VOLUME 1
AUGUST 2018
published by the Patient Safety Team
ADK HOSPITAL

QUALITY *Matters*

Keeping patients safe

ADK Hospital
caring about you, when you need it most!

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QUALITY *Matters*

VOLUME 1

AUGUST 2018

WELCOME

At ADK Hospital, we are committed to providing high quality and safe care to our patients. A number of programs, processes and procedures are put in place to continuously improve the quality and safety aspects of patient care.

Quality Matters is a periodical newsletter that has originated from the work of a dedicated group of patient safety champions at this hospital. These dedicated staff have continuously assessed, monitored and intervened to improve care processes to achieve the patient safety goals of the hospital. As can be seen from the brief analyses presented here, focus has been put on areas such as infection control, surgical safety, preventing healthcare associated infections, clinical incident management and the like. Based on these findings, the team continuously thrive to put in measures to improve the patient experience.

The hospital's management is actively involved in and engaged in evaluating and reviewing the quality and safety of services that we provide to our patients. We are always on the look out for discussions and opportunities to improve our services further.

Quality Matters will periodically update our achievements, and those areas where we need improvement, based on the evidence we gather as we continue to improve our performance. Quality and safety is a journey that takes time. We assure you that the team at this hospital are working with enthusiasm and dedication to reach our destination.

In good health,

Ahmed Afaal
Managing Director

CMO'S MESSAGE

I, perhaps like many of my colleagues, believed that my clinical practice was always patient-centered and safe. As healthcare providers, we all go to work everyday, to do the best we can, to get the best outcomes possible for our patients and to do so in a safe manner. We self-regulated ourselves, critically reviewed our practices and brought in changes to improve ourselves and our practices. Each, in our own value-based assessment, perhaps, were content with what we were doing.

Few years ago, we came to a , rather obvious realization that, despite individual and personal efforts, our practice wasn't achieving either patient-centered or safety-oriented care for our patients.

We were each part of a group of healthcare delivery individuals, each looking after and delivering components of care, all with good intentions, sometimes going extraordinary lengths to achieve the outcomes we did. Mostly good outcomes. Sometimes, not so good. Occasionally, tragic. With the quality improvement drive we undertook, we realized, patient safety required each of those individual healthcare providers to work together, in a team and with the same guiding principles. Our individual team members being from different nationalities, cultures, training backgrounds, workplace systems, in addition to the unique personality variations we inevitably were to have, would require us to leave many of our old ways behind and embrace a common system of values to work together as a team. Change is often difficult. More so with the diversity we have.

We want better outcomes. We want a system that is driven towards those improved outcomes. A system that places patients at the center of attention. It is after all they, whose wellbeing and even life we are trying to save.

The journey began when we realized we needed to do better. We study what we do, what needs to change, why they need to change, what the changes could be and how the change would be brought about. Then study further, what those changes achieve, how we can improve it further and plan again.

If improvement is possible, change to achieve that must be possible. At each step. With each individual. By every individual. To improve. To be safe. To place the patient in the center of what we do. That is the new culture towards which we are headed.

Quality Matters documents the key bits and pieces of what we are learning on our journey.

Dr Abdulla Niyaf
Chief Medical Officer

ADKScore

detecting patient deterioration early

Khadhiyya Simany, Patient Safety Nurse SSN3

ADKScore is a tool used at ADK Hospital as an early warning system to detect deterioration in a patient's condition. It was adapted from the National Early Warning System (NEWS) used in Scotland, and TOKS used in Denmark as early warning scores. The need for such a tool was recognized after the death of a patient, where the patient's deterioration went unidentified soon enough. The death was a turning point where the review led to the need of having an early warning mechanism. The ADK score was developed in consultation and with support from Healthcare Improvement Scotland and the Centre for Quality in Denmark. The name ADKScore was chosen in the memory of Abdul Rahman Dhon Kaleyfaan.

Evidence show that 70% (45/64) of patients arrests with evidence of respiratory/neurological deterioration within 8 hours [Schien, Chest 1990; 98: 1388-92] and 66% (99/150) of patients show abnormal signs and symptoms within 6 hours of arrest and the attending doctor is notified in 25% (25/99) of cases [Franklin C, Mathew J.. Crit Care Med. 1994;22(2):244-247].

This supports the need to have a system that can track the changes which can lead to such an event.

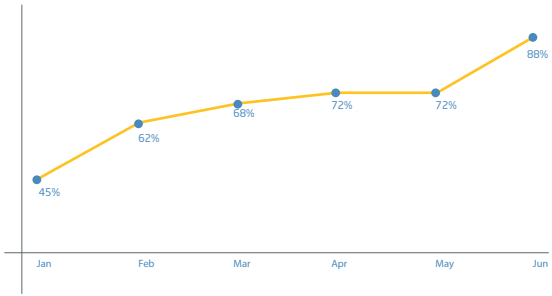
In hospitals where such early warning systems have been established, it has known to reduce post-operative emergency ICU transfers by (58%) and deaths by (37%) [Bellomo R, Goldsmith D, Uchino S, et al. Crit Care Med. 2004;32:916-921]. A reduction in arrest prior to ICU transfer (4% vs. 30%) [Goldhill DR, Worthington L, Mulcahy A, Tarling M, Sumner A. Anesthesia. 1999;54(9):853-860.], and a 50% reduction in non-ICU arrests [Buist MD, Moore GE, Bernard SA, Waxman BP, Anderson JN, Nguyen TV.. BMJ. 2002;324:387-390.]

ADK score was introduced at ADK Hospital in December 2015 and has been in use since then with good outcomes. The tool provides a systematic method to measure simple physiological parameters to track changes and the cumulative score acts as a trigger to improve the timeliness of response. The response will be a clinical review, or an escalation of care where the patient may be moved to a high intensive care setting such as the HDU or the ICU. The ADKScore is complimented by a new patient observation chart with visual triggers to indicate when a particular parameter is out of the normal range.

At present the ADKScore is used only for adults in the non-intensive care setting. The score will be expanded to use in all patients, with modifications based on the Between the Flags program in Australia later this year.

The auditing of the compliance of ADK score was started in September 2017. The audit tool for ADK Score was adapted from NEWS (Scotland) audit tool. Our initial compliance rate in completion of the ADKScore was 43%, which has come up to 63% this March. The main area of improvement in general for all audits is whether the action has been taken as per the ADK score. This is something we have to build on further. The recording of all parameters and correct documentation has been identified as mostly 100 percent compliance rate in all the audits.

ADKScore Compliance Rate



The audit is based on 5 case sheets from all unit areas where the scoring is done. Initially it began with 7 units and now has come up to 10 units. Each case sheet is assessed for 13 individual components. For a case sheet to score 100 percent each of these 13 components must be complete. The graph indicates the overall hospital compliance rate for ADK score from January 2018 till June 2018.

ADK SCORE	3	2	1	0	1	2	3
Respiratory Rate	⩽8		9-11	12-20		21-24	⩾25
O_2 saturation %	⩽91	92-93	94-95	⩾96			
O_2 supplement		Yes		None			
Systolic BP	⩽90	91-100	101-110	111-219			⩾220
Pulse	⩽40		41-50	51-90	91-110	111-130	⩾131
AVPU score				Alert			VPU
Temperature	⩽35.0		35.1-36.0	36.1-38.0	38.1-39.0	⩾39.1	

Concern about a patient should lead to escalation, regardless of the score

ADK SCORE	ACTION
0	Continue routine monitoring
1	Assess every 2 hours
2	Assess every 1 hour
3-4 (or >2 in any basic observation)	Call MET
⩾5	Call MET+ Specialist

SEPSIS

Consider SEPSIS if 2 or more of these:

Temp: <36 or >38.3 ^{0} C
Pulse: >90 bpm
Respiratory rate: >20/min
WCC>12 or <4 x10^3
Acutely altered mental state
Hyperglycemia
Plus new infection

Components of ADK SCORE; The physiological parameters used in the calculation of the score are routinely collected for each patient. The ADK SCORE helps to detect deterioration of the patient before the patient crashes, or is in the danger zone. This helps in quick escalation of care.

CLINICAL INCIDENTS

learning from adverse events

Fairooza Hassan, Head Quality Improvement, Occupational Health and Safety

Despite of best efforts and intentions, sometimes patients are harmed while receiving care that is intended to help and heal them. While patients and their families bear the primary burden of this harm, well-intentioned healthcare clinicians and healthcare organizations are also impacted.

Worlwide, even in developed health systems such as the NHS, it is believed that a serious adverse event or critical incident occurs in up to 10% of all hospital admissions.

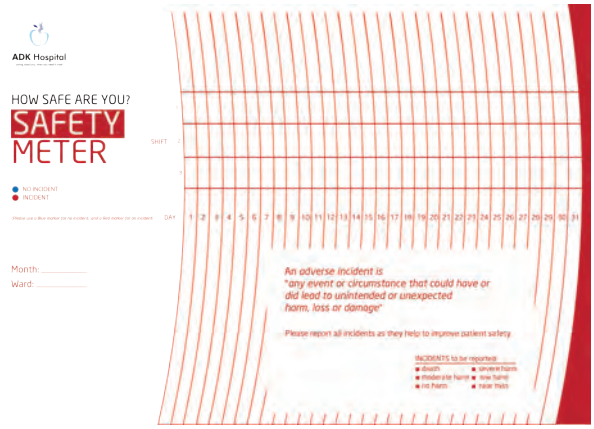
Although it is difficult to prevent errors, it is possible to put in place procedures which act as barriers to making mistakes.

Therefore, in ADK Hospital, we have placed a protocol aiming to effectively manage clinical incidents with a view to reduce preventable patient harm. This can be achieved through processes that:

- Identify and treat hazards before they lead to patient harm.
- Identify when patients are harmed and promptly intervene to minimize the harm caused to a patient as a result of the incident.
- Disclose a clinical incident resulting in patient harm.
- Ensure that lessons learned from clinical incidents are communicated and applied by taking preventive actions designed to minimize the risk of similar incidents occurring in the future.

The established Incident Reporting and Management System in the hospital is functioning well to achieve this. However, it is limited by the reporting practices, as a number of incidents go unreported.

The Safety Meter was designed in part to address this issue, including, as a tool to; promote good practice by looking at how many days have gone by without an incident; provide real time data and link the data to improvement aim.

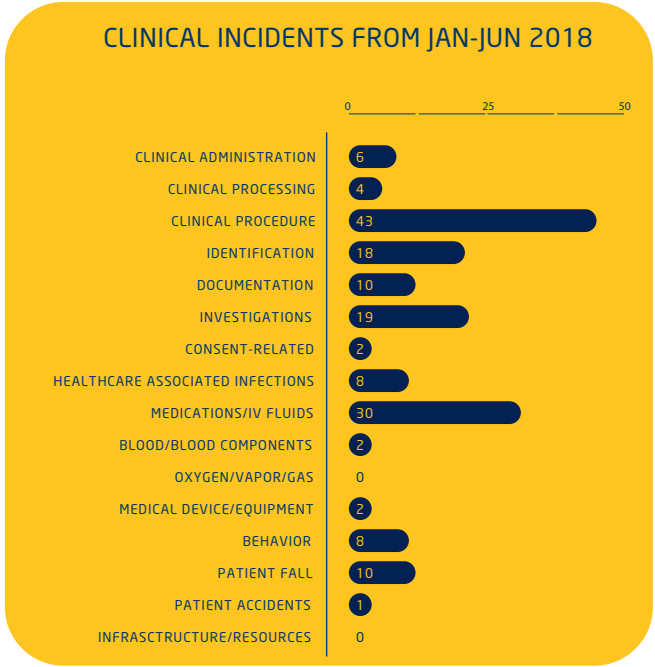


The Safety Meter is placed in all the clinical areas, where it is visible to everyone, as a measure to ensure transparency about errors. It aims to show what has gone right, which is the majority of the time, as well as what goes wrong.

A red dot is placed if an incident occurs and a blue dot is placed if there are no incidents or safety concenrs. For each red dot from the individual clinical area, an incident report will be generated, which will be submitted to patient safety committee for review.

From Jan to June 2018, there were 163 incidents reported, out of which 43 incidents were clinical procedure related. Thirty incidents were medication incidents which includes near misses. Out of 163 incidents, 18 were identification incidents and 19 incidents were of investigations, where patient were issue wrong reports and verification errors. Ten incidents were documentation errors and there were other incidents such as patient falls, health care associated infection, incidents related to clinical administration and clinical processing.

Each incident provides an opportunity to learn from to improve the care we provide to our patients, and it is urged that all clincial staff report events promptly.



55%

inappropriate care
(RAND Study by McGlynn et al 2002)

57%

inappropriate care
(Runciman et al 2012, Australia)

98,000

preventable deaths
(IOM *To Err Is Human* Report, 1999)

10%

subjected to iatrogenic harm
(Vincent et al 2008, UK Study)

Errors are made even in the best health systems

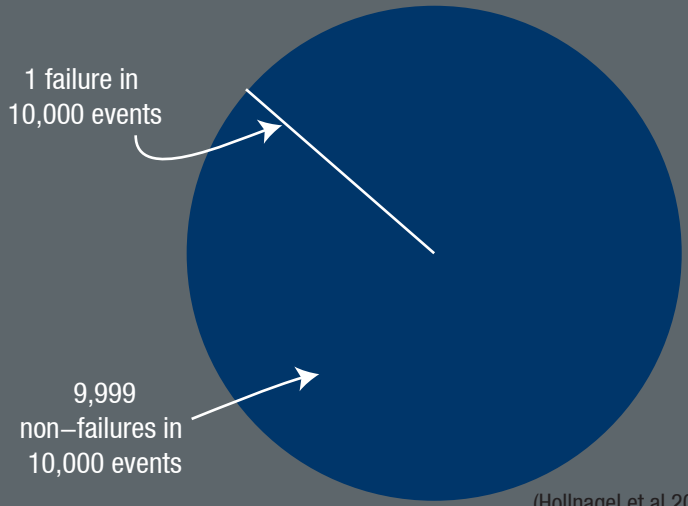
1:10

Ratio of unsafe:safe care

Carthey, de Leval and Reason (2001)

"First, do no harm"

Hippocrates



(Hollnagel et al 2013)

The ADK Safety Meter aims to celebrate these non-failures, while acting on the failures

QUALITY Matters

Activities to achive the

INTERNATIONAL PATIENT SAFETY GOALS

GOAL 1

Identify patients correctly

All inpatients are provided with ID bands with specific identifiers to ensure correct patient identity.

GOAL 2

Improve effective communication

SBARS tool is used to ensure essential and critical information is effectively handed over at clinical encounters

GOAL 3

Improve safety of high alert medications

Look alike and sound alike medications are identified and stored seprately; color codes are used to identify high alert medications

GOAL 4

Ensure safe surgery

The WHO Surgical Safety Checklist is used for all surgeries and audits are carried out monthly to provide feedback; a new Clinical Procedure Safety Checklist is being introduced to ensure safety for clinical procedures such as bronchosco-py/endoscopy.

GOAL 5

Reduce risk of Healthcare Associated Infections

Surveillance of all HAIs are carried out by the Infection Control Team; hand hygiene compliance is audited monthly; an Antibiotic Stewardship program is in place

GOAL 6

Reduce risk of patient harm resulting from falls

To address the increase in number of patient falls, the Falls Risk Assessment and Management Plan (FRAMP) is being adapted for implementation

SBARS

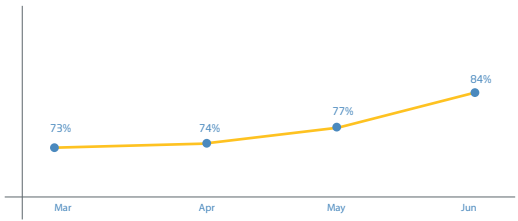
communicating effectively

Cesilia R Climned, CLN, Patient Safety Nurse

Communication errors are a common cause of adverse patient safety events in a health care institute. One of the factors of breaking down of communication during patient care is a lack of a structured method of communication between the health care providers. Therefore, to prevent communication related errors, a communication model called SBARS was introduced to ADK hospital in mid-2016.

SBAR (which stands for Situation, Background, Assessment, and Recommendation) is a structured communication tool designed to convey a great deal of information in a concise and brief manner. It is a way for health care providers to communicate effectively with one another, and it also allows information to be transferred accurately. As means of improving patient safety in ADK hospital one more element for the SBAR tool was added; an S which stands for safety). Whether information is shared through phone or during shift handover process, the SBARS models is the standard tool through which the transfer of patient care information must occur.

SBARS Compliance Rate



S **SITUATION**
Brief description of the current situation. Clear succint overview.

B **BACKGROUND**
Pertinent history. What got us to this point?

A **ASSESSMENT**
Summary of facts and best assessment. Any observations (ADKScore) What is going on?

R **RECOMMENDATION**
What actions are you asking for? What do you want to happen next?

S **SAFETY CONCERNS**
How safe was care? Are there any safety concerns and/or risks?

To determine the compliance of the SBARS method of communication an audit tool was developed in March 2018. Our initial compliance rate was 73%, and the compliance rate has increased with the last audit showing a compliance rate of 84% in June 2018. The main area to be improved is patient safety concerns element, where there is a need to clarify what constitutes a safety concern. With the introduction of new SBARS handover checklist in July 2018 hopefully a good improvement would come to the patient safety component in the future.

The graph represents the overall hospital compliance rate of SBARS from March 2018 till June 2018. SBARS use has improved the communication between the doctors and the nurses to some extent by helping transfer of patient information in a standardized manner. But there is a need to spread the use of the tool to all communications across the hospital including those that happen between doctors and between other health care professionals

HAND HYGIENE

keeping patients safe from HAIs

Zarana Mohamed Ali, Head Infection Control

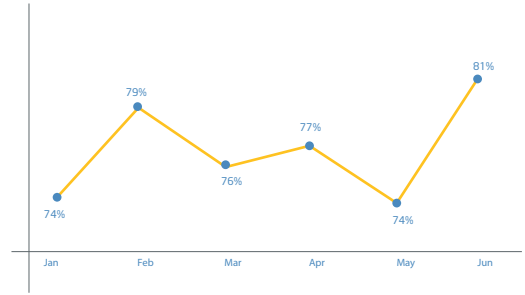
Health care associated infections affects millions of patients around the globe annually. In the emergence of the growing burden of health care associated infections (HCAIs), health care practitioners (HCPs) are focusing on the basics of infection prevention by simple measures like hand hygiene.

Hand hygiene is considered as the primary measure to reduce infections. Over 1.4 million people worldwide are suffering from infections acquired from hospitals (WHO, 2013). Annually 2 million patients in the United States get an infection in hospitals, and about 90,000 of these patients die as a result of their infection (CDC, 2016). The recorded global hand hygiene compliance rate among health care workers were 40% (WHO, 2009). Although hand hygiene is a simple action, lack of compliance among health care workers to hand hygiene practices is challenging and a worldwide concern. Non-compliance can contribute to extended hospital stays, increased patient mortality, higher readmission rates, and increase financial burdens on patients and families and the health system.

In 2016 September, baseline data of Hand hygiene compliance rate of ADK Hospital was 43% (40% among doctors and 45% among nurses). The optimal target set for all staff was to increase our hand hygiene compliance rate to more than 90% monthly and to sustain it throughout. In August 2016, education classes were conducted for nurses and 15 auditors were trained. The audit tool used was Hand Hygiene Observation Data Collection form from Hand Hygiene Australia (HHA).

In September 2016 hand hygiene audit in various departments was conducted which specifically looked into moments of hand hygiene, health care worker's compliance rate and total compliance rate of the hospital. In January 2017, hand rubs were kept in easily accessible areas of the hospital.

Hand Hygiene Compliance



Looking at the current statistics, there are now a total of 30 trained auditors, who has audited 1067 moments from 18 areas. With the expansion of the Hospital, additional 7 areas totaling to 25 areas will be audited in the month of July and it is anticipated to extend this audit further to more areas of the hospital.

The overall hand hygiene compliance rate of ADK Hospital is on the increase, with the latest compliance rate reached at 85%.

DOCUMENTATION

capturing essential patient information

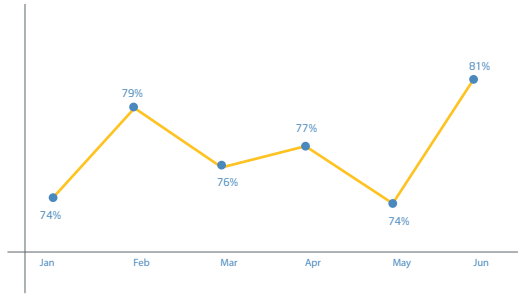
Angelee Rose SSN3, Patient Safety Nurse

In any health care setting, it is vital to keep records of patient care as it provides the details of the care provided to every patient from the moment they walk in to the hospital until they get discharged. The patients chart records the continuity of care and ensures the standard of care is met for every single patient in whatever service they are seeking from the hospital.

As part of the patient safety activities, audits of the documentation are carried out to see whether the documentation standards are met and where improvements can be made in the documentation process. The first documentation audit was conducted in July 2016. Three case sheets in each units were reviewed using the audit tool that has been put together to assess how effective and how transparent was the care given to a patient. The initial result of the audit was 68% compliance with the documentation standards. From this result, areas for improvement were identified and the audit tool was revised to capture the significant details needed in the documentation.

After analyzing the initial result, the documentation audit was increased from three to five case sheets in every inpatient unit, including the Emergency Room and Observation Room. As the audit is carried out monthly, feedback is given on a monthly basis as well. Feedback is delivered personally to each unit in-charge, emphasizing to each of them how the documentation in their respective units are going on, identifying specifically what needs to be improved and that it should be in accordance to the hospital guidelines.

Documentation Compliance Rate



Classes for nursing documentation are conducted and the audit results are presented in the monthly CNE for nurses, where total hospital compliance is being presented and the specific areas where improvement is needed are being discussed and emphasized. Documentation has been made as one of the topics being discussed in every induction class for the newly joined nurses. A brief explanation of the hospital guidelines in documentation are being explained and introducing them few checklists and charts to note the progress of the patients, such as the ADK score chart.

There has been significant improvement from the initial result of the audit of 68% compliance with the documentation, and the current hospital compliance is 81%. At present there are number of new forms being introduced, and ongoing revisions of the existing forms, such as the hospital progress notes to further improve the documentation.

MEDICATION SAFETY

preventing harm from medication use

Manoharajoy Gnanamony, CLN, Patient Safety Nurse

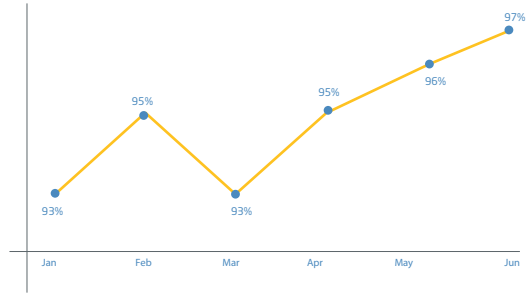
Medication safety is defined as freedom from preventable harm associated with medication use (ISMP Canada, 2017). Medication safety issues can impact health outcomes, length of stay in health care facility, readmission rates and overall to health care system and patients as well. "Medication Safety" is one of the International Patient Safety goals as well.

Medication management involves prescribing, transcribing, ordering, dispensing, supplying, administering and storing. Medication errors are prone to happen at any of this stage. In order to locate a gap clinical audit is necessary in an organization.

The goal of ADK hospital in medication safety is "To gain 100%complaince in medication management and to reduce medication errors to zero" by the end of December 2018.

Auditing medication includes assessing the competency of staff administering medication on an ongoing basis and to identify the gaps in medication management system. ADK Hospital has done a random medication audit on August 2016 without the knowledge of the staff, in order to get a baseline compliance rate of hospital, with an audit tool which based on "Maldives National Medication Practice Standards". The audit tool was focused on two main areas; (1) the completeness of prescription including patient identifiers, and (2) the medication administration procedure including six rights of medication. The hospital compliance was 87% on August 2016. A plan was developed to carry out medication audit every three months.

Medication Management Compliance



The auditors found that there were different practices in between the units in the hospital. Auditors also noticed the risk or allergies were not notified in the progress sheet, where the doctors write the orders for inpatients. The concern was discussed in patient safety committee meeting and it was decided that a stamp be put on progress sheet and medication chart, which showed the allergies and risks of patients. Training on medication administration was given to the nursing staff and the audit tool was introduced to them. In December 2016, medication management compliance increased to 88%.

In January 2017, the medication audit tool was revised and implemented with the ten rights of medication. A group of staff were selected as medication auditors and training was given to them with the revised audit tool. It was decided in Patient Safety meeting to do medication management audit every month. Each unit compliance rate and feedback was given to the units every month. After the training of auditors and monthly feedback, a marked improvement in compliance rate was noticed.

WHO Surgical Safety Checklist

Safe surgery saves lives

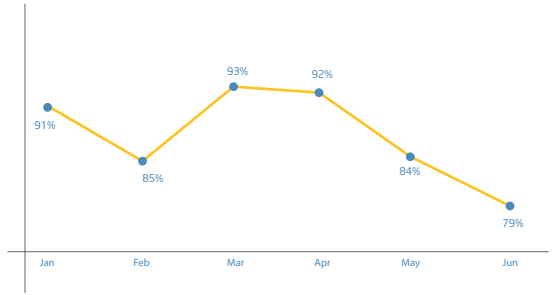
Niyaza Abdul Rahman, Head Nurse and Patient Education

Although there have been major improvements over the last few decades, the quality and safety of surgical care has been dismayingly variable in every part of the world. 'The Safe Surgery Saves Lives initiative aims to change this by raising the standards that patients anywhere can expect, ' states Dr Atul Gawande Associate Professor and surgeon Harvard School of Public Health. The WHO Surgical Safety Checklist focuses on the important safety issues, including inadequate anesthetic safety practices, avoidable surgical infections, poor communication among team members and aims to ensure that key safety elements are incorporated into the operating room routine.

WHO Surgical Safety Check List (SSCL) was started in ADK Hospital on September 2016 after an adverse event relating to the retention of a surgical instrument. The initial compliance for SSCL was 43% which was alarmingly low for the safety culture of the operating room. Thus, staff were given training and education on the topic, which included all the core components on how to use SSCL. Additionally, this is being continued in the induction program for the newly recruited nursing staff. Monthly audits are being done randomly for multiple surgeries using a quantitative audit tool, where separate auditors are selected for the audits. Our target compliance is to reach 90% and above, in order to ensure a safety culture among theatre team members.

A number of modifications have been brought to the checklist , such as the inclusion of the confirmation of implants/prosthesis/special equipment availability, size and expiry date.

WHO Surgical Safety Checklist compliance



Certain positive outcomes have been brought upon after implementing Surgical Safety Checklist to some extent; identification was one of the major areas which has improved after implementation of SSCL and there is an improvement in communication among team members. However, there are marked variations with the use of the Checklist, and the compliance with the Checklist has failed to reach the 90% mark and is on the decline over the last months. Given the importance in ensuring safe surgery through the checklist, the reason for this decline needs to be explored.

Assessing the CULTURE *of* SAFETY *at ADK Hospital*

BUILDING A SAFETY CULTURE

assessment of the culture of safety at ADK Hospital

Dr Faisal Saeed, Director Clinical Governance

If a hospital wants to prevent severe errors and harm that should never happen, it needs to foster a culture of safety. A culture of safety, is:

"a product of the individual and group values, attitudes, competencies and patterns of behaviour that determine the commitment to, and the style and proficiency of, and organisation's health and safety programs",
or simply put,

"***how the organisation behaves when no one is watching***"

It is characterised by a belief that, even though patient harm is an inevitable and unfortunate by-product of the complexity of the healthcare environment, the hopsital systems can be designed to minimise harm. There must be a commitment to detect and learn from errors, and an environment that is perceived to be just. The preoccupation with failure and the need to learn from them, must not be associated with a temptation to blame the individuals who have to operate within a poorly designed system that is favorurable to error. An evironment where it is safe to speak up is essential, where mistakes can be openly discussed as a source of learning, while swift action follows quickly to remedy an unsafe act.

To assess if the cutlure at ADK Hospital was one that prioritised safe patient care, the AHRQ Hospital Survey on Patient Safety Culture (HSOPSC) was carried out in Septeber 2017.

Key questions to ask

1. Do leaders create an environment that is safe to speak up?
2. When someone voices a concern, do people stop, listen and validate it?
3. Do leaders act quickly to remedy the unsafe situation?
4. Do people openly discuss mistakes as a source of learning?

Three hundred survey questionnaires were distributed and there was a 95% response rate. The HOSPSC looks into important components of a safety culture; teamwork within and across units, manager expectations and actions promoting patient safety, management support for patient safety, organisational learning and continuous improvement, overall perception of patient safety, feedback and communication about error, openness in communication, frequency of events reported, staffing, safety in relation to handoffs and transitions in care and non-punitive response to error.

A summary of the results from each composite area is provided below.

1. TEAMWORK WITHIN UNITS [% positive responses]

93%

People support one another in this unit

91%

When a lot of work needs to be done quickly, we work together as a team to get the work done

90%

In this unit, people treat each other with respect

75%

When one area in this unit gets really busy, others help out

2. MANAGER EXPECTATIONS & ACTIONS PROMOTING PATIENT SAFETY [% positive responses]

79%

My supervisor says a good word when he/she sees a job done according to established patient safety procedures

76%

My supervisor seriously considers staff suggestions for improving patient safety

62%

Whenever pressure builds up, my supervisor wants us to work faster, even if it means taking shortcuts

18%

My supervisor overlooks patient safety problems that happen over and over

3. ORGANIZATION LEARNING: CONTINUOUS IMPROVEMENT [% positive responses]

92%

We are actively doing things to improve patient safety

82%

After we make changes to improve patient safety, we evaluate their effectiveness

87%

Mistakes have led to positive changes here

4. MANAGEMENT SUPPORT FOR PATIENT SAFETY [% positive responses]

78%

Hospital management provides a work climate that promotes patient safety

86%

The actions of hospital management show that patient safety is a top priority

59%

Hospital management seems interested in patient safety only after an adverse event happens

5. OVERALL PERCEPTIONS OF PATIENT SAFETY [% positive responses]

26%

It is just by chance that more serious mistakes don't happen around here

70%

Patient safety is never sacrificed to get more work done

37%

We have patient safety problems in this unit

74%

Our procedures and systems are good at preventing errors from happening

6. FEEDBACK AND COMMUNICATION ABOUT ERROR [% positive responses]

54%

We are given feedback about changes put in place based on event reports

83%

We are informed about errors that happen in this unit

85%

In this unit, we discuss ways to prevent errors from happening

7. COMMUNICATION OPENNESS [% positive responses]

58%

Staff will freely speak up if they see something that may negatively effect patient care

34%

Staff feel free to question the decision or actions of those with more authority

41%

Staff are afraid to ask questions when something does not seem right

8. FREQUENCY OF EVENTS REPORTED [% positive responses]

73%

When a mistake is made, but is caught and corrected before affecting the patient, how often is this reported?

68%

When a mistake is made, but has no potential to harm the patient, how often is this reported?

77%

When a mistake is made that could harm the patient, but does not, how often is this reported?

9. TEAMWORK ACROSS UNITS [% positive responses]

62%

Hospital units do not coordinate well with each other

77%

There is good cooperation among hospital units that need to work together

61%

It is often unpleasant to work with staff from other hospital units

87%

Hospital units work well together to provide the best care for patients

10. STAFFING [% positive responses]

76%

We have enough staff to handle the workload

15%

Staff in this unit work longer hours than is best for patient care

46%

We use more agency/ temporary staff than is best for patient care

19%

We work in 'crisis mode' trying to do too much, too quickly

11. HANDOFFS AND TRANSITIONS [% positive responses]

57%

Things 'fall between the cracks' when transferring patients from one unit to another

72%

Important patient care information is often lost during shift changes

40%

Problems often occur in the exchangeof information across hospital units

75%

Shift changes are problematic for patients in this hospital

12. NONPUNITIVE RESPONSE TO ERROR

[% positive responses]

42%

Staff feel like their mistakes are held against them

30%

When an event is reported, it feels like the person is being written up, not the problem

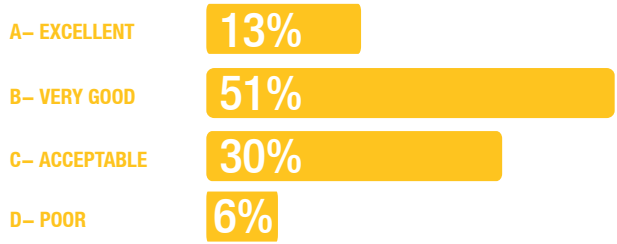
23%

Staff worry that mistakes they make are kept in their personal file

The results form an initial baseline assessment of the culture of safety at ADK Hospital. There are certain key findings that show (1) an existing reporting culture through the incident mechanism system, the Safety Meter, and a positive outlook towards patient complaints, (2) a just culture that conveys the message that disciplinary measures against individuals will not be taken where the errors result of system failure, and (3) a learning culture where errors reported are analysed and appropriate change implemented based on the learnings from that error. However, there are a number of areas that require active intervention to strengthen the existing culture of safety.

Overall Patient-Safety Grade

[% positive responses]



How will we know if we have a culture of safety?

Psychological Safety

Individuals must feel safe in speaking up

Staff must know they will not be punished

Active Leadership

Create an environment where all staff are comfortable expressing their concerns

Support and focus on the culture of safety

Transparency

Open communication with each other, with patients and families

Use transparency as a vehicle for learning

Fairness

People are accountable for their behaviours

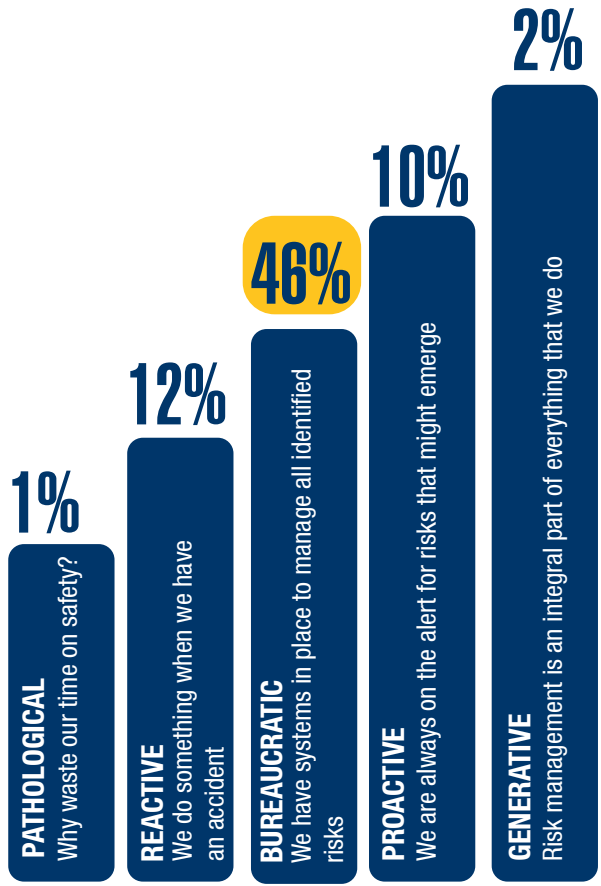
But we must not blame individuals for system problems

How mature is the SAFETY CULTURE *at ADK Hospital?*

MANCHESTER PATIENT SAFETY ASSESSMENT FRAMEWORK

The Manchester Patient Safety Assessment Framwork (MaPSaF) provides a framework to assess how mature the safety culture is in an organisation. During the Patient Safety Workshop that was organised in September 2017, we asked the participants where they would place ADK Hospital on the MaPSaF. Majority (46%) said that they believe we have systems in place to manage all identified risks, while 10% said we are always on the alert for risks that might emerge.

The vast number of safety projects in action at the hospital, the governance frameworks in the place and the policies centered around patient safety gives credit to that assessment. It will take further effort to make risk management an integral part of everything we do, as we make the culture at ADK Hospital predicated on patient safety.



Where will you place ADK Hospital on the MPSF?

Upcoming PROJECTS

Falls prevention

Patient falls are a major safety and quality risk at hospitals. However, this has remained ignored in the Maldives with not much available data on the extent of the problem, particularly because the falls are under-reported and unmeasured. But falls do occur, resulting in patient harm and extending the length of hospital stay.

To address the issue, a falls prevention and harm minimisation plan has been developed by the Patient Safety Team and will be implemented based on best practice and evidence.
Using the *Ontario Modified Stratify* (*Sydney Scoring*) *Falls Risk Screen*, ADK Hospital will start screening all patients for the risk of fall at the time of admission, and implement a Falls Risk Assessment Management Plan (FRAMP). Falls will become part of the hospital clinical audits, providing us with a clear picture of the extent of the prevalence of falls in the hospital setting.

Clinical Procedure Checklist

The Clinical Procedure Checklist is an upcoming safety project that will address the patient safety risks associated with clinical procedures. The Checklist will be an extension to the existing WHO Surgical Safety Checklist, but will be used in clinical procedures such as bronchscopy, endoscopy, and Cath Lab procedures. It will improve the matching of the patient to the correct procedure, improve communication between the members of the procedure team, and reduce the number of incidents related to clinical procedures.

VIEWPOINT

After participating at the Patient Safety Workshop organised by ADK Hospital in September 2017, a participant shared her thoughts

"First of all, I would like to thank on behalf of all the participants for giving us this opportunity to participate in this Patient Safety Workshop, because as healthcare providers our main concern is always patient safety .....I think this was a very good refresher for many of us because some of the things are such that we know it but we don't do it because we don't usually use it, so this was a good refresher...And as an educator I was very happy that even the students were given the opportunity to join in this workshop because they will definitely benefit from such things... to see nurses working hard for patient safety developing different tools is some things that was very encouraging for us and it is very interesting as well, so well done to ADK for developing such tools and actually working towards improvement of patient quality.

And the other thing I noticed was in this workshop I think we can do is think a bit critically now. So the first step toward improvement is actually accepting that we do make mistakes. We make mistakes and that is the turning point. Without actually acknowledging we make mistakes, we cannot improve it. From this entire workshop what I understood was that ADK Hospital is actually accepting that mistake tend to happen, but instead of hiding everything, working for betterment of the patient is really important. So as a consumer of health I can fairly well say that I will be much happier to actually get health care treatment from ADK Hospital because we know you are doing something, because we can trust when people do things.

One other very important thing that this workshop actually gave us the impression that you [ADK Hospital] are open for change; so that's a very positive thing. Thank you very much for giving me this opportunity to actually thank on behalf of the participants and highlight some of the things we learned. Thank you very much"

QUALITY *Matters*

VOLUME 1

AUGUST 2018

Quality Matters ia a periodical publisehd by the Patient Safety Team of ADK Hospital. The publication will highlight and provide an update on the outcomes of the projects and events that are carried out by the hopsital to improve the quality and safety of the care we provide to our patients.

The publication will be available for download at www.adkhospital.mv