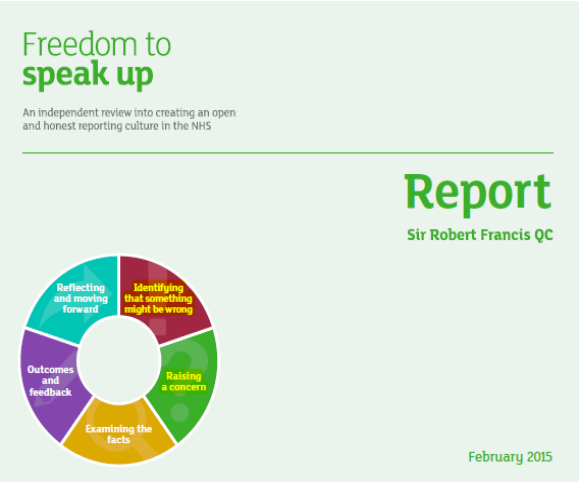
SPEAKING UP FOR SAFETY

led by Ms Pang Nguk Lan, Director QSRM, KKH

Failure to Speak Up can Cost Lives

- There are many documented cases where an harm or death would have been avoided if someone with a critical piece of information had brought it forward.

- Not speaking up is a major safety issue and “can cost lives”
  - JCI 2002 – “Speak Up™” patient safety program
  - NHS 2015 – “Freedom to Speak Up” review



Failure to Speak Up DID Cost Lives

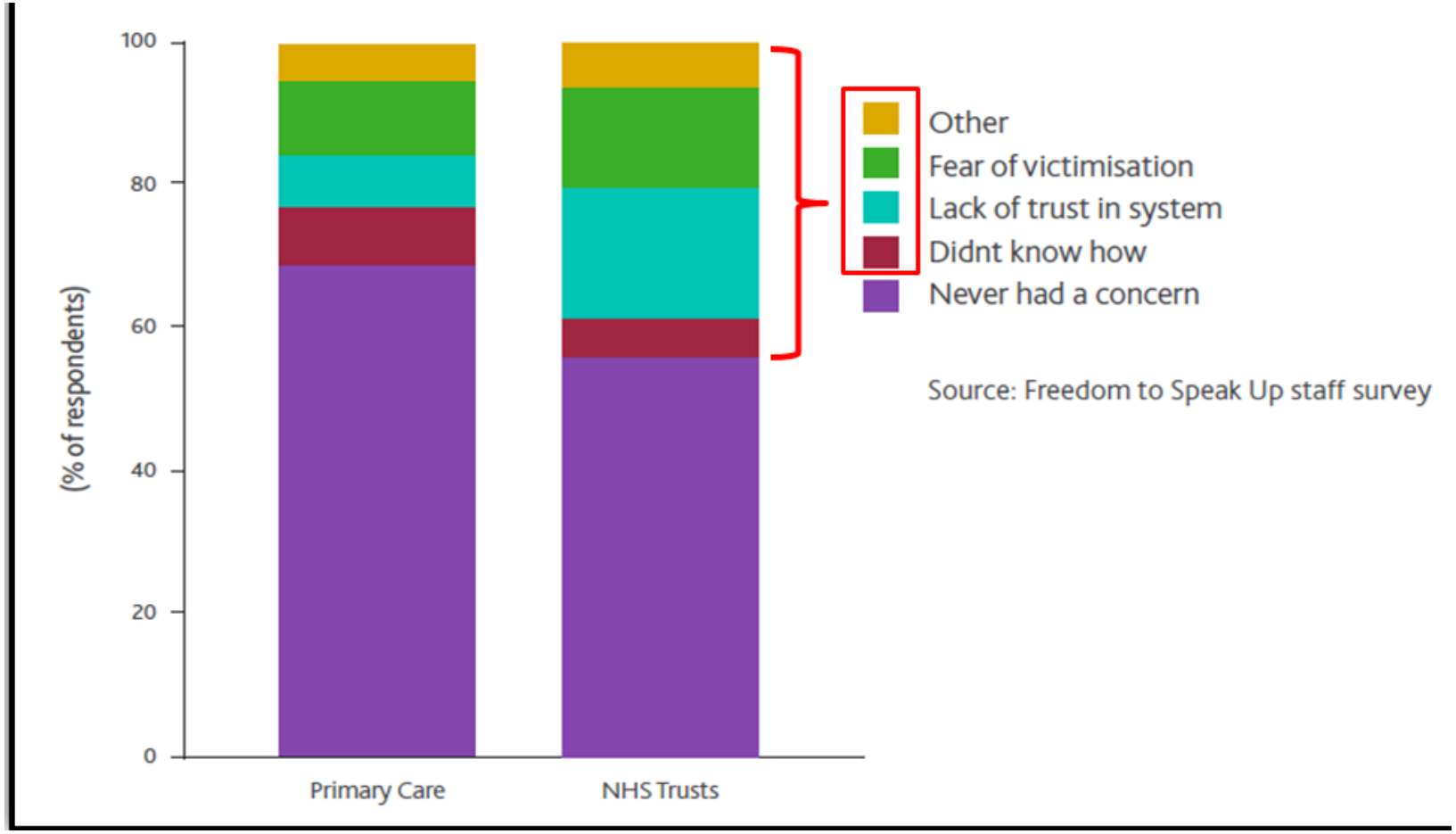
Dear Secretary of State

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

As you know, I was appointed by your predecessor to chair a public inquiry under the Inquiries Act 2005 into the serious failings at the Mid Staffordshire NHS Foundation Trust. Under the Terms of Reference of the Inquiry, I now submit to you the final report.

Building on the report of the first inquiry, the story it tells is first and foremost of appalling suffering of many patients. This was primarily caused by a serious failure on the part of a provider Trust Board. It did not listen sufficiently to its patients and staff or ensure the correction of deficiencies brought to the Trust's attention. Above all, it failed to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities. This failure was in part the consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking foundation trust status to be at the cost of delivering acceptable standards of care.

Reasons for NOT Speaking up from NHS



Speak Up For Safety

Speak Up For Safety is a workshop organized by Cognitive Insitute (Australia) that increases the ease and motivation for all staff to raise patient safety concerns with colleagues through a graded assertiveness communication skills training.

A critical aspect of achieving a safe and reliable culture is a common language where clinicians support each other speak up whenever there is a safety concern.

“Having your back culture”

What concerns can I raise?

1. **Concerns about unsafe patient care**
   - **Near miss, non-compliance to standard practice which impact on safety**
2. **Unsafe working conditions**
   - **lapses, rule breaking, and reckless behaviours**
3. **Disruptive behaviours**

Patient Safety Leads & Patient Safety Council Members

selected to become the

18 Patient Safety Champions

with **passion** and **commitment** for **safety**

Intense Train-The-Trainer Training

ACTIVITY	DATE/DURATION	DESCRIPTION OF THE WORKSHOP
Stage 1 Safety Champion Training	11- 13 July 2016 3 consecutive days	1) Increase the capabilities of the champions in leading reliability improvement through an advanced understanding of reliability science and "AlwaysChecking approach" 2) Enhance capacity to manage difficult conversations with colleagues 3) Advance their coaching and feedback skills to support peers in safety and reliability improvement 4) Understand all the dimensions of their safety advocacy role
Stage 2 Speaking up for Safety Presenter Training (SUFS train-the-trainer)	29-30 August 2016 2 consecutive days	This seminar underpins an organizational culture that enables and encourages clinicians to "speak up for safety and respectfully raise issues with colleagues when they are concerned about a patient's safety.
Stage 3 Champion Accreditation (to become licensed trainer)	3-4 October 2016 1.5 days	Each trainee is assessed and accredited to present the one-hour Speaking Up for Safety presentation. Cognitive Institute will observe and assess Safety Champions deliver the training in order to provide accreditation.

Commitment, Collaboration, & Mutual Sharing

Support from Senior Leaders

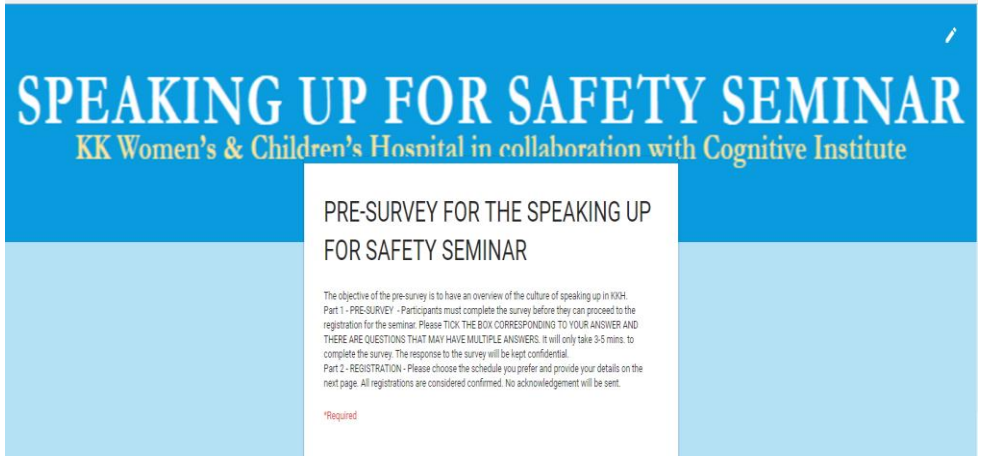
Safety Champions are empowered to speak and will be supported by Senior Leaders to influence others around them to buy into the initiative.

Safety champions will be enabled to identify the activities that a hospital can do to improve patient safety, and also understand how it improves patient safety.

Speaking Up for Safety Seminar (SUFS)

- Compulsory seminar for all KKH staff
- Started 17 January 2017
- 3 – 5 sessions a day, 2 days in a week for 6-7months
- Coordination led by Ms Annellee Camet and Ms Zann Lee, working alongside various department administrators
- Need to complete the SUFS Pre-survey before attending the seminar

Boardroom	Boardroom	Boardroom	Boardroom
Tuesday, 28 February, 2017	**Thursday, 2 March, 2017**	**Wednesday, 8 March, 2017**	**Friday, 10 March, 2017**
SESSION 2 - (10:00 - 11:30hrs) Trainer: Dr Yin Shanqing	SESSION 1 - (8:30 - 10:00hrs) Trainer: NM Rani Krishnan/NM Jocelyn Chng	SESSION 1 - (8:30 - 10:00hrs) Trainer: Dr Suzanna Sulaiman/Dr Lional Karumary	SESSION 1 - (8:30 - 10:00hrs) Trainer: Dr Suzanna Sulaiman/Dr Lional Karumary
SESSION 2 - (10:00 - 11:30hrs) Trainer: Dr Yin Shanqing	SESSION 2 - (10:00 - 11:30hrs) Trainer: Mr Ricky Chan		SESSION 2 - (10:00 - 11:30hrs) Trainer: Dr Siow Yew Nam
SESSION 3 - (11:30 - 13:00hrs) Trainer: Khairuldin Shah	SESSION 3 - (11:30 - 13:00hrs) Trainer: Dr Alvin Chang	SESSION 3 - (11:30 - 13:00hrs) Trainer: Dr Alvin Chang	SESSION 3 - (11:30 - 13:00hrs) Trainer: NM Loh Poh Leng/NC Nah Jaslin
SESSION 4 - (13:30 - 15:00hrs) Trainer: Ms Jenny Yap	SESSION 4 - (13:30 - 15:00hrs) Trainer: NM Ho Wah Pong/SNC Rena Hooi	SESSION 2 - (13:30 - 15:00hrs) Trainer: NM Rani Krishnan/NM Chng Jocelyn	SESSION 4 - (13:30 - 15:00hrs) Trainer: Dr Luke Toh
SESSION 5 - (15:00 - 16:30hrs) Trainer: NM Loh Poh Leng/ NC Nah Siew Noy	SESSION 5 - (15:00 - 16:30hrs) Trainer:Mr Mohamed Nazri Abdul Ghani	SESSION 3 - (15:00 - 16:30hrs) Trainer: NM Ho Wah Pong/SNC Rena Hooi	SESSION 5 - (15:00 - 16:30hrs) Trainer: Prof Chong Chia Yin



Stories Of Speaking Up

"I would like to commend Ward 44 nurses especially Sister Jocelyn Chng and Ms Nurhidayah Abdul Aziz who stayed vigilant on a patient in Ward 44...

They "spoke up" and identified the red flags for a possible stroke patient. The patient was restless the entire night; the nursing team monitored closely and escalated the case by calling the MO which they felt was something more complicated for a HO to manage. They suggested a CT Brain which confirmed a stroke. This patient nearly proceeded for a hysteroscopy D&C if not for the vigilant actions of the nurses who picked up that the behaviour of the patient was not the "norm". Patient is now safely in NNI for further treatment.

19 Jan 2018, Dr Suzanna Sulaiman, Head, Inpatient Service, Department of O&G, KKH

Panel Discussion

Dr Yin Shanqing (Moderator)
Dr Alvin Chang
Ms Rena Hooi
Ms Jenny Yap
Mr Ricky Chan