Project Title

Recognizing the Importance of Speaking up for Patient Safety

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Organisation(s) Involved

KK Women's and Children's Hospital

Lessons Learnt

Changing an organisational culture can be difficult because of deeply engrained practices. The change has got to come from the top with senior staff leading by example. By engendering the ethos of "we are all in this together" towards patient safety, trust and working relationships across the team will be improved

Project Category

Safety, Staff Education, Culture Change

Keywords

KK Women's and Children's Hospital, Safety, Patient Safety, Open Communications, Effective Clinical Communications, Organisation Culture, Leadership, Culture Change, Obstetrics & Gynaecology, Quality, Safety and Risk Management Department, Staff Empowerment, Patient Safety Champions, Cognitive Institute, Psychological Safety, Speaking Up for Patient Safety Seminar, Zero Patient Harm, Senior Management Support, Trust, Staff Survey, Education Video

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Recognizing the Importance of Speaking up for Patient Safety

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Introduction

Openness in communication is important in delivering safe patient care. Often, health care professionals hesitate to voice concern due to differing professional perspectives on clinical management, hierarchy, lack of organizational support for change, and fear of retribution. Recognizing the importance of non-technical skills in preventing patient harm the senior management at KKH introduced the Speaking up for patient safety Seminars (SUFS) to all staff in the hospital. This seminar focuses on effective clinical communication in a respectful, clear, direct, and explicit manner. Speaking up is important for patient safety. Understanding the influencing factors can help to improve speaking-up behaviour and team communication.

Aim

To measure the changes in attitudes and practices of medical professionals in the department of Obstetrics and Gynecology after attending the SUF seminar.

Method and Results

KKH in collaboration with Cognitive Institute implemented Speaking Up for Safety Seminar as part of the journey to High Reliability and Safety Programme. There were 218 participants from the Department of O&G, majority of participants were from the Nursing and Paramedical followed by the Junior doctors and Administrative staff as shown in figure 1.

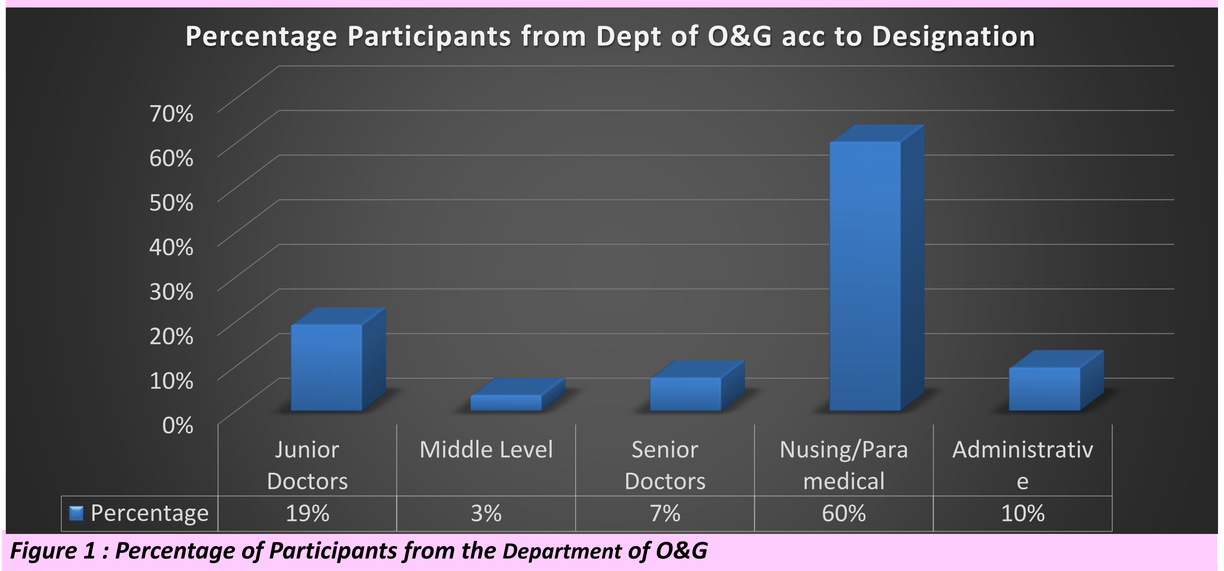

Figure 1 : Percentage of Participants from the Department of O&G

A preliminary survey was conducted among healthcare professionals working in Obstetrics and Gynaecology and 69 staff (30%) had witnessed practices they considered unsafe to patients as shown in figure 2.

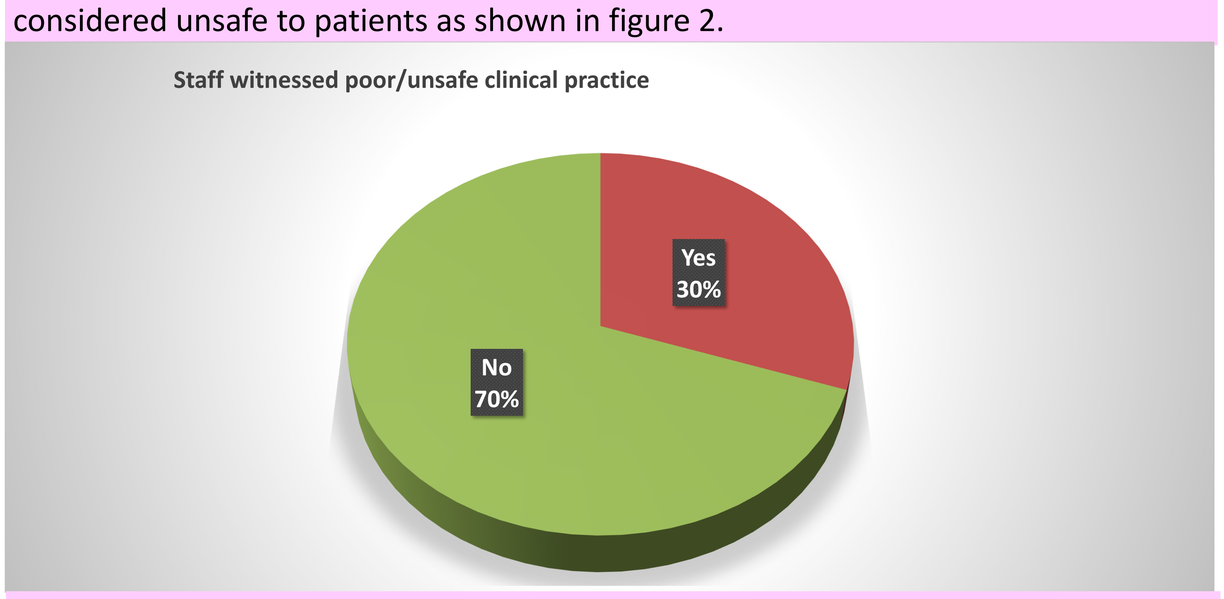

Figure 2 : Percentage of Staff who witnessed poor/unsafe practices

There were 91% of the respondents were willing to raise their concerns through different avenues as shown in figure 2. Majority of the staff (144) will directly raise the concern to their Head of the Department or Supervisor as shown in figure 3.

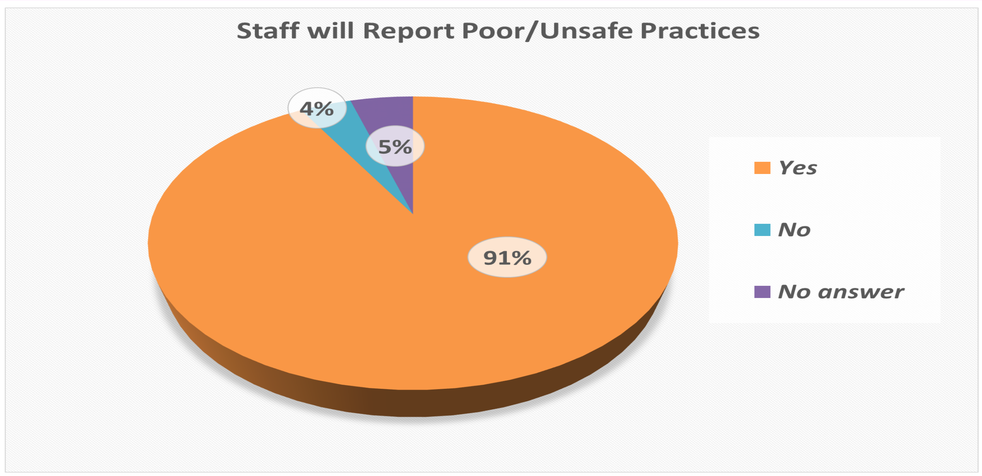

Figure 3 : Percentage of Staff who will report poor/unsafe practices

Majority of the staff (144) will directly raise the concern to their Head of the Department (HOD) or Supervisor as shown in figure 4.

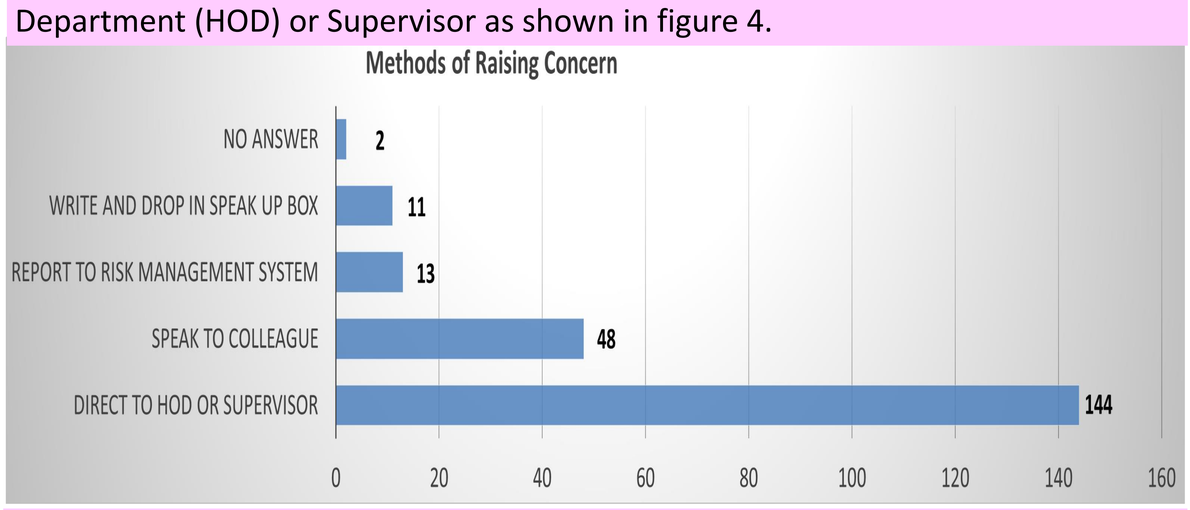

Figure 4 : Avenues of Raising Concern

A minority 9 (3.9%) expressed unwillingness to report unsafe practice either due to fear of repercussions (5) , lack of time (3) or a feeling of their concerns being unanswered (1) as shown in figure 4.

Figure 5 : Reasons for Unwillingness to Report

Several initiatives were introduced Speaking up for Safety Seminar, Speak-up and Safe to Speak up video were implemented. Thus, The encouragement and support from senior management was the strongest motivation for employees to speak up as shown in figure 6.

Factors influencing the decision to SUFS	No. of staff	Percentage
Management support to SUFS	94	41.2%
Organizational awareness	73	32.0%
Family test (if this is my loved one)	44	19.3%
Advice from others	6	2.6%
No answer	1	0.5%

Figure 6: Factors influencing the Decision to Speak up.

Following attendance at the seminar the number willing to raise concerns for patient safety had risen to 218 (95%); the main reasons cited for speaking up being willingness to practise what they had learned at the seminar (41%) and supporting the institutions initiatives of "achieving zero patient harm" (82.8%) and "speaking up for patient safety" (40%).

Discussion

Changing an organizational culture can be difficult because of deeply engrained practices. The change has got to come from the top with senior staff leading by example. This is supported by the constant messaging during patient safety forums and walkabouts. Corporate communications created a video of the senior leaders talking about their support to the staff when staff speak up concerning safety issues and another video on psychological safety "how to react when someone has spoken up". By engendering the ethos of "we are all in this together" towards patient safety, trust and working relationships across the whole team will be improved.

Conclusion

From the authors perspective we have found training in respectful and assertive communication breaks down barriers and brings health workers closer together with a common goal of patient safety.

The SUFS is empowering all members of the team regardless of their role and level to speak up.

Acknowledgments:

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