From “Hush-Hush!” To “Share & Learn!”
Education Nuggets to Change Safety Culture

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Introduction
National University Hospital (NUH) in Singapore is a tertiary teaching hospital with 1,275 beds providing comprehensive range of services, and over 8,500 staff of diverse cultures.

Translating learning points from incidents and adverse events (AEs) to improve quality and safety of care is challenging due to the multifold complexities and difficulties. Communicating the right message to the ground is one of the key challenges. The main communication channel to staff about incidents was through respective supervisors or formal meetings. This communication channel was fraught with problems:

- Staff were not comfortable sharing their incidents with others or
- The supervisors not being able to communicate effectively.

Objective
In order to provide an effective channel of communication; NUH, in 2012 made a courageous move to share its incidents/ AEs with the staff directly through monthly emails. This was a paradigm shift from the 6-monthly newsletters to intensify safety awareness, education and encourage reporting.

Materials and Methods
The data from Web-based reporting system is reviewed and analysed to identify cases to provide an insight into quality improvement strategies, including planning and prioritizing. Sharing of learning points and safety alerts are done via bite-sized educational bulletins called “Safety Watch”, “Theme-based Patient Safety Briefings”, and “Patient Safety Leadership Walkrounds”.

Furthermore, sharing of anonymized sentinel events including learning points is done by the respective Heads in Auditorium. These ventures complement the existing Risk-Management framework.

Result
More than 65 “Safety Watch” bulletins have been issued since 2012. Annually 4 Safety Briefings and 2 sentinel events sharing sessions have been held since 2010.

There were around 150 Leadership Walkrounds with 290 areas visited from 2005 to Sep 2017. This has helped to enhance an open and fair reporting culture that is the hallmark of an organization with just culture. The hospital occurrence reporting rate has increased by 200% from 2,878 to 5,791 in 2011 and 2016 respectively.

Patient Safety Climate Survey questions on “Feedback and communication about errors” fared well with significant improvement. “Staff are always informed about the errors” improved from 72.9% in 2011 to 78.5% in 2016 and “Staff are always given feedback about changes put into place based on the even reports” improved from 49.9% in 2011 to 60% in 2016.

Lesson Learnt and Conclusion
Sharing incidents anonymously and learning points using email, intranet and through large-sharing sessions has a wider reaching capability to more number of staff and helps to improve safety culture.