CULTURE OF SAFETY AMONG STAFF OF KD HOSPITAL, AHMEDABAD

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ABOUT THE ORGANISATION

- Kusum Dhirajlal (KD) Hospital is a 300+ beds super speciality/multi-speciality, NABH accredited hospital located in Ahmedabad Gujarat. The hospital is incorporated with Shri Harihar Maharaj Charitable Trust and has around 45 specialities spread over a 6 acre campus.

- It is one of the first hospitals in Gujarat having 6 NABH accreditations and is amongst the only 2 hospitals in India to achieve NSCI Safety Award.

- **Vision:** Ensuring ‘well being’ as a humane commitment to enliven humanity.

- **Mission:** The ‘well being’ ensured by extension of Available, Accessible, Affordable, Safe, Efficacious, Professional and Ethical comprehensive healthcare through state-of-art facilities.

INTRODUCTION

Medical errors are one of the five most common causes of death all over the world.

Patient safety: one of the most crucial components of quality of care; a grave public health issue

Organisational Culture
A core of values surrounded by layers including shared beliefs, attitudes, norms, rituals and behavioural characteristics of employees.

Patient Safety Culture
complex phenomenon which represents the values, conceptions and beliefs in any organisation that contribute towards safety in the healthcare organisation

Individual's attitudes & behaviours towards patient safety

PATIENT SAFETY

It is very important to assess the safety culture of any hospital to plan intervention programmes to curtail adverse events related to patient safety.

Developing countries like India are still lagging behind when it comes to mandatory reporting of patient safety errors and a system to prevent such errors

Considering the dearth of information in this area, this study was carried out in a private sector tertiary care hospital (KD Hospital) in Ahmedabad, Gujarat, India.

WHAT IS THE KNOWLEDGE AND ATTITUDE OF THE STAFF OF KD HOSPITAL TOWARDS THE PATIENT SAFETY CULTURE?

STUDY OBJECTIVES

1

To understand and assess the knowledge of staff of KD Hospital about communication with respect to patient safety events.

2

To understand and assess the knowledge of staff of KD Hospital about the available resources for patient safety

3

To analyse the attitude towards the patient safety culture among the staff of KD Hospital Ahmedabad

METHODOLOGY

STUDY DESIGN

Cross sectional study

STUDY POPULATION

Staff of the hospital from all departments, clinical as well as non-clinical

INCLUSION CRITERIA

All the permanent employees of the hospital

EXCLUSION CRITERIA

All students, interns and trainees

METHODOLOGY

SAMPLE SIZE

Members of the staff who responded to the questionnaire- 423

SAMPLING TECHNIQUE

No sampling was done. The questionnaire was provided to all the employees but responding to it was voluntary

DATA COLLECTION PROCEDURE

- The data was collected in two forms: **Online and physically**.
- The form link was circulated amongst the upper management who can fill it virtually.
- For others, the questionnaire was available on a tablet (in **all 3 languages: Hindi, English, Gujarati**) as well as on paper and was taken to all the employees to get filled.
- The responses via the form link were directly recorded online while the physical ones were input manually in the record.

- **Informed consent was taken from all the study participants.**
- **Neither the employee ID or names of the participants were noted down to preserve their identity, prevent anxiety and social desirability bias.**
- **It was completely voluntary to respond to the questionnaire or refuse to participate in the study.**

THE QUESTIONNAIRE

PSC cannot be assessed qualitatively and hence; it has to measured using a quantifiable questionnaire.

One of the most widely accepted and used tool is the HSOPSC developed by the Agency for Health Research & Quality (AHRQ); hence it was taken as a reference. This tool was released in 2004 and it incorporates 42 items (questions) that measure 12 PSC dimensions. This tool, since its release has been translated into various languages and has been used worldwide

A close ended questionnaire was developed in virtual as well as physical form in English. It was then translated to Hindi and Gujarati so that the hospital staff can understand the questions easily and answer them comfortably.

The final questionnaire that was developed had 26 questions, keeping in mind the 11 PSC dimensions

Dimensions	Questions
Communication openness	In this department, staff speak up if they see something that may negatively affect patient care and those with more authority are open to their patient safety concerns
	When staff in this department see someone with more authority doing something unsafe for patients, they speak up
	In this department, staff are afraid to ask questions when something does not seem right
Feedback and communication about errors	We are informed about errors that happen in this department and we discuss ways to prevent them from happening
	In this department, we are informed about changes that are made based on event reports
Frequency of events reported	When a mistake is caught and corrected before reaching the patient, it is reported in this department
	When a mistake reaches the patient and could have harmed the patient, but did not, it is reported in this department
Handoffs and transitions	When transferring patients from one department to another, important information is often left out
	During shift changes, there is adequate time to exchange all key patient care information
Management support for patient safety	The actions of hospital management show that patient safety is a top priority and they provide adequate resources to improve it
	Hospital management seems interested in patient safety only after an adverse event happens

Dimensions	Questions
Nonpunitive response to error	When an event is reported in this department, it feels like the person is being written up, not the problem and their mistakes are held against them
	When staff make errors, this department focuses on learning rather than blaming individuals
Organizational learning/continuous improvement.	This department regularly reviews work processes to determine if changes are needed to improve patient safety
	In this department, changes to improve patient safety are evaluated to see how well they worked
	In this department, there is a lack of support for staff involved in patient safety errors and the same patient safety problems keep happening
Overall perception of patient safety	The work pace in this department is so rushed that it negatively affects patient safety
	I would feel safe being treated as a patient here
Staffing	Staff in this department work longer hours than is best for patient care
	This department relies too much on temporary staff
Supervisor/manager expectations and actions promoting safety	My supervisor or manager seriously considers staff suggestions for improving patient safety
	My supervisor or manager wants us to work faster during busy times, even if it means taking shortcuts
	My supervisor or manager takes action to address patient safety concerns that are brought to their attention
Teamwork within units	In this department, we work together as an effective team and have enough staff to handle the workload
	During busy times, staff in this department help each other
	There is a problem with disrespectful behaviour by those working in this department

RESULTS, ANALYSIS & DISCUSSION

Data was checked, entered into MS Excel and exported to Stata for statistical analysis.

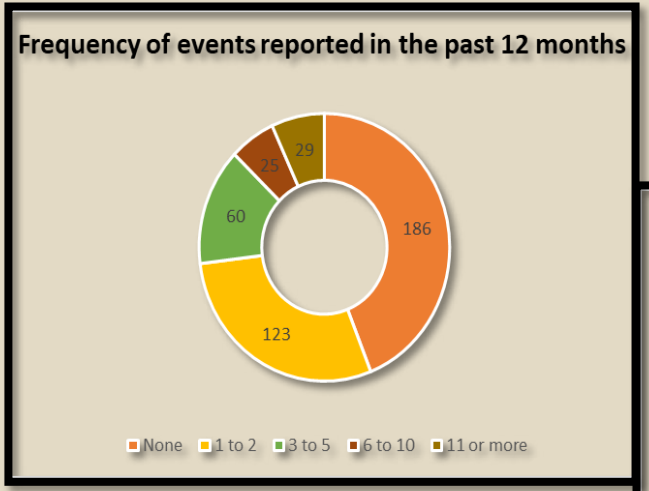
The response to each item was assessed using **a five-point Likert scale: Strongly agree, Agree, Neither agree nor disagree, disagree & strongly disagree.**

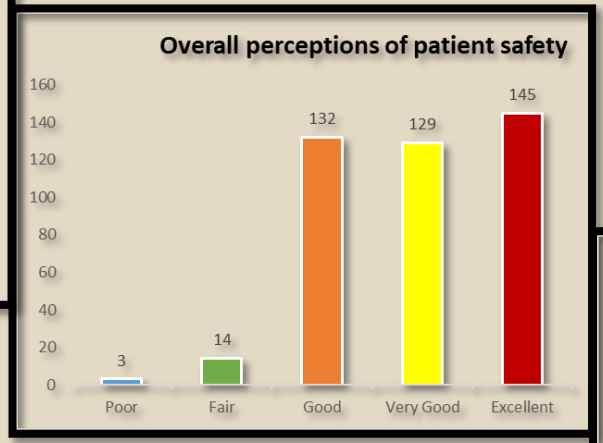
There were two questions with outcome variables:

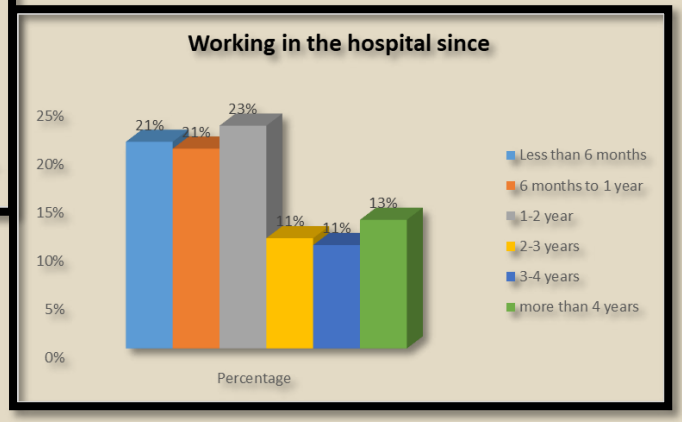
1. **Overall patient safety grade** (poor, fair, good, very good, excellent)
2. **Number of patient safety events reported in the past 12 months** (none, 1-3, 3-5,6-10, 11 or more).

Department of the participants and the duration since they have been working in this hospital was also asked.

SOCIODEMOGRAPHIC DETAILS OF THE RESPONDANTS

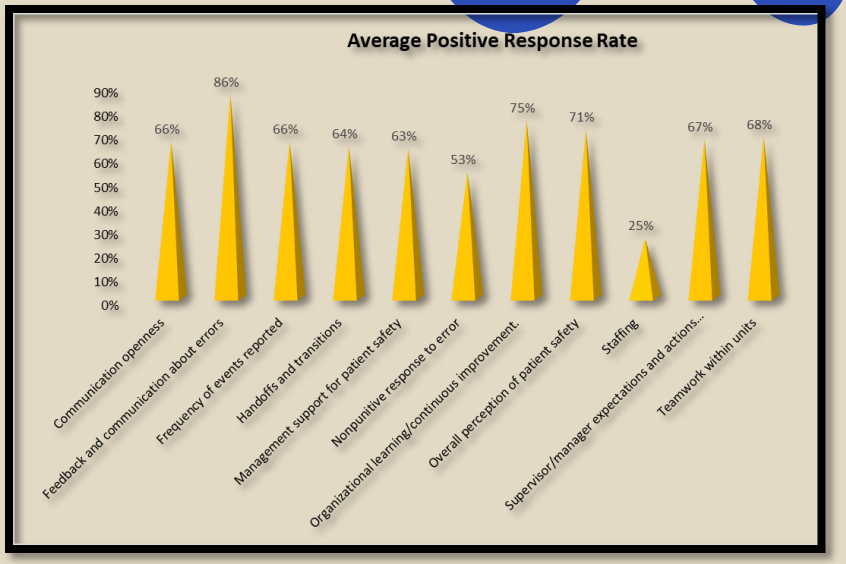






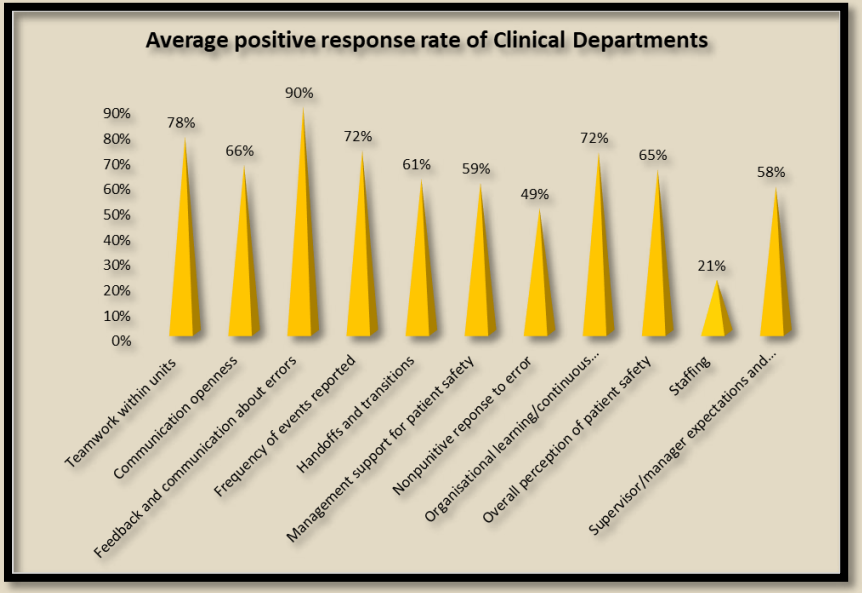
POSITIVE RESPONSE RATE FOR EACH DIMENSION

Sr No	Dimension	No. of questions	Mean	Standard Deviation
1	Communication openness	3	65.6	17.39
2	Feedback and communication about errors	2	86	4.24
3	Frequency of events reported	2	66	7.07
4	Handoffs and transitions	2	63.5	24.75
5	Management support for patient safety	2	63	33.94
6	Nonpunitive response to error	2	53	35.35
7	Organizational learning/continuous improvement.	3	75	19.47
8	Overall perception of patient safety	2	71.5	23.33
9	Staffing	2	24.5	28.99
10	Supervisor/manager expectations and actions promoting safety	3	67.3	30.07
11	Teamwork within units	3	68.3	35.92
	Total	26	64.76	24.59

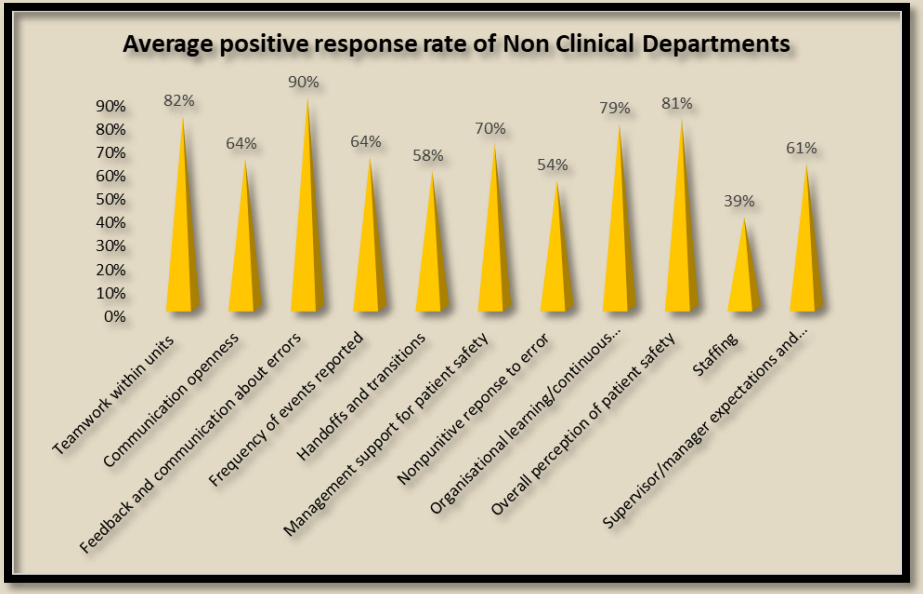


- There were 17 positively worded questions and 9 negatively worded questions. For the positively worded questions, the responses “strongly agree” and “agree” were considered as positive responses.
- For the negatively worded questions, the response “strongly disagree” and “disagree” were considered as positive responses.

POSITIVE RESPONSE RATE FOR CLINICAL & NON CLINICAL DEPARTMENTS



27 clinical departments



17 non-clinical departments

CORRELATION BETWEEN DIFFERENT DIMENSIONS OF SAFETY CULTURE & OVERALL PATIENT SAFETY GRADE

Sr No	Dimension	Pearson's coefficient	p value
1	Communication openness	0.4531	<0.0001
2	Feedback and communication about errors	0.3852	<0.0001
3	Frequency of events reported	0.4619	<0.0001
4	Handoffs and transitions	0.4616	<0.0001
5	Management support for patient safety	0.5004	<0.0001
6	Nonpunitive response to error	0.5676	<0.0001
7	Organizational learning/continuous improvement.	0.4288	<0.0001
8	Overall perception of patient safety	0.4510	<0.0001
9	Staffing	0.6496	<0.0001
10	Supervisor/manager expectations and actions promoting safety	0.4750	<0.0001
11	Teamwork within units	0.4743	<0.0001

There is a positive correlation between all the dimensions of patient safety culture and patient safety grade.

All the values are statistically significant ($p<0.0001$).

CONCLUSION

Every organization is different and it will take time to change the culture in any organization.

STAFFING NEEDS IMPROVEMENT

- Reduce the working hours
- Reduce the temporary staff

MORE SUPPORT TO STAFF, BETTER PATIENT SAFETY

EMPLOYEES NEED TO FEEL THAT THEIR MISTAKES ARE NOT HELD AGAINST THEM

This can be achieved by CMEs, seminars, trainings

RECOMMENDATIONS

1 LEADERSHIP WALK ROUNDS

- Engage executives and clinical leaders and use direct communication to break down barriers surrounding patient safety
- Depends on frequency and duration

MULTI-FACETED UNIT-BASED PROGRMMES 2

The interventions should focus on every unit rather than the hospital as a whole.

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THANK YOU