

Study on Assessment to Patient Safety at BLK Super
Speciality Hospital, New Delhi

By

Anamika Jha

*Dissertation submitted in partial fulfillment of the requirements of the degree
MBA Hospital and Health Management*

Academic year, 2017-2019



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TO WHOMSOEVER MAY CONCERN

This is to certify that Anamika Jha, student of MBA Hospital and Health Management from The IIHMR University, Jaipur has undergone internship training at BLK Super Specialty Hospital, New Delhi from 4th February 2019 to 3rd May 2019 April 2019

The Candidate has successfully carried out the study assigned to her during internship training and her approach to the study has been sincere, scientific and analytical.

The Internship is in fulfillment of the course requirements.

I wish her all success in all her future endeavors.

A handwritten signature in blue ink, appearing to read 'Ashok Kaushik'.

Col. (Dr.) Ashok Kaushik

Dean, Academics and Student Affairs

The IIHMR University, Jaipur

A handwritten signature in blue ink, appearing to read 'Sameer Phadnis'.

Dr. Sameer Phadnis

Associate Professor

The IIHMR University, Jaipur

Ref: - BLBLK/HR/2019/May/013

Dated: 05.05.2018

TO WHOMSOEVER IT MAY CONCERN

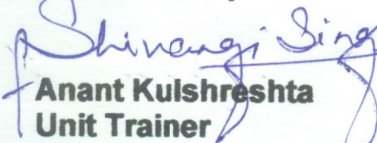
Sub: Internship Completion Letter

This is to certify that **Ms. Anamika Jha** has undertaken Internship Training at BLK Super Speciality Hospital from **2nd February, 2019** to **3rd May, 2019** in the department of **Quality Management**.

During her tenure, her conduct was found to be excellent.

We wish her all the best for her future.

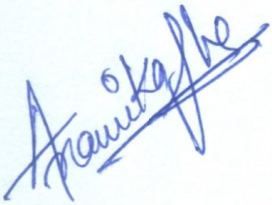
**Yours Sincerely,
For BLK Hospital**


**Anant Kulshreshta
Unit Trainer**



CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled **A Study on Assessment Of Patient Safety In BLK Super Specialty Hospital, New Delhi** and submitted by **Anamika Jha, Enrollment No IIMR-U/01/2017/-19/536** under the supervision of **Dr. Sameer Phadnis** for award of MBA in Hospital and Health of the University carried out during the period from 2nd February to 3rd May embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other institute or other similar institution of higher learning.



Signature

Acknowledgment

I would like to express my hearty thanks to **Mr.Ashok Kaushik** (Dean, IIHMR University) for providing me opportunity to pursue my summer internship at **BLK Super Specialty Hospital, New Delhi.**

I would like to express heartfelt gratitude to the Director, Dr. B. L Kapur Memorial Hospital DR. Anil Handoo for providing me the opportunity to undergo the internship in the esteemed organization.

I sincerely thank my mentor, Dr. Sanjay Durani for supporting us at each step and for providing us opportunities of judicious learning by allotting us projects and always being open for constructive discussions. And also, for giving me opportunity to work with different staffs of hospital.

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I would also like to extend a note of thanks to our mentors at The IIHMR University, Dr. Sameer Phandis for being my constant guides and for always being available whenever I needed their guidance.

Project report

A STUDY On ASSESSMENT OF PATIENT SAFETY IN BLK
SUPER SPECIALTY HOSPITAL, NEW DELHI

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ABSTRACT

TITLE: A Study on Assessment of Patient Safety in BLK Hospital , New Delhi

Name of Author: Anamika Jha

Patient safety goal is one of the important chapter in JCI accreditation of Hospitals. Patient safety goals highlight problematic areas in health care and describe evidence and expert based consensus solutions to these problems. Recognizing that sound system design is intrinsic to the delivery of safe high-quality health care the goals generally focus on system wide solutions wherever possible. WHO Member States agreed on a World Health Assembly resolution on 10 patient safety issues in order to improve patient safety, harm caused by a range of errors, risk of health care associated infection, hand hygiene to reduce health care associated infection, safety of medical equipment, infection due to reused needles, surgical safety, the economic benefit of improving patient safety, perceived higher risk industries had better safety record compared to health care and patient experience and their health.

METHODOLOGY

This study was observational cross sectional study. The study was performed in tertiary care hospitals BLK hospital New Delhi for the periods of 3 months in which all the patient admitted in the hospital and the staff of BLK was audited and observed.

DATA COLLECTION:

Primary data was collected by auditing and observation in BLK hospital through a self-assessment questionnaire tool from JCI 6th edition. The data was collected and then analyzed in excel.

OBJECTIVE

- To assess the adherence to Patient Safety Goals at BLK Super Speciality Hospital as per International Patient Safety Goals Joint Commission International, JCI.
- Suggest the remedial actions for patient safety improvement if any.

KEY RESULT:

In patient identification the patient id band was not checked before collection of blood sample and also patient identification was not done while transferring the patient. In patient communication emergency verbal order were written but not signed by treating doctor within 24 hours. In medication labelling sticker were not placed in high risk and LASA drugs also high risk and LASA drugs were not separately

placed. In surgical safety the procedure under local minimal and moderated sedation was not documented. In hospital acquired infection hand washing is not followed by after and before touching patient also after touching patient surroundings. In fall risk assessment strap belt on wheel while transportation was not done also red ID band is not placed in some of the patients.

CONCLUSION:

From the study it was concluded that patient safety was one of the major area of quality parameter in hospital as patient are the revenue generators of any hospital so their care and safety should be on priority. Depending upon the respondents in various dimensions of patients safety focus areas require continuous quality improvements efforts can be identified and improved.

1. INTRODUCTION:

The purpose of international patient safety goals(IPSG) is to promote specific improvements in Patient safety. The goals highlight problematic areas in health care and describe evidence and expert based consensus solutions to these problems. Recognizing that sound system design is intrinsic to the delivery to safe high-quality health care the goals generally focus on system wide solutions wherever possible.

WHO Member States agreed on a World Health Assembly resolution on 10 patient safety issues in order to improve patient safety, harm caused by a range of errors, risk of health care associated infection, hand hygiene to reduce health care associated infection, safety of medical equipment, infection due to reused needles, surgical safety, the economic benefit of improving patient safety, perceived higher risk industries had better safety record compared to health care and patient experience and their health.

Wrong patient error occurs in virtually all aspects of diagnosis and treatment. Patient may be sedated, disoriented, not fully alert or comatose may change beds, rooms or locations within the hospital may have sensory disabilities may not remember their identity or may be subject to other situations that may lead to error in correct identification. The intent of this goal is two-fold: first, to reliably identify the individual as the person for whom the service or treatment is intended; second to match the service or treatment to that individual.

Effective communication which is entirely accurate complete unambiguous and understood by the recipient reduces errors and results in improved patient safety.

However high alert medications cause harm more frequently and the harm they produce is likely to be more serious when they are given in error. This can lead to increased patient suffering and potentially additional costs associated with caring for these patients.

Significant patient injury and adverse and sentinel events resulting from wrong site, wrong procedure and wrong patient surgery are ongoing concern for hospitals. Such events result from ineffective or inadequate communication between members of team. Hence review of all this step is somewhat become necessary for patient safety.

Infection prevention and control are challenging in most health care settings and rising rates

Of health care associated infection are a major concern for patient and healthcare practitioners.

Many injuries in hospital to both inpatients and outpatients are result of falls. The risk for falls is related to the patients, the situation and / or location. Risk associated with patient might include patient history of

falls medication use alcohol consumptions, gait or balance disturbances visual impairments altered mental status and the like.

1. LITERATURE REVIEW:

International Patient Safety Goals

Standard IPSG.1

The hospital develops and implements a process to improve accuracy of patient identifications.

Intent of IPSG.1

The intent of this goal is twofold: first, to reliably identify the individual as the person for whom the service or treatment is intended; second, to match the service or treatment to that individual.

The identification process used throughout the hospital requires at least two ways in which to identify a patient, such as the patient's name, identification number, birth date, a bar-coded wristband, or other ways. The patient's room number or location cannot be used as identification. These two different identifiers are utilized in all locations within the hospital; for example, in the ambulatory care or other outpatient location, the emergency department, the operating theatre, diagnostic departments and the like.

Two different patient identifiers are required in any circumstance involving patient interventions. For example, patients are identified before providing treatments (such as administering medications, blood, or blood products; serving a restricted diet tray; or radiation.

therapy); performing procedures (such as insertion of an intravenous line or haemodialysis); and before any diagnostic procedures (such as taking blood and other specimens for clinical testing, or performing a cardiac catheterization or diagnostic radiology procedure).

Identification of the comatose patient with no identification is also included.

Measurable Elements of IPSG.1

1. Patients are identified using two patient identifiers, not including the use of the patient's room number or location.
2. Patients are identified before providing treatments and procedures.
3. Patients are identified before any diagnostic procedures.

Goal 2: Improve Effective Communication

Standard IPSG.2

The hospital develops and implements a process to improve the effectiveness of verbal and/or telephonic communication among caregivers.

Standard IPSG.2.1

The hospital develops and implements a process of reporting critical results of diagnostic tests.

Standard IPSG.2.2

The hospital develops and implements a process for handover communication.

Intent of IPSG.2 through IPSG.2.2

Effective communication, which is timely, accurate, complete, unambiguous, and understood by the recipient, reduces errors and results in improved patient safety. Communication can be electronic, verbal, or written. Patient care circumstances that can be critically impacted by poor communication include verbal or telephone patient care orders, verbal or telephone communication of critical test results, and handover communications. Handover communications can also be referred to as handoff communications. The most error-prone communications are patient care orders given verbally and those given over the telephone, when permitted under local laws and regulations. Different accents, dialects, and pronunciations can make it difficult for the receiver to understand the order being given. Background noise, interruptions, and unfamiliar drug names and terminology often compound the problem. Once

received, a verbal order must be transcribed as a written order, which adds complexity and risk to the ordering process.

The reporting of critical results of diagnostic tests is also a patient safety issue. Diagnostic tests include, but are not limited to, laboratory tests, radiology exams, nuclear medicine exams, ultrasound procedures, magnetic resonance imaging, and cardiac diagnostics. This includes critical results from any diagnostic tests performed at the bedside, such as point-of-care testing, portable radiographs, bedside ultrasounds, or transoesophageal echocardiograms. Results that are significantly outside the normal range may indicate a high-risk or life-threatening condition. A formal reporting system that clearly identifies how critical results of diagnostic tests are communicated to health care practitioners and how the information is documented reduces patient risks.

Safe practices for verbal or telephone communications include the following:

- Limiting verbal communication of prescription or medication orders to urgent situations in which immediate written or electronic communication is not feasible. For example, verbal orders can be disallowed when the prescriber is present and the patient's chart is available. Verbal orders can be restricted to situations in which it is difficult or impossible for hard-copy or electronic order transmission, such as during a sterile procedure.
- The development of guidelines for requesting and receiving test results on an emergency or STAT basis, the identification and definitions of critical tests and critical values, to whom and by whom critical test results are reported, and monitoring compliance.
- Writing down (or entering into a computer) the complete order or test result by the receiver of the information; the receiver reading back the order or test result; and the sender confirming that what has been written down and read back is accurate. Permissible alternatives for when the read-back process may not always be possible may be identified, such as in the operating theatre and in emergent situations in the emergency department or Intensive Care Unit.

Handovers of patient care within a hospital occur

- between healthcare providers, such as between physicians and other physicians or health care providers, or from one provider to another provider during shift changes;
- between different levels of care in the same hospital such as when the patient is moved from an intensive care unit to a medical unit or from an emergency department to the operating theatre;

- From inpatient units to diagnostic or other treatment departments, such as radiology or physical therapy.

Breakdowns in communication can occur during any handover of patient care and can result in adverse events. Background noises, interruptions, and other distractions from unit activities can inhibit clear communication of important patient information. Standardized, critical content for communication between the patient, family, caregiver, and healthcare providers can significantly improve the outcomes related to handovers of patient care.

Measurable Elements of IPSG.2

1. The complete verbal order is documented and read back by the receiver and confirmed by the individual giving the order.
2. The complete telephone order is documented and read back by the receiver and confirmed by the individual giving the order.
3. The complete test result is documented and read back by the receiver and confirmed by the individual giving the result.

Measurable Elements of IPSG.2.1

1. The hospital has defined critical values for each type of diagnostic test.
2. The hospital has identified by whom and to whom critical results of diagnostic tests are reported.
3. The hospital has identified what information is documented in the patient record.

Measurable Elements of IPSG.2.2

1. Standardized critical content is communicated between health care providers during handovers of patient care.
2. Standardized forms, tools, and methods support a consistent and complete handover process.
3. Data from handover communications are tracked and used to improve approaches to safe handover communication.

Goal 3: Improve the Safety of High-Alert Medications

Standard IPSG.3

The hospital develops and implements a process to improve the safety of high-alert medications.

Standard IPSG.3.1

The hospital develops and implements a process to manage the safe use of concentrated electrolytes.

Intent of IPSG.3 and IPSG.3.1

When medications are part of the patient treatment plan, appropriate management is critical to ensuring patient safety. Any medication, even those that can be purchased without a prescription, if used improperly can cause injury. However, high-alert medications cause harm more frequently, and the harm they produce is likely to be more serious when they are given in error. This can lead to increased patient suffering and potentially additional costs associated with caring of these patients.

High-alert medications include

- medications that are involved in a high percentage of errors and/or sentinel events, such as insulin, heparin, or chemotherapeutics; and
- Medications whose names, packaging and labelling, or clinical use, look alike and/or or sound alike, such as Xanax and Zantac or hydralazine and hydroxyzine.

There are many medication names that sound or look like other medication names. Confusing names is a common cause of medication errors throughout the world. Contributing to this confusion is

- incomplete knowledge of drug names;
- newly available products;
- similar packaging and labelling;
- similar clinical use;
- similar strengths, dosage forms, and frequency of administration; and
- Illegible prescriptions or misunderstanding during issuing of verbal orders.

A frequently cited medication safety issue is the incorrect or unintentional administration of concentrated electrolytes. Errors can occur when staffs are not properly oriented to the patient care unit, when contract nurses are used and not properly oriented, or during emergencies. The most effective means to reduce or to eliminate these occurrences is to develop a process for managing high-alert medications that includes removing the concentrated electrolytes from the patient care units to the pharmacy.

The hospital makes a list of all medications that pose a significant risk to patients using hospital data related to medication use within the hospital, adverse and near-miss events, and other relevant information. The list includes medications identified as high risk for adverse outcomes as well as those at risk for look-alike/sound-alike confusion. These medications are stored in a way that reduces the likelihood of inadvertent administration or ideally provides directions on the proper use of the medication. Strategies to improve the safety of high-alert medications maybe tailored to the specific risk of each medication and should include consideration of prescribing, preparation, administration, and monitoring processes, in addition to safe storage strategies. The hospital also identifies any areas where concentrated electrolytes are clinically necessary as determined by evidence and professional practice, such as the emergency department or operating theatre, and identifies how they are clearly labelled and how they are stored in those areas in a manner that restricts access to prevent inadvertent administration.

Measurable Elements of IPSG.3

1. The hospital has a list of all high-alert medications, including look-alike/ sound-alike medications, that is developed from hospital-specific data.
2. The hospital implements strategies to improve the safety of high-alert medications, which may include specific storage, prescribing, preparation, administration, or monitoring processes.
3. The location, labelling and storage of high-alert medications, including look-alike/ sound-alike medications, is uniform throughout the hospital.

Measurable Elements of IPSG.3.1

1. The hospital has a process that prevents inadvertent administration of concentrated electrolytes.
2. Concentrated electrolytes are present only in patient care units identified as clinically necessary.
3. Concentrated electrolytes that are stored in patient care units are clearly labeled and stored in a manner that promotes safe use.

Goal 4: Ensure Correct-Site, Correct-Procedure,Correct-Patient Surgery

Standard IPSG.4

The hospital develops and implements a process for ensuring correct-site, correct-procedure, and correct-patient surgery.

Standard IPSG.4.1

The hospital develops and implements a process for the time-out that is performed in the operating theatre immediately prior to the start of surgery to ensure correct-site, correct-procedure, and correct-patient surgery.

Intent of IPSG.4 and IPSG.4.1

Wrong-site, wrong-procedure, wrong-patient surgery is an alarmingly common occurrence in hospitals. These errors are the result of ineffective or inadequate communication between members of the surgical team, lack of patient involvement in site marking, and lack of procedures for verifying the operative site. In addition, inadequate patient assessment, inadequate medical record review, a culture that does not support open communication among surgical team members, problems related to illegible handwriting, and the use of abbreviations are frequent contributing factors.

Surgery and invasive procedures include all procedures that investigate and/or treat diseases and disorders of the human body through cutting, removing, altering, or insertion of diagnostic/therapeutic scopes. Organizations need to identify all areas within the hospital where surgical and invasive procedures take place. The approach the hospital takes to ensuring correct-site, correct-procedure, and correct-patient surgery applies to all areas of the hospital in which surgical and invasive procedures occur.

The essential processes found processes found in the Universal Protocol are

- marking the surgical site;
- a preoperative verification process; and
- A time-out that is held immediately before the start of a procedure.

Marking the surgical and invasive procedure site involves the patient and is done with an instantly recognizable mark. The mark must be consistent throughout the hospital; must be made by the person performing the procedure; should take place with the patient awake and aware, if possible; and must be visible after the patient is prepped and draped. The surgical site is marked in all cases involving laterality, multiples structures (fingers, toes, lesions), or multiple levels (spine).

The purpose of the preoperative verification process is to

- verify the correct site, procedure, and patient;
- ensure that all relevant documents, images, and studies are available, properly labelled, and displayed; and
- Verify that any required special medical technology and/or implants are present.

There are various elements of the preoperative verification process that can be completed before the patient arrives at the preoperative area-such as ensuring that documents, imaging and test results, and paperwork are properly labelled and available; and marking the surgical site. In fact, waiting until the time-out to complete the preoperative verification process may unnecessarily delay surgery if paperwork or imaging are not labeled and available when surgery is about to begin. It is more likely that portions of the preoperative verification may occur more than once and in more than one place. For example, the surgical consent may be obtained in the surgeon's office and then verification that it is completed may take place in the preoperative holding area; marking the surgical site may occur in the preoperative holding area; and verifying that the right medical technology is available may occur in the operating theatre.

The time-out, held immediately before the start of the procedure with all team members present, permits any unanswered questions or confusion to be resolved. The time-out is conducted in the location at which the procedure will be done, just before starting the procedure, and involves the entire new operative team. The team does not have to participate in the time-out procedure. The hospital determines how the time-out process is to be documented.

Measurable Elements of IP SG.4

1. The hospital uses an instantly recognizable mark for surgical-and invasive procedure- site identification that is consistent throughout the hospital.
2. Surgical-and invasive procedure-site marking is done by the person performing the procedure and involves the patient in the marking process.
3. The hospital uses a checklist or other process to document, before the procedure, that the informed consent is appropriate to the procedure; that the correct site, correct procedure, and correct patient are identified; and that all documents and medical technology needed are on hand, correct, and functional.

Measurable Elements of IP SG.4.1

1. The full surgical team conducts and documents a time-out procedure in the area in which the surgery/invasive procedure will be performed, just before starting a surgical/invasive procedure.
2. The components of the time-out include correct patient identification, correct side and site, agreement of the procedure to be done, and confirmation that the verification process has been completed.
3. When surgery is performed, including medical and dental procedures done in settings other than the operating theatre, the hospital uses uniform processes to ensure the correct site, correct procedure, and correct patient.

Goal 5: Reduce the Risk of Health Care-Associated Infections

Standard IP SG.5

The hospital adopts and implements evidence-based hand-hygiene guidelines to reduce the risk of health-care associated infections.

Intent of IP SG.5

Infection prevention and control are challenging in most healthcare settings, and rising rates of healthcare-associated infections are a major concern for patients and healthcare practitioners. Infections common to all healthcare settings include catheter-associated urinary tract infections, bloodstream infections, and pneumonia (often associated with mechanical ventilation).

Central to the elimination of these and other infections is proper hand hygiene. The hospital adopts and implements currently published evidence-based hand-hygiene guidelines. Hand-hygiene guidelines are posted in appropriate areas, and staff is educated in proper hand-washing and hand-disinfection procedures. Soap, disinfectants, and towels or other means of drying are located in those areas where hand-washing and hand-disinfecting procedures are required.

Measurable Elements of IP SG.5

1. The hospital has adopted currently published, evidence-based hand-hygiene guidelines.
2. The hospital implements an effective hand-hygiene program throughout the hospital.
3. Hand-washing and hand-disinfection procedures are used in accordance with hand-hygiene guidelines throughout the hospital.

Goal 6: Reduce the Risk of Patient Harm Resulting from Falls

Standard IP SG.6

The hospital develops and implements a process to reduce the risk of patient harm resulting from falls.

Intent of IPSG.6

Many injuries in hospitals to both inpatients and outpatients are a result of falls. The risk of falls is related to the patient, the situation, and/or the location. Risks associated with patients might include patient history of falls, medications use, alcohol consumption, gait or balance disturbances, visual impairments, altered mental status, and the like. Patients who have been initially assessed to be at low risk for falls may suddenly become at high risk. Reasons include, but are not limited to, surgery and/or anaesthesia, sudden changes in patient condition, and adjustment in medications. Many patients require reassessment during their hospitalization. Documented criteria identify the types of patients who are considered at high risk for falls.

An example of a situational risk is the patient who arrives at the outpatient department from a long term care facility via ambulance for a radiologic examination. The patient may be at risk for falls in that situation when transferring from ambulance cart to exam table, or when changing positions while lying on the narrow exam table. Specific locations may present higher fall risks because of the services provided. For example, a physical therapy department has many types of specialized equipment used by patients that may increase the risk of fall, such as parallel bars, freestanding staircases, and exercise equipment.

In the context of the population it serves, the services it provides, and its facilities, the hospital should evaluate patient falls and take action to reduce the risk of falling and to reduce the risk of injury should a fall occur. A fall reduction program may include risk assessment and periodic reassessment of a particular patient population and/or of the environment in which care and services are provided. The hospital has responsibility to identify the locations, situations, and types of patients who may be at high risk for fall.

The hospital establishes a fall risk reduction program based on appropriate policies and/or procedures. The program monitors both the intended and unintended consequences of measures taken to reduce falls. For example, the inappropriate use of physical restraints or fluid intake restriction may result in injury, impaired circulation, or compromised skin integrity.

Measurable Elements of IP SG.6

1. The hospital implements a process for assessing all inpatients and those outpatients whose condition, diagnosis, situation or location identifies them as at high risk for fall.
2. The hospital implements a process for the initial and ongoing assessment, reassessment, and intervention of inpatients and outpatients identified as at risk for falls based on documented criteria.
3. Measures are implemented to reduce fall risk for those identified patients, situations, and locations assessed to be at risk.

3 RESEARCH QUESTION:

- What is the adherence to patient safety goals in BLK Super Speciality hospital?

4 OBJECTIVES:

- To assess the adherence to Patient Safety Goals at BLK Super Speciality Hospital as per International Patient Safety Goals Joint Commission International, JCI.
- Suggest the remedial actions for patient safety improvement if any.

5 MATERIALS AND METHODS:

STUDY DESIGN: observational cross-sectional study

SAMPLE SIZE–210 respondents which includes all the staff and the patients who are admitted in hospital.

STUDY TECHNIQUE: Observation and Documented Review.

DATA COLLECTION TOOL – Questionnaire (Structured)

SAMPLING METHOD: non-probability convenience sampling

INCLUSION CRITERIA: all the staff and patient who are admitted in hospital.

EXCLUSION CRITERIA: OPD patients.

6. METHODOLOGY:

The study design was cross sectional observational study which was carried out the period of two months in a tertiary care hospital, New Delhi.

The data collection tool was used administered questionnaire which was prepared by using International Patient Safety Goals as per JCI standard.

Based on the questionnaire the checklist was prepared as the each goal has been studied. The study pattern includes both observation and audit of various areas and remarks was given in the form of compliance (C) or non-compliance (NC)

The data then analyzed in excel.

7. RESULT:

TABLE 7.1 PATIENT IDENTIFICATION:

ACTIVITIES	COMPLIANCE	NON COMPLIANCE	TOTAL
Patient name and MRD no.	50	0	50
patient ID band checked before blood collection - nursing station	40	10	50
ID band while transferring the patient	35	15	50
vacutainor or bottle labeled before withdrawing the blood	50	0	50
new born applied for identification	50	0	50
ID band for patient in (emergency, dialysis, endoscopy, executive health check up, radiation oncology, bronchoscopy, minor OT, nuclear medicine	46	4	50

ACTIVITIES	% COMPLIANCE	% NON COMPLIANCE	% TOTAL
Patient name and MRD no.	100	0	100
patient ID band checked before blood collection - nursing station	80	20	100
ID band while transferring the patient	70.00	30.00	100
vacutainor or bottle labelled before withdrawing the blood	100	0	100
new born applied for identification	100	0	100
ID band for patient in (emergency, dialysis, endoscopy, executive health check up, radiation oncology, bronchoscopy, minor OT, nuclear medicine	92	8	100
OVERALL PERCENTAGE	90.33	9.66	

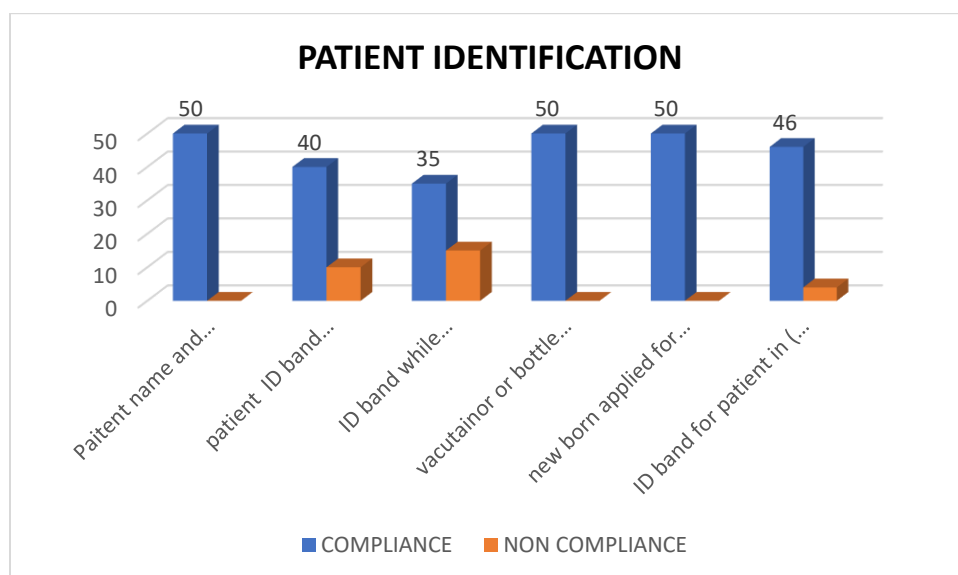
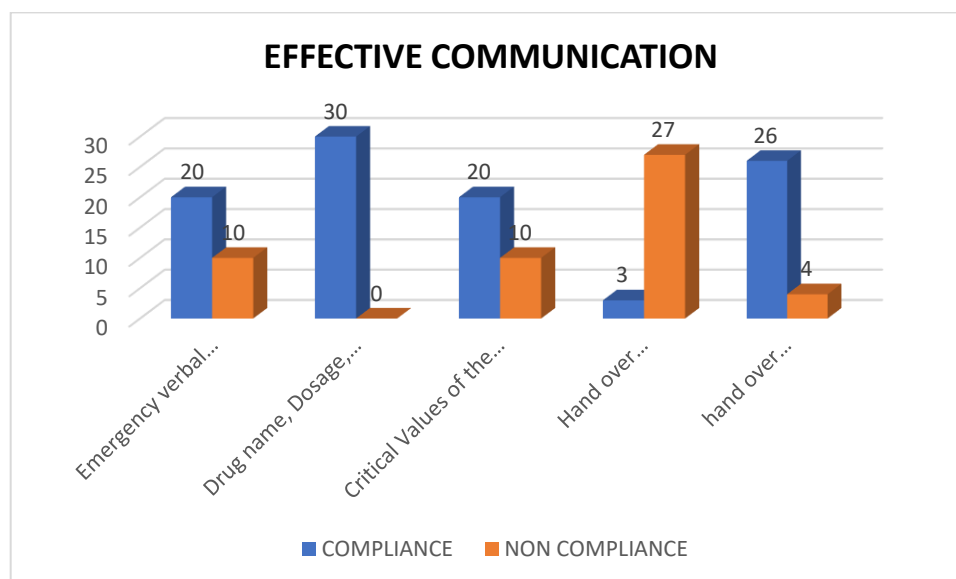




TABLE 7.2 EFFECTIVE COMMUNICATIONS:

ACTIVITY	COMPLIANCE	NON COMPLIANCE	TOTAL
Emergency verbal order maintained & documented with name, date and time (24 hrs. signature)	20	10	30
Drug name, Dosage, Strength and concentration with frequency	30	0	30
Critical Values of the test reported to the doctor documented in critical callout register (laboratory/radiology)	20	10	30
Hand over communications present in patient files	3	27	30
hand over communication duly filled and signed by nurse with instructions	26	4	30

Communication:-	% COMPLIANCE	% NON COMPLIANCE	TOTAL %
Emergency verbal order maintained & documented with name, date and time (24 hrs. signature)	66.67	33.33	100
Drug name, Dosage, Strength and concentration with frequency	100	0	100
Critical Values of the test reported to the doctor documented in critical callout register (laboratory/radiology)	66.67	33.33	100
Hand over communications present in patient files	10	90	100
hand over communication duly filled and signed by nurse with instructions	86.67	13.33	100
OVERALL PERCENTAGE	66	34	



OVERALL COMPLIANCE

■ % COMPLIANCE ■ % NON COMPLIANCE

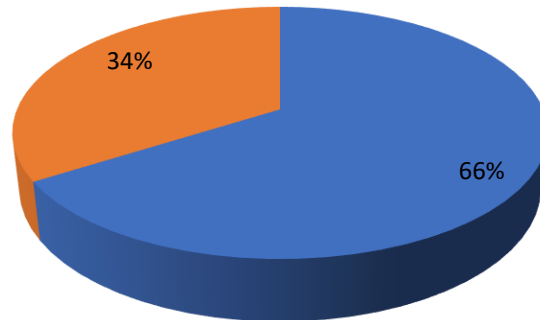
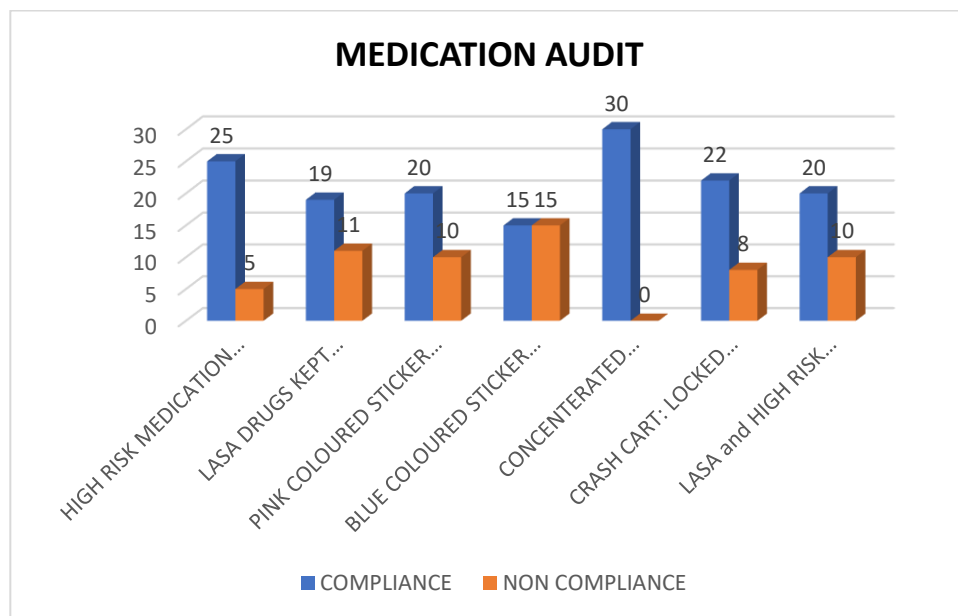


TABLE 7.3 IMPROVE SAFETY OF HIGH ALERT MEDICATION:

ACTIVITY/OBSERVATION	COMPLIANCE	NON COMPLIANCE	TOTAL
high risk medication listed area wise	25	5	30
LASA drugs kept separately	19	11	30
pink colored sticker on LASA medication	20	10	30
blue colored sticker on sound alike medication	15	15	30
concentrated electrolytes present in OT ICU and emergency	30	0	30
crash cart: locked LASA and high risk medication is separate	22	8	30
LASA and high risk medication storage is separate or not	20	10	30

ACTIVITY/OBSERVATION	% COMPLIANCE	% NON COMPLIANCE	TOTAL (%)
high risk medication listed area wise	83.33	16.67	100
LASA drugs kept separately	63.33	36.67	100
pink colored sticker on LASA medication	66.67	33.33	100
blue colored sticker on sound alike medication	50.00	50.00	100
concentrated electrolytes present in OT , ICU and emergency	100	0	100
crash cart: locked LASA and high risk medication is separate	73.33	26.67	100
LASA and high risk medication storage is separate or not	66.67	33.33	100
OVERALL PERCENTAGE	71.9	28.1	



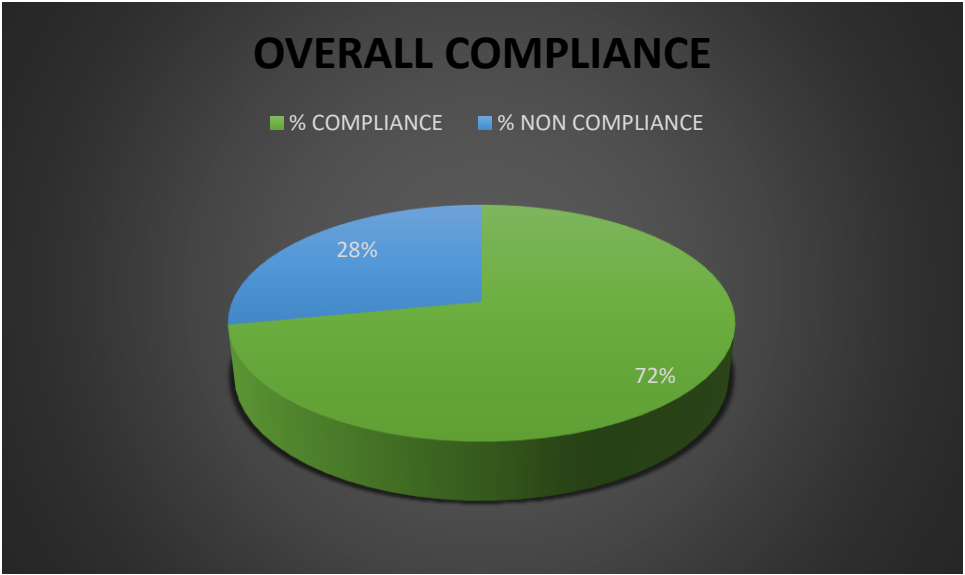
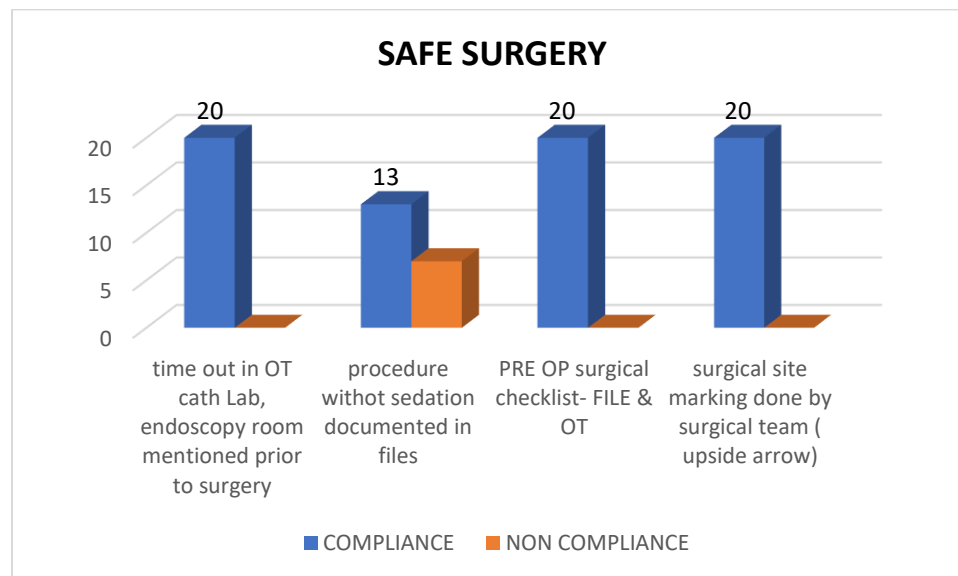


TABLE 7.4 ENSURES CORRECT SURGERY:

ACTIVITY	COMPLIANCE	NON COMPLIANCE	TOTAL
time out in OT cath Lab, endoscopy room mentioned prior to surgery	20	0	20
procedure with local minimal and moderate sedation documented in files	13	7	20
PRE OP surgical checklist- FILE & OT	20	0	20
surgical site marking done by surgical team (upside arrow)	20	0	20

ACTIVITY	% COMPLIANCE	% NON COMPLIANCE	% TOTAL
time out in OT cath Lab, endoscopy room mentioned prior to surgery	100	0	100
procedure withot sedation documented in files	65	35	100
PRE OP surgical checklist- FILE & OT	100	0	100
surgical site marking done by surgical team (upside arrow)	100	0	100
OVERALL PERCENTAGE	91.25	8.75	



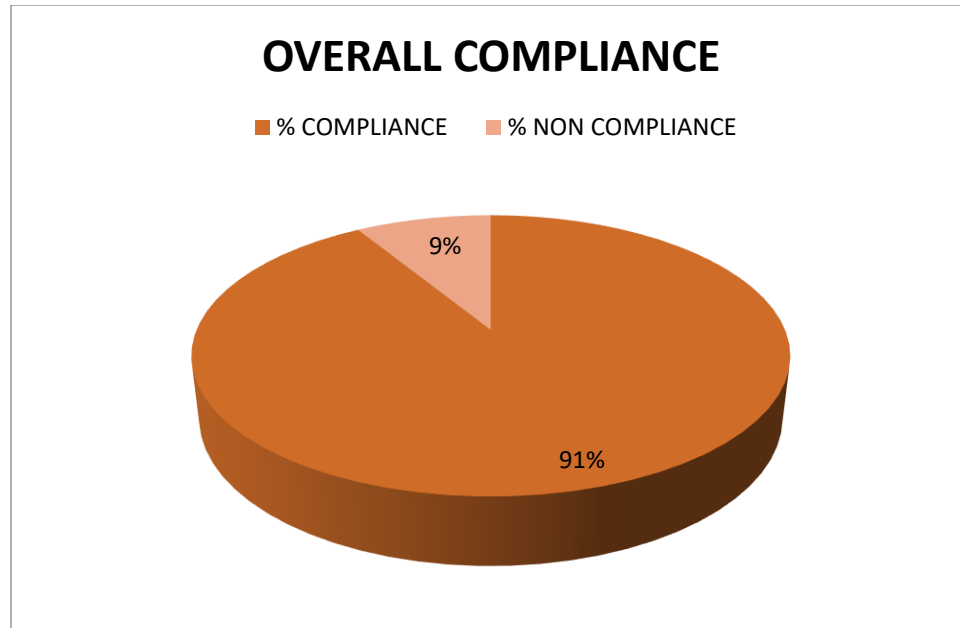
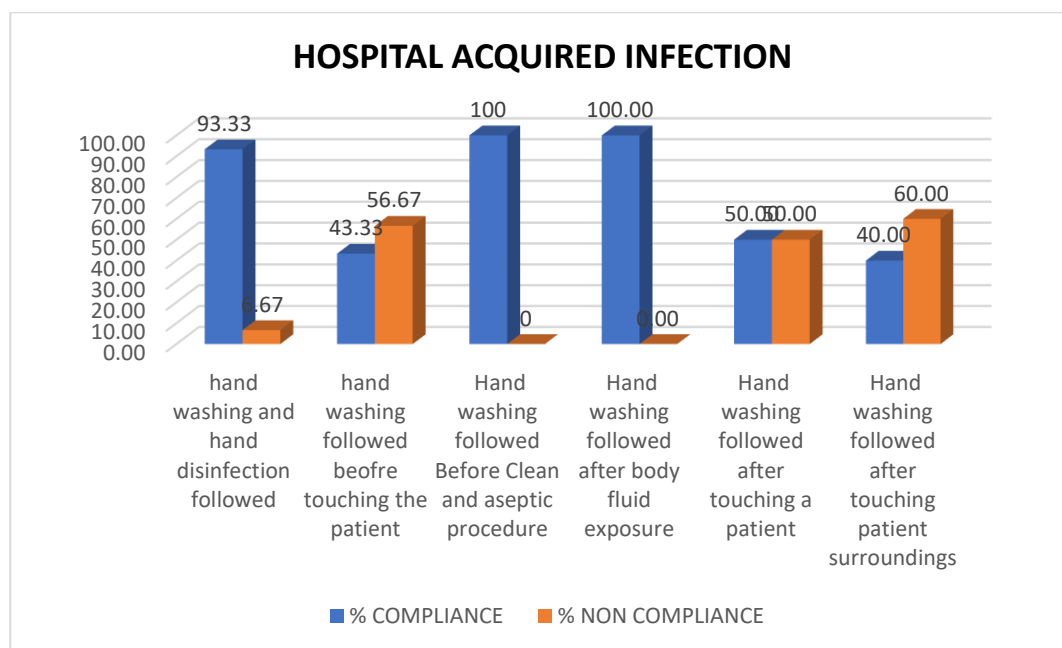


TABLE 7.5 REDUCE THE RISK OF HOSPITAL ACQUIRED INFECTION:

ACTIVITY	COMPLIANCE	NON COMPLIANCE	TOTAL
hand washing and hand disinfection followed	28	2	30
hand washing followed before touching the patient	13	17	30
Hand washing followed Before Clean and aseptic procedure	30	0	30
Hand washing followed after body fluid exposure	30	0	30
Hand washing followed after touching a patient	15	15	30
Hand washing followed after touching patient surroundings	12	18	30

ACTIVITY	% COMPLIANCE	% NON COMPLIANCE	TOTAL (%)
hand washing and hand disinfection followed	93.33	6.67	100
hand washing followed before touching the patient	43.33	56.67	100
Hand washing followed Before Clean and aseptic procedure	100	0	100
Hand washing followed after body fluid exposure	100.00	0.00	100
Hand washing followed after touching a patient	50.00	50.00	100
Hand washing followed after touching patient surroundings	40.00	60.00	100
OVERALL PERCENTAGE	71.11	28.89	



OVERALL COMPLIANCE

■ % COMPLIANCE ■ % NON COMPLIANCE

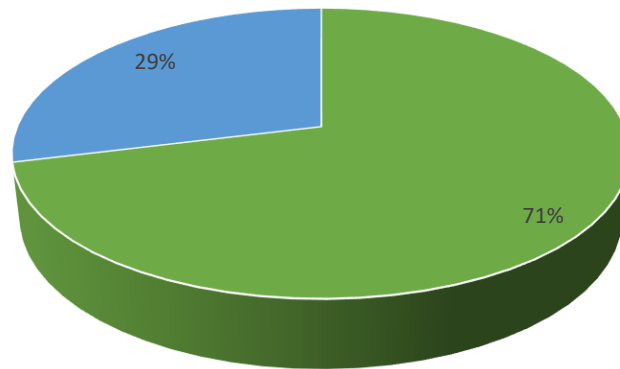
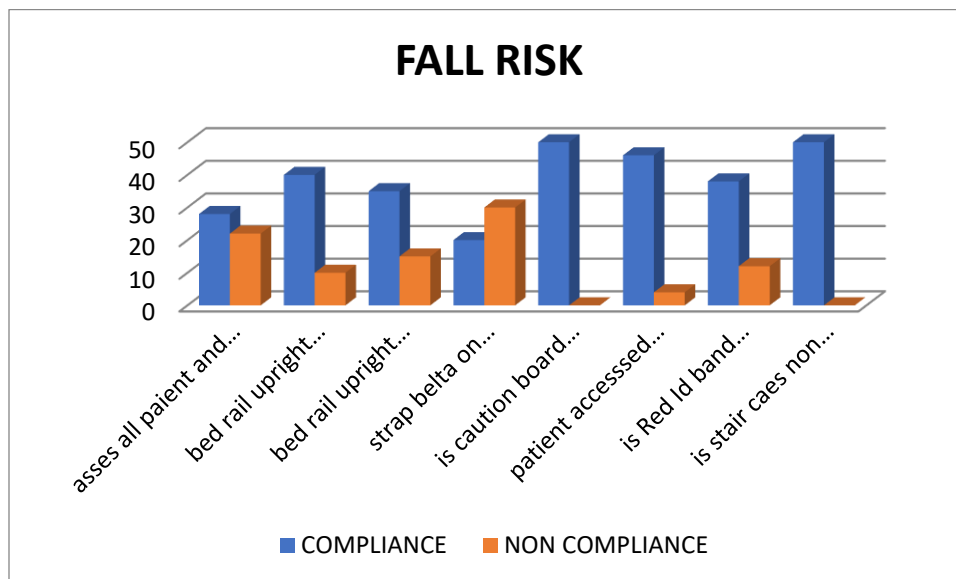
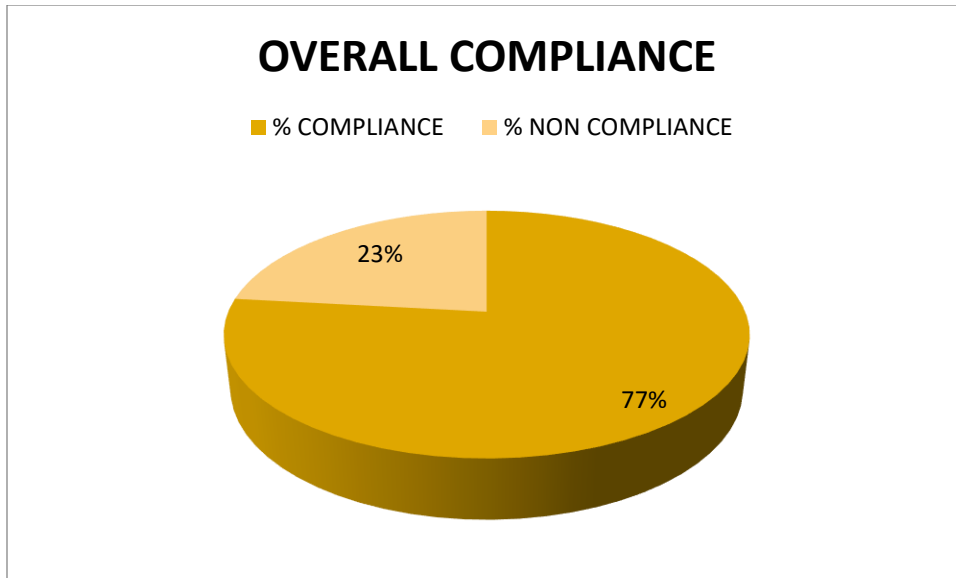


TABLE 7.6 REDUCE THE RISK OF PATIENT FALL:

ACTIVITY/ OBSERVATION	COMPLIANCE	NON COMPLIANCE	TOTAL
asses all patient risk for fall	28	22	50
bed rail upright while room risk off fall	40	10	50
bed rail upright while transportation	35	15	50
strap belt on wheel chair while transporting	20	30	50
is caution board placed moping on floor	50	0	50
patient accessed by nurse on daily basis and documented	46	4	50
is Red Id band present in patient	38	12	50
is stair case non slippery and obstruction free	50	0	50

ACTIVITY/ OBSERVATION	% COMPLIANCE	% NON COMPLIANCE	TOTAL%
asses all patient and outpatients risk for fall	56	44	100
bed rail upright while room risk off fall	80	20	100
bed rail upright while transportation	70	30	100
strap belt on wheel chair while transporting	40	60	100
is caution board placed moping on floor	100	0	100
patient accessed by nurse on daily basis and documented	92	8	100
is Red Id band present in patient	76	24	100
is stair case non slippery and obstruction free	100	0	100
OVERALL PERCENTAGE	76.75	23.25	





8. DISCUSSION:

All the six goals were studied which includes patient identification (six dimensions and 50 observation were made,) effective communication(five dimensions and 30 observation were made), ensure safety of medication (seven dimensions and 30 observation were made), ensure safe surgery (four dimensions and 20 observation were made), reduce risk of hospital acquired infection (six dimensions and 30 observation were made) and reduce risk of patient fall (eight dimensions and 50 observation were made) . All these goals were audited and observation were made accordingly the following are the reasons of non-compliance in the specific areas.

The reasons of lowest compliance in the following areas are:

1. In patient identification the patient id band was not checked before collection of blood sample and also patient identification was not done while transferring the patient.
2. In patient communication emergency verbal order were written but not signed by treating doctor within 24 hours.
3. In medication labelling sticker were not placed in high risk and LASA drugs also high risk and LASA drugs were not separately placed.
4. In surgical safety the procedure under local minimal and moderated sedation was not documented.

5. In hospital acquired infection hand washing is not followed by after and before touching touching patient also after touching patient surroundings.
6. In fall risk assessment strap belt on wheel while transportation was not done also red ID band is not placed in some of the patients.

9. LIMITATIONS:

- Cross sectional study.
- Limited duration of time
- Since it is observational, one time study and for the exact duration follow up study needed hence non compliance cannot be defined.

10. CONCLUSIONS:

From the study it was concluded that patient safety was one of the major area of quality parameter in hospital as patient are the revenue generators of any hospital so their care and safety should be on priority. Depending upon the respondents in various dimensions of patients safety it was observed that adherence in the hospital is quite better some areas are working excellent whereas some are not. It is really the responsibility of the hospital to sensitize the staff regarding patient safety and train them on regular basis as it is the base and standard of any organization.

11. SUGGESTIONS:

- Regular training and update sessions for every employee for their regular up gradation about quality parameters.
- Staff should be sensitized about the fall risk involved due to noncompliance of strap belt on wheelchairs.
- Regular audits of documentation should be done and the respected team should be trained accordingly.
- Staff should be sensitized about the hospital acquired infection and importance of five movements of hand hygiene.

APPENDICES

Department :-

Date:-

Ward no :-

Patient Safety Questionnaire	Audit	Observation
Patient Identification :-		
Patient name and MRD number (Patient File)		
Patient ID band with two ID placed on the Patient		
Patient ID band checked before blood sample collection- Nursing station		
Patient ID band checked before administering the drugs		
ID band are there while transferring the patient		
Vacutainer or bottle labelled before withdrawing the blood.		
New born applied for identification (NICU & Nursery)		
ID band for patient in (emergency, dialysis,endoscopy,interventional radiology,radiation oncology, bronchoscopy,executive health checkup,minor OT and nuclear medicine).		
Communication:-		
Emergency verbal order maintained & documented with name, date and time (24 hrs. signature)		
Drug name, Dosage, Strength and concentration with frequency		
Critical Values of the test reported to the doctor documented in critical callout register (laboratory/radiology)		
Hand over communications present in patient files		
Hand Over communication duly filled and signed with special instruction.(nurses)		
Medication :-		
Are all high alert medications listed area wise		
LASA (Look Alike & Sound Alike)drugs kept separately and uniformly		
Pink coloured warning sticker label on Look Alike Medications cupboard		
Blue coloured warning sticker label on Sound Alike Medications		
Concentrated electrolytes only present in ICU, OT and Emergency		

Crash cart: Locked , LASA and High risk medication storage is separate or not		
Surgical Safety :-		
Time out in OT, Cath lab, Endoscopy room mentioned prior to surgery		
Procedure with local minima and moderate sedation documented		
Pre op Surgical checklist -FILE & OT		
Surgical site marking done by surgical team (upper side arrow)		
Health care Associated Infection:-		
Hand washing and hand disinfection followed		
Hand washing followed before touching the patient		
Hand washing followed before Clean and aseptic procedure		
Hand washing followed after body fluid exposure		
Hand washing followed after touching a patient		
Hand washing followed after touching patient surroundings		
Fall :-		
Assess all inpatients and outpatients for risk of fall		
Bed rails upright while at the room-RISK OF FALL		
Bed rails upright while transportation		
Strap belts on wheel chair while transporting		
Is caution board Placed moping the floor		
Patient accessed by nurse on daily basis and documented		
Is Red ID band present on the patient		
Is Stair case non slippery and obstruction free		

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