



Enhancing patient safety culture

NHG institutions recently conducted a Patient Safety Culture Survey to assess how healthcare workers view patient safety culture within their settings. This is the fourth time NHG has conducted this survey.

The tool, developed by the [Agency for Healthcare Research and Quality \(AHRQ\)](#), was conducted in primary care, specialty centre, community hospital and acute hospital settings. Here is a closer look at the findings.

Why is safety culture important?

[Safety culture](#) is the way in which organisations live and breathe safety. It is the foundation of delivering quality care, as a positive safety culture is linked to favourable staff safety behaviour and outcomes.

In order to improve the quality of healthcare, the assessment of safety culture is

paramount as the results have the potential to enable an organisation to understand its strengths and weaknesses.

One of the building blocks of a safety culture is having an open and fair culture for providers and patients. In an open and fair environment, the organisation focuses on rectifying the flaws of the system.

Staff are open about the incidents they have been involved in and report them, knowing that while they will not be punished for system-induced errors, they need to be accountable for their actions.

There are policies that describe how the organisation will respond to an adverse event. Staff are treated fairly while patients are not withheld information on harm done to them.

How did NHG fare in the latest

2017 Patient Safety Culture Survey?

According to the Patient Safety Index developed by [Concordia](#), the results for NHG institutions were as follows:

- Polyclinic - 65 per cent
- Specialty centre - 69 per cent
- Acute hospital - 64 per cent
- Community hospital - 66 per cent

The Patient Safety Index takes into account responses from across all 12 dimensions in the Patient Safety Culture Survey. The index also shows where NHG institutions are on the journey towards a Mature Patient Safety Culture (see diagram).

Based on the results, NHG has a “proactive culture” where management cares and knows how to improve. The organisation also models the behaviour of just

The Patient Safety Culture Journey

		20%	40%	60%	80%	100%
Rate of Incidents	LOW	Lack of: <ul style="list-style-type: none"> Culture awareness Board / Governance awareness Leadership Communication Learning Incident reporting Management support Investigation & feedback Investment & resources Behaviour: <ul style="list-style-type: none"> Passive – not care Blame and control Patient safety issues ignored Denial "She'll be right" attitudes 	Lack of: <ul style="list-style-type: none"> Culture awareness Board / Governance understanding Leadership Activities: <ul style="list-style-type: none"> Statistics collection Top-down edicts Legal compliance Talk v's Role-model Overreact to incidents Minimum training 	Lack of: <ul style="list-style-type: none"> Culture understanding Board / Governance monitoring Activities: <ul style="list-style-type: none"> Compliance communication Audits & training Safety participation Safety meetings Data collection 	Leadership: <ul style="list-style-type: none"> Board agrees policy & resource activities Management & employees engaged Open communication loop 	MATURE CULTURE Patient Safety Culture: <ul style="list-style-type: none"> Presence on Board of Safety and Quality Director Patient Safety Culture Index Management/workforce shares responsibility in partnership to identify and resolve risk Patient & Staff Safety recognised as good for all organisational outcomes Strategy for contiguous improvement Genuine ability to achieve sustainable outcomes Behaviour: <ul style="list-style-type: none"> Proud of organisation Up to date best practice Financial sustainability & safety equally essential Innovative ideas Share knowledge with others
	HIGH	ACCEPTANCE CULTURE Management doesn't know – doesn't care	REACTIVE CULTURE Behaviour: <ul style="list-style-type: none"> Blame & discipline Ad hoc interest Pre-inspection 'window dressing' Withheld communication Management knows but doesn't always care	COMPLIANCE CULTURE Behaviour: <ul style="list-style-type: none"> Focus on numbers & targets not outcomes Blame and control Caring safety environment Builds and implements processes & systems Management cares but doesn't always know	PROACTIVE CULTURE Activities: <ul style="list-style-type: none"> Walkabouts High level training Culture survey Peer evaluation and discussion Root cause analysis to understand 'why' 'Just' culture implemented Behaviour: <ul style="list-style-type: none"> Just culture practiced Effective learning Patient Safety priority before throughput Staff involved but <i>ruled</i> by management Management cares and knows how to improve	



Concordia's Patient Safety Index which shows that NHG has a "proactive culture" of patient safety based on results from the 2017 Patient Safety Culture Survey.

culture and effective learning.

What were our areas of strengths?

NHG ranked above the national average in the following areas:

- Management support for patient safety
- Feedback and communication about error
- Teamwork across units

What are some opportunities for improvement?

- Communication openness
- Non-punitive response to errors
- Supervisor/manager expectations and actions in promoting safety

What plans are there to improve our patient safety culture?

NHG will continue to strengthen its safety culture building

work. Apart from Just Culture, and [Open Disclosure and Second Victim Support](#), other initiatives in the pipeline include:

Speaking up for Safety

Even though [speaking up](#) is important for patient safety, healthcare workers often hesitate to voice concerns.

In 2017, the [Speaking Up for Safety® Programme](#) was introduced in [Yishun Health](#) under the Safety and Reliability Improvement Partnership Framework, a collaboration between Yishun Health and the [Cognitive Institute](#) in Australia.

This involves training staff to be more at ease and motivated in speaking up for safety.

Staff are also equipped to develop insights and skills to respectfully raise issues with colleagues when they are concerned about a patient's safety.

Good Catch Programme

Changi General Hospital (CGH) launched the Good Catch Initiative in January 2016.

The initiative aims to improve the culture of reporting in the hospital and remove the stigma behind it. It honours staff whose timely interception of an error, prevented an adverse outcome or led to improvements in patient care.

Every six months, candidates are selected through a review of cases in the Incident Reporting System and from supervisors' nominations. The final award winners are then selected by a panel.

NHG is thinking of starting its own programme within institutions. Various representatives from NHG institutions will be attending a sharing session to learn more about CGH's Good Catch Programme in April. ☞



QI Project
Spotlight

TTSH cardiologist Dr Chia Yew Woon (centre) with a PACE Nurse Clinician (left) and an anaesthetist at a PACE-CVM round.

Keeping PACE with referrals

Background

AT TTSH's [Pre-Admission Counselling and Evaluation \(PACE\)](#) clinic, inputs from other specialists are often requested to help optimise a patient's medical conditions before elective surgery.

It was found that six in 10 referrals made pre-operatively from PACE are to Cardiology.

In an effort to reduce delays in scheduling surgeries and minimise patients' visits to the Cardiology clinic, a combined

PACE-CVM round, comprising a cardiologist, an anaesthetist and a PACE nurse clinician was started in 2015 to review the referrals.

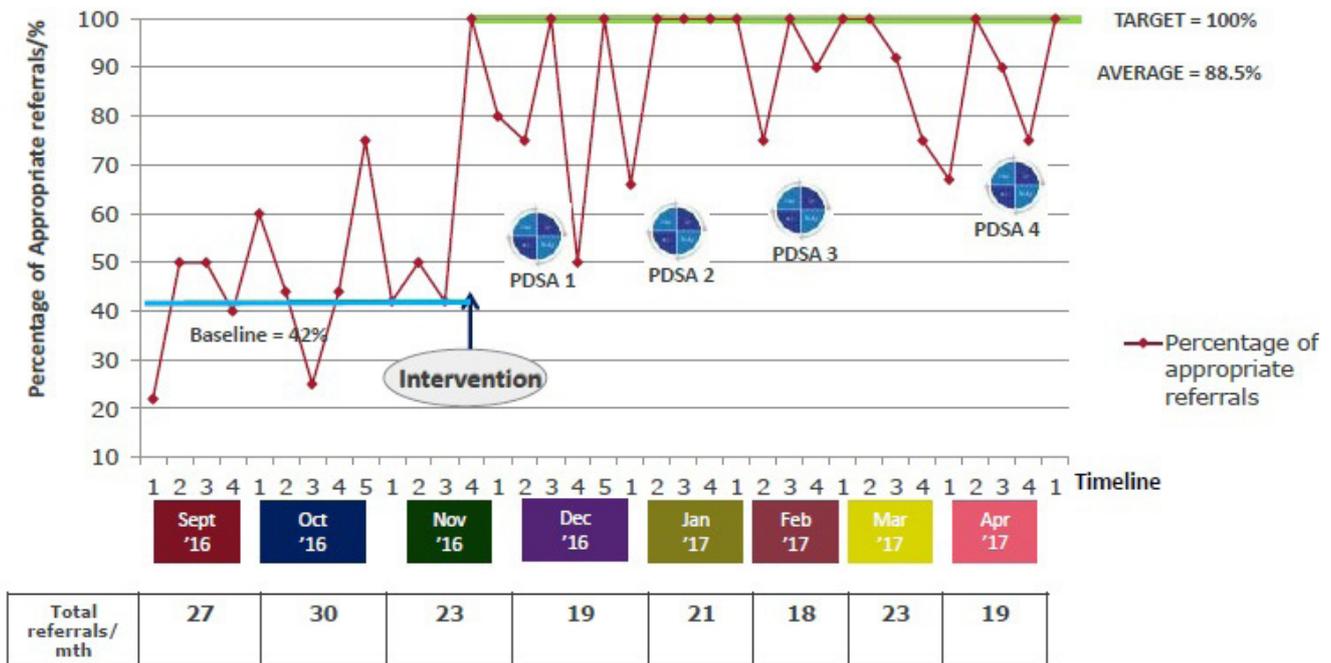
Unsuitable referrals

However, one of the problems that surfaced was that only three in 10 referrals to the PACE-CVM round were deemed appropriate. Inappropriate referrals delayed surgery confirmation, wasted resources and caused unnecessary

patient anxiety.

To solve this problem, a quality improvement team was formed in 2016. It was led by consultant anaesthetist Dr Flora Yuan and consultant cardiologist Dr Chia Yew Woon.

After numerous discussions, the group concluded that the root cause of the inappropriate referrals was due to the lack of common understanding between anaesthetists and cardiologists on the types of cardiac



A run chart showing the percentage of appropriate referrals to the PACE-CVM round. There was a significant increase in the number of appropriate referrals with the team achieving the 100 per cent target in 12 out of the 23 weeks followed up.

conditions that require pre-operative evaluation and optimisation. The team thus set out to close this gap.

PDSAs

1st PDSA: The team reviewed and updated the PACE-CVM referral guidelines, in accordance with the latest evidence-based literature.

Based on feedback from users, they also reformatted the guide to risk-stratify patients.

The new guide made it easier to link investigations and test results with recommended actions for different patient risk groups.

It proved to be a useful tool and soon after it was rolled out, the team was able to hit its target of 100 per cent appropriate referrals for a few months.

2nd PDSA: But the team found that the initial 100 per cent compliance could not be sustained. A quick analysis revealed that

versions of the old guidelines could still be accessed.

“We discovered there were physical copies of the old guidelines still lying around,” Dr Yuan recalled. “We had to purge all of these and replace them with the new guidelines.”

3rd PDSA: Another factor affecting appropriate referrals was discovered when the team analysed inappropriate referrals and realised that some junior doctors were referring directly to the PACE-CVM round, bypassing the PACE consultant.

This was likely the result of frequent rotation of junior doctors, who may not be aware of the workflow.

A gentle reminder was sent out to all doctors to follow the standard process for making referrals to the round.

4th PDSA: Further cases of inappropriate referrals led to the realisation that some doctors

were not familiar with ECG interpretation, and referrals were made when they did not fulfill the referring criteria.

“Even though this was in the guidelines, we realised perhaps the doctors on the ground didn’t understand the exact ECG criteria for referrals,” noted Dr Yuan.

Therefore, an ECG refresher was organised during a morning department meeting, using actual cases to illustrate which types of ECG changes were significant enough to require referral.

Safety and balance measures

Following these series of interventions over 18 months, the median for appropriate referrals to the PACE-CVM round increased from 30 to 90 per cent.

Despite the success, it was important to follow up with safety and balance measures.

The team wanted to make sure there were no increased in-

idents of [peri-operative major adverse cardiac events](#) and no same-day cancellation of surgeries from the reduction in referrals.

To date, no such cases have been highlighted.

The project has improved timeliness to surgery, reduced unnecessary patient anxiety and improved both patients' and physicians' satisfaction.

It has also generated potential manpower and resource savings of more than \$25,000 per year for the hospital.

Lessons learnt

Dr Chia felt the project, with the constant fine-tuning required, taught him the importance of continuously monitoring progress and effectiveness, to ensure long-term sustainability in improvement.

Both doctors agreed that the most challenging part was getting buy-in from stakeholders

and encouraging behavioural changes, especially as this involved a change in clinical practice that varies from person to person.

The team also had to address the sometimes differing priorities of the two separate disciplines.

The team tried to overcome this by ensuring good evidence to back up the initiatives, and to give everyone enough time to give feedback. There is give-and-take, to establish margins that the institution can work within.

"It was also important to close the entire feedback loop – to our colleagues who are still referring inappropriately we will highlight those to them gently," said Dr Yuan.

"We keep a close eye for our safety and balance measures and with time and patience, as the initiatives prove their safety, the buy-in would be expected to improve."👉

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The project team which comprised of anaesthetists, cardiologists and nurses, worked on improving the number of appropriate referrals to the PACE-CVM round from 30 per cent to 100 per cent.