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World Hospitals and Health Services

The Official Journal of the International Hospital Federation

Service Delivery in Asia

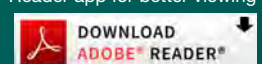
- | Introduction of the development of the mobile smartphone application, “PWH easyGo” to help patients and visitors to navigate different departments and facilities on the hospital premises with ease.
- | An approach to improve patient safety and quality beyond accreditation
- | Perception of Healthcare Providers Regarding Hospital Bed Utilization: A prerequisite for quality improvement initiatives in Healthcare institutions
- | Highlighting Service Excellence in Lorma
- | Pre-operative Verification, Site Marking and Time Out - Spreading Patient Safety Culture from Major Operating Theatre to Day Surgery
- | National University Health System (NUHS) Transitional Care Program
- | Using online and scenario-based learning to improve nurse-patient interaction and enhance patient experience
- | MAA Medicare – Crossing Borders

Opinion matters

- | Emerging Grandeur Niche in Chinese Wellness Tourism at Phuket Island

Abstracts: Français, Español, 中文

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South and East Asia as a Global Center for HealthCare Innovation and Investment Opportunities



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In this issue of the World Hospitals and Health Services Journal (WHHSJ) we continue to explore the Asia Miracle in HealthCare, building on previous editions of the Journal focused on Asia.

Despite earlier gloomy forecasts at the end of 2015 about China's economic downturn and resulting global impact, economists are now much more optimistic about the near and medium-term economic outlook for China and other countries in South and East Asia. On April 15, 2016, the IMF reported: "Since the beginning of 2016, growth in China has remained firm, with key indicators showing signs of improvement." GDP grew by 6.7 percent in the first quarter of 2016 year-on-year, with retail sales of consumer goods posting a stable year-on-year growth of 10.7 percent. In 2015, India even surpassed China in its economic growth. Other countries in the region were not far behind. This is good news for the 2016 global growth outlook and more specifically the health sector in South and East Asia.

Carlton Chen, CEO of SinApac Group (a US-based investment advisory firm focusing on US-China cross border transactions) recently returned from China after meeting with a range of institutional and individual investors from Beijing, Jinan, Shenyang, Shenzhen and Guangzhou, business associations, incubators, and health technology companies, together with officials from the Shenzhen Stock Exchange. His trip shed light on why the China health sector has suddenly become such a focus for investors and why Chinese investors are so interested in the health sector both locally and internationally.

Several favorable conditions are thought to contribute to a frenetic rise in investments by Chinese investors in the Chinese and overseas health sector:

- Strong demand for better health given visible air pollution and vehicular traffic
- A large, aging population with an increased standard of living
- Favorable investment policies and Government support
- Relatively stable currency and low interest rates
- Emergence of a strong financial sector (banking and stock market)
- Accumulation of wealth by both individuals and companies and
- Support and investment by the Government with a focus on improving the people's health and healthcare (the Government is supporting over 2,000 business incubators in Shenzhen alone and has set up dynamic economic zones in that Province with a low corporate tax rate.

This has led to paradigm shifts during the past few years from seeing health care as a "bottomless pit" that the Chinese Government must continually fill with new money and fiscally straining the China's treasury, to seeing the health sector as a viable and even potentially lucrative target for commercial and Government investments. Due to the double and triple digit financial returns from investments in some areas of the health sector like bio technology, medical technology and health information systems, some investors now even see the health sector as one of the best investment opportunities in the economy.

The contributing authors to this issue of the WHHS Journal highlight show how the significant investments by both governments and the private sector in South and East Asia during recent years is now reaping results in terms of new innovative care models which is improving health care and the health of several billion people in this populous region of the world.

In addition, this issue highlights the dynamism of health providers that develop numerous small scale innovations. These innovations are coming from the Hospital Management Asia Awards. If all of these are put together, they amount to significant changes in healthcare by enhancing the performance of service delivery. The role of IHF is to promote new approaches contributing to accelerate innovation adoption, and showing that there is nothing that should be dismissed as insignificant. Healthcare is by definition very fragmented and it covers a very large range of activities. So, small scale improvements should be looked at because they have a double merit: they improve results and better mobilize teams. This double dynamic is the one that makes organizations vivid. No wonder that investors are looking at healthcare with such interest.

The International Hospital Federation remains committed to supporting value for money in this trend and has started working more closely with privately owned hospitals and hosted a venture fair for investors, innovators and companies at the time of the Chicago World Hospital Congress in October 2015. A similar meeting for investors and innovators is being planned for Durban, in South Africa in November 2016.

In addition IHF contributes to the international recognition of innovative practices with the three **IHF Excellence Awards and the IHF Grand Award**. Look closely on how to submit one of your achievements http://congress.ihf-fih.org/ihf_awards and celebrate with your teams your accomplishments... But hurry because the deadline for submission will be closing soon.

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- » Corporate Social Responsibility

ELIGIBILITY

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- » Demonstrated excellence and outstanding achievement at hospital, institution or unit level through an activity or project with proven results

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- ✓ *International exposure through IHF publication and healthcare media network*

Runners-up:

- ✓ *1 complimentary Congress registration per category*
- ✓ *International exposure through IHF publication and healthcare media network*

Submission deadline:

July 11, 2016

Winner announcement:
September 5, 2016

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2016 IHFD URBAN

40th World Hospital Congress

“Addressing the Challenge of Patient-centered Care and Safety”

31 October - 3 November | Durban ICC | South Africa



Pre-Congress Events Programme Monday, 31 October (10:00 – 16:30)

- 10:00 - 16:30 REGISTRATION
 10:00 - 16:30 PRE-CONGRESS EVENTS
 10:00 - 11:30 **ANADACH GROUP:** *African Private healthcare for the 21st century – Opportunities for Improving Patient Centered Care*
WORKSHOPS:
*Introduction to miniHTA:
 A potential management and decision support tool for the hospital environment*
*Health Technology Assessment:
 The essentials*
 17:30 - 19:30 **AFRICAN REGIONAL MEETING** (*Download abstract*)

Day 1 Programme Tuesday, 1 November (09:00 – 18:30)

- 09:00 - 09:30 **OPENING CEREMONY:** *Dr. Aaron Motsoaledi, Honourable Minister of Health, Republic of South Africa* (*Download Minister's Message*)
 09:30 - 10:30 Inauguration Expo and Exhibition / Break
 10:30 - 11:30 **Plenary 1: FINANCING AND UNIVERSAL HEALTH COVERAGE:** *Dr. Nicolas Crisp, Freelance Consultant (South Africa) & Prof. Joan C. Lo, Member, National Health Insurance Committee, Ministry of Health and Welfare (Taiwan)*
 11:30 - 13:00 Concurrent Sessions
Special Session: WHO (AFRO): *Improving quality of Care in Hospitals: A Comprehensive Information Technology Solution*
BRAZIL - ANAHP: *Quality of Care and Sustainability / A Brazilian Perspective*
BELGIUM: BELGIAN HOSPITAL ASSOCIATION: *How to become an excellent hospital? Strategies for transformation*
HONG KONG – HOSPITAL AUTHORITY: *System improvements in Public Hospitals in Hong Kong*
SOUTH AFRICA: DEPARTMENT OF HEALTH: *Capacity building in leadership and management for hospital managers: local and international perspective*

- 14:00 - 15:00 **PARALLEL FREE PAPER**
Plenary 2: GOVERNANCE AND ACCOUNTABILITY: *Christopher Drexler Regional Minister for Healthcare, Science and Personnel (Styria Region (Austria)*
 13:00 - 14:00 Lunch / Expo / Posters
 15:00 - 16:30 Concurrent Sessions
Special Session – IHF UNIVERSITY HOSPITALS SIG: *Relationship and governance between universities and academic medical centers : A Global survey*
TAIWAN – TAIWAN HOSPITAL ASSOCIATION: *Delivering Inclusive Smart Health Care by Innovative and Comprehensive e-Health System*
USA: AMERICAN HOSPITAL ASSOCIATION & AMERICAN COLLEGE OF HEALTHCARE EXECUTIVES: *Innovative responses: Making care equitable and accessible*
SOUTH AFRICA – HOSPITAL ASSOCIATION OF SOUTH AFRICA
PARALLEL FREE PAPER
 16:30 - 17:00 Break / Expo / Posters
 17:00 - 18:30 Concurrent Sessions
Special Session – HEALTH PARTNERSHIPS: *Engaging professionals: The importance of institutional partnerships*
SPAIN: UNIO CATALAN D'HOSPITALS: *Transforming organization's structures to improve health outcomes during a period of financial constrain*
PHILIPPINES: PHILIPPINE HOSPITAL ASSOCIATION: *The Philippine experience in growing leaders: what we have, where we want to go and what it means to the country's healthcare*
JOINT COMMISSION INTERNATIONAL: *Innovations in quality and safety evaluation in health care organizations*
SOUTH AFRICA – DEPARTMENT OF HEALTH: *Use of health technology for delivery of innovative health care*
 Special Session: **INVESTOR-OWNED HOSPITALS** (By invitation only)
PARALLEL FREE PAPER
 19:30 Welcome Reception

2016 IHFD URBAN

40th World Hospital Congress

“Addressing the Challenge of Patient-centered Care and Safety”

31 October - 3 November | Durban ICC | South Africa



Day 2 Programme Wednesday, 2 November (08:00 – 18:30)

- 08:30 - 09:30 IHF INTERNATIONAL AWARDS: PRESENTATIONS & PRIZE GIVING CEREMONY
- 10:30 - 12:00 **Special Session: WHO GENEVA**
Special Session: IHF HEALTHCARE EXECUTIVES SIG:
A Global need for the professionalization of Healthcare Management
FRANCE – FRENCH HOSPITAL FEDERATION & UNICANCER: *Increasing patients and staff involvement to face hospital challenges*
NIGERIA – LAGOS STATE HEALTH SERVICE COMMISSION: *Universal Health Coverage in Lagos Nigeria: Financing Prospects and Medico-Legal Perspectives*
SOUTH AFRICA – DEPARTMENT OF HEALTH: *Standardisation of hospital services for improving quality of care*
PARALLEL FREE PAPER
- 12:00 - 13:00 **Plenary 1: TECHNOLOGY: ROLE IN DETERMINING CLINICAL PATHWAYS IN PATIENT CARE:** *Anne Hafstad, Project Director (Defining and Developing Clinical Pathways); Norwegian Directorate of Health (Norway)*
- 13:00 - 14:00 Lunch / Expo / Posters
- 14:00 - 15:00 **Plenary 2: CAPACITY BUILDING IN LEADERSHIP AND MANAGEMENT:** *Dr. Paulo Chap Chap, CEO, Hospital Sírio Libanes (São Paulo, Brazil)*
- 15:00 - 16:30 Concurrent Sessions
Special Session: CEO FORUM: *Performance excellence techniques to improve outcomes*
NORWAY - NORSK SYKEHUS-OG HELSETJENESTEN (NSH): *End of life care*
SOUTH AFRICA – HOSPITAL ASSOCIATION OF SOUTH AFRICA
UNITED ARAB EMIRATES: DUBAI HEALTH AUTHORITY (DHA): *Innovations in Delivery of Care and Hospital Services*
PARALLEL FREE PAPER
- 16:30 - 17:00 Break / Expo / Posters
- 17:00 - 18:00 IHF GENERAL ASSEMBLY
- 18:15 - 19:15 CEO CIRCLE COCKTAIL RECEPTION
- 19:30 GALA DINNER

Day 3 Programme Thursday, 3 November (08:00 – 16:30)

- 07:00 - 08:15 IHF Governing Council – Breakfast Meeting
- 08:30 - 09:30 **Plenary 1: SERVICE DELIVERY: INNOVATIONS IN DELIVERY OF CARE AND HOSPITAL SERVICES:** *Dr. Jonathan Perlin, President, Clinical Services and Chief Medical Officer, Hospital Corporation of America, Inc. (USA)*
- 09:30 - 11:00 Concurrent Sessions
Special Session: INTERNATIONAL UNION OF ARCHITECTS: IHF – UIA: *Collaboration project: Reducing hospital operating cost through better design*
PAKISTAN AND EAST AFRICA: *Setting high standards of quality, care and delivery in the developing world*
SOUTH AFRICA – DEPARTMENT OF HEALTH: *Best practices in Hospital care in South Africa*
Special Session: CEO FORUM (By invitation only)
PARALLEL FREE PAPER
PARALLEL FREE PAPER
- 11:30 - 12:30 CLOSING CEREMONY AND POSTER AWARDS
- 11:00 - 11:30 Break / Expo
- 12:30 - 13:30 Lunch
- 13:30 - 16:30 HOSPITAL VISITS / SIDE EVENTS
Addington Children’s Hospital
Ethekwini Hospital and Heart Centre
King Dinuzulu Hospital
Prince Mshiyeni Memorial Hospital
Inkosi Albert Luthuli Central Hospital

Introduction of the development of the mobile smartphone application, "PWH easyGo" to help patients and visitors to navigate different departments and facilities on the hospital premises with ease



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ABSTRACT: "PWH easyGo" is a mobile smartphone application (app) designed to help patients and visitors to look for different departments and facilities on the hospital premises. Posters with QR code are displayed at various hospital entrances. Users with the app installed can scan the QR codes printed on posters on site or manually select their current locations and destinations in the app, and the system will display the relevant routes with photos. It is the first such app developed by the Hong Kong Hospital Authority and is available for download at Apple Store (iOS version) and Play Store (Android version).

A video file demonstrating the use of "PWH easyGo" can be found at URL: http://www3.ha.org.hk/pwh/film/pwheasygo20150608_eng.mp4.

Introduction. The Prince of Wales Hospital (PWH) is a regional public hospital situated in Shatin, Hong Kong. Patient services are located at different sites at six major blocks scattered around a vast hospital complex with a total floor area of over 160,000 square meters. These buildings are interconnected via footbridges, corridors or zebra crossings on the ground level. Adding to the complexity, names of the inpatient wards are very

similar and could be confusing to visitors. For example, Ward 7A, Ward 7E and Ward 7H are located on the 7th floor of 3 different buildings which are far apart. It is not uncommon to see visitors getting to the wrong building. Even chronic patients who come regularly for follow-up, may have difficulties finding their way to some less frequently visited areas such as the specimen collection centre.

The mobile smartphone app “**PWH easyGo**” was therefore developed to help patients and visitors find the right routes to the ‘hot destinations’ in the hospital, including wards, clinical units and public facilities. Users can either manually select their starting point and destination in the app, or scan the relevant QR codes which are displayed in various entrances of the hospital. The app will then show the most direct route with step-by-step textual instructions and photos. With the use of QR codes, users are able to locate themselves even without Wi-Fi and GPS coverage, which are unavailable in the hospital compound due to physical constraints.

With “**PWH easyGo**”, users can find the most direct routes to their destinations by following step-by-step textual instructions and photos. It can reduce the chance of patients and visitors going to the wrong places, saving them time and walking distance. It can serve as a useful supplement to the standard signage, floor directories and enquiry counter service.

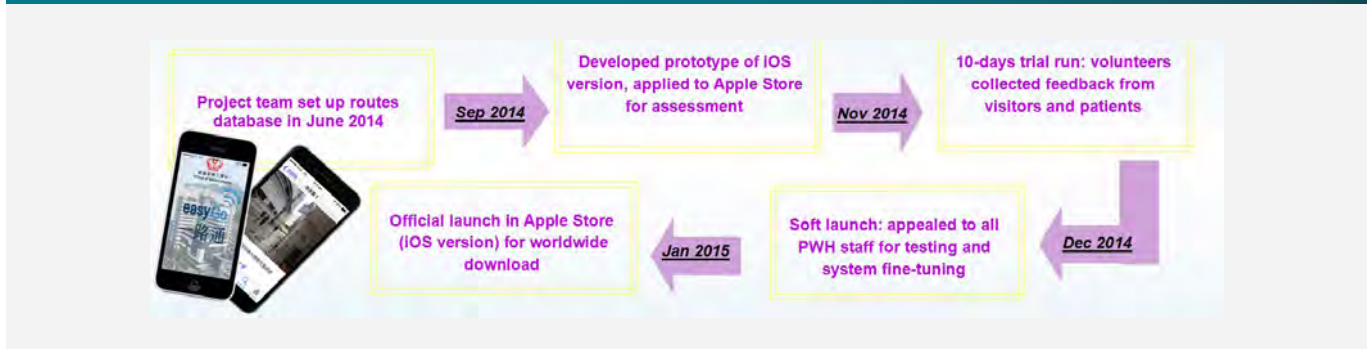
The app not only helps patients and visitors find their destinations when they are already physically inside the hospital, it also gives them the option of planning their routes ahead at home.

The idea of “**PWH easyGo**” originated from the Hospital Chief Executive. It was then developed with the concerted efforts of Administrative Services Division, Information Technology Department, Patient Relations Office, Communications and Community Relations Section and Health Resource Centre with valuable inputs from volunteers.

Results:

In August to September 2014, the project team collaborated to set up an extensive database of 307 paths (to various patient services and public facilities with bilingual textual instructions and photos. Volunteers (with a mean age of 55) then helped to carry out a promotional trial run in November 2014.

TABLE 1: ROADMAP FOR DEVELOPING THE SMARTPHONE APP, “PWH easyGo”



Case illustration

Let’s illustrate the use of this path-finding app with a hypothetical case.

There are three main clinical blocks in the hospital and each has a 7th floor which houses a children ward, a neurosurgical ward and an antenatal ward respectively. They all have the prefix of “7”. A visitor intending to visit ward 7B (neurosurgical ward) might have been misguided to go to ward 7L (Children Surgical and Orthopaedic Ward) which is situated in another block. He has to take another 7-minute walk to reach ward 7B from 7L. The whole trip would cost him 11 minutes of walking. With a path-finder app, he could take the shortest route which just takes him 3 minutes, saving him 8 minutes. The savings of “8-minutes”, when generalized to just 1% of the number of patients’ visitors alone (2014/15 figure), will be a whopping 400 hours! (Calculation: 150,000 patient episodes x 2 visitors x 8 minutes ÷ 60 minutes).

TABLE 2: SCREEN DUMP FOR THE 4 KEY FUNCTIONS OF THE SMARTPHONE APP, “PWH easyGo” INCLUDING “APPS GUIDE”, “TRAFFIC ROUTES TO GET TO PWH”, “HOSPITAL MAP AND FLOOR GUIDES”, “SEARCH LOCATIONS BY USING QR CODE” AND “ABOUT PWH”.



Table 3: Survey results of the promotional trial run between 17 November and 2 December 2014 (total no. of survey results collected was = 162)

Question	Percentage of “yes” answers	Percentage of “no” answers
----------	-----------------------------	----------------------------

Do you like the app?	134 (93%)	10 (7%)
Do you think it is useful?	134 (90%)	15 (10%)
Will you use it to find your paths?	131 (91%)	13 (9%)

Table 4: Categorization of free text comments given by patients during the promotion run between 17 November and 2 December 2014 (total no. of survey results collected with free text comments was = 114)

Category	Percentage of free comments received in each category
Data (includes asking for more new paths defined)	51 (45%)
Appreciation for the app development	8 (7%)
Concern of network speed in retrieving data	24 (21%)
System enhancements suggested (including the feature supporting the disable to use the app, use of QR code supporting workflow in specialist outpatient's clinics workflow.)	31 (27%)

Discussion

During 11-working days, a survey was conducted during the promotional trial run in November 2014. Out of the 162 patients and visitors surveyed, 93% gave the app a "Like". 90% found it useful and 91% said they would download it for use.

The primary aim was to test if the app was simple and easy enough for users, especially senior patients. They also helped to collect comments for further fine-tuning of the app.

"PWH easyGo" has been further enhanced to support patient flow in the specialist outpatient clinics (SOPD). After follow-up consultation in SOPD, patients often need to undergo investigations at various locations such as Blood Taking Centre, Endoscopy Centre, Electro-diagnostic Unit and Diabetes or Endocrine Centre.

Corresponding QR codes have been created to guide patients from SOPD to these units. The app enables patients to scan a QR code once to capture both their current location in the outpatient clinic and the respective clinical unit, then the right route will be shown directly.

Investigation forms preprinted with information about the functions of "PWH easyGo" and QR codes of commonly visited units are distributed to patients.



Blood Taking Centre



Diabetes and Endocrine Centre (DMEC)

Conclusion

PWH has a huge pedestrian traffic volume due to the large number of patients it serves. In 2014/15, there were over 150,000 inpatient discharges and the total attendance of A&E, specialist outpatient clinics and allied health services were over one million. For many patients, a trip to the hospital often means visiting multiple locations which may include investigative units, outpatient clinics and pharmacy. "PWH easyGo" helps them navigate between these locations independently, saving them time and effort. It also enhances patient flow and operational efficiency.

As Dr. Hung Chi-tim, the Chief Executive of the hospital has noted, "the Prince of Wales Hospital is a place serving patients. Besides fulfilling their clinical needs and delivering necessary treatments, providing the information required to support their care in a convenient way is also our primary duty. It is our mission to continuously enhance our service to the public and the patients."

Furthermore, the iOS version of "PWH easyGo" complies with web accessibility requirements, enabling people with disabilities to obtain the same information with ease. It was given the **Gold Award in the Web Accessibility Recognition Scheme 2015** jointly organized by the Office of the Government Chief Information Officer and the Equal Opportunities Commission of the Hong Kong Special Administrative Region. This pioneering work of the Prince of Wales Hospital also won the **Excellence Award of Asian Hospital Management Awards 2015 - Innovations in Healthcare IT category**.

References

- Prince of Wales Hospital: Hospital map and services information is available at http://www3.ha.org.hk/pwh/index_e.asp
- Global Positioning System from Wikipedia: Global Positioning System is available at https://en.wikipedia.org/wiki/Global_Positioning_System
- Wi-Fi Positioning System from Wikipedia: Wi-Fi Positioning System is available at https://en.wikipedia.org/wiki/Wi-Fi_positioning_system
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- QR Code Generator: Online web QR Code Generator is available at <https://www.the-qrcode-generator.com/>
- Hong Kong SAR Web Accessibility Recognition Scheme is available at http://www.ogcio.gov.hk/en/community/web_accessibility/recognition_scheme/2015/awardees_list_mobileapp/
- Web Accessibility: Mobile Application Accessibility Handbook is available at http://www.ogcio.gov.hk/en/community/web_accessibility/maahandbook/doc/mobile_app_handbook.pdf
- Asia Hospital Management Awards 2015 is available at <http://www.asianhospitalmanagementawards.com/Winners2015>

An approach to improve patient safety and quality beyond accreditation



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ABSTRACT: Patient safety improvements demand a complex system-wide effort, involving a wide range of actions in performance improvement, environmental safety and risk management, including infection control, safe use of medicines, equipment safety, safe clinical practice and safe environment of care.

Healthcare accreditation is one of the major steps towards improving quality and patient safety. Amongst the several accrediting agencies across the world, the Joint Commission International, (JCI) stands out as the gold standard in healthcare accreditation. The patient safety journey for hospitals like the Apollo Group, formally started with Apollo Hospitals, Delhi becoming the first JCI accredited Hospital in India, in 2005. In the years to come, eight hospitals of the Group also became JCI accredited; taking the number of hospitals accredited by JCI to twenty-three in the country. The National Accreditation Board for Hospitals and Healthcare providers (NABH) was formed thereafter and today nearly three hundred hospitals are accredited by NABH across the country.

There is more to patient safety and healthcare quality beyond just accreditation. With a view to further improve patient safety; Apollo Hospitals have taken several initiatives.

Introduction:

Patient Safety, defined as freedom for a patient from unnecessary harm or potential harm associated with healthcare, is an issue of increasing concern all over the world. It is of foremost concern that ailing patients coming to hospitals for treatment be protected from any further harm. So says even the Hippocratic Oath. Different healthcare organizations have gone the distance to tackle

this global issue using different tools and taking examples from other industries like the airlines and nuclear reactors, where risk is carefully managed to prevent harm and create high reliability organizations.

The Institute of Healthcare Improvement under the leadership of Don Berwick has laid down seven steps for improving patient safety. The first is to build a safety culture in the organization. The second step is to lead and support

your staff. The third step is to integrate your risk management policy. The fourth step is to promote reporting. The fifth step is to involve and communicate with patients and the public. The sixth step is to learn and share safety lessons. The seventh step is to implement solutions to prevent harm. (www.ihl.org/)

One can clearly understand the concept of patient safety encompassing the concept of “reliability.” It involves human lives. “Safety shows itself only by the events that do not happen” Erik Hollnagel had said. No one can understand it better than a patient harmed by medical error. Deaths and harm from medical errors are not inevitable but preventable. We must have this clarity of the task before us and commit to rolling up our sleeves and making it a reality.

Method:

There is more to patient safety and healthcare quality beyond accreditation. With a view to further improve patient safety; Apollo hospitals have taken several initiatives. Apollo Hospitals have implemented standardized patient safety processes across their hospitals under the initiative “The Apollo Standards of Clinical Care” (TASCC) to establish standards of clinical care to ensure that all its hospitals deliver safe and quality clinical care to all its patients, irrespective of location and size of the hospital.

TASCC comprises six components including Apollo Clinical Excellence @25 (ACE@25), Rocket ACE (RACE), Apollo Quality Plan (AQP), Apollo Mortality Review (AMR), Apollo Critical Policies, Plans and Procedures (ACPPP), Apollo Incident Reporting System (AIRS) and Safe surgery and ICU checklist.

ACE@25- Apollo Clinical Excellence @25

In the year 2008, the Apollo Hospitals Group completed its journey of twenty-five glorious years in the healthcare sector, which transformed the medical landscape of the country thereby creating an edifice that houses the hopes and dreams of millions. Keeping the expectations of our patients and the medical fraternity in mind, Apollo Hospitals created a dashboard, “ACE @ 25”.

“ACE @ 25” is a clinical balanced scorecard focusing on clinical excellence, and incorporates parameters which are mission critical for the clinical milieu of our organization. This balanced score card focuses on providing evidence-based quality care and a safe environment to our patients and strengthening the functional efficiency of our hospitals, stimulating quality improvement while reducing variations.

The scorecard consists of 2 sets of indicators. Each hospital reports on a set of compulsory parameters and few location specific parameters defined for each hospital based on availability of services. Each indicator has been lucidly defined and the numerators and the denominators have been clearly delineated. Benchmarking defines our Group expectations with weighted scores for the outcomes. The scoring system ensures that the segments measure up to a statistically significant range of figures which are further

colour coded as green, orange and red. The cumulative score achievable is capped at 100. The ACE @ 25 balanced score card has been developed online, with live capabilities using our online ‘Apollo Lighthouse’ platform for monthly inputs with relevant data, using the Dot Net architecture hosted out of a central server at one of our locations. The mechanism is so devised to maintain the integrity and confidentiality of data with respect to each of the Apollo Hospitals. The same also has an added layer of security over the web, lest it is accidentally accessed by any unauthorized personnel. To authenticate the data reported by the Group Hospitals, an ACE @ 25 audit team validates the records of all the Group hospitals. ACE is monitored in more than 35 hospitals of Apollo Group.

Few examples of ACE @25 indicators and institutes from where benchmarks are adopted. (Table 1)

Table 1

Indicator	Benchmark
CABG mortality rate	Cleveland Clinic
Upper GI Endoscopy complication rate	Mayo Clinic
Catheter Related Blood Stream Infections (CR-BSI)	National Healthcare Safety Network
Ventilator Associated Pneumonia (VAP)	National Healthcare Safety Network
Catheter related Urinary Tract Infection (CR-UTI)	National Healthcare Safety Network
ALOS post living donor nephrectomy	Wiley Cochrane review

RACE - Rocket ACE

A dashboard of 25 clinical parameters was created to assess the outcomes of the six specialties under the Centres of Excellence (COEs). RACE safeguards that when the volumes increase the quality should not be compromised.

AQP - Apollo Quality Plan

Apollo Hospitals also developed a comprehensive set of best practices by way of the Apollo Quality Program; a plan for the Group-wide implementation of standardized

methodologies for clinical handovers, International Patient Safety Goals, surgical care improvement, zero medication errors, standardization of medical records, diagnosis and procedure codes and promoting innovation in quality improvement.

ACPPP- Apollo Critical Policies, Plans and Procedures

Apollo critical policies, plans and procedures were developed into 25 policies covering clinical care, nursing care, managerial processes and utility systems and infrastructural requirements. All Apollo Hospitals have established and implemented policies to address these processes. Prototype policies were provided to all hospitals which could customize these policies according to their own procedures and processes.

AMR- Apollo Mortality Review

Triggers were identified for mortality reviews to be conducted by every Apollo Hospital; the deaths qualifying as triggers were peer reviewed as per a predefined peer review checklist, presented in a mortality review meeting and categorized into defined categories. Sequential monitoring using statistical process control methods were useful in the early identification of unfavourable trends. Formal, structured review of all deaths (not just 'unexpected' deaths) helped detect quality issues that would otherwise remain hidden, particularly around every day processes of care.

AIRS - Apollo incident reporting system

Apollo Hospitals endeavoured to establish clear systems for reporting of information related to specific patient and staff incidents/near misses, along with certain other serious health care errors and all sentinel events to the central leadership and to provide a mechanism of tracking, trending, and follow-up of all such incidences that posed an actual or potential safety risk to patients, families, visitors and staff. These included patient fall rates, needle stick injury rates, patient pressure ulcers, missing patient records and legal cases. Hospitals with higher rates were advised on improvement measures and to follow best practices being adopted by other hospitals. By concentrating on the events actually experienced by patients, our hospitals helped to foster a culture of safety that shifts from individual blame for errors to comprehensive system redesign that reduces the chances of patient suffering and harm.

Checklists

Surgical safety was ensured through preoperative site marking, preoperative checklists and a final verification check before the start of the surgery by the whole operating team, called the 'time out.' At the same time, we developed in consultation with intensivists and anaesthetists, a unique checklist which was used in all the ICUs for each and every patient admitted. The ICU checklist of care comprised of issues that were addressed daily for every patient in an intensive care unit and helped deter omissions and

mistakes wherever possible. It helped with memory recall, especially with routine matters that were easily overlooked in patients undergoing more drastic events. It made explicit the minimum, expected steps in complex processes. The checklist augments the daily, multidisciplinary team rounds and alerts the doctor when important items have been missed. In addition, the ICU team's collegiality and team bonding were enhanced by using an evidence-based tool to achieve care goals. Both the Safe Surgery Checklist and the ICU Checklist implementation across the Apollo Group are closely monitored using defined indicators.

Result:

TASCC was an extensively planned program which objectively monitored and evaluated special indicators and the clinical and internal processes involved in patient care. Aside from this, it helped in identifying opportunities for improvement and provided a mechanism through which action was taken to make and sustain those improvements. In addition, TASCC sought to improve patient care and outcomes through systematic review of care against clearly defined criteria. This evaluation helped in achieving a better quality of patient care and service delivery leading to better utilization of resources and lowering costs in the long run. In this manner, TASCC makes up the double helix of the Apollo Group's clinical fabric. Institution of this program scorecard has helped improve clinical care in the Group Hospitals, with most hospitals showing a steady improvement in their scores, taking them beyond just accreditation.

References

1. WHO Patient Safety 2016 http://www.who.int/topics/patient_safety/en/
2. Leadership guide to patient safety www.ihl.org › Home › Resources › IHI White Papers
3. "Resilience Engineering: Concepts and Precepts" by Erik Hollnagel, David D. Woods, Nancy Leveson, Asgate E-book

Perception of Healthcare Providers Regarding Hospital Bed Utilization: A prerequisite for quality improvement initiatives in Healthcare institutions



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ABSTRACT. Background: Hospital bed utilization is influenced by various factors which can be divided into patient, physician and administration related. These factors should be seen from the eyes of healthcare providers so that any improvement initiative taken by the administration is matched with the health worker's perception which ultimately affect the hospital efficiency and quality of care.

Aim and Objective: To ascertain the factors influencing hospital bed utilization from the perspective of healthcare providers.

Methods: This cross sectional study was conducted in an apex tertiary care public institution in northern region of India. All the resident doctors and nurses in the 18 wards of 7 specialties and 7 super specialties were interviewed using a structured validated self-administered questionnaire.

Results: A total of 279 participants (117 doctors and 162 nurses) were enrolled in the study. The factors significantly influencing bed utilization with regard to doctors are patients (2.34, 0.36), physician (2.47, 0.32), administrative (2.61, 0.29) and with regard to nurses are patient (1.97, 0.40), physician (1.97, 0.46), administrative (2.39, 0.40).

Conclusion: Changing healthcare trends in the recent past (innovations in policy decisions, technological advances, business sustainability aspect, quality initiatives etc.), gave an insight to policy makers (administrators) to consider the perception of healthcare providers (human resource) regarding bed utilization as an important component of healthcare delivery system.

Keywords: Perception, Healthcare providers, Bed Utilization, Quality of care.

Introduction.

The perception of healthcare providers (doctors, nurses and others) regarding characteristics of healthcare organization and its subsystems can play a vital role in improving

structures, systems and processes of the organization. The first and foremost criterion to improve any healthcare institution is to know how their employees perceived regarding actual performance (of utilization) to desired performance.

Perception of healthcare providers can be considered as mechanism of internal audit, quality improvement initiatives [1]. The term "hospital bed utilization" denotes the manner in which a certain community makes use of its hospital resources. Over utilization or underutilization are two primary components of inappropriate utilization [2]. Over utilization refers to care or use of hospital resources (beds, manpower) which is of no benefit to the patient (such as staying more days after the patient has recovered enough to go home) or care which can be provided at a lower level, less costly healthcare setting [3,4] whereas underutilization refers to the care or the use of hospital resources which is below its expectations.

Inappropriate utilization of hospital resources is not a new phenomenon and has been an issue of concern to medical staff, administrators and policy makers worldwide. The utilization of beds in a hospital is influenced by various factors which can be divided into patient related factors, physician related or administration related. Most of the previous studies [5,6,7,8,9,10,11] attempt to identify the factors associated with inappropriate utilization of hospital beds, Patient-related factors include patient demographic, social, financial status. Physicians and staff related factors include little autonomy of decision-making among resident doctors, fear of law suits, lack of training and job description, heavy duty hours, whereas administrative related factors include lengthy admission and discharge procedure, ineffective HIS, non-uniform admission policy, lack of quality assurance. To know exactly, where to intervene during any policy decision making or quality initiative, one must ascertain these factors from the perspective of healthcare providers. It has been observed that most previous studies were conducted either in developed countries or in the private/corporate hospitals of developing nations, that consider these indicators for their quality improvement programs. The present study was conducted with the objective of ascertaining the perception of healthcare providers regarding hospital bed utilization of a tertiary public sector medical institute of India.

Methods

Study Design: Cross sectional descriptive study

Settings: This study was conducted in a tertiary care medical institution of northern India, an Institute of national importance by the Act of parliament of India. The institute caters to approximately 2 million outpatients and 0.05 million indoor patients every year.

Study period: The study was carried out over a period of 4 months (Feb till May 2012) in various patient care areas of the institute.

Data Collection: All the resident doctors (Senior and Junior residents) of all 7 specialties and 7 super specialties of the non-emergency areas of the institute were enrolled in the study. All the Nursing staff (Deputy nursing superintendent, Assistant Nursing Superintendent, Sister Grade-I and Grade-II) of the respective wards, who were directly involved in direct patient care and in administrative services of the area were also enrolled. A structured questionnaire for healthcare providers was designed and pretested on 15 respondents

(7-Resident doctors, 8-Nurses) of two clinical areas, not a part of the study. The content and consensus validity of the questionnaire was increased by extensive literature search and inviting suggestions by circulating it among experts in the field. Each unit was visited personally by the principal researcher after making due appointments with the study participants. The self-administered questionnaire was distributed to them and the completed questionnaire was collected from them at pre-arranged times. The confidentiality of the data was assured by collecting the completed questionnaires directly in a box.

Ethics approval: Prior Approval was obtained from the Institute ethics committee and the consent for conducting the study was obtained from the participants, after briefing them on the objectives of the study.

Data Analysis: The difference in the perception of doctors and nurses was assessed by stratifying the data into various groups and calculating their percentages and mean scores. The responses were taken on a 3 point scale where 3 (maximum) was for agree, 2 for cannot say and 1 (minimum) for disagree. The mean score value (agree score) between 2 and 3 was considered as strongly agree, between 1 and 2 as agree and between 0 to 1 as disagree. The difference of significance between respondents were calculated by applying chi square and Anova.

The inclusion criteria included resident doctors of all 7 specialties and 7 super specialties in non-emergency areas of the hospital who had been serving the institute for more than 6 months. The emergency areas of the hospital were excluded as health care staff were too busy in managing critically ill patients. The participants who denied consent or refused to participate were also excluded

Results

A total of 279 participants (117 Resident doctors and 162 Nurses) were enrolled in the study. The overall response rate was 93%. The socio demographic profiles of the participants are given in Table-1

More Resident doctors (83%) than Nurses (43.8%) expressed (Table-2) that there is a longer stay of patients in hospital (**p value < .05**). The associated factors like satisfaction of every need, large number of beds, inability of family members to take care of patients and uncooperative attitude of patients were agreeable to a lesser number of respondents (11-43.8%). However, the respondents feel that patient referred with critical condition and age, socioeconomic status were the prime reason for overstay of the patients (65-84.6%). The mean S.D, 95% C.I score of patient-related factors among resident doctors and nurses related to overstay was 2.34 (0.37, 2.29-2.40) and 1.97 (.40, 1.91-2.03) respectively (Table-3). There was a significant difference (**p < 0.05**) in the perception among resident doctors and nurses in patient, physician administrative related factors.

The physician related factors are shown in (Table-2) which depicts that most of the doctors agreed to all the physician related factors (39.3-81.2%) whereas the agreement of nurses varies and was comparatively less (17.9 to 52.5%). The

mean (S.D, 95% CI) of physician related factors among residents and nurses were 2.47 (.33, 2.40-2.53) and 1.97 (.47, 1.89-2.04) respectively (Table-3).

The majority of doctors agreed that the admission and discharge policy of the institute plays a role in bed utilization. Both groups agreed on the administrative factors (66.7-82.9%). The mean scores (S.D, 95% CI) for administrative related factors among doctors and nurses were 2.61 (.29, 2.55-2.66) and 2.39 (.47, 2.32-2.45) respectively (Table-3).

The agreement score of nurses with regard to patient, physician and administrative factors range from 1.97-2.39 with maximum agreement in the administrative factor. Similarly, the agreement score of nurses with regard to patient, physician and administrative factors range from 2.34-2.61 with maximum agreement in the administrative factor.

Discussion

The result of the present study shows that a substantial percentage of healthcare providers perceived that hospital beds are inappropriately utilized. It could be argued that the perception regarding causes of inappropriate utilization of hospital beds would have been different if it had solely been based only on the patients' perception. The justification for our approach was based on the fact that the decision of healthcare providers plays a crucial role in the patient's stay in the hospital and any policy decision of any organization [2,12,13]. In the present study, most of the respondents were in a young age group who will serve the organization for a longer time, hence their perceptions and viewpoints are important for implementation and policy decision of any patient care related activity. More resident doctors in our study perceived that patients are staying longer in the hospital depicting that doctors were more aware of the inefficient hospital bed utilization than nurses. Most of the respondents did not agree that satisfying every need of the patient, the uncooperative attitude of family members and the availability of a large number of the beds are the causes for overstay. These results were in line with the previous research [14,15,16,17,18,19] which reported that the patient or the patient's family can contribute to unnecessary bed utilization by insisting that the physician admit the patient or delay the discharge [20,21]. In addition, although not examined in this study, patient characteristics such as lack of family support, age and lack of health checkup after discharge influence inappropriate hospital utilization [22]. Other studies, however, indicate that the patient and the patient's family are relatively insignificant contributors to inappropriate bed utilization.[23] Most of the respondents in the study perceived public perception of better services, high status of public doctors, reputation of research institution and little autonomy of resident doctors as the causes for overstay. The existing literature also indicates that the overutilization of hospital resources may be influenced by training doctors on the use of hospital resource. The doctors may sometimes practice defensive medicine where they order investigations (e.g. lab tests and x-rays, more procedures) to protect themselves in case of law suits or to satisfy the

patient, thus leading to overstay in a hospital. The present study did not highlight the practice of defensive medicine as a reason for overstay, which can be explained as ignorance of laws among healthcare professionals. It was also observed in the study that resident doctors considered lack of training, clear cut job descriptions in ward management, heavy workloads and long duty hours of doctors as reasons for inappropriate bed utilization, whereas nurses did not perceive it so. It could be explained by the fact that duty hours of the nurses are usually for six hours shifts whereas residents doctors are bound to work beyond the duty hours which leads to stress and affects their performance, thus affecting stay of the patients. Most of the doctors in the study agreed that lack of admission and discharge policy and the lengthy admission and discharge procedures of the hospital influence the hospital stay, nurses response for the same was not so high, but overall response rate advocates strongly about standardizing all admissions and discharges in the hospital. This study also provides an insight to redesign patients' pathways and improve the patient flow system for better hospital bed utilization. Respondents in this study also reported that frequent technical errors, absence of guidelines and procedures, poor health computing systems and the absence of a quality management department were among the important factors influencing the utilization of hospital resources, these findings were in congruence with previous research. This study depicts that the majority of the nurses and doctors perceived that ineffective hospital information systems, absence of standard operating procedures and quality assurance mechanisms in ward management could influence hospital stay. Similar findings were also observed in various studies where it was interpreted that modern healthcare is technology driven and if we use technology it will smoothen various processes and thus improve efficiency of any organization. Among all factors, patient, physician and administrative factors, nurses perceived most of the administrative factors as the causes for overstay and considered them important, while doctors (Residents) perceived all factors equally important with maximum agreement on administrative factors.

Conclusion

With changing healthcare trends in the recent past (innovations in policy decisions, technological advances, business sustainability aspect, quality initiatives etc.) policy makers and administrators consider the perception of healthcare providers (human resource) regarding bed utilization as an important component of the healthcare delivery system.

Furthermore, it is pertinent to mention here that the understanding and intervention of these factors can be used for effective change management or for reengineering today's healthcare institutions and helps health decision makers to optimize the appropriateness of hospital bed utilization and improve the quality of care.

Limitations of the study: This study was conducted in one institution, hence the results cannot be generalized, the results may vary in different set ups. The definition of health-

care providers was only limited to resident doctors and nurses, the range of healthcare providers could be widened by including other staff members (senior doctors, paramedics) of the hospital. This study did not include emergency areas of the institution. The perception of healthcare providers in these areas may differ and could be a topic of further research.

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Conflict of Interest

The authors declared that they have no conflict and any competing interests.

Table 1: Socio-Demographic Profile of the Respondents in the study

Variable	Doctors (n=117)		Nurses (n=162)	
	N	%	N	%
Gender				
Male	76	64.9	56	34.7
Female	41	35.1	106	65.3
Age (in years)				
Less than 25	0	0	57	35
25 – 40	117	100	50	31
More than 40	0	0	55	34
Years of Experience				
Less than 5	91	77	57	35
5 – 15	26	23	50	31
More than 15	0	0	55	34
Area of Work				
Specialty Ward	77	66	106	66.5
Super Specialty Ward	40	34	56	34.5

Table 2: Perception of health care providers regarding various factors affecting hospital bed utilization

Factors	Doctors N (%)	Nurses N (%)	Chi-Square	p value
Patient related				
Satisfaction of every need of patient	52(43.8)	48(29.6)	34.1	0.00
Large number of hospital beds	39(33.3)	28(17.3)	66.9	0.00
Inability of family members to take care	27(23.1)	18(11.1)	22.3	0.00
Patient's uncooperative attitude & Refusal for discharge	63(53.8)	62(38.5)	19.3	0.00
Too Serious to discharge	76(65)	137(84.6)	24.4	0.00
Socio demographic factors of patients	91(77.8)	115(71)	15.4	0.00
Physician related				
Expertise of doctors	79(67.5)	91(56.2)	26.6	0.00
Being research & teaching Institute	70(59.8)	85(52.5)	33.9	0.00
Little autonomy of Junior doctors to discharge patients	86(52.5)	69(42.6)	31.7	0.00
Practice of defensive medicine/fear of law suits under CPA	26(22.2)	29(17.9)	17.8	0.00
Lack of training/clear cut job description	93(79.5)	49(30.2)	85.9	0.00
Long duty hours of doctors	95(81.2)	75(46.3)	54.6	0.00
Administrated related				

Lengthy admission & discharge procedure	71(60.7)	58(35.8)	65.7	0.00
Lack of admission and discharge policy	94(80.3)	54(33.3)	89.71	0.00
Non proficient Hospital information system	80(68.4)	73(45.1)	25.8	0.00
Lack standard operating procedure (SOP) in ward management	77(65.8)	119(73.5)	10.8	0.01
Lack of quality assurance department	69(59)	131(80.9)	24.8	0.00
Hurdles in mode of payment	46(39.3)	78(48.1)	29.6	0.00

Table 3: Perception of Healthcare providers regarding Hospital Bed Utilization in Different Groups viz Patient, Physician, Administrative

Factors	Doctors* (n = 117)		Nurses** (N = 162)	
	Mean score (SD)	95% C.I	Mean score (SD)	95% C.I
Patient	2.34 (.36)	2.27 – 2.40	1.97 (.40)	1.91 – 2.03
Physician	2.47 (.32)	2.40 – 2.53	1.97 (.46)	1.89 – 2.04
Administrative	2.61 (.29)	2.55 – 2.66	2.39 (.40)	2.32 – 2.45

* p value < 0.01, F = 51.43

** p value < 0.01, F = 19.43



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References

1. Anand TR. Hospital Services and Management Methods. Background and reading material for training course on Hospital Management. 1982:6.
2. Backe, B. "Overutilization of antenatal care in Norway."2001:6-9.
3. Black D, Pearson M: Average length of stay, delayed discharge and hospital congestion. *Br Med J* 2002, 325:610–1.
4. Campbell J: Inappropriate admissions: thoughts of patients and referring doctors. *Journal of the Royal Society of Medicine* 2001,94(12):628-631.
5. Celik Y, Celik S, Bulut H, Khan M and Kisa A. Inappropriate use of hospital beds: A case study of university hospitals in Turkey. *World Hosp.*2001; 37(1):6-13.
6. DeCoster C and Roos N. Inappropriate hospital use by patients receiving care for medical conditions: targeting utilization review. *Can Med Assoc J.*1997; 157(7): 889-896.
7. Panis L, Gooskens M, Verheggen F, Pop P and Prins M. Predictors of inappropriate hospital stay: a clinical case study. *Int J Qual Health Care.*2003; 15 (1): 57-65.
8. Payne S. Identifying and managing inappropriate hospital utilization. *Health Serv Res.*1987; 22(5): 709-769.
9. Dempsey J. The appropriateness of admissions and the influences on a decision to admit.*J QualClin Pract.*2000; 20: 95-99.
10. Alche-Gautier, Maiza MJ and Chas tang F. Assessing the appropriateness of hospitalization days in a French university hospital. *Int J Health Care Qual Assur.*2004; 17(2): 87-91. Gertman M and Restuccia J. The appropriateness for assessing unnecessary days of hospital care.*Med Care.*1981; 19(8): 855-870.
11. Gertman M and Restuccia J. The appropriateness for assessing unnecessary days of hospital care.*Med Care.*1981; 19(8): 855-870.
12. Bener, A.,Sankaran-Kutty, M.,Achan, N.,Abo-Azab, I.,Chandran, P.,Glasgow, N. and Norman, J. (1998). "Over utilization of the accident-emergency and X-ray departments in Al-Ain Hospital, United Arab Emirates." *Emirates Medical Journal* 16(1): 33-37.
13. Maria Kelly et al.: Factors predicting hospital length-of-stay and readmission after colorectal resection: a population-based study of elective and emergency admissions. *BMC Health Services Research* 2012 ,12:77.
14. Anson, O.,Carmel, S. and Levin, M. (1991). "Gender differences in the utilization of emergency department services." *Women and Health* 17(2): 91-104.
15. Cheng, C. and Chiang, T. (1998). "Disparity of medical care utilization among different health insurance schemes in Taiwan." *Social Science and Medicine* 47(5): 613-620.
16. Harmon, C. and Nolan, B. (2001). "Health insurance and health services utilization in Ireland." *Health Economics* 10(135-145): 135-145.
17. Alonso Ma ,Anto JM . The Appropriateness Evaluation Protocol Group of the Hospital Universitari del Mar using length of stay and inactive days in the hospital to assess appropriateness of utilization in Barcelona,Spain. *J Epidemiol Community Health.* 1996;50:196-201.
18. NZHTA (1998). "Acute medical admissions: A critical appraisal of the literature." *The New Zealand Health Technology Assessment, (Report No. 6):* 1-173.
19. Moffitt BL, Butler M: Changing a medical unit culture. *Clin Nurse Specialist J AdvNursPract*2009, 23:187–191.
20. Strumwasser I, Paranjpe N, Ronis D, Share D and Sell L. Reliability and validity of utilization review criteria. *Med Care.* 1990;28(2): 95-111.
21. McDonagh MS, Smith DH, Goddard M: Measuring appropriate use of acutebeds.A systematic review of methods and results. *Health Policy* 2000, 53:157–84.
22. Fernandez-OlanoC, Hidalgo J, Cerda-Diaz R, Requena-Gallego M, Sanchez-Castano C, Urbistondo-Cascales L and Otero-Puime A. Factors associated with health care utilization by the elderly in a public health care system. *Health Policy.*2005; 72(2):131-139.

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ABSTRACT: Service Excellence Training is an important continuing priority in Lorma Medical Center. Its design and contents are modified as needed to respond to patients' comments on the quality of service by Lorma staff. Noted inadequacies in customer satisfaction were bared in the Patient Surveys of Lorma in 2013. Floating of Satisfaction Assessments is done monthly by the Patient Relations Officer and summaries of the same are submitted by the Executive Secretary to the Department Heads concerned for immediate action, monitoring and reporting on improvements made. The premise is that process improvements should be based on data (1).

Behavioral components of the patient surveys subsequently improved a year after implementation. The Smile Survey, a new tool designed to gauge outcomes of the new program, also revealed affirmative results.

INTRODUCTION. Now a 200-bed hospital, Lorma's vision and mission remained Service Excellence since 82 years ago. Its founders, Dr. Rufino Macagba, Sr. and Dra. Crispina Lorenzana Macagba instilled personalized patient care starting in Lorma's early years, when Dra. Crispina would ask patients what they wanted for dinner and have it served. Over the years, Service Excellence was transformed in improvements and new practices were introduced. A famous original is the Lorma Smile, where every worker considers it a duty to smile when talking to patients, relatives and fellow workers and give a friendly greeting to everyone a worker meets in the hospital. This practice soon became a culture. Despite this, constant efforts to improve the quality of service are needed since patients and clients from diverse social backgrounds have higher expectations and because of changes in healthcare landscapes (2). Reaching this goal of elevating patient care entailed a set of undertakings heading to the program on Service Excellence where the first ground rule is high employee engagement (3).

METHOD

When people are treated with respect and given the right tools to connect with customers, amazing things happen (4). Taking

this as a stand, Lorma's president and chairman of the board would constantly remind employees of the three core values of Lorma: 1) putting God first in all its activities and decisions, 2) respect for people including employees and 3) continuous innovation (5).

On these values, the heart of Lorma's brand evolved, creating a human resource faithful in upholding these principles and take responsibility to be guided by them (6).

Focus on a distinct image and set behaviors to give patients a pleasant stay and aid in recovery and healing was identified as a major program for manpower development (7). It is people who serve and complete the delivery of healthcare services.

The Human Resource Team with the guidance of the president and the hospital administrator met on several occasions to draw-out the concept of behavioral standards in Lorma. Conferences were focused on how to align behaviors and attitudes to the institution's vision, mission and quality policy such that a set of shared-values were identified as the focal point of a series of training sessions now known as the Service Excellence Program. As Liker and Franz put it, "managers in excellent companies valued customers and had a passion for innovation." (8)

Several modules for the programs were identified: **Values**

Formation - to emulate character models set as standards by Lorma; **The Basics of Service Excellence** – that imparted welcoming actions and statements and that discussed the importance of customer service (9). **Teamwork: Ways to Improve How We Work Together** – discussed synergy as an effective tool for getting things done in an organization, it also encourages commitment and clarifies individual roles and how they relate to company goals. Harmonious interpersonal relationships among all staff as crucial to Lorma’s patient-centered culture were also discussed in the training.

Included in the series is a session on **How to Handle Difficult People** – training that teaches techniques for handling difficult situations; **Managing Stress** that emphasizes how employees could have quality life; **Time Management** for employee productivity and efficiency and **Personality Development** to give employees confidence in the workplace by projecting a professional image. **Ensuring Patient Satisfaction** is another training that emphasizes the winning traits employees should have.

Results were monitored through the different surveys (10).

The Training and Chaplaincy Office, with the guidance of the president and the executive vice president, has shown commitment on Service Excellence by the diligent implementation of the program since inception shown in Graph 1, presenting organizational attainment of Service Excellence.



DISCUSSION

High employee engagement is a requisite of Service Excellence, for when employees are satisfied, they take positive action to further the good reputation and goals of their employers.

The internal focus on developing exceptional people became an aspiration in 2013 to improve customer satisfaction found to be deficient. The thrust is to make employees content in their jobs to be fully productive (11). The Job Satisfaction Survey is an essential data gathering tool used yearly for organizational improvement.

Employee engagement is also tested through the annual performance reviews for regular employees and new hire performance reviews on their 5th and 12th month. So designed,

the appraisal system’s aim is to determine help needed by new employees to practice service standards. Depending on how the staff performed, an increase in compensation is given (12). This review is an integral part of substantiating training effectiveness aside from rewarding employee performance.

Benefits are a special component of the Service Excellence Program. When employees are highly motivated, high productivity follows. Employees cannot give what they do not have (13). Lorma employees enjoy annual check-ups, hospitalization benefits, profit sharing yearly, loyalty awards and scholarships for dependents.

Rest and recreation activities provide for quality of life (14). Lorma also enjoins its interested staff to join its Corporate Social Responsibility Programs to satisfy calling to do civic works.

A hospital chaplain conducts departmental devotions and non-sectarian hospital-wide devotions for the spiritual uplift of employees. The chaplain also holds counseling sessions for employees who need the service (15).

For Lorma, unless management creates the right conditions for employees to make their greatest contributions, management cannot expect the best from them.

Table 1. Constant Uptrend in Job Satisfaction

Predictors	Organization	Incentives	Opportunities	Work	Environment	LORMA GWA	
2013	WM	3.85	3.58	3.85	4.06	3.80	3.83
	Interpretation	Strongly Agree	Strongly Agree	Strongly Agree	Strongly Agree	Strongly Agree	Strongly Agree
2014	WM	4.02	3.68	3.92	4.22	3.94	3.96
	Interpretation	Strongly Agree	Strongly Agree	Strongly Agree	Very Strongly Agree	Strongly Agree	Strongly Agree
2015	WM	3.99	3.71	4.07	4.17	3.97	3.98
	Interpretation	Strongly Agree	Strongly Agree	Strongly Agree	Strongly Agree	Strongly Agree	Strongly Agree

CONCLUSION

Evidenced-based enrollment data for the programs reflect a well-participated organizational learning activity. Participation is mixed and attended by all levels; rank and file, middle managers and staff physicians.

Employee-confidence, an off shoot of all training activity, boosted staff morale. Lectures and workshops completed staff awareness of excellent customer service. Helping participants unlock the potential of individuals and teams were emphasized during the sessions. Clarity of organizational focus was highlighted and related to staff roles and job descriptions (16).

Ultimately, improved patient-experience is the strongest parameter to measure program impact. The post-evaluation tool--the Smile Survey--was deployed to ascertain project outcomes.

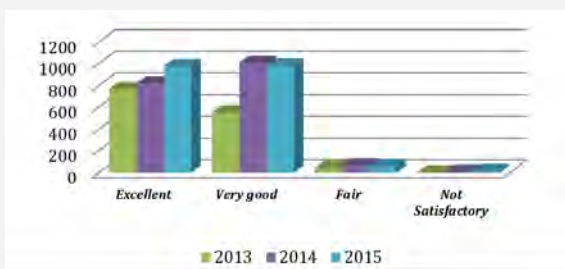
All departments interfacing with patients are evaluated; presented data in Table 2 indicate an increasing general average in patient satisfaction.

Table 2. Results of the Smile Surveys

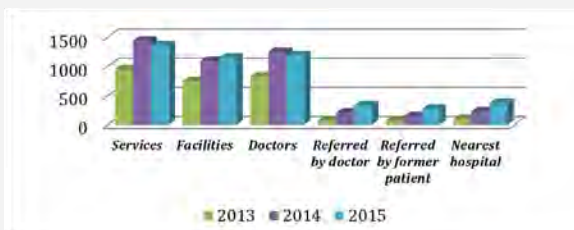
General Averages of the Smile Survey	
YEAR	AVERAGE
2013	87.77%
2014	91.37%
2015	95.76%

A nurturing culture and the approach by which the advocacy is realized is what constitutes the Service Excellence Program, producing an atmosphere conducive to healing in Lorma. Lorma continues to reinforce the general maxim “Patients as First and Foremost” by maintaining a Patients Relations Officer who takes care of the special needs of patients, and a greeter who stands by the main lobby to welcome each person entering Lorma (17). This distinction on Service Excellence is reflected in the general impression patients have of Lorma on Graph 2 and Graph 3.

GRAPH 2. 2013-2015 PATIENT SATISFACTION - OVERALL IMPRESSION OF LORMA



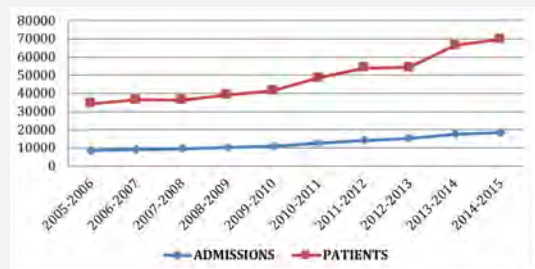
GRAPH 3. 2013-2015 PATIENT SATISFACTION - WHAT PATIENTS MOST LIKE ABOUT LORMA



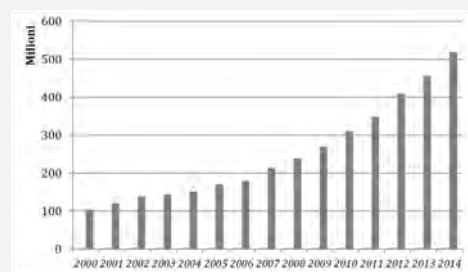
Make employees want what you want them to do through training, leads to good business outcomes as seen in Graphs 4 and Graphs 5.

Hospital staff are discouraged from saying “no” to patients and families as long as requests are not impossible to provide. This promotes the spirit of satisfying human nature’s desire to feel important, that Lorma steadfastly aspires to have (18). Many hospitals all over the world and in the big cities in the country may have more advanced equipment and capabilities, while on the contrary, others may fall short compared to Lorma. Still, Lorma wants to maintain a stellar defining distinction on Service Excellence and continuously improve on it.

GRAPH 4. 10-YEAR TREND OF PATIENTS AND ADMISSIONS



GRAPH 5. ANNUAL REVENUE



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References

1. Wiley, John & Sons, Inc. 2008. **Results that Lasts**. New Jersey: John Wiley & Sons
2. Kinni, Theodore, 2011. **Be Our Guest**. New York: Disney Editions
3. **Advocate Good Samaritan Hospital. 2010**. Malcolm Baldrige National Quality Award 3815 Highland Ave. Drowners Grove, IL 60515
4. Eliason, Frank. 2012. **@Your Service**. New Jersey: John Wiley & Sons, Inc.,
5. Graban, Mark. 2012. **Lean Hospitals**. 2nd ed. 6000 Broken Sound Parkway NW, Suite 300 Boca Raton, FL 33487-2742
6. Collins, Ji, 2011. **Good to Great**. 10 East 53rd Street, New York, NY 10022. HarperCollins Publishers Inc.
7. Bossidy, Larry and Charan, Ram. 2002. **Execution the Discipline of Getting Things Done**. New York: Crown Business
8. Liker, Jeffrey K., Franz, James K. 2011. **Toyota Way to Continuous Improvement**. United States of America: The McGraw-Hill Companies, Inc.
9. Lencioni, Patrick. 2005. **The Baptist Health Care Journey to Excellence**. New Jersey: John Wiley & Son, Inc.
10. Scherkenback, William W. 1991. **Deming's Road to Continual Improvement**. SPC Press Inc. 5908 Toole Drive, Suite C Knoxville, Tennessee 37919.
11. Kaory, Ishikawa, 1985. **What is Total Quality Control? The Japanese Way**. David J. Lu.
12. Hall, Bradley W. 2008. **The New Human Capital Strategy: Improving the Value of Your Most Important Investment – Year after Year**.
13. Pascale, Richard T., Athos, Anthony G., 1982. **The Art of Japanese Management**.
14. Weil, Andrew. 1995. **Spontaneous Healing**
15. Lawson, Douglas M.1999. **More Give to Live, How Giving Can Change Your Life**. ALTI Publishing
16. Drucker, Peter F. 2008. **The Essential Drucker**. Collins Business Essentials paperback ed. HarperCollins Publisher, 10 East 53rd Street, New York, NY 10022
17. Covey, Stephen R. 2006. **The 8th Habit Personal Workbook**. New York: Simon & Schuster, Inc.
18. Carnegie, Dale. 1981. **How to Win Friends & Influence People – The Big Secret of Dealing with People**. New York: Simon & Schuster, Inc.

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Pre-operative Verification, Site Marking and Time Out - Spreading Patient Safety Culture from Major Operating Theatre to Day Surgery



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ABSTRACT: In this article, we describe how we spread safety culture of correct site surgery from Major Operating Theatre to Day Surgery. We discuss how we integrated the High 5s Project Correct Site Surgery protocol into the Day Surgery Operating Theatre (DSOT) workflow and monitored compliance through audit and feedback. We also reflect on how human factors analysis (HFACS) helps in bridging the gaps by providing a tool for recognizing possible causes of non-compliance.

Background: The High 5s Project, established by World Health Organization (WHO), in 2007, is an international collaboration carried out in seven countries – Australia, Germany, France, the Netherlands, Singapore, Trinidad & Tobago and the United States of America – and coordinated by the WHO Collaborating Centre on Patient Safety, The Joint Commission. Its mission is to facilitate implementation and evaluation of standardized patient safety solutions within a global learning community, to achieve measurable, significant and sustainable reductions in high-risk patient safety problems.

Introduction. Wrong site surgery (WSS) is an infrequent but potentially catastrophic event and is classified as "Sentinel Event". Nwosu¹ reported that wrong site surgery is more of a system lapse than individual failure, and proposed having a structured systems approach through institutionalization of patient safety protocols to prevent such adverse outcome. Fraser and Adams² also suggested that one way to reduce WSS is to have a consistent and robust protocol that is universally followed.

KK Women's and Children's Hospital (KKH) has implemented High 5s Project Correct Site Surgery (CSS) protocol in the Major Operating Theatre (MOT) from 2011 with success³. This was in collaboration with the Singapore Ministry of Health (MOH), KKH High 5s team and MOT team with full support from senior management. The protocol recommends three minimum requirements for preventing wrong site

surgery namely: pre-operative verification, site marking, and time-out, which were successfully implemented and complied with in MOT.

One of the goals of the High 5s team is to spread this patient safety culture from MOT to relevant clinical areas. Spread is defined by the Clinical Excellence Commission (CEC) as actively disseminating best practice and knowledge, and implementing each intervention in every available care setting⁴. The team had planned to spread improvement to areas that perform invasive procedures. In selecting which area to start with, the team considered the area that is in synergy with MOT setting, the Day Surgery Operating Theatre (DSOT).

Objective

To spread the culture of patient safety from Major Operating The-

atre to Day Surgery and evaluate spread of the culture and the compliance rate for complete pre-operative verification, site marking and complete time-out in Day Surgery.

Methodology

There are a number of tools for facilitating a project's spread and sustainability listed by CEC. The tool that we have found applicable to our project is the Spread and Sustainability Wheel/ The New Improvement Wheel, from the NHS Institute of Innovation and Improvement (UK).⁴ The wheel describes the main factors that contribute to the successful spread and sustainability of service improvement.⁴ The factors are Ownership of initiative, Effective relationships, People who influence, Leadership, Dedicated resources, Process of implementation, Incentives, Integration into practice, Evidence of improvements, Readiness for improvement, Nature of initiative, Local context, Support at senior level and Staff engagement. The presence of all factors indicates the potential for the spread to be strong, while their absence weakens that potential by varying degrees.⁷

The spread was assessed in each factor. The compliance rate was also measured for Pre-operative Verification, Site Marking and Time Out over a two-year period from January 2013 to January 2015. Human Factors Analysis and Classification System (HFACS) (Table 1) was applied to analyze the causes behind non-compliance.

Results

Of the 14 factors described in the New Improvement Wheel, the following have helped in spreading patient safety culture of correct site surgery from Major Operating Theatre to Day Surgery:

1. **Ownership of initiative:** DSOT leaders took the initiative to adopt the protocol. In line with the institution's aim of prioritizing patient safety and standardization, the spread of High 5s project from MOT to DSOT started when DSOT leaders took the initiative to integrate the protocol into the workflow in mid-2011.
2. **Effective relationships:** The High 5s team is a multidisciplinary team composed of surgeons, nurses, administrators and project coordinator. Having a common goal of enhancing patient safety, the team has developed an effective relationship with the MOT team as well as the DSOT team.
3. **People who influence:** Existence of influencers at all levels and in all staff group. The main influencer is our Clinical Quality Director who leads the team and encourages strict compliance to the protocol.
4. **Leadership:** There must be credible leadership to steer, focus and maintain momentum. MOT nursing leaders who were more familiar with the protocol guided and directed the DSOT staff during integration and implementation stage.
5. **Process of implementation:** DSOT initiated integration of protocol from mid-2011; this included the use of the MOT checklist. Training sessions and talks were conducted for the staff to familiarize with the protocol.
6. **Integration into practice:** The High 5s Correct Site Surgery protocol was integrated into practice. Pre-operative verification and time-out became more comprehensive as it included more elements to be checked; surgical site marking was implemented in a stricter manner.

7. **Evidence of improvements:** Monthly audit and feedback and reporting compliance rates to the stakeholders.

In January 2013, the High 5s team performed a preliminary real-time observation survey at DSOT to assess the practice. It was verified that implementation of the CSS protocol was successfully integrated into the DSOT workflow, in that the checklist was being used, surgical site was being marked as needed and time-out was being conducted on all cases.

Documentation audit was done from January 2013 through January 2015 in a randomized retrospective approach. A total of 750 cases have been audited with each speciality represented. Documentation audit (Figure 1) showed average compliance rates of 97% and 100% for site marking and complete time-out, respectively. The average rate for complete pre-operative verification was 92%, with rates ranging from 77% to 100%. The aim was to achieve 100% rates for all three elements.

Interventions were done which include: revision of checklist whereby the site marking section layout was simplified (Figure 2), reinforcement of protocol through sharing of audit findings, and group discussions emphasizing the importance of good practice and accurate documentation. This consequently improved the compliance rates for all three elements to 100% in November 2014.

8. **Nature of initiative:** The project is compatible with the institution's priority of enhancing patient safety and gearing toward standardization.
9. **Local context:** It is our institution's vision to be the best healthcare leader for women and children and we aim for zero patient harm; hence spread successful patient safety practice from one area to another.
10. **Support at senior level:** There was full support from senior management.
11. **Staff engagement:** Staff was empowered to implement the protocol. Data analysis was done and feedback was provided to the DSOT team.

Human Factors Analysis and Classification System (HFACS) (Table 1) was applied to analyze the causes behind non-compliance. Skill-based error under unsafe acts level was identified. There were checklist error by nurses and missed documentation by doctors. Perceptual error was also identified for some new trainee doctors that did not complete documentation, as they were unfamiliar with the protocol and the checklist itself.

As for the preconditions for unsafe acts level, the physical environment was busy with high patient turn-over rate during the months with lower compliance rates for complete pre-operative verification. The increase in number of cases had a great impact on workload. For the technological environment, the checklist layout was found to be confusing especially to the new doctors, hence incomplete documentation.

Discussion & Lessons Learnt

The 11 factors contributed to the spread of improvement and patient safety culture from MOT to DSOT. The protocol, requiring the three elements - pre-operative verification, site marking and time-out - to be implemented, was successfully integrated into the workflow and compliance was monitored consistently.

We concur with Clarke et al⁵ who had reported that pre-operative verification is the most effective of the three elements. The average

compliance rate for complete pre-operative verification was 92%, with rates fluctuating from 77% to 100%. HFACS was used to identify the cause for non-compliance to complete pre-operative verification.

HFACS looks at four levels of active errors and latent failures, including unsafe acts, preconditions for unsafe acts, unsafe supervision, and organizational influences. It is a comprehensive human error framework, defining 19 causal categories within four levels of human failure.⁷ In our case, HFACS has helped in bridging the gaps by providing a tool for recognizing the possible causes of non-compliance. It revealed that a part of the checklist, the site marking section, was almost always being missed out. Hence, this was improved.

The goal of HFACS is not to attribute blame, but rather to understand the underlying causal factors that lead to non-compliance. By using the HFACS framework for investigation, we were able to identify

the breakdowns within the entire system that allowed an incident to occur. This allowed us to identify weak areas and implement targeted, data-driven interventions that will ultimately reduce errors.⁸

We agree with Kliger⁶ that there is no one solution to guarantee that the benefits achieved by quality improvement initiatives will sustain. To make success last, culture modification is a significant factor. And this is what we have inculcated with our staff. Achieving and continuing improvements can appear overwhelming at the start, as implementation is often challenging. Sustaining quality improvement requires adherence to the protocol, continuing measurement, and relentless vigilance, even after the goal has been achieved.⁶ Slaghuys reported that effective spread is (i) the extent to which the knowledge, skills and materials for a changed work practice are available and used beyond the pilot site and (ii) the extent to which results are known and obtained beyond the pilot site.⁹

Tables and Figures

FIGURE 1: HIGH 5s DOCUMENTATION AUDIT RESULTS FROM JANUARY 2013 TO JANUARY 2015

This graph shows average compliance rates of 97% and 100% for site marking and complete timeout, respectively; while 92% for complete pre-operative verification with rates ranging from 77% to 100%. Remarkable improvement is noted from November 2014 to January 2015 whereby all three elements have achieved 100% compliance.

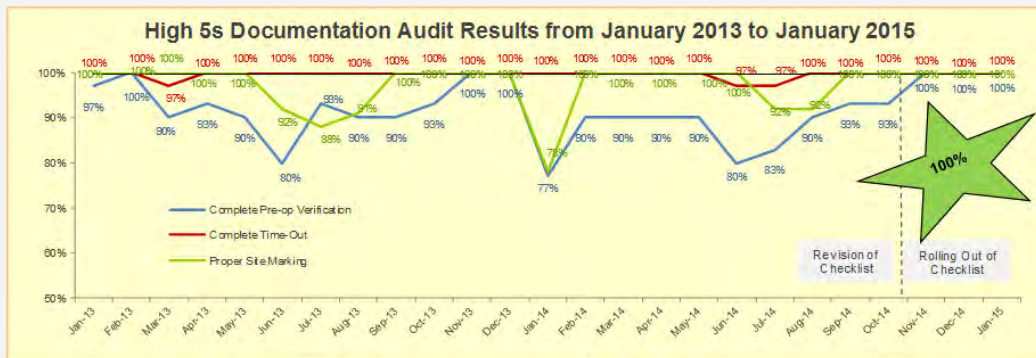


FIGURE 2: REVISED CHECKLIST: SITE-MARKING SECTION SIMPLIFIED

TABLE 1: HUMAN FACTORS ANALYSIS FOR DAY SURGERY INCOMPLETE PRE-OPERATIVE VERIFICATION

HFACS Level	Causal Category	Causal Factor	Description
Unsafe Acts	Errors	Skill-Based Error	Checklist error by nurse
	Errors	Perceptual Error	New doctors, unfamiliar with the protocol, did not fill out a part of the checklist
Preconditions for Unsafe Acts	Environmental Factors	Physical Environment	High patient turn-over rate during peak months
		Technological Environment	Checklist - site marking section was confusing
	Condition of Operators	Adverse Mental State	Stress
	Condition of Operators	Adverse Physiological State	Physical fatigue
Personnel Factors	Crew Resource Management	Poor communication	issue between team members

Conclusion

The culture of patient safety had spread into the DSOT as evidenced by full compliance of the protocol. Good communication and closer collaboration between doctors, nurses and other DSOT staff is a key factor in adopting the culture. Human factors analysis has helped in bridging the gaps by providing a tool for recognizing the possible causes of non-compliance. This has led to developing data-driven intervention strategies such as checklist simplification to improve compliance. The safety of our patients has been enhanced.

Future Plans

The team plans to continue monitoring compliance and attain sustainability at Day Surgery, and further spread patient safety culture to other areas performing invasive procedures.

AUTOBIOGRAPHY

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References

1. Nwosu Arinze. The horror of wrong-site surgery continues: report of two cases in a regional trauma centre in Nigeria. *Patient Safety in Surgery* 2015;9:6
2. Fraser SG, Adams W. Wrong site surgery. *Br J Ophthalmol* 2006;90:814-816
3. Dayuta JC, Ong LT, Pang NL, Chia SN, Tan KK, Gomez JM, Tan KH. Process reengineering of preoperative verification, site marking and time-out for patient safety. *World Hosp Health Serv.* 2013;49(2):4-9.
4. Clinical Excellence Commission (CEC), Enhancing Project Spread and Sustainability – A Companion to the 'Easy Guide to Clinical Practice Improvement'. Sydney: CEC
5. Clarke JR, Johnston J, Blanco M, Martindell DP. Wrong – site Surgery: Can we prevent it? *Adv Surg.* 2008;42:13-31
6. Sustaining and Spreading Quality Improvement. By the Innovations Exchange Team, based on a conversation with Julie Kliger, MPA, BSN, Director, Integrated Nurse Leadership Program, University of California San Francisco
7. <http://www.qualitasconsortium.com/index.cfm/reference-material/service-transformation/the-new-improvement-wheel/>
8. <http://hfacs.com/hfacs-framework.html>
9. Slaghuys SS, Strating MMH, Bal RA, and Nieboer AP. A measurement instrument for spread of quality improvement in healthcare. *International Journal for Quality in Health Care* 2013; Volume 25, Number 2: pp. 125–131

National University Health System (NUHS) Transitional Care Program



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ABSTRACT: Frail elderly patients require a longer time to recuperate after hospitalization, and are often discharged home from the hospital with little support despite their needs for complex care. They are particularly vulnerable to hazards of hospitalization and fragmented care if not appropriately managed.

A geriatrician-led transitional care program called NUH-to-Home (NUH2H) was started in March 2014 to provide high-quality person-centered interdisciplinary care for older adults who were discharged from the National University Hospital (NUH) Singapore. It aims to enhance the quality and safety of post-discharge care at home, leading to an eventual reduction in readmissions and prolonged hospital stay.

In the first year of implementation, there was a 67%, 68% and 75% reduction in readmissions, emergency room visits and length of hospital stay respectively.

Introduction. The Changing Healthcare Needs of an Aging Population

Populations around the world are aging due to declining fertility rates and rising life expectancy.¹ Based on the Singapore Committee on Aging Issues Report in 2006, Singapore has one of the fastest aging populations in the world. By 2030, one in five Singaporeans will be aged 65 and above.

As the population ages, healthcare providers will inevitably see more elderly patients in their practices. Therefore, while we have achieved excellent healthcare outcomes in acute

hospital care in Singapore over the past decades, there is now a need to transform the way care is delivered to our seniors, in anticipation of growing healthcare demands of the elderly population.

Elderly patients who present acutely to hospitals are usually vulnerable and frail with multimorbidity. It is well known that hospitalized elderly patients are at risk of complications unrelated to the initial admitting diagnosis such as functional decline, falls, delirium and nosocomial infections², lengthening their hospital stay. Approximately 35% of elderly will

experience functional decline during hospitalization and the risk is greater in those aged 80 and above and they tend not to recover from their functional loss of activities of daily living (ADL).³

Unlike their younger and fitter counterparts, frail elderly patients require a longer time to recuperate after a hospitalization episode as they are very vulnerable to hazards of hospitalization and are at high risk of readmission without proper transitional care.

As a result, the costs to the patient as well as the society as a whole will increase from the frequent hospital admissions, longer length of stay, high bed occupancy rates and longer waiting times for inpatient beds.⁴ This does not include the caregiver stress and work productivity lost for their family members. Besides having to cope with changes in functional needs on discharge, there are other problems like medication errors and fragmentation of post-discharge care plans, which can result in poor transition to the home⁵ and contribute to readmissions of nearly 20% of patients within 30 days of discharge.⁶

Hence, providing adequate and targeted transitional care to those most in need can have an overall positive impact on patients' care as well as a reduction in healthcare cost.

Transitional care, in this case, is a broad term used for care interventions which facilitate the safe and timely transfer of patients across care settings, like from the hospital to the home.⁷ The interventions include communication between different inpatient care providers about discharge assessment and care plans, patient and caregiver education on self-management, reconciliation of medications, and the formulating of a long-term follow-up plan.⁸ Interventions such as follow-ups via phone calls or home visits, in support of the patients and their caregivers, during the early post-discharge period can result in fewer readmissions.^{9,10}

A Singapore nation-wide Aged Care Transition (ACTION) program had shown a reduction in unplanned readmissions and emergency department visits for older adults hospitalized with complex care needs and limited social support.¹¹ This led to the setup of a multidisciplinary transitional care program called NUH to Home (NUH2H) at the National University Hospital (NUH) Singapore.

This article provides an outline of the program and its impact on patients' outcome.

NUH2H – A Transitional Care Program

In March 2014, NUH2H, a geriatrician-led transitional care program, was started at NUH Singapore to provide high-quality person-centered interdisciplinary care service for older adults with complex care needs. Majority of our clients are frail and home bound due to their limited mobility status and ongoing medical needs

The main aim of NUH2H is to optimize the positive outcomes for our discharged elderly as well as to improve their functional status and facilitate recovery from their acute illness. We also provide end of life care support for those who are frail with limited life expectancy or suffering from terminal diseases, together with our community partners like home

healthcare team and home hospice.

One of the key features of NUH2H is that it consists of multidisciplinary team members including doctors, nurses and allied health professionals to support post hospital care over a period of time until they are stable. At the same time, community based partners like the General Practitioners (GP) and home based healthcare providers are kept in the loop on the progress of these patients who will eventually take over the care.

In the first year of service, NUH2H served a total of 260 patients.

The Core Project team comprises of a Geriatrician, an Advanced Practice Nurse and 5 registered nurses, supported by hospital based allied health professionals who meet weekly to discuss care plans of all the patients under NUH2H. The registered nurses are all equipped with geriatric competencies to manage a variety of common problem seen in the elderly patients. The nurses will conduct home visits and telephone calls post discharge to ensure patients care needs are met. Caregivers are also given a hotline to call the nurses in the event of an emergency or queries regarding patient care.

The Medical and Nursing team focus primarily on patient care delivery with clear protocols and criteria for patient recruitment, care planning and discharge pathway to the community. NUH2H team also works hand in hand with our community healthcare partners including the home medical service, nursing and allied health teams to optimize support for our patients in the community.

The Multidisciplinary Approach

Our multidisciplinary team approach look at patient care from a biopsychosocial aspect, delivering tailored care suited to their condition. Some of the common problems faced by these elderly include polypharmacy, multiple outpatient specialists' appointment, caregiver stress and end of life issues.

Polypharmacy in elderly patients is known to have adverse consequences, including falls and delirium.^{12, 13} All patient medication regimens are reviewed during the weekly multidisciplinary meeting. We aim to reduce the overall pill burden and hopefully minimize potential medication related complications. This also directly reduce healthcare cost for the patients. In some instances where the medication issue is too complex, the pharmacist would also make a home visit and assist in medication reconciliation.

Outpatient specialists' appointments are also consolidated during these meetings to minimize unnecessary visits to the hospital. The majority of these patients will eventually have a community healthcare provider taking over care in view of their poor mobility status and multimorbidity and the goals of care is communicated to the community healthcare provider.

While the medical and nursing needs are being sorted out, caregivers are given equal attention to ensure they are coping well in their caregiving duties. We reinforce their competencies and empower them to flag up any problems they or the patient might be experiencing. If necessary, home help services are put in place to ease their burden to prevent caregiver burnout. Our effort in this is seen clearly in our patient

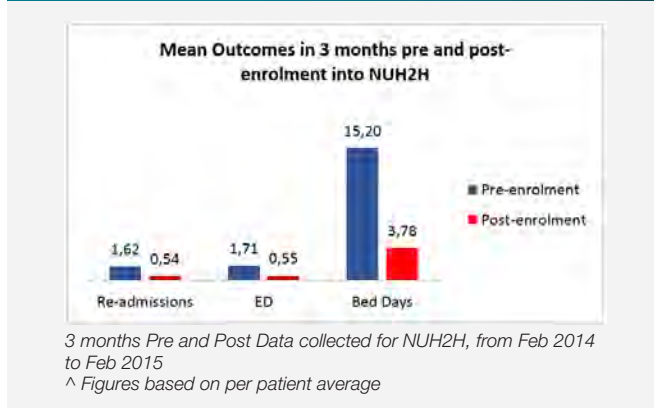
satisfaction feedback (Figure 2) where majority of the caregivers rank us highly.

Last but not least is the topic of end of life discussion which is frequently avoided by not just healthcare personnel but family members too as this can be a very sensitive matter in our Asian culture. However, ongoing communication enabled trust building with patients and family throughout the transitional care period and they were able to open up to us on their preferred end of life journey, allowing us to have an Advanced Care Plan (ACP) drawn up for them to respect their last wishes. Almost all of these frail elderly preferred to receive care at home towards the end of life and our data showed that 63% of those who passed away while under our NUH2H care were able to do so at home instead of hospital; which is a reversal of national trend in Singapore whereby the norm is to have death occur in hospital (61%) versus home (27%).¹⁴

Key Program Outcome

Figure 1 shows the key outcomes achieved by NUH2H over the first year of implementation. There is a 67% and 68% reduction in hospital readmission and emergency department visits respectively. In addition, the length of stay in hospital per patient decreased by 75%. This has translated to an estimated savings of \$4.26 million Singapore Dollars (SGD) over the past one year for the hospital. We were able to achieve this outstanding outcome by targeting the high acute hospital utilizer who tends to be a frail and vulnerable elder with complex medical problems.

FIGURE 1: NUH2H OUTCOME CHART



Patient Satisfaction

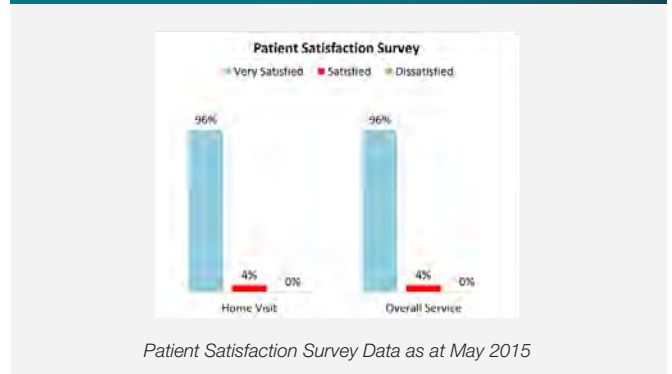
96% of patients also indicated (Figure 2) that they were "Extremely or Very Satisfied" with the home visit provided by the transitional care nurses.

Many felt that their care transitions were well-coordinated, as patients who require community support services were referred and transited smoothly, thus relieving their caregivers' stress.

Caregivers also felt that the education given by the transitional care nurses were very helpful. The nurses were able to take their time and explain the effects and side effects of the medications to them, as well as teaching them on how to

prevent certain complications from their medical conditions.

FIGURE 2: PATIENT SATISFACTION SURVEY



Conclusion

In the past, when there was no adequate transitional care service, the only avenue available for elderly patients would be to present themselves to the emergency department once they encountered a problem. Sometimes these problems stemmed from minor complaints that could be sorted out by consulting with a transitional care team. Personalized assistance is essentially a phone call away from at the comfort of their own home.

NUH2H is an ideal care model for frail older adults who are high users of healthcare resources and are at high risk of re-admission. It provides a targeted multi-pronged value-based interventions which allows them to be treated in the comfort of their own home which in turn can facilitate early recovery and will improve patient experience.

AUTOBIOGRAPHY OF AUTHORS

Dr Ng Shu Ee graduated from the University of Melbourne and obtained her postgraduate qualification from the Royal College of Physicians United Kingdom in 2010. She is a Geriatrician and Transitional Care Program Director for National University Health System Singapore.

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References

1. Uhlenberg P. Demography is not destiny: The challenges and opportunities of global population aging. *Generations*. 2013; 37(1):12–18.
2. Creditor MC. Hazards of hospitalisation of the elderly. *Ann Intern Med* 1993; 118:219.
3. Covinsky, K. E., Palmer, R. M., Fortinsky, R. H., Counsell, S. R., Stewart, A. L., Kresevic, D., Burant, C. J. and Landefeld, C. S. Loss of Independence in Activities of Daily Living in Older Adults Hospitalized with Medical Illnesses: Increased Vulnerability with Age. *J Am Geriatr Soc*. 2003, 51: 451–458.
4. Jencks SF, Williams MV, Coleman EA et al. Rehospitalizations among patients in the Medicare fee-for-service program. *N Engl J Med* 2009; 360:1418-1428.
5. Coleman EA. Falling through the cracks: challenges and opportunities for improving transitional care for persons with continuous complex care needs. *J Am Geriatr Soc*. 2003 Apr; 51(4):549-55.
6. Jencks SF, Williams MV, Coleman EA et al. Rehospitalizations among patients in the Medicare fee-for-service program. *N Engl J Med*. 2009 Apr 2; 360(14):1418-28.
7. Naylor M, Keating SA et al. Transitional care. *J Soc Work Educ*. 2008; 44(Supplement):65–73.
8. Coleman EA, Boulton C et al. Position Statement of the American Geriatrics Society Health Care Systems Committee. Improving the quality of transitional care for persons with complex care needs. *J Am Geriatr Soc* 2003; 51:556–557.
9. Coleman EA, Parry C, Chalmers S, Min SJ et al. The care transitions intervention: results of a randomized controlled trial. *Arch Intern Med*. 2006 Sep 25; 166(17):1822-8.
10. Harrison PL, Hara PA, Pope JE, Young MC, Rula EY et al. The impact of post discharge telephonic follow-up on hospital readmissions. *Popul Health Manag*. 2011 Feb; 14(1):27-32.
11. Wee SL, Loke CK, Liang C, Ganesan G, Wong LM, Cheah J. Effectiveness of a national transitional care program in reducing acute care use. *J Am Geriatr Soc*. 2014 Apr; 62(4):747-53.
12. Richardson K, Bennett K, Kenny RA. Polypharmacy including falls risk-increasing medications and subsequent falls in community-dwelling middle-aged and older adults. *Age and Ageing* 2015. 44(1): 90-96.
13. Hein C, Forgues A, Piau A, Sommet A, Vellas B, Nourhashemi F. Impact of polypharmacy on occurrence of delirium in elderly emergency patients. *J Am Med Dir Assoc* 2014. 15(11): 850.e11-5.
14. Singapore, Immigration and Checkpoints Authority. June 2015. Report on Registration of Births and Deaths 2014.

Using online and scenario-based learning to improve nurse-patient interaction and enhance patient experience



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ABSTRACT: In this article, we describe our project to initiate an online learning course, using real-world scenarios to help nurses enhance their communication skills with patients so as to improve the patient experience. The philosophy behind our project is 'a complaint is a gift'. We discuss how patients' complaints are incorporated into our curriculum and the use of HEART language to provide patients a better hospital experience. The 'HEART' acronym refers to five attributes which we believe all nurses should embody: Be HUMBLE, be EMPATHETIC, use APPEALING statements, be RESPONSIBLE and TELL the facts when interacting with patients. The communication modules are hosted online as an alternative to classroom teaching, as this offers increased learning flexibility.

Introduction

The Ministry of Health (MOH) Patient Satisfaction Survey (PSS) FY2012 at KK Women's and Children's Hospital (KKH) identified areas for improvement in the delivery of care and concern, communication and knowledge and skills provided by nurses. The use of communication skills is recognized as being an integral part of the nurse's role (Huang et al 2011). Nowadays, nursing care puts emphasis on holistic care – which includes the emotional, spiritual, physical, environmental, social, economic and rehabilitative requirements of patients. Holistic care also involves helping the patient and the patient's family to adjust to the new situation of one of their members being ill (Matthews 1987). To fulfill this role, having effective communication skills is important.

After a retrospective review on patients' feedback, we realized that much of the negative feedback regarding the services provided by nurses was due to inadequate communication skills in responding to certain challenging situations. Training is needed so that our staff would be equipped to apply the learned skills at work to meet and maintain service

standards. However, it was a challenge for the staff to attend classroom sessions due to operation issues based on a high workload and shift duties. In today's learning environment, it is important to keep up with changes in learning trends and technology. Thus, we have developed online learning modules to incorporate scenarios which modeled the favorable behaviors and HEART language that would result in a better patient experience.

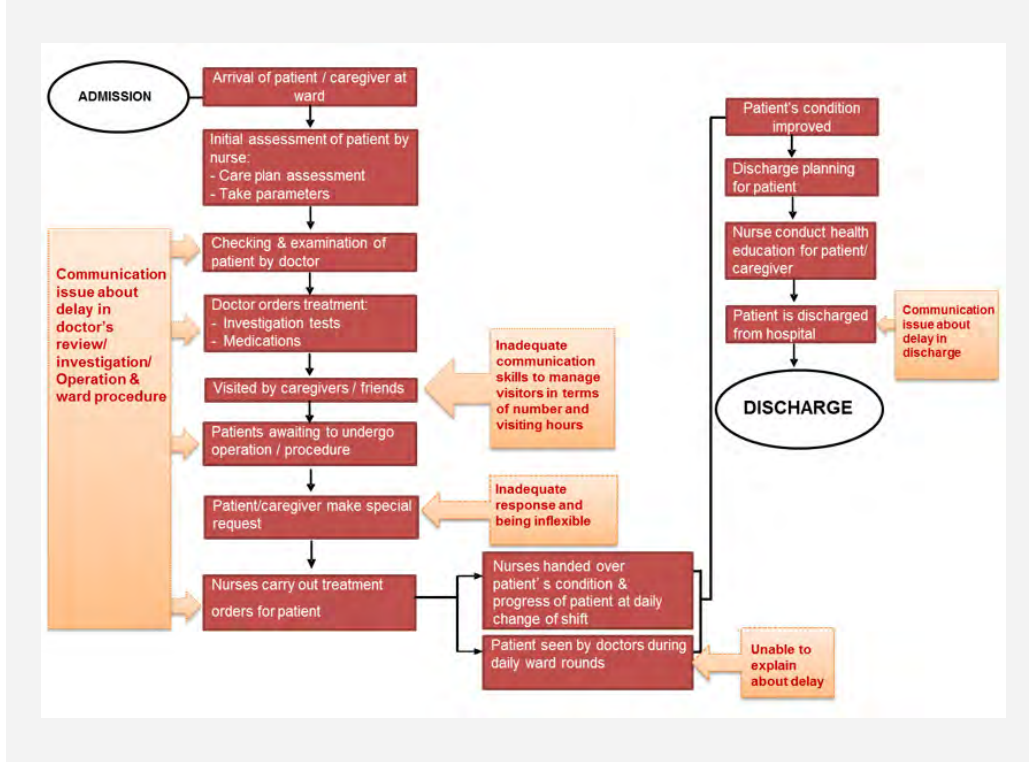
OBJECTIVE

Our objective was to improve nurse-patient interaction and enhance patient experience through online and scenario-based learning.

ASSESSMENT

A retrospective study of patients' feedback identified area for improvement in the aspect of nurse-patient communication. Our team brainstormed the improvement methodology based on an in-patient experience from admission to discharge as detailed in Figure 1.

FIGURE 1: FLOWCHART ON IN-PATIENT JOURNEY WITH COMMUNICATION ISSUES (BEFORE)



O'Hagan et al (2014) pointed out that to communicate effectively, we need to be aware of our approach, skills and mannerisms. Our patients' verbatim feedback revealed that there were areas for improvement during nurse-patient interaction. Half of the negative feedback was communication-related, of which the majority was related to delays. Other areas that needed to be addressed were inadequate responses and communication skills in relation to hospital policy.

Using the Ishikawa Diagram, we were able to identify six vital factors that would boost areas requiring improvement:

1. Communication of clinical knowledge
2. Effective communication
3. Meeting patients' expectations
4. Culture of service
5. Empathy
6. Image perception

We aimed to identify ways to better meet our patients' needs. The Pareto Diagram was used to rank vital factors that would boost areas requiring improvement in communicating "Knowledge & Skills", "Care & Concern" and "Clear Explanation". The team aimed to achieve the most improvements by targeting the major issues identified.

Through the 80-20 principle, the Pareto diagram identified vital factors "Effective Communication" and "Culture of service" as primary areas for improvement to achieve our goal. The TREE DIAGRAM, which is based on 5 criteria, was used to assist the team in deciding the most feasible solutions to implement. After voting, our team decided to focus on the communication issue.

Reinforcement on communication skills is required for better convey of knowledge, care and concern. By addressing our

nurses' needs, we would be able to uplift their ability to care for patients and their families. Focus groups and interviews with different levels of staff were conducted to attain a more specific understanding on the current performance (Actual) and the desired performance (Optimal) of nurses at work (Barbazzette, 2006). Results revealed that the nurses would benefit from increased confidence and communicative skills to convey relevant information to patients and caregivers. We then developed a training solution to broaden our nurses' communication skills in managing various challenging situations.

PLANNING

Information was collected from stakeholders involving staff of all levels from various departments in Division of Nursing and analyzed to determine learning solutions. In view of operational issues such as a high workload and shift duties, sending staff for training was a challenge. The idea of using on-line learning was mooted.

The conceptual framework was used to set the foundation of the curriculum. Table 2 shows the relationship between the key areas needing improvement, structure, process and outcomes.

The course began with a scene where a nurse was struggling with different challenging situations. Insights into current behaviors and the consequences of poor communication skills were revealed. We introduced the concept of HEART language to help nurses communicate effectively during complex clinical situations.

The use of education videos helped with the internalization and transfer of knowledge. The design of the set of interactive scenario-based learning was created – this is great for setting context when related to relevant and real world applications. Each scenario was concluded with research findings to reinforce learning. This would allow our staff to understand the purpose behind the educational experience, so as to be motivated to learn. Elements of how to show 'care and concern' and 'going the extra mile' were included in the model answers.

A Superstar award winner from Singapore Health Quality Service Award (SHQSA) was engaged as the facilitator. To personalize the experience, the video showed the facilitator having a one-to-one conversation with the learner. Due to her credibility, her delivery of the Service Quality (SQ) message had a powerful impact on the nurses viewing the video. Through this close-knit relationship, we provided a clear step-by-step instruction

Table 2: Conceptual Framework

Key Areas Needing Improvement	Structure	Process	Outcome
Clarity of explanation when experiencing delays	HEART Language	<ul style="list-style-type: none"> ▮ Needs assessment was conducted to identify potential problems ▮ Solutions implemented: <ul style="list-style-type: none"> - Scenario-based - Use of rich media - Interactive animations using images of KKH staff - SQ Award winner as facilitator 	<ul style="list-style-type: none"> ▮ Improve SQ Performance in the following areas: <ul style="list-style-type: none"> i) Knowledge & Skills; ii) Care & Concern and iii) Clear Explanation ▮ Enhance professional and hospital image
Empathy of response to visitors	Achieving Win-Win Situation		
Choice of words	<ul style="list-style-type: none"> ▮ Do's and Don'ts in communication ▮ Turning negative to positive 		

to keep the learners on track and interested. This was the key factor to the success of the course.

The whole course was divided into “small bite sizes” for easy absorption and retention of information. Online tests with audio and visual components were used at the end of each module to reinforce information and motivate learning (Barbazette, 2013). Upon completion of the four modules, nurses were required to complete a reflective journal. Through this reflective journal, they discovered the ways to contribute to SQ. Since they were the ones who identified the ways to improve their service, it would enhance their commitment towards SQ.

Figures 3 (A) to 3 (N) are a series of images of the module illustrating the concept of using HEART to address challenging situations.



FIGURE 3 (A)

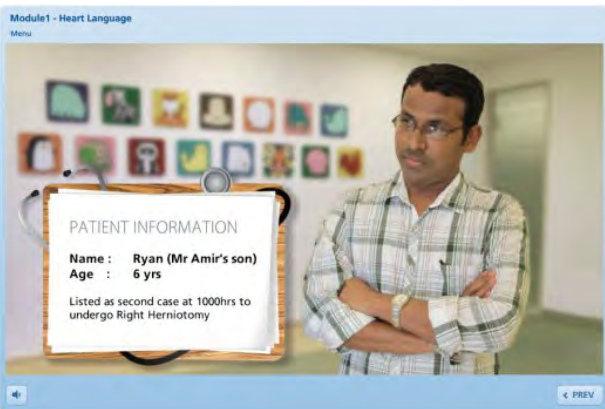


FIGURE 3 (B)

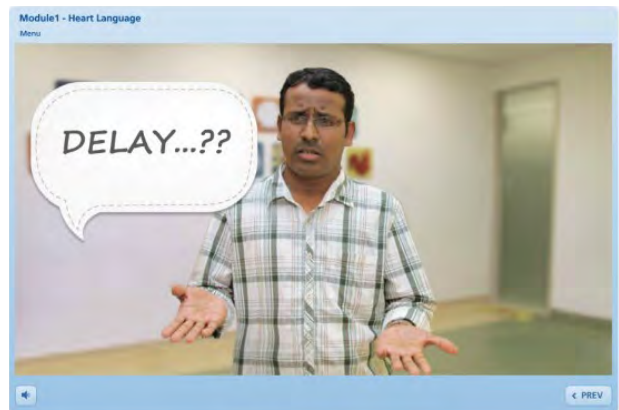


FIGURE 3 (C)

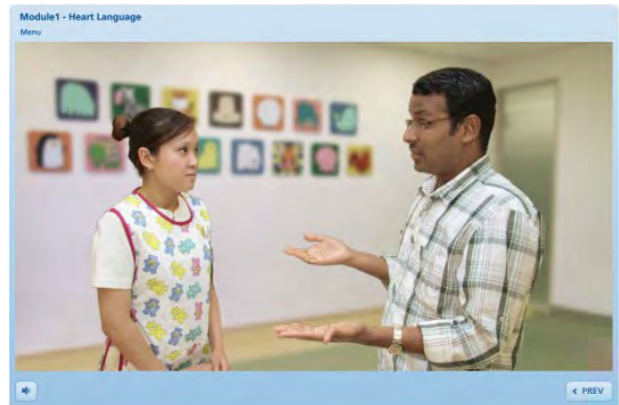


FIGURE 3 (D)



FIGURE 3 (E)

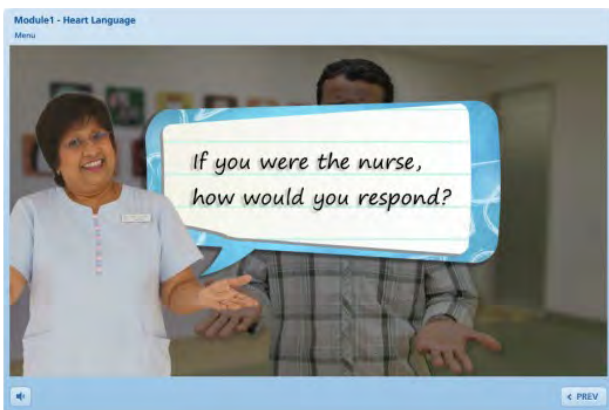


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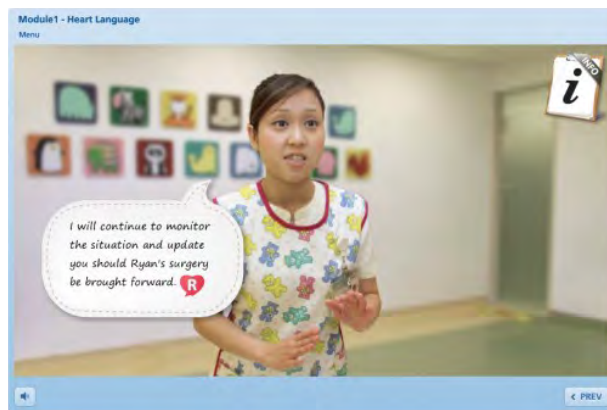


FIGURE 3 (J)



FIGURE 3 (G)



FIGURE 3 (K)



FIGURE 3 (H)

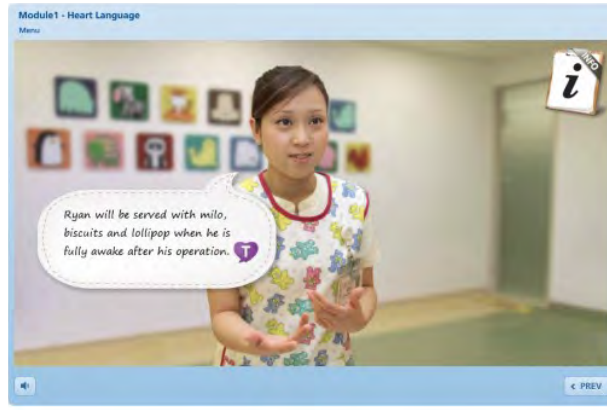


FIGURE 3 (L)



FIGURE 3 (I)

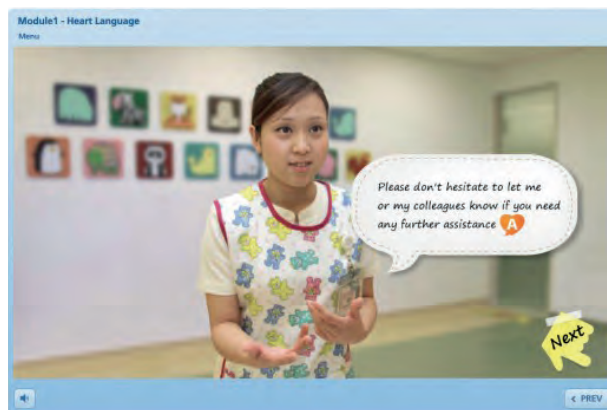


FIGURE 3 (M)

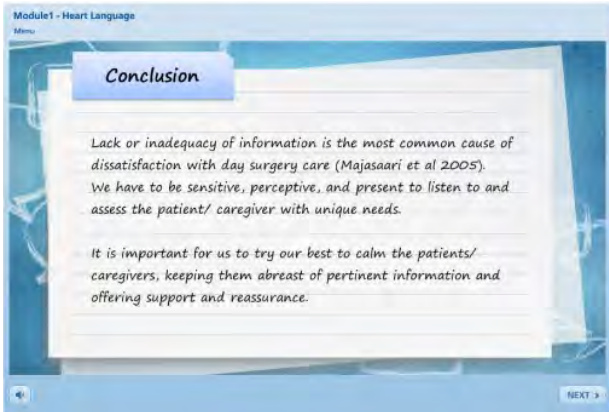


FIGURE 3 (N)

Altogether there were eight scenarios that captured the use of HEART language to communicate with patients/ caregivers about delays, and to offer alternatives in the event they are unable to accede to special requests.

IMPLEMENTATION

A pilot test was conducted from February to March 2014. Fourteen staff of all levels were selected to evaluate the structure and process for this program. Based on the feedback from this pilot test, modifications were made to the technical aspects to ensure a seamless flow.

The e-learning module was launched in April 2014 as one of the core training courses with a total of 1663 (88.4%) participating staff. Learner assessments are essential in education (Barbazette, 2013). It is important to provide just-in-time methods to assess and evaluate learner progress. This information

helped us assess the success of teaching methods and course structures. During the implementation phase, feedback was consistently obtained and support given to address the needs and concerns of our nurses.

The conventional mindset of the educators was to take charge of training. Our team took on the challenge and proposed a team effort. Nurse Managers (NMs) monitored the completion of the online learning for their own staff and followed up on the application of practice in their clinical work. A monthly individual SQ report was sent to NMs to feedback to their staff so that our staff will know the outcome of their effort. This approach empowered staff to take ownership and be motivated to a change in mindset in the approach to the SQ capabilities. This resulted in enhanced SQ standards, and in return, boosted staff’s morale and enhanced cooperation.

EVALUATION

Post-course, a total number of 1579 (95%) online evaluations were received, showing a favorable response. The staff commented that the course was informative, useful and educational. Participants verbalized that it was a highly commendable effort.

The use of scenarios modelling challenging situations enabled participants to better relate to patients and learn appropriate communication skills. Hence, they were better equipped to apply learned skills to convey holistic care to patients and caregivers. Internal patients’ feedback forms were used to determine the effectiveness of our training. Figure 4, 5 and 6 showed SQ ratings of nursing key performance indicators have improved tremendously since the implementation of the course.

This eLearning module was a success, the nursing teams have successfully improved the effectiveness of their communication skills. This is evident through the feedback received.

FIGURE 4: DISPLAYS PROFESSIONAL KNOWLEDGE AND SKILLS FROM YEAR 2013 TO 2014

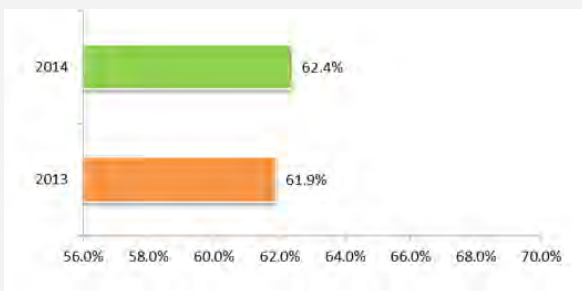


FIGURE 5: EXPLAINS & UPDATES ON CARE AND TREATMENT FROM YEAR 2013 TO 2014

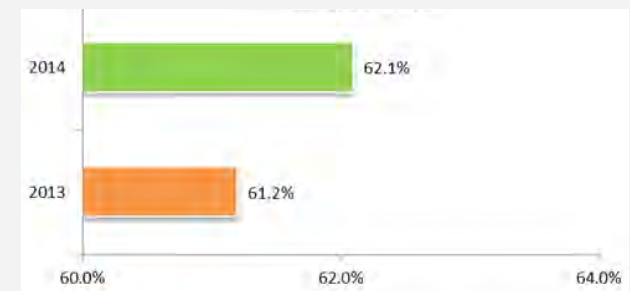


FIGURE 6: SHOWS CARE & CONCERN FROM YEAR 2013 TO 2014



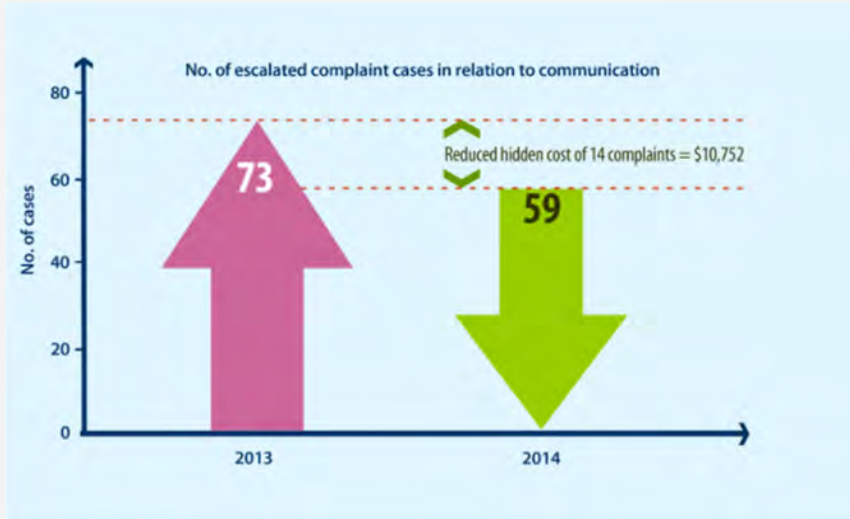
There was a reduction of 14 communication-related complaints in 2014 compared to 2013, showing improved patient experience. Every complaint has a hidden cost, requiring time spent on investigations and service recovery. This reduction in complaints equates to a cost saving of S\$10,752 over a period of 52 weeks (refer to figure 7).

audience within a short time frame. This approach also offers consistent delivery of the training materials and provides a platform for staff to absorb and retain the information at their own convenience. A total of **\$200,502** manpower cost was saved as compared to traditional classroom teaching approach.

Lessons Learnt

Complaint is a gift (Barlow et al 2008). It is one of our greatest sources of insight and suggestions for improvement (Ron Kaufman 2012). We use real-world examples of patient experiences throughout the course. Every scenario tells a story close to our staff’s heart. It is great at setting context and relates training to relevant and real world applications. Learning works in an authentic situation (Silber 2007). The scenarios used jolted prior memories. It captured the staff’s attention, increased their level of enjoyment and deepened their engagement, leading to active learning. From this approach, our staff

FIGURE 7: No. OF ESCALATED COMMUNICATION-RELATED COMPLAINTS

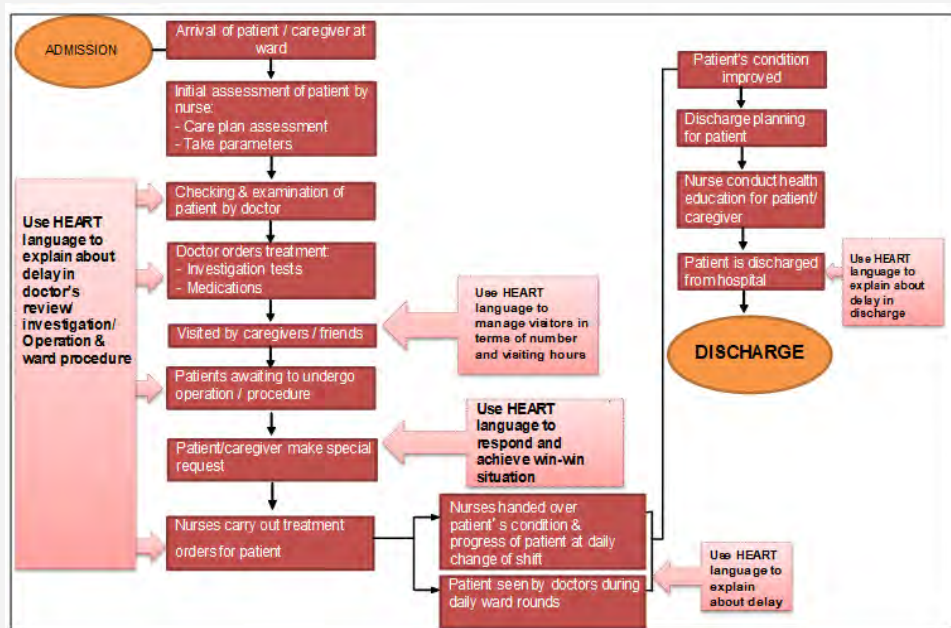


The latest MOH PSS report (2014) reflected significant improvements in our nurses’ abilities to demonstrate knowledge, skill, care, concern and clarity of explanation. Our service classification has also improved from normal to excellent level.

took pleasure in learning this subject and this led to higher levels of motivation, internalization and commitment in meeting patient satisfaction.

Service improvements in the areas of knowledge & skills as well as care & concern and clear explanation by nurses were clear indications of meeting patients’ expectations. We have received numerous positive feedback including compliments to local media to commend our nurses on the quality of their care.

FIGURE 8: FLOWCHART DEPICTING THE JOURNEY OF AN IN-PATIENT (AFTER)



After attending the online communication course, staff were able to better convey knowledge, skills, care, concern and clarity of explanation using the HEART language as shown in flowchart below.

Online learning was more convenient and cost-effective as it has the ability to reach out to a massive group of

This enhanced emotional engagement which is critical for learners to adopt an improved change in behaviors. This online learning was a breakthrough for training in SQ with a departure from the traditional classroom teaching approach. Nurses commended this approach for being relevant and applicable to their daily work. The communication course also boosted their confidence in communicating with the patients and caregivers.

CONCLUSION

Effective teamwork engagement is an important aspect to the success of any project. With the teamwork, each individual will give one's input to work toward a common goal. It will then lead to successful achievements and positive outcomes. Leveraging on technology and scenario-based learning for continual education will enable our staff to perform better to meet the growing needs and expectations of our patients.

AUTOBIOGRAPHY

Ms. **Wong Kin Ling** is an Assistant Director of Nursing at KK Women's & Children's Hospital. In this role, she is responsible for overseeing the service quality (SQ) in Division of Nursing. Her work involves systematically driving Service Quality in Nursing using a multifaceted approach.

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References

- Barbazatte, J. 2006. *Training Needs Assessment*. San Francisco: Pfeiffer.
- Barbazatte, J. 2013. *How to write terrific training materials*. San Francisco: Pfeiffer.
- Barlow, J., Moller, C., Hsieh, T. (2008) *Recovering Customer Loyalty When Things Go Wrong: A Complaint is a Gift*. San Francisco: Berrett-Koehler Publishers.
- Huang, Y.C., Hsu, L.L., Hsieh, S.I. (2011) "The effect of a scenario-based communications course on self-confidence in novice nurse communications." *Journal of Nursing*. 58(5): 53-62.
- Kaufman, R. 2012. *Uplifting Service!* Singapore: Ron Kaufman Pte. Ltd.
- O'Hagan, S., Manias, E., Elder, C., Pill, J., Woodward-Kron, R., McNamara, T., Webb, W., McColl, G. (2014) "What counts as effective communication in nursing? Evidence from nurse educators' and clinicians' feedback on nurse interactions with simulated patients." *Journal of Advanced Nursing*. 70(6): 1344-1355.
- Matthews, A., 1987. *In Charge of the Ward*. 2nd ed. London Oxford: Blackwell Scientific Publications.
- Silber, K.H., 2007. *A Principled-Based Model of Instructional Design: A New Way of Thinking about and Teaching ID*. Educational Technology, XLVII (5) September-October 2007.



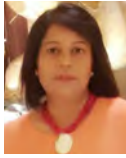
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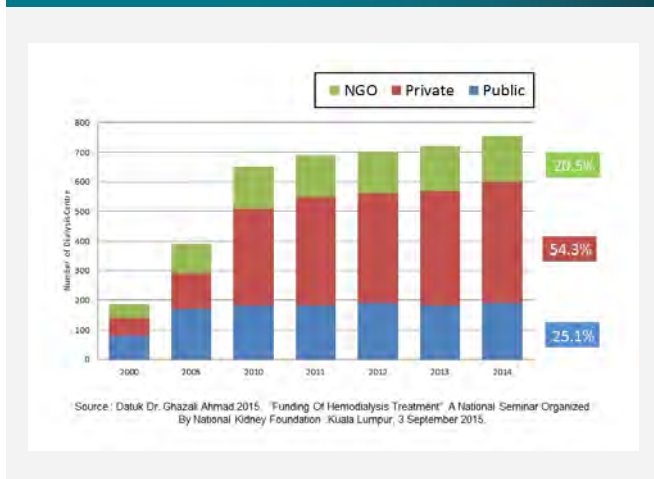


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ABSTRACT: This article describes the activities of MAA Medicare Charitable Foundation, which provides support for two charitable arms - the MAA Medicare Kidney Charity Fund and the MAA Medicare Heart Charity Fund. Author describe how such charitable organizations can play a vital role in supporting the care of patients with kidney disease in cases where such care is not available through the public programs offered by the government. Public employees and government retirees who need dialysis can receive care from private dialysis centers, through government subsidies. But many low income patients who cannot afford the high price of dialysis would be deprived of care without the MAA Medicare and other non-profit programs for dialysis. The article highlights how a public private partnership between NGOs that finance such a program, can play an imprint role in strengthening the health system and accessing effective and affordable care in a setting where such care would not otherwise be available to vulnerable segments of the population.

Introduction. The ‘dialysis scenario’ in Malaysia has rapidly changed over the last 3 decades. Today, End Stage Renal Failure (ESRF) patients are able to easily obtain treatment, with almost 800 facilities throughout the country (Figure 1).

FIGURE 1: NUMBER OF DIALYSIS CENTRE IN MALAYSIA BY SECTOR, 2000 TO 2014



Sadly, the number of patients diagnosed with ESRF each year is steadily increasing at an alarming rate, with approximately 7,000 new cases each year (Figure 2).

With its current population of 32 million people, about 36,000 patients are currently on dialysis. This number is expected to rise to 50,000 by the year 2020 says the National Kidney Foundation (Figure 3) based on the Renal Replace-

FIGURE 2: NEW DIALYSIS PATIENTS FROM 2004-2014 IN MALAYSIA

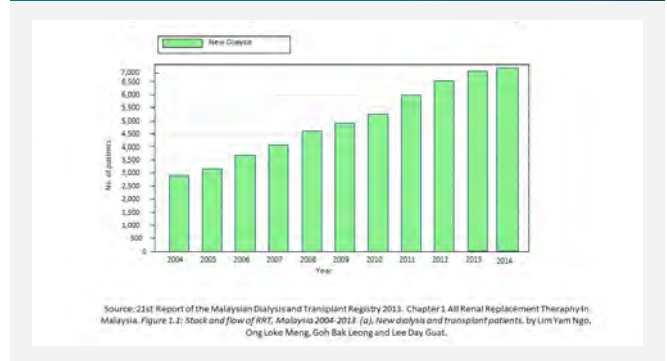


FIGURE 3: RENAL REPLACEMENT THERAPY (RRT) CHART 2005-2014

Year	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
New dialysis patient	3,167	3,709	4,103	4,640	4,852	5,305	6,073	6,690	6,885	7,055
New Transplants	172	151	112	131	141	128	127	107	98	81
Dialysis deaths	1,515	1,820	1,967	2,191	2,801	3,047	3,292	3,645	4,001	4,015
Transplant deaths	49	58	47	59	49	48	55	64	56	45
Dialyzing at 31 st December	13,356	15,080	17,084	19,388	21,590	23,709	26,328	29,223	32,025	34,767
Functioning Transplant at 31 st December	1,716	1,771	1,788	1,808	1,852	1,881	1,907	1,891	1,870	1,844

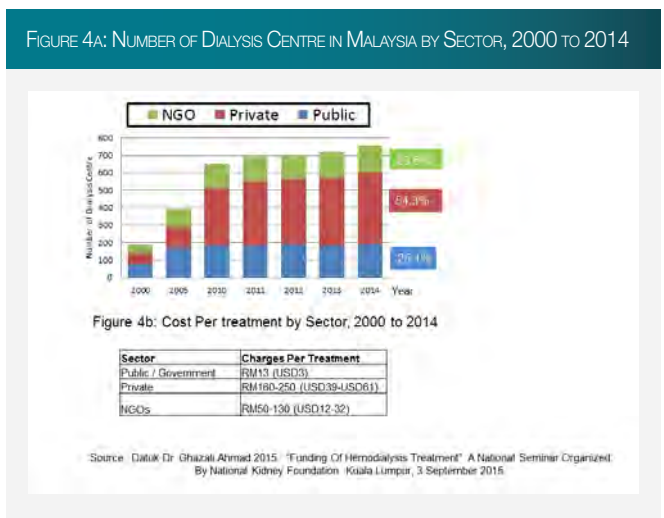
In 2014: 7,055 new patients on regular dialysis. 34,767 living on regular dialysis in Dec 2014

Source: Datuk Dr. Ghazali Ahmad 2015. "Funding Of Hemodialysis Treatment" A National Seminar Organized By National Kidney Foundation Kuala Lumpur, 3 September 2015.

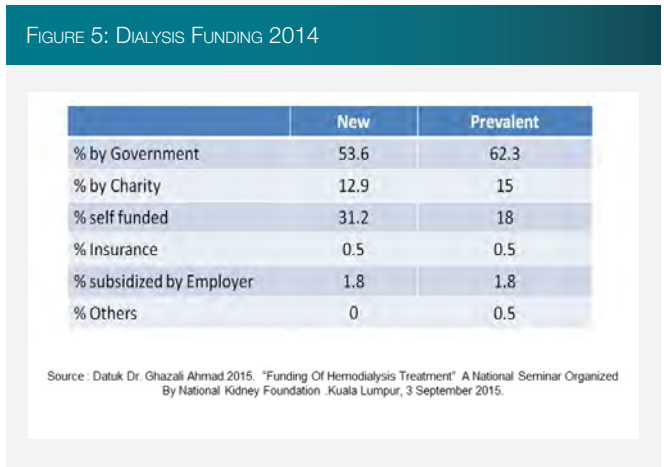
ment Therapy (RRT) chart 2005-2014.

Charges, Subsidy and Funding

The charges for each dialysis treatment varies, depending on the type of treatment provided and the facility which provides the treatment. 3 main providers dominate the market; the Government, which provides treatment to the hard core poor and for chronic cases; private, located in private medical centers or stand alone centers, where sponsored patients or those in the ‘affordable’ category dialyse and the NGO centers, like MAA Medicare, which focuses on the poorer groups of patients (Figure 4a and 4b).



Since the Government cannot provide care and treatment to all needy patients because of various reasons, the NGO centers play a significantly important role as the ‘back up’ provider. Today, the Government has placed 6,300 patients at NGO centers, with a financial assistance of RM50 per treatment to ease their burden. Public servants or government retirees mostly dialyse at private dialysis centers, with a hefty fee sponsored by the government (Figure 5).



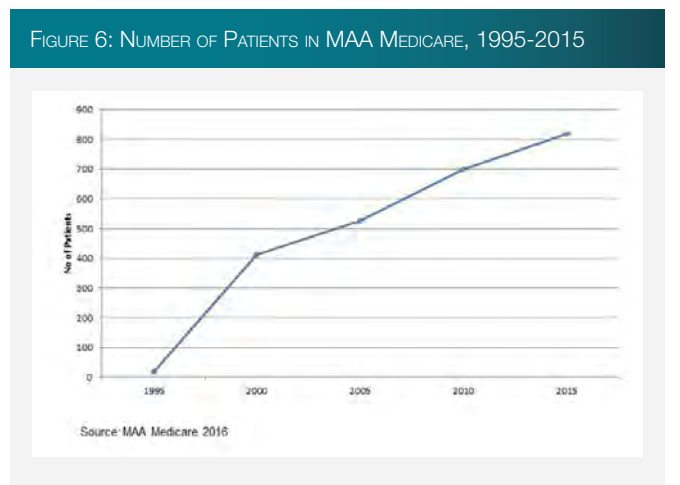
Malaysia does not have a national healthcare plan, whereby patients are automatically covered by insurance. The general insurance policies offer a one-off or very mini-

mal assistance over a short period of time. Hence the background of the patients diagnosed is crucial in determining where they will end up for treatment and what their charges would be.

The role of MAA Medicare Kidney Charity Fund (MAA Medicare)

MAA Medicare was initially established by the parent company, MAA Group as a CSR program to provide assistance and treatment to kidney patients who were trapped in the “Kidney Disease Dilemma”. These patients were not civil servants, and did not enjoy priority access to hemodialysis treatment in Government Hospitals and were too poor to pay for treatment at private medical clinics; and yet, they were not poor enough to be treated at the National Kidney Foundation. In short, this group of patients were really in a dilemma – too poor, but not poor enough.

MAA Medicare was then established to provide treatment and care to those whose household monthly income was between RM1,200 (USD285) to RM2,500(USD594). From a 6-machine center, assisting some 30 patients, 21 years ago, MAA Medicare has spread its wings across the country and assisted thousands of kidney patients with highly subsidized quality treatment over the many years (Figure 6).



Today this noble effort continues, with 12 visiting nephrologists, 111 medical staff and a management team of 23, who diligently care for 820 patients, who walk through its’ doors three times a week. 12 dialysis centers, equipped with 180 dialysis machines are located nationwide. A 13th center is in the pipeline.

MAA Medicare today

In line with the Ministry of Health’s regulations, all 12 MAA Medicare’s dialysis centers have been relocated to new, larger premise. Every center is licensed and equipped with the advanced medical equipment and disabled-friendly services (Figure 7).

MAA Medicare’s patients pay a subsidized fee of RM110 (USD27), while private centers charge between RM160-RM250 (USD39-USD61) per treatment. (‘Single use’ treat-

ment charges are significantly higher).

A survey done in January 2016, showed that 66% of MAA Medicare patients were in need of additional financial assistance and aid to get them by on a daily basis as their net household income was less than RM1,000 (USD 244) (Figure 8).

FIGURE 7: LOCATION OF MAA MEDICARE'S 12 DIALYSIS CENTERS



Source: MAA Medicare 2016

FIGURE 8: SURVEY RESULTS OF MAA MEDICARE'S PATIENTS NETT HOUSEHOLD INCOME 2016

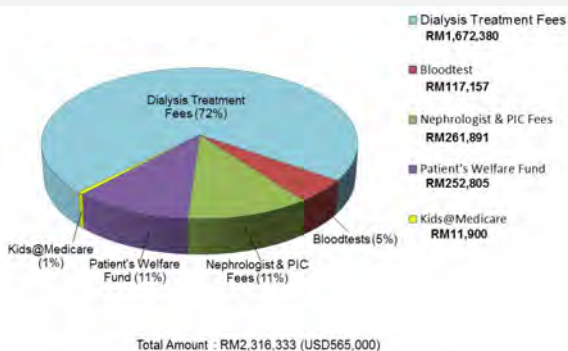
Category	Nett Household Income	Number of Patients	Percentage (%)
Level 1	< RM1,000 (USD244)	353	43%
Level 2	RM1,000 to RM2,000 (USD244 to USD488)	191	23%
Level 3	RM2,000 to RM3,000 (USD488 to USD732)	44	5%
Level 4	>RM3,000 (USD732)	232	28%
Total		820	100%

Source : MAA Medicare 2016

Bearing in mind that most patients could not afford the bare minimum and deserved to be further assisted, MAA Medicare established and conducted various programs, events and campaigns to raise the much-needed funds and awareness.

80% of the funds raised are channeled back to the patients via highly subsidized dialysis treatments, blood tests, medication and EPO injections costing approximately RM2.3 million each year (USD550,000) (Figure 9).

FIGURE 9: SUBSIDY PIE CHART 2015



The Patients' Welfare Fund Program (PWF) (Figure 10)

FIGURE 10: PWF LOGO



Established in 2009, the PWF is the most active program and over the last 6 years has assisted over a thousand poor patients in continuing with dialysis treatment for a minimum cost, or often for FREE. PWF provides additional subsidies for medications, EPO Injections and sponsors minor surgeries, medical aid and equipment.

PWF focuses on those who are in extreme need and to add cheer, PWF organizes festive celebrations, mothers' and fathers' day outings, talks and social activities. Some families are given monthly groceries to ease their financial burden (Figure 11, 12 and 13).

FIGURE 11, 12 AND 13: BIRTHDAYS, MONTHLY GROCERIES AND FREE TRANSPORTATION FOR PWF PATIENTS



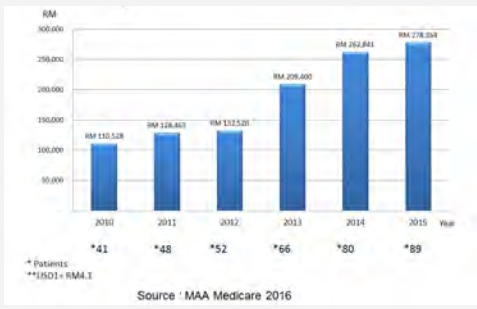
Source: MAA Medicare PWF Program 2016

A special team, consisting of nurses and administrative staff, conducts home and hospital visits and provides counseling sessions after clinical hours. Over the years PWF has gradually increased the number of patients and provisions under its care (Figure 14).

Care-ing Wheels

Under the PWF program, The **Care-ing Wheels Project** was first initiated in 2013. FREE transportation was provided mainly to those who were disabled, elderly, to those who could not afford public transport charges or lived a distance from the dialysis centers. 4 vehicles today ease the lives of many patients, who no longer skip dialysis treatments and

FIGURE 14: NUMBER OF PWF PATIENTS AND SUBSIDIES PROVIDED



have easy accessibility to MAA Medicare’s centers (Figure 15, 16 and 17).

FIGURE 15, 16 AND 17: CARE-ING WHEELS OFFERS FREE TRANSPORTATION TO DISABLED, ELDERLY AND THE POOR



A designated driver at each center is hired to shuttle needy patients to and from the centers for treatment. The patients and their families are extremely appreciative of the additional service provided.

Since all the 4 vehicles are sponsored, it is huge publicity for donors to have their logo on the vehicles. Indirectly it’s a win-win situation for both parties, benefitting the patients.

Other programs:

Kids@Medicare Program (Figure 18)

FIGURE 18: KIDS@MEDICARE LOGO



As a special initiative to assist the school-going children of our dialysis patients, the Kids@Medicare program was initiated. Holiday outings and fun activities are conducted to put a cheer on the children’s faces. Back to school assistance; new school supplies including shoes, bags and books are provided on a yearly basis. Children who have excellent results are rewarded as a motivation. Each year over 200 children of MAA Medicare’s patients benefit from the program (Figure 19, 20, 21 and 22).

FIGURE 19, 20, 21 AND 22” KIDS@MEDICARE PROVIDES ASSISTANCE TO MAA MEDICARE’S PATIENTS’ CHILDREN



C.A.R.E (Figure 23)

FIGURE 23: C.A.R.E PROGRAM



C.A.R.E (Care And Respect the Environment) is the MAA Medicare’s program for encouraging all staff and patients to continue caring for the environment. Since established in 2014, it has grown to be an internal platform for the staff outreach that is widely celebrated in all centers.

Eco friendly products are used and waste is disposed efficiently and effectively. Bottles, canisters, boxes and paper are recycled and turned into saleable items. Income earned is channeled back to the respective centers (Figure 24 and 25).

MAA Medicare at its best

Over the years, millions of dollars have been raised to support the growing number of patients and their needy families. Much support has been provided by a committed Board of Trustees, partners, the government, statutory and social bodies, supporters and donors; all who have strongly

FIGURE 24 AND 25: MAA MEDICARE'S STAFF SUPPORTING THE C.A.R.E PROGRAM



Source: MAA Medicare C.A.R.E Program

believed in the cause of MAA Medicare's good work towards the less fortunate.

Recognizing the efforts of MAA Medicare on an international level was rewarding when MAA Medicare won at the Asian Hospital Management Awards (AHMA) in 2014 (CSR category) and again in 2015 (Community Hospital Improvement and Marketing, PR or Online Presence categories)

The European Society for Quality Research (ESQR) has awarded MAA Medicare with the European Awards for Best Practices 2016, at a ceremony in Brussels (Belgium) in June.

As the Foundation has embarked on establishing the first cardiac diagnostic center for the under-privileged in Malaysia, it looks forward to International and local support especially in terms of financial assistance.

For more news on MAA Medicare please visit us on www.maa-medicare.org.my

BIOGRAPHY

'Aliyah Karen is the CEO of the MAA Medicare Charitable Foundation and has been involved with non-profit work for the past 20 years. She is an International speaker and trainer and her forte is community, social and personal development. She is in the midst of establishing the first cardiac diagnostic centre in Malaysia. 'Aliyah was recently knighted by the Patron of the Foundation, the Ruler of Negeri Sembilan, Malaysia, with the title of Dato'.

References

1. Datuk Dr. Ghazali Ahmad. 2015. "Funding of Hemodialysis Treatment" A National Seminar Organized by National Kidney Foundation .Kuala Lumpur, 3 September 2015.
2. 21st Report of the Malaysian Dialysis and Transplant Registry 2013. Chapter 1 All Renal Replacement Therapy in Malaysia. *Figure 1.1: Stock and flow of RRT, Malaysia 2004-2013 (a), New dialysis and transplant patients*, by Lim Yam Ngo, Ong Loke Meng, Goh Bak Leong and Lee Day Guat.
3. MAA Medicare 2016
4. MAA Medicare PWF Program
5. Care-Ing Wheels Program
6. Kids@Medicare Program
7. MAA Medicare C.A.R.E Program

Emerging Grandeur Niche in Chinese Wellness Tourism at Phuket Island



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ABSTRACT: China's biggest population size is the foremost intriguing factor in the country's wellness tourism opportunity. Preventative medicine and health prevention is one of the most growing healthcare sectors due to state-of-the-art advanced medical diagnostics and technology. However, wellness tourism in China is still in its infancy, it offers massively new opportunities for the outbound wellness tourism industry. Several reports reveal that environmental assets, including fresh air, clean water and natural features, are considered the most important attributes for the development of wellness tourism for the Chinese. Phuket Island is one of the best tourism destinations with a great reputation for environmental leisure and beach activities. Additionally, advanced medical facilities and specialist physicians at hospital providers in Phuket Island provide the opportunity to serve a proven outcome-based preventative medicine and wellness intervention for clients or patients who are seeking wellness tourism and healthy longevity.

Introduction. China's large population size is the foremost intriguing factor in the country's wellness tourism opportunity. Preventative medicine and health prevention is one of the most growing healthcare sectors due to state-of-the-art advanced medical diagnostics and technology. However, wellness tourism in China is still in its infancy, it offers massively new opportunities for the outbound wellness tourism industry. Several reports reveal that environmental assets, including fresh air, clean water and natural features, are considered the most important attributes for the development of wellness tourism for the Chinese. Phuket Island is one of the best tourism destinations with a great reputation for environmental leisure and beach activities. Additionally, advanced medical facilities and specialist physicians at hospital providers in Phuket Island provide the opportunity to serve a proven outcome-based preventative medicine and wellness intervention for clients or patients who are seeking wellness tourism and healthy longevity.

China's economy has grown massively for decades. The continuous growth of China's economy has involved, with the manufacturing and industrial phase, technological development and, most importantly, advanced internet-based commercialization. For the next decades of China's economy, the healthcare industry has been forecasted to drive the progression of China's economy [1]. Currently, over 100 million Chinese travel aboard each year. Their primary objectives for travelling overseas are lei-

sure, business and medical treatment. In 2015, thousands of Chinese patients went aboard, including America, Europe, Thailand, Japan, Korea, etc., seeking medical intervention for health and beauty [2]. The number of such Chinese medical tourism demands is rapidly growing. Analytical data shows that wellness and lifestyle tourism are trendy and the size of the market industry is enormous. Medical intervention related to wellness tourism mainly involves rejuvenation and longevity (anti-aging) management. Wellness and health prevention is the future of our global healthcare management system [3].

Phuket is the biggest island of Thailand located in the South. It is also surrounded by several small beautiful islands. The number of people on Phuket Island increases to over a million during the high season of the tourism period, ranging from November to April. Over 4 million tourists travel to Phuket every year for their relaxation and sightseeing. Unveiling an oasis in the sky, traditional Spa treatment is one of the foremost famous activities for Phuket Island. Thai traditional massage traces its roots back more than a thousand years to combined Chinese and Indian art. Thai food is world-renowned for its wonderful flavors and fresh ingredients. Phuket is particularly popular for its seafood at an affordable cost. The variety of cuisine and dining experiences is one of the major attractions of the island, and was awarded the "City of Gastronomy" by UNESCO [4].

Phuket's reputation as a quality medical hub and the increasing global movement towards beauty enhancements are leading a shifting focus of market offerings and attraction for overseas patients or clients. Aesthetic procedures have dominated the market with cosmetic surgery being the most popular product. Hospital and clinic providers collaborate with travel operators, including hotels and transportation, to provide inclusive packages combining medical intervention and holidays on Phuket Island. Annually, thousands of Australians travel to Phuket seeking cosmetic and aesthetic facial and body enhancements [5], contributing to the largest proportion, by nationality, of medical tourists coming to Phuket Island.

For thousands of Chinese medical tourists who visit Phuket Island each year, not only have a chance to relax in the sun and sand, but also to access medical intervention and treatment not available in China [6]. Chinese tourists mostly come for various kinds of treatment, in particular, anti-aging and wellness intervention. When it comes to healthcare, China is still in the initial phase of developing equal opportunity to obtain standard and good quality health treatment and prevention.

Bangkok Hospital Phuket, as part of BDMS hospital network, has started working with Chinese medical tourists since 2013 when I was an assistant hospital director and responsible for the Chinese medical tourism project. We first started with small groups of patients each month. Until now we develop our services to be capable of serving up to hundreds of patients at the certain period of time when groups of patients come. The average length of stay in Phuket for Chinese medical tourists varies between five to seven days for anti-aging treatment and wellness tourism. We offer advanced services in preventative medicine and anti-aging treatment. Among our services, heavy metal analysis with detoxification along with hormonal replacement therapy is one of our more popular programs sought by Chinese medical tourists. We are continuously developing processes and extending our lifestyle services to organ-specific preventative medicine such as brain and heart wellness. The comprehensive innovation in genetic and molecular testing, gives people the opportunity to predict the disease and prevent the clinical consequences of genetic and molecular risk predisposition. This, together with Phuket Island's holiday appeal and tourist attraction, is turning Phuket into a prime medical tourism destination for all Chinese. In June 2015, Bangkok Hospital Phuket received the prestigious award from the Minister of Tourism and Sports of Thailand for being the "BEST MEDICAL SERVICE PROVIDER" voted by Chinese tourists. The number of votes has been announced to hit more than 80,000 votes in the period of 14 days of voting competition [7]. The award was also co-sponsored by Sina Weibo that is the largest social media platform in China. Moreover, we are a leading hospital in Thailand to have successfully established such a new innovative business model and marketing strategies with proven outcomes in terms of patient satisfaction, revenue generation, marketing channels, and brand perceptions. Other leading hospitals in Thailand to be mentioned, are Bangkok Hospital Rayong, Phayathai Hospital, etc. have come to visit our hospital to observe and gain experience in service design and how to productively generate and market this Emerging Chinese Wellness Tourism.

We believe that sustainable growth in the healthcare sector will come from identifying personal strength, creating knowledge, innovating products and services, developing strong teamwork, designing marketing strategies, gaining experiences, and, essentially, sharing our merits with healthcare communities.

BIOGRAPHY

My name is **Dr. Tanasit Technukul**. I completed medicine in Thailand and further graduated with a PhD in stem cell medicine from the UK. I participated the hospital management team of the Bangkok Dust Medical Services (BDMS) as junior management team. My personal interest for hospital management is currently focused on the international medical tourism industry and the quality of hospital products and services.

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References

- [1] Franck Le Deu, Rajesh Parekh, Fangning Zhang, and Gaobo Zhou. 2012. "Healthcare in China: Entering 'uncharted waters'" Mckinsey & Company.
- [2] Medical Tourism Magazine. 2015. "In Market for Medical Tourism? Chinese Seek Healthcare Overseas". Medical Tourism Association.
- [3] Whitney Baldwin, Philip J. Davis, and Mikael Stenstrand. 2013. "The Changing Future of Consumer Health" Accenture.
- [4] "47 Cities Join the UNESCO Creative Cities Network" 2016. UNESCO Headquarter. <http://en.unesco.org/creative-cities/events/47-cities-join-unesco-creative-cities-network>
- [5] "Australian Medical Tourists Head Abroad For Medical Care" 2011. International Medical Travel Journal. <http://www.imtj.com/news/australian-medical-tourists-head-abroad-medical-care/chinese>
- [6] "Chinese Medical Tourists Flock to Phuket" 2015. Phuket Gazette. <http://www.phuketgazette.net/phuket-business/Chinese-medical-tourists-flock-Phuket/48323#ad-image-0>
- [7] "Chinese Tourists Vote for Their Top Thai Tourism Products and Services" 2015. Tourism Authority of Thailand. <http://www.tat-news.org/chinese-tourists-vote-for-their-top-thai-tourism-products-and-services/>

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Résumés en Français

Introduction du développement de l'application pour smartphone, « PWH easyGo » pour aider les patients et les visiteurs à se rendre dans les différents services et installations dans les locaux de l'hôpital en toute simplicité.

« **PWH easyGo** » est une application (app) pour smartphones conçue pour aider les patients et les visiteurs à chercher des différents services et installations dans les locaux de l'hôpital. Des affiches portant un code QR sont installées aux différentes entrées de l'hôpital. Les utilisateurs ayant installé l'application peuvent scanner les codes QR imprimés sur les affiches sur le site ou sélectionner manuellement leurs emplacements actuels et les destinations dans l'application et le système affichera les liaisons concernées avec des photos. C'est la première application développée par l'administration hospitalière de l'hôpital de Hong Kong et est disponible en téléchargement sur l'Apple Store (version iOS) et sur le Play Store (version Android).

Un fichier vidéo illustrant l'utilisation de « PWH easyGo » se trouve à l'adresse : http://www3.ha.org.hk/pwh/film/pwheasygo20150608_eng.mp4.

Une approche pour améliorer la sécurité des patients et la qualité au-delà de l'accréditation

Les améliorations de la sécurité des patients exigent un effort complexe de l'ensemble du système, comprenant un large éventail d'actions dans l'amélioration de la performance, la sécurité environnementale et la gestion des risques, y compris le contrôle de l'infection, l'utilisation sûre des médicaments, la pratique clinique sûre et un environnement sûr des soins.

L'accréditation des soins de santé est l'une des principales mesures visant à améliorer la qualité et la sécurité des patients. Parmi les nombreux organismes d'accréditation à travers le monde, la commission internationale conjointe (JCI) se distingue comme le meilleur dans l'accréditation. Le voyage en toute sécurité des patients pour se rendre dans les hôpitaux comme le Groupe Apollo, a officiellement commencé avec Apollo Hospitals, à Delhi en devenant le premier hôpital en Inde accrédité JCI en 2005. Dans les années qui ont suivi, huit hôpitaux du groupe sont également devenus accrédités par la JCI ; en portant à vingt-trois le nombre d'hôpitaux accrédités dans le pays par la JCI. Le conseil national d'accréditation pour les hôpitaux et les prestataires de soins de santé (NABH) a été formé par la suite et aujourd'hui, près de trois cents hôpitaux sont accrédités par NABH à travers le pays.

Au-delà de l'accréditation, il y a plus une plus grande sécurité des patients et une plus grande qualité des soins de santé. En vue d'améliorer encore la sécurité des patients, Apollo Hospitals a pris plusieurs initiatives.

Perception des prestataires de soins au sujet de l'utilisation de lits d'hôpital : Une condition sine qua non pour les initiatives d'amélioration de qualité dans les établissements de santé.

Contexte : L'utilisation de lits d'hôpital est influencée par divers facteurs qui peuvent être divisés en patient, médecin et administration concernée. Ces facteurs doivent être considérés du point de vue des prestataires de soins de santé afin que toute initiative d'amélioration prise par l'administration corresponde à la perception du travailleur de santé, qui au final, influence l'efficacité de l'hôpital et de la qualité des soins.

But et objectif : Pour déterminer les facteurs influençant l'utilisation de lits d'hôpital du point de vue des prestataires des fournisseurs de soins de santé.

Méthodologie : Cette étude transversale a été menée dans une institution publique de santé de pointe dans le nord de l'Inde. Tous les médecins résidents et les infirmières dans les 18 domaines de 7 spécialités et 7 super spécialités ont été interrogés à l'aide d'un questionnaire validé structuré auto-administré.

Résultats : Un total de 279 participants (117 médecins et 162 infirmières) a participé à l'étude. Les facteurs influençant significativement utilisation des lits en ce qui concerne les médecins sont les patients (2.34, 0.36), le médecin (2.47, 0.32), l'administration (2.61, 0.29) et en ce qui concerne les infirmières sont les patients (1.97, 0.40), les médecins (1.97, 0.46), l'administration (2.39, 0.40).

Conclusions : L'évolution des récentes tendances en matière de soins de santé (innovations dans les décisions politiques, avancées technologiques, aspects de la durabilité des entreprises, démarches qualité, etc.) a donné un aperçu aux décideurs (administrateurs) pour tenir compte de la perception des prestataires des soins de santé (ressources humaines) en ce qui concerne l'utilisation des lits comme un élément important du système de prestation de soins de santé.

Mots-clés : Perception, Prestataires de soins de santé, Utilisation de lits, Qualité des soins.

Souligner l'excellence du service à Lorma

La formation à l'excellence de service est une importante priorité continue au Lorma Medical Center. Son design et ses contenus sont modifiés au besoin pour répondre aux commentaires des patients sur la qualité du service dispensés par le personnel de Lorma. Des notes d'insuffisance dans la satisfaction de la clientèle ont été reportées dans l'enquête de satisfaction du patient de Lorma en 2013. Le rapport des évaluations de satisfaction se fait mensuellement par l'agent le bureau des relations des patients et ses résumés sont soumis par le Secrétaire exécutif aux chefs

des départements concernés pour action immédiate, surveillance et comptes-rendus des améliorations apportées. La prémisses est que des améliorations de processus de processus devraient reposer sur des données (1).

Les composantes comportementales des enquêtes des patients se sont améliorées un an après la mise en œuvre. L'enquête Smile, un nouvel outil conçu pour évaluer les résultats du nouveau programme a également révélé des résultats positifs.

Vérification au stade préopératoire, marquage de site et arrêt - diffusion de la Culture de la sécurité des patients du bloc opératoire principal à la chirurgie en journée

Dans cet article, nous décrivons comment nous diffusons la culture en toute sécurité du site de chirurgie, du bloc opératoire principal à la chirurgie en journée. Nous discutons de comment nous avons intégré le protocole «Projet 5 High pour une chirurgie correcte sur site» dans le flux du bloc opératoire de chirurgie en journée (DSOT) et mesuré la conformité grâce à l'audit et au feedback. Nous réfléchissons aussi à l'analyse des facteurs humains (HFACS) en vue de combler les lacunes en fournissant un outil permettant de reconnaître les causes de non-conformité.

Programme de soins de transition Système national du système national de santé universitaire (NUHS)

Les patients âgés fragiles nécessitent plus de temps pour récupérer après l'hospitalisation, et ils sont souvent déchargés de l'hôpital avec peu de soutien en dépit de leurs besoins en soins complexes. Ils sont particulièrement vulnérables aux risques et de soins de santé fragmentés si non gérés de façon appropriée.

Un programme de soins de transition gériatrique appelé NUH à la maison (NUH2H) a été lancé en mars 2014 pour fournir des soins interdisciplinaires centrés sur la personne pour les personnes âgées qui sont sorties de l'hôpital universitaire national (NUH) de Singapour. Il vise à améliorer la qualité et la sécurité des soins post-décharge à la maison, ce qui conduit à une réduction éventuelle des réadmissions et du séjour prolongé à l'hôpital.

Dans la première année de mise en œuvre, il y avait respectivement 67 % 68 % et 75 % de réduction des réadmissions, des visites aux urgences et la durée du séjour.

Utiliser des scénarios de formation en ligne pour améliorer l'interaction patient-infirmière et améliorer l'expérience des patients

Dans cet article, nous décrivons notre projet d'ouverture d'un cours de formation en ligne, à l'aide de scénarios réels pour aider les infirmières à améliorer leurs compétences de communication avec les patients afin d'améliorer l'expérience du patient. La philosophie de notre projet est « une plainte est un cadeau ». Nous discutons sur le comment les plaintes des patients sont intégrées dans notre programme d'études et sur l'utilisation du langage HEART (cœur) pour donner aux patients une meilleure expérience de l'hôpital. L'acronyme « HEART » (cœur) fait référence aux cinq attributs qui, selon nous, toutes les infirmières doivent incarner : Être HUMBLE, avoir de l'EMPATHIE, utiliser des phrases ATTRACTIVES, être RESPONSABLE et TELL (DIRE) les faits quand on interagit avec les patients. Les modules de communication sont hébergés en ligne comme alternative à l'enseignement en classe, car cela offre une plus grande flexibilité d'apprentissage.

MAA Medicare – Aux croisement des frontières

Cet article décrit les activités de la fondation de bienfaisance MAA Medicare, qui supporte deux causes de bienfaisance - MAA Medicare Kidney Charity Fund (Fond de bienfaisance MAA Medicare pour les insuffisances rénales) et MAA Medicare Health Charity Fund (Fond de bienfaisance MAA Medicare pour la santé). Les auteurs décrivent comment ce type d'organisations de bienfaisance peut jouer un rôle vital dans le support au soin au patients atteints d'insuffisance rénale dans les cas où ces soins ne sont pas pris en charge par les régimes publics offerts par le gouvernement. Les fonctionnaires et les retraités du service public qui ont besoin de dialyse peuvent recevoir des soins des centres de dialyse privés, grâce aux subventions gouvernementales. Mais, de nombreux patients à faible revenu, qui ne peuvent pas payer le prix élevé des dialyses, seraient privés des soins sans le programme MAA Medicare pour la dialyse. L'article met en évidence comment un partenariat privé entre ONG qui finance ce programme, peut jouer un rôle majeur dans le renforcement du système de santé et de l'accès à des soins efficaces et abordables dans un cadre où ces soins ne seraient pas donnés aux couches vulnérables de la population.

Niche de grandeur émergente dans le tourisme du bien-être à l'île de Phuket

La grande taille de la population de la Chine est avant tout le facteur le plus intéressant dans l'opportunité de tourisme du bien-être dans le pays. La médecine préventive et de prévention de la santé est un des secteurs des soins de santé à plus forte croissance à cause du fait en raison de diagnostics médicaux à la pointe de la technologie et de la technologie. Toutefois, bien qu'en Chine, le tourisme du bien-être soit encore à ses débuts, il offre d'importantes nouvelles opportunités pour l'industrie du tourisme du bien-être. De nombreux rapports indiquent que les actifs environnementaux, y compris l'air frais, l'eau propre et des caractéristiques naturelles, sont considérés comme des attributs les plus importants pour le développement du tourisme pour les chinois. L'île de Phuket est l'une des meilleures destinations avec une grande réputation pour les activités en plein air et sur la plage. De plus, les installations médicales avancées et les médecins spécialistes à l'hôpital de Phuket offrent la possibilité de dispenser une médecine préventive sur la base de résultats prouvés et une intervention de bien-être pour des clients ou des patients qui cherchent un tourisme de bien-être et la longévité en bonne santé.

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Resumen en Español

Presentación del desarrollo de la aplicación para smartphone, "PWH easyGo" que ayuda a pacientes y visitantes a encontrar fácilmente diferentes departamentos y estructuras dentro del hospital.

"PWH easyGo" es una aplicación para teléfono smartphone (app) diseñada para ayudar a pacientes y visitantes a buscar diferentes departamentos y estructuras dentro de las instalaciones del hospital. Carteles con el código QR se exponen en las diferentes entradas del hospital. Los usuarios que tienen instalada la app pueden escanear los códigos QR impresos en los carteles situados en el lugar o elegir manualmente su localización y los destinos en la app y el sistema mostrará los recorridos pertinentes con fotografías. Es la primera app en su tipo desarrollada por las Autoridades del Hospital de Hong Kong y se encuentra disponible para descargar en Apple Store (versión iOS version) y Play Store (versión Android).

En URL se encuentra un archivo vídeo que muestra cómo utilizar "PWH easyGo": http://www3.ha.org.hk/pwh/film/pwheasy-go20150608_eng.mp4.

Un enfoque para mejorar la seguridad del paciente y la calidad más allá de las certificaciones

Las mejoras en la seguridad del paciente requieren un vasto esfuerzo y un sistema complejo, abarcando una extensa gama de acciones para mejorar los resultados, la seguridad ambiental y la gestión del riesgo, incluyendo el control de las infecciones, el uso seguro de los fármacos, la seguridad del instrumental, las prácticas clínicas seguras y el ambiente seguro de la asistencia.

La certificación sanitaria es uno de los mayores pasos hacia el mejoramiento de la calidad y de la seguridad del paciente. De entre las muchas agencias de certificación mundiales, la Joint Commission International (JCI) se destaca como el patrón de referencia para la certificación de la asistencia sanitaria. El recorrido seguro del paciente por hospitales como el Apollo Group, nacido formalmente como Apollo Hospitals, de Delhi, se convirtió en 2005 en el primer Hospital con certificado JCI de la India. En los años siguientes, ocho hospitales del grupo fueron acreditados como JCI; llegando a un total de veintitrés hospitales certificados JCI en todo el país. El Comité de Certificación nacional para hospitales y Profesionales de la Sanidad (NABH) se formó después y actualmente alrededor de trescientos hospitales en todo el país han sido certificados por NABH.

Detrás de cada certificación hay mucho más que seguridad para el paciente y calidad de la asistencia sanitaria. Con el objetivo de mejorar la seguridad del paciente, Apollo Hospitals han

adoptado numerosas iniciativas.

Percepción de los Profesionales Sanitarios con respecto al Uso de Camas en el Hospital: Un pre-requisito para las iniciativas de mejora de la calidad en Instituciones Sanitarias.

Premisa: El uso de las camas se ve influenciado por diferentes factores que pueden dividirse en relativos al paciente, al médico y administrativos. Estos factores son analizados desde el punto de vista de los profesionales sanitarios de modo que cualquier iniciativa de mejora que la administración disponga se ajuste a la percepción de los profesionales de la sanidad que definitivamente afectará a la eficiencia del hospital y a la calidad de la asistencia.

Finalidad y Objetivo: Establecer los factores que influyen en el uso de las camas de hospital desde la perspectiva de los profesionales de la sanidad.

Métodos: Este estudio sectorial se realizó en una institución pública de atención terciaria en la región del norte de India. Todos los médicos y enfermeros residentes de los 18 pabellones de 7 especialidades y de 7 súper especialidades fueron entrevistados empleando un cuestionario de administración autónoma, estructurado y validado.

Resultados: Un total de 279 participantes (117 doctores y 162 enfermeras) participaron en el estudio. Los factores que significativamente influenciaron el uso de camas con respecto a los médicos fueron el paciente (2.34, 0.36), el médico (2.47, 0.32), administrativos (2.61, 0.29) y con respecto a las enfermeras fueron el paciente (1.97, 0.40), el médico (1.97, 0.46), administrativos (2.39, 0.40).

Conclusión: El cambio de las pautas sanitarias en el pasado reciente (innovaciones en las decisiones políticas, avances tecnológicos, factor de sostenibilidad empresarial, iniciativas sobre la calidad, etc.) dio una nueva perspectiva a los responsables de las políticas (administradores) para que consideren la percepción de los profesionales sanitarios (recursos humanos) en relación con el uso de camas como un componente importante del sistema de asistencia sanitaria.

Palabras clave: Percepción, Profesionales sanitarios, Uso de camas, Calidad de la atención.

Destacamos la Excelencia del Servicio en Lorma

La Capacitación para la Excelencia de los Servicios es una prioridad constante en el Lorma Medical Center. Su diseño y contenido se modifican según las necesidades, respondiendo a los comentarios de los pacientes relativos a la calidad del servicio del personal de Lorma. Las discordancias nota-

das en la satisfacción del cliente quedaron en evidencia en las Encuestas al Paciente de Lorma realizadas en 2013. La Oficina de Relaciones con el Paciente realiza mensualmente Encuestas de Satisfacción y los resúmenes de las mismas son presentados, por intermedio de la Secretaría Ejecutiva, a los respectivos Jefes de Departamento para una acción inmediata, monitorizando e informando sobre las mejoras obtenidas. La premisa es que las mejoras del proceso deben basarse en datos (1).

Como consecuencia, los patrones de comportamiento de las encuestas de los pacientes mejoraron un año después de su aplicación. La Smile Survey, una nueva herramienta diseñada para evaluar los resultados del nuevo programa, también reveló resultados positivos.

Comprobación Pre-operativa, Señalización del lugar - Tiempo de espera - Divulgación de la Cultura de la seguridad del Paciente desde el Quirófano Principal a la Cirugía Ambulatoria

En este artículo, describimos cómo difundimos la cultura de la seguridad de la cirugía en el lugar correcto desde el Quirófano Principal a la Cirugía Ambulatoria. Analizamos cómo integramos el protocolo Correct Site Surgery del proyecto High 5s en el flujo de trabajo del Quirófano Ambulatorial (DSOT) y cómo monitorear las reclamaciones a través de la auditoría y la respuesta. También reflexionamos sobre cómo el análisis de los factores humanos (HFACS) ayuda a salvar las diferencias brindando una herramienta para reconocer las posibles causas de no conformidad.

Sistema sanitario Universitario Nacional (NUHS) Programa de Asistencia Transitoria

Los pacientes ancianos y frágiles requieren más tiempo de recuperación después de ser hospitalizados y, a menudo, el hospital los da de alta a su domicilio con escasas ayudas, a pesar de las necesidades de cuidados complejos que requieren. Son especialmente vulnerables a los peligros de una hospitalización y la asistencia fragmentada no es adecuadamente gestionada.

En marzo de 2014 se lanzó un programa de asistencia geriátrica transitoria llamado NUH-to-Home (NUH2H) para brindar asistencia multidisciplinaria personalizada y de alta calidad a adultos ancianos que hubiesen sido dados de alta del National University Hospital (NUH) de Singapur. Esto ayudó a incrementar la calidad de la atención domiciliar en el hogar después del alta, destacando una reducción final de las readmisiones y de las estancias prolongadas en el hospital.

En el primer año de aplicación, hubo respectivamente una reducción del 67%, 68% y 75% en readmisiones, visitas a salas de emergencia y duración de las hospitalizaciones.

Uso del aprendizaje online y en el lugar para favorecer la interacción enfermera-paciente y mejorar la experiencia del paciente

En este artículo describimos nuestro proyecto de lanzar un curso de aprendizaje online, usando situaciones del mundo real para ayudar al personal de enfermería a mejorar sus capacidades de comunicación con los pacientes a fin de mejorar la experiencia del paciente.

La filosofía que soporta nuestro proyecto es «un reclamo

es un regalo». Debatimos sobre cómo los reclamos de los pacientes se incorporan en nuestro programa y sobre el uso del lenguaje HEART para ofrecer al paciente una mejor experiencia hospitalaria. La sigla 'HEART' hace referencia a cinco atributos que creemos todo el personal de enfermería debe adoptar: Ser HUMILDE, ser EMPÁTICO, emplear una comunicación ATRACTIVA, ser RESPONSABLE y TRANSMITIR los hechos cuando se interactúa con los pacientes. Los módulos de comunicación se encuentran online como una alternativa a la enseñanza en aula, dado que ofrece una mayor flexibilidad para el aprendizaje.

MAA Medicare – Cruce de Fronteras

En este artículo describimos las actividades de la fundación caritativa MAA Medicare Charitable Foundation, que apoya dos secciones benéficas - la MAA Medicare Kidney Charity Fund (Fundación benéfica renal) y la MAA Medicare Health Charity Fund (Fundación benéfica de la salud). Los autores describen cómo las organizaciones caritativas pueden jugar un papel vital apoyando el cuidado de pacientes con enfermedades renales en los casos en que dichos cuidados no se encuentran disponibles a través de programas públicos gubernamentales. Los empleados públicos y gubernamentales jubilados que necesitan el tratamiento de diálisis pueden recibir cuidados de centros de diálisis privados gracias a subsidios gubernamentales. Sin embargo, muchos pacientes con bajos recursos que no pueden afrontar los elevados costos de la diálisis se verían privados del cuidado sin el programa para diálisis del MAA Medicare. El artículo destaca cómo una colaboración público-privado entre ONG que financia este programa, puede jugar un papel fundamental en el fortalecimiento del sistema sanitario y el acceso a cuidados efectivos y asequibles en un contexto donde dichos cuidados no estarían al alcance de segmentos vulnerables de la población.

Nuevos Nichos del Turismo del Bienestar Chino en la Isla de Phuket.

El tamaño creciente de la población de China es el factor enigmático primordial en la oportunidad del turismo del bienestar del país. La medicina preventiva y la prevención sanitaria son sectores en crecimiento de la asistencia sanitaria debido a los avances en el campo de la tecnología y de los diagnósticos médicos. En cualquier caso, el turismo del bienestar en China está aún en sus albores, ofreciendo masivas oportunidades para la industria del turismo del bienestar en el extranjero. Numerosos informes revelan que para un ciudadano chino los bienes medioambientales como el aire puro, el agua limpia y las características naturales, son considerados como los tributos más importantes para el desarrollo del turismo del bienestar. La Isla de Phuket es uno de los mejores destinos turísticos, con una gran reputación debido a las atracciones medioambientales y a las actividades en la playa. Por otro lado, las instalaciones médicas de vanguardia y los médicos especializados de los centros hospitalarios en la Isla de Phuket brindan la oportunidad de ofrecer una probada medicina de prevención basada en resultados e intervenciones de bienestar para clientes o pacientes que buscan el turismo de bienestar y una saludable longevidad.

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中文摘要

一款移动智能手机应用的开发简介。“PWH easyGo”这款应用能为患者和探视人员导航，帮助他们轻松地去到医院的各个科室和设施。

“PWH easyGo”是一款移动智能手机应用（app），用于帮助患者和探视人员寻找医院里的各个科室和设施。医院的各个入口张贴了印有二维码的海报。安装了这款应用的用户就可以通过扫描这些海报上的二维码，或者在应用里手动选择他们当前的位置以及目的地，然后系统就可以显示相应的路线，并配以图片。这是由香港医院管理局开发的第一款这样的应用，可以从Apple Store（iOS）和Play Store（安卓）下载。

下面这个网址的视频示范了怎样使用“PWH easyGo”：http://www3.ha.org.hk/pwh/film/pwheasygo20150608_eng.mp4。

除评审外的另一个提高患者安全和质量的方法

患者安全的提升需要整个医疗系统范围内的努力，涉及性能提供、环境安全与风险管理中大量的行动，包括感染控制、药品的安全使用、设备安全性、临床操作的安全性和护理环境的安全性。

卫生保健评审是一个提升质量和患者安全的主要步骤。在多家全球性评审机构中，JCI国际医院质量认证是卫生保健评审领域中的金牌标准。对于像印度的阿波罗集团这样的医院集团，患者安全的道路起源于新德里的阿波罗医院集团在2005年第一个获得了JCI国际医院质量认证。接下来的几年间，这个集团的八家医院也陆续通过了JCI国际医院质量认证，从而使国内得到这项认证的医院数量增加到了二十三家。此后，成立了全国医院及卫生保健服务供应商认证委员会（NABH）。现今，国内有近三百多家通过了它的评审和认证。

除了评审认证以外，患者安全和卫生保健质量还有很多其它工作有待进行。为进一步提升患者安全，阿波罗医院集团采取了多项手段。

卫生保健服务供应商对床位使用率的认知：卫生保健机构质量提升措施的前提

背景： 医院病床床位的使用率，受多种因素的影响，分别与患者、医生和管理相关。应从卫生保健服务供应商的角度出发分析这些因素，以使管理机构采取的改进措施能与卫生保健工作人员的认知保持一致，从而最终对医院的效率和护理质量起到作用。

宗旨和目的： 明确卫生保健服务提供商眼中影响医院床位使用率的因素。

方法： 本研究为针对印度北部地区一家排名前三的公立机构开展的横向研究。研究使用结构验证自填式问卷，共采访了7个科室和7个专科共18个病房的所有住院医师和护士。

调查结果： 参与共有279人接受问卷调查（117名医师、162名护士）。对医师而言，对床位使用率有重要影响的因素为患者（2.34，0.36）、医师（2.47，0.32）和管理（2.61，0.29）；

对护士而言，这些因素分别为患者（1.97，0.40）、医师（1.97，0.46）和管理（2.39，0.40）。

结论： 近年来随着卫生保健趋势的变化（决策改革、技术发展、业务可持续方面、质量措施等），让政策制定者（管理当局）有机会来关注卫生保健服务提供商（人力资源）在床位使用率这一健康卫生服务系统重要因素方面的认知。

关键词： 认知，卫生保健服务提供商，床位使用率，护理质量

Lorma对于优质服务的关注

Lorma医疗中心一直以来都把优质服务培训作为重中之重。根据患者对于Lorma工作人员服务质量的评价，培训的安排和内容都有所调整。2013年的患者调查，揭示了客户满意度方面的不足之处。患者关系主管会每个月进行一次满意度评估调查，由行政将汇总提交给相关部门领导以便尽快采取措施，监督改进情况并上报。改进必须以数据（1）为基础进行。

带来的结果是：实施之后，患者调查的行为有所改进。为测定这一新项目实施结果而开发的新工具“微笑调查”，也取得了确定性的成果。

术前确认、手术位置标识和休息时间——从主要手术室到日间手术传播患者安全文化

本论文介绍了我们从手术室到日间手术传播正确手术位置安全文化的方式。文中讨论了我们如何将“5防”项目正确位置手术协议集成到日间手术室（DSOT）工作流程中，以及如何通过审核和反馈，实现合规性监管。文章还论及人为因素分析（HFACS）通过提供工具识别造成不合规的可能原因，在弥补差距方面起到的作用。

国立大学医学组织（NUHS）的过渡性护理项目

虚弱的老年病人入院以后需要长时间才能康复。哪怕他们有复杂的护理需求，也经常会在没有后续支持的情况下出院。如果得不到适当的管理，那么，他们对住院的危险性和不完全护理就会很敏感。

一项由老年病学专家主导名为NUH-to-Home（NUH2H）的过渡性护理项目于2014年3月启动，用来为从新加坡国立大学医院出院的老年人提供高质量以人为本的跨学科护理。其目的是提升出院后在家护理的质量和安全性，并最终达到减少再次入院和长期住院的目的。

项目实施一年以来，再次入院、紧急病房入住次数以及住院时间长度分别降低了67%、68%和75%。

通过在线和基于场景的教学，改善医护人员与病人之间的互动关系，并提供更好的病人体验

这篇论文介绍了我们的一个在线教学课程项目。它能利用现实生活中所发生的场景，来帮助医护人员加强与病人之间的沟通技能，从而为病人提供更好的体验。我们项目的观点就是“

抱怨是一份礼物”。我们讨论了病人的抱怨是怎样整合到我们的课程中，以及怎样通过HEART语言来为病人提供更好的就医经历。这里的缩写“HEART”代表了我们认为所有护理人员都应该具备的五点素质：**谦逊、耐心、感染力、责任心、与患者沟通时坦率不隐瞒**。我们开设的在线教学课程中有关于沟通的模块，以增加学习灵活性。

马联医药护理——跨界

本文介绍了马联医药护理慈善基金会 (MAA Medicare Charitable Foundation) 的活动，该组织为两个慈善部门——马联医药护理肾脏慈善基金会和马联医药护理健康慈善基金会 (MAA Medicare Health Charity Fund) 提供支持。文中描述了这些慈善组织在为政府公共项目所不能覆盖的肾病患者提供护理服务方面的至关重要的作用。需要进行透析的公务人员和政府公共退休人士，可以接受私人透析中心提供的护理服务，费用由政府补贴支付。但许多难以负担高额透析费用的低收入患者，若不是因为MAA的医药护理计划，就难以享受这样的护理服务。本文重点介绍了为这类计划提供资金的非营利组织的公共-私人合作关系，在改进卫生系统和人们能享受到有效、价格合理的护理方面所起的重要作用——若非这些因素的作用，那些弱势群体就不可能享受到这类护理服务。

新兴的中国人普吉岛养生旅游

中国巨大的人口数量是这个国家的养生旅游契机中最有趣的因素。因为有最先进的医学诊断和技术，预防性医药和预防性保健是卫生保健领域中增长最快的领域之一。但是，中国的养生旅游仍然处于其婴儿期。它能为出国养生旅游业提供新机遇。多项报告显示，包括清新的空气、干净的水和大自然特征在内的环境资源被认为是中国养生旅游发展中最重要因素。普吉岛是最佳的旅游目的地之一，其环境的悠闲和海滩活动极具胜名。另外，普吉岛上医院里的先进医疗机构和专家为寻找养生旅游和健康长寿的客户或病员提供了被广为证实、成效显著的预防医药和健康干预。

IHF events calendar

2016

IHF

40th World Hospital Congress

October 30 – November 1, Durban, South Africa

Visit www.worldhospitalcongress.org

For more information, contact sheila.anazonwu@ihf-fih.org

2017

IHF

41st World Hospital Congress

November 7 – 9, Taipei, Taiwan

For more information, contact sheila.anazonwu@ihf-fih.org

2016

MEMBERS

BELGIUM

Annual Congress

June 1, Diamant Center, Blvd Auguste Reyerslaan, 80, 1030 Brussels, Belgium

Association Belge Des Hopitaux - ASBL

www.hospitals.be/announced-events.php

COLOMBIA

5th International Health Forum - MEDITECH 2016

June 28 – July 1, Centro Internacional de Negocios y Exposiciones, Corferias, Bogotá

Asociacion Colombiana De Hospitales

www.meditech.com

FRANCE

Paris Healthcare Week

May 24 – 26, Paris Expo, Paris, France

Federation Hospitaliere De France

www.parishealthcareweek.com

French Society for Oncology Congress

Theme: Interpreting and sharing advances in oncology

June 29 – July 1, Palais des Congrès, Porte Maillot, Paris

Unicancer – Federation Francaise Des Centres De Lutte Contre Le Cancer

www.congres-sfcancer.com

MAP Conference – Molecular Analysis for personalized therapy

Theme: Interpreting genomic alterations for clinical use

September 23 – 24, London

Unicancer – Federation Francaise Des Centres De Lutte Contre Le Cancer

www.map-onco.net

World Cancer Congress

Theme: Mobilising Action, Inspiring Change

October 31 – November 1, Palais des Congrès, Porte Maillot, Paris

Unicancer – Federation Francaise Des Centres De Lutte Contre Le Cancer

www.worldcancercongress.org

GERMANY

German Hospital Conference

November 14 – 17, Düsseldorf Fairgrounds, Düsseldorf, Germany

German Hospital Federation

www.medica.de

INDONESIA

National Seminar

October 19 – 22, Jakarta Convention Center, Jakarta, Indonesia

Indonesian Hospital Association

www.pdpersi.co.id; www.hospital-expo.com

(All conferences are in Indonesian language)

KOREA

The 7th Korea Healthcare Congress 2016

November 17 – 18, Ninetree Convention, Seoul, Korea

Korean Hospital Association

NORWAY

National Congress, Rehabilitation

May 19 – 20, Oslo Kongressenter, Oslo

Norwegian Hospital & Health Service Association

National Congress, Mental Health

October 12 – 13, Oslo Kongressenter, Oslo

Norwegian Hospital & Health Service Association

www.nsh.no/Script/ListOpenConferences.aspx

(All conferences are in Norwegian language)

PORTUGAL

Best Practices in Health Award: 10th Edition Meeting

November 23

Portuguese Association for Hospital Development (APDH)

www.boaspraticasemsaude.com/

6th International Hospital Congress

November 24 – 25

Theme: Innovation in Health – Myth or reality?

Portuguese Association for Hospital Development (APDH)

www.apdh.pt/

USA

HIMSS

Ministry of Health & HIMSS Middle East Conference

May 2016, Four Seasons Riyadh Saudi Arabia

www.himssmeconference.org

HIMSS Turkey

May 26-27, Istanbul Turkey Greenpark Pendik Hotel & CC

www.himss-turkey.org

eHealth Week

8-10 June Amsterdam The Netherlands Beurs van Berlage

www.ehealthweek.org

Asia Pac16 Conference & Exhibition

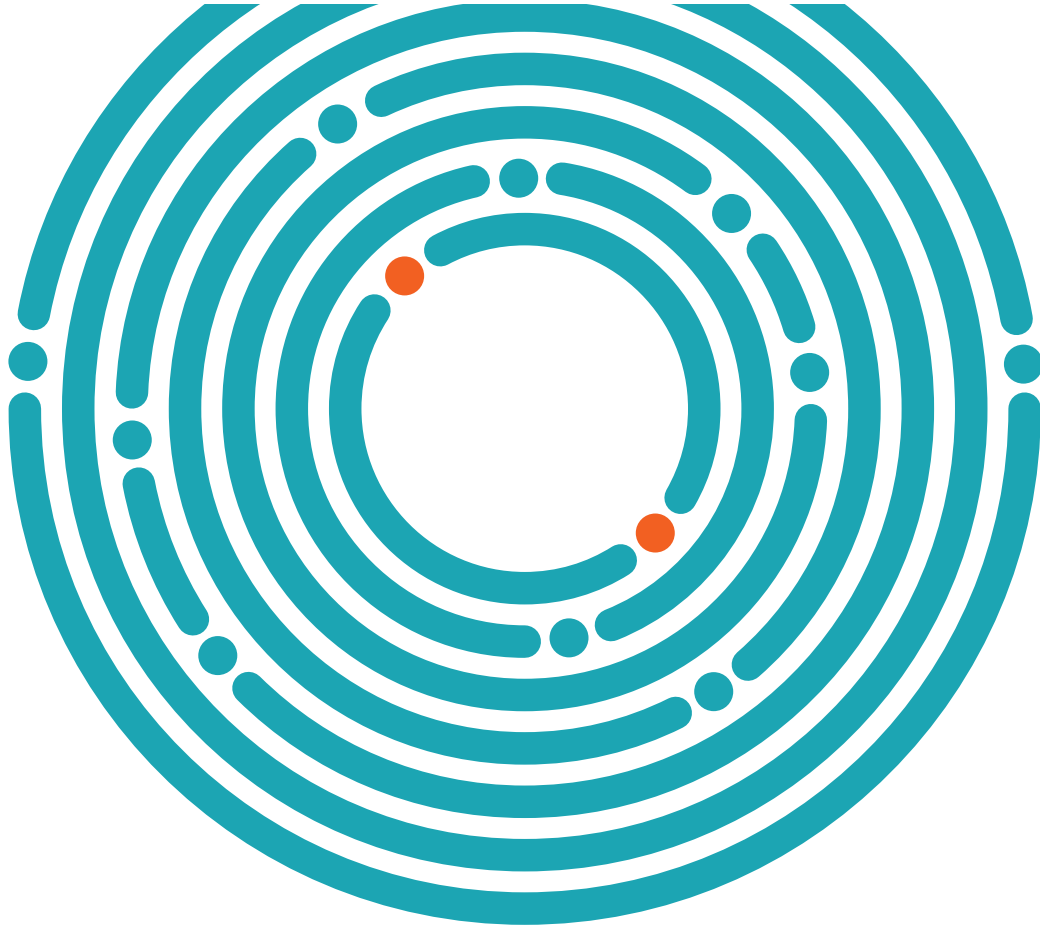
Aug 22-25, Bangkok Thailand QSNCC

www.himssasiapacconference.org

2016 VIZIENT CONNECTIONS SUMMIT, (VIZIENT members only)

September 29 – 30, Dallas, TX, USA

For further details contact the: IHF Partnerships and Project, International Hospital Federation, 151 Route de Loëx, 1233 Bernex, Switzerland; E-Mail: sheila.anazonwu@ihf-fih.org or visit the IHF website: <https://www.ihf-fih.org/ihf-events>



One world. Shared mission. The power of collaboration.



Barbara Anason
Senior Vice President
Academic Medical Center
Networks and Strategy

barbara.anason@vizientinc.com
1 (312) 775-4107

**Experience the power of collaboration by joining the
IHF's University Hospital Special Interest Group (UH-SIG).**

To advance knowledge exchange, performance improvement, and collaboration among university hospitals around the world, UH-SIG members participate in benchmarking projects, innovative studies, online collaborations, and international meetings.

Vizient (formerly University HealthSystem Consortium) serves as Secretariat of the UH-SIG. At Vizient, we envision a world where efficiency and empathy work hand in hand. We have supported university hospitals for more than 30 years, acting as a catalyzing force for performance improvement.

Coming soon: Participate in the 2016 survey

This global survey will explore the relationship and governance models between universities and academic medical centers. The survey will be conducted in collaboration with the University of Eastern Finland.

The UH-SIG is open to IHF members' university hospital leaders, and the survey will be distributed to all UH-SIG members.

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2016 IHFDURBAN

40th World Hospital Congress

"Addressing the Challenge of Patient-centered Care and Safety"

1- 3 November | Durban ICC | Durban, South Africa



**JOIN LEADERS AND DECISION-MAKERS
IN EXCHANGING EXPERIENCES AND
SHOWCASING INNOVATIONS
IN HEALTHCARE !**



PROGRAMME

<http://bit.ly/IHFDurbanProgramme>



REGISTRATION & FEES

<http://bit.ly/IHFDurbanRegistration>



ACCOMMODATION

<http://bit.ly/IHFDurbanAccommodation>



HOSPITAL VISITS

<http://bit.ly/IHFDurbanHospitalVisits>

MAXIMISE YOUR NETWORKING EXPERIENCE!

- 1 WELCOME RECEPTION
- 2 GALA DINNER
- 3 EXHIBITION/MARKET PLACE
- 4 INTERNATIONAL AWARDS

The IHF World Hospital Congress remains the unique one-stop shop for healthcare professionals seeking an international forum in which to engage in a 360 degree learning and knowledge-sharing experience among peers.

At the 2016 Durban Congress world-renowned leaders, practitioners, academics, IHF member countries will, through oral and poster presentations cover the following topics:

- Quality of Care
- Capacity Building in Leadership and Management
- Governance and Accountability
- Ethics and Medical Legal Issues
- Financing and University Health Coverage
- Technology: Role in determining Clinical Pathways in Patient Care
- Service Delivery: Innovations in delivery of Care and Hospital Services

PLENARY SPEAKERS



MINISTER
CHRISTOPHER
DREXLER



JONATHAN B. PERLIN
(USA)



DR. NICHOLAS CRISP
(SOUTH AFRICA)



DR. PAULO CHAPCHAP
(BRAZIL)



PROF. JOAN C. LO
(TAIWAN)



ANNE HAFSTAD
(NORWAY)

MEMBER SESSIONS

- » Belgian Hospital Association (*BELGIUM*)
- » National Association of Private Hospitals (*BRAZIL*)
- » French Hospital Federation & Unicancer (*FRANCE*)
- » Hospital Authority (*HONG KONG*)
- » Norwegian Hospital And Health Services Association (*NORWAY*)
- » Aga Khan University (*PAKISTAN & EAST AFRICA*)
- » Philippine Hospital Association (*PHILIPPINES*)
- » Department of Health (*SOUTH AFRICA*)
- » Union Catalanda d'Hospitals (*SPAIN*)
- » Taiwan Hospital Association (*TAIWAN*)
- » American Hospital Association & American College of Healthcare Executives (*USA*)
- » Joint Commission International (*USA*)
- » Lagos State Health Service Commission (*NIGERIA*)

SPECIAL INTEREST SESSIONS

- » Collaboration Between IHF AND UIA Work Programme Public Health
- » CEO Forum
- » Global Group for Health Partnerships
- » Healthcare Executives: IHF Special Interest Group
- » University Hospitals: IHF Special Interest Group
- » The World Health Organization, the Regional office for Africa, Republic of Congo
- » The World Health Organization, Geneva, Switzerland



IHF SECRETARIAT

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www.ihf-fih.org/ihfcongress



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