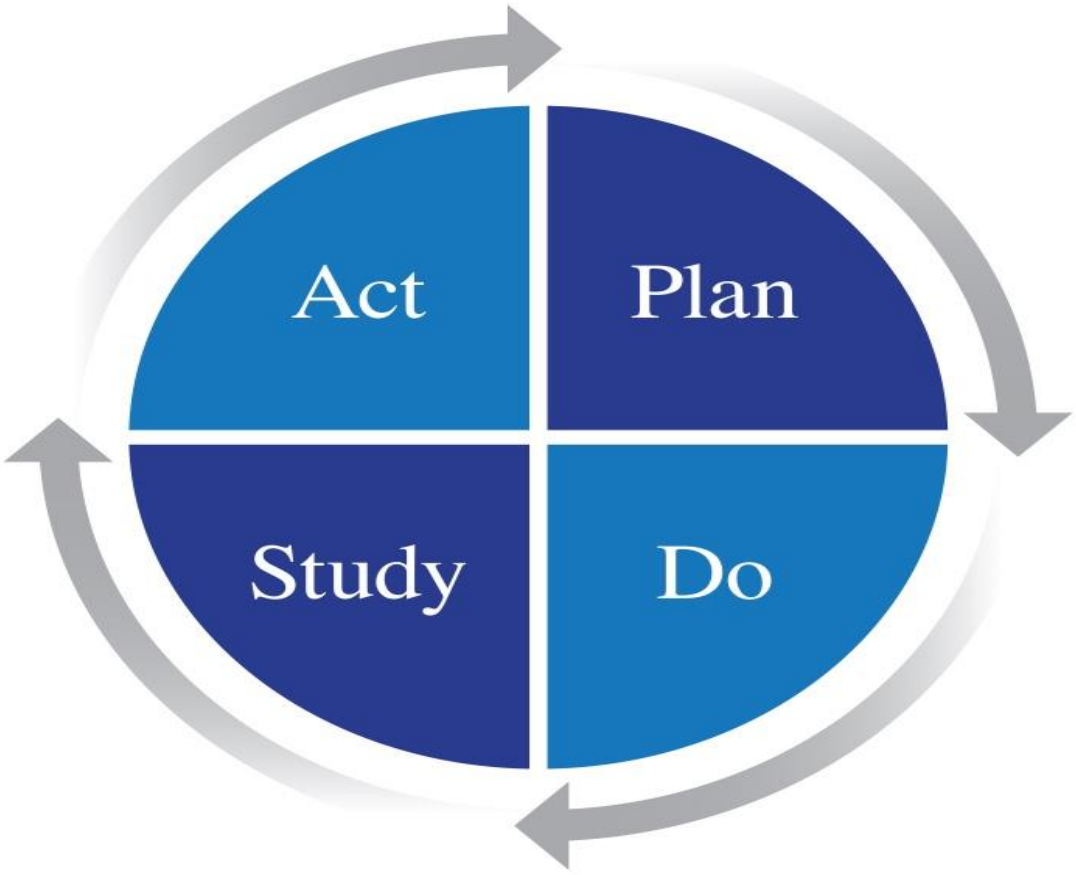
Quality Management & Patient Safety Department

Performance Improvement Project Report

Impact of IPSG Certified Course in Harm Prevalence & Staff Compliance



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FOCUS-PDCA

KAH has a consistent approach for performance improvement; based on the measurement outputs, where variation in performance is identified, multidisciplinary teams are formed to investigate the causes of variation and to set action plans for improvement accordingly.
This approach is translated into the widely known nine-step performance improvement cycle 'FOCUS-PDSA' that is used by the multidisciplinary teams in their improvement initiatives.

Project Title	Project Leader	Team Members	Project start Date	Project Expected completion Date	Data collection start date	Objective
IPSG improvement staff Compliance	Dr. Sara	Mr. Ramzi Mr. ANAS Mr. Sultan	1/1/2016	1/12/2020	1/1/2016	Achieving 100% of compliance With IPSGs by the end of 2020 (Zero harm)

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PROJECT SUMMARY

F: Find a process to improve

Patient safety is a global challenge that requires knowledge and skills in multiple areas, including human factors and systems engineering. Patient safety has received attention by international health organizations in 2004; the World Health Organization launched the World Alliance for Patient Safety. The World Alliance for Patient Safety has targeted the following patient safety issues: prevention of healthcare-associated infections, hand hygiene, surgical safety, and patient engagement. Some care settings or care situations are particularly prone to hazards .Joint Commission International and the WHO conjointly promoting the six international patient safety goals for increasing awareness about these goals and ensure safe delivery of care. Here in King Abdulaziz hospital we have good opportunity to improve compliance of KAH staff in international patient safety goals (IPSGs) by the end of December 2020 by 100%. We selected the lowest compliance areas among the six goals to improve which are:
IPSG2.3: Percentage of completely documented Critical Radiological Findings by Radiologist in PACS System
IPSG 4.1: Ensure Correct-Site, Correct-Procedure, Correct-Patient Surgery.
IPSG 6: Reduce the Risk of Patient Harm Resulting From Falls.

O: Organize a team

Complete a detailed action plan to including the tasks that need to be done to resolve the causes identified in the 'S' phase, the responsible staff, and the expected completion date for each task.		
Task	Responsible Person	Expected Completion Date
1. Percentage of completely documented Critical Radiological Findings by Radiologist in PACS System.	Mr. sultan/Mr. Anas	1/12/2020
2. Ensure Correct-Site, Correct-Procedure, Correct-Patient Surgery.	Mr. sultan/Ramize	1/12/2020
3. Reduce the Risk of Patient Harm Resulting From Falls.	Mr. Sultan	1/12/2020

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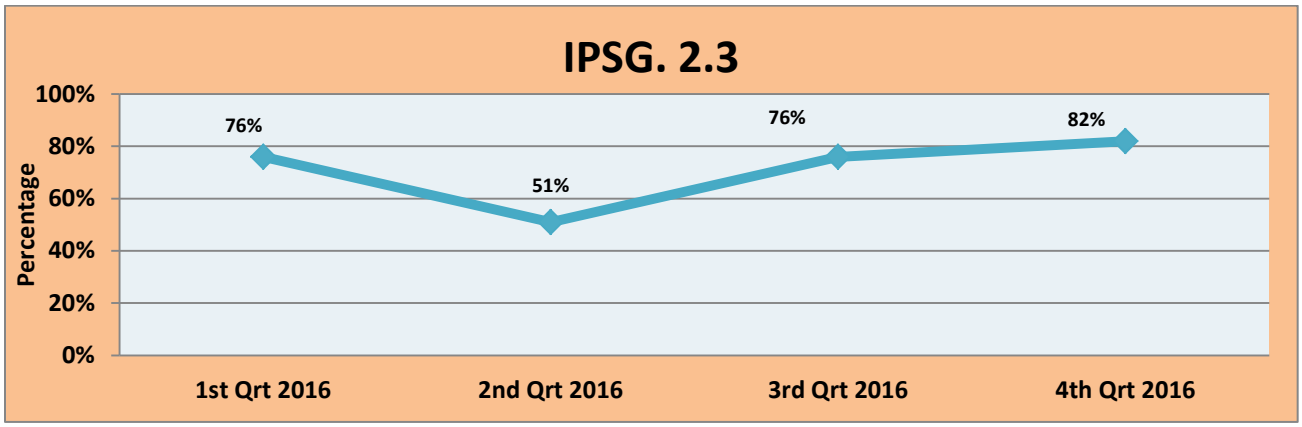
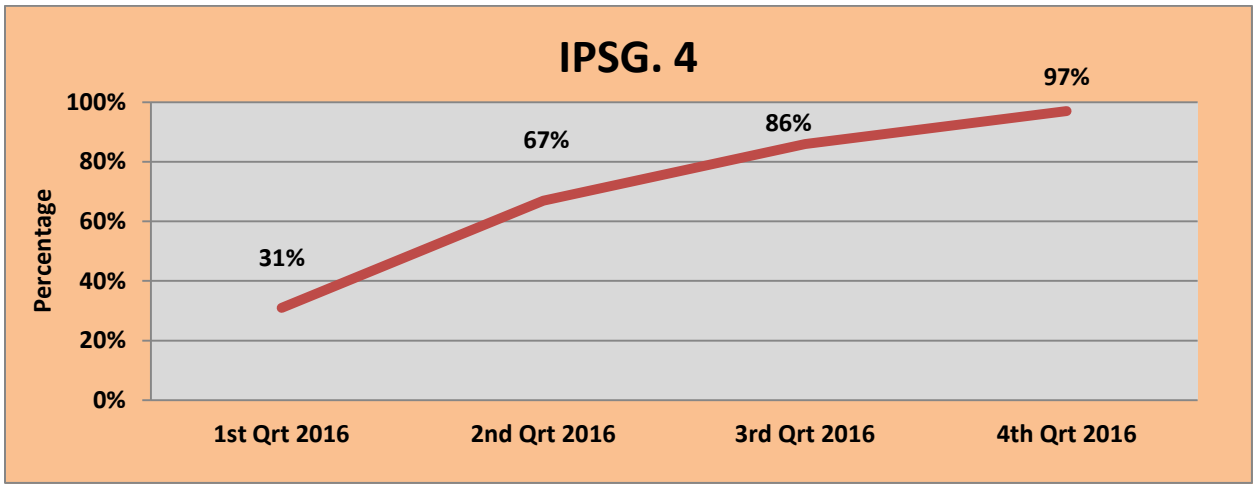
C: Clarify current situation:

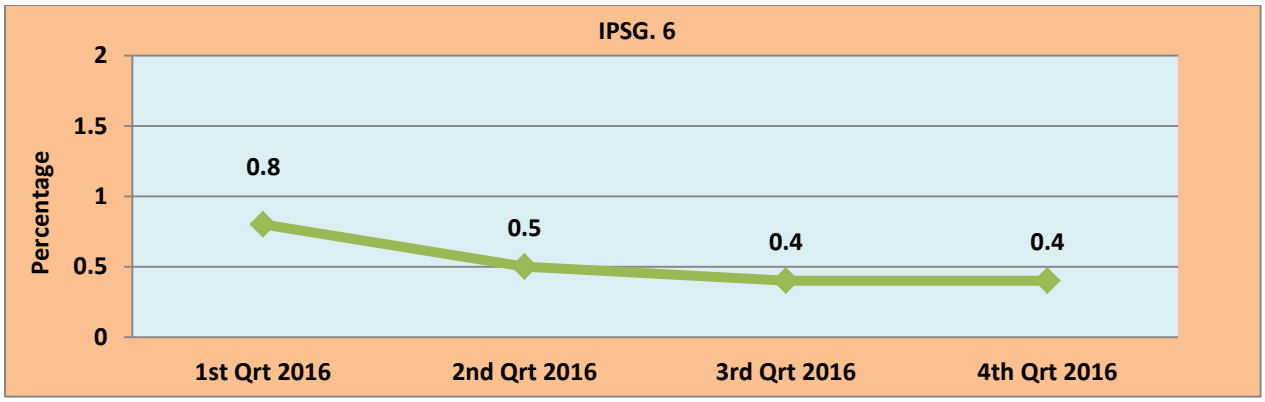
IPSG2.3: Percentage of completely documented Critical Radiological Findings by Radiologist in PACS System



Goal 4.1: Ensure Correct-Site, Correct-Procedure, Correct-Patient Surgery.



Goal 6: Reduce the Risk of Patient Harm Resulting From Falls.



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U: Uncover causes of variation:

IPSG#2

The researchers found that communication problems were relatively straightforward and fell into four categories:(1) communications that were too late to be effective, (2) failure to communicate with all the relevant individuals on the team, (3) content that was not consistently complete and accurate, and (4) communications whose purposes were not achieved—i.e. issues were left unresolved until the point of urgency. Examining the outcomes of communication, other researchers have found associations between better nurse-physician communication and collaboration and more positive patient outcomes, i.e. lower mortality, higher satisfaction, and lower readmission rates. Effective communication among health care professionals is challenging due to a number of interrelated dynamics.

Disseminating the 'Critical lab test results' is all together similar approach to improve the effectiveness of communication among caregivers and applies to both the pre- and post-analytical phases of the total laboratory testing process. Verbal and telephone requests (pre-analytical phase) and the reporting back of critical test results (post-analytical phase) are specifically mentioned as areas for action. As described earlier, 'Critical values' are defined as those which represent potentially life-threatening situations and in which reporting delays can result in serious adverse patient outcomes. Policies or procedures are required for verbal and telephone orders that includes the writing down (or entering into a computer) of the complete order or test result by the receiver of the information; the reading back of the order or test result; and confirmation that what has been written down and read back is accurate.

IPSG# 4 Ensure Correct-Site, Correct-Procedure, Correct-Patient

A new report published 20 November 2017 by the Surgical Never Events Taskforce has made a series of recommendations for new Standards and systems to further improve the safety of surgery in UK hospitals. In response, NHS England has committed to identifying practical ways to take forward the report's recommendations to eradicate never events from surgical procedures. The Surgical Never Events Taskforce was commissioned by NHS England last year to examine why currently available preventative tools and guidance are not succeeding in completely eliminating surgical never events – a number of identified types of serious errors that should never occur, such as surgery on the wrong part of the body. In its report, the taskforce has recommended much greater consistency between different hospitals in all areas of the country, focusing on three themes: Standardize– The development of high-level national standards of operating department practice that will support all providers of NHS-funded care to develop and maintain their own more detailed standardized local procedures. The report also recommends the establishment of an Independent Surgical Investigation Panel to externally review selected serious incidents. Educate– Consistency in training and education of all staff in the operating theatres, development of a range of multimedia tools to support implementation of standards and support for surgical safety training including human factors; and Harmonize– Consistency in reporting and publishing of data on serious incidents, dissemination of learning from serious incidents and concordance with local and national standards taken into account through regulation.

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IPSG #6

In 2005, the Joint Commission International added the requirement for fall risk assessment and periodic reassessment as an International Patient Safety Goal in the acute care setting. The goal of this requirement is to ensure that all patients are screened for falls and thus seeks to reduce harm from falls. However, the outcome is unpredictable because fall and injury risk assessment instruments have shown inconsistent reliability and validity. A more promising extension of this goal starting in 2006 and continuing forward is the additional requisite of implementing and evaluating a fall-prevention program. Compliance with these goals has the potential to significantly impact the problem of falls in the acute care setting. Efforts to enhance quality of care in the long-term care environment via improved reporting have the potential to reduce falls and related injuries in these particularly vulnerable patients; however, the successful implementation of fall-prevention programs will be necessary to improve the problem. The risk for falls is related to the patient, the situation, and/or the location. Risks associated with patients might include patient history of falls, medications use, alcohol consumption, gait or balance disturbances, visual impairments, altered mental status, and the like. Patients who have been initially assessed to be at low risk for falls may suddenly become at high risk. Reasons include, but are not limited to, surgery and/or anesthesia, sudden changes in patient condition, and adjustment in medications. Many patients require reassessment during their hospitalization. Documented criteria identify the types of patients who are considered at high risk for falls. An example of a situational risk is the patient who arrives at the outpatient department from a long term care facility via ambulance for a radiologic examination. The patient may be at risk for falls in that situation. When transferring from ambulance cart to exam table, or when changing positions while lying on the narrow exam table. Specific locations May present higher fall risks because of the service provided.

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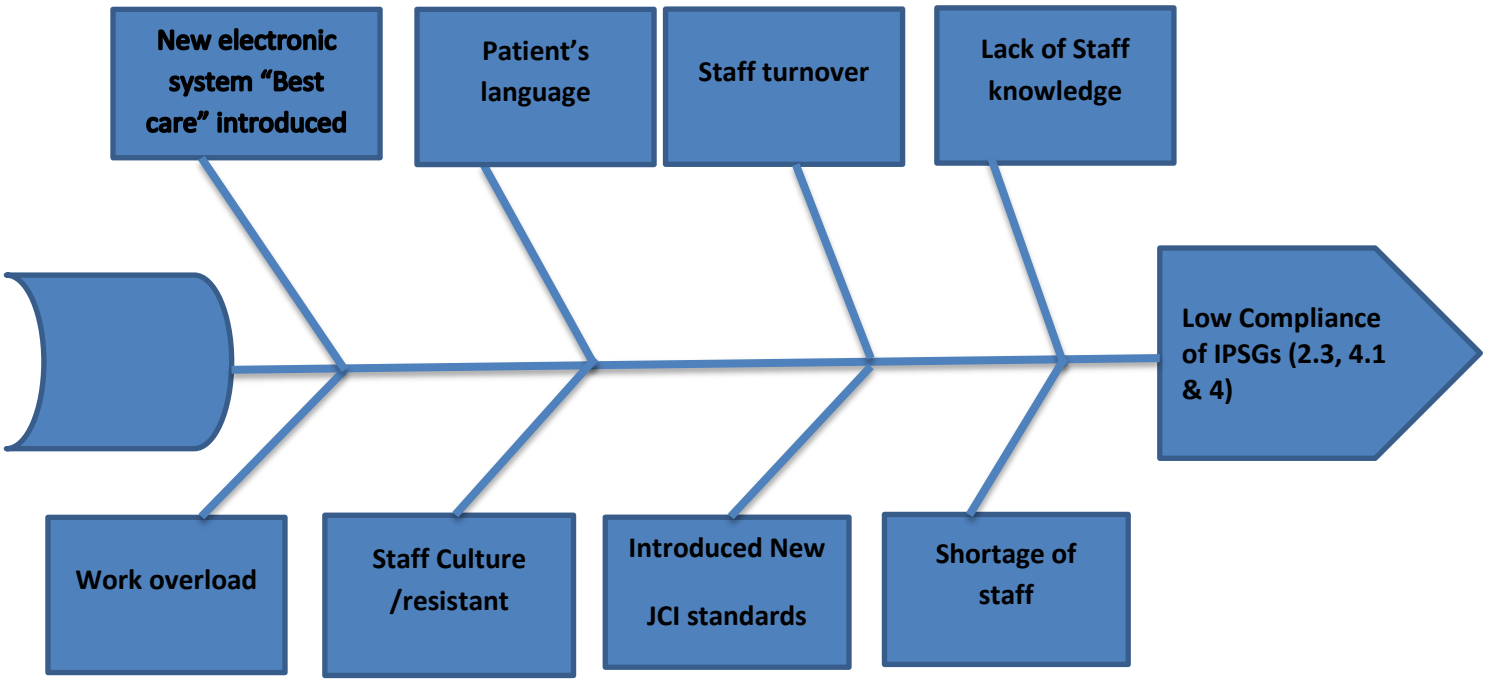

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Prioritization Matrix

	High priority	Low priority
In our control	1-Staff knowledge 2-Staff Culture /Resistant	1- Shortage of staff 2- work overload
Out of Our control	1- New electronic system "Best care" introduced 2-Staff turn over	1- Introduced New JCI standards 2-Patients language

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S: Select improvement process:

Based on the identified areas/ categories we selected those causes that have the most impact on the process/that contribute the most to the major problem.

1. Increase staff Knowledge by provides continuous education and training regarding IPSGs.
2. Continuous monitoring the compliance of staff against IPSGs.
3. Analyze and review all SRS related to IPSGs.
4. Measure safety culture.
5. Encourage staff to speak up.
6. Increase support, motivate and appreciation of hospital staff.

P: Plan for improvement

Complete a detailed action plan to including the tasks that need to be done to resolve the causes identified in The 'S' phase, the responsible staff, and the expected completion date for each task.

Task	Responsible Person	Expected Completion Date
Propose IPSGs course to hospital leadership and get Approval to be mandatory course required from all healthcare professionals	QPS Department Dr. Sara	May 2016
Develop IPSGs course	QPS Department Dr.Sara Mr.Ramzi Mr.Anas Mr.Sultan	August 2016
Prepare Pre and Post exam to ensure staff get benefit from such course	QPS Department Dr.Sara Mr.Ramzi Mr.Anas Mr.Sultan	August 2016
Monitoring the compliance of staff against IPSGs	QPS Department - Mr.Sultan	Monthly basis and continuously
Generate Quarter report of IPSGs compliance	All QPS Department staff	Quarterly basis
Escalating Department(s) with low compliance rate to hospital leadership	QPS Department Dr.Sara	Quarterly basis and continuously
Department(s) with low compliance rate should develop an action plan to improve their compliance.	All service(s)/department(s) leaders	Quarterly basis and continuously

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D: Do the improvement:

We start to lead an effort to raise awareness of IPSGs for patient's safety by conducting mandatory monthly Lecture with pre –course examination to measure staff knowledge 25 Questions during the course. Our teaching tools is power point presentation focusing on IPSGs with different clinical scenarios and after the lecture we will conducting post-test with 25 Questions the participant should answer correctly at least 22 Questions of 25 for all staff in all level, In same time we start to do our intensive audit in all care area by various methods such as observation and chart review. We generate the result to all hospital staff through email distribution on quarterly basis. We are focusing on the department(s) with low compliance rate which will escalating their result to the leadership which will ask the concern department to develop an action plane to improve their compliance.

Task	Responsible Person	Expected Completion Date	Status
Propose IPSGs course to hospital leadership and get Approval to be mandatory course required from all healthcare professionals	QPS Department Dr. Sara	May 2016	Done
Develop IPSGs course	QPS Department Dr.Sara Mr.Ramzi Mr.Anas Mr.Sultan	August 2016	Done
Prepare Pre and Post exam to ensure staff get benefit from such course	QPS Department Dr.Sara Mr.Ramzi Mr.Anas Mr.Sultan	August 2016	Done
Monitoring the compliance of staff against IPSGs	QPS Department - Mr.Sultan	Monthly basis and continuously	Done and continuously
Generate Quarter report of IPSGs compliance	All QPS Department staff	Quarterly basis and continuously	Done and continuously
Escalating Department(s) with low compliance rate to hospital leadership	QPS Department Dr.Sara	Quarterly basis and continuously	Done and continuously
Department(s) with low compliance rate should develop an action plan to improve their compliance.	All service(s)/department(s) leaders	Quarterly basis and continuously	Done and continuously

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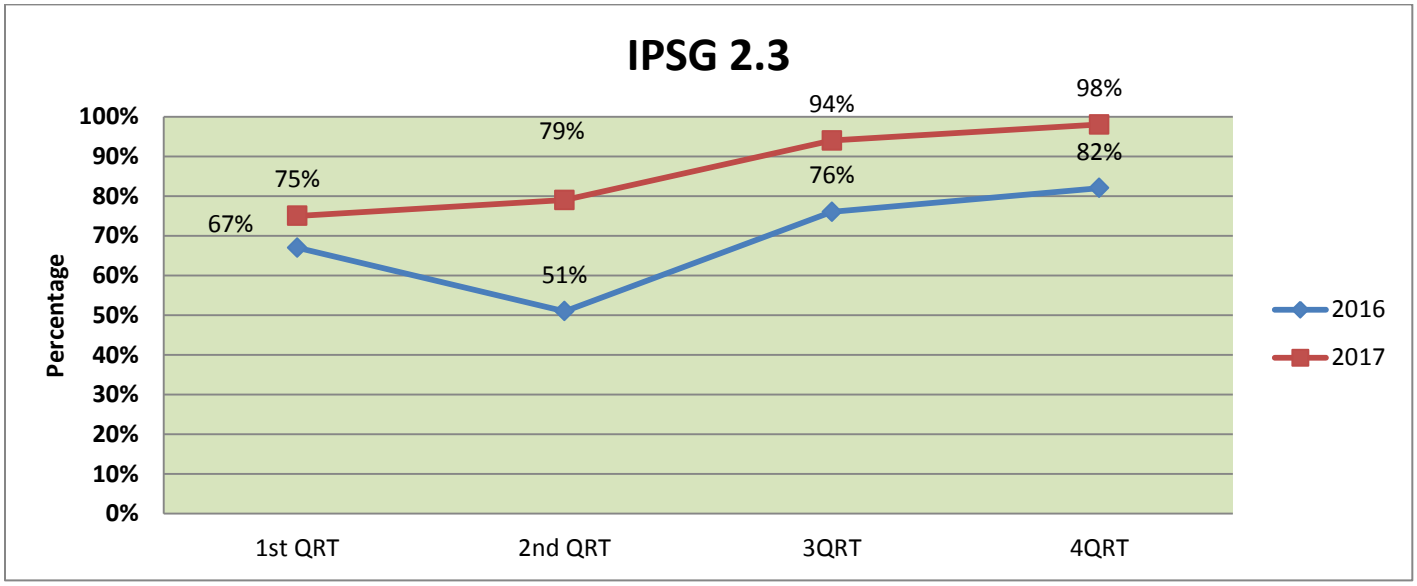
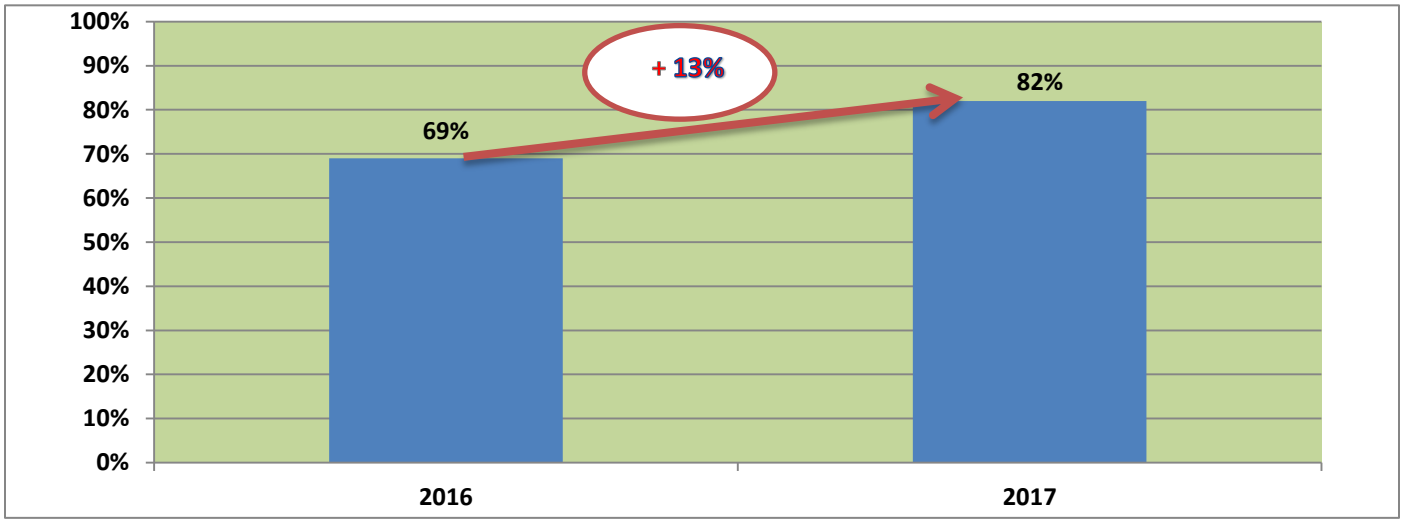
Study: Analyze the data to evaluate improvement

IPSG 2.3

Percentage of completely documented Critical Radiological Findings by Radiologist in PACS System Compliance per Quarter



Compliance per year



	Mean	Variation	STANDARD DEVIATION
2017	81.5	94.25	11.2
2016	69	182	13.4

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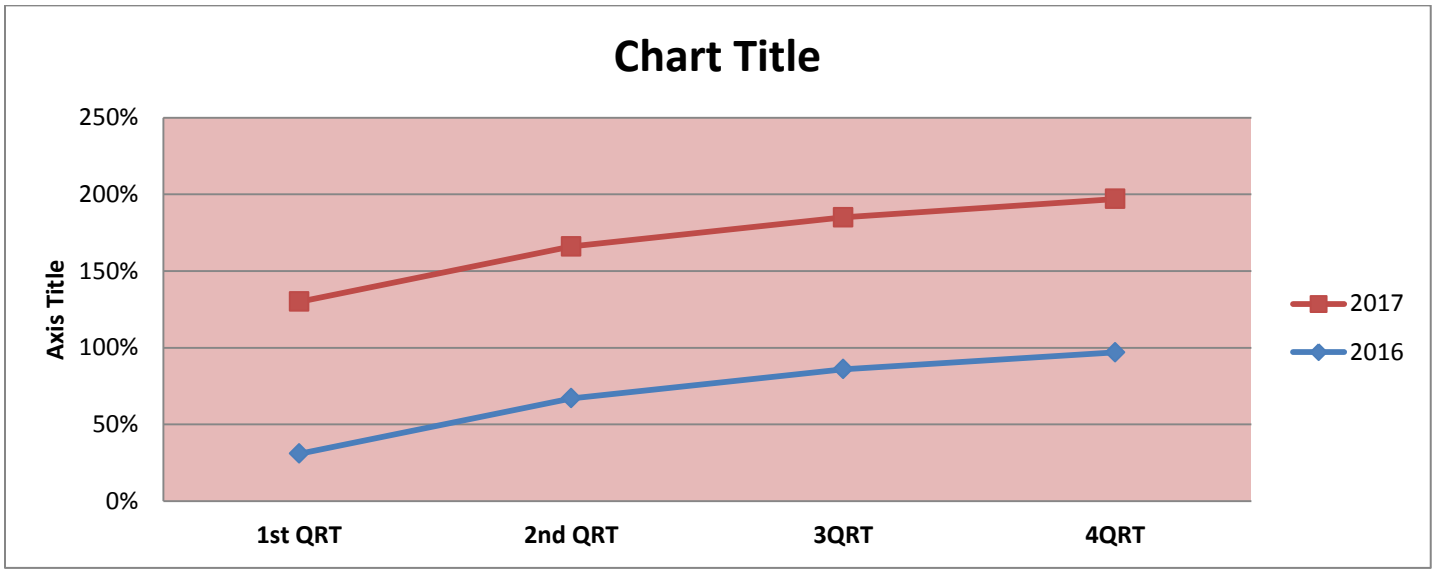
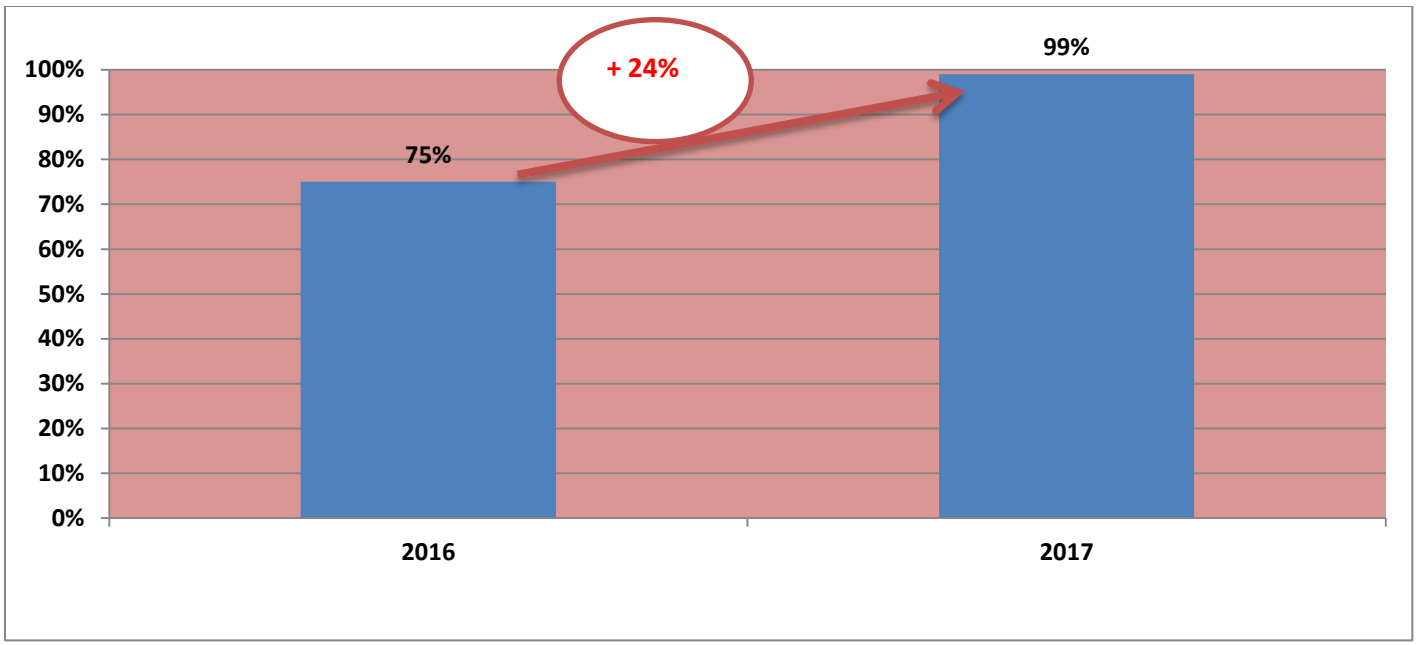
IPSG4

Compliance per Quarter



Compliance per year



	Mean	Variation	STANDARD DEVIATION
2017	99	.25	.6
2016	70	838	29

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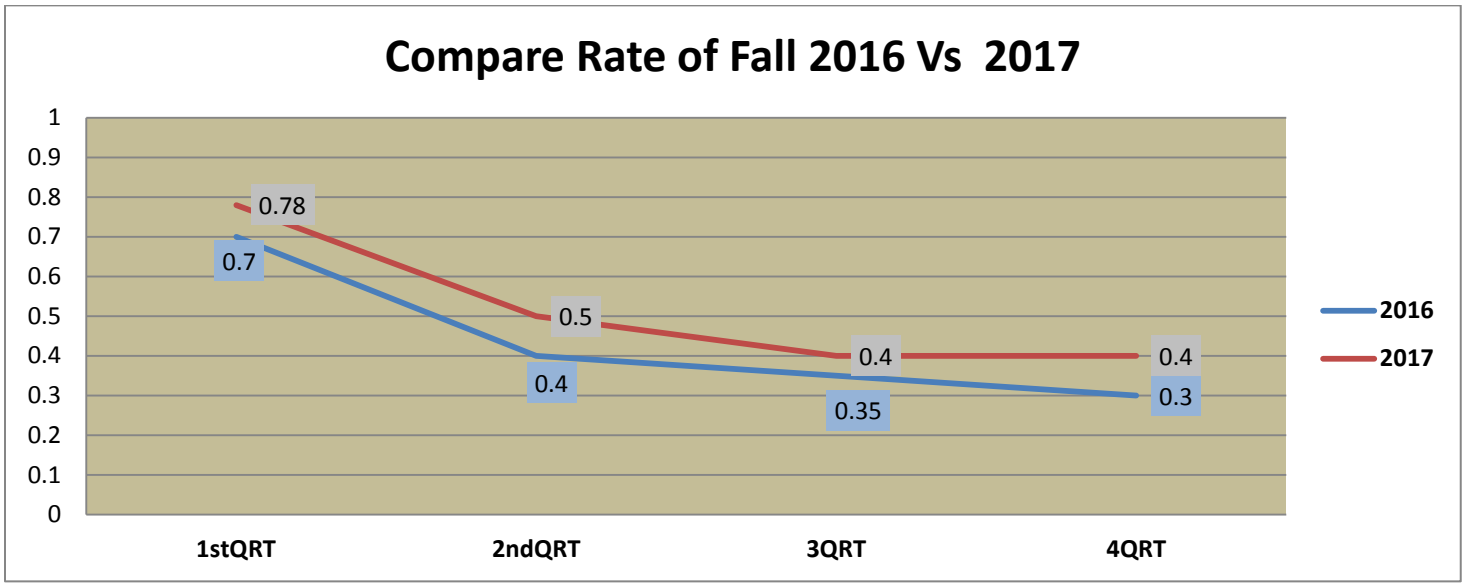
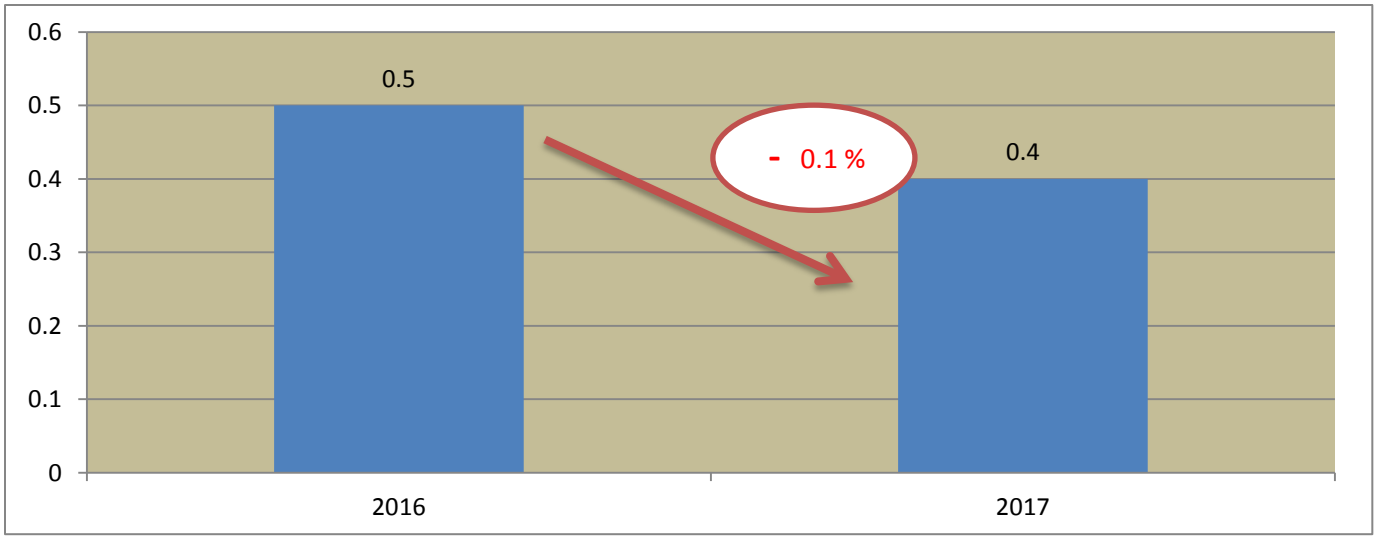
IPSG6:

Compliance per Quarter



Compliance per year:



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Our Hospital is a 270 bed and we are accredited by Joint Commission International since 2008 and part of the requirement is to implement International Patient Safety Goals. Data on the compliance to all the sixth international patient safety goals were collected for 2016and 2017 up to now and we are going to counting improve for the IPSGs based on the data collected, we select the lowest compliance to improve we did it in the plane phase :

IPSG 2.3

The Mean for 2016 was 69% with 31% gap due to staff not aware on the standard practices and insufficient knowledge among staff. For 2017 the Mean was 81.5%, increased by 12.5% as compared to year 2016 due to the increase awareness of staff

IPSG4.

The Mean for 2016 was 70 % with 30% gap due to staff not aware on the standard practices and insufficient knowledge among staff. For 2017 the Mean was 99 %, increased by 29% as compared to year 2016 due to the increase awareness of staff and intensive auditing and personal training.

In term of IPSG 6,

Data collected from January to December 2016, the total fall patients 34 patients in 61684 Patient days with rate .5%

Total number of falls in 2017 is 26 patients in 59274 with rate .4%

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Act: What steps will be taken next:

Task	Responsible Person	Expected Completion Date	Status
IPSGs course	QPS Department Dr.Sara Mr.Ramzi Mr.Anas Mr.Sultan	DEC 2020	continuously
Monitoring the compliance of staff against IPSGs	QPS Department - Mr.Sultan	Monthly basis and continuously	continuously
Generate Quarter report of IPSGs compliance	All QPS Department staff	Quarterly basis and continuously	continuously
Escalating Department(s) with low compliance rate to hospital leadership	QPS Department Dr.Sara	Quarterly basis and continuously	continuously
Department(s) with low compliance rate should develop an action plan to improve their compliance.	All service(s)/department(s) leaders	Quarterly basis and continuously	continuously