Culture Eats Strategy - the KKH Journey in Improving Patient Safety

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KK Women's and Children's Hospital
SingHealth

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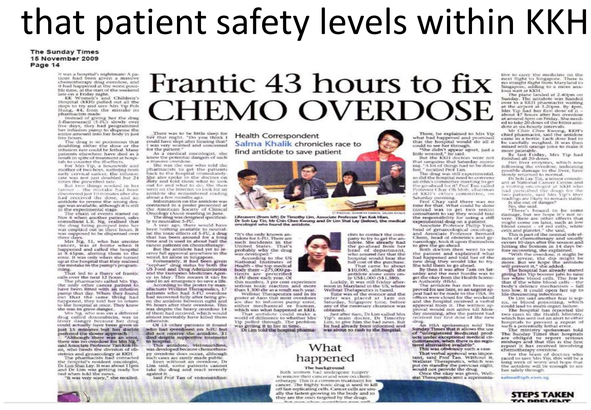
BACKGROUND

Healthcare is a complex system, at least 10% of patients suffer harm in healthcare institutions. The near fatal chemotherapy incident where a patient was overdosed with 5-fluorouracil 24 times the actual dosage in 2009 and the accidental babies swapped incident in 2012 indicated that patient safety levels within KKH was not reliable.


The Sunday Times
15 November 2009
Page 14

Frantic 43 hours to fix CHEMO OVERDOSE

Health Correspondent Salma Khalik chronicles race to find antidote to save patient

What happened

The background

STEPS TAKEN TO PREVENT

Efforts to beef up patient safety levels in KKH became a priority, especially the safety culture. Hence, the objective of this was to assess effectiveness of interventions directed at improvement of patient safety culture

METHOD

Patient safety culture survey using the validated questionnaire of the Agency for Healthcare Research and Quality (AHRQ) tool was conducted in years 2010 and 2017.

Areas for improvement identified from the 2010 survey where the following interventions were implemented:

1. ***Leadership rounds****
2. ***Safety as a standing items at Senior Management and Medical Board meetings***
3. ***Patient Safety Leads (PSLs)**** - individuals appointed to champion safety matters within their departments.
4. ***Training-*** in-house workshops on Root Cause analysis, Human Factors and Quality Improvement and Institute for Healthcare Improvement (IHI) Open School course online.
5. ***Speak up for Safety-*** to equip staffs with skills at communicating concerns to colleagues that unintended patient harm may occur. 97% of KKH staffs were trained within a one-year period.

** These help ensured a ground-up approach to problems.*

RESULTS

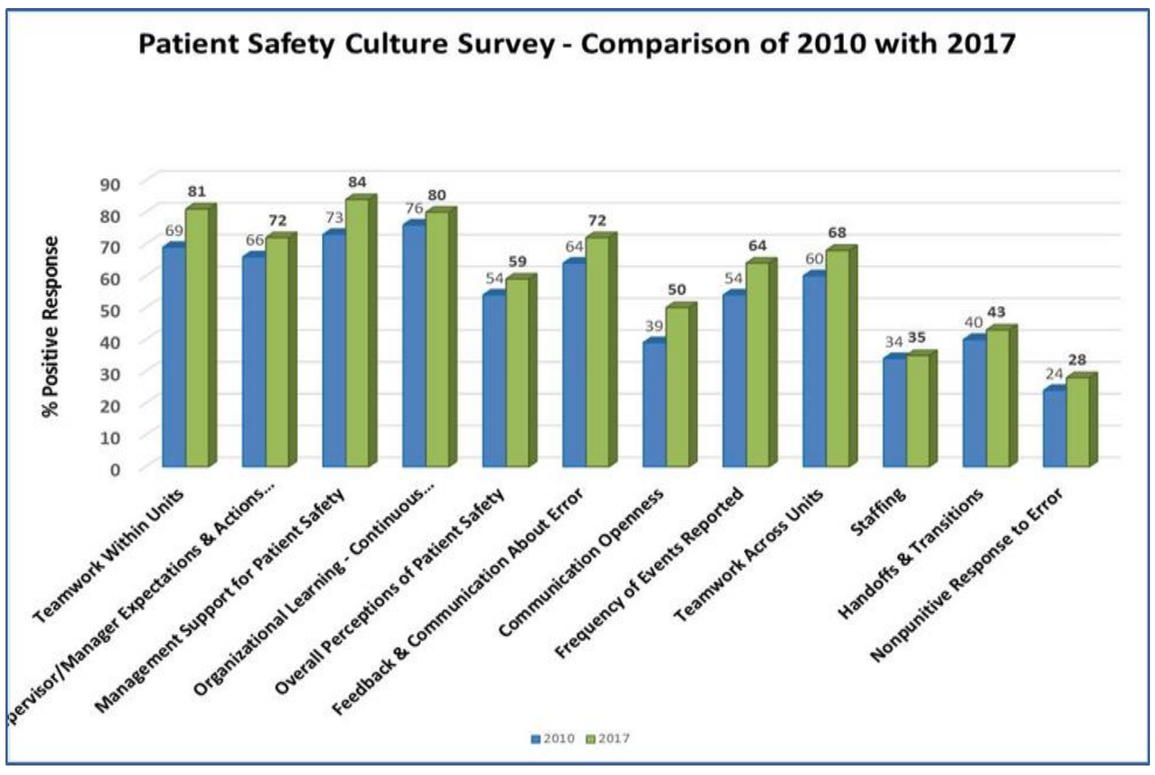


Figure 1- AHRQ survey results 2010 vs 2017- percentage positive responses

Improvement in percentage positive responses in **all** dimensions between 2010 and 2017. Teamwork within units (69% vs 81%), Management support for patient safety (73% vs 84%) and Communication openness (39% vs 50%).

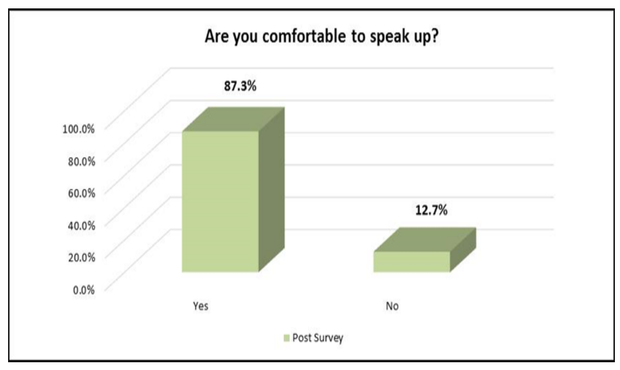


Figure 2- Comfort able speaking up

Figure 3- Mode of raising concerns

Figure 4- Reaction when being spoken to

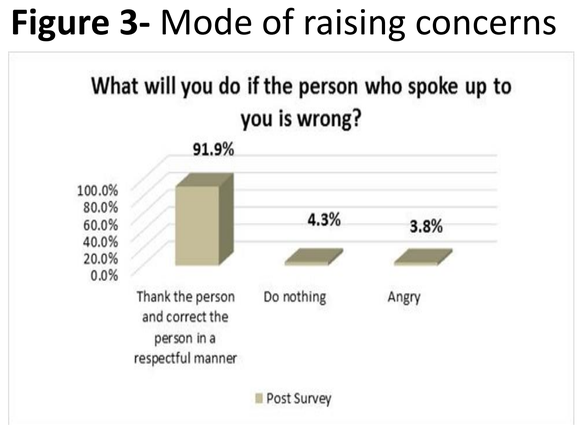


Figure 5- Reacting when person who spoke up was wrong

- 87.3% of our staff was comfortable at speaking up for safety post-training (Figure 2).
- 45.1% and 44.2% of staff surveyed were willing to speak up directly to the individual concerned and the supervisors respectively when faced with a safety issue (Figure 3).
- 97.5% of staff surveyed will respond positively when being spoken to (Figure 4).
- 91.9% would thank the individual who had spoken up even if he/she turns out to be wrong (Figure 5).

CONCLUSION AND MOVING FORWARD

- There was improvement in the safety culture levels between 2010 and 2017 evidenced by increased percentage positive responses among hospital staffs.
- Culture changes take time to bear its fruits allowing people to adapt incrementally, internalize efforts and embrace it at the core
- Areas for further improvement include:
  - Non-punitive response to errors
  - Handoffs and Transitions
  - Staffing
- Efforts are underway to address the above to create a psychologically safe environment
- These include programmes on Foundations Accountable and Safe Culture (ASC) Roadshows, Promoting Professional Accountability (PPA), Improving Resilience at work and promoting Joy In Work (Figure 6)

Figure 6- KKH Roadmap to Target Zero Harm