# Integrating Patient Safety in to the culture of the organization

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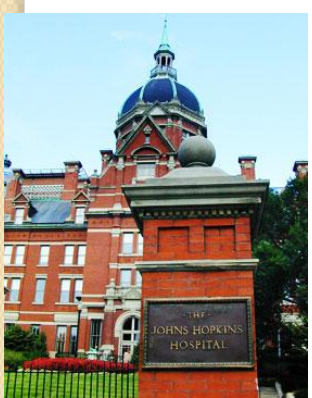
Disclosure: The presenter has nothing to disclose

# 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

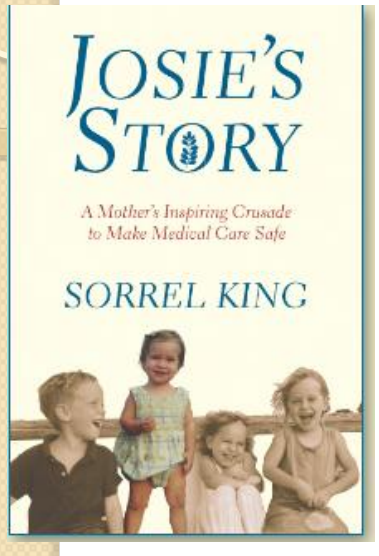
- Commit to no harm
- Focus on ***systems*** not people
- Value Communication/teamwork
  - Assertive communication
  - Teamwork
  - Situational awareness
- Accept responsibility for systems in which we work
- Recognize culture is local
- Seek to expose (not hide) defects
- Celebrate safety
  - Workers 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, M.D., Ph.D.*

**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)

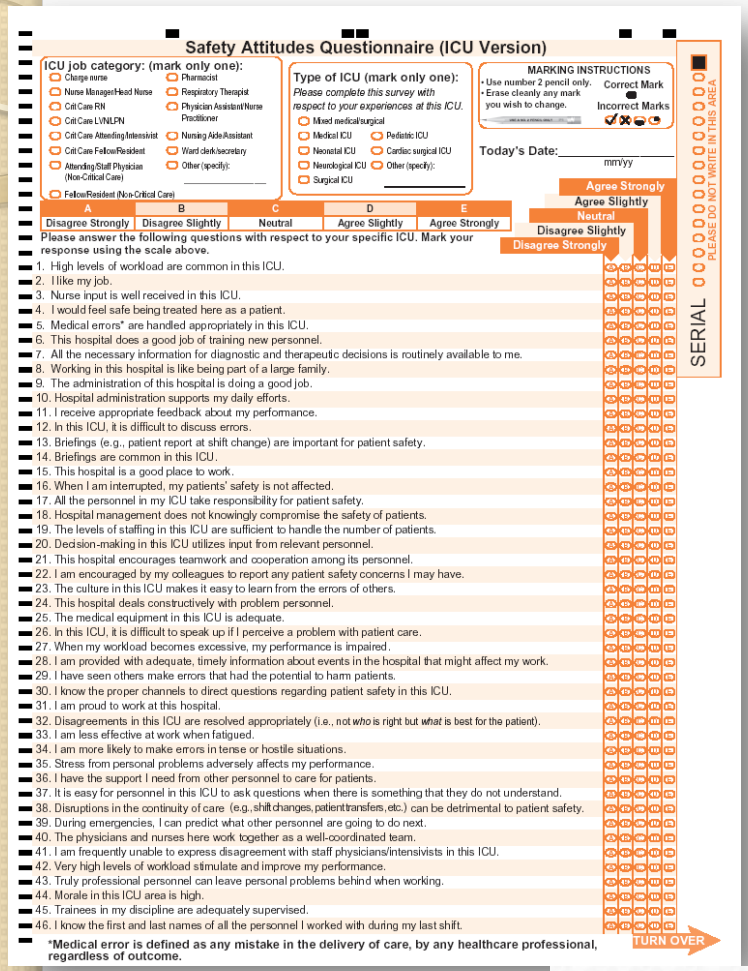
CUSP is a 6-step safety program

- 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:

| NNU | Pediatric Oncology | ICU |
|---|---|---|
| Mr. Gregory Schaffer  | Mr. Saeed Al Kuwaiti  | Dr. Steven Matarelli  |
| CEO | CFO | COO |

# Safety Attitude Questionnaire (SAQ)



Safety Attitudes Questionnaire (ICU Version)

ICU job category: (mark only one):
- Charge nurse
- Nurse Manager/Head Nurse
- Crit Care RN
- Crit Care LVN/LPN
- Crit Care Attending/Intensivist
- Crit Care Fellow/Resident
- Attending/Staff Physician (Non-Critical Care)
- Fellow/Resident (Non-Critical Care)
- Pharmacist
- Respiratory Therapist
- Physician Assistant/Nurse Practitioner
- Nursing Aide/Assistant
- Ward clerk/secretary
- Other (specify):

Type of ICU (mark only one):
*Please complete this survey with respect to your experiences at this ICU.*
- Mixed medical/surgical
- Medical ICU
- Pediatric ICU
- Neonatal ICU
- Cardiac surgical ICU
- Neurological ICU
- Other (specify):
- Surgical ICU

MARKING INSTRUCTIONS
- Use number 2 pencil only.
- Erase cleanly any mark you wish to change.

Correct Mark
Incorrect Marks

Today's Date: _____ mm/yy

SERIAL 0000000000000 PLEASE DO NOT WRITE IN THIS AREA

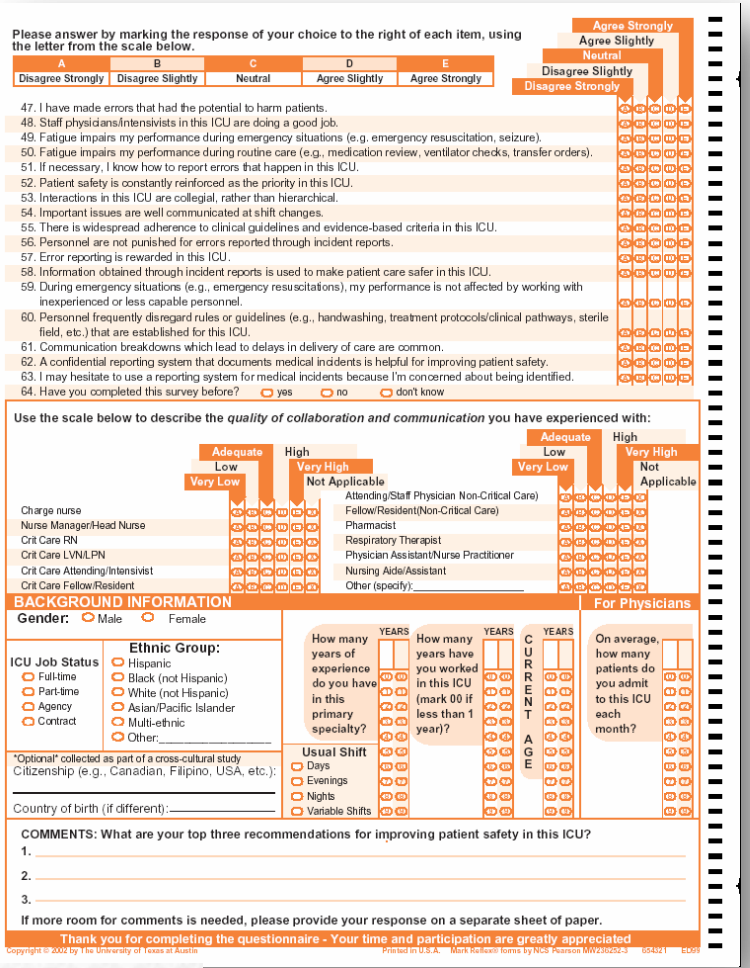
| A | B | C | D | E |
|---|---|---|---|---|
| Disagree Strongly | Disagree Slightly | Neutral | Agree Slightly | Agree Strongly |

Please answer the following questions with respect to your specific ICU. Mark your response using the scale above.

1. High levels of workload are common in this ICU.
2. I like my job.
3. Nurse input is well received in this ICU.
4. I would feel safe being treated here as a patient.
5. Medical errors* are handled appropriately in this ICU.
6. This hospital does a good job of training new personnel.
7. All the necessary information for diagnostic and therapeutic decisions is routinely available to me.
8. Working in this hospital is like being part of a large family.
9. The administration of this hospital is doing a good job.
10. Hospital administration supports my daily efforts.
11. I receive appropriate feedback about my performance.
12. In this ICU, it is difficult to discuss errors.
13. Briefings (e.g., patient report at shift change) are important for patient safety.
14. Briefings are common in this ICU.
15. This hospital is a good place to work.
16. When I am interrupted, my patients' safety is not affected.
17. All the personnel in my ICU take responsibility for patient safety.
18. Hospital management does not knowingly compromise the safety of patients.
19. The levels of staffing in this ICU are sufficient to handle the number of patients.
20. Decision-making in this ICU utilizes input from relevant personnel.
21. This hospital encourages teamwork and cooperation among its personnel.
22. I am encouraged by my colleagues to report any patient safety concerns I may have.
23. The culture in this ICU makes it easy to learn from the errors of others.
24. This hospital deals constructively with problem personnel.
25. The medical equipment in this ICU is adequate.
26. In this ICU, it is difficult to speak up if I perceive a problem with patient care.
27. When my workload becomes excessive, my performance is impaired.
28. I am provided with adequate, timely information about events in the hospital that might affect my work.
29. I have seen others make errors that had the potential to harm patients.
30. I know the proper channels to direct questions regarding patient safety in this ICU.
31. I am proud to work at this hospital.
32. Disagreements in this ICU are resolved appropriately (i.e., not *who* is right but *what* is best for the patient).
33. I am less effective at work when fatigued.
34. I am more likely to make errors in tense or hostile situations.
35. Stress from personal problems adversely affects my performance.
36. I have the support I need from other personnel to care for patients.
37. It is easy for personnel in this ICU to ask questions when there is something that they do not understand.
38. Disruptions in the continuity of care (e.g., shift changes, patient transfers, etc.) can be detrimental to patient safety.
39. During emergencies, I can predict what other personnel are going to do next.
40. The physicians and nurses here work together as a well-coordinated team.
41. I am frequently unable to express disagreement with staff physicians/intensivists in this ICU.
42. Very high levels of workload stimulate and improve my performance.
43. Truly professional personnel can leave personal problems behind when working.
44. Morale in this ICU area is high.
45. Trainees in my discipline are adequately supervised.
46. I know the first and last names of all the personnel I worked with during my last shift.

TURN OVER

*Medical error is defined as any mistake in the delivery of care, by any healthcare professional, regardless of outcome.



Please answer by marking the response of your choice to the right of each item, using the letter from the scale below.

| A | B | C | D | E |
|---|---|---|---|---|
| Disagree Strongly | Disagree Slightly | Neutral | Agree Slightly | Agree Strongly |

47. I have made errors that had the potential to harm patients.
48. Staff physicians/Intensivists in this ICU are doing a good job.
49. Fatigue impairs my performance during emergency situations (e.g. emergency resuscitation, seizure).
50. Fatigue impairs my performance during routine care (e.g., medication review, ventilator checks, transfer orders).
51. If necessary, I know how to report errors that happen in this ICU.
52. Patient safety is constantly reinforced as the priority in this ICU.
53. Interactions in this ICU are collegial, rather than hierarchical.
54. Important issues are well communicated at shift changes.
55. There is widespread adherence to clinical guidelines and evidence-based criteria in this ICU.
56. Personnel are not punished for errors reported through incident reports.
57. Error reporting is rewarded in this ICU.
58. Information obtained through incident reports is used to make patient care safer in this ICU.
59. During emergency situations (e.g., emergency resuscitations), my performance is not affected by working with inexperienced or less capable personnel.
60. Personnel frequently disregard rules or guidelines (e.g., handwashing, treatment protocols/clinical pathways, sterile field, etc.) that are established for this ICU.
61. Communication breakdowns which lead to delays in delivery of care are common.
62. A confidential reporting system that documents medical incidents is helpful for improving patient safety.
63. I may hesitate to use a reporting system for medical incidents because I'm concerned about being identified.
64. Have you completed this survey before? yes no don't know

Use the scale below to describe the *quality of collaboration and communication* you have experienced with:

| Adequate Low / Very Low | High / Very High / Not Applicable |
|---|---|
| Charge nurse | Attending/Staff Physician Non-Critical Care) |
| Nurse Manager/Head Nurse | Fellow/Resident(Non-Critical Care) |
| Crit Care RN | Pharmacist |
| Crit Care LVN/LPN | Respiratory Therapist |
| Crit Care Attending/Intensivist | Physician Assistant/Nurse Practitioner |
| Crit Care Fellow/Resident | Nursing Aide/Assistant |
| | Other (specify): |

BACKGROUND INFORMATION — For Physicians

Gender: Male Female

ICU Job Status
- Full-time
- Part-time
- Agency
- Contract

Ethnic Group:
- Hispanic
- Black (not Hispanic)
- White (not Hispanic)
- Asian/Pacific Islander
- Multi-ethnic
- Other:

*Optional* collected as part of a cross-cultural study
Citizenship (e.g., Canadian, Filipino, USA, etc.):
Country of birth (if different):

Usual Shift
- Days
- Evenings
- Nights
- Variable Shifts

How many years of experience do you have in this primary specialty? YEARS

How many years have you worked in this ICU (mark 00 if less than 1 year)? YEARS

CURRENT AGE YEARS

On average, how many patients do you admit to this ICU each month?

COMMENTS: What are your top three recommendations for improving patient safety in this ICU?
1. _____
2. _____
3. _____

If more room for comments is needed, please provide your response on a separate sheet of paper.

Thank you for completing the questionnaire - Your time and participation are greatly appreciated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Pascal Metrics
The Social Apgar™ Group

# SAQ items are grouped into 6 factors:

| Factor: Definition | Example items |
|---|---|
| ***Job satisfaction:*** positivity about the work experience | -I like my job<br>-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)<br>-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<br>-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<br>-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<br>-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<br>-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

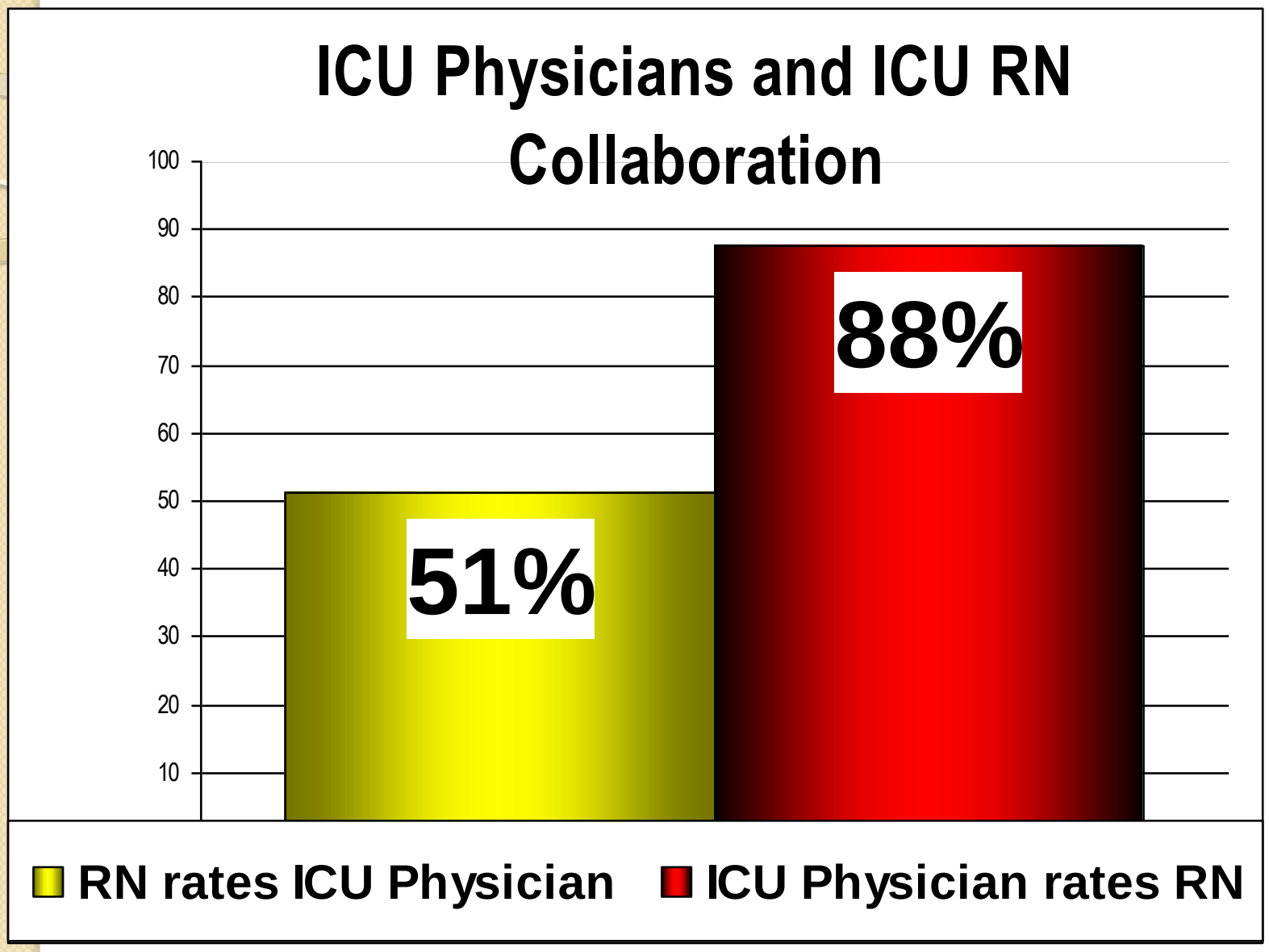
- Burnout
- Unit size
- Communication breakdowns
- Familiarity
- Spirituality
- Most validated: **Qual. Saf. Health Care 2005;14;364-366**

# CUSP-Safety Attitude Questionnaire Results (SAQ) 2008

| Domain / Percentage Positive | ICU | Pediatric Oncology | NNU |
|---|---|---|---|
| Teamwork | 54.90% | 64.70% | 66.70% |
| Safety | 41.80% | 50% | 70.80% |
| Job Satisfaction | 69.20% | 82.40% | 75% |
| Stress Recognition | 41.80% | 20.60% | 48.60% |
| Perceptions of Hospital Management | 12.10% | 26.50% | 41.70% |
| Perceptions of Unit Management | 28.60% | 38.20% | 59.70% |
| Working Conditions | 46.20% | 44.10% | 52.80% |

# Teamwork Climate Results:

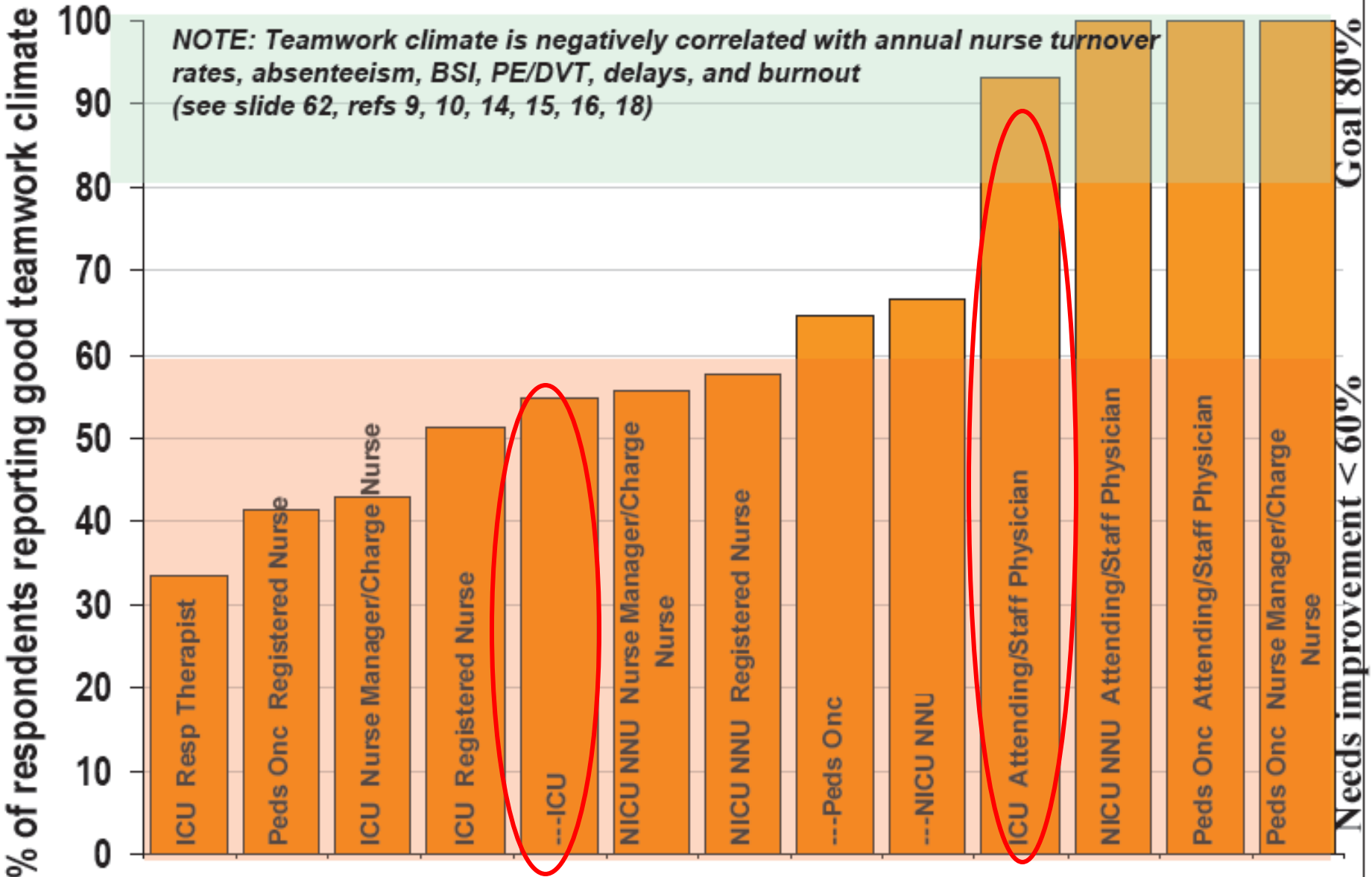
*Perceived quality of collaboration between personnel*


ICU Physicians and ICU RN Collaboration
100
90
80
70
60
50
40
30
20
10
51%
88%
RN rates ICU Physician
ICU Physician rates RN

# Teamwork Disconnect

- **RN: Good teamwork means I am asked for my input**
- **MD: Good teamwork means the nurse does what I say**

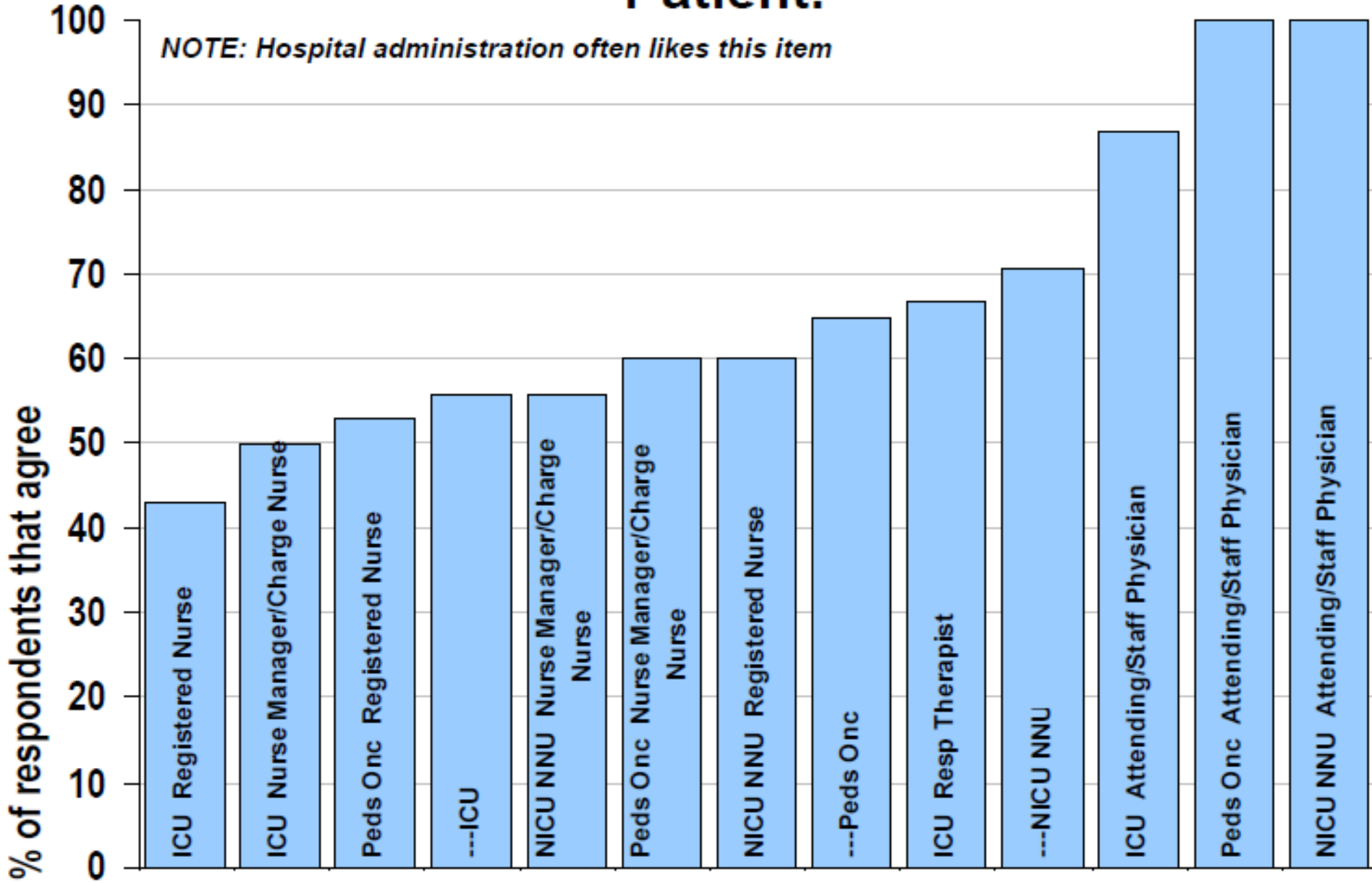
# Teamwork Climate Across Clinical Areas



# Safety Climate Results:

*Perceptions of a strong and proactive organizational commitment to patient safety*

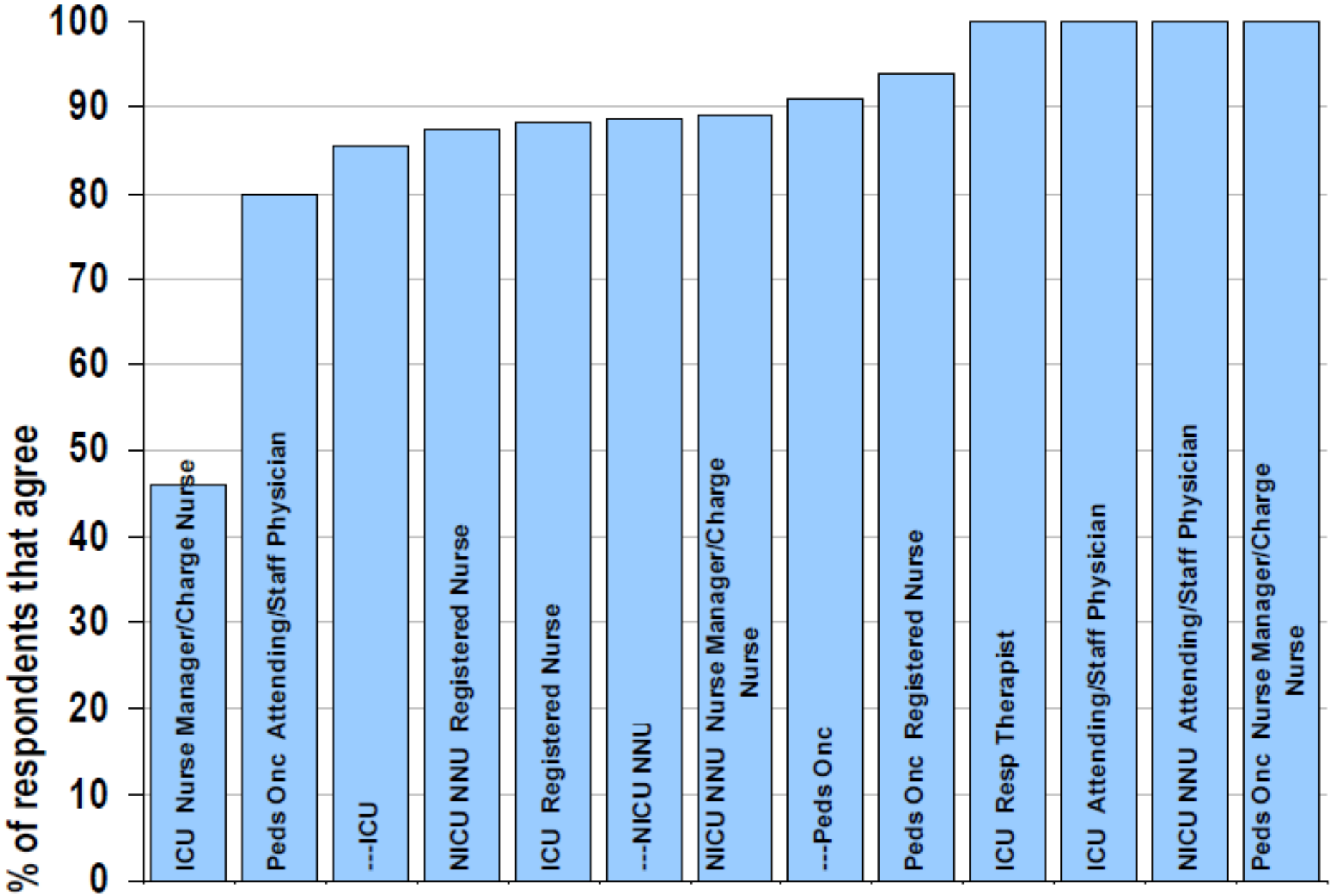
# "I Would Feel Safe Being Treated Here As A Patient."



# Job Satisfaction Results:

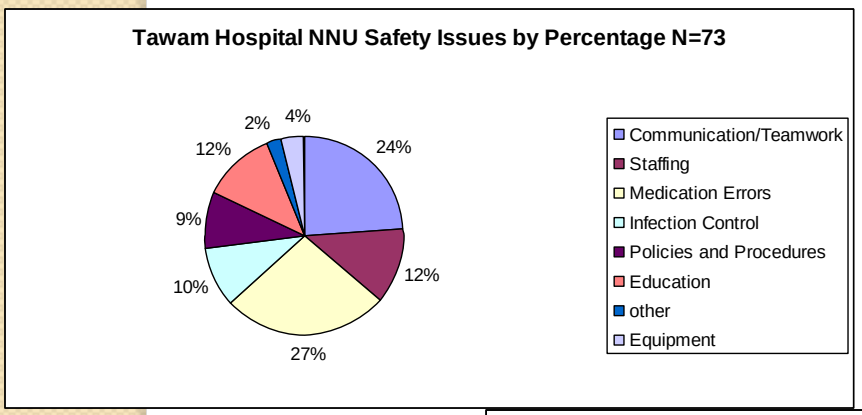
*Positivity about the work experience*

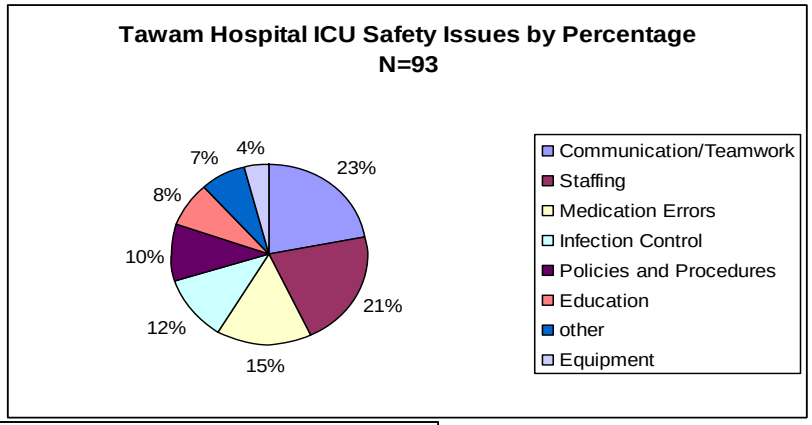
# "I Like My Job."

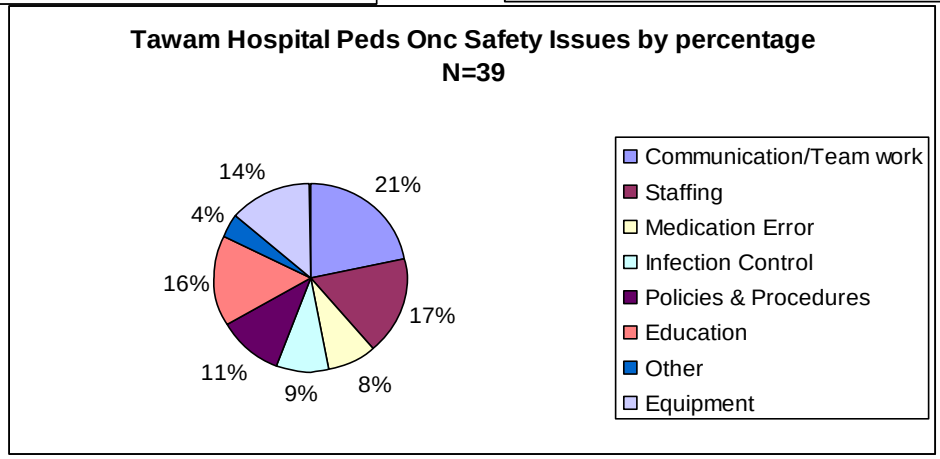

% of respondents that agree
100
90
80
70
60
50
40
30
20
10
0
ICU Nurse Manager/Charge Nurse
Peds Onc Attending/Staff Physician
---ICU
NICU NNU Registered Nurse
ICU Registered Nurse
---NICU NNU
NICU NNU Nurse Manager/Charge Nurse
---Peds Onc
Peds Onc Registered Nurse
ICU Resp Therapist
ICU Attending/Staff 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?**



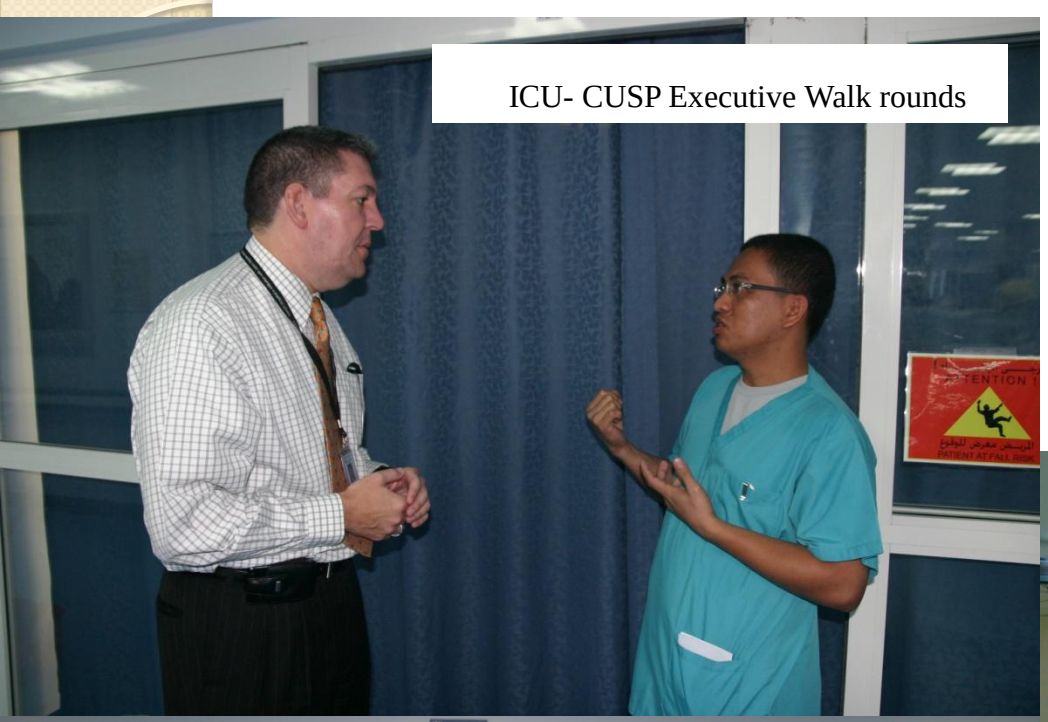
# CUSP Executive Walk rounds:

- 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?

ICU- CUSP Executive Walk rounds

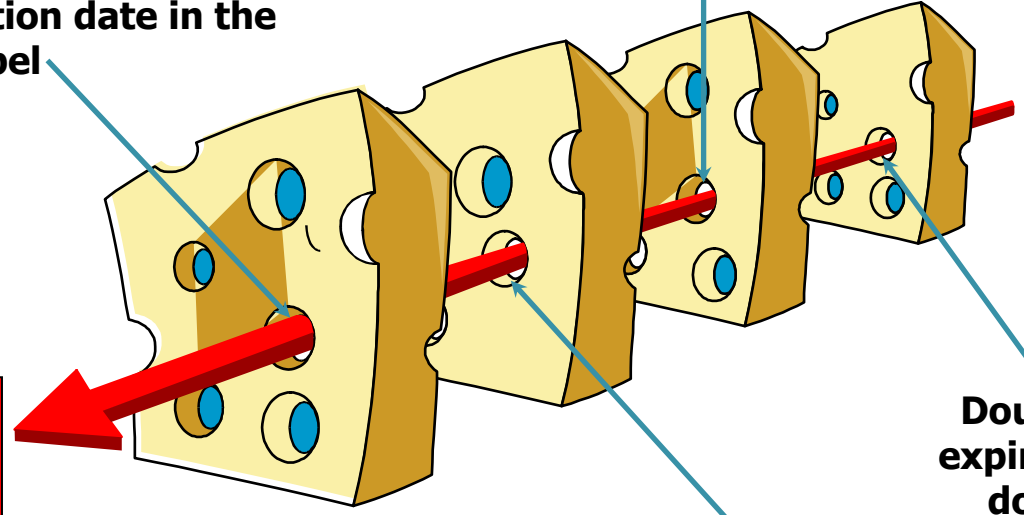


Peds Oncology - CUSP Executive Walk rounds

Steve Talking to the House Keeping staff

# “Learning from Defects”

# Medication Error Story-1



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

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

Expired vaccine arrived from Pharmacy

Error reached the patient but did not cause harm

Double check for expiration date not done properly

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

SWISS CHEESE MODEL

# Medication Error Story-2

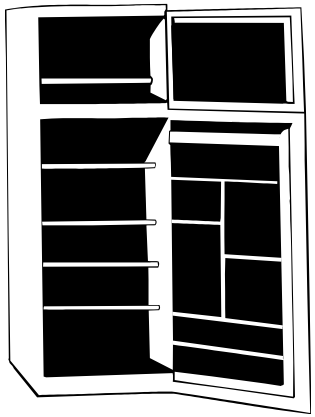
Chemotherapy Written by MD. Vincristine doxorubicin And l_aspargenes

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

L-Asp returned to fridge



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

# 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.

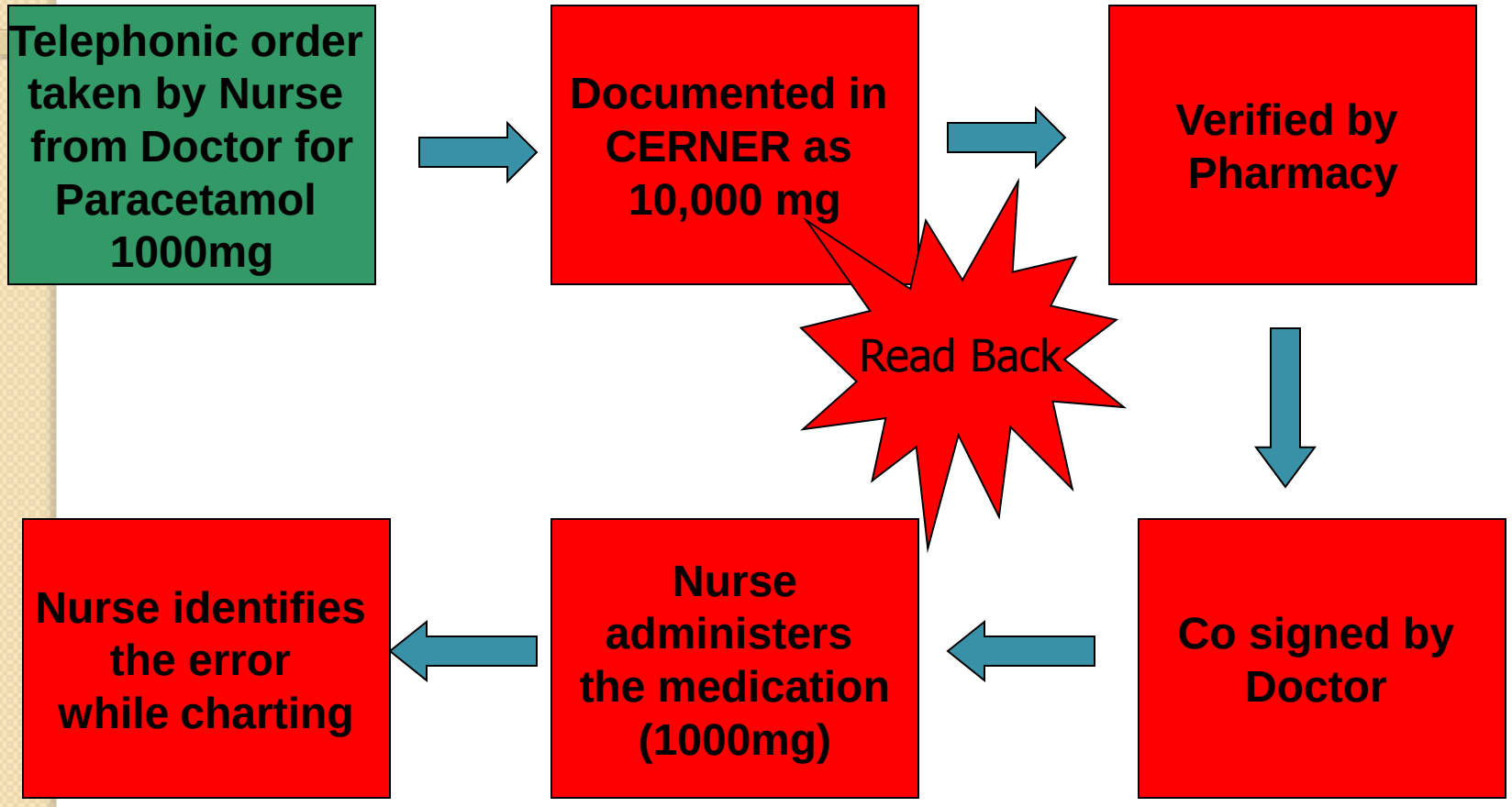
# Patient Safety Net

- 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

# Best Catch Award 2009

## Medication Error Story-3



# Best Catch Award 2009

# Best Catch Award 2010

Charge Nurse, Pediatric Oncology Department

## Abdulla Odat
## RN

Synopsis :

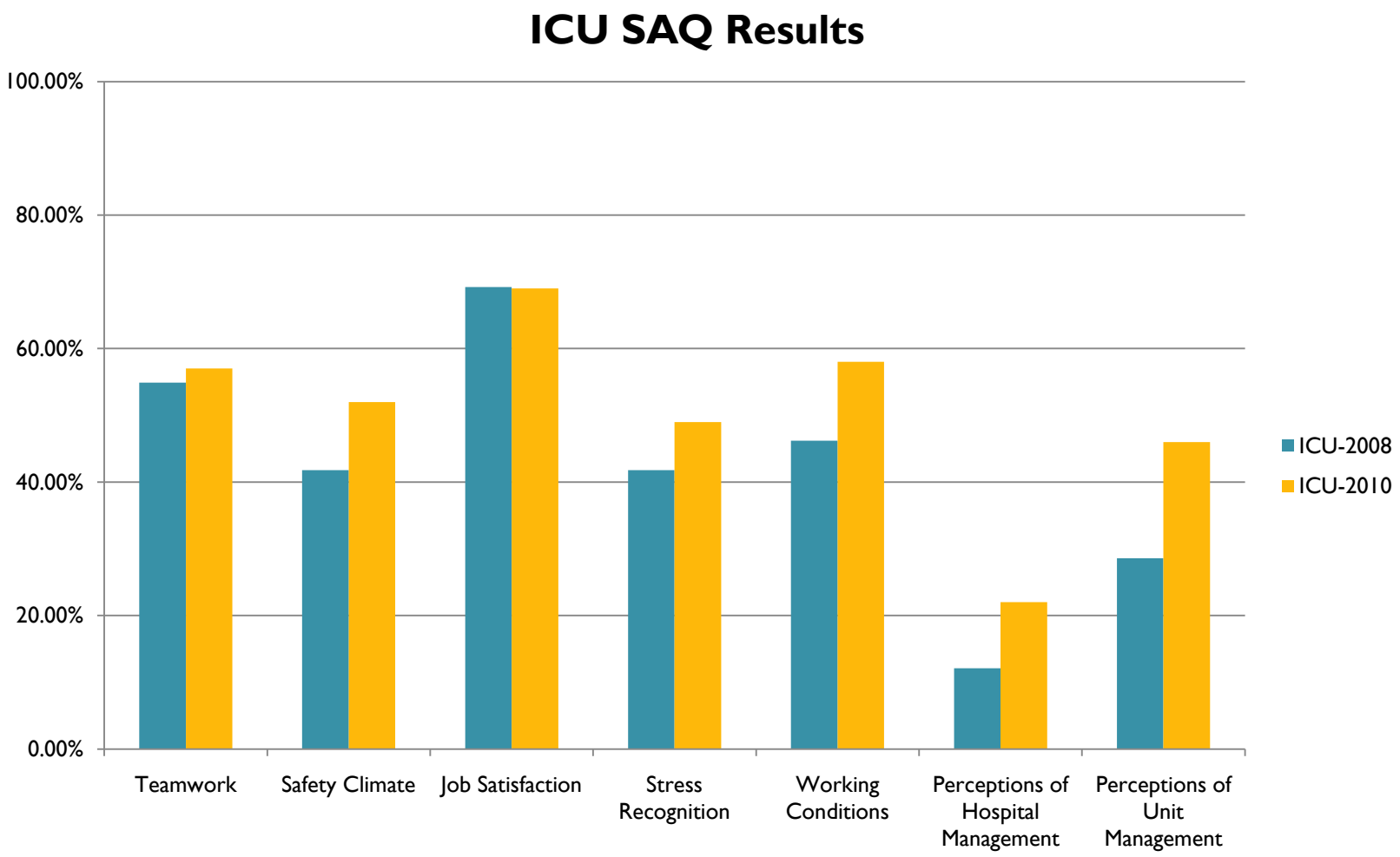
Chemotherapy IFOSFAMIDE per protocol is for four doses, and it was written for 5 days. The fifth dose arrived , nurse checked protocol and prevented.

# First Year Celebration

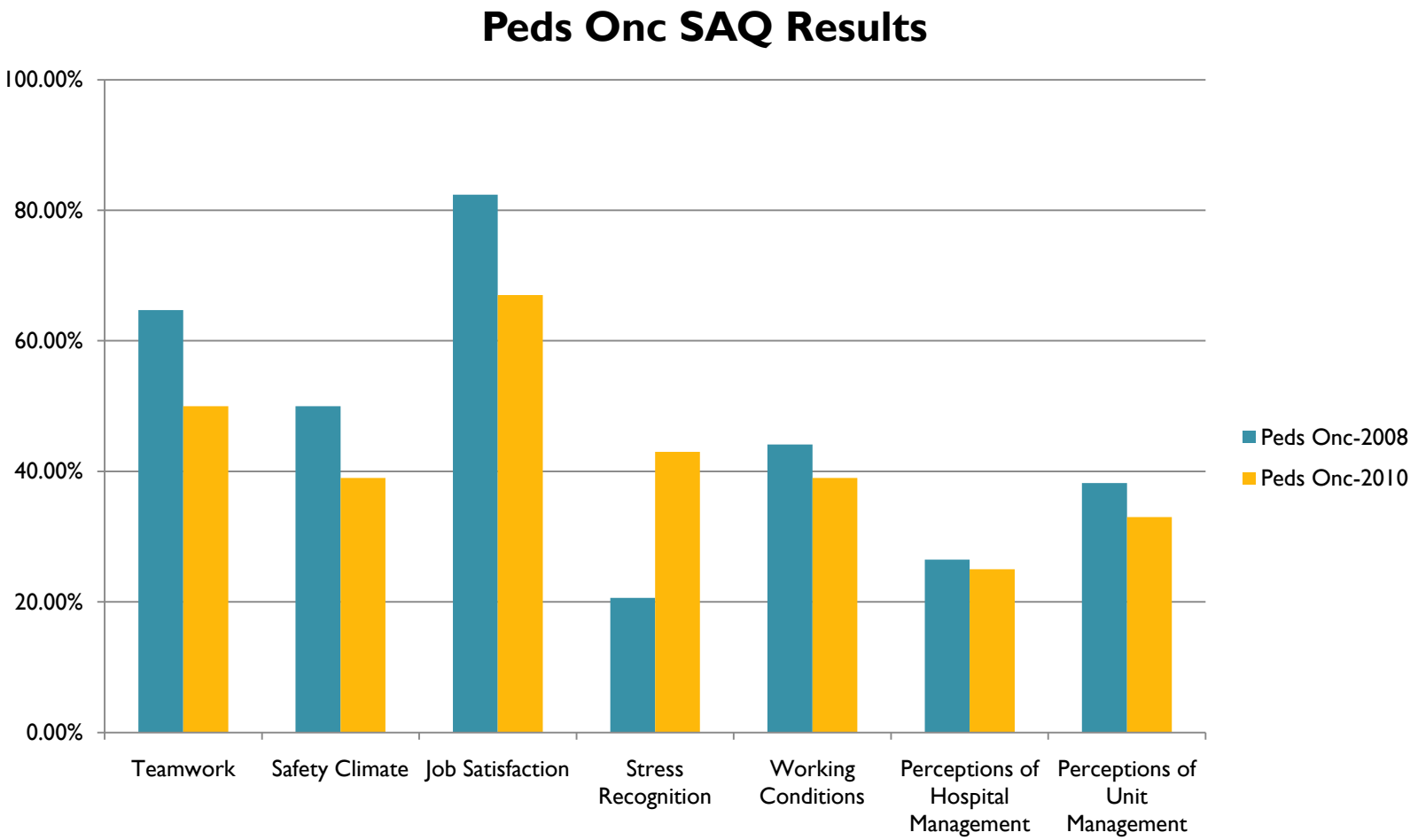
Second Year Celebration

# Two years of CUSP implementation

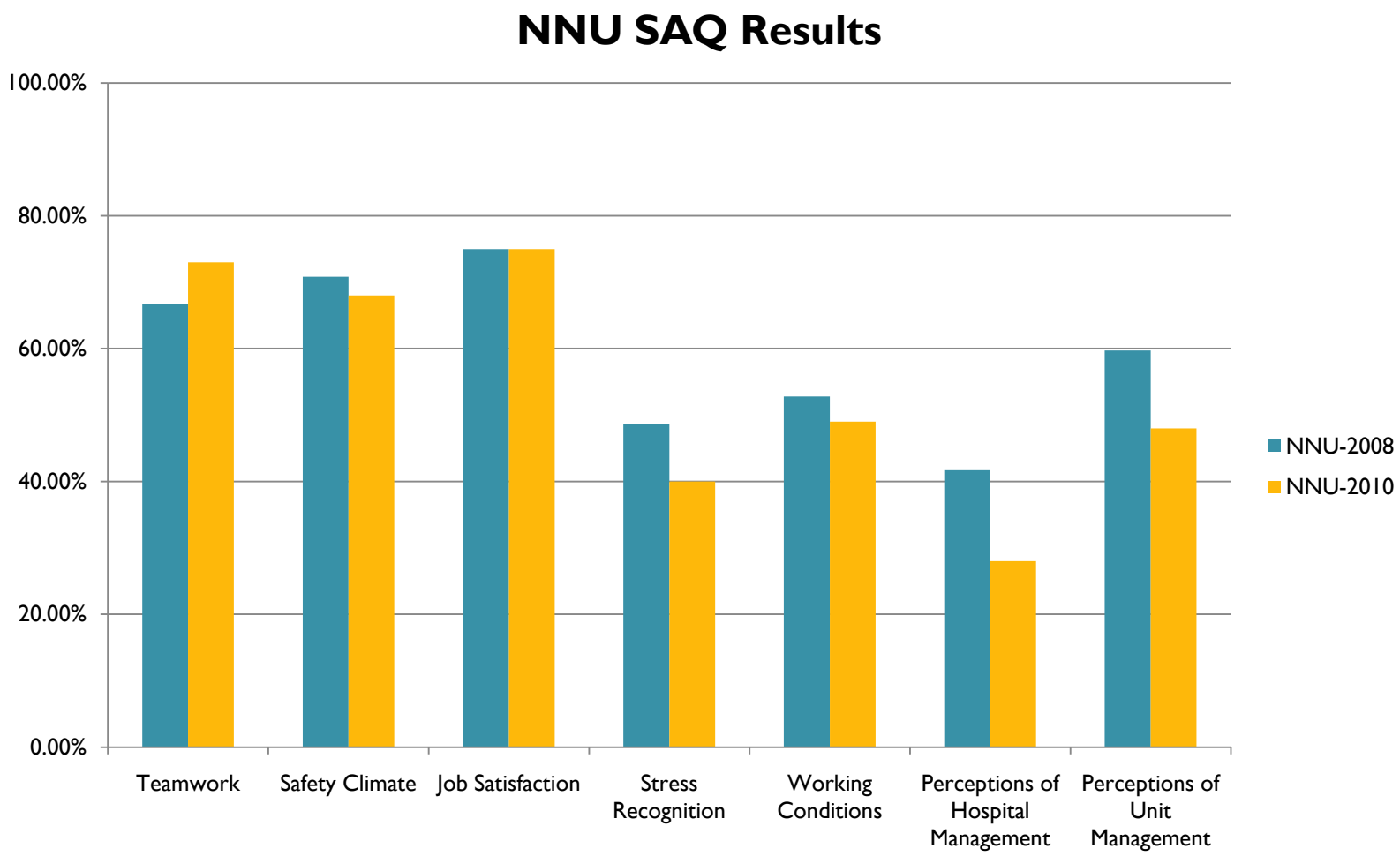
# ICU


ICU SAQ Results
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
Teamwork
Safety Climate
Job Satisfaction
Stress Recognition
Working Conditions
Perceptions of Hospital Management
Perceptions of Unit Management
ICU-2008
ICU-2010

# Pediatric Oncology



# NNU


NNU SAQ Results
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
Teamwork
Safety Climate
Job Satisfaction
Stress Recognition
Working Conditions
Perceptions of Hospital Management
Perceptions of Unit Management
NNU-2008
NNU-2010

# Next Step:

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

# Resources

- Josie King Foundation http://www.josieking.org/
- AHRQ http://www.psnet.ahrq.gov/resource.aspx?resourceID=3601
- Institute of medicine http://www.iom.edu/
- Patient Safety Group https://www.patientsafetygroup.org/main/index.cfm
- Institute for healthcare improvement 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”*