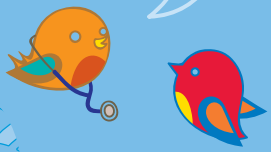
THE NHG Open Communication HANDBOOK



This publication is produced by the National Healthcare Group (NHG) Quality Resource Management (QRM) department.

If you have any suggestions or feedback, please email ihq@nhg.com.sg.

November 2011

Message from The CEO

Patient safety is the right of every patient and the responsibility of every healthcare provider. As healthcare workers, our mission is to provide relief from disease or harm. Yet despite the best of intentions and efforts, sometimes things go wrong and the care we deliver may cause unanticipated harm to patients.

Adverse events can have devastating emotional and physical consequences for patients, their families and can be distressing for the healthcare professionals involved. This publication on open communication is designed to help you learn how to discuss clinical incidents promptly and compassionately after harm has occurred, so that you and your patients can cope better with the after-effects.

In NHG, we adopt a patient-centred approach by looking at adverse events from the point of view of the patient and asking, "What would I want if I were harmed in my treatment?" We advocate open communication – because that is the right thing to do.

Today, medical errors, though less prevalent than before, still impact the lives of patients and their families profoundly. Historically, errors have been viewed as an inevitable by-product of complex care. Yet in reality, they are symptoms of defective

systems. That is why redesigning the system and fixing its inherent flaws is the only way to prevent the same errors from happening. Our goal is to build a culture of openness to enhance patient safety and improve the quality of care.

Enjoy the read!

Professor Chee Yam Cheng
Chief Executive Officer

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Introduction

Introduction

"The very first requirement in a hospital is that it should do the sick no harm."

— Florence Nightingale

An adverse event is an injury, harm, or complication that results from an unexpected and unintended occurrence in healthcare delivery (rather than a patient's underlying condition), which may or may not have been preventable. It may arise from an act of commission (e.g. administration of wrong medication) or omission (e.g. failure to perform a test or treatment).

How we respond when things go wrong is an important part of the care we deliver. Traditionally healthcare organisations have refrained from disclosing adverse events to patients and their families for fear of lawsuits and negative publicity. However, patients today value transparency. As healthcare providers, we have the responsibility to tell them the truth because that is respecting patient autonomy.

Nurturing an Open and Fair Culture

An open and fair culture is one where:

- You are open about incidents you have been involved in
- You feel able to talk to your colleagues and superiors about any incident
- You are treated fairly and are supported when an incident happens
- Your organisation and its staff are accountable for their actions
- Your organisation is open with patients, the public and its staff when things have gone wrong

Promoting a culture of openness is essential to improving patient safety. This is because individuals are less likely to report errors or raise concerns on safety if they are punished or blamed. An open culture ensures that communication is transparent. Being honest with ourselves and our patients about our weaknesses and inadequacies is a starting point to any real improvement.

Understanding What and Why Patients Want to Know about Adverse Outcomes

Grief is a normal part of the response of patients and their families following an adverse event. Yet their reactions are also influenced by the manner in which the incident is handled; inadequate or insensitive management may cause further emotional harm.

Patients generally expect ongoing communication, honesty and transparency from their healthcare providers. In the case of an error, they want to receive a genuine apology, know the details about the incident, understand the implications for their care, how the consequences will be mitigated and how recurrences will be prevented so that the same thing does not happen to another patient.

Even when there has been no error on the part of the healthcare provider, the grief of patients and their families is real and needs to be addressed to help them overcome disappointment and to move on with other care decisions.

What is Open Communication?

Patients experience disappointment and sometimes anger when they do not attain the outcome they expect from the delivery of clinical care. In such instances, honesty on our part matters because these patients are ill and vulnerable, with pressing questions which require truthful answers.

The four elements of effective open communication include:

- An expression of regret
- A factual explanation of what happened
- Consequences of the event
- Steps being taken to manage the event and prevent a recurrence

You will read more about each of these in the next few pages.

Barriers to Open Communication

Taking ownership and communicating about adverse events is not easy. There are several reasons why healthcare professionals generally do not want to communicate to patients and their families when something bad happens:

- A psychologically reactive need to preserve a sense of self
- Fear of admitting responsibility for making an error that may have hurt someone
- Fear of anger from the patient and/or someone in authority
- Fear of loss of job or position
- Threat of censure
- Threat of medical malpractice claims
- Fear of colleague disapproval
- Fear of negative publicity

(Source: Banja J. *Medical Errors and Medical Narcissism.* Sudbury, Massachusetts: Jones & Bartlett Publishers. 2005)

Sharing bad news becomes much harder when the outcome is the immediate result of one's own action. Most healthcare professionals have never been trained to communicate with patients and their families after an adverse event. This presents another barrier to open communication.

Benefits of Open Communication

The communication of an adverse event is important because ethically, it is the right thing to do. Patients and their families have the right to know what happened, how it happened, and how it can be prevented for the next patient.

Trust is a key part of caring and healing. Open communication promotes trust and provides reassurance to the patient that you and your organisation are acting in his best interests and committed to the truth.

Research has shown that being open can decrease the emotional trauma, anger and frustration felt by patients. It also helps to reduce the stress experienced by healthcare providers, relieves their feelings of worry and guilt, and alleviates their fear of "being found out". They are able to cope better and recover emotionally.

It is commonly assumed that communicating with patients after adverse events increases the risk of malpractice claims and lawsuits. However, the reverse is true. Patients are more likely to file lawsuits when there is a lack of empathy and a perceived or actual withholding of information by healthcare providers.

Open communication enables us to identify opportunities for improvement by gaining a better understanding of incidents from the perspective of patients and their families. It serves the best interests of the patient, the healthcare professional and the organisation. Honesty is the best policy.

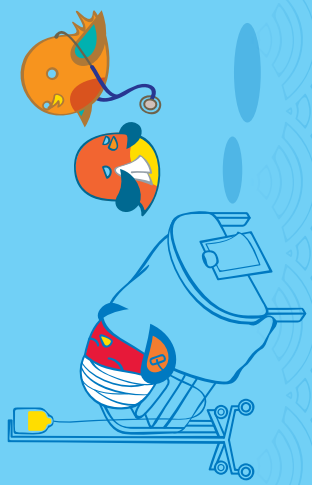
Principles of Open Communication

The following principles underlying the approach to open communication help create and embed a culture of openness:

Open Communication Principles
1. Acknowledgement
2. Truthfulness, timeliness and clarity of communication
3. Apology
4. Recognising patient and family expectations
5. Professional support
6. Risk management and systems improvement
7. Multi-disciplinary responsibility
8. Clinical governance
9. Confidentiality
10. Continuity of care

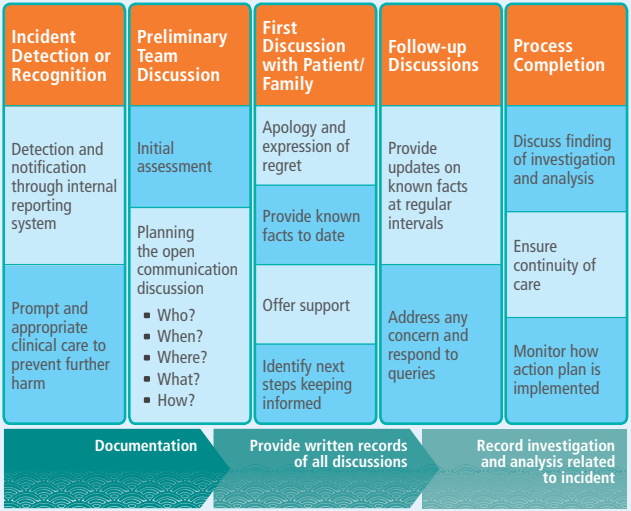
(Source: NHS National Patient Safety Agency. *Being Open: Communicating Patient Safety Incidents with Patients, their Families and Carers.* 2009)

The Open Communication Process



The Open Communication Process

There are several stages involved in the open communication process:



(Modified from NHS National Patient Safety Agency Publication - *Being Open: Communicating Patient Safety Incidents with Patients, their Families and Carers*)

The duration of the open communication process depends on the nature of the incident, the needs of the patient and his family, and the progress of the investigation.

Incident Detection, Reporting and Escalation

The open communication process begins with the recognition and acknowledgement that a patient has suffered harm as a result of an adverse event.

Adverse events can generally be identified by:

- Staff at the time of the incident or retrospectively when an unexpected outcome is detected
- Patients/families who express dissatisfaction with the care provided either at the time of the incident or retrospectively
- Incident reporting systems and medical record reviews
- Complaint channels or procedures

Reporting is the first step in learning from an incident. It leads to an investigation to uncover the system failures underlying the event.

Your organisation's internal reporting system and procedures would specify:

- The individuals, departments or agencies who should be notified of the incident
- How the incident should be reported
- Who is responsible for reporting
- The process for what happens after the incident is reported

According to the severity and nature of the incident, the level of response by the organisation is then determined. Priority is usually given to incidents which are fatal and cause significant morbidity (e.g. death, permanent loss of function, and need for surgery) or represent a significant breach in practice. These cases should be escalated to the appropriate administrative and clinical leadership.

Our First Response to an Adverse Event

When an adverse event occurs, the top priority is *always* to take care of the patient's physical needs and protect him against further harm by providing the required medical care. Assess the patient's condition and determine what, if anything, needs to be done immediately.

To protect evidence, you should immediately secure all implicated drugs, equipment and records. Eliminate any remaining threat to safety. If the adverse event was equipment-related, do not experiment with the equipment, otherwise you may run the risk of altering important information.

Determine the circumstances surrounding the adverse event quickly while memories of those involved are fresh. This information can be crucial to the immediate clinical treatment plan for the patient.

The multi-disciplinary team should meet as soon as possible after the event to:

- Establish the basic clinical facts
- Assess the incident to determine the level of immediate response
- Identify who will be responsible for discussion with the patient and his family
- Identify the immediate support needs of the patient and healthcare staff involved
- Ensure that there is a consistent approach around discussion with the patient and his family

Sometimes, it may not be in the patient's best interests to know about an adverse event immediately, so communication may be deferred. Disclosure may also not be appropriate when there is a suspicion or actual knowledge of abuse or neglect by the patient's family, or when there are police investigations or psychological concerns for the patient.

Initial Assessment and Investigation of the Event

The initial assessment determines whether the care delivered for the patient has met minimal acceptable standards, whether there were breaches or non-compliance to policy and whether there were unintended errors that led to the incident. This would allow the organisation to decide if further investigation is warranted to determine its level of accountability to the patient, and to find out what the root causes are so that system changes can be made to prevent recurrence.

In any investigation process:

- Ascertain that an adverse event has occurred and ensure that it is formally reported.
- Trigger the investigation policy and notify the investigation team for assessment.
- Conduct staff interviews to establish the chronology of events (*i.e. "what happened"*). Identify care management problems (*i.e. "how did it happen"*) and record the clinical events or condition of the patient at that time and the contributory factors (*i.e. "why did it happen"*).
- Using Root Cause Analysis (RCA), drill down to the root causes.
- Compile a report listing the root causes of the problem and make recommendations to prevent recurrence.
- Submit the report to senior leadership.
- Establish processes to ensure that corrective actions are implemented.
- Monitor both the effectiveness and possible negative effects of changes.

The investigation should be thorough, multi-disciplinary and non-judgemental, focusing less on individuals and more on organisational factors. Although a particular action or omission may be the immediate cause of an adverse event, close analysis usually reveals a series of departures from safe practice, each influenced by the working environment and the wider organisational context.

Throughout the investigation process, it is important to provide support for all healthcare professionals involved in the adverse event. Do not unfairly expose them to punitive disciplinary action, increased medico-legal risk or any threat to their registration.

Framework of Factors Influencing Clinical Practice and Contributing to Adverse Events	
Framework	***Contributory Factors***
Institutional	▪ Regulatory context ▪ Medico-legal environment
Organisation and management	▪ Financial resources and constraints ▪ Policy standards and goals ▪ Safety culture and priorities
Work environment	▪ Staffing levels and mix of skills ▪ Patterns in workload and shift ▪ Design, availability and maintenance of equipment ▪ Administrative and managerial support
Team	▪ Verbal communication ▪ Written communication ▪ Supervision and willingness to seek help ▪ Team leadership
Individual staff	▪ Knowledge and skills ▪ Motivation and attitude ▪ Physical and mental health
Task	▪ Availability and use of protocols ▪ Availability and accuracy of test results
Patient	▪ Complexity and seriousness of condition ▪ Language and communication ▪ Personality and social factors

(Source: Charles Vincent, Ph.D. *Understanding and Responding to Adverse Events.* New England Journal of Medicine. 2003)

Breaking the News – Who, When, Where, What and How?

While investigation is ongoing, it is important to start planning with regard to how the incident will be presented to the patient and his family, who does the disclosing, who apologises (if necessary), how and whether the patient will be offered forms of support (e.g. follow-up treatment, tests). Where possible, such information should be shared in person.

Plan the initial conversation carefully. Ensure that required medical information is available. Anticipate the needs of the patient and his family. A structured approach to discussing a difficult topic will result in more effective communication and a better outcome.

As you plan for the initial communication, remember these guiding points:

- Keep it simple
- Express empathy and compassion
- Do not attribute blame

Who?

Disclosures by administrative staff or management alone are usually not well received. The initial communication should be led by clinicians or nurses (with a supervisor) with whom the patient has had previous contact. These individuals should have a good grasp of the facts relevant to the incident and have sufficient experience and expertise in relation to it.

As representatives of the organisation, one should communicate with the patient and his family in a way they can understand. Avoid excessive use of medical jargon and refrain from being defensive. Be committed, compassionate, and maintain the relationship with the patient and his family for continued support.

Prior to the meeting, the patient should be informed of the identity and role of all attendees. It may be overwhelming to the patient if too many people are involved in the discussion. Hence, keep the group size small. If the discussion is anticipated to be complex or difficult, the patient should be encouraged to have his family members present.

When?

The occurrence of an adverse event should be communicated to the patient as soon as it is recognised and the patient is medically stable and ready psychologically to receive this information. Typically, this should occur within 24 hours after the incident is detected, or when there are some preliminary findings from the initial investigation.

Early acknowledgement is essential to maintaining trust. Avoiding or delaying such a conversation may be perceived as an attempt to cover up the mistake on the part of the organisation and this may increase the patient's sense of anxiety, anger or frustration.

Some factors to consider when timing this discussion include:

- Clinical condition of the patient
- Patient preference
- Privacy and comfort of the patient
- Availability of the patient and his family
- Availability of key staff involved in the incident and in the open communication process

Where?

The choice of the setting for communicating adverse events is important, particularly if apology or restitution is appropriate. Where possible, the meeting should be pre-scheduled, and arranged in a private and quiet area that supports both confidentiality and the feelings of the patient and his family.

If you are involved in the discussion, avoid speaking in hallways and corridors. Notify your colleagues that you do not wish to be interrupted during the discussion. Set your phone on vibration mode. Ensure that all participating in the discussion are seated.

Because the purpose of the initial conversation is to inform and support the patient, it should be held in a manner that empowers the patient and avoids any demonstration of rank. It is important to make the patient and his family comfortable; all discussions should be conducted with their concerns in mind.

What?

As in any other communication, you may wish to assess the patient's understanding of the situation. This will not only help you transit to breaking the news but also assess his perception of the circumstances surrounding the incident.

The initial explanation to the patient and his family should include a clear, objective jargon-free review of the facts of the adverse event, how this has affected or will affect the patient, and what is being done to mitigate the effects of the harm including care plans and follow-up. Acknowledge the event, express regret and explain what happened step-by-step.

If an error has been made, the organisation should admit it, take responsibility for it, apologise and commit to finding out why it occurred. Determining the causes of an adverse event and whether or not it was preventable requires careful analysis and is likely to be time-consuming. Inform the patient and his family of the steps that are being taken for investigation and the likely timelines. Assure them that further information will be shared with them as soon as it is available.

Ensure that the patient and his family receive consistent communication and they know who to approach for information regarding the incident and its investigation.

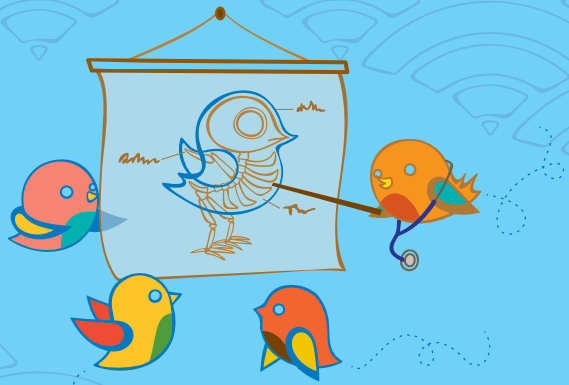
Throughout the discussion, choose words carefully especially when talking to the patient and do not admit liability without prior discussion and agreement of the organisation's management or insurer. Summarise the conversation including the undertakings made to the patient and his family and the key issues raised.

How?

How the communication process is handled profoundly influences the reaction of the patient and his family. At the first meeting, explain clearly the purpose of the discussion and introduce everyone. Use the relevant language, be sensitive to cultural values, and tap on communication aids to facilitate the discussion. If necessary, arrange for an interpreter.

Use appropriate language and terminology when speaking to the patient and his family. For example, using the term "adverse event" may be meaningless to them. Try to use short sentences and keep the message simple.

Be objective. Opinions, speculation and attribution of blame should be avoided, especially since preliminary conclusions are often misinterpreted by patients and their families and may cause unnecessary alarm. Be careful not to make judgements about individual culpability as this will undermine any trust the patient has in the healthcare team.



Facilitating the Discussion

Facilitating the Open Communication Discussion

Even in the absence of adverse events, patients feel vulnerable by virtue of them being ill. Therefore, when their condition worsens, they may have particularly severe or complex emotional reactions including fear, anxiety, depression, anger, frustration, loss of trust, and feelings of isolation. This is especially so in the case of an error where patients are unintentionally harmed by the very people whom they entrusted to help them.

In all your communication with the patient and his family, speak clearly, slowly, and directly. Pause often to allow them to collect their thoughts since they may find it difficult to process complex information.

Be empathetic and try to look at issues from the patient's perspective. Often, it is not just what is said but how one says it that predicts the patient's reaction. If done in a compassionate and thoughtful manner, the conversation can mitigate anxiety and rebuild the patient's trust in the team, the organisation and the healthcare system.

Dealing with Anger and Disappointment

Patients and their families often react to the disclosure of error with anger, confusion and suspicion. Be prepared for the unexpected. They may cry, faint, scream or remain silent. Whatever the response, allow for strong emotions to be expressed. Do not talk excessively to minimise any awkwardness. Do not respond to accusations or threats.

Occasionally patients are harmed, or die, as a direct consequence of receiving treatment. Whatever the cause, people experiencing grief and disappointment are not always receptive to explanations and they need to have their emotions validated. In the case of unexpected death or a late or mistaken diagnosis, the desire to blame someone may be strong. Therefore, do not react in a defensive manner but give appropriate support (e.g. listening without being quick to judge).

Communicating an Apology or Expression of Regret

Patients and their families should receive a meaningful apology as early as possible – one that is appropriately worded. A sincere apology can be immeasurably healing to the patient. In most cases, the physician responsible for the patient's care is the one most suitable to make the apology.

The nature of the apology should depend on whether there was a deviation from the expected standard of care or not. In the case of an error, the apology should acknowledge the error and the harm done, express an appropriate emotional response and commit to future action that will prevent a recurrence.

Often, the perceived sincerity of an apology is more important than the actual words used. Avoid apologies that are scripted as you are more likely to anger patients rather than comfort them.

Deciding how to word an apology can be complex. The word "sorry" helps to reduce anger but it must be used appropriately. Do not word an apology as an attribution or acceptance of blame or as an admission of liability until all the facts are known.

Apologising effectively is not something that comes naturally to most people and thus is a skill to be learned and practised. Learn to do it properly – a shoddy apology can do more harm than good.

Listening Effectively and Empathetically

An important element of assisting patients and their families in dealing with grief is to provide them the opportunity to be listened to. Being able to tell their story and express their concerns to a considerate and attentive listener is an important aspect of the healing process.

In all conversations with the patient, focus not only on the content of what is being said, but also acknowledge key emotions that are expressed. Doing too much talking is a common pitfall. Ask open-ended questions and do not interrupt the patient. Ensure good non-verbal communication, including making eye contact and having an open body posture.

Providing Honest Answers to Questions

Honest communication conveys respect for the patient and his family. If, however, the evidence has not been systematically examined, they should be informed of this.

Allowing the patient to ask questions rather than providing explanations helps the conversation to remain patient-centred. While patients may prefer that their questions are answered immediately, it is important that all answers given to the patient are factual. If the facts are not known, you should highlight that you would prefer to give the right answer in the future rather than a potentially wrong answer immediately. Make the commitment to provide honest answers once they are known after further investigation.

Avoiding Arguments and Misguided Comments

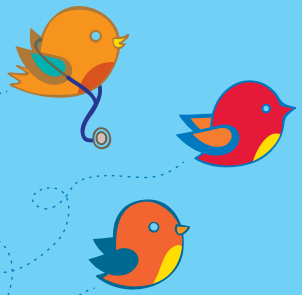
In any difficult conversation with patients and their families, disagreement may arise. It is important to focus on addressing the problem in such situations. You may be tempted to respond to differences of opinion or interpretation by trying to convince the other person that you are "right", but you must avoid arguments. Resist the urge to start your sentences with "But…".

Analysis of claims and complaints data shows many of these arise because of misguided or incorrect comments made by healthcare providers. Therefore, focus on facts and not interpretation of facts in discussions with patients and their families.

Informing the Patient of Ways Lessons Will Be Learned

Patients generally want to know how their incident will be examined so that lessons can be learnt from them. Most patients who have experienced harm have a strong interest in seeing to it that what happened to them does not happen to someone else. Knowing that changes were made helps patients and their families cope with their pain or loss.

As you end every conversation, thank the patient and his family and leave with an empathetic connection. Let them know that you care.



Process Completion

Documentation

Following an adverse event, to prevent potentially confusing and contradictory communications, it is essential that all information concerning the event is documented.

Documentation facilitates learning from the incident and provides an accurate record if legal or regulatory action ensues. Because there is a risk that a patient or family member who hears an apology or words of regret about their experience may misinterpret that liability is being admitted, you should ensure that these are recorded in the clinical record and witnessed.

The clinical details concerning the event that should be recorded include:

- Objective details of the incident, including date, time and place
- Patient's condition immediately before the time of the incident
- Incident description and outcome
- Medical intervention and patient response
- Notification of healthcare professionals involved in patient care
- Plan for further incident management and investigation

All communications with the patient and his family should also be documented in the same record, including location of meeting, date and time, attendees, contents of the conversation (e.g. questions asked, concerns raised and responses given), apology or expression of regret, patient reaction, the level of understanding exhibited by the patient, the next steps to be taken (e.g. offers of assistance and support) and ongoing treatment plans.

Retain copies of letters sent to the patient and his family, any statements taken in relation to the incident and a copy of the incident report.

Privacy and Confidentiality

Details of an adverse event should at all times be considered confidential.

Seek consent of the patient concerned prior to disclosing information beyond the healthcare professionals involved in treating him. Ensure that any special restriction to openness raised by the patient is respected. Communication with parties outside of the clinical team should also be on a strictly need-to-know basis and, where practicable, records should be anonymous.

Follow-up Care for Patients and their Families

Patients and their families may need considerable practical and emotional help and support after experiencing an adverse event. It is therefore important to discuss with them their individual needs.

Following the incident, patients should continue to receive the necessary treatment. Establish a structure that keeps patients and their families informed of scheduled times for follow-up visits, communication and updates on all findings from investigations and any remedial actions taken.

Attention should also be paid to the emotional and social needs of patients. Ask them specifically about their feelings related to their injury or harm and about any anxieties they may have about future treatment. Take these concerns seriously, address them completely and help refer patients to counsellors or social workers if necessary. Sometimes, patients may want to be referred to another organisation for care or a second opinion. This should be arranged as long as it does not compromise patient care.

Financial support should also be extended promptly where appropriate. Prolonged hospital stay or disability may lead to substantial unexpected expenses. Although offers of compensation may be premature in the initial conversation, patients should be reassured that they will not be billed for extra care needed if an error has been made. All billing should also be put on hold until after the incident has been investigated.

After discharge, patients should be provided with the names and contact information of individuals of the organisation who are available to address their questions, complaints, and concerns.

Support for Fellow Colleagues

Like patients and their families, healthcare professionals implicated in adverse events can be emotionally vulnerable. Many become fearful of disciplinary action, legal implications and damage to their reputation. They may feel isolated and experience shame and guilt towards their patients. There is also the anxiety about having to talk with patients and their families about the incident. These conversations require huge amounts of energy and may leave them feeling drained.

Sometimes, in face of harsh judgement by colleagues, these individuals lose confidence in their professional competencies. Hence, all healthcare professionals need to be taught how to deal with their own feelings when they are the proximal cause of patient harm.

Whether or not minor or significant harm has been resulted, these healthcare professionals are often the unrecognised "second victims" and they need emotional support for recovery. Specifically, they need:

- To feel that they are supported;
- To feel that they are not being unfairly judged;
- To feel that those involved understand what they are going through;
- To have any concerns about their performance conveyed honestly based on factual analysis; and
- To have their good intentions acknowledged

If you are involved in a serious clinical incident, you may wish to take some time off, take a walk, or find a close friend or colleague to talk to. If necessary, approach a counsellor and seek out ways to address your feelings. Do not just shake off the incident or deny your feelings. Accept that you are also harmed by the adverse event and need help and support to address your pain.

Conclusion

"Trust is a mutual covenant, a fragile but enduring commitment between individuals. Trust in the medical relationship explains why patients will expose their body, allow their flesh to be cut, and ingest poisons – all in the hope of preserving or restoring health. Patients not only expect to be told the truth by their physician, but also to be protected from harm. When the latter is not possible, the former is required."

— Theresa Drought

Responding to adverse events involves honesty, empathy and taking responsibility when warranted. Yet no two responses will be exactly the same. Different patients, different healthcare providers, and different situations will result in differences in what is said, who says it, and how it is received.

While open communication is not easy, it is the right thing to do. Ultimately, as healthcare providers, it is our responsibility to patients to explain the facts and be supportive and empathetic. This is about promoting and maintaining an open learning environment to achieve improvements in quality and safety.

Adding years of healthy life

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