SQHN PUBLICATION

Dr. Wole Abiodun-Wright

Contact Us:

Society for Quality in Healthcare in Nigeria
5th Floor, Mulliner Towers,
39, Alfred Rewane Street
Ikoyi, Lagos
08080532925
www.sqhn.org

MESSAGE FROM THE PRESIDENT

Dear Member,

Now in its 12th year the Society for Quality in Healthcare in Nigeria remains dedicated to improving the quality of care and patient safety in Nigeria. We continue to focus on building capacity, advocacy, creating and nurturing platforms for exchange of information and provision of technical support to our members that will encourage participation and improve healthcare service delivery in their facilities.

It is satisfying to note that the number of SQHN members, both individual and corporate, continues to grow steadily as we continue to provide support consistent with our mission.

A major objective for producing the newsletter is to keep our membership informed and involved. Since we want the newsletter to be as relevant as possible to your Quality management needs, we look forward to receiving your comments on the first issue. You can also participate by writing an article or sharing your Quality management experiences by sending an email to info@sqhn.org.

I hope you find this edition of the newsletter interesting and useful to your practice of quality in healthcare in Nigeria.

SQHN

Promoting the principles and practices of Quality improvement

SAFETY CULTURE

According to the Institute of Medicine, the biggest challenge to moving toward a safer health system is changing the culture from one of blaming individuals for errors to one in which errors are treated not as personal failures, but as opportunities to improve the system and prevent harm. [1]

The culture of healthcare such as increase in production, control of costs and refusal to acknowledge in fallibility etc has increasingly been regarded as potential risk factors in threatening the safety of patients that care is being provided for.[2]

Healthcare is inherently risky and must be seen as an industry with high hazards. In order to promote safe patient care practices there is need for changes in the culture of the organization and profession.[3]

It must focus on designing or redesigning systems for safety rather than requests for perfect, error free performance from staff. There is also the need for the movement from the current "blame and shame" culture that prevents acknowledgement of error and therefore obstructs the possibility of learning from error. In order to promote systems that both prevent errors and mitigate the impact of errors that occur, there is the need for healthcare systems to have ready access information that supports learning from experience.[4]

A positive safety culture recognizes the inevitability of error and proactively identify latent threats contrary to a "pathological culture" where failure is punished or concealed and people refuse to acknowledge that problems exist. While a variety of levers—clinical training and guidelines, information technology, organizational structures and industry regulations—are being pushed in healthcare organizations to improve patient safety, the belief is growing that an institution's ability to avoid harm will be realized only when it is able to create a culture of safety among its staff. Safety culture is a performance shaping factor that guides the many discretionary behaviors of healthcare professionals toward viewing patient safety as one of their highest priorities.[5]

Maintaining Patient Safety Culture

1. **It starts with the leaders**. If patient safety culture does not start from the leaders of the organization it would be difficult to establish and maintain it. The leaders must be committed to making it a priority of the organization. The leaders include the Governing Board, directors and executive leadership and they must be able to communicate same to the staff of the organization. Patient safety must be the first thing the members of staff think about when they come to work and the last thing they think about when they leave work. This tone must be set by leadership and what is talked about once in a while. Leaders of the organizations must also walk the talk i.e move from their offices to visiting patient or care areas of the hospital. Leaders can also show their commitment to patient safety by ensuring that it is the first thing on the agenda of their Board meetings.

> *"A positive safety culture recognizes the inevitability of error and proactively indentify latent treats"*

2. **Patient Safety culture exceeds the leadership**. The best way to know if patient safety has become a culture of an organization is when there is a change of leadership i.e. the culture should not depend on an individual or a group, it should be part of fabric of the organization .

3. **Consistency in your commitment to Patient Safety.** Inconsistency to leadership's commitment to patient safety is a major setback in patient safety. An example of inconsistency to patient safety culture by the leaders is how leadership handles medical error. It is important the leaders must remember that medical errors are almost always the result of systemic flaws rather than individual competency. The leaders must look at ways to improve the system and address systemic issues to prevent future errors rather than punish the individual that made the mistake. Another good example could be in the area of finance, if the organization is in a difficult financial state, the leaders may decide to put cut sponsorship for quality and patient safety education programs .

4. **It is everyone's business at every level**. Once the gaps have been identified, the organization leaders can begin to make action plans to fill the gaps and this begins with

communicating those gaps with everyone in the organization from the most senior officer to the least. It is imperative that everyone is involved in developing the action plan, leaders must encourage the staff to speak up (this might require breaking down some of the traditional internal structure between multidisciplinary team members and clinicians and non-clinicians) and nurture an environment of accountability, otherwise it would fail. Every voice must be heard!!!

5. **Progression is required in patient safety**. Patient safety culture is not a one –size-fits all approach. Healthcare facilities are complex structures, comprised of many different units with different needs, different staff members and different patients. It is good for organizations to look at safety culture not as a one-time fix or a few simple steps to improve quality .It must be seen as a journey that there are a few steps that must be taken to make it a success Vision drives patient safety. The organization's vision must be such that drives patient safety. It is important for the organization to identify where it is at in terms of patient safety and begin to put in measures in place to fill in those gaps. These could include clinical metrics like post- surgery infections, unexpected mortalities as well as patient satisfaction (Becker's hospital, 2013).

REFERENCES

1. Institute of Medicine, (2001), 'Crossing the quality chasm: a new health system for the 21st century' Washington, DC: National Academy Press.
2. V F Nieva and J Sorra, (2003), 'Quality Safety Health Care' 12: ii17-ii23, doi:10.1136/qhc.12.suppl_2.ii17.
3. Leape LL, Woods DD, Hatlie MJ, et al., (1998), 'Promoting patient safety by preventing medical error', JAMA, 280:1444–1447.
4. Reason JT, (1997), 'Organizational accidents: the management of human and organizational factors in harzadous technologies', Cambridge: Cambridge University Press.
5. Westrum R, (1992), 'Cultures with requisite imagination', Wise JA Hpkin VD Stager P eds. Verification and validation of complex systems: human factors, Issues 1992: 401-416.
6. Beckers hospital, (2018), '6 Elements of a True Patient Safety Culture', Clinical Leadership and Infection Control. Issue 2018.