Apollo Safety Development Model:
Building a Culture of Safety at Apollo Specialty Hospitals

Apollo Health & Lifestyle Ltd.
India
Our mission is to bring healthcare of international standards within the reach of every individual. We are committed to the achievement and maintenance of excellence in education, research and healthcare for the benefit of humanity.

Dr. Prathap C Reddy
Chairman, Chairman, Apollo Hospitals Group

THE ARCHITECT

Widely credited as the architect of modern Indian healthcare, Dr. Pratap C. Reddy dedicated his life’s efforts to bringing world-class healthcare within the economic and geographic reach of millions. The institution he built and the values and vision he inculcated led the private healthcare revolution that transformed the Indian healthcare landscape.

THE LEGACY
Outlined Objectives & Proposed Targets

Acknowledgment of the high-risk nature of the hospital's activities and the determination to achieve consistently safe operations. A target for average patient safety score of 80 against a baseline of 60.

A blame-free environment where individuals are able to report errors or near misses without fear of reprimand or punishment. Increase in the overall number of incidents reported from 8-10 per month to more than 50 per month.

Encouragement of collaboration across ranks and disciplines to seek solutions to patient safety problems. Average overall grade for the departments of 4 out of 5, against a target of 2.5.

Organizational commitment of resources to address safety concerns
“Improving the culture of safety within health care is an essential component of preventing or reducing errors and improving overall health care quality.”

Safety First

for both patients and employees

Workplace with fewer errors & incidents

Regular evaluation of safety culture in the organization

Safe work environment means happier patients and employees
Project Stakeholders & Project Team

CEO
Direction & providing resources

Quality Head
Project Champion

Quality Team
Data collation & Analysis

Executive Committee
Functional Support

Business Heads & Hospital Staff
Members & implementers
Opportunity for Improvement

Safety Culture Survey based on AHRQ guidelines was conducted in Aug-Sep 2017.

876 employees across 21 specialty hospitals participated in the survey.

Safety Meter:

Safety meter depicts the average score attained by all the hospital for “Patient Safety”, based on the participants’ response to each question in the survey.

Overall Rating:

Average rating given by all the participants for their work area/unit in the hospital on patient safety:

2.46 out of 5

Incident Reporting Awareness:

Percentage of participants who said that they are aware of the incident reporting process:

68.79%

Hence, a scope for improvement was identified regarding the Safety culture in the hospitals.
Implementation Approach

‘Safety Leadership Team’
(Management + HODs) formulated

Apollo internal innovations

‘Apollo Safety Development Model’ designed

Brainstorming
Supported by data

Research for best practices around the world.
References taken from;
Agency for Healthcare Research & Quality
Joint Commission International
World Health Organization
Occupational Safety & Health Administration
American College of Healthcare Executives

Implementation of the Model

Bi-annual ‘Safety Culture Survey’ for monitoring progress & sustenance
Implementation Approach

Apollo Safety Development Model
Transforming the Culture of Safety

1. Leadership
   - Leadership Safety Rounds
   - Committee Meetings

2. Teamwork
   - Daily Safety Huddles
   - Buddy Program

3. Effective Behavioral Change
   - Star Department
   - Q4E Toolkits
   - Departmental Checklists

4. Evidence Based
   - SSC with ‘Voice Over’
   - High Alert Drug Check

5. Just Culture
   - Rewards & Recognition

6. Communication
   - Safety Leaders
   - Nursing Kanban Board
   - Apollo Educational Video
   - Online Incident Reporting

7. Learning
   - Safety Fair
   - Code Blue Mock Drill Day
   - Infection Control Week
   - Fire Safety Week
Solutions Implemented

Leadership

Leadership Safety Rounds
- Monthly “Safety Rounds” by the Hospital head
- Identification of safety issues & potential risks for timely mitigation
- Designated “Patient Safety Officer” in every unit

Committee Meetings
- 3 mandatory committees in all the units
- Quality Steering, Safety & Infection Control
- All the HODs including physicians and consultants part of the committee
- Meet periodically to take decisions on critical issues
Solutions Implemented

**Teamwork**

**Daily Safety Huddles**

- Involves the entire team along with the administration
- Staff are encouraged to speak up about the issues in their respective areas or departments
- Gives a spirit of collegiality, collaboration, and cooperation exists among staff by empowering the employees

![Staff sharing their experiences in one of the ‘Daily Huddles’](image)

**Buddy Program**

- For new recruitments
- A buddy is assigned to the new employee, who is part of the hospital team for a minimum period of time
- Orientation to their respective department and the hospital
- Helps in imbibing the culture of the hospital from the beginning
Solutions Implemented

Effective Behavior

Star Department
- Based on 5S principle of workplace organization
- Helps in infection control and safety
- Quarterly competition with a trophy to the winning department as “Star Department” for motivation

Q4E Toolkits
- Focused approach towards a critical parameter
- Team is formed to formulate the toolkit
- Designing the resource tool for implementation to tackle the issue
- Standardization across units

Departmental Checklists
- Monthly checklists tailor-made for the departments
- Sustenance of initiatives
Solutions Implemented

Evidence Based

SSC with ‘Voice Over’
- The standard WHO checklist for surgical safety has been implemented uniformly across all the hospitals
- A process of “Voice Over” during ‘Time Out’
- Compliance to IPSG

Medication Safety
- High alert medications are counterchecked during administration
- Also double checked and signed by the pharmacist while dispensing
- Every high alert drug is documented
- Has to pass through two levels of monitoring thus reducing medication errors
Solutions Implemented

- A culture that recognizes errors as system failures rather than individual failures
- Employee accountability with a non-punitive approach
- Employees identifying & raising incidents are appreciated in the monthly “Rewards & Recognition” program

One of the “R&R” programs conducted
Solutions Implemented

Communication

Safety Leaders

• Designated SPOC for the central Quality team in every unit who drives ahead the quality & patient safety activities
• Clearer communication from the management & central quality team down to the team through the Safety Leaders for sustainable results.

Nursing Kanban Board

• The board contains care dues with time which creates a “visual signal”
• Easier and improved communication in handovers
• Reduced missing or delayed nursing care

Apollo Educational Videos

• Short videos on different topics like safety, infection control, etc.
• Easily accessible to all through YouTube
• Video links given in the Annexure
Online Incident Reporting

- In-house online incident reporting software
- More convenient & accessible reporting system – better compliance to incident reporting
- Direct intervention by HODs centrally
- Daily reminders and alerts to HODs for closure of reports
- Swift closure of reported incidents
- Stakeholders can directly track the status and closure of different incidents
Solutions Implemented

Incident reporting portal page

Status of closure of different incidents

Provision for documenting Quality Analysis
Solutions Implemented

- Knowledge imparted in innovative ways – more effective and sustainable
- Staff were trained in various aspects of Patient Safety through Infection Control Week, Safety Fair, Fire Safety Week, Code Blue Mock Drill Day, etc.
- The innovative methods included skits, quizzes, dance, etc. apart from the regular lectures and on the job trainings.

Poster released after successfully conducting Code Blue Mock Drills across AHLL
Challenges faced in implementation

- Multiple locations
- Lack of awareness among staff regarding standard requirements
- Resistance to change & bringing the staff to understand the importance and priority of improving the quality & patient safety (publishing case studies in newsletter is helping us overcome this)
- Too ‘many’ things at the same time
Safety Culture Survey was conducted again in **March 2018**. **1150 employees** across **21 specialty hospitals** participated in the survey.

**Safety Meter:**

- **87**

Safety meter depicts the average score attained by all the hospitals for “Patient Safety”, based on the participants’ response to each question in the survey.

**Overall Rating:**

- **4.24 out of 5**

Average rating given by all the participants for their work area/unit in the hospital on patient safety.

**Incident Reporting Awareness**

- **89.2%**

Percentage of participants who said that they are aware of the incident reporting process.
<table>
<thead>
<tr>
<th>Metric</th>
<th>Sep 2017</th>
<th>Mar 2018</th>
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<tbody>
<tr>
<td>Average Patient Safety Score (out of 100)</td>
<td>59.2</td>
<td>87</td>
</tr>
<tr>
<td>Grade for Overall Safety at the Unit (out of 5)</td>
<td>2.46</td>
<td>89.2</td>
</tr>
<tr>
<td>Awareness about Incident Reporting (in Percentage)</td>
<td>68.79</td>
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The project was a great success in various terms;

- Statistically numbers indicate the success of the project
- The ultimate goal was Patient Safety which was evident in the subsequent survey
- Substantial improvement in facility and process safety led to increased employee satisfaction
- Streamlined processes helped in improving overall patient satisfaction
- Ground staff got a sense of involvement, accountability & responsibility towards safety initiatives and eventually became responsible for further improvement of their respective processes
- The project also fostered team work and activity, through different activities
Steps to Sustain Benefits

- Continuous trainings and workshops for all the staff on up to date safety standards
- Periodic internal audits with ATRs lead to focus on solutions to overcome potential risks & safety issues, leading to continuous quality improvement & sharing of best practices
- Monthly ‘Rewards & Recognition’ programs, giving the teams a sense of motivation and to take ownership towards improvement of quality & patient safety
- Periodic assessment of patient safety levels at the hospitals through the safety culture survey will help the management to delineate the critical areas and work towards improvement
Annexure

Safety Culture Survey Tool

- A comprehensive survey questionnaire with 45 questions was designed
- Based on Agency for Healthcare Research & Quality’s Safety Culture Survey tool.
- The questionnaire broadly encompassed the following 12 areas of patient safety culture;
  1. Communication openness
  2. Feedback and communication about error
  3. Frequency of events reported
  4. Handoffs and transitions
  5. Management support for patient safety
  6. Non-punitive response to error
  7. Organizational learning—continuous improvement
  8. Overall perceptions of patient safety
  9. Staffing
  10. Supervisor/manager expectations and actions promoting safety
  11. Teamwork across units
  12. Teamwork within units

Complete Safety Culture Survey Questionnaire
Contact us

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Thank you