



Critical Success Factors To Implementing New Patient Safety Programs

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What is CSF?

- CSF is a management term for an element that is necessary for an organisation or project to achieve its mission.
- An activity required for ensuring the success of a process, company or organisational objectives.



Success Criteria

- Success criteria are KPIs . Developed by Ronald Daniels of McKinsey & co in 1961.
- Refined into CSF by John F. Rocket between 1979 -1981
- Applied to health in 1995.



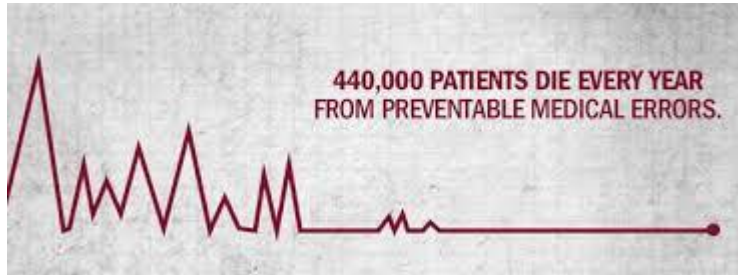
Hippocratic Oath

- Hippocratic Oath :-
- No harm,
- Protect from injustice &
- Ensure confidentiality.



Importance of Patient Safety

Patients are at risk in the hospital because it is an unfamiliar environment for them and they are exposed to germs, procedures and processes that may cause harm.



Importance of Patient Safety



Patient Safety & Safe Care is discussed under four sub division:

1. Patient fall
2. Health Care Associated Infections (HCAI)
3. Health Care Associated Medical Errors
4. Incident/Event reporting



Common Dispensing Errors in Pharmacies

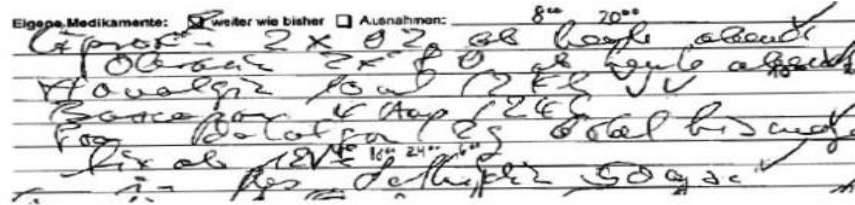


Figure 7: Example of Paper-based Prescription

- **Leadership**

Management / Leadership commitment to developing a safety culture. Strong administrative, executive and performance improvement leadership. Active involvement of the board of trustees.



Source: ACM/NPSF



• Organisational Culture Change

Shared perceptions on safety, mutual trust, blame free culture but ensure accountability. Safety culture that promotes continuing innovation and improvement irrespective of methods. Link regulatory goals to safety culture expectations. Rewarding safety improvements. Sentinel events data collections. Encourage patient / consumer involvement. Report and encourage open discussion of errors.

Types of Safety Cultures



Q: If you only want an SMS 'because there is a regulation' you are...?



Team Training and Continuous Engagement



- Focus on competences, communication, and pattern of behaviour.
- Teamwork.
- Attention to standard of care.
- Active staff involvement.
- Effective oversight structure, physician involvement and accountability.
- Appoint champions or expert performance improvement staff to lead activities.

Reporting and data collection

- Effective use of information technology resources and data for decision making.
- Risk assessment periodically, Sentinel events policy, develop protocols, policies using evidence based guidelines.
- Adverse events surveillance, develop list of root causes and contributing factors.
- List Patient Safety Improvement initiatives.
- Align policies to international and local standard of care whichever is available.



Patient Engagement, Feedback and Advocacy

- Develop a patient and family right charter which summarises the standard expectation of patients and family and their responsibilities to the hospital staffs.
- Steal shamelessly.



Baseline Survey / Gap analysis

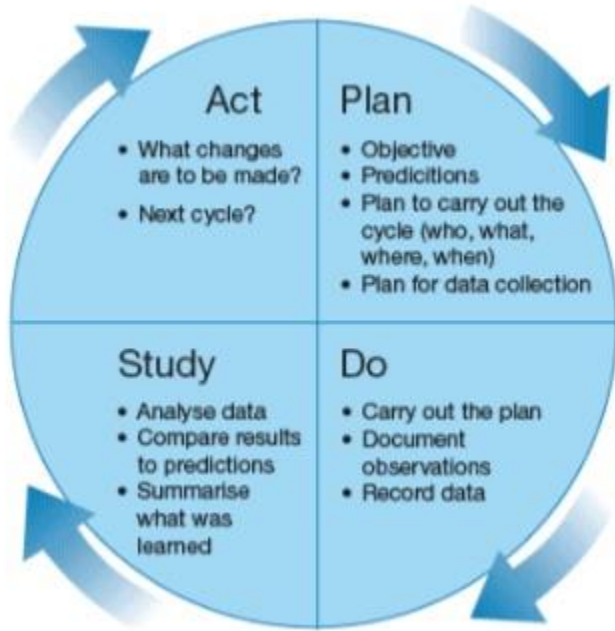
- Pre implementation survey against a chosen quality of care standard.
- Implement corrective actions to close gaps,
- Post –implementation survey
- Use PDSA (plan-do-study-act) cycles to achieve continuous improvement in all areas of assessment.

Use standard tools:-

- TeamSTEPPS – Strategies and tools to Enhance Performance and Patient Safety
- AHRQ's HSOPSC (Agency for healthcare research and quality's Hospital Survey On Patient Safety Culture)



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Formalise

- Enrol in an accreditation program or use a standard quality assurance questionnaire.
- Joint commission
- Cohsasa
- Safecare
- NICE
- SQHN





THANK YOU!