



## **King Abdulaziz University Hospital Jeddah . . . .**

# **ACI EDUCATIONAL WORKSHOPS**

### **President:**

**Mr.Hussam Al-Baz**  
Quality Director

### **Chief editor:**

**Ahlam Alghanmi**  
QI Consultant

### **Newsletter Designer**

**Fawziah Mashhour**  
Quality PR

### **Editorial Board:**

**Sana Al-Eiderous**  
Quality Specialist and  
Data Analyst

**Crescencia Javonillo**  
Quality Coordinator

**Biji P Thomas**  
Quality Coordinator

**Corazon Albino**  
Quality Coordinator

**Manju K Joseph**  
Quality Coordinator

**Yasmeen Ashour**  
Quality Coordinator



# **Quality Newsletter**

## **Issue 1 March 2017**



[hospital-tqm@kau.edu.sa](mailto:hospital-tqm@kau.edu.sa)

# Table of Content

- **ACI Educational Workshops P.1**

**By: Mary Jane J. Gaspar , Quality Department**

- **Clinical Guideline and Pathway Differences P.3**

**By: Mr. Hussam Al-Baz , Director of Quality Management Department**

- **Common Mistakes in Root Cause Analysis P.4**

**By : Ms. Ahlam Alghanmi , Quality Improvement Consultant**

- **Are we Patient Safety culture P.6**

**By : Sana Aleidarous , Quality Specialist & Data Analyst**

- **Seven Waste P.7**

**By : Yasmeen Ashoor**

- **ACI Educational Workshops in the Newspaper P.9**



# ACI Educational Workshops



Categories of Policies and Procedures

- 3 categories of policies and procedures are recommended for health care organizations:

- Organization-wide
- Service-specific
- Program-specific



# *ACI Educational Workshops*

**(27-30 March 2017)**

By: Mary Jane J. Gaspar , Quality Department

The recently concluded two Educational Workshops organized by Quality Department were fruitful undertakings. Conducted by ACI in collaboration with CPSI (Canadian Patient Safety Institute), the tandem workshops were attended by selected representatives from 30 departments.

Held in four consecutive days, the workshops dealt with paradigms of quality in health care as the workshops' names elicit:

- 1. Leading Improvement with Patient Safety** (27-28 March 2017) facilitated by **Ms. Dawn Hartfield** (CPSI);
- 2. Policies & Procedures in Health Care Organizations including Clinical Practice Guidelines & Clinical Pathways** (29-30 March 2017) conducted by **Ms. Eileen Goudy (ACI)**.

There was active interaction among the participants in the various exercises – definitely a positive indication that a smooth multi-disciplinary/cross-functional collaboration is possible. This possibility when amply fostered shall serve as the cornerstone to KAUH's ability in sustaining the standards of patient safety and quality of hospital care/service it provides to its valued patients.

**Dr. Amro Al-Hibshi**, in his closing remarks, expressed sincere appreciation for the time, attention and support of everyone involved starting with the ACI/CPSI facilitators, all the participants and the organizer of the workshops: Department of Quality with Support Services Department.

**Mr. Hussam Al-Baz** reiterated that the aim in having these workshops is to 'train the trainer', i.e., prepare/enable the participants to cascade the learning in their respective units/departments. The bottom-line is – 'Quality and Patient Safety' is the responsibility of everyone.

By: Mr. Hussam Al-Baz , Director of  
Quality Management Department



**Clinical practice guidelines (CPGs)** can be defined as propositions developed to help the medical practitioner and the patient in their decisions concerning the appropriateness of care in a given clinical setting. CPGs can apply to prevention, diagnostic procedures, treatments or follow up policies of a given disease or group of diseases.

They are typically used to

- a) describe appropriate care based on current scientific evidence and a consensus of healthcare professionals
- b) reduce inappropriate variation in practice
- c) support quality improvement

**Clinical Pathways** is a multidisciplinary care plan that outlines the main clinical interventions that are carried out in the hospital or clinic by a group of professionals responsible for the care of the patient. While pathways are also aimed at providing decision making support in a clinical setting, they may also assist organizations in a number of management issues. For example, risk management, clinical audit, continuity of care, patient flow

management, etc.

**Clinical protocols** are much like clinical practice guidelines, but are adapted to local circumstances. For example, a clinical practice guideline may provide recommendations that cannot be implemented in a specific clinical setting due to resource constraints or availability of healthcare professionals. In this situation protocols can be used that a) incorporate as many recommendations from the CPG as possible; b) describe alternative steps to those not implementable.

# CLINICAL GUIDELINES & PATHWAYS DIFFERENCES

Reference: Policies & Procedures and Evidence-Based Guidelines/ ACI

## Common Mistakes in Root Cause Analysis

**By : Ms. Ahlam Alghanmi , Quality Improvement Consultant**

### **What is Root Cause Analysis?**

Root cause analysis is a problem solving process for conducting an investigation into an identified incident, problem, concern or non-conformity. Root cause analysis is a completely separate process to incident management and immediate corrective action, although they are often completed in close proximity. Root cause analysis (RCA) requires the investigator(s) to look beyond the solution to the immediate problem and understand the fundamental or underlying cause(s) of the situation and put them right, thereby preventing re-occurrence of the same issue. This may involve the identification and management of processes, procedures, activities, inactivity, behaviors or conditions.

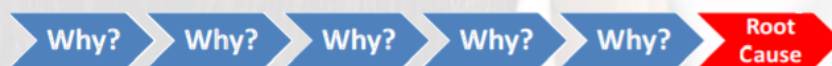
**The benefits of comprehensive root cause analysis include:**

- Identification of permanent solutions
- Prevention of recurring failures
- Introduction of a logical problem solving process

### **Methods of Root Cause Analysis**

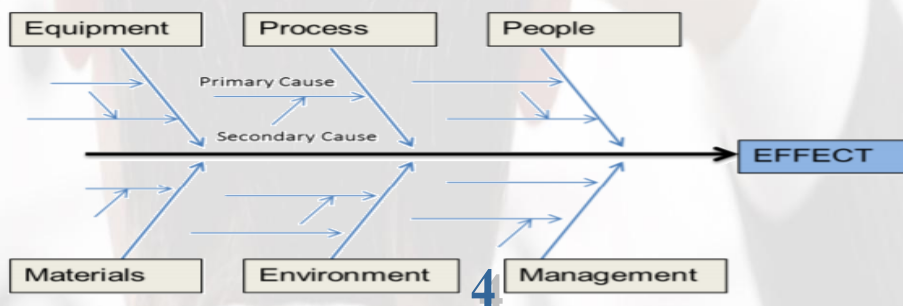
#### **\*The '5 Whys':**

The '5 Whys' is the simplest method for structured root cause analysis. It is a question asking method used to explore the cause/effect relationships underlying the problem. The investigator keeps asking the question 'Why?' until meaningful conclusions are reached.



#### **\*Fishbone Diagrams:**

Fishbone diagrams (sometimes referred to as Ishikawa models or Herringbone diagrams). They are most useful when the '5 whys' is too basic, for example, where a complex issue needs to be considered in bite size pieces or where there is a lot of data that needs to be trended. In the diagram, the various causes are grouped into categories (such as equipment, materials or processes) and the arrows in the image indicate how the causes cascade .



## Common Mistakes :

### 1.Unmanageable Conclusions

The root cause should be something that can be managed or changed, which means that it normally relates to a system or process and occasionally an alterable behaviour. For example, it is often tempting to reach a conclusion such as ‘they forgot’, ‘not enough time’, ‘not enough money’, ‘not enough staff’, ‘staff sickness’ or ‘made a mistake’, these answers may be true, but in most cases they are out of our control, whereas root cause analysis should lead to controllable, manageable or adjustable processes. If these answers are evident it is worth going back into the process to establish whether there is any other cause, for example by asking specific questions such as, ‘Why did the process fail?’ or ‘What system allowed the mistake to be made?’

### 2.Duplication of the Immediate Corrective Action

It is important that immediate action is taken to correct . However, this is separate from the **root cause analysis** and **proposed action plan**. The **purpose of root cause analysis** is to look beyond the immediate action, to investigate what system or process allowed the error to occur. Once this is established, the proposed action plan can focus on ensuring that the system or process is amended such that the fault cannot occur in future. Therefore the **proposed action plan should not be a repeat of the immediate corrective action**.

### 3.People

It is sometimes tempting to reach a conclusion such as; ‘oversight’, ‘mis-understood’, or ‘forgot’, **however people are rarely the true root cause** and the investigator will need to establish what system, policy or process allowed the human error to occur.

### 4.Proposed Action Plan Doesn’t Prevent Re-occurrence

Occasionally, even with root cause analysis and the implementation of a proposed action plan the incident re-occurs. There are a number of potential reasons why this might happen, including:

- Incomplete initial root cause analysis
- Incorrect root cause conclusions (i.e the true root cause was not established)
- Multiple root causes (the proposed action plan needs to manage every root cause)
- Proposed action plan **not fully implemented or trained to staff** In these situations it may be necessary to re-visit the root cause analysis and identify additional causes and appropriate controls.

**Reference :**Understanding Root Cause Analysis -BRC Global Standards .

# ARE WE A PATIENT SAFETY CULTURE?



By : Sana Al-Eidarous , Quality Specialist & Data Analyst

The organization will be considered as patient safety culture when everybody' thought, opinions, act and advocate for patient safety. It consists of four dimensions explained as follow:

1 – informed cultured: which mean every person identify sources of hazards and risks in the institution and act upon reducing this risk areas.

2- Reporting culture: Everyone is encouraging to report when an error happened to a patient (adverse events) or about to happen but caught (near miss). Root cause analysis to explore the factors leading the events.

3-Learning culture: we should learn from our mistakes and errors to prevent reoccurrence of the events on other areas through awareness sessions.

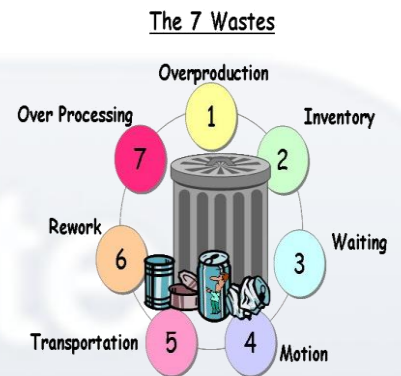
4- A just culture: Mostly people who involve in any error (second victims) feel the shame and impressed. They need the support and encouraged to overcome the situation. It should be differentiated form the negligence.

Base on the above explanation: Are we A patient safety culture organization? Let's work on that.



# seven wastes

By : Yasmeen Ashoor , Quality Coordinator



What are the seven wastes?

The seven wastes are categories of unproductive manufacturing practices identified by Taiichi Ohno, the father of the Toyota Production System (TPS).

The TPS was first launched in the West as Just in Time, or JIT, when the initial visits from the US and Europe to see how Japanese industry had stolen such a march resulted in people returning with stories .

On the following there are seven wastes, categorized by Taiichi Ohno some of them faces everyday activities in healthcare :

- **Overproduction** -- Manufacture of products in advance or in excess of demand wastes money, time and space .An example of Overproduction in healthcare, is lack of discharge planning when patient discharge weekly instead of daily due to physician rounds and Unnecessary diagnostic tests.
- **Waiting** -- Processes are ineffective and time is wasted when one process waits to begin while another finishes. Eg; emergency department patients and physicians waiting for test results. ED patients waiting to be admitted to the hospital.
- **Transportation** -- The waste of transportation occurs when materials are moved around inefficiently. In healthcare it occurs when: Patients are moved from department to department or room to room.

**Inappropriate processing** -- Over-processing means doing more work, making it more complex or more expensive than is necessary. It takes the form of:

- **Ordering complex diagnostic imagery (MRI) when a simpler method would suffice (X-ray) and unnecessary paperwork.**
- **Excessive inventory wastes resources through costs of storage and maintenance. Like medication that may expire and excess bedside equipment.**
- **Unnecessary motion -- Resources are wasted when workers have to reach or walk distances to do their jobs.**  
**Workplace ergonomics assessment should be conducted to design a more efficient environment. Eg; Supplies are not stored where needed and sharing equipment.**
- **Defects -- Inspecting and quarantining inventory takes time and costs money.**

**In healthcare Defect it occur in medication errors and incorrect patient information.**

**References:**

1. <http://www.mlg.uk.com/html/7w.htm>
2. [Whatis.techtarget.com](http://Whatis.techtarget.com)
3. <https://blog.kainexus.com/improvement-disciplines/lean/7-wastes-of-lean-in-healthcare>

# ACI Workshops in the Newspaper

## اختتام ورشتين للتطوير الريادي بمستشفى الجامعة



جماعة المشاركين في الورشتين (مكة)

مكة  
جدة

اختتمت فعاليات ورشتي عمل بمستشفى جامعة الملك عبد العزيز، بعنوان «التطوير الريادي لسلامة المرضى»، وبالشكر والإجراءات في منظمات الرعاية الصحية» التي نظمتها إدارة الجودة بالمستشفى.

وشكر مدير مستشفى الجامعة الدكتور عمرو حبشي الحضور على وجودهم والتزامهم وخص بالذكر المفتشة الكندية إيلين فاووي، لوجودها لمدة 4 أيام بمقر المحاضرات وقسم الجودة على مجهوداتهم الفعالة في إقامة المحاضرات الهادفة إلى تطوير الموظفين والموظفات بالمستشفى والتي على مشاركة قسم الخدمات المساندة على كل ما قدموه من تجهيزات وترتيبات لورشتي العمل وشمل بالشكر إدارة الخدمات المساندة بالمستشفى. وتطلع إلى أن يتم تطبيق كل ما ورد بالمحاضرات والمساهمة في نشرها لنعمة الفائدة المرجوة منها، كما تقدم بالشكر لمدير إدارة الجودة حسام الباز. وأعرب عن تطعمهم إلى أن تسهم هذه الورشتين في نشر ثقافة الجودة في الكادر الطبي وتحقيق الأهداف المرجوة، حيث إن الفترة المقبلة ستشهد مزيداً من الفعاليات التوعوية لإيجاد بيئة صحية مثالية.



