EFFICACIOUS STRATEGY FOR DYNAMIC ASSESSMENT OF PATIENT SAFETY CULTURE

وزارة الصحة
Ministry of Health

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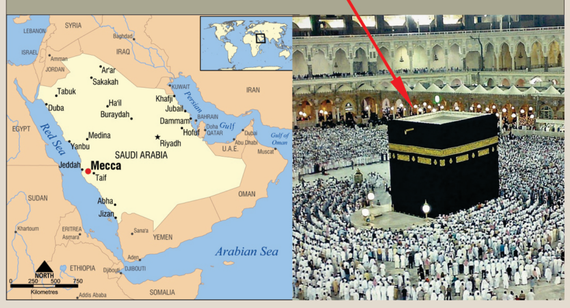
Quality Started From Here



"First Do No Harm"

"HIPPOCRATES OATH"

TO ERR IS HUMAN

- 44,000-98,000 deaths annually occurred in USA due medical errors.

IOM, 1999

AHRQ

- Agency of Health care research and quality is a Leader Federal Agency in USA
- It's **Goal** is to support a culture of safety & quality improvement in the nation's healthcare system through speed the adoption of research findings into practice & policy

Safety Culture

* **The safety culture of an organization is the product of individual and group:**
  - –Values, attitudes, perceptions, competencies and patterns of behavior
* **Positive Safety Cultured Organization is characterized by:**
  - –Communications founded on mutual trust
  - –Shared perceptions of the importance of safety
  - –Confidence in efficacy of preventive measures

Patient Safety Culture

* ***"Patient safety"*** is defined as the avoidance and prevention of patient injuries or adverse events resulting from the processes of health care delivery

Values of Patient Safety Culture Survey

* **Assessment tool for the safety culture within the hospital or in specific units within hospitals.**
* **Evaluation tool of patient safety interventions.**
* **Tracking tool for the changes in patient safety over time.**

PLAN

Patient Safety Culture Survey Plan

Tasks	Responsibility	Resources	Timeline monthly 2011					
			1	2	3	4	5	6
Survey Awareness	Quality Consultant	Survey hard, soft copies & Web based						
Hospital Staff Sample Selection	Quality Team	Staff list						
Survey Distribution	Survey Awareness	Survey hard copy						
Survey completion	Quality Team	Survey hard copy						
Survey Data Entry	Quality team	Filled Survey Hard copies						
Data Analysis	Quality Consultant	Survey wed-based program						
Measuring Safety Culture Dimensions	Quality Consultant	Survey wed-based program						
Survey findings Prioritization	MRHB	Survey report						
Intervention's Implementation	Responsible staff	Resources needed						

DO

Patient Safety Culture Survey

5622 stratified systematic random sampled from 30 MOH hospitals within Makkah Region at Kingdom of Saudi Arabia were involved in this study

Overall patient safety outcomes	Hospital-wide patient safety dimensions	Departmental patient safety dimensions
`1- Overall perceptions of safety	5- Hospital management support for patient safety	8- Supervisor/manager expectations & actions promoting patient safety
2- Frequency of events reported	6- Teamwork across hospital units	9- Non-punitive response to error
3- Number of events reported	7- Hospital handoffs & transitions	10- Staffing
4- Overall patient safety grade		11- Organizational learning
		12- Teamwork within units
		13- Communication openness
		14- Feedback & communications about error

ACT

Recommendations

* **Develop an unified event reporting system for enforcing, sharing information & lessons learning.**

AHRQ Common Formats

* **Enhance the Non-Punitive Response to Errors & Communication Openness.**

* **Overcome the Hands-off & Transition Obstacles.**

CHECK

Average Positivity of Safety Dimensions compared with those of USA Hospitals