Integrating Patient Safety into the culture of the organization

Presented at the Safety 2010 World Conference
21st-24th September UK

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Disclosure: The presenter has nothing to disclose
About Tawam

- Tawam Hospital is a 477-bed tertiary care facility located in Al Ain, Abu Dhabi, and the largest of the United Arab Emirates.
- In 2006 Tawam Hospital entered a ten year affiliation with Johns Hopkins Medicine.
Objectives

- Understand the principles of the Science of Safety
- Review the organizational characteristics that foster a culture of safety
- Discuss the Comprehensive Unit-based Patient Safety program
What is Culture*?:

“The way we do things around here”

1 attitude = opinion...everyone’s attitude = culture

*aka Climate
Culture in Safe Organizations

- Commit to no harm
- Focus on **systems** not people
- Value Communication/teamwork
  - Assertive communication
  - Teamwork
  - Situational awareness
- Accept responsibility for systems in which we work
- Recognize culture is local
- Seek to expose (not hide) defects
- Celebrate safety
  - Workers viewed as heroes
How we started at Tawam?

- January-08 Created the Patient Safety dept. recruited 4 patient safety officers and medication safety officer.
- February-08 Leadership training on Patient Safety
- April-08 “Culture of Safety” Conference & Comprehensive Unit based Safety Program Roll-Out.
- June 09-Implemented “Patient Safety Net" online incident reporting system.
The Johns Hopkins - Comprehensive Unit-based Safety Program (CUSP)
On February 22, 2001, eighteen-month old Josie King died from medical errors at the Johns Hopkins Hospital.

Peter J. Pronovost, MD, PhD is a practicing anesthesiologist and critical care physician, teacher, researcher, and international patient safety leader.
Comprehensive Unit-based Safety Program (CUSP)

CUSP is a 6-step safety program
- Step 1: Safety Attitude Questionnaire (SAQ)
- Step 2: Staff education on the Science of Safety
- Step 3: 2-item Staff Safety Survey
- Step 4: Executive Walk Rounds
- Step 5: a) Learning from our mistakes
  b) improve teamwork and communication
- Step 6: Resurvey staff about Safety Culture (annually)
Senior Executive Leaders assigned to each CUSP unit:

<table>
<thead>
<tr>
<th>NNU</th>
<th>Pediatric Oncology</th>
<th>ICU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr. Gregory Schaffer</td>
<td>Mr. Saeed Al Kuwaiti</td>
<td>Dr. Steven Matarelli</td>
</tr>
<tr>
<td>CEO</td>
<td>CFO</td>
<td>COO</td>
</tr>
</tbody>
</table>
SAQ items are grouped into 6 factors:

<table>
<thead>
<tr>
<th>Factor: Definition</th>
<th>Example items</th>
</tr>
</thead>
</table>
| **Job satisfaction:** positivity about the work experience | -I like my job  
-This hospital is a good place to work |
| **Teamwork climate:** perceived quality of collaboration between personnel | -Disagreements in this clinical area are appropriately resolved (i.e., what is best for the patient)  
-Our doctors and nurses work together as a well coordinated team |
| **Safety climate:** perceptions of a strong and proactive organizational commitment to safety | -I would feel safe being treated in this clinical area  
-Medical errors are handled appropriately in this clinical area |
| **Perceptions of management:** approval of managerial action | -Hospital management supports my daily efforts in this clinical area  
-Hospital management does not knowingly compromise the safety of patients |
| **Stress recognition:** acknowledgement of how performance is influenced by stressors | -I am less effective at work when fatigued  
-When my workload becomes excessive, my performance is impaired |
| **Working conditions:** perceived quality of the work environment and logistical support (staffing, training, etc.) | -Trainees in my discipline are adequately supervised  
-This hospital deals constructively with problem personnel |
Culture linkages to Clinical, Operational & other Outcomes

- Wrong Site Surgeries
- Decubitus Ulcers
- Delays
- Bloodstream Infections
- Post-Op Sepsis
- Post-Op Infections
- Post-Op Bleeding
- PE/DVT
- RN Turnover
- Absenteeism
- VAP
- Burnout
- Unit size
- Communication breakdowns
- Familiarity
- Spirituality
# CUSP-Safety Attitude Questionnaire Results (SAQ) 2008

<table>
<thead>
<tr>
<th>Domain / Percentage Positive</th>
<th>ICU</th>
<th>Pediatric Oncology</th>
<th>NNU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teamwork</td>
<td>54.90%</td>
<td>64.70%</td>
<td>66.70%</td>
</tr>
<tr>
<td>Safety</td>
<td>41.80%</td>
<td>50%</td>
<td>70.80%</td>
</tr>
<tr>
<td>Job Satisfaction</td>
<td>69.20%</td>
<td>82.40%</td>
<td>75%</td>
</tr>
<tr>
<td>Stress Recognition</td>
<td>41.80%</td>
<td>20.60%</td>
<td>48.60%</td>
</tr>
<tr>
<td>Perceptions of Hospital Management</td>
<td>12.10%</td>
<td>26.50%</td>
<td>41.70%</td>
</tr>
<tr>
<td>Perceptions of Unit Management</td>
<td>28.60%</td>
<td>38.20%</td>
<td>59.70%</td>
</tr>
<tr>
<td>Working Conditions</td>
<td>46.20%</td>
<td>44.10%</td>
<td>52.80%</td>
</tr>
</tbody>
</table>
Teamwork Climate

Results:

Perceived quality of collaboration between personnel
Teamwork Disconnect

- **RN**: Good teamwork means I am asked for my input

- **MD**: Good teamwork means the nurse does what I say
NOTE: Teamwork climate is negatively correlated with annual nurse turnover rates, absenteeism, BSI, PE/DVT, delays, and burnout. (see slide 62, refs 9, 10, 14, 15, 16, 18)

% of respondents reporting good teamwork climate

- ICU Resp Therapist
- Peds Onc Registered Nurse
- ICU Nurse Manager/Charge Nurse
- NICU Nurse Manager/Charge Nurse
- NICU Registered Nurse
- Peds Onc
- NICU NNU
- NICU Attending/Staff Physician
- Peds Onc Attending/Staff Physician
- Peds Onc Nurse Manager/Charge Nurse

Needs improvement < 60%
Safety Climate Results:
Perceptions of a strong and proactive organizational commitment to patient safety
"I Would Feel Safe Being Treated Here As A Patient."

NOTE: Hospital administration often likes this item
Job Satisfaction Results:

Positivity about the work experience
“I Like My Job.”

% of respondents that agree

- ICU Nurse Manager/Charge Nurse
- Peds Onc Attending/Staff Physician
- NICU NNU Registered Nurse
- ICU Registered Nurse
- NICU NNU Nurse Manager/Charge Nurse
- Peds Onc Registered Nurse
- ICU Resp Therapist
- ICU Attending/Staff Physician
- NICU NNU Attending/Staff Physician
- Peds Onc Nurse Manager/Charge Nurse
2 question survey:

1. How you think the next patient in your unit/clinical area will be harmed?

2. What you think can be done to prevent or minimize this harm?

Tawam Hospital NNU Safety Issues by Percentage N=73

Tawam Hospital ICU Safety Issues by Percentage N=93

Tawam Hospital Peds Onc Safety Issues by percentage N=39
CUSP Executive Walk rounds:

- The CUSP Executive monthly walk round is a process to improve patient safety and the culture.
- The purpose is to strengthen collaboration among senior hospital leaders, department chairs/unit managers and frontline caregivers.
- The end result being improved patient safety.
Typical question asked during the walk rounds are:

- How have you prevented a patient from being harmed?
- What keeps you up at night?
- What bothers you after you have left the hospital?
- How will the next patient be harmed?
- What are some barriers you have faced in patient safety?
- If your loved one was a patient in this unit, what would you be worried about?
- How can you better involve patients and their families in their care?
Steve Talking to the House Keeping staff

ICU - CUSP Executive Walk rounds

Peds Oncology - CUSP Executive Walk rounds
“Learning from Defects”
Medication Error Story-1

First Nurse proceeded to administer the vaccine without taking the tablet PC to the patient bed side.

Expired vaccine arrived from Pharmacy.

Double check for expiration date not done properly.

Vaccine Injected and asked second Nurse to chart in Cerner on his behalf.

Second Nurse baffled after seeing the expiration date and the missing expiration date in the label.

Error reached the patient but did not cause harm.
Medication Error Story-2

Chemotherapy
Written by MD.
Vincristine
doxorubicin
And
L_aspargenes

Checked
according
To the protocol
Then faxed
to pharmacy

Prepared by
Pharmacy

Medication
Received from
Pharmacy,
Checked with
Another
Chemotherapy
Competent
Nurse
VCR
DOXO
L-Asp

Two medication
taken to
patient room
VCR
and
DOXO
And
Emla cream

L-Asp returned to
fridge

[Diagram showing the flow of medication: chemotherapy written by MD, checked according to protocol, prepared by pharmacy, received from pharmacy, checked with another chemotherapy competent nurse, two medications taken to patient room, L-Asp returned to fridge]
Implication of the errors.

- Both the staffs reported the incidents
- Helped institute a Fair and Just Culture
- Investigation of the two incidents, examined the processes and not just people.
- The two nurses have now become advocates of patient safety by sharing their experiences.
Patient Safety Net

- PSN is an electronic “incident report” and reporting system.
- From the University Health System Consortium.
- P.C. based from the units and compatible with CERNER Tablet and COW computers.
- When IR is needed it is constructed in a self-guided software program then forwards to selected parties.
- Provides comparative databases for evidence-based benchmarking.
The Best Catch Award
Celebrate safety
Medication Error Story-3

Telephonic order taken by Nurse from Doctor for Paracetamol 1000mg

Documented in CERNER as 10,000 mg

Verified by Pharmacy

Nurse identifies the error while charting

Nurse administers the medication (1000mg)

Co signed by Doctor

Read Back
Best Catch Award 2009
Abdulla Odat
RN

Synopsis:
Chemotherapy IFOSFAMIDE per protocol is for four doses, and it was written for 5 days. The fifth dose arrived, nurse checked protocol and prevented.
First Year Celebration

Second Year Celebration
Two years of CUSP implementation
NNU SAQ Results

NNU - 2008
NNU - 2010

- Teamwork
- Safety Climate
- Job Satisfaction
- Stress Recognition
- Working Conditions
- Perceptions of Hospital Management
- Perceptions of Unit Management

0.00% - 100.00%
Next Step:

- Continue the journey on establishing a “Culture of Safety”
- Implement CUSP in three more units.
Resources

- Institute of medicine [http://www.iom.edu/](http://www.iom.edu/)
- Institute for healthcare improvement [http://www.ihi.org/IHI/Topics/PatientSafety/](http://www.ihi.org/IHI/Topics/PatientSafety/)
Resources

- National Patient safety foundation
  http://www.npsf.org/
- Institute for safe medication practice
  http://www.ismp.org/default.asp
- Canadian Patient Safety Institute
  http://www.patientsafetyinstitute.ca/index.html
- http://www.asmso.org/
President Kennedy once visited a NASA site and encountered a janitor. Kennedy asked the janitor, "And what's your job?" The reply was, "Mr. President, I'm helping to put a man on the moon."

Suppose you walk round your hospital and the house keeping were to tell you “we’re making this the safest hospital.”
Thank you

Patient Safety Top Priority

“Cultural change is both evolutionary and revolutionary”