



Quality Café Initiative: A Step Closer to Positive Patient Safety Culture At QCH

Background

- Qatif Central Hospital acknowledges the critical importance of maintaining an exemplary patient safety culture. This commitment to excellence in care delivery led to the
- examination of patient safety culture surveys (AHRQ) conducted in 2019, 2021, and 2022. Through meticulous analysis of these surveys, it became evident that there are specific
- areas demanding focused attention: **response to errors, communication about errors, management support, and reporting safety events.** These findings prompted the
- inception of a targeted initiative aimed at addressing these crucial domains and effecting positive change within our hospital's safety culture (Quality & Patient Safety café).

Why the Quality Café?

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The initiative was created after review of AHRQ patient safety culture surveys conducted in 2019, 2021 and 2022.

1

Response to errors

Focus on how the organization responds to safety events and errors.

2

Communication

Strengthen open communication about errors and safety concerns.

3

Management support

Increase visible leadership support for patient safety.

4

Reporting

Promote reporting of safety events as a learning mechanism.

Quality & Patient Safety Café: a quarterly forum connecting staff voice, leadership engagement, learning and recognition.

From blame & fear to learning & accountability



The challenge

The source presentation describes a need to strengthen patient safety culture through:

- accountability and learning
- leadership support
- patient-centeredness
- staff engagement
- transparent reporting
- change management

DESIRED CULTURE SHIFT





Aim



Primary goal: Our target Over 5 years starting from 2021 is to enhance the positive patient safety culture and increase average positive scores per domain in the Agency for Healthcare Research and Quality (AHRQ) survey by 40%, reaching a minimum of 75% in four selected domains: response to errors, management support, reporting of patient safety, and communication about errors.

Secondary goal: To increase the average of reporting safety events by 60% over 5 years from 2021 to 2025.

SMART Aim & success measures

Five-year target beginning in 2021

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+40%

Increase average positive scores per selected AHRQ domain

≥75%

Target minimum positive score in four selected domains

+60%

Increase average safety-event reporting over five years

2021–2025

Primary improvement horizon

Selected AHRQ domains

Response to errors • Management support • Reporting of patient safety • Communication about errors

Primary goal: enhance positive patient safety culture. Secondary goal: increase reporting of safety events.

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How the Quality Café implements change

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Positive Patient Safety Culture

LEADERSHIP

Engagement & safety walks

LEARNING

Education & safety huddles

REPORTING

Feedback & standardized guidance

RECOGNITION

Risk Hunt & staff rewards



A driving diagram implementing the change

Driver Diagram

SMART Aim

Improve positive patient safety culture by 40% over 5 years

Primary Drivers

Improve reporting patient safety events

Improve leadership support

Secondary Drivers

Improve response to errors

Improve communication about errors

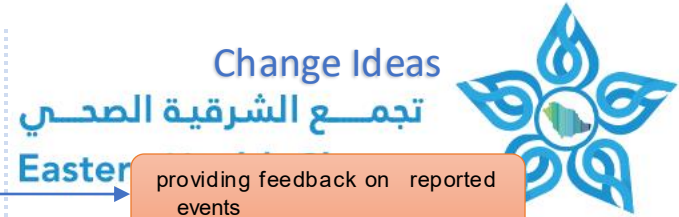
Provide the education

Conduct Safety Huddle

rewarding staff

leadership engagements

Change Ideas



providing feedback on reported events

Provide the education

Automating the reporting system and modifying it as needed

Adopt a rewarding program - Risk Hunt Ambassadors: bronze for adverse events, silver for near-miss reports, and golden for self-report sentinel events.

disseminate lessons learned and patient safety alerts.

Safety education program

Conduct open discussions with top and middle managers to share patient safety concerns by staff

Standardizing the guideline

Risk Hunt program

Patient safety Leadership walks around.



KPI

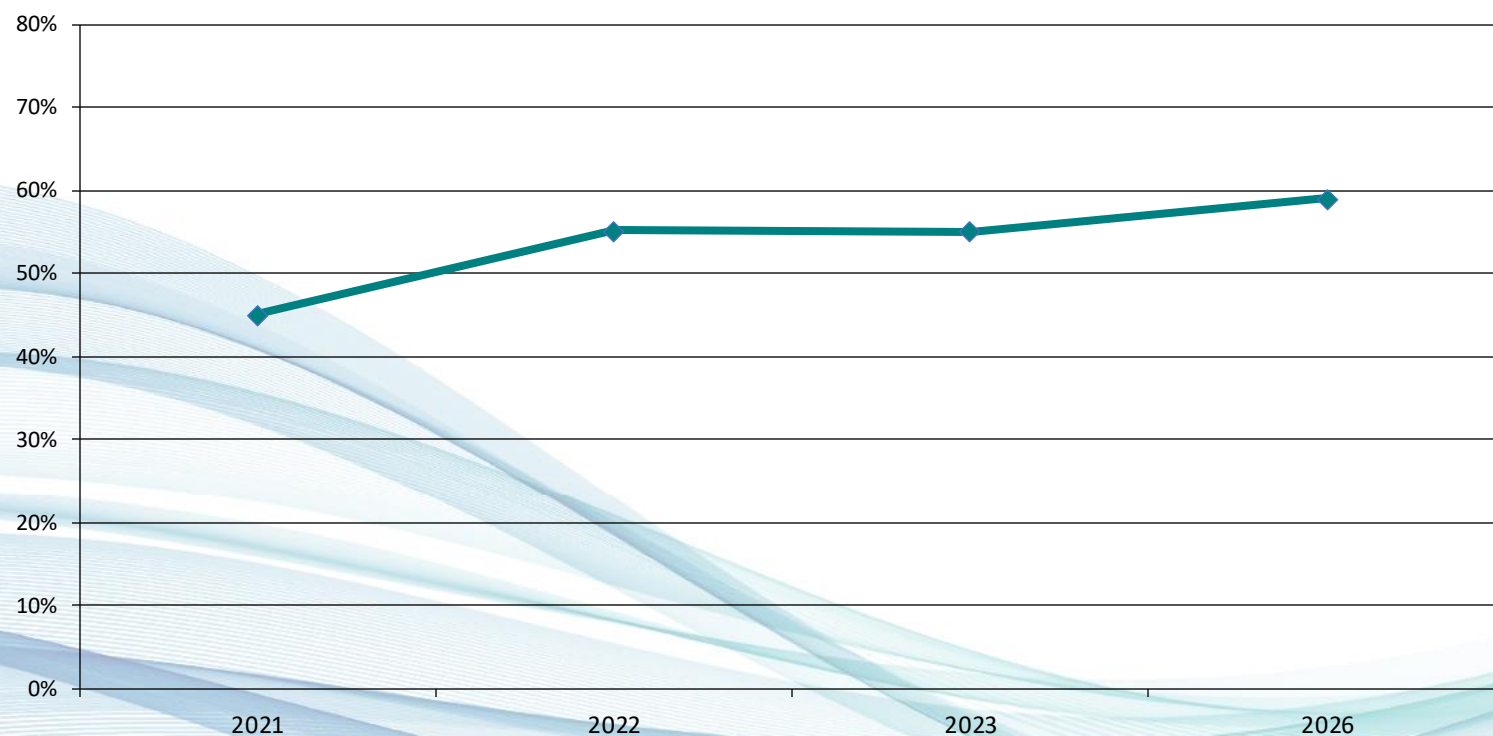


Patient Safety Culture — Average Positive Score per Domain

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Average positive score



2021 baseline

45% average positive score

2026 reported

59% average positive score

Direction

Progress toward the $\geq 75\%$ target

Source: EHC values: 0.45, 0.5516, 0.55, 0.59.

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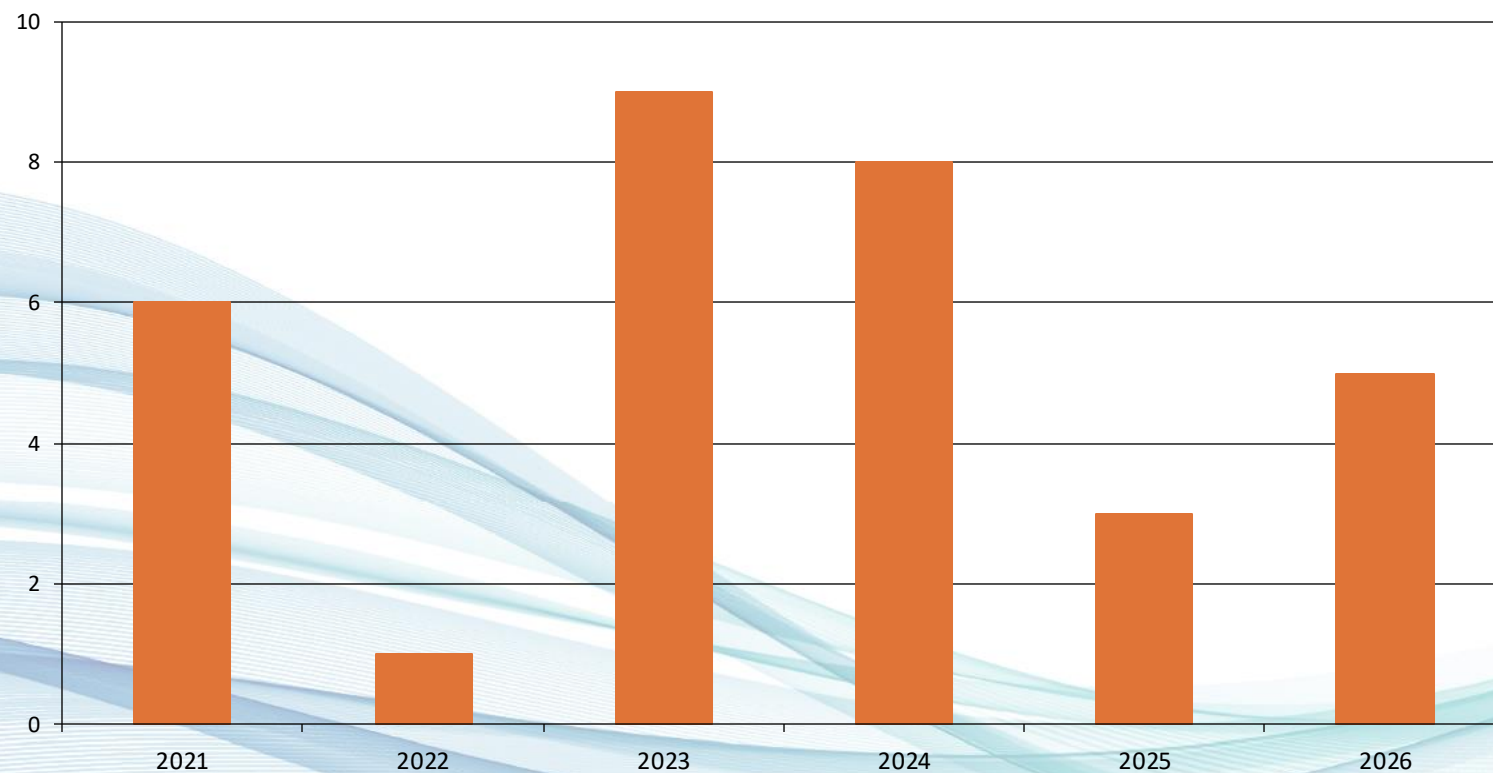
Sentinel Events Reported per Year

Values reproduced from the source presentation

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Sentinel events



6 → 5

Reported sentinel events: 2021 vs 2026

Interpret carefully

Event counts should be interpreted alongside reporting, detection and case-mix context.

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2021 6 | 2022 1 | 2023 9 | 2024 8 | 2025 3 | 2026 5

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Safety Events Reported per Year

Source presentation data, shown as provided



Source table also lists 2020 = 46,235; this value is not plotted with 2021–2025 to preserve scale readability.

Reporting volume

1,358 → 5,600

Pattern

Increasing reported safety events across 2021–2025.

2020 value

46,235 appears in the source table; retained as provided.

Staff awarding 2026

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5



12



21

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What the Initiative Contributed

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+10%

AHRQ patient safety culture result increase reported for 2022 (54%–65%).

100%

Reported survey response rate in 2023.

99%

Reported survey response rate in 2025.

59+

Employees honored for positive impact on safety-event reporting.

+30%

Increase in average safety-event reports, as stated in the source.

+89%

Increase in serious-event reports, as stated in the source.

Sustainability



Continuous evaluation and improvement are identified as the mechanism for sustaining impact and strengthening patient safety engagement.

Content and figures are based on the uploaded QCH Quality Café presentation.