Hospital
Al-Sultan Abdullah

QUALITY NEWSLETTER

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QUALITY IMPROVEMENT AND PATIENT SAFETY DEPARTMENT (QIPS)
HOSPITAL AL-SULTAN ABDULLAH UITM

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by Dr. Mahfuzah Ruselan

Lately, we have noticed a trend in our RCA reports: "Educate or Remind Staff" has become a go-to action plan. While there's no doubt that education is essential, relying on it as the only solution is like putting a Band-Aid on a broken bone—it's just not enough.

Education should be a part of a bigger, bolder action plan, not the whole plan itself. We've seen too many RCAs that stop at "educate staff" and call it a day, which wont results on lasting improvements. Let's shift our focus toward stronger, more impactful solutions that address the real issues at hand.

TIME TO MOVE BEYOND "EDUCATE STAFF"

by Dr. Mahfuzah Ruselan

Systemic RCA Solutions

To make RCA² truly effective, teams should always aim to include at least one strong or intermediate action. Think bigger than just education—consider actions like redesigning physical spaces to prevent falls, implementing new devices that are tested for usability, or engineering controls that eliminate common errors.

Let's remember rather than directing our efforts at fixing individuals, we should be concentrating on enhancing the systems they work within. The systems require more attention and repair than the people do.

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	Action Category	Example
Stronger Actions	Architectural/physical plant changes	Replace revolving doors at the main patient entrance into the building with powered sliding or swinging doors to reduce patient falls.
	New devices with usability testing	Perform heuristic tests of outpatient blood glucose meters and test strips and select the most appropriate for the patient population being served.
	Engineering control (forcing function)	Eliminate the use of universal adaptors and peripheral devices for medical equipment and use tubing/fittings that can only be connected the correct way (e.g., IV tubing and connectors that cannot physically be connected to sequential compression devices or SCDs).
	Simplify process	Remove unnecessary steps in a process.
	Standardize on equipment or process	Standardize on the make and model of medication pumps used throughout the institution. Use bar coding for medication administration.
	Tangible involvement by leadership	Participate in unit patient safety evaluations and interact with staff; support the RCA[2] process; purchase needed equipment; ensure staffing and workload are balanced.
Intermediate Actions	Redundancy	Use two RNs to independently calculate high-risk medication dosages.
	Increase in staffing/decrease in workload	Make float staff available to assist when workloads peak during the day.
	Software enhancements, modifications	Use computer alerts for drug-drug interactions.
	Eliminate/reduce distractions	Provide quiet rooms for programming PCA pumps; remove distractions for nurses when programming medication pumps.
	Education using simulation-based training, with periodic refresher sessions and observations	Conduct patient handoffs in a simulation lab/environment, with after action critiques and debriefing.
	Checklist/cognitive aids	Use pre-induction and pre-incision checklists in operating rooms. Use a checklist when reprocessing flexible fiber optic endoscopes.
	Eliminate look- and sound-alikes	Do not store look-alikes next to one another in the unit medication room.
	Standardized communication tools	Use read-back for all critical lab values. Use read-back or repeat-back for all verbal medication orders. Use a standardized patient handoff format.
	Enhanced documentation, communication	Highlight medication name and dose on IV bags.

TIME TO MOVE BEYOND "EDUCATE STAFF"

by Dr. Mahfuzah Ruselan

"An incident is just the tip of the iceberg, a sign of a much larger problem below the surface." – Don Brown.

See the Tip, Uncover the Iceberg!

SCAN ME

Report patient safety incidents and NEAR MISSES ! (Incident.uitm.edu.my)

CLINICAL INQUIRY

Lessons From CLINICAL INQUIRY

01/2024

As the examining staff, it's your duty to ensure your patient doesn't fall during the examination **—whatever it takes.**

FAMILY CONFERENCE

To err is human, but it's important to own up to mistakes. It's best for the involved staff to meet with the patient and their family **within 24 hours** to explain what happened. Taking quick action is the best way to ease any frustrations.

SEEK ASSISTANCE

If one-man or two-man lifts are unfamiliar to you and your patient has limited mobility, it's best to ask the nurse in charge of the patient for assistance. The nurse should at least be nearby.

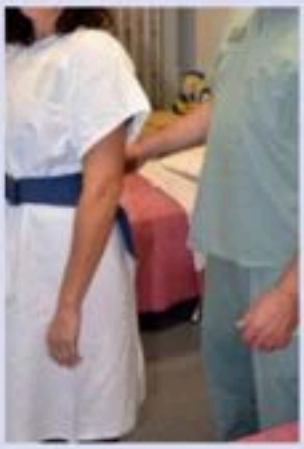
DOCUMENTATION

Thorough documentation is essential after an incident including location, date, time, people involved, care provided, informed superiors, and precautions to prevent recurrence.

When documenting family conferences, **note full names and identification numbers** of family members. You might think you've spoken to one wife, not realizing the patient has four.

ANTICIPATE FALL:

Position yourself behind the patient, remain attentive, and hold the waist or hip area, or by gripping the gait belt.



Place your leg between the patient's legs and bend it slightly for a secure grip, allowing you to safely guide the patient in case of a fall.

SIQ

WHAT IS SIQ?

- **Shortfall in quality (SIQ)** in terms of Key Performance Indicator (KPI) is a term used when **an indicator fails to reach the set target.**

- Analysis and investigation of the causes of this SIQ occurrence are crucial to identify weaknesses within the service delivery system.

- The failure to achieve a certain target resulting in SIQ needs to be seen as a platform to address existing weaknesses and should be viewed as an opportunity for improvement to enhance the quality of service.

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WHAT SHOULD BE DONE?

- To investigate and manage SIQ, it is recommended to form an investigative team at the department level.

- Each team comprises 4 to 6 investigating officers, including a team leader and members from various job backgrounds.

- Quality improvement initiatives should be carried out using tools like root cause analysis, process mapping, and the Plan-Do-Study-Act (PDSA) cycle, followed by the implementation of an action plan. Regular audits must then be conducted to confirm that the action plan effectively addresses the issue.

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TIPS ON EFFICIENT FILING

TIPS ON EFFICIENT FILING

by Muhamad Raizuddin Mohd Rosmi

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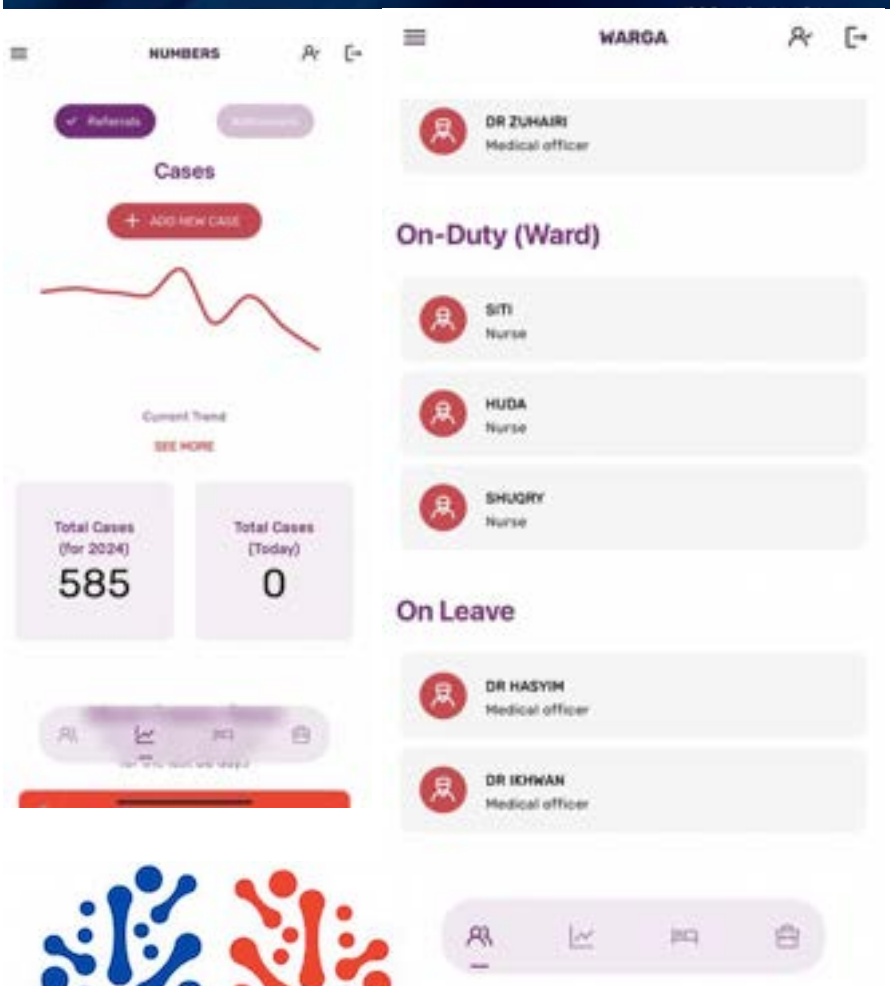
HOSPITAL AL-SULTAN ABDULLAH

KUMPULAN INOVATIF DAN KREATIF (KIK)



We extend our congratulations to the Psychiatry Department for winning the *Anugerah Inovasi Negeri Selangor 2024* in the *'Trek Social Sektor Awam'* category.

This achievement highlights their successful implementation of the Psych-Ease mobile application to improve management within the department.

Keep on innovating!

PSY SHIELD

CLINICAL AUDIT

Our Clinical Audit Masterclass series has concluded, and we appreciate your participation. Our supervisors are currently reviewing the registered topics.

All clinical audit project at HASA must be registered. HASA's Clinical Audits Panels will assess the topic and forward it to Hospital Director for approval.

This is to ensure that the project is truly a clinical audit project with no element of research.

Let us help you !

We provide hands-on clinic session

Register Your Clinical Audit Topic Here!

Clinical Audit Unit,
QIPS HASA

JOIN NOW

Klinik OpenKM

Knowledge Management

Tatacara Penggunaan Sistem

Sepanjang Tahun
(Mengikut Lampiran)

9:30 Pagi- 10:30 Pagi

Bilik Makmal Komputer Perpustakaan,
Aras 03, HASA UiTM

30 Pax SAHAJA Setiap Sesi

SERTAI SEKARANG!

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