Driving towards a Safer Culture-starting a Programme of informal Patient Safety Walkrounds in the Pediatric Department , HGH

HMC/SickKids Partnership Project

Problem:
The Senior Leaders looked to improve the safety culture in the Pediatric Department by increasing their awareness of the issues that affect patient care.

PROJECT SPONSORS:
Dr Mohammed Janahi; Chairman Pediatric department
HMC/SickKids Partnership Project

Aim:
Improve the safety of the care we provide to all our patients
•Develop open "no blame" environment on the units
•Improve communication between all staff working in Pediatrics
•To improve the communication links for patients and families in our care
•To look at trends generated by incident reports as a means to direct improvement plans
•To feed back to staff regularly about issues raised and actions taken

Intervention:
• Carried our a trial Patient Safety Walkround on Unit 2N1 in October 2013 with input from SickKids Quality Specialist
• Developed core questions with information from SickKids and research from other Evidence Based Sources and IHI
• Developed a timeline of actions to be taken so the event will run smoothly and information is sent in timely fashion to those involved in the event.
• Documented the issues raised by the staff questioned
• Focus on 3 main issues from the Patient Safety Walkround
• Feed back issues that will be actioned to the staff and the QPS Committee, complete report in 7 days

Results:
• The Patient Safety Walkround Calendar has been fixed for the next year, plan to visit each unit twice in the year ahead.
• The team should meet prior to brief each other prior to the Patient Safety Walkround so everyone is clear about who is leading the questions and who will keep time, and again following the event to agree on the 3 main issues raised and who will action them .
• The QPS Coordinator will write up the Patient Safety Walkround and distribute to the QPS Committee and the Pediatric Department, and liaise with the Head nurse of the unit regarding the actions to be taken.
• The questions are open and allow staff to answer freely, as they are aware it is confidential and no names are mentioned.
• Staff indicated that they enjoyed being asked their opinion on improving care for their patients, and were able to raise many concerns
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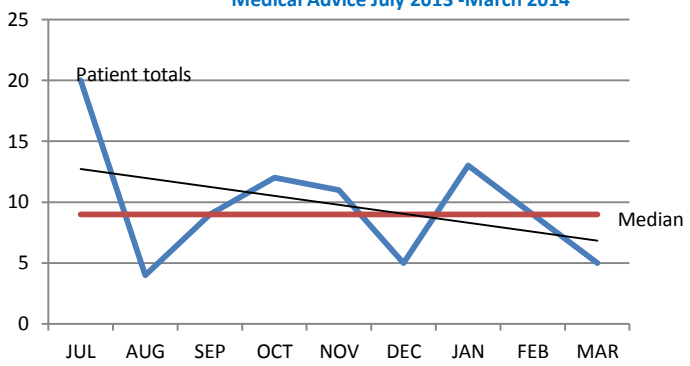
Conclusion:
• The Patient Safety Walkround has the potential to increase awareness of safety issues to all staff, patients and families in our care.
• It will encourage open communication and confidence in reporting issues and incidents that affect the care of our patients
• It will increase the number of incidents reported, thus allowing us to focus on the trends to develop improvement projects
• It has alerted Leaders to issues they may not have been aware
• It has allowed staff to raise matters freely, directly to the Senior Management team of the Pediatric department
• Staff are enthusiastic to improve the quality and safety of patient care

Next Steps
To liaise with the Executive Team Safety Walkround of HGH, align our questions
•To involve patients and families and different staff members
• To see that the improved communications with staff and families reduces the number of patients that leave against medical advice.
•Improved safety environment reduces the number of incidents in the department

Team Members:
Dr Mohammed Janahi: Chairman Pediatric Departments
Dr Basema Al Houri: Chair Pediatric Quality and Patient Safety Committee
Dr Fouad Abounahia: Deputy Chair Pediatric Quality and Patient Safety Committee
Dr Amira Mustafa: Member of Quality and Patient Safety Committee
Dr Khalid Mohammed: Member Pediatric Quality and Patient Safety Committee
Dr Magda Wagdy, Member Pediatric Quality and Safety Committee
Ms. Alison Bello: Pediatric Quality and Patient Safety Coordinator, HGH

Number of Patients who left the Pediatric Department against Medical Advice July 2013 -March 2014



Questions asked:
•When was the last patient incident or near miss on the unit, did you report it?
•If you make or report and error are you concerned for personal consequence?
•Are there any obstacles that make it difficult to provide safe care?
•What intervention from the Leaders would make the work you do safer for the patients in your care?
•Would you be happy for a member of your family to be treated here?

Selection of comments received:
• Poor communication between nursing and medical staff
• Poor communication with patients and families- translation of information a concern
• Noise on the units during medical rounds