# Creating a Safety Culture

## (The CGH Journey So Far)

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SingHealth

SingHealth DukeNUS
ACADEMIC MEDICAL CENTRE

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Sengkang General Hospital
KK Women's and Children's Hospital
National Cancer Centre Singapore
National Dental Centre Singapore
National Heart Centre Singapore
National Neuroscience Institute
Singapore National Eye Centre
SingHealth Community Hospitals
Polyclinics SingHealth

# Framework for Safe, Reliable, and Effective Care

Culture

Psychological Safety

Accountability

Teamwork & Communication

Negotiation

Leadership

Engagement of Patients & Family

Transparency

Reliability

Improvement & Measurement

Continuous Learning

Learning System

© Institute for Healthcare Improvement and Safe & Reliable Healthcare

Source: Frankel A, Haraden C, Federico F, Lenoci-Edwards J. *A Framework for Safe, Reliable, and Effective Care*. White Paper. Cambridge, MA: Institute for Healthcare Improvement and Safe & Reliable Healthcare; 2017. (Available on ihi.org)

# Safety Culture

- The sum of what an organization ***is*** and ***does*** in the pursuit of safety

- The product of individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior

- Characterized by
  - communications founded on mutual trust
  - shared perceptions of the importance of safety
  - confidence in the efficacy of preventive measures

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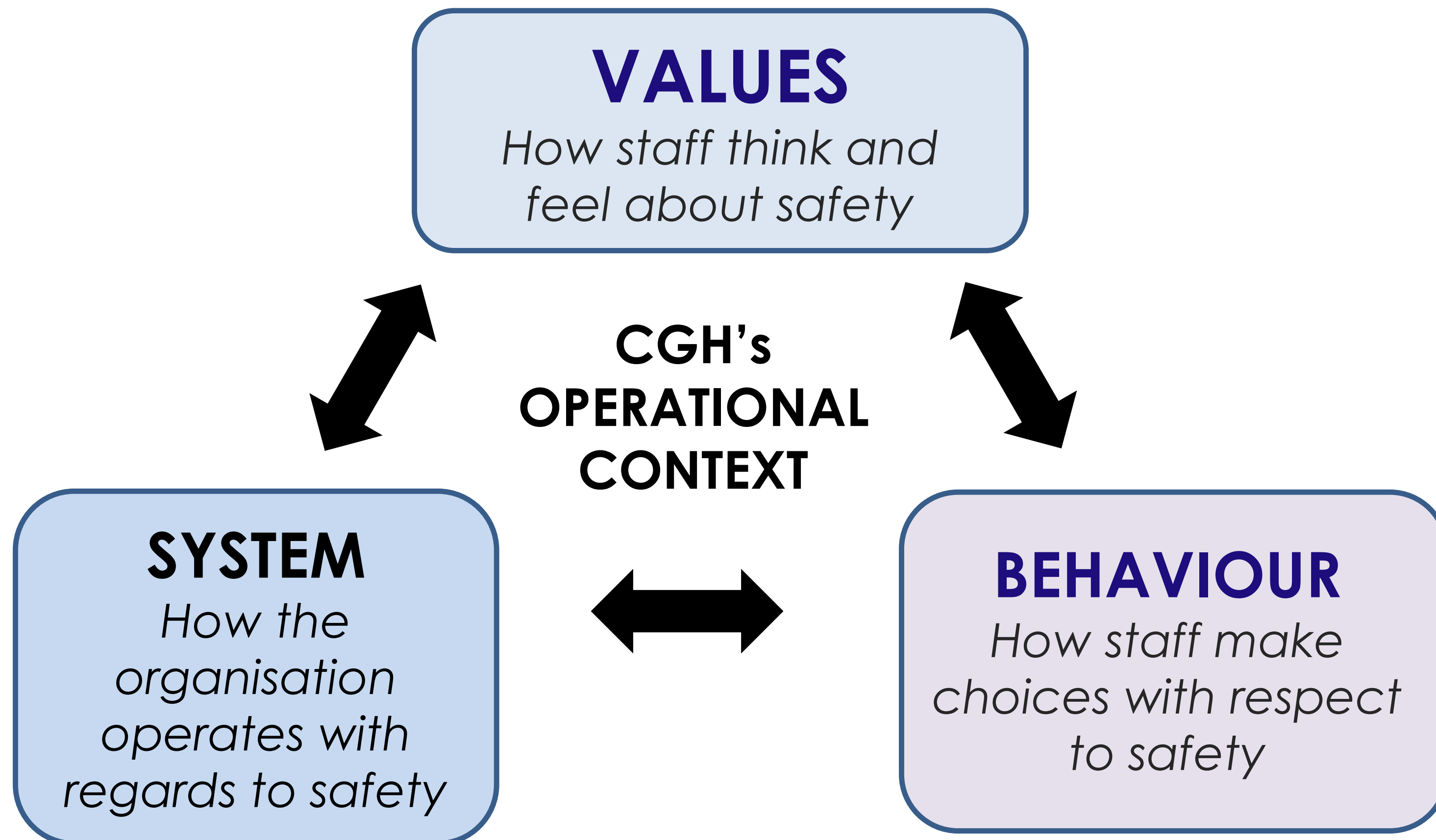
# What It Looks Like

Joy and meaning at work

- Individuals within the organization treat each other and their patients with dignity and respect.
- Staff are productive, engaged, learning, and collaborative
- Workforce feels valued, safe from harm, and part of the solution for improvement

# CGH's Approach to Safety Culture




*Adapted from Reciprocal Safety Culture Model (Cooper, 2000)*

# Knowing Our Why

*Start with Why*
*Simon Sinek*

**CULTURE = VALUES x BEHAVIOURS**

Actions driven by the right motivations

# Leveraging on Resonant Beliefs

**AMPLIFY THE WHY,**
**LET THE WHY DRIVE THE HOW**

**THE CGH IDENTITY**

**"A Caring & Trusted Hospital"**
**"Best with passion and empathy"**
**"Teamwork, Ownership, Professionalism"**

# Our Mission

To deliver the "BEST" patient care…

- A choice and commitment
- Learn, Unlearn, Relearn

…..with passion and empathy

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# Duty with Passion

- Duty recognises that we are part of a bigger picture, but we're *not* the "whole picture."
- Passion excites and energises

BUT

- Duty without passion can be depleting
- Passion without duty can be self-serving,

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# Empathy – more than a feeling

## Know Yourself, Understand Others

**WHAT VALUE DOES IT CREATE FOR PATIENT?**

Other Processes that Mine Depends on

**My Process**

Other Processes that Depend on Mine

- What does their process do for patient?
- What does their process do for me?
- What does their process need from me to do these things?
- How and when do they need it?

- What does their process do for patient?
- What do I do for their process?
- What does their process need from me to do these things?
- How and when do they need it?

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Time Out

- Reflect
- Regroup
- Refocus
- Recharge

- Why I started this journey
- Why I need to continue



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# Are we asking the right questions?

**1. AIM**

**What are we trying to accomplish?**

*The quality improvement goals, scope and team are defined*

**2. MEASURE**

**How will we know a change is an improvement?**

*Specific quantitative measures are established to measure the impact of the improvement*

**3. CHANGE**

**What changes can we make that will result in improvement?**

*Potential interventions are identified and developed for testing*

- ✓ To plan test of change and be systematic
- ✓ To be based on reliable evidence and accurate analysis
- ✓ To be carried out with effective teamwork and communication

*•Developed by the Associates in Process Improvement. Building on the work of W.E.Deming and Walter Shewhart Langley et al, The Improvement Guide, 2009*

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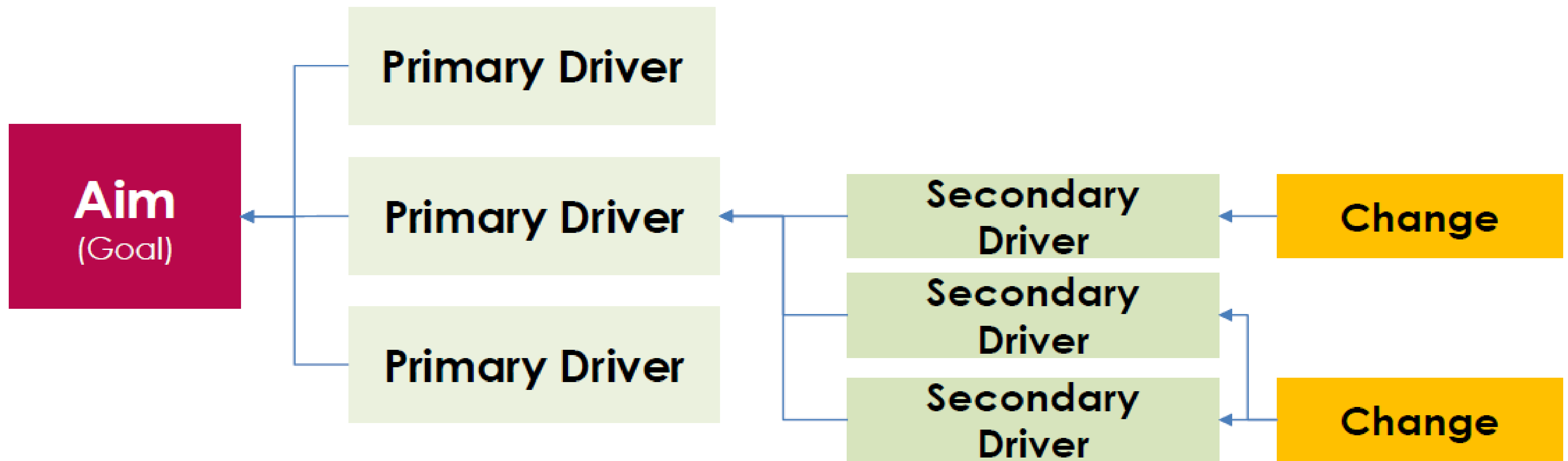
# What are we testing ?

Make Theory Explicit

Every intervention presupposes a certain type of problem




### The Aim

The driver diagram starts with a clearly defined and measurable goal.

This is the focal point for your change efforts.

### Primary Drivers

The first breakdown of a goal creates **primary drivers**. They drive the achievement of your main goal.

These drivers may act independently or in concert to achieve the overall goal.

### Secondary Drivers

The process of breaking down a goal can continue to lower levels to create **secondary drivers.**

### Change / Action

The ultimate aim of a driver diagram is to define the range of **change initiatives** that you may want to undertake.

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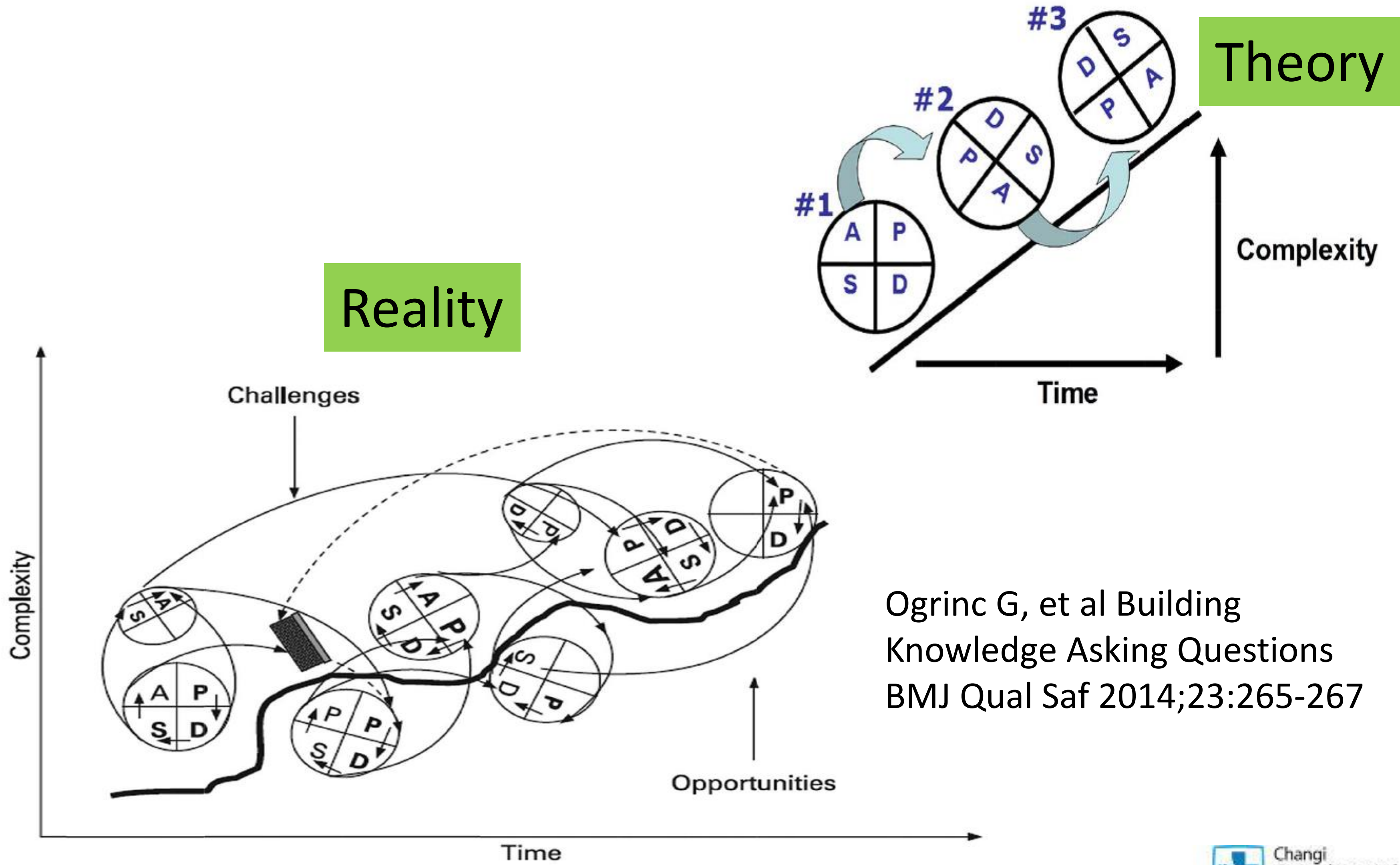
# Who have we forgotten?

- Iatrogenic non- compliance

- What matters to our patients and their caregivers
  - Encourage patients to share their concerns and be transparent
  - Build trust

- Develop solutions with patients
  - Collaborative negotiation : work together to gain genuine agreement on matters of importance and find mutually agreeable solution(s)

# Are our expectations realistic?




Ogrinc G, et al Building Knowledge Asking Questions BMJ Qual Saf 2014;23:265-267

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# Just Culture

**Accountable for the quality of choices we make…..**

- produce an outcome, follow a procedural role, avoid unjustifiable risk
- act with respect to others in ways that embody organisational values

**regardless of the outcome**

- outcomes are the result of a combination of individual choices, system design and ……

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# Just Culture

- Organization has a duty and responsibility to employees (and ultimately to patients)
  - Design safe and reliable systems
  - Create safety awareness in their staff and giving them the training and support to do so
  - Treat individuals fairly and justly ‘when things go wrong’

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# Learning Culture

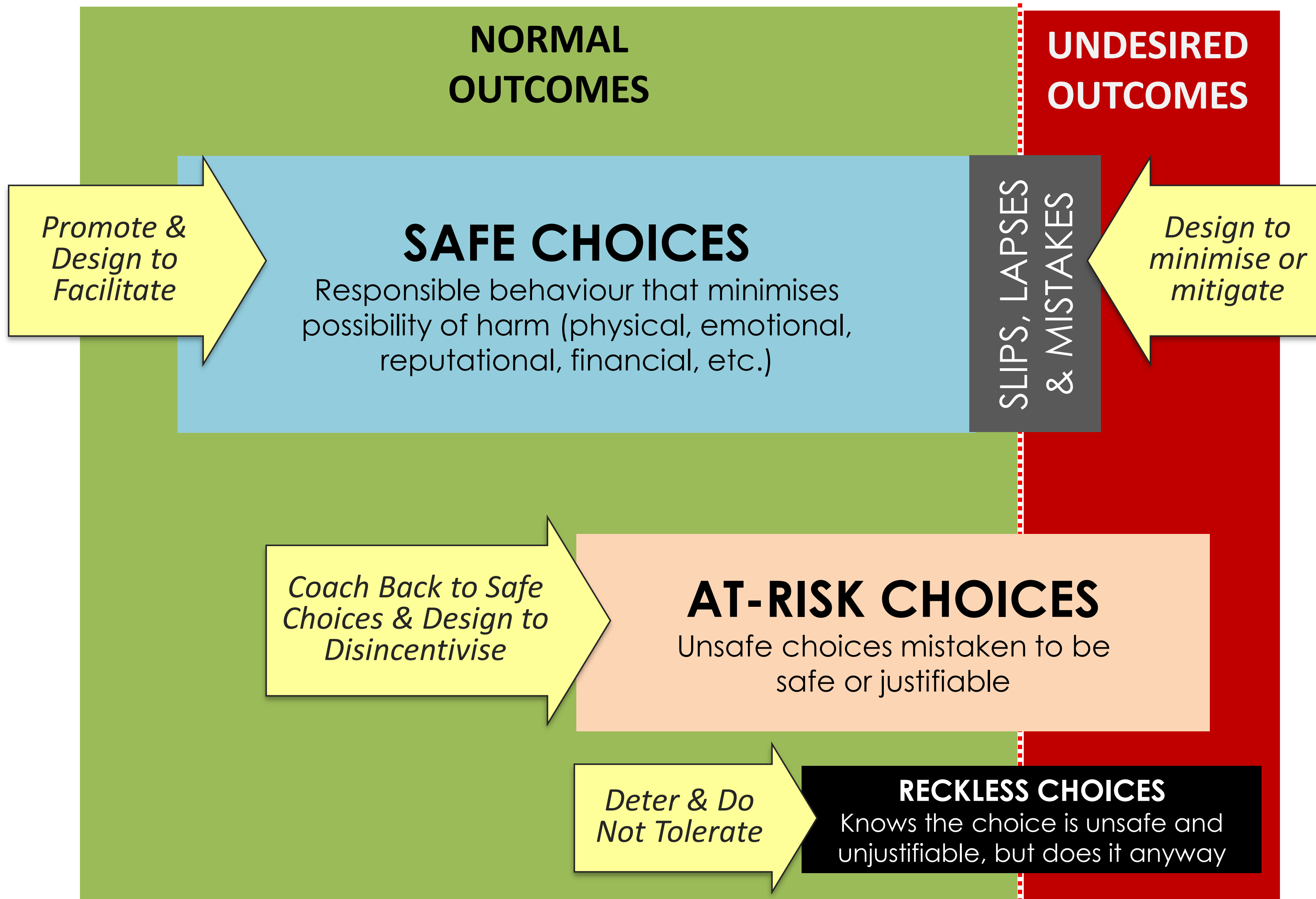
We are honest and open about understanding our individual and system shortcomings.

We speak up, report errors/defects and offer solutions

We strive to improve our choices and our systems, to produce safer and more reliable outcomes

We design systems that do not allow our inadvertent errors to translate to harm

# CHOICES IN A JUST & LEARNING CULTURE

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# Just & Learning Culture

# Communicate Clearly and Consistently

## CORE SAFETY CULTURE THEMES

## MOVING FORWARD & CONSOLIDATING THE CORE THEMES

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# Communicate Clearly and Consistently

**PASSIVE & ACTIVE ENGAGEMENT OF STAFF**

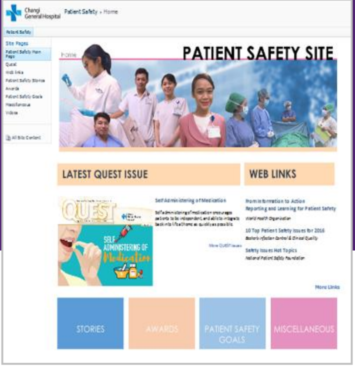
VIDEO CAMPAIGN

POSTER CAMPAIGN

**Safety Culture**

PATIENT SAFETY DAY

PLEDGE CAMPAIGN




PATIENT SAFETY SITE

If you want to learn about the culture, listen to the stories. If you want to change the culture, change the stories

Michael Margolis

# Making it Relevant

## Aim

- sharing stories of serious patient safety events
- encourage openness in reflection, sharing and learning

## Key Features

- What happened during the incident?
- What was learnt from the incident?
- What changes or improvements have been made, if any?

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# Making it Personal

"When we take care of patient safety, we are safeguarding our people."

Ms Yasmin Ng
*Principal Pharmacist*

"Our priority is patient safety with care and compassion. Their loved ones have entrusted them to us."

Ms A Punithavathi
*AD Nursing*

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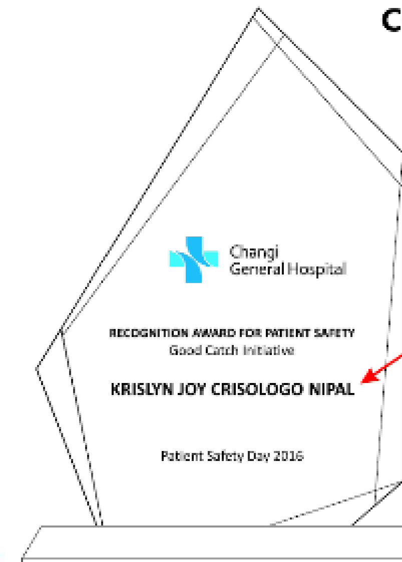
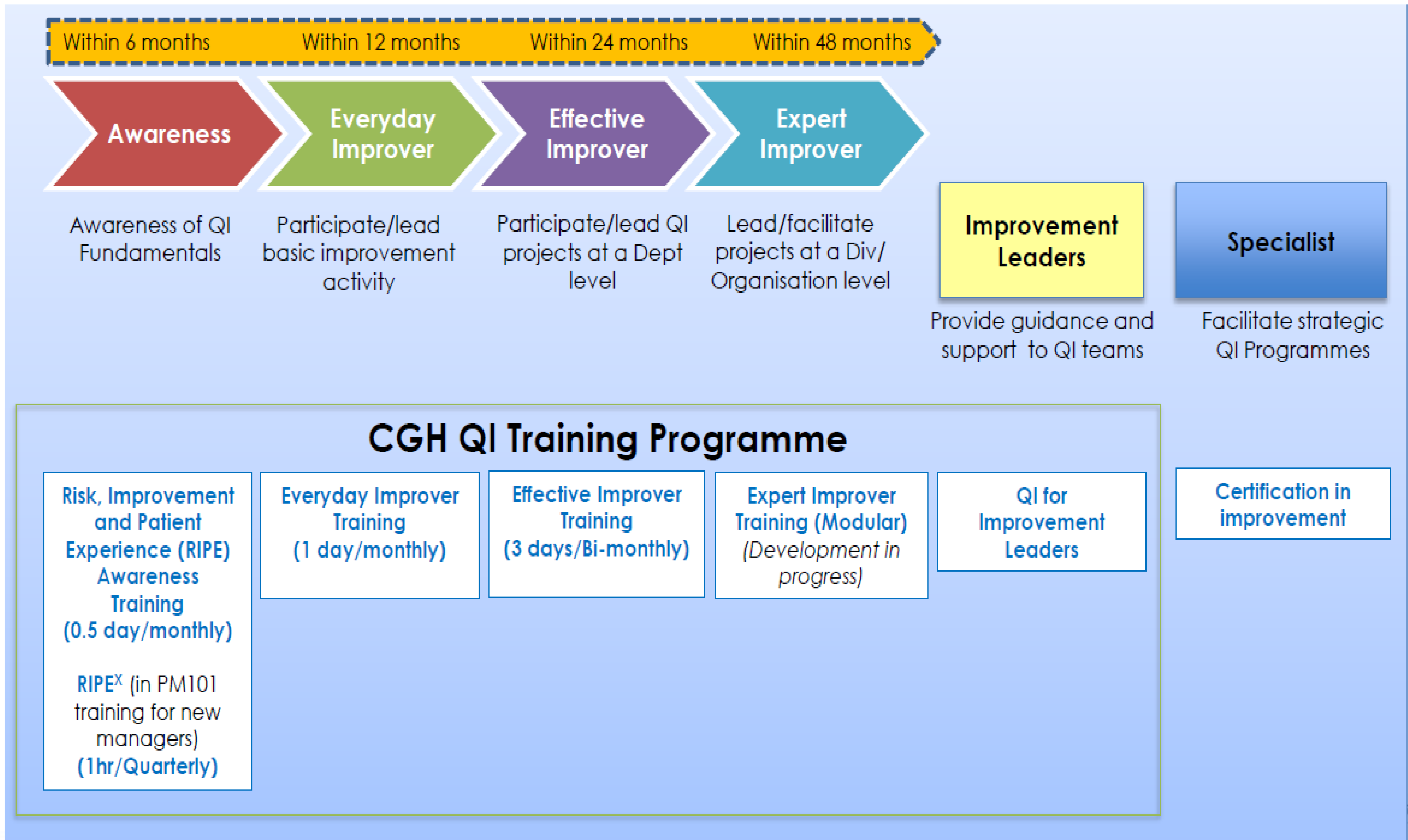
# Making it Personal

CONGRATULATIONS TO OUR AWARD RECIPIENTS

Recognise staff for reporting a near miss and/or having intercepted a error that could have caused harm to a patient



# Making it Possible



# Making it Possible

## Enabling Concepts and Tools

System of Profound Knowledge

Problem and Aim Statement

Team & Team Dynamics

Intro Human Factors & Systems Thinking

Change Management

Overview of the following:
- Patient Experience
- Patient Safety
- Risk Management
- Improvement

### QI Tools Covered in Training

**A. Planning and Tracking**
- Kaizen / Improvement Form

**B. Problem Identification & Analysis**
- DOWNTIME
- Process Mapping
- 5 Whys

**C. Data Collection and Visualisation**
- Tally Sheet
- Survey
- Bar Chart
- Run Chart

**D. Solutioning**
- Brainstorming
- SCAMPER
- Prioritisation Tool (PICK Chart)
- 6S and Visual Management
- Quick Set-up
- Error Proofing

**A. Planning and Tracking**
- QI Project Tracker

**B. Problem Identification & Analysis**
- Value Stream Mapping (VSM)
- Benchmarking
- Cause & Effect
- Observation
- Interview / Survey
- Run Chart
- Other Visualisation Tools*

**C. Solutioning & Test through PDSA Cycles**
- Benchmarking
- Standardisation & Checklist
- Driver Diagram
- Change Concept
- Run Chart
- Other Visualisation Tools*

**D. Implement & Monitor Performance**
- QI Project tracker
- Run Chart
- Other Visualisation Tools*

*E.g. Bar charts, scatter charts, histogram etc.

### Core Modules

- Data Analytical Skills for QI
- QI Project Scale, Spread and Sustainability
- Facilitation Skills
- Project Management
- Creative Solutions for Quality Improvement *(existing in AM-EPIC)*

### Elective Modules

- Human Factors
- Design Thinking *(existing in AM-EPIC)*
- Presentation Skills

*Modules are still subject to change

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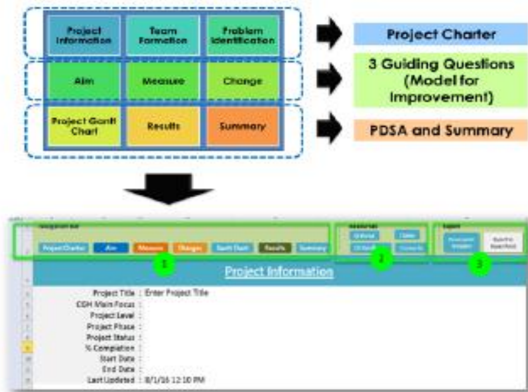
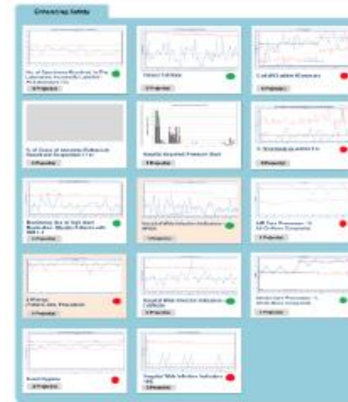
# Making it Possible

## Enabling Improvement Infrastructure




QI Project Tracker



CGH Lifeboard

QI Pocket Guide

QI Handbook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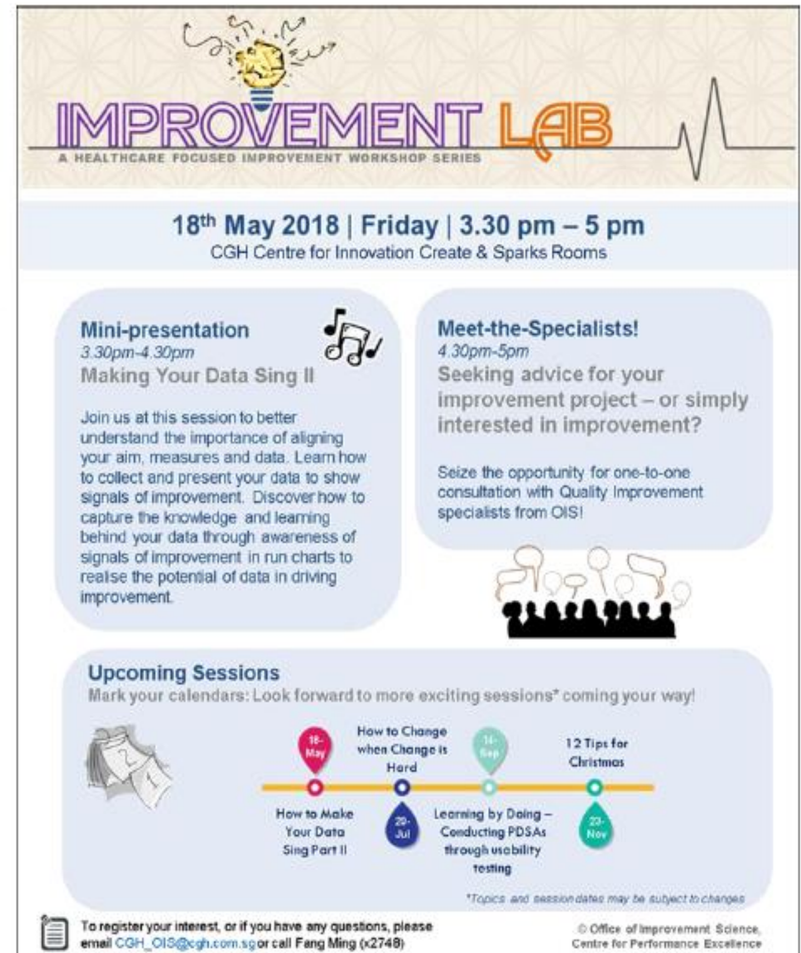
# Making it Happen - Together

## Improvement Lab

**Objectives:**

- Generate awareness and interest in Improvement Science through highly-accessible mini-presentations on specific areas of Improvement Science
  - target areas/teams having problems
- Provide an informal session for CGH staff to obtain QI consultation from CGH OIS team
  - QI projects scoping, QI tools, etc.

**Frequency:** Bi-monthly
*(Dovetailed with Everyday and Effective Improver Training)*



# Making it Fun

## CGH Improvement Festival

Annual QI Celebration to recognise improvement efforts and advocate QI learning and sharing

**CGH IMPROVEMENT FESTIVAL 2017!**

Collaborate. Improve. Inspire.

30th August 2017, Wednesday, 11am - 5pm
CGH Training Centre [Award Ceremony*, 3pm]

MORNING EVENT (CGH Level 1 Training Centre & CFI)

11am to 3pm

Come & support your colleagues & have fun!!!

- Project Booth Showcase
- Photo Booth
- Poster Displays
- Pop Corn and Candy Floss
- Learn Improvement Tools
- Best Booth Voting

AFTERNOON EVENT (CGH Auditorium)

3pm to 5pm

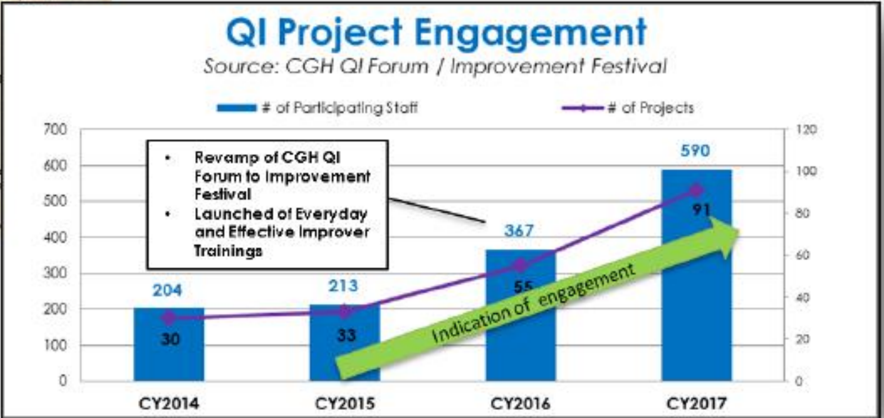
Be inspired by our Keynote Speaker!

"Live a Life from Good to Significance" by Ms Elim Chew, Founder and President of 77th Street

What's NEW this year?

Find out the winners of the inaugural Promising & Pinnacle Improver Awards

Grab your Door Gift (starts at 2.30pm)



# Creating, Nurturing and Sustaining a Safety Culture

- Will
  - Anchored on Mission, Vision and Values
- Idea
  - Systemic
  - Inclusive
- Execute
  - Competency
  - Enabling environment

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Courage doesn’t always roar.
Sometimes courage is the quiet voice at the end of the day saying : I will try again, tomorrow

Mary Ann Radmacher

“The world is moved along, not only by the mighty shoves of its heroes, but also by the aggregate of tiny pushes of each honest worker.”
– *Helen Keller*