CREATING SAFETY SYSTEM for PATIENT SAFETY in HOSPITAL

(Cengkareng Hospital experience)

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Hotel Kartika Plasa - Kuta, Bali 19 – 21 Juli 2006

SAFETY IN THE AIR START ON THE GROUND

SAFETY IN HOSPITAL START FROM THE SYSTEM

NOT FROM THIS

OUR CONDITION

THE HOSPITAL

(Job Descriptions and Organizational Analysis for HOSPITALS and Related Health Services – revised edition 1971 , U.S. Department of Labor, Man Power Administration)

- **The hospital is a complex organization utilizing combinations of intricate, specialized scientific equipment and functioning through a corps of highly trained personnel educated to the goals and technique of modern medical science. All these are blended into the common purpose of restoration and maintenance of good health**

THIS IS HEALTH CARE

- ***CRISIS ARE DAILY*** **AND** ***ANTICIPATED EVENT***
- ***SOSIAL DYNAMIC ORGANIZATION*** **(ABOUT PEOPLE)**
- ***WHAT APPROACH*** **DO YOU TAKE TO HANDLING THE PROBLEM ?**
- **YOUR** ***REACTION*** **AND** ***PROCEDURES*** **YOU USE ARE** ***IMPORTANT*****, AS YOUR STAFF WILL TAKE THEIR CUE FROM YOU FOR** ***HOW TO BEHAVE IN A CRISIS***
- ***PROBLEM SOLVING*****,** ***QUICK DECISION MAKING*** **, AND** ***CRISIS MANAGEMENT*** **WILL BE AMONG YOUR** ***PRIMARY TASKS AS A MANAGER/FRONTLINER***

The job of today's health care leader/manager is to *design* and *operate systems* that provide safe care --- systems, in the word of

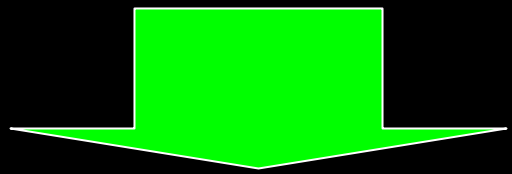
HIPPOCRATES

DO NO HARM

(MEDICAL – NON MEDICAL
CLINICAL – NON CLINICAL)

THE HOSPITAL

- SERVICE
- QUALITY
- PATIENT SAFET



DO NO HARM

change SYSTEM, change STRUCTURE, change PROCESS, culture CHANGE

need STRATEGY – ORGANIZATION - MANAGEMENT

CHALLENGES FOR HOSPITAL

- One of the main challenges facing health *professionals*, *managers*, and *administrators* is trying to make the best use of *limited resources* while providing *high-quality*, *timely care*, customer satisfaction, safety
- THE CRITICAL POINT ARE
  - Professionalism
  - Acceptability
  - Accessibility
  - Appropriateness
  - Competence
  - Continuity
  - Effectiveness
  - Efficiency; and
  - Safety

simuoltaneusly

COORDINATED

(ASSAMBLY - SYNCHRONIZE)

STRATEGY — OPERATIONAL

A Definition of "Patient Safety Practices"

- ***A Patient Safety Practice is a type of process or structure whose application reduces the probability of adverse events resulting from exposure to the health care system across a range of diseases and procedures.***

Health Services – Technology Assessment Text
National Library of Medicine, Chapter 1. An Introduction to the Compendium

- **Healthcare workers go about their daily work wanting the best for their patients and do not intend to harm them**
- **The truth is professionals are devastated by error when occurs, and they create safety everyday by *anticipating*, *compensating*, and *recovering from risk***

The work of patient safety is certainly not about cautioning people to be more careful

It is about changing the medical culture and changing our personal responses to error and unintended events

- **This not a program that you roll out in the organization with banners and coffee mugs**
- **It's a new way of thinking and seeing the world and hence, a new way of working with real organization and healthcare/hospital issues**
- ***The work of patient safety is about transforming and fundamentally changing how care delivery is***

  - designed,

  - organized,

  - managed,

  and that is leader's job.

- *"A system is any collection of components and the relations between them, whether the components are human or not, when the components have been brought together for a well-defined goal or purpose."* (ACP, Patient Safety. Frequently Asked Question)
- Stephen G. Haines (1998) defines *a system as "a set of components that work together for the overall objective of the whole."* .
- Haines defines systems thinking as *"a new way to view and mentally frame what we see in the world; a world view and way of thinking whereby we see the entity or unit first as a whole, with its fit and relationship to its environment as primary concerns"*

Patient Safety Management System

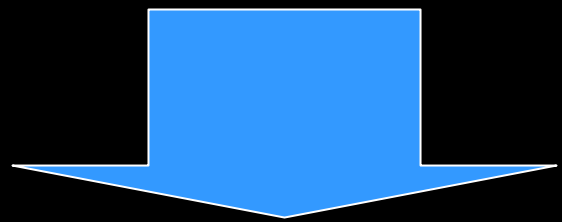
- **Is a series of *cross functional* *organizational and management processes in operational* designed to protect against risks.**
- **The processes are used *simultaneously activities* to identify, classify and manage risks to the safety of an organization's operation. They are an *integral part* *of an organizations risk management framework*. They are generally used to:**
  - ***Minimize the direct and indirect costs of incidents and accidents;***
  - ***Meet legal responsibilities to manage safety;***
  - ***Improve productivity; and quality***
  - ***Market the standards of an organization.***

The goal of a patient safety management system is to actively seek to minimize harm to patients as they journey through the health care system.

It is a system based on :

- **DEVELOPMENT OF SAFETY CULTURE**

(community safety competence culture)



- ***HIGH RELIABILITY SYSTEM :***

A HEALTH CARE SYSTEM THAT ACHIEVES A COMMUNITY CULTURE OF SAFETY

HOSPITAL IS A HIGH RELIABILITY SYSTEM

- **COMMUNICATION** : ***everyone announces what is going on as it happens, to increase the likelihood that someone will notice and react if something starts to go wrong***
  - **controllers constantly watch out for one another**
  - **listening and looking for signs of trouble**
  - **trading advice**
  - **offering suggestions for the best way to route of safety**
- **RISK ACKNOWLEDGEMENT** ***: all practitioners or employees face complexity in their work processes and appreciate that front-line workers must cope with ever-escalating change and information overload.***
- **EMPHASIS IS ON ACTIVE LEARNING** ***: all practitioners and employees know why procedures are written as they are, but they can challenge them and look for ways to make them better and more relevant***

Components of a safety culture include an :

- ***informed culture*** (those who manage and operate the system have current knowledge about the factors that determine the safety of the system),
- ***a reporting culture*** (people are prepared to report their errors and near-misses),
- ***a just culture*** (people are encouraged and even rewarded for providing safety-related information, but must be clear about what is acceptable and unacceptable behavior), and
- ***a learning culture*** (the willingness and know-how to draw the right conclusions from a safety-information system and to implement reforms).

CURRENT CONCEPTS IN MODERN RISK MANAGEMENT, PATIENT SAFETY, QUALITY OF THE SERVICES

SUGGEST THAT

ACCIDENTS IN *COMPLEX SYSTEM*

BASICALLY RESULT FROM

INTERFACE PROBLEMS

(HUMAN – SYSTEM MISFITS)

Creating Safety System

An Organizational Approach

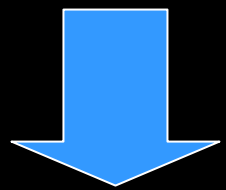
for Patient Safety in Hospital

(Cengkareng Hospital Experience)

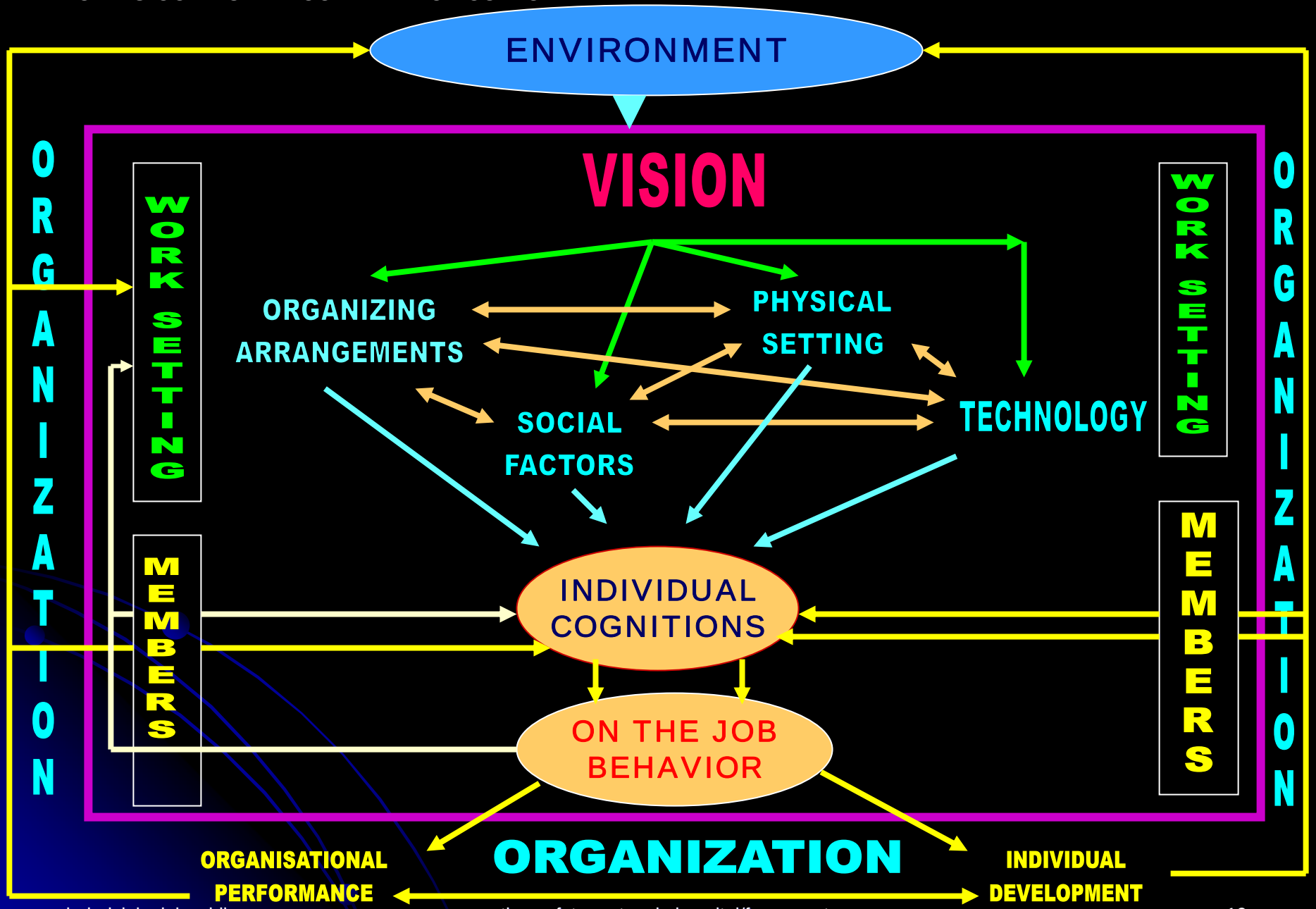
UNIFIED CARE TO PATIENT AIM TO HAVE :

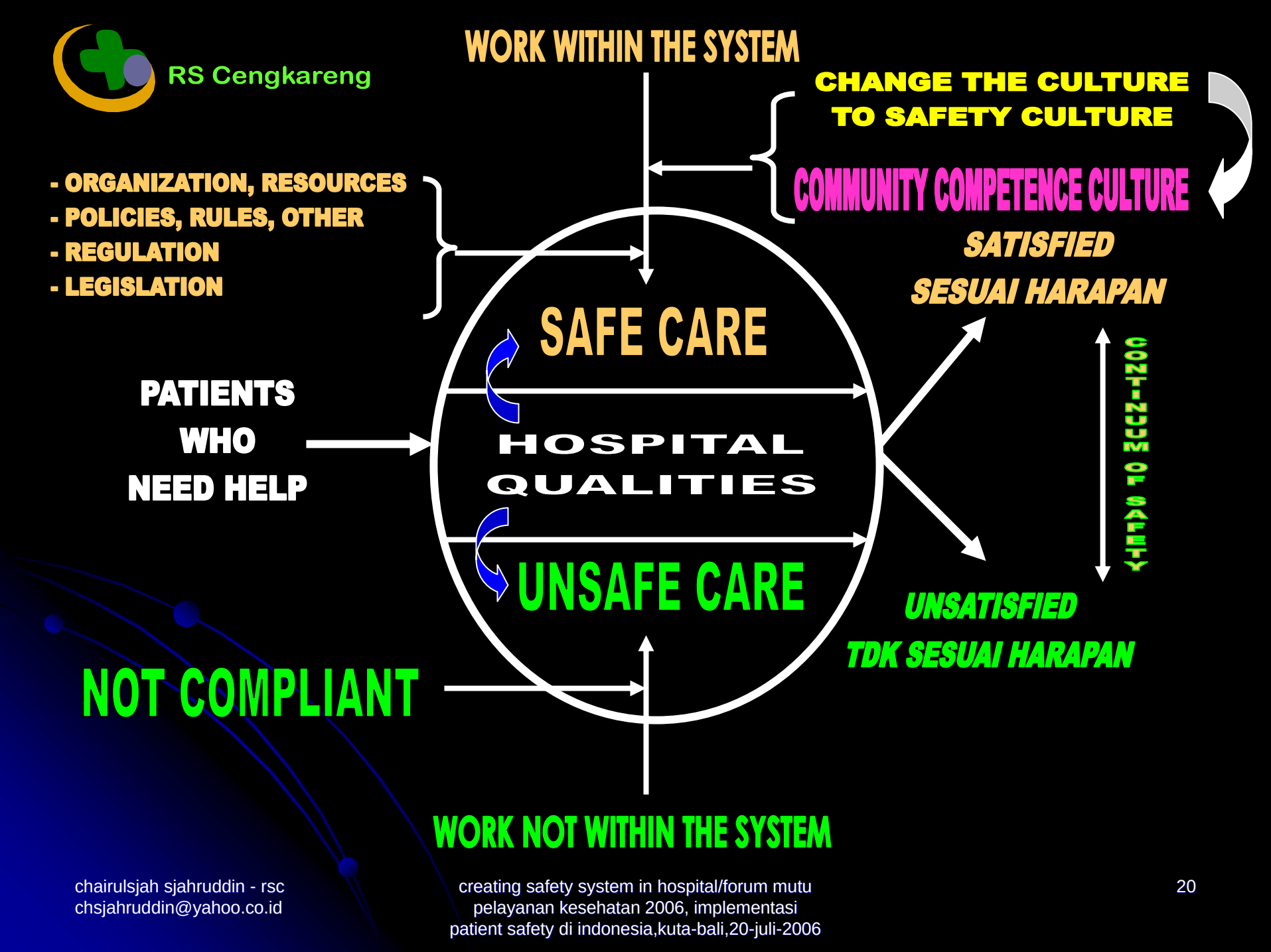
10 RIGHT'S for PATIENT SAFETY

1. THE RIGHT PEOPLE
2. DOING THE RIGHT THINGS
3. IN THE RIGHT ORDER
4. AT THE RIGHT TIME
5. IN THE RIGHT PLACE
6. TO THE RIGHT PEOPLE
7. WITH THE RIGHT RESOURCES
8. WITH THE RIGHT OUTCOME
9. ALL WITH RIGHT ATTENTION TO THE PATIENT EXPERIENCE

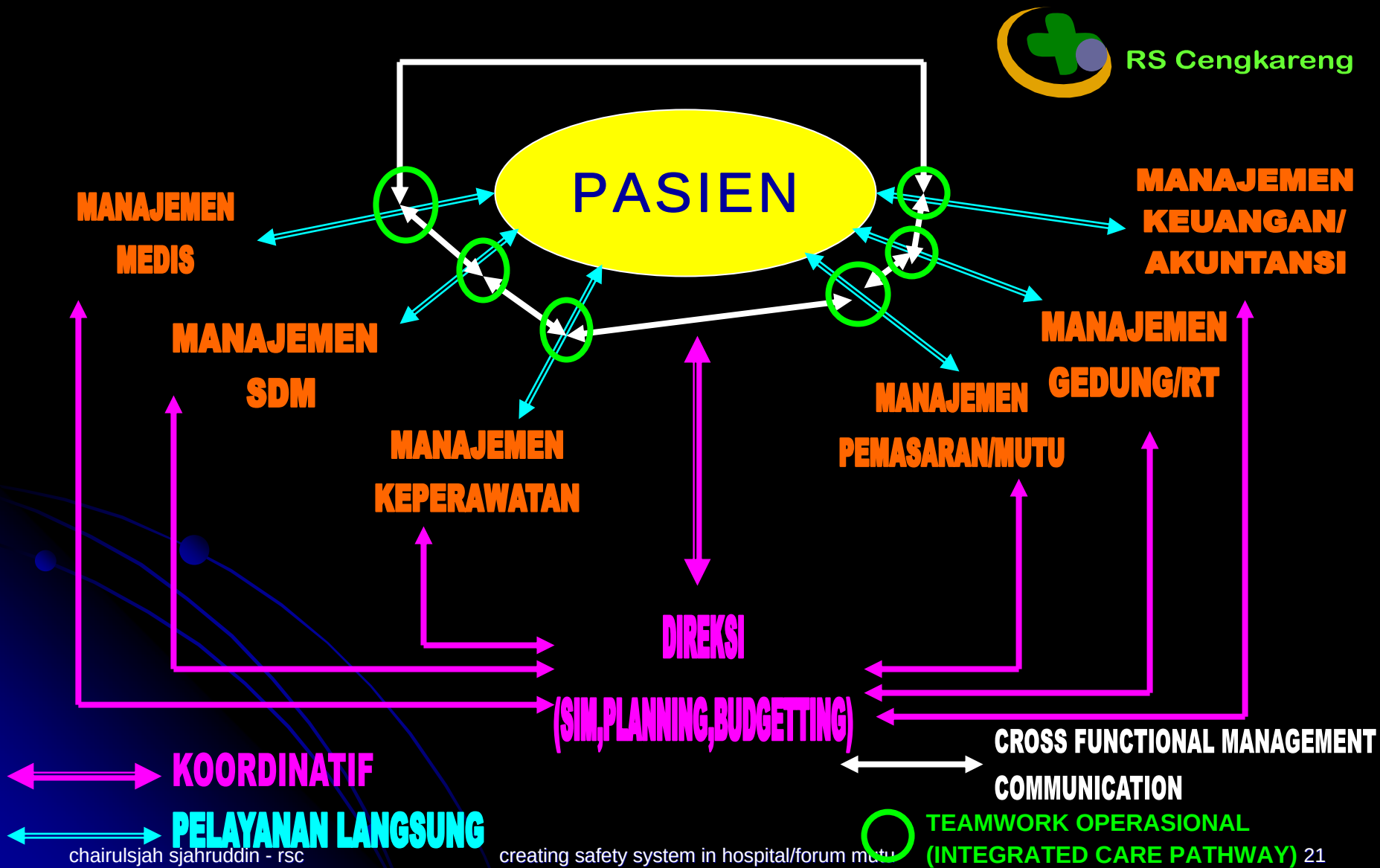


10. AND TO RIGHT COMPARE PLANNED WITH ACTUAL CARE

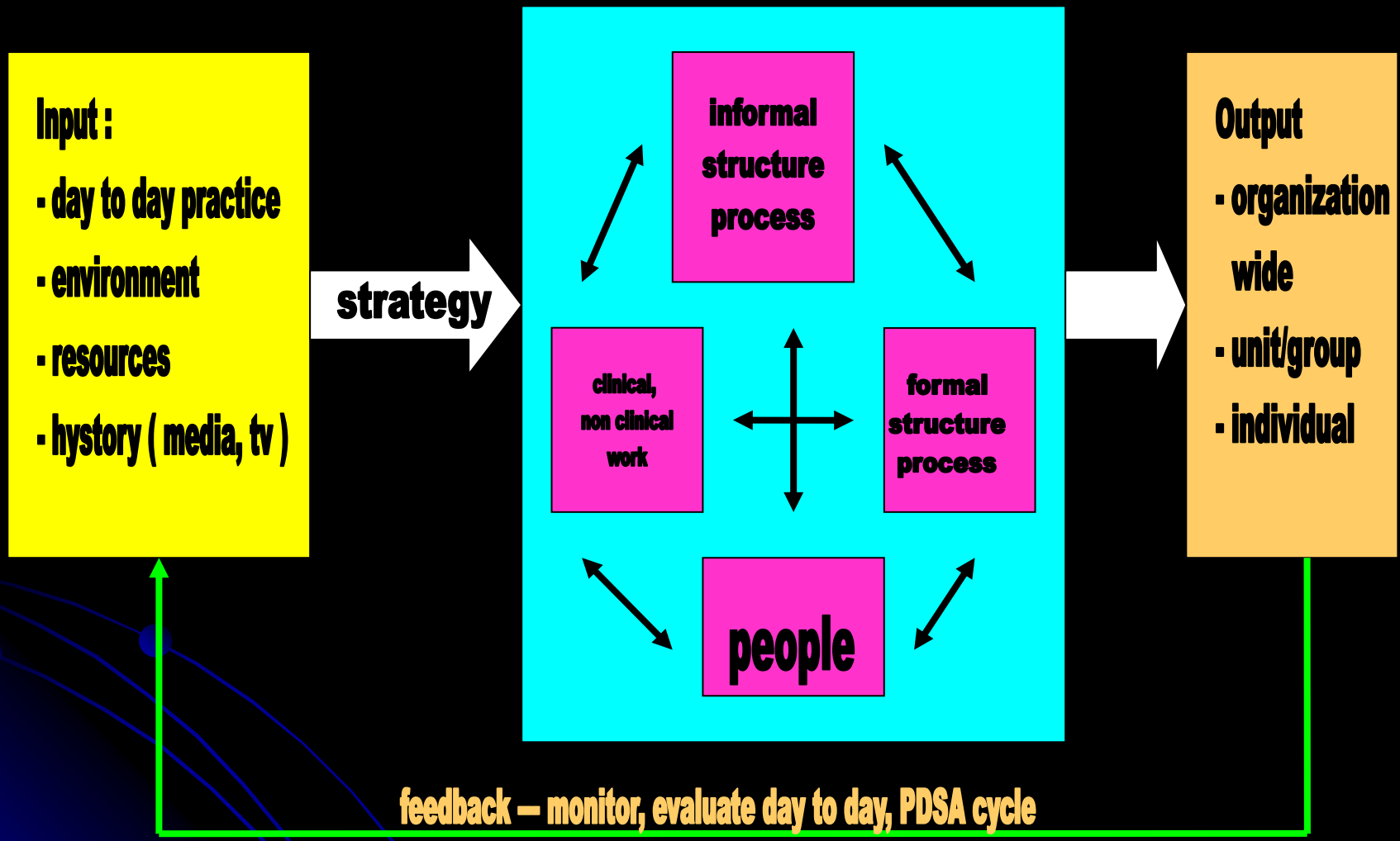

ENVIRONMENT
VISION
ORGANIZATION
WORK SETTING
WORK SETTING
MEMBERS
MEMBERS
ORGANIZING ARRANGEMENTS
PHYSICAL SETTING
SOCIAL FACTORS
TECHNOLOGY
INDIVIDUAL COGNITIONS
ON THE JOB BEHAVIOR
ORGANISATIONAL PERFORMANCE
INDIVIDUAL DEVELOPMENT
ORGANIZATION
ORGANIZATIONAL DEVELOPMENT


RS Cengkareng
WORK WITHIN THE SYSTEM
CHANGE THE CULTURE
TO SAFETY CULTURE
COMMUNITY COMPETENCE CULTURE
- ORGANIZATION, RESOURCES
- POLICIES, RULES, OTHER
- REGULATION
- LEGISLATION
SATISFIED
SESUAI HARAPAN
SAFE CARE
PATIENTS
WHO
NEED HELP
HOSPITAL
QUALITIES
CONT-ZCUS OF SAFETY
UNSAFE CARE
UNSATISFIED
TDK SESUAI HARAPAN
NOT COMPLIANT
WORK NOT WITHIN THE SYSTEM

Operasionalisasi Organisasi dan Manajemen RS Cengkareng (day by day)
PURPOSE : TO ENSURE CLINICAL PROBITY AND TO OPTIMISE PATIENT CARE



our org. - manag. design for day to day practice (cengkareng hospital)



RELATIONSHIP OF GOVERNANCE, INTERNAL CONTROL, AND QUALITY ASSURANCE IN CENGKARENG HOSPITAL

GOVERNANCE

CLINICAL CARE :

- Rules and regulation medis dan keperawatan
- Pedoman Perilaku Profesi Medis
- Perjanjian pemberian pelayanan profesional
- Medical Staff Bylaws
- Asuhan Keperawatan
- Tata tertib keperawatan
- Pedoman Penilaian Kinerja Keperawatan

THE ENVIRONMENT OF CARE

- Peraturan Perusahaan
- Peraturan Pegawai
- Kebijakan Akuntansi
- Sistem Pengadaan
- Sistem Perpajakan

FINANCIAL RESOURCE

- Cash Flow

SENINAN

MORNING REPORT

RONDE KAMISAN

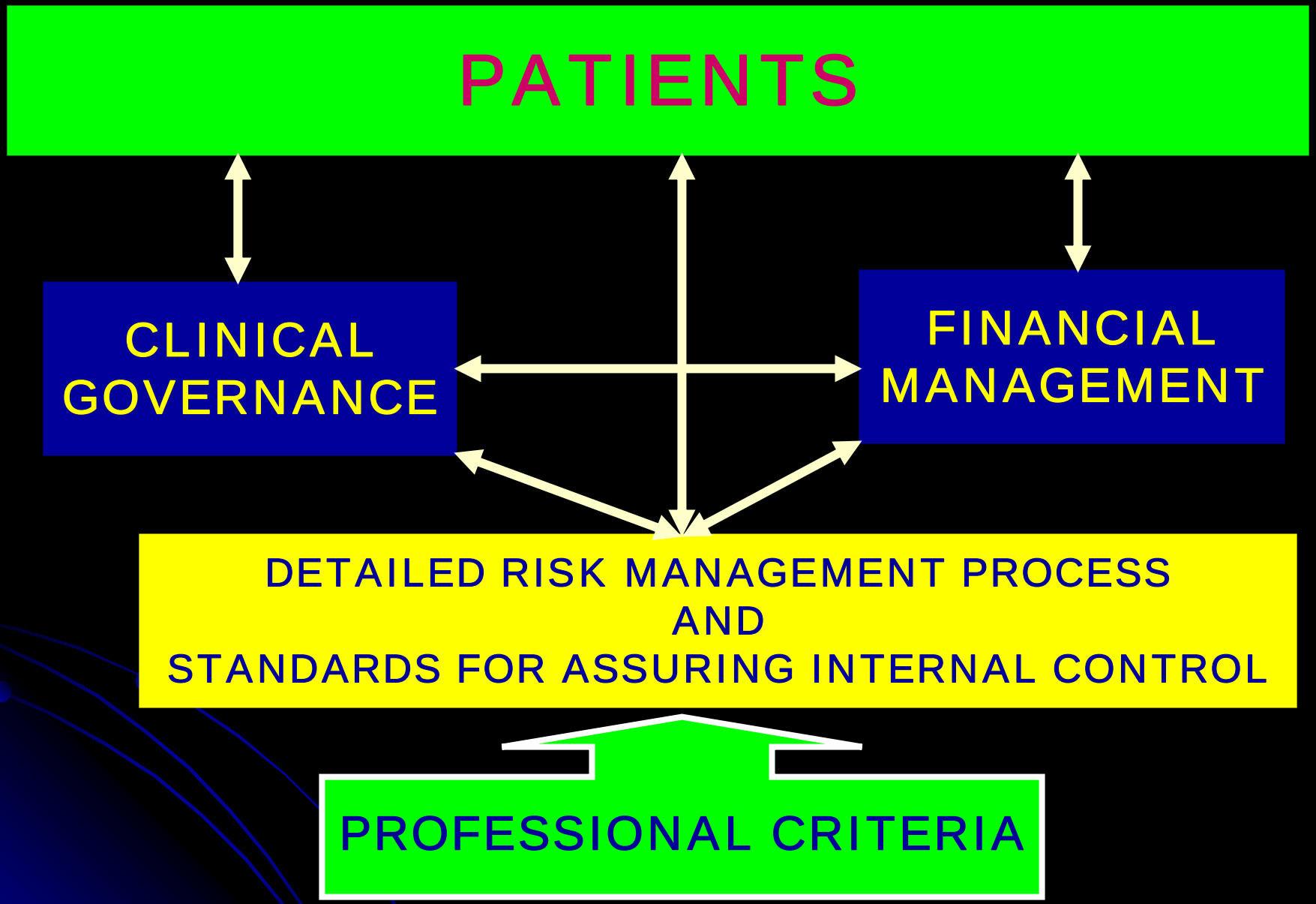
REBOAN MANEJEMEN

KUESIONER MR SMILE

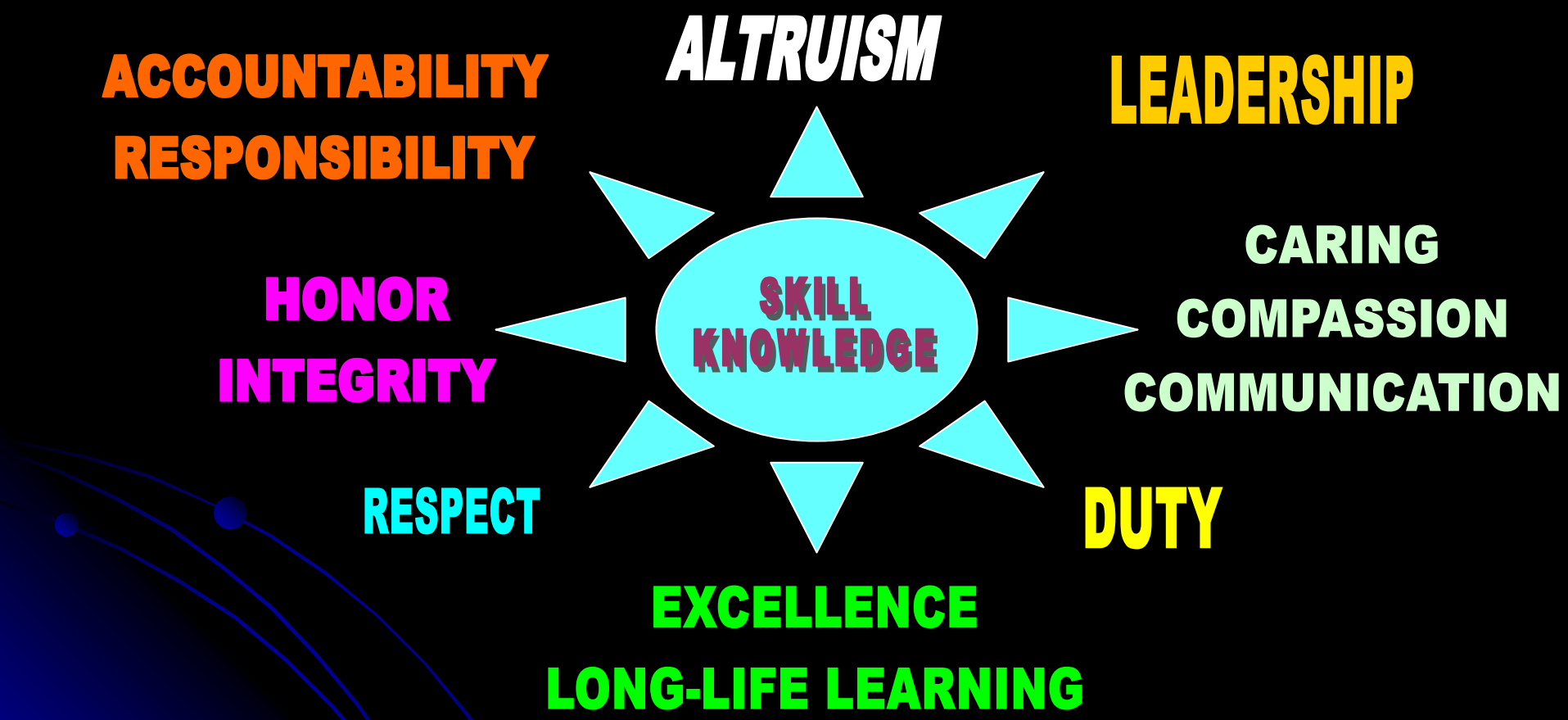
REBOAN PENGELOLA ANGGARAN

Principle of an Integrated whole System Approach

- **Governance is an** INTEGRAL PART OF EVERYDAY BUSINESS and NOT AN ADD-ON TO CLINICAL ACTIVITY
- EVERYONE in the company/hospital has a CONTRIBUTION **to make in delivering quality patient care and helping to resolve problems**
- **Staff need to be** ACTIVELY encouraged to **bring any problems to the company/hospital attention in an open manner without fear of recrimination**
- It compromises the SYSTEM and PROCESSES for MONITORING and IMPROVING services

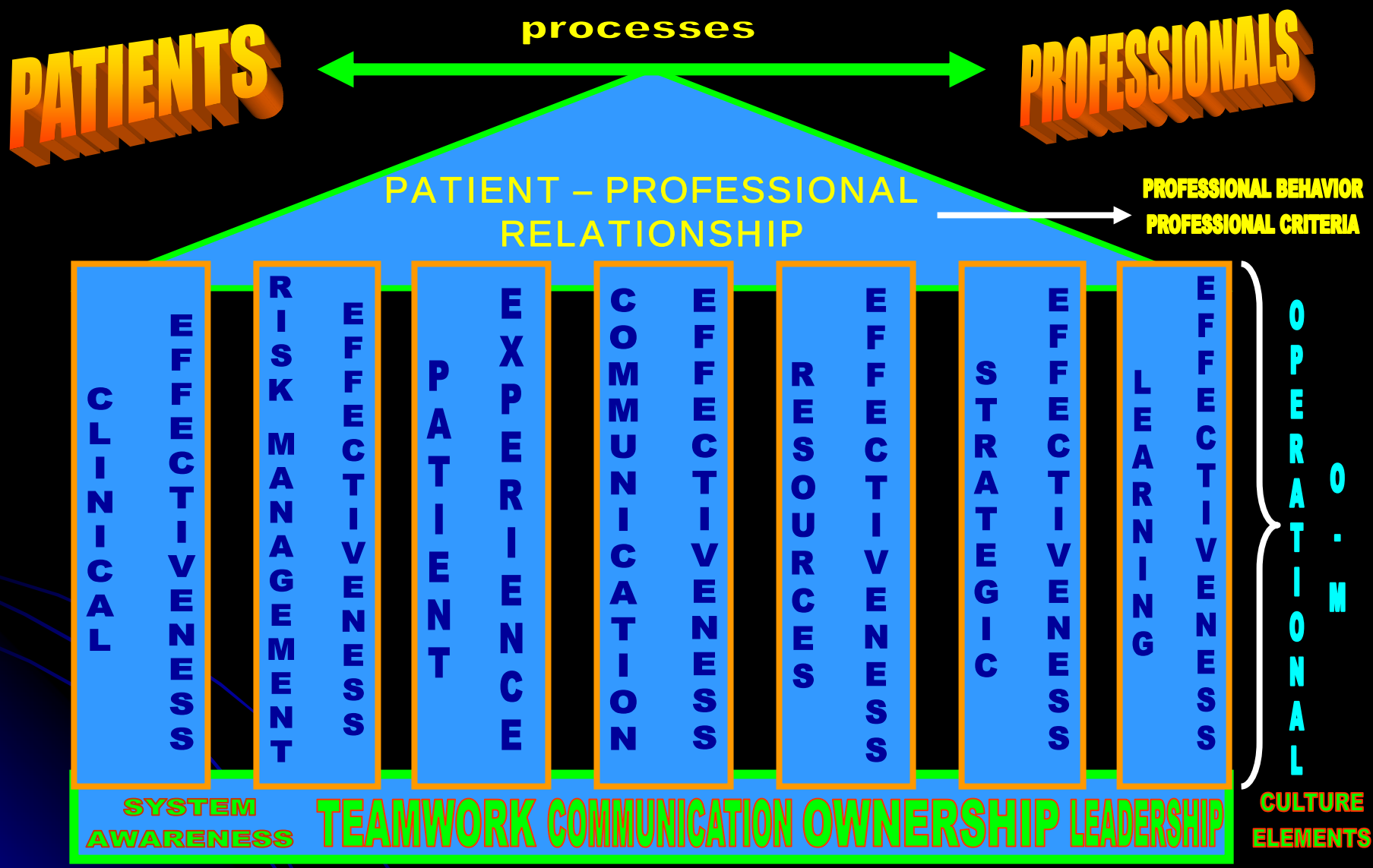

PATIENTS
CLINICAL GOVERNANCE
FINANCIAL MANAGEMENT
DETAILED RISK MANAGEMENT PROCESS
AND
STANDARDS FOR ASSURING INTERNAL CONTROL
PROFESSIONAL CRITERIA

THE BEHAVIOR OF MEDICAL PROFESSIONALISM

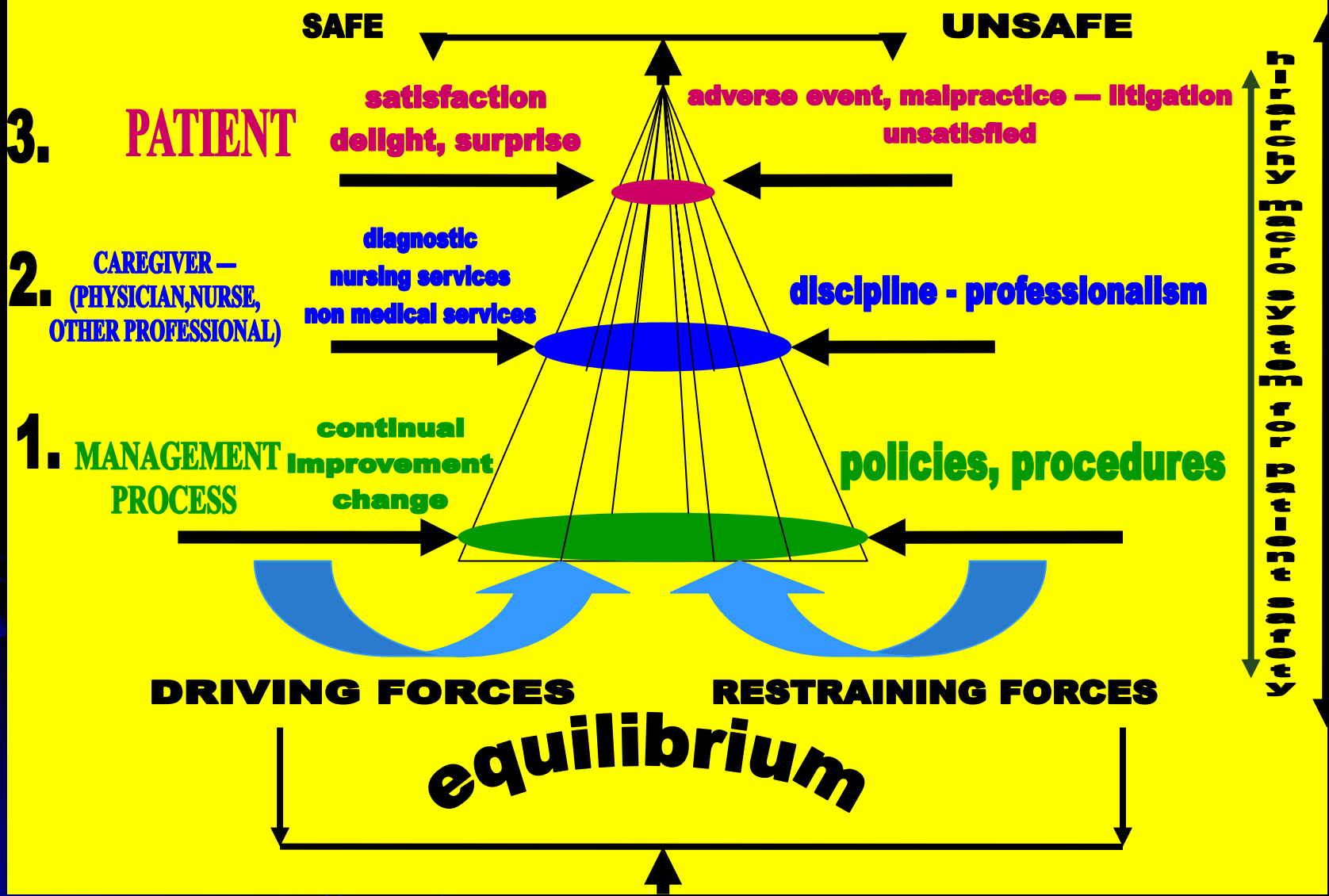


- Shrank et all, Element of Professionalism
- http://ci.nbme.org/professionalism/

THE REALIZATION ARE



3 SYSTEM LEVEL FOR PATIENT SAFETY (macro system) CENGKARENG HOSPITAL




SAFETY
is strong medicine
PATIENTS • EMPLOYEES • VISITORS • ENVIRONMENT

Cengkareng hospital have a unique opportunity to play a leadership role in changing the status quo, through :

- C ommitment --- **quality, safety and service**
- H uman --- **human dignity, human right**
- A ccountability --- **obligation to demonstrate**
- I mprovement --- **continuous improvement**
- R elationship --- **develop professional relationship**
- U rgency --- **sense of urgency**
- L eadership --- **we need leader not worker**
- S how --- **demonstrate professional behavior**
- J udgment --- **need professional judgment**
- A ppreciative inquiry --- **a way of thinking**
- H arm --- **what ever you do, *do no harm*,**

Thank u so much for attention