Singapore General Hospital
SingHealth

Safety Checks Save Lives

Singapore Healthcare Management 2024

Kellyn Lim Li Juan, Singapore General Hospital
Jesvin Dave Kaur, Singapore General Hospital
Nurshifa Shaik Hussain, Singapore General Hospital
Lee Yean, Singapore General Hospital
Pi Guangyan, Singapore General Hospital
Magdalene Ng Kim Choo, Singapore General Hospital

Background of the Problem

Ward 46 and 46A is a 92 bedded Internal Medicine and Psychiatric ward with patients on suicide precaution. Ensuring the safety of patients on suicide precaution involves regular monitoring, providing mental health support, carrying out interventions and performing safety checks to remove access to potential means of self-harm. Nurses self –confidence in caring for suicidal patients are highly affected by their suicide literacy level. Staff who are poorly informed on self-harm are less likely to identify at risk individuals.

Continuous education, updates on best/standardized practices/policy and open communication channels can help nurses stay informed and capable for providing the necessary support to patients at risk of suicide. This project is aligned with SGH Quality Priorities:

1) Safety: Focusing on providing a safe environment for patients by removing access to potential means of self-harm
2) Efficiency: Focusing on improving nurses' efficiency by conducting safety checks thoroughly.

Mission Statement

To reduce the number of suicidal risk associated incidents in Ward 46 and 46A from a median of 2 episodes per fortnight to 0 episode per fortnight within 9 months.

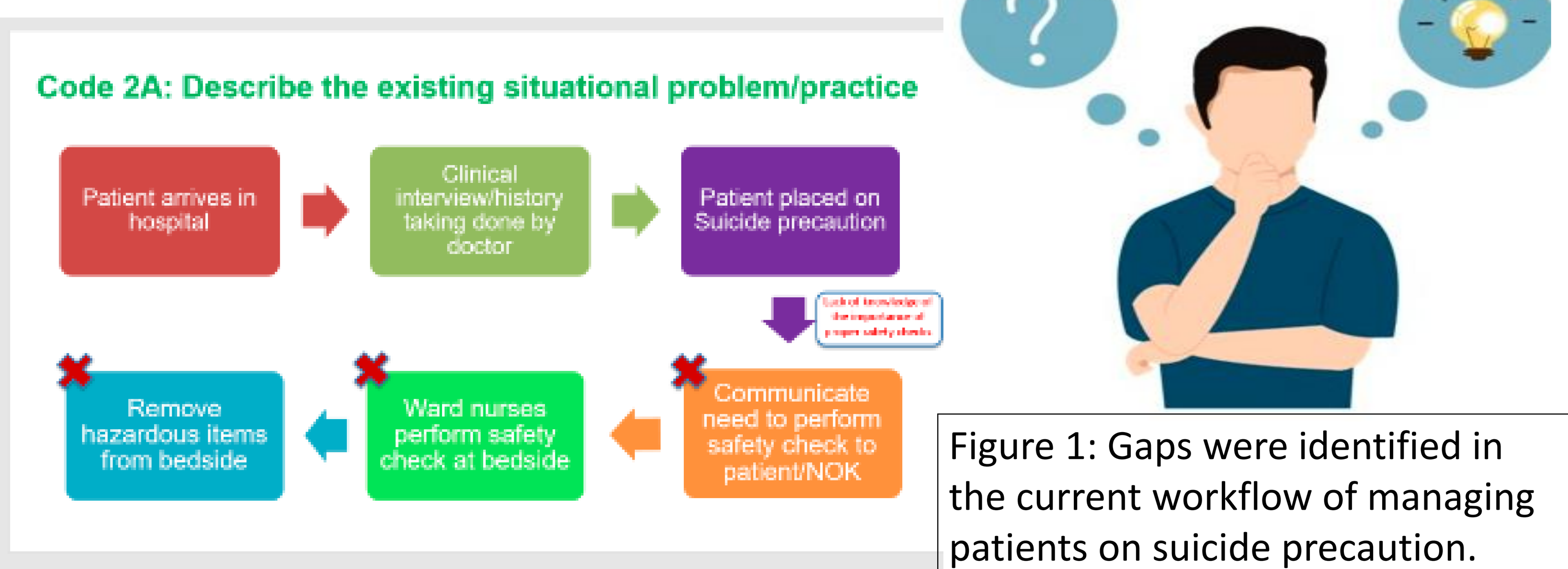


Figure 1: Gaps were identified in the current workflow of managing patients on suicide precaution.

Analysis of Problem

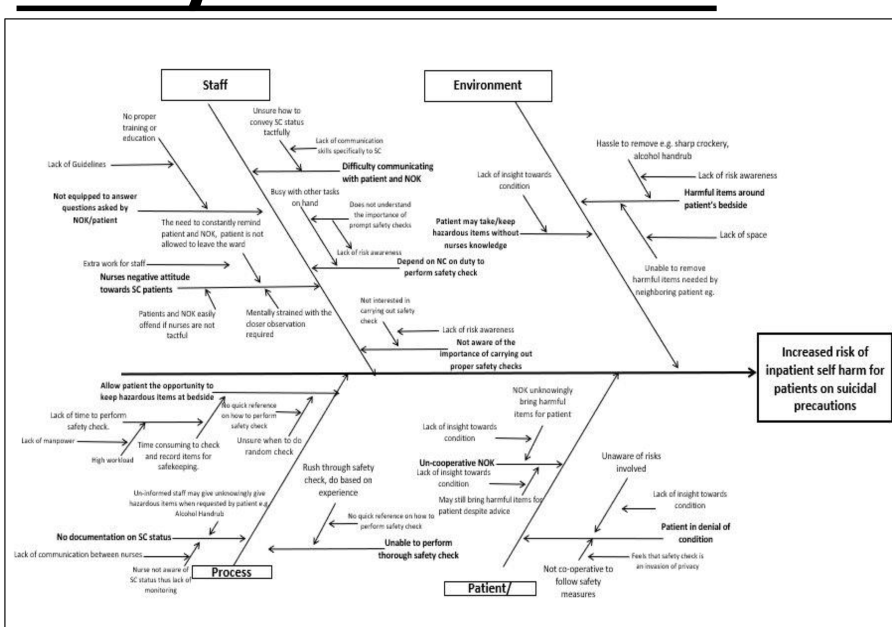


Figure 2: Root Causes identified Using Cause-and-Effect Diagram

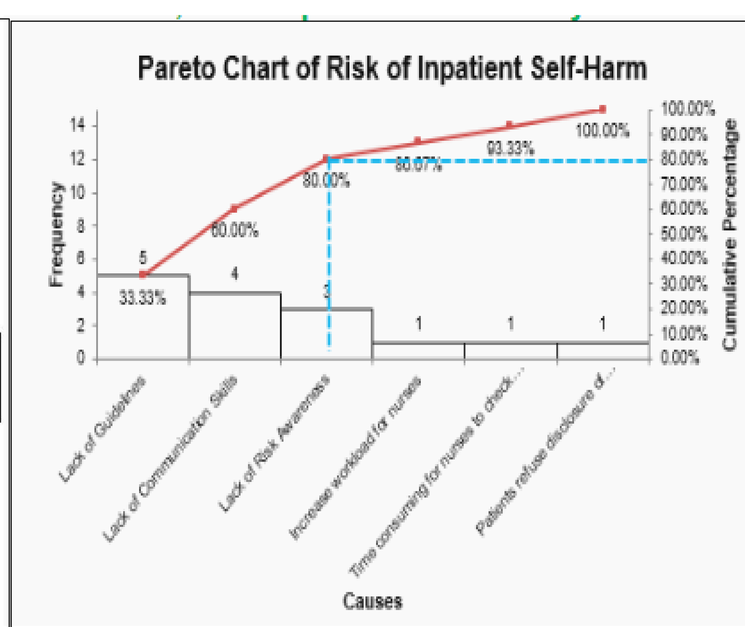


Figure 3: Pareto Chart

- Team has conducted a preliminary survey on nurses at Ward 46 & 46A.
- FormSG survey was created to explore nurses' knowledge, skills and perception towards managing suicidal patients (questions adopted from institution's policy on Managing Patient on Suicide Precaution)
- The result showed, majority of staff would like to acquire specific skills & knowledge when nursing patients on Suicidal Precautions.

3 Final root causes were voted as depicted in the Pareto Chart after a second round of multi-voting among team members (Figure 3);

1) **Lack of guidelines.** Existing guidelines are not detailed/ updated to the latest practices. Nurses are often confused with the process of performing safety checks.
2) **Lack of communication skills.** Nurses displayed lack in confidence when dealing with sensitive conversations
3) **Lack of risk awareness.** Nurses does not see the importance of carrying out safety checks thoroughly

Interventions/Initiatives

PDSA 1: The team designed a '**Quick Reference Poster**' for the nurses to refer to when the need arises. Briefings were conducted for staff during rollcalls. Information such as items to look out for during safety check such as jewellery, alcohol handrub, toiletries, sharp objects, patient' own medication and topical cream/ ointment were greatly emphasized. The use of visual aids enhance memory retention and have a stronger impact on memory recall. The poster was placed at the Nursing Counter for reference.

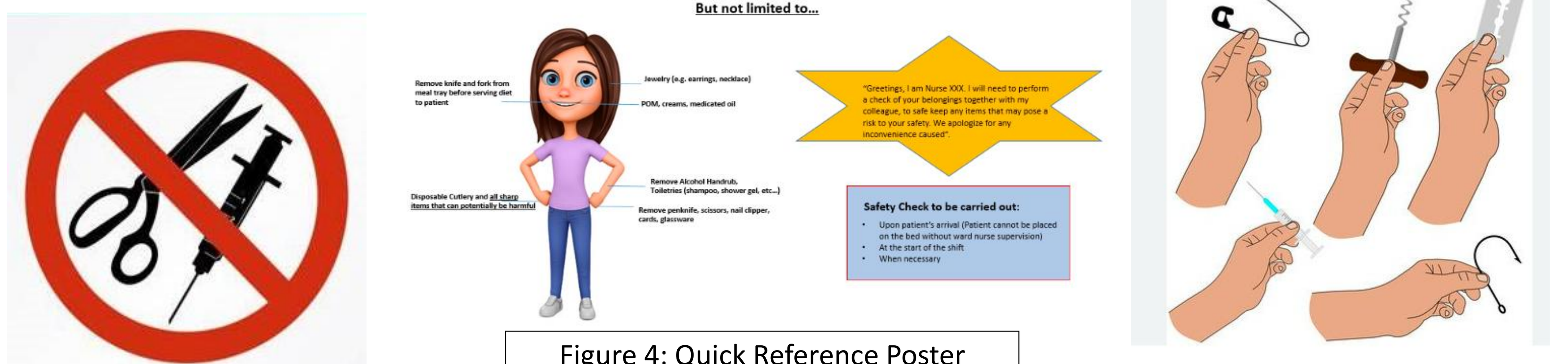


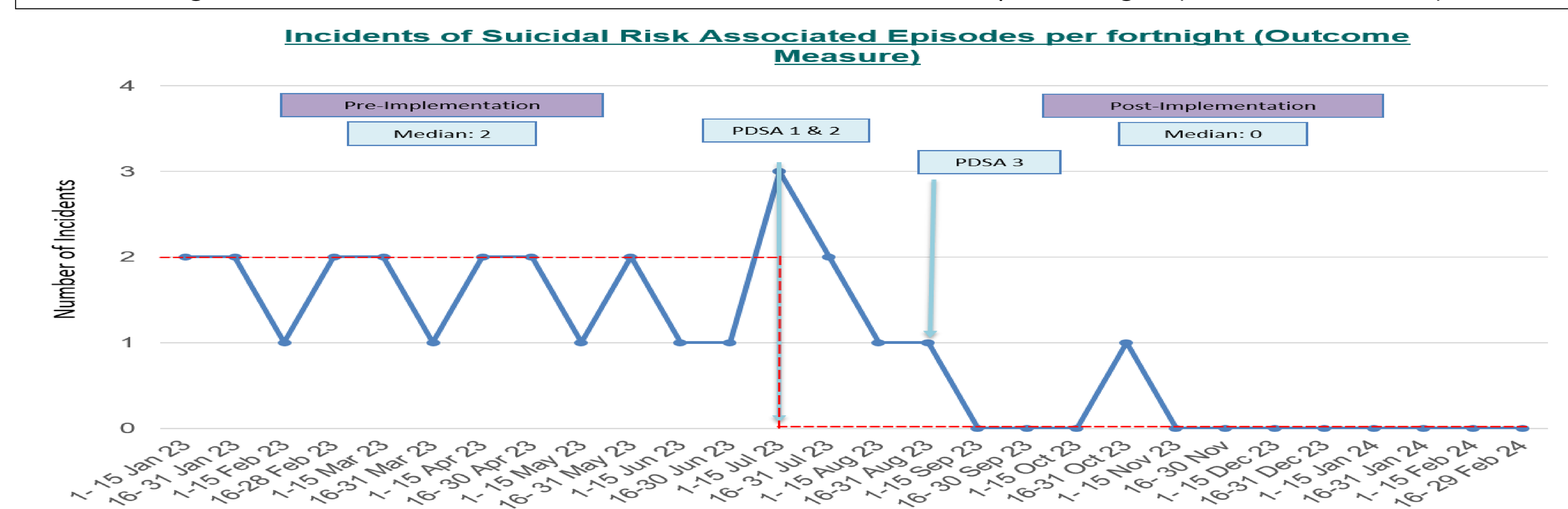
Figure 4: Quick Reference Poster

PDSA 2 : Staff found that the earlier method has facilitated their learning, and they gradually became more confident in conducting safety checks. To further strengthen the change process, team implemented a **tiered learning approach** whereby the staff is paired up with a Nurse Clinician when performing safety checks. This helps to increase staff's confidence in communication and competence in performing safety checks.

PDSA 3: To further enhance the communication process, the team developed a **script and FAQ** to enable nurses to communicate the need for a safety check to patients tactfully. This allow nurses to refer to and facilitate them from answering uncomfortable questions from patients & family members. Team conducted briefing for staff during rollcalls to share the content of the script. **Policy** was revised and updated to the latest guidelines and practices.

Results (Tangible)

Figure 5: Run Chart: Number of suicidal risk associated incidents per fortnight (Outcome measures)



Significant result was evident comparing the pre and post implementation findings that was carried out to reduce the median episodes of suicidal risk associated incidents. There was a **decrease in the median episodes from 2 to 0** since it was last implemented. Although initiatives are in place to ensure patient safety, there are instances where self harm may be inevitable e.g. patient biting tongue, hitting head against bed rails/ wall.

Results (Intangible)

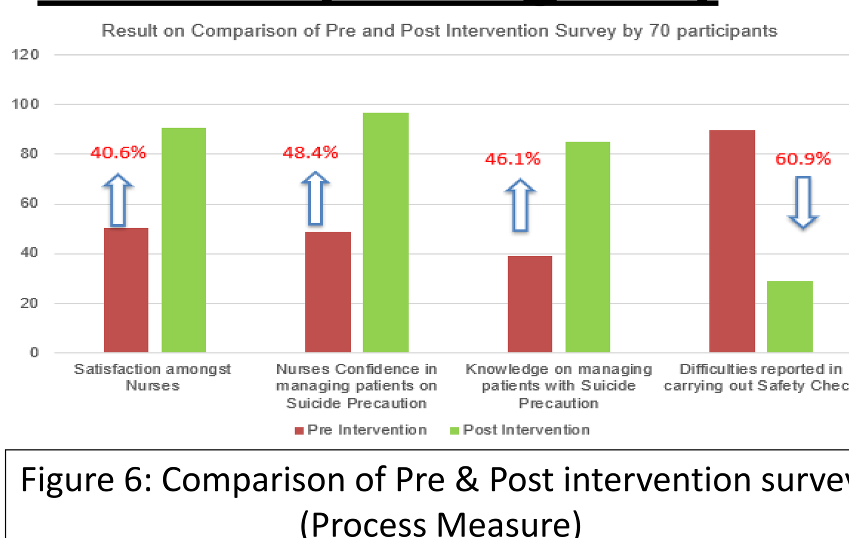


Figure 6: Comparison of Pre & Post intervention survey (Process Measure)

- The results from our project reinforces SGH's Safety culture by ensuring our patients remain safe throughout their stay
- Nurses are more aware and confident when managing patients on Suicidal Precautions thus will be able to work more efficiently and safely
- Improving the safety check process experience for both patients and nurses by allaying anxiety and providing the best experience
- In summary, the project had displayed team's commitment as they worked together in developing and implementing effective strategies to magnify patient safety

Sustainability Plans

To further sustain these initiatives in Ward 46 and Ward 46A, the team will:

- Continue gathering feedback to address further queries on the interventions
- Disseminate the updates and initiatives to other wards within the same division
- Random internal audits by unit supervisors to ensure compliance of Safety Checks
- Ongoing tiered learning – buddying staff with Nurse Clinicians when conducting safety checks
- Shared and implemented initiatives in Ward 64A/C