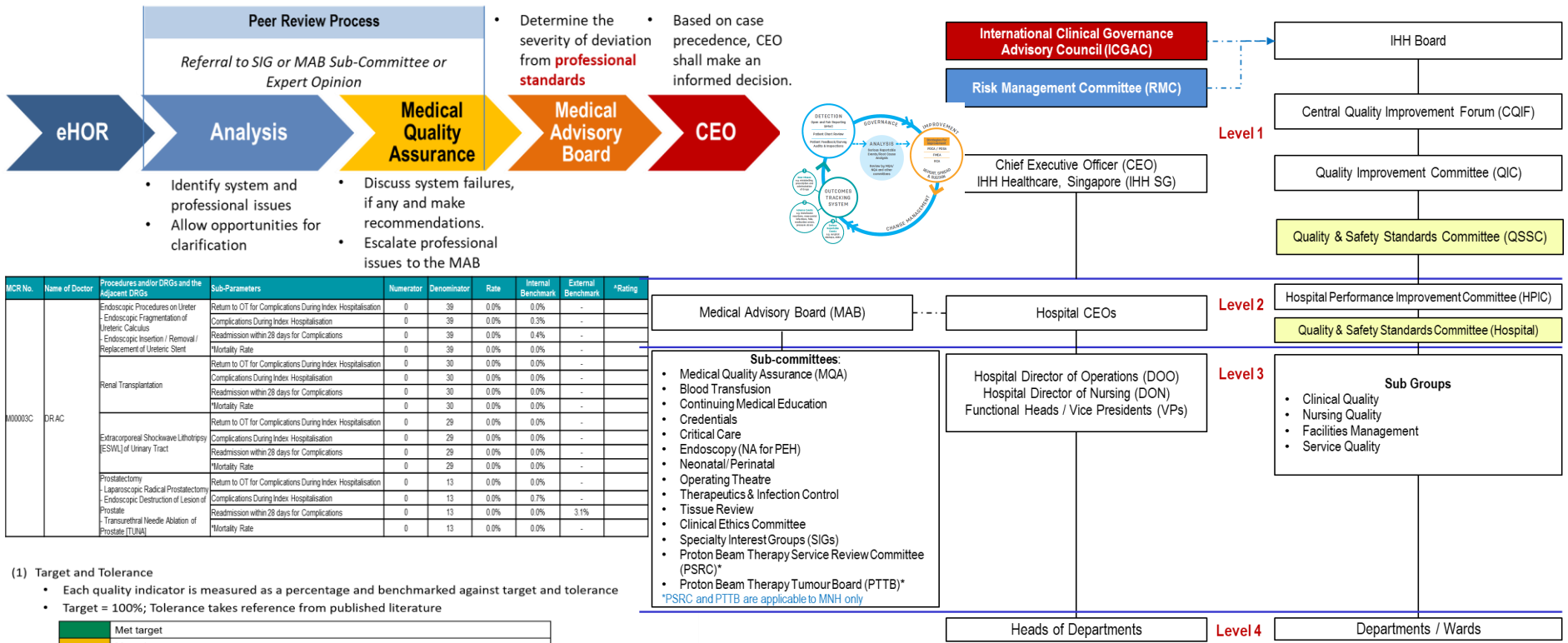
Becoming a High Reliability Organisation Through Partnership – A System and Physician’s View



Ms. Alicia Vasu (Head, Medical Affairs & Quality, IHH Healthcare Singapore)

Dr. Bertha Woon (Chairman, Medical Advisory Board, Gleneagles Hospital, Singapore)

Background



MCR No.	Name of Doctor	Procedures and/or DRGs and the Adjacent DRGs	Sub-Parameters	Numerator	Denominator	Rate	Internal Benchmark	External Benchmark	*Rating
M0003C	DRAC	Endoscopic Procedures on Ureter - Endoscopic Fragmentation of Ureteric Calculus - Endoscopic Insertion / Removal / Replacement of Ureteric Stent	Return to OT for Complications During Index Hospitalisation	0	39	0.0%	0.0%	-	-
			Complications During Index Hospitalisation	0	39	0.0%	0.3%	-	-
			Readmission within 28 days for Complications	0	39	0.0%	0.4%	-	-
		Renal Transplantation	Return to OT for Complications During Index Hospitalisation	0	30	0.0%	0.0%	-	-
			Complications During Index Hospitalisation	0	30	0.0%	0.0%	-	-
			Readmission within 28 days for Complications	0	30	0.0%	0.0%	-	-
		Extracorporeal Shockwave Lithotripsy (ESWL) of Urinary Tract	Return to OT for Complications During Index Hospitalisation	0	29	0.0%	0.0%	-	-
			Complications During Index Hospitalisation	0	29	0.0%	0.0%	-	-
			Readmission within 28 days for Complications	0	29	0.0%	0.0%	-	-
		Prostatectomy - Laparoscopic Radical Prostatectomy - Endoscopic Destruction of Lesion of Prostate - Transurethral Needle Ablation of Prostate (TUNA)	Return to OT for Complications During Index Hospitalisation	0	13	0.0%	0.0%	-	-
			Complications During Index Hospitalisation	0	13	0.0%	0.7%	-	-
			Readmission within 28 days for Complications	0	13	0.0%	0.0%	3.1%	-
			*Mortality Rate	0	13	0.0%	0.0%	-	-

- (1) Target and Tolerance
- Each quality indicator is measured as a percentage and benchmarked against target and tolerance
 - Target = 100%; Tolerance takes reference from published literature
- | |
|---|
| Met target |
| Met tolerance |
| Did not meet tolerance/ Did not meet target and there is no tolerance |

(2) Optimal Care Index (OCI)

- Measures whether each case has met all the quality indicators.

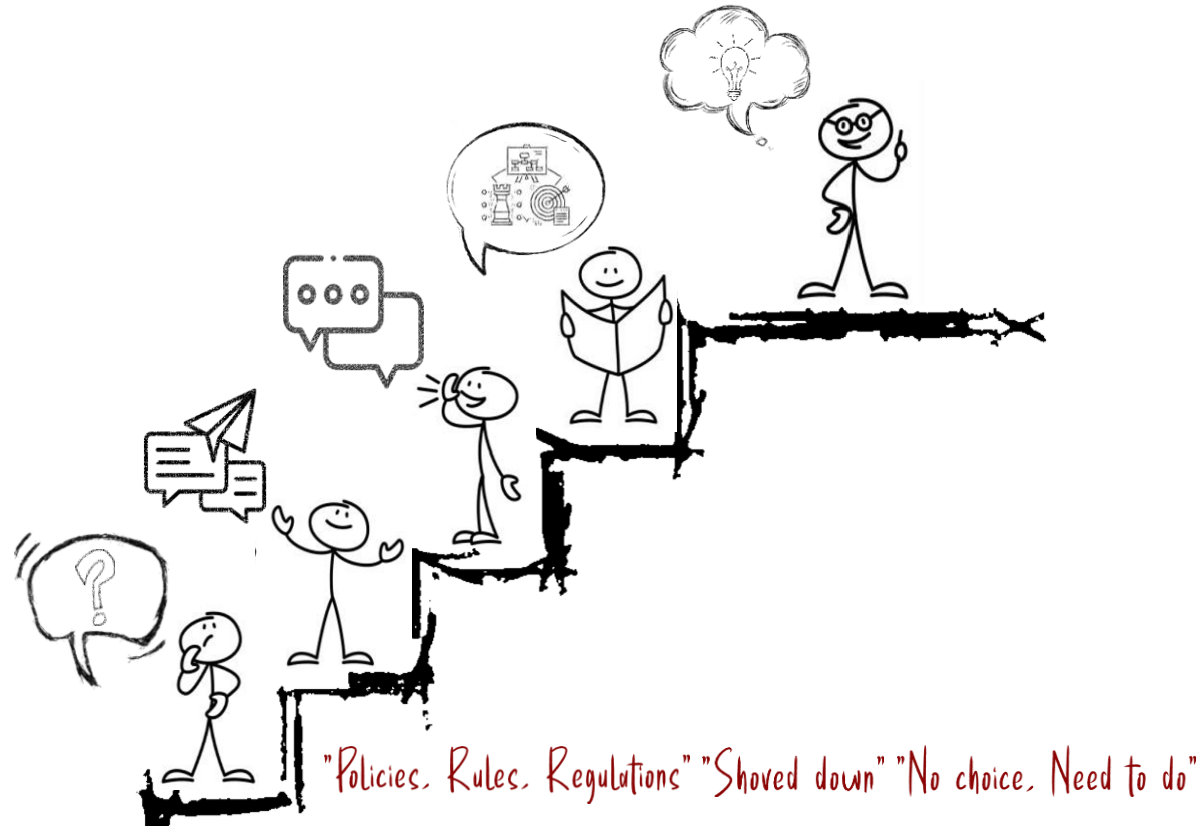
e.g. TKR Quality Indicators	Case 1	Case 2	Case 3	Case 4	Case 5	Case 6	Case 7	Case 8
	1	1	1	0	1	1	0	1

Logistic regression output on factors associated with positive Overall Patient Safety Grade

Composite Measures	Sig.	Odds Ratio	95% C.I. for OR	
			Lower	Upper
1. Teamwork Within Units	.000	1.600	1.312	1.952
3. Organizational Learning - Continuous Improvement	.006	1.398	1.099	1.780
4. Management Support for Patient Safety	.000	1.520	1.237	1.859

Data Rich and Information Poor

OCI SCORE FOR EACH CASE	1	1	1	0	1	1	0	1
11. Handoffs & Transition	.278	1.100	.926	1.307				
12. Non-punitive Response to Errors	.539	1.049	.900	1.222				



Cascading information is a real struggle

1. Revised QI Training Modules
2. Sharing data at various platforms
3. Patient Safety Leadership Rounds

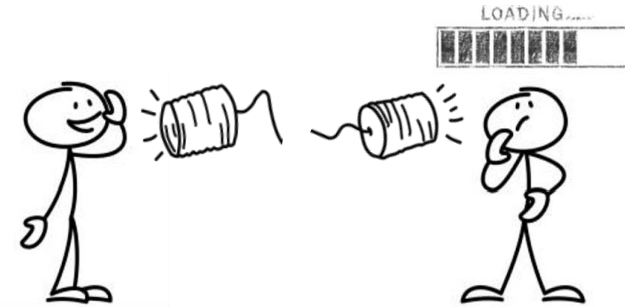
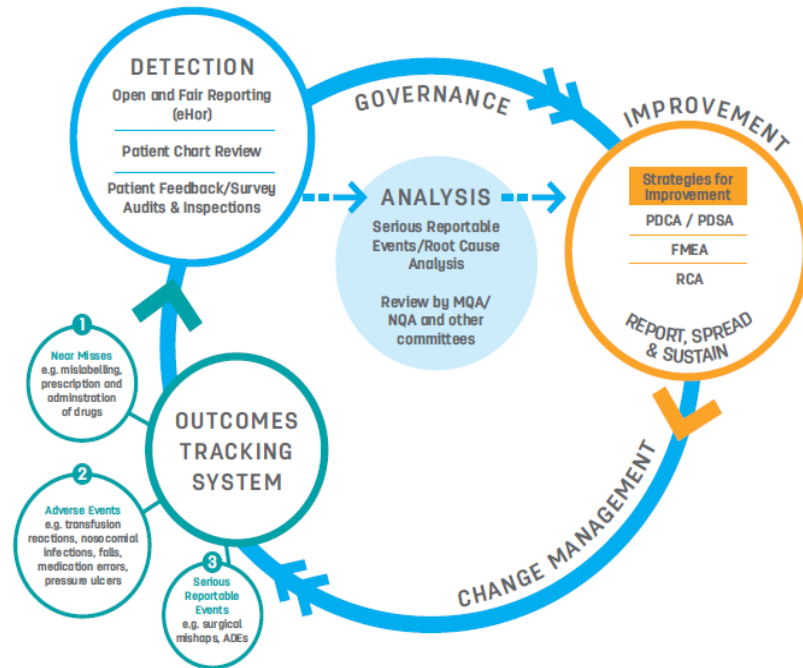
We thought that these activities were helpful . . .

Patient Safety Culture Composite	Composite Measure % Positive Response (2023)	Vs AHRQ	Vs 2019
1. Teamwork Within Units	75%	-7% ◆	0%
2. Supervisor/Manager Expectations & Actions Promoting Patient Safety	68%	-12% ◆	-1%
3. Organizational Learning - Continuous Improvement	77%	6% ◆	-5%
4. Management Support for Patient Safety	69%	0%	-4%
5. Overall Perceptions of Patient Safety	55%	-11% ◆	-3%
6. Feedback & Communication about Error	63%	-6% ◆	-7% ◆
7. Communication Openness	44%	-22% ◆	0%
8. Frequency of Events Reported	60%	-8% ◆	-6% ◆
9. Teamwork Across Units	61%	0%	-2%
10. Staffing	26%	-27% ◆	-7% ◆
11. Handoffs & Transition	44%	-4%	-6% ◆
12. Nonpunitive Response to Errors	23%	-26% ◆	-3%
13. Health IT System Training	59%	-5%	1%
14. Health IT System Support and Communication	51%	1%	-5%
15. Health IT System Workflow / Work Process	32%	-10% ◆	-6% ◆

Scores from each hospital weighted equally

How are we doing ...





"...and that's why this is so important to the organisation"

"i see!"

"I'm so glad you get me!"

Embody, Empower, Encompass, Enable

A different perspective on how we are doing...

A Physician's View...

The Hard Truth . . .

What are your thoughts...

Simplifying processes is a leadership responsibility to enable employees to do the right thing.

Maintain a high level of situational awareness, in hope to reduce errors.

Navigating Differences – generational, cultural, historical

Above all, communication is key – the intent and purpose