A paradigm shift from blame to fair just culture- A UAE hospital experience
NNU - Tawam Hospital-UAE

BACKGROUND

The concept of safety culture originated from the High Reliability Organizations (HROs), such as the aviation and nuclear power industries. HRO's consistently minimize adverse events despite carrying out intrinsically complex and hazardous work. HRO's maintain a commitment to safety at all levels, from frontline providers to managers and executives.[1]

Tawam Hospital, a Johns Hopkins Medicine affiliated facility, one of the largest hospitals in the United Arab Emirates, realized the need for establishing culture of safety. Hence in 2008 implemented the Johns Hopkins Culture of Safety program called Comprehensive Unit –based Safety Program (CUSP). Neonatal Intensive Care (NNU) Unit, Intensive Care Unit, and Pediatric Oncology Unit (ICU/ NNU/ Pediatric Oncology) were selected as pilot units for implementation of CUSP. The units were selected in part due to their high-risk, high-volume nature and use of closed medical staffs.

Objective

CUSP aims at integrating safety into the culture of a unit/clinical area and ultimately the entire hospital, and to strengthen collaboration among senior hospital leaders, department chairs/unit managers and frontline caregivers, the end result being improved patient safety

METHODS

CUSP is a 6-step process:

Culture Assessment Survey

Safety culture is generally measured by surveys of providers at all levels. Validated surveys include the Hospital Survey on Patient Safety Culture (HSOPS) from the Agency for Healthcare Research &Quality and the Safety Attitudes Questionnaire (SAQ) from Pascal Metrics.

SAQ was administered to NNU staff in 2008, and in 2010. HSOPS was administered in 2012 and 2013 . On an average 80% of the staff participated in the survey with the response rate exceeding 75%.

Staff education on Science of Safety:

90% of staff were trained on topics such as

Historical context of Patient Safety, Second Victim, Comprehensive Unit-based Patient Safety program, Leadership engagement, Learning from defects and Celebrating Safety.

Assigning a senior executive

The CEO of the hospital adopted NNU as the CUSP Executive. A multi-disciplinary team was created. The CEO does the monthly executive walk round and the multi-disciplinary team meets monthly.

Executive walk rounds & meetings.

The meetings and walk rounds provided an opportunity for the executive leaders and the frontline staff to address safety issues. This helped in bridging the gap between the hospital leaders, department managers and frontline staff

Learning from defects and Improve teamwork and communication

To encourage non punitive approach to reporting, enhance staff awareness on incident reporting, learning from defects and implement risk reduction strategies. The unit established Safety Analysis Teams (SEAT). The team analysis the incidents and identifies one or two defects and plans implementation of systems changes wherever required to reduce the probability of the incident from recurring.

Resurvey staff about Safety Culture (annually)

Repeat the Culture Assessment Survey every 12-18 months to evaluate the improvements .

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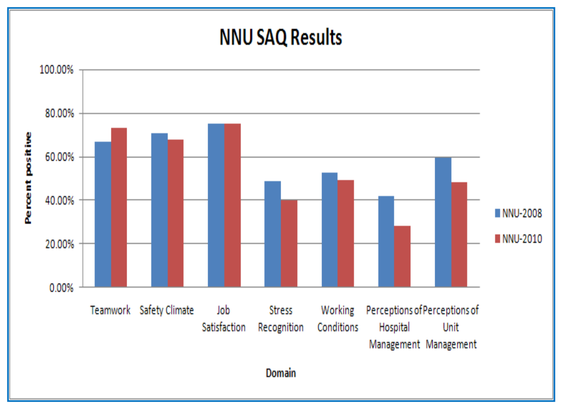
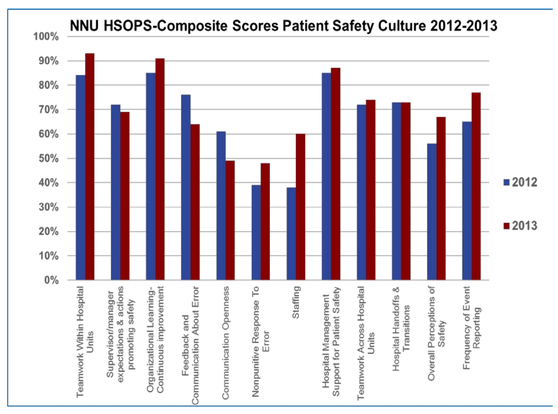
RESULTS

Culture Assessment Survey

Figure 1 illustrates the SAQs results of 2008 and 2010, the results show that the progress in the SAQ domain scores is gradual. The unit had sustained the job satisfaction scores, improved the team work scores and fallen back on the safety climate scores.



(Figure-1)



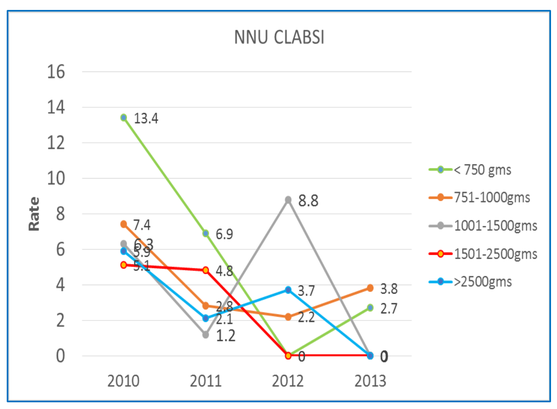
(Figure-2)

Figure 2 illustrates the HSOPS results of 2012 and 2013. Overall, the average score on each aspect or dimension of safety culture changed to some extent. The overall perceptions of safety shows 11% improvement, and frequency of event reporting has been improved by 12 %, which indicates that staff are more free to speak up. Staffing demonstrate the largest average improvement (22% improvement from 38% positive to 60% positive), and non-punitive response to error revealed remarkable improvement (9% improvement from 39% positive to 48% positive), while teamwork within unit improved 9% from an average of 84% to 93%.

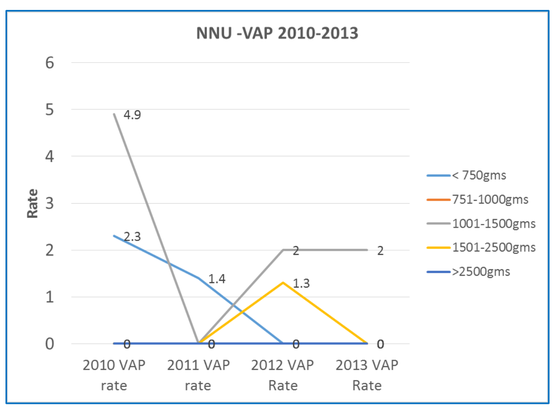
It also demonstrates that the majority of positive improvements in safety culture occurred around the areas of Non-punitive response to error and Teamwork in the unit. These are areas specifically targeted for improvement in CUSP.

Culture of Safety linkages to clinical outcomes

Culture of Safety has significant linkages to clinical outcomes. On a monthly basis, data on the infections prevalence are analyzed. Figure 3 shows Central Line Blood stream Infection (CLABSI) in NNU. The unit managed to reduce CLABSI rates to zero in 3 out of 5 weight groups. Figure 4 shows that ventilator-associated pneumonia (VAP) was also reduced to zero in 4 out of 5 weight groups. The prevalence rates of CLABSI and VAP have maintained a steady state below evidence-based benchmarks and in compliance with our corporate key performance indicators.



(**Figure-3**)



(Figure-4)

CONCLUSION

The safety culture among units within the same hospital can vary greatly. For this reason, it is important that efforts to create a culture of safety are undertaken by individual unit teams, as well as at the organizational level by senior hospital leaders.

What began as a pilot project in 2008 at Tawam has now expanded to include nine additional units. Tawam Hospital now has 12 actively functioning CUSP units representing critical care, pediatrics, ob/gyn, general medical surgical services, and recently emergency, operating room services. The culture of each unit is unique.

Research suggests that it may take as long as 5 years to develop a culture of safety that is felt throughout an organization (Ginsburg et.al 2005).

Today, the three pilot CUSP units have completed 5 years of implementation; six CUSP units have completed 2 years; and one CUSP unit has completed 1 year.

A patient safety culture change is both ***evolutionary and revolutionary***!

An organization's ***Culture of Safety*** is a never-ending journey.

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