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Patient Safety

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Ziekenhuis Oost-Limburg (ZOL) of Genk (Belgium) took the first place at the second prize-giving ceremony of the Tyco Healthcare Award for Excellence in Hospital Management.

ZOL submitted a project showing its long-term strategy on “patient safety” In 2002, our hospital finalised its renewed mission statement after a process of acquiring fresh ideas through discussions with the most important stakeholders. A draft of a new mission statement was proposed to a representation of doctors, nursing representatives and the management team. A more elaborate document with input of the abovementioned was finalised by the board. As the board represents the community they made certain that the patients’ interests were met. A striking innovation in the statement is that quality care must also mean safe care. We are determined to see tangible results in our hospital in the near future through the promotion of several projects on patient safety, starting with a focus on the “safety culture in the hospital”.

The Risk of Death by Error is Higher When in Hospital than on the Road

At the end of the nineties the first reports about a significant number of patients dying through avoidable errors during hospitalisation were published in the United States. Now at the end of 2005 there is consensus that the organisational culture of a hospital is the cornerstone for improving patient safety. A climate of open communication and trust where errors can be used as opportunities to learn from is essential for progress. To evaluate progress one needs measurements. We used one of the validated questionnaires developed by the Agency for Healthcare Research and Quality as a tool to assess the safety culture in our hospital; this is the first scientific investigation of this nature and of this magnitude in Belgium. Here we present the results and propose some measures for improvement as the first step in our longterm strategy.

Organisational Culture

Improvements in patient safety are best achieved when healthcare delivery organisations adopt a culture of safety. This change of attitude is the first step that needs to be taken throughout the entire healthcare system. But little evidence is available of how to develop a programme in order to achieve this.

A culture of safety in a healthcare organisation can be defined as an integrated pattern of individual and organisational behaviour, based on shared beliefs and values, that continuously seeks to minimise patient harm that may result from the processes of care. Communication and trust should be properties of the organisation in order to create a climate where an error, accident, adverse event or near-accident becomes an opportunity to learn and improve. It is also crucial to involve the patient as an effective partner in this process. Medical litigation issues of course need to be taken into account. Transparency should not lead to more legal procedures against doctors and hospitals. A no-fault insurance system could be a possible solution.

Measuring Tools for Evaluation of the Safety Culture

Several validated questionnaires are available as a tool. After thorough research of the literature on the subject we decided to use the “Hospital Survey on Patient Safety” that was developed by the Agency for Healthcare Research and Quality. In the translated version the same validation techniques were used as for the original; this was done in cooperation with Censtat, the department of epidemiology and statistics of the University of Hasselt.

The questionnaire was sent to all doctors and employees of the hospital who have contact with patients. 1323/1757 responded which constitutes a response ratio of 75.3%. After applying the exclusion criteria, 1300 questionnaires were retained for further analysis. ZOL is the first Belgian

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hospital to organise an enquiry of this nature throughout the hospital. An overwhelming amount of valuable information on the hospital organisation with regards to patient safety was obtained. Based on these results, methods will be designed to improve patient safety.

Applying Insights

Of the total questionnaires, a number of statements were med tech more significant in needing attention regarding patient safety than others. We will name a few: At times there is insufficient staff for the workload; management is not supportive in patient safety issues; organisational culture is experienced as punitive; staff fear that reports of an error are noted in their personal file; the transfer of patients between departments is unsafe because of insufficient communication; almost everyone has experienced errors involving medication. The first step consists of integrating our newfound insights into the long-term strategy of the hospital management through communication at all levels.

After obtaining the necessary insights into the organisational structure and its culture a careful approach is needed to implement changes and improvement. Change needs to take place in a stepwise fashion and clear communication at all times is the keystone to success. First, the results were explained to the departmental heads (medical and nursing). The importance of creating a non-sanctioning climate for our hospital staff was emphasised. Secondly an internal committee for patient safety is responsible for the coordination of projects. The hospital management plays a very important role here. Thirdly discussion of the long-term strategy is ongoing with the departmental representatives. In a fourth step approval is obtained from the necessary committees in the hospital. Thereafter communication of concrete measures can be effected to all involved. Evaluation and correction can be done on a sixmonthly basis.

Specific Projects

1. Active reporting of errors will be encouraged as well as creating a “non-sanctioning” climate. A new module on the internal hospital website has been developed for this purpose. Errors will also be discussed on the work floor. The experiences will also be brought to a forum where measures can be proposed to bring about structural changes (root cause analysis). A decision tree will be used in each analysis of an error, adverse event, near-accident or accident.

2. Simple measures can lead to improvement: making certain that the right intervention takes place for the right patient at the right time and by the right staff member. Examples are: careful identification of the patient by bracelet, legibility of notes, theatre checklists, etc.

3. Drawing up a set of clear guidelines will improve the coordination between departments when patients are transferred.

4. As medication errors are one of the most frequently occurring problems a lot of attention will be directed to this area. All steps from the prescription until the administration of the drug at the patient’s bedside will deserve our attention. The pharmacist will have an important role in this process. Clinical pharmacy will be encouraged and soon the pharmacist will be more involved in the wards.

A pilot study will take place in the department of geriatrics. What is happening already?

As part of our strategy, a “5-year-plan for patient safety”, we recently organised a conference day for the hospital staff. It was very encouraging to notice that the participation and enthusiasm were overwhelming, even from the medical staff. Openness of communication was particularly impressive. This is an excellent basis for continuing our efforts.

The evolution of the safety culture will be re-assessed at a later stage.

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