

Risk Register for Clinical Departments at Thumbay Hospital-
Ajman,U.A.E

By

Shimona Seth

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

Academic year, 2017-2019



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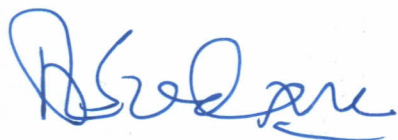
TO WHOMSOEVER MAY CONCERN

This is to certify that Dr. Shimona Seth, student of MBA Hospital and Health Management from The IIHMR University, Jaipur has undergone internship training at Thumbay Hospital, Ajman from 24th February to 20th May, 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 his future endeavors.



Dr. P.R. Sodani

Pro - President

The IIHMR University, Jaipur



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May 20, 2019

To Whom It May Concern

This is to certify that Dr. Shimona Seth holder of Indian Passport Number N9790272 has undergone internship in our organization from 24th February 2019 till 20th May 2019, as a part of dissertation of her MBA in Hospital and Health Management program. She has completed the assigned project.

We wish all the best for her future endeavor.

For Thumbay University Hospital Complex, Ajman



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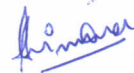
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CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled -A Study on Risk Register for Clinical Departments at Thumbay Hospital- Ajman, U.A.E and submitted by Dr Shimona Seth Enrolment No. MBA -HM22 under the supervision of Dr P.R Sodani for award of MBA in Hospital and Health in Health and Hospitals of the University carried out during the period from 24-2-2019 to 20-5-2019 embodies my original work and has not formed the basis for the award of any degree, diploma association, fellowship, titles in this or any other institute or other similar institution of higher learning.


Signature

ABSTRACT

The best quality of care to patients is the responsibility of hospital. Due to increased rate of medical errors there has been alarming rate of adverse events related to patient safety. To combat the situation of preventing error, a systematic approach was defined by the medical and the administrative staff is adopted to reduce the adverse events in the hospital. The aim of the study was to prepare and implement the risk register for all the clinical departments of the Thumbay hospital. The objectives of study was to develop the staff knowledge on clinical risk register, creating a patient safety culture amongst staff, improving the adherence to compliance with Hospital's policy on risk management and achieving the equal status on implementation of risk register with other healthcare units of Thumbay Group. The study done was a cross-sectional study and both primary research and secondary research was used for data collection. The primary research included the interviews with the key stakeholders, brainstorming for the significant risks, predefined checklists for common risks and affinity diagram where participants wrote down risks and then risks sorted into defined categories. The secondary research was done by using Incident reports of past 1 year, online research and hospital quality department's database. A validated risk register template was used to register risks pertaining to each clinical department. The results showed that in total 99 clinical risks were identified. Out of which 49 risks had actually taken place in past and 50 risks had potential to occur in future. This paved the way to design mitigation strategies to prevent the probability of adverse events in future. On the basis of these observations it was concluded that the management of clinical risks in a hospital is a way to identify and prevent medical errors and adverse events from happening and thereby, ensuring patient as well as staff safety.

Acknowledgement

The successful completion of the project is always due to collaborative team effort. It always requires the support, active participation and learning experience of the members to fulfil the needs of the project. My dissertation project was also the same. First, I would like to thank my parents for their support and for always being there to appreciate my efforts.

I would like to extend my gratitude The IIHMR University for providing me knowledge which helped me in understanding the details of the project. I would also like to thank Dr P.R Sodani for guiding at every step.

A note of thanks to Dr Pawan Gupta who provided me the opportunity to work on Risk Register for Thumbay Hospital, Ajman which has not only helped me to learn about the probable risks in patient and employee safety but also an exposure to work in a team.

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List of Abbreviations:

RM- Risk Management

CRM-Clinical Risk Management

MR-Medical Records

AIDS- Acquired Immuno Deficiency Syndrome

PDCA- Plan-Do-Check-Act

FMEA- Failure Mode Effect Analysis

RPN- Risk Priority Number

HIMS- Hospital Information and Management System

SWOT- Strength, Weakness, Opportunity And Threats Matrix

JCI- Joint Commission International

1.Introduction

The safety of patients is of utmost importance to healthcare professionals, government and researchers globally. In broader terms, the concept of risk can be defined as: “Risk is an uncertain event or a condition which can occur at any point of time, which can have either a positive impact which can be called an opportunity but if it has a negative impact it is called as a threat”. However, the process of risk management includes coordinated efforts for initiating the risk management planning, identification, evaluation and constant monitoring to minimize the probability/impact of any adverse event.

Risk Management (RM) is the best way that can help to prevent errors or any adverse event in the hospital. One way to ensure the high performance of the healthcare institution is to have a compilation of the risks thereby focussing on the value-based healthcare to patients. Maintenance of risk register in clinical areas can improve patient safety and efficiency of the hospital. By forecasting the potential risks and developing strategies for them can cut down the cost of extra resources and can create a safety culture.

Clinical risks put healthcare institutions under financial burden due to its serious adverse impact and high cost involved. Due to high prevalence of clinical errors, near misses, wrong procedures and other clinical incidents have created a criticality for hospitals. Therefore, it was concluded that the system should supply a safety network and that efforts should be directed towards the management of risks (de Vries, Ramrattan, Smoenburg, Gouma, and Boormeester,2008; Khalify-Nejad, Ateaei, and Hadizadeh,2008).To handle these challenges, one way is the establishment of a clinical risk management (CRM) system (Briner et al.,2013;Khalify-Nejad et al.,2008)

The CRM is defined as all instruments, structures, processes, and activities that focus on identifying, analysing, preventing, monitoring, and managing clinical risks (Briner,Kessler et al. 2010). This will not only ensure safety the patients but also create awareness among employees to create a safety culture for both the visitors and patients. Clinical risks have caused serious problems in healthcare and annually kill more people than AIDS or breast cancer(Adibi et al.,2012;Reynard and Stevenson,2009).

This study integrated the risks from all the clinical departments of Thumbay Hospital and developed additional strategies for achieving improvement in quality and patient centred care.

1.1 Aim: The aim of the study is to prepare the risk register for the clinical departments of Thumbay Hospital, Ajman.

1.2 Objective:

- To develop staff knowledge on risk register(risk identification, analysis, monitoring) for their respective departmental clinical risk registers.
- To create patient safety culture amongst staff.
- To improve adherence to compliance with Hospital's policy on Risk Management.
- To achieve equal status on implementation of risk registers with other healthcare units of Thumbay Group.

1.3 Outline of the study performed:

The study was performed using both primary and secondary research. The primary research includes: Interviews with the key stakeholders having defined questions with relevant to their department, brainstorming for the significant risks related to different categories, predefined checklists for common risks, affinity diagram where participants wrote down risks and then risks sorted into defined categories.

For secondary research, incident reports, quality department's database was used. The data collected through above mentioned methods was segregated and analyzed for the successful completion of clinical risk register.

1.4 Limitation of the study

- Financial feasibility could not be done.
- Post-implementation results could not be studied.
- The risk register compilation is with respect to a particular hospital and cannot be applied in general to any healthcare facility.

1.5 Purpose: The statistics have shown that adverse event rates in healthcare globally continue to be a leading cause of injury and death ([Sheps& Cardiff, 2011](#)). Therefore, it is necessary and the need of an institution to forecast and maintain the risk register to prevent errors and improve the knowledge of staff on clinical risk management.

2. Review of literature

- A study on “Risk Management in Hospitals”, [Balbir Singh](#),(2012), states that hospitals and medical staff are liable for providing the quality of care to patients. The risk management is pre-requisite for accreditations in USA. Initiation of maintenance of risk register by western Professionals working in developing countries have introduced the concept of risk register acting as protector against the medical negligence cases. This has helped the healthcare in reducing extra cost burden and enhancing the patient safety.
- A Thesis on “Introducing and Populating Risk Registers in Four Clinical Units in a Teaching Hospital”, [Siobhan Milliken](#) ,(2014), he mentioned about robust risk management can help in preventing the adverse events and medical errors. In his project he has mentioned that the effective introduction of risk register in clinical departments had increased the compliance on adherence to National Healthcare policy on risk register maintenance. He had used online risk register template which was made available to staff on hospital’s intranet. Special trainings and workshops were provided to staff to educate them about risk register compilation. For effective completion he has used PDCA cycle. Further audits were done to assess the knowledge of staff on risk registers which showed that the knowledge has improved.
- A study on “Assessment of Clinical Risk Management System in Hospitals: An Approach for Quality Improvement”,[JamilehFarokhzadian](#), [Nahid DehghanNayeri](#),and [FaribaBorhani](#), (2015), he suggested that the risks in clinical department have posed major threat to safety of the patients and increasing the cost of health care. Thus, to provide higher quality of care to

patients there is a need of maintaining clinical risk register and thus enhancing the safety of services being provided.

- A study on “Risk Management In Hospital Settings: Understanding and Improving the Current Practices”, [Gulsum Kubra Kaya, Tuba Canbaz, Mecit Can Emre Simsek](#), (2016), their study aims to understand the practices of risk management undertaken in the hospital and also suggested the ways to improve the current practices that are followed. To ensure current practices, they designed a questionnaire survey. They have used FMEA, brainstorming and risk matrix for risk analysis. The results showed that more than seventy percent of professionals(physicians and managers) believe that RM defines threats to patient only.

3. Methodology

This study was conducted as a part of the dissertation programme in ThumbayHospital,Ajman. The various methods and material used are described below:

3.1 Study Methodology

Research Question: The following research question formed the basis of the study:

- What are the risks for clinical department at Thumbay Hospital?
- Is there any strategy in place to mitigate these risks?

Research Design: A cross-sectional study design was used for this study.

Duration: 2 months

- Understanding the project needs: 1 week
- Preparation of risk register template,List of physicians and clinical departments:1 week
- Secondary Research:1 week
- Primary Data Collection:3 weeks
- Data Analysis:1 week
- Report Writing and Approval: 1 week

S.No.	Task Name	Time in weeks	1 March-7 March	8 March-15 March	16 March-22 March	23 March- 29 March	30 March- 5 April	6 April- 12 April	13 April- 19 April	20 April- 27 April
1	Understanding the project needs	1								
2	Preparation of risk register template, List of physicians and clinical departments	1								
3	Secondary Research	1								
4	Primary Data Collection	3								
5	Data Analysis	1								
6	Report writing and Approval	1								

Figure3.1: Gantt chart for the proposed study

3.2 Data Collection: The study involved the collection of primary and secondary data followed by a comprehensive data analysis.

Secondary Data: The sources for secondary data were:

- Incident reports of past 1 year (2018)
- Online research
- Hospital Quality department's database

Primary Data: The sources for the collection of primary data were:

- Interviews with the key stakeholders having defined questions with relevant to their department.
- Brainstorming for the significant risks related to different categories.
- Predefined checklists for common risks.

- Affinity diagram where participants wrote down risks and then risks sorted into defined categories.

The data was collected in terms of :

Risk ID no.- Unique Id which includes initials of department and serial number for simple understanding.

Risk Description- Defines risk pertaining to specific department.

Risk Owner- the person responsible for effective implementation

Risk Type: Actual/Potential

Risk Category: Patient and safety, employee, financial, operational, quality, legal and institutional risk.

Existing Controls: Policies and procedures in place.

RPN- Risk prioritisation number on the basis of likelihood and consequences.

Strategy: Strategies in place to mitigate the described risk.

Data Collection Tool: A risk register template was used for compilation of clinical risk register.(Appendix)

Qualitative Data: Open ended discussion reflecting the key stakeholders perspective and support on maintenance of risk register.

Quantitative Data: The data collected on risks mentioned were given RPN which is categorised into Low, medium, high and extreme risks.

4.Risk Assessment Process at Thumbay Hospital: Risk assessment is done under following phases:

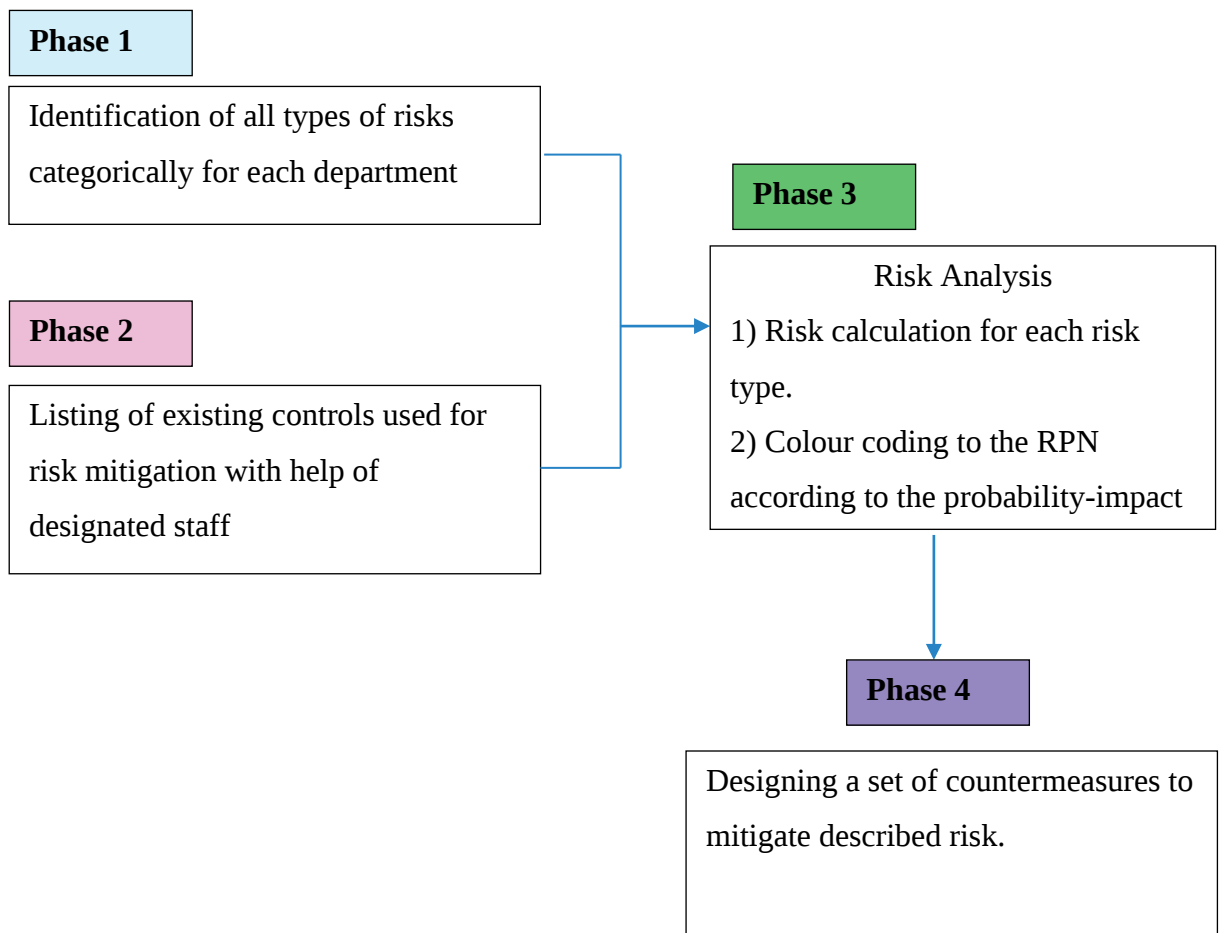


Figure 4.1: Framework for Risk Assessment

4.1 Risk Identification:

- It is done by the stakeholders responsible for maintaining the safety and care of patients (HODs' and staff).
- Screening of risks on the basis of likelihood and relative impact.
- Affinity diagram where participants wrote down risks and then risks sorted into defined categories.

Building a Project Team: Key people are identified to assess whom to contact and gain support for the completion of project.

Stakeholders Analysis: On the basis of power and interest of the key stakeholders:

HIGH ↑ POWER	CEO COO CNO Radiation committee FMO	Chief Quality Officer Operations team Infection Control Physician/nurse Project Team HODs' of Clinical Departments
	Housekeeping Supervisor Security Officer	Administration Staff Staff Nurses Health care Assistants Housekeeping supervisor
	LOW INTEREST → HIGH	

Table4.2 shows Stakeholder Matrix

Screening of Risks :

Risks are described for all the clinical departments.

Risk types are defined.(Annexure)

Risk owners who are accountable for the risk for each risk is mentioned.

Risk Characterisation- If risk has occurred in past , it is called as “Actual Risk”but if it has not occurred but has a potential to occur in future is termed as “Potential Risk”.

Risk-Probability Matrix:

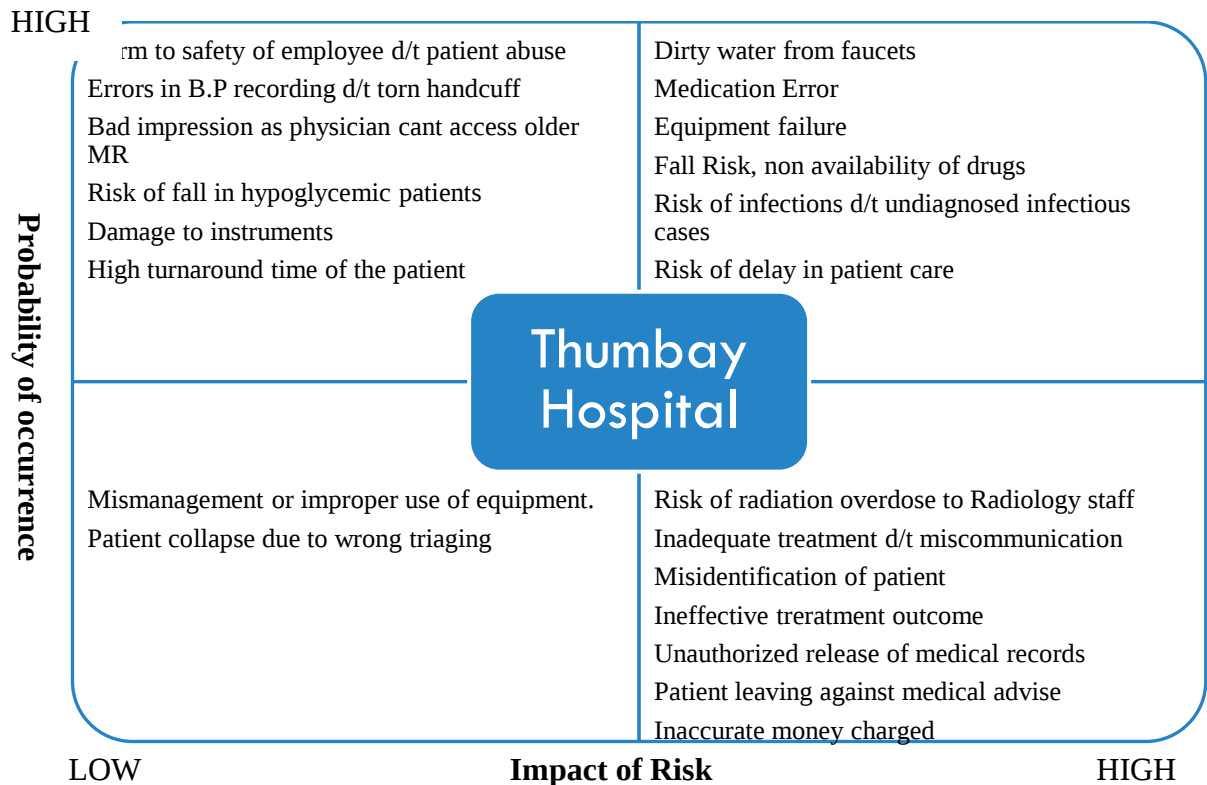


Figure 4.3: A Risk Probability-Impact Matrix for Thumbay Hospital

- **Low impact/low probability-** These risks are rare to occur. Do not require strict efforts.
- **Low impact/high probability-** These risks are of moderate importance. We can try to reduce the likelihood that they'll occur in future.
- **High impact/low probability-** These risks are unlikely to take place. So as to reduce the impact (they'll have if they occur) is to have contingency plan/additional strategies in place.
- **High impact/high probability –** Risks towards the top right corner are of critical importance. These are of highest priority risks that requires immediate attention and strategies in place to mitigate the impact.

Methods used for Risk Identification:

- Interviews with the key stakeholders having defined questions with relevant to their department.
- Brainstorming for the significant risks related to different categories.
- Predefined checklists for common risks.
- Affinity diagram where participants wrote down risks and then risks sorted into defined categories.

4.2 Listing of Controls: Controls are listed according to:

- Documented policies and procedures
- Quality assurance programs
- Processes in place

5. Results: The study was conducted in 23 clinical departments of Thumbay Hospital to identify, analyse and evaluate the risk management strategies. Some of the graphs are depicted below to summarize the results.

5.1 In total 99 clinical risks were identified.

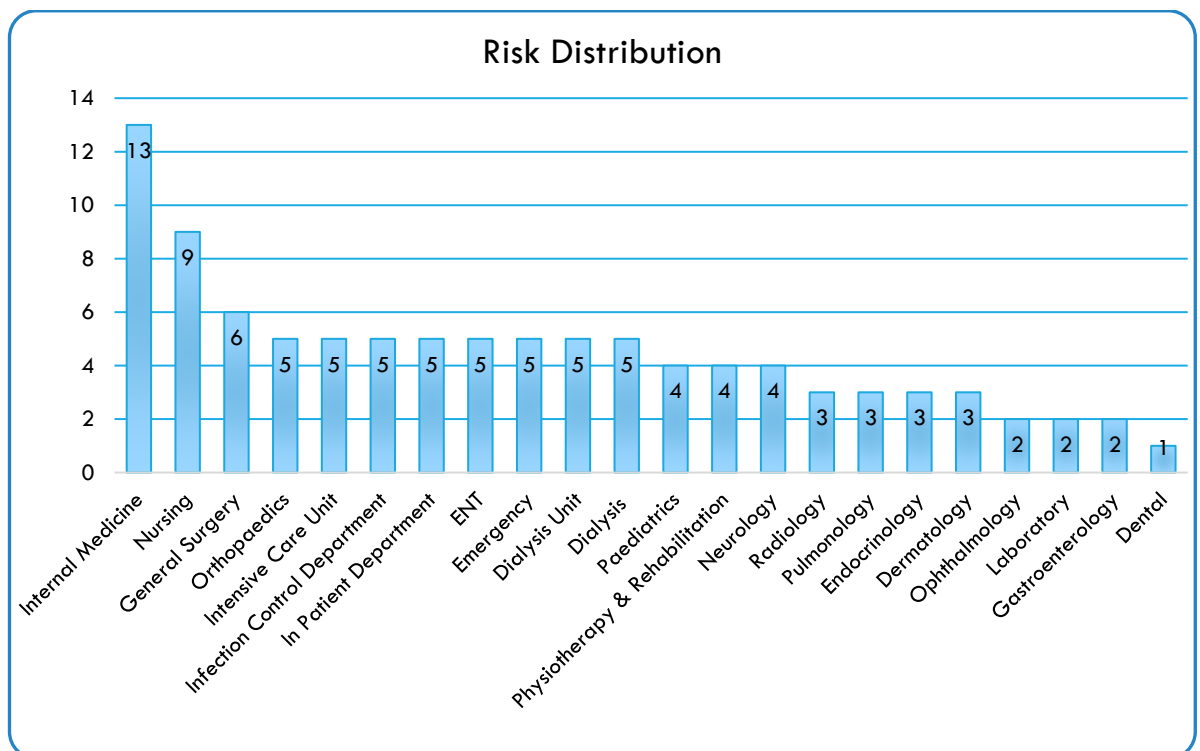


Figure 5.1 Shows Total Number of Risk Specific to Each Department

5.2 Risks are further categorized according to the risk type.

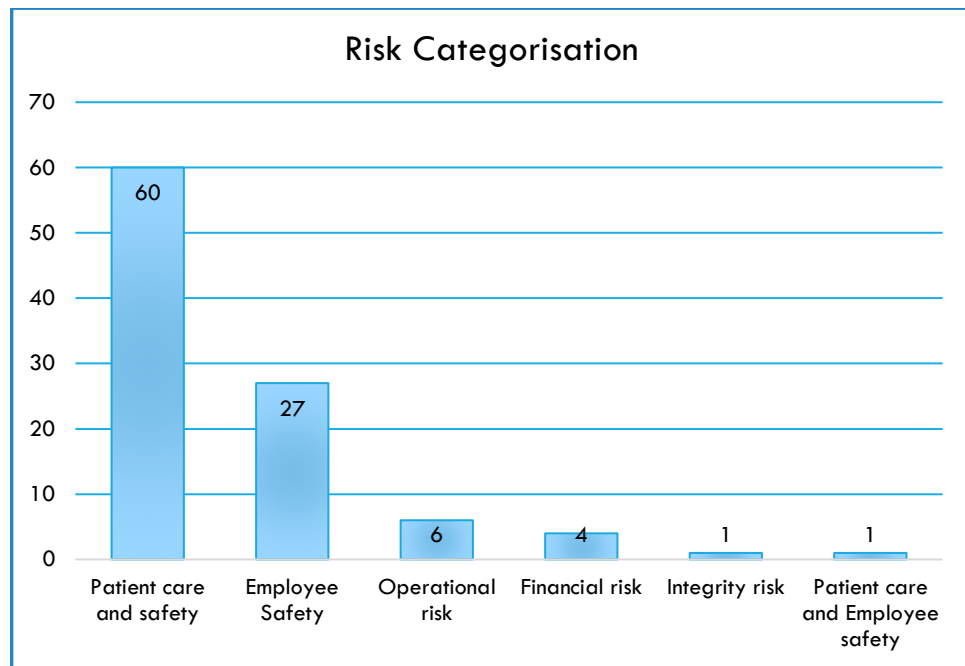


Figure 5.2 Shows the Category of Risk

5.3 Out of 99 risks 49 risks are actual risks and 50 risks are potential risks.

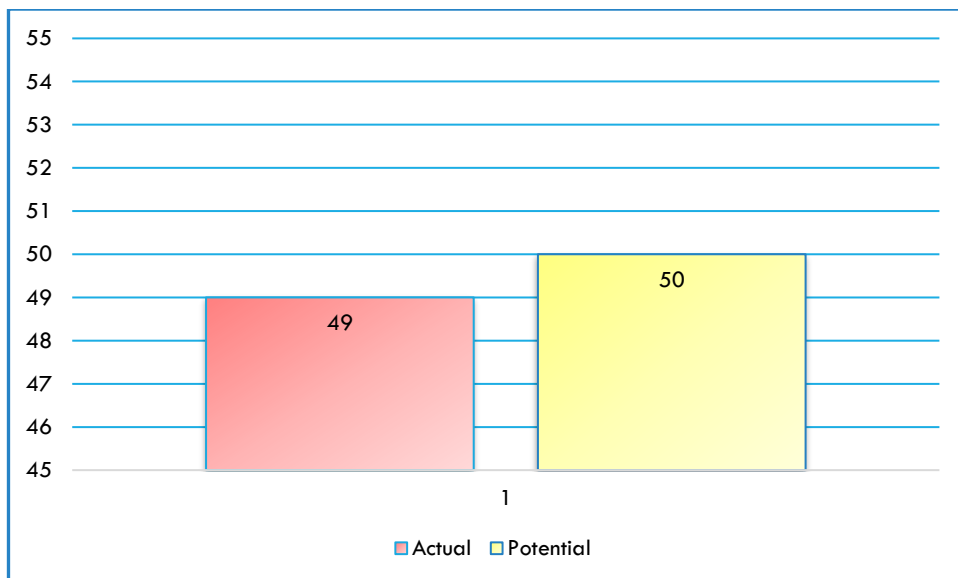


Figure 5.3 Shows the Type of Risk

6.Risk Evaluation: On the basis of likelihood and consequence of the RPN is calculated and colour coded according to the matrix mentioned below:

Likelihood/ Probability	Consequence/Impact				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Severe (5)
Almost Certain(5)	High	High	Extreme	Extreme	Extreme
Likely(4)	Medium	High	High	Extreme	Extreme
Possible(3)	Low	Medium	High	Extreme	Extreme
Unlikely(2)	Low	Low	Medium	High	Extreme
Rare(1)	Low	Low	Medium	High	High

Table 6.1: Risk Quantification Matrix

Risk Priority Number = Consequence*likelihood

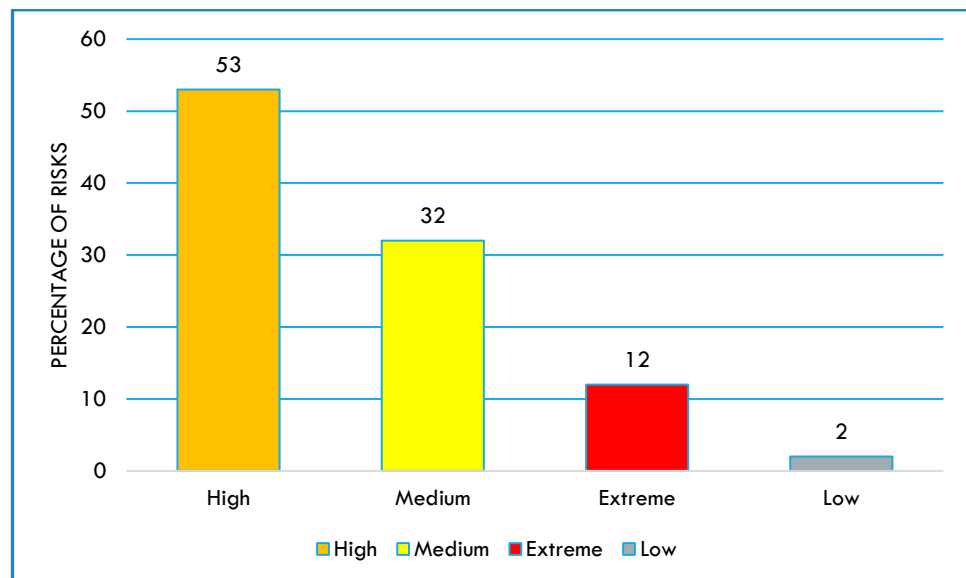


Figure 6.2 shows the Number of Risks in Each Category of Matrix

7. Discussion:

It was found that physicians and concerned staff were informed about the risk registers. Most of the physicians had an idea about the risk register maintenance. Also, it was found that staff had done the prior risk assessment but risk mitigation strategies were not given priority by the administration staff. Therefore, a systematic approach was used for assessment and management of the risks in the clinical departments. Quality Department of the hospital was mainly involved in the maintenance of risk register which means the paramedical staff and physicians were not really involved with regular maintenance of risk register. So, with the help of risk register template, all the risks (99 in nos.) were identified with the help of interviews and brainstorming sessions with concerned staff and physicians followed by analysing the compliance to existing policy and guidelines and other controls to limit the risks in their department. Risk evaluation was done on basis of RPN. Extreme risks require immediate attention and measures in place whereas low risks are rare to occur and do not require more efforts to mitigate the risk. Hence, risk management strategies were planned to mitigate the risk and improve the patient and staff safety. However, this study showed there was no maintenance of clinical risk register by the departments due to staff time allowance, lack of strict implementation and lack of proper knowledge to staff.

Different healthcare institution can have different types of risks but timely management of clinical risk can cut down the cost and can improve quality of care.

8. Conclusion:

Management of clinical risks in a hospital is a way to prevent medical errors and adverse events. Thereby stressing on patient as well as employee safety. During this study it was observed that the risk that has happened in past is almost equal to the risks which has propensity to occur in future. This is due to lack of maintenance of clinical risk registers by staff, no priority for risk identification and proper knowledge of risk register to paramedical staff. Therefore, there is a need to improve the RM practices and creating a culture of patient safety in the hospital.

9. Recommendations:

- Effective incident reporting system shall be implemented which not only defines the incident but also the lessons learnt from it.
- Risk register template shall be available on HIMS so departmental heads can easily maintain and update their departmental risk register.
- Training of paramedical staff to improve their knowledge about risk assessment and management practices.

10. A Way Forward

- SWOT analysis shall be done before undertaking the project.

Internal Environment	
Strengths	Weaknesses
• Support of higher management • Training on importance of risk register • Hospital's policy on RM • Dedicated team work • JCI Standards adherence • Regular meetings • Audits • Regular monitoring • Best performance awards	• Lack of knowledge • Time allowance • Fatigue • Attitude of professionals

External Environment	
Opportunities	Threats
• Meeting JCI Standards • Compliance to adherence of risk management policy. • Enhanced reputation • Cost cutting	• Change in MOH guidelines • Media

Table 9.1 shows Matrix for SWOT Analysis.

Appendix:

 مستشفى ثمبي THUMBAY HOSPITAL HEALTHCARE • EDUCATION • RESEARCH Clinical Risk Register										
				Risk Ownership, Definition and Existing Controls			Initial risk		Proposed risk treatment	
S. No.	Clinical Department (Medical Specialities)	Risk Owner	Risk type (see common risk language)	Risk description	'Actual' or 'Potential' risk?	Existing Controls	Consequences	Likelihood	Initial Risk Rating	Risk reduction strategies/additional controls required

1	Internal medicine	HOD of Internal Medicine	Patient Care and Safety	Risk of misdiagnosis/wrong diagnosis	Actual	1) The provision of case discussion with the colleagues within the same department and also cross department via cross consultation forms. 2) A team of doctors from different specialities(inter-disciplinary team) goes on rounds for patient evaluation. 3) The cases with difference in preoperative and postoperative diagnosis discrepancy are monitored as one of the key performance indicator. 4) Availability of clinical practise guidelines.	3	3	9	1) Provision of accessibility of patients diagnosis and previous treatment for the complex care patients. 2) Encourage proactive patient and family participation in the treatment plan which would result in discussions between the patient /family and the physician. 3) Work with clinicians to create a standardized protocol for these errors and turn them into learning experiences. Such errors shall be percolated among the staff so that an action plan is formulated and implemented.
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2	Internal medicine	HOD of Internal Medicine	Patient Care and Safety	Risk of misidentification of the patient	Actual	1) Two patient identifiers are used for the inpatients as well as the outpatients for patient identification. 2) Monitoring of patient identification protocols as one of the quality indicators. 3) Patient identification is done at nurse station & reassured again by a doctor. 4) Policy on Patient identification -IPSG1. 5) Regular training on IPSG.	3	2	6	Nil
3	Internal medicine	HOD of Internal Medicine	Patient Care and Safety	Risk of injury to the patient due to the patient fall attributed to the patient's underlying condition, due to the treatment/medication (s) administered to the patient or due to the unintended consequences of the measures taken to reduce falls (For example: risk of child falling by slipping through the bed rails)	Actual	1) Fall risk assessment is done for all the patients at the time of admission and during outpatient visit. 2) The patients prone to increased risk of fall are identified as vulnerable patients and fall prevention precautions are initiated including patient and family education during their stay/visit in the hospital. 3) Placing LEAF signage at bed side (Let's Eliminate All Falls) for all the patients who are identified at a risk of fall. 4) Fall prevention education is documented by nurses in patient's record. 5) Provision of call bell in the	3	3	9	1) Taking account of physical disabilities such as poor vision, limited mobility in planning and design will help to reduce the risk. 2) Floor contamination and obstacles can prevent contamination (wet floors, greasy floors, paper wrappings etc) and improve housekeeping and will reduce if not eliminate the risk. 3) Report any health and safety risks to HODs and raise an

						washrooms in case the patient needs assistance. 6) Provision of side rails for inpatient beds and seat belts for wheel chairs.				incident report(OVR).
4	Internal medicine	HOD of Internal Medicine	Employee Safety	Risk of injury due to the use of demo equipment	Actual	1) Policies for the use of the demo equipment. 2) Use of demo equipment under the supervision of product engineer/expert as per manufacturing guidelines. 3) Staff are trained before use.	3	3	9	1) Maintain equipment in a good state and proper working order . 2) Develop a planned preventative maintenance programme to ensure equipment is kept in good state.
5	Internal medicine	HOD of Internal Medicine	Patient Care and Safety	Risk of inadequate treatment due to miscommunication or errors in documentation	Actual	1) Policy for verbal communication in place to prevent errors during verbal communication. 2) Regular trainings of the physicians on documentation. 3) The first dose of medication administration is verified by the clinical pharmacist before being administered. 4) Regular closed and open audit are conducted to identify the deficiencies and the identified physicians are personally contacted and trained for avoiding the	2	3	6	1) Active systems or reminders should be established for the prescriber to be notified that therapy will discontinue, with the opportunity to renew the order. 2) All unclear orders should be regarded as potential errors and clinical pharmacist/nursing should be empowered to confirm orders with the prescriber. 3) Verbal/telephonic

						recurrence of the same.				orders to be given only in case of emergencies and to be countersigned by the prescriber within 24 hours.
6	Internal medicine	HOD of Internal Medicine	Patient Care and Safety	Risk of patient injury as a part of procedural complication including burns	Actual	1) Department specific clinical practice guidelines are identified and practised. 2) To follow the OT protocols for preparing patients for surgery(using of alcohol rub for disinfecting the area). 3) Random Clinical Review of the cases as per the triggers. 4) Clinical Audit Committee in place to discuss the identified cases.	3	3	9	Nil

7	Internal medicine	HOD of Internal Medicine	Patient Care and Safety	Risk of ineffective treatment outcomes	Potential	1) Use of advanced medical technology in providing patient care. 2) Provision of detailed discharge Summary including discharge instructions provided to the patient. 3) Discharge planning assessment is done for all the inpatients so as to assess the patient's status during the stay and also to identify the need of education on any kind of support required at home. 4) Treatment based on identified CPGs and CPs. 5) Patient education.	2	3	6	1) Improve outcomes through greater transparency(seamless flow of information along the treatment pathway). 2) Optimal treatment planning by using clinical pathways, fuelled by evidence-based practices. 3) Automatic stop orders for therapy discontinuations active systems/reminders should be established for the prescriber to be notified that therapy will discontinue, with the opportunity to renew the order, if required(EMR). 4) Encourage patients to educate themselves on their condition and involve them in alternative treatment options available.
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8	Internal medicine	HOD of Internal Medicine	Employee Safety	Risk of staff injury (e.g. Needle prick, Human Bite etc)	Actual	Staff trained on following universal precautions for handling sharps.	3	3	9	1) Implementation of a needleless system and transition to safety intravenous (IV) catheter products. 2) Safety-engineered devices to allow for needle-safe intravenous (IV) delivery, blood collection, IV insertion, and intramuscular and subcutaneous injection. 3) Surveillance on primary prevention such as educating health care providers, preventing exposure and wearing appropriate Personal Protective Equipment (PPE).
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9	Internal medicine	HOD of Internal Medicine	Patient Care and Safety	Risk of Prescription Error	Actual	1) Protocols defined for documentation of medication orders 2) Training of physicians on prescribing medication orders. 3) Online system of medication prescription in OPD/IPD.	3	3	9	1) All unclear orders should be regarded as potential errors, as staff should not have to interpret what the physician is ordering and the staff should be empowered to clear the doubts by asking questions to prescribers. 2) The use of standard order sets by implementing best practices through multiple disciplinary team. 3) E-prescribing systems with decision support tools built in helps to automatically checks for duplicate or incorrect doses or tests. 4) Decision support tools can generate insignificant on-screen alerts presented as pop-up boxes on prescribing errors.
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10	Internal medicine	HOD of Internal Medicine	Patient Care and Safety	Risk of barrier in continuing treatment /care to the patient due to the unaddressed spiritual/religious needs of the patient	Potential	Availability of religious/spiritual leaders as and when needed.	3	2	6	Training on sensitive listening skills to engage the spiritual beliefs of patients in the healing process.
11	Internal medicine	Chairperson - Ethics Committee	Patient Care and Safety	Risk of ethical dilemma	Potential	1) Ethical dilemmas can be reported to Hospital Ethics committee via an ethical reporting form. 2) Medical bylaws. 3) Code of ethics.	3	3	9	Nil
12	Internal medicine	HOD of Internal Medicine	Patient Care and Safety	Risk of patient injury by physical/chemical restraint	Potential	1) Restraint policy. 2) Monitoring of the patient on restraints every 2 hours. 3) Healthcare providers trained on restraint policy.	3	1	3	Nil
13	Internal medicine	All hospital staff	Patient Care and Safety	Risk of unauthorized release of medical information	Potential	1) Limited access to medical records. 2) Ethics Committee in place to deal with such issues relating release of medical records.	3	2	6	1) Development of protocols for handling cases where confidentiality is breached. 2) HIPAA Risk Assessment by the Compliance Officer reports on whether the Protected health information(PHI) has been acquired or viewed, and determines the extent of the risk to the PHI,

										following both federal HIPAA guidelines as well as appropriate state laws.
14	Dental	HOD Of Dental department	Employee Safety	Risk of staff injury (e.g. Needle prick, Human Bite etc)	Actual	1) Policy on handling of sharps. 2) Staff trained on following universal precautions of handling sharps. 3) Use of mouth guards in patients treated with dental procedures.	2	3	6	Sharps are placed in neutral zone, no recapping technique is recommended to avoid injury.
15	Emergency	HOD of ER	Patient Care and Safety	Risk of patient collapse due to wrong triaging	Potential	1) Nursingstaff is trained on triaging. 2) Front Desk Associates are trained on Basic Life Support and identifying patients needing emergency response. 3) MET call(code blue)system in place.	1	1	1	1) Improved triaging(immediate bedding,bedside registration) and resource allocation method. 2) Advanced triage protocols involve the identification of certain illness conditions and implementation of standardized treatment pathways. 3) Deployment of better-trained advanced triage nurses or a team based triage approach.

16	Emergency	HOD of ER	Patient Care and Safety	Risk of physical injury due to violent and aggressive patients and stress of medico-legal cases	Potential	1) Restricted access to the treatment area. 2) Hospital policy on action against violent patients and handling of medicolegal cases is followed.	3	1	3	At the time of admission, the In-patient Department can counsel the patient families/visitors regarding the medico-legal cases.
17	Emergency	HOD of ER	Employee Safety	Exposure to radiation from portable x-rays machines	Actual	1) Health care staff wearing the TLD badges while working. 2) Use of Personal Protective Equipment 3) Radiation dose is being monitored at regular intervals.	3	3	9	1) Development of documentation tools on laser safety. 2) Audits can help in determining compliance with occupational health and safety rules
18	Emergency	HOD of ER	Employee Safety	Risk of infections due to exposure to undiagnosed infectious cases and contaminated aerosols	Potential	1) Hand hygiene protocols are followed by staff. 2) Universal safety precautions are followed. 3) Use of Personal Protective Equipment. 4) Compliance to Hand Hygiene Protocol is monitored as Hospital Wide Quality Indicator and actions taken for improve the same.	4	4	16	1) Monitor Health Care Workers adherence to recommended hand hygiene practices and provide them with performance feedback. 2) Encourage Health Care Workers to promote hand hygiene practices to prevent the risk of infections. 3) Audits to monitor compliance on usage of Personal Protective Equipment and hand

										hygiene practices.
19	Emergency	HOD of ER	Employee Safety	Risk of occupational hazards such as needle stick injuries, Hospital associated infections	Actual	1) Policy on safe handling and disposal of sharps. 2) Policies on post exposure prophylaxis. 3) Training on the use of sharps.	3	3	9	1) Needle Stick Injuries- Implement the use of devices with safety features and evaluate their use to determine which are most effective and acceptable. 2) Sharps are placed in neutral zone, no recapping technique is recommended to avoid injury.
20	General Surgery	HOD of General Surgery	Employee Safety	Physical -Risk of cuts, pricks, electrical shocks, burns, fall(occupational hazards)	Actual	1) Training on prevention of occupational hazards. 2) Proper grounding of the equipment can prevent staff fall due to wires running in the working area. 3) Use of PPE during drug administration. 4) Slip resistant footwears. 5) Planned preventive measures for the maintenance and repair of equipment to prevent malfunctioning and in turn prevent electrical shocks.	3	3	9	1) Trunking of wires to prevent tangled wires in the working area. This would prevent falls as well as risk of electrical shocks. 2) Planned preventive measures for the repair and maintenance of equipment. 3) User guidelines/ manuals to be made available alongside equipment to remind operators and others of the dangers they

										impose and safe work practices.
21	General Surgery	HOD of General Surgery	Employee Safety	Biological-1) Exposure to number of diseases such as HIV and Hepatitis. 2) Risk of splash in the eyes.	Actual	1) Serology done prior to all procedures. 2) Use of appropriate PPE during procedure.	4	2	8	Procurement of good quality PPE can limit the incidences of needlestick injuries and exposure to blood and body fluids.
22	General Surgery	HOD of General Surgery	Employee Safety	Chemical-Leakage of and exposure to anaesthetic gases	Potential	Regular repair and maintenance of fume cupboards and exhaust systems.	4	2	8	1) Identify part of exhaust system which must be tested or examined at predetermined intervals and make arrangement for these services. 2) Ensure workers who carry out repairs, modifications, maintenance and servicing are competent.
23	General Surgery	HOD of General Surgery	Patient Care and Safety	Accidental- related to patient such as faulty procedure, fall from a OT table while positioning and identification	Potential	1) Use of Surgical check list in the OT to prevent any adverse events such as wrong patient, wrong procedure/surgery. 2) Availability of straps to secure the patients during procedure.	2	4	8	Ensure the continuous training of staff to avoid such adverse events.

24	General Surgery	HOD of General Surgery	Employee Safety	Health- most of the time spend hunched on operating table so overtime can cause anxiety and burnout	Potential	Duty rota and weekly offs for equal work distribution and to avoid work load on staff.	2	3	6	Patient staff ratio should be as per the international standards.
25	General Surgery	HOD of General Surgery	Patient Care and Safety	Risk of discarding the tissues specimen(required for histopathology) after the surgical procedures	Potential	1) Policy on surgical care is defined which includes collection of specimen during surgery, transportation and disposal. 2) Sign out performed after surgery.	4	2	8	Communication amongst the surgical team shall be clear on collection of specimen before the surgery begins(sign-in).
26	ENT	HOD of ENT	Patient Care and Safety	Risk of bad impression on patient as doctor can't access the older medical records(records issued by any other doctor)	Actual	1) Access of the entire medical records are given to the clinical HODs. 2) Older medical records are available only on request to MRD.	3	5	15	1) Improving the flow of clinical information between health professionals. 2) Develop integrated electronic health records where information on patients, clinical activity, and health services are easily accessible by physicians. 3) Improving the speed and reliability of Hospital Information and Management System.

27	ENT	HOD of ENT	Patient Care and Safety	Risk of horizontal transmission as there is no screening of patients is done for infectious diseases in OPD consultation	Potential	1) Use of Personal Protective Equipment(PPE). 2) Hand hygiene practices are followed.	4	3	12	Implementation of policies for screening of patients for infectious diseases(Hepatitis B and C, HIV) in OPD consultation.
28	ENT	HOD of ENT	Patient Care and Safety	Risk of cross-contamination as the disinfectant solution used for instruments is not approved by hospital infection control team	Potential	Any kind of disinfectant brought to the hospital is first approved by infection control team and end user feedback for the same is obtained.	4	3	12	Protocols shall be adhered to at all the time and feedback from the users shall be obtained.
29	ENT	HOD of ENT	Patient Care and Safety	Risk due to shortage of instruments	Actual	No control	3	4	12	Automated inventory management will automatically place orders for items before there is a shortage.
30	ENT	HOD of ENT	Patient Care and Safety	Risk of increased turn-around time of the patient as the system is slow	Actual	IT department ensures the efficient working of the system.	2	5	10	To increase the storage capacity/versions of the computers being used.
31	Pulmonology	HOD of Pulmonology	Patient Care and Safety	Particles in the air from many sources can cause lung problems because of absence of proper air ventilation system affecting other patients, visitors and	Potential	1) Air conditioning unit. 2) Window for natural ventilation.	3	4	12	Mechanical ventilation can be integrated easily into air-conditioning for air filtration.

				staff.						
32	Pulmonology	HOD of Pulmonology	Patient Care and Safety	Common waiting area can predispose other patients at a risk of lung problems.	Potential	No control	3	3	9	Portable Hepa filters (Air purifier) can be placed in pulmonology department.
33	Pulmonology	HOD of Pulmonology	Patient Care and Safety	Dirty water from the faucet can pose an increased risk of infection in immunocompromised patients	Potential	Inspection of FEWA water at fixed intervals. The water reports are monitored by the infection control department.	4	5	20	1) To prevent proximal colonization of water systems faucet filters may serve as a final barrier. 2) Prospective water management program that are updated regularly (which includes proper monitoring, supplemental disinfection of the water distribution system, and physicians to be vigilant to the possibility of breakthrough

										contamination and infections).
34	Ophthalmology	HOD of Ophthalmology	Patient Care and Safety	Risk of falls to kids visiting with their mothers	Actual	1) Watch your steps signages placed throughout the hospital. 2) Caution boards are placed near wet floors. 3) Anti-skid strips are placed at all the ramps.	2	4	8	Visitors policy regarding number of visitors including children to be implemented in OPDS.
35	Ophthalmology	HOD of Ophthalmology	Operational Risk	Risk of damage to instruments (kids picking up and playing with instruments).	Actual	No control	2	5	10	Parents should be counselled regarding playing with instruments which might lead to injury in children.
36	Dialysis Unit	HOD of Nephrology	Patient Care and Safety	Availability of only one computer system in dialysis for recording the details for both regular and emergency cases which might lead to errors in documentation.	Potential	No control	3	3	9	Additional computer system shall be provided so as to avoid errors in documentation in busy hours.

37	Dialysis Unit	HOD of Nephrology	Employee Safety	There is only one exit in the department which might not allow the worker to get out in time in case of fire or any emergency.	Potential	No control	3	1	3	1) Training of the staff for evacuation in a confined place in case of emergency . 2) Any hazardous material should be stored according to the guidelines so as to eliminate the risk of any fire.
38	Dialysis Unit	HOD of Nephrology	Patient Care and Safety	Patient are shifted to the ICU for catheterization which can cause discomfort to the patient.	Actual	No control	3	2	6	Provision to be made of sterile area in the dialysis unit for patient catheterisation.
39	Dialysis Unit	HOD of Nephrology	Operational Risk	The department's structure often does not allow easy movement of the people or the equipment within it(in case of emergency).	Actual	No control	2	4	8	Ensure that aisles are always kept open and free for easy movement of staff, wheel chairs and stretchers.
40	Dialysis Unit	HOD of Nephrology	Patient Care and Safety	Risk of medication error due to reduced nursing manpower.	Potential	Policies and procedures regarding medication management and use are strictly adhered to.	4	3	12	To ensure that a sufficient number of nursing manpower are available to provide best care.
41	Dialysis	HOD of Nephrology	Patient Care and Safety	Risk of infection as there is no proper ventilation.	Potential	Infection control department is keeping a close watch on infection rates in dialysis.	3	2	6	Nil

42	Dialysis	HOD of Nephrology	Employee Safety	Poor lighting in the room strains eyes and may cause eye irritation and headaches.	Actual	General maintenance and repair done by maintenance department.	2	5	10	1) Add more light fixtures(LEDs). 2) Replace bulbs on a regular schedule.
43	Dialysis	HOD of Nephrology	Patient Care and Safety	Risk of air contaminants due to frequent breakdown of ventilation system.	Potential	No control	3	4	12	Maintenance department should ensure that ventilation system is checked on regular basis so as to avoid any breakdown.
44	Dialysis	HOD of Nephrology	Operational Risk	Slow computer system and faded letters on keyboard can cause increased patient waiting time and spelling errors in patient medical records.	Actual	Regular maintenance of computers done on regular basis.	2	4	8	Advanced computer system with high RAM to be provided along with replacement of faded keyboards.
45	Dialysis	HOD of Nephrology	Patient Care and Safety	Errors in Blood Pressure recording due to torn handcuff(equipment error).	Potential	Preventive maintenance of biomedical equipment done on regular basis.	4	3	12	Additional handcuffs to provide to prevent the occurrence of erroneous readings.
46	Neurology	HOD of Neurology	Patient Care and Safety	Neurological/balance impairments can increase the risk for falls.	Potential	1) Nurses and physicians work together to evaluate medications that interfere with neurologic exam and alter patient's fall risk status. 2) Physician is actively involved with delirium prevention, including	5	2	10	1) For high-risk patients, a computerized evaluation to be conducted to determine required assistance with mobility aids or use of

						avoidance of medications that may contribute to delirium. 3) Education and assistance provided by the nurses if required after assessing the fall risk status. 4) Pharmacy reviews medication profile for each patient.				lift equipment. 2) Interventions for patients with cognitive deficits should include more staff in care planning and asking family to stay with patient. 3) Pharmacy reviews medication profile for each patient.
47	Neurology	HOD of Neurology	Patient Care and Safety	Risk of delay in treatment due to non-availability of medicines.	Actual	Pharmacy department ensures adequate stock is kept for all the medications to prevent stockouts. However, in case of stock outs cash purchases are made.	3	5	15	1) Selection and formulary management by a multidisciplinary committee. 2) Pharmacy management systems which provides real-time inventory quantities 3) Electronic traceability system to determine the demand for certain medications to prevent stockouts.
48	Neurology	HOD of Neurology	Patient Care and Safety	Risk of patients leaving against medical advice in neurology department.	Actual	No control	2	3	6	Patients taking LAMA must be educated regarding risks and complications of discontinuing the

										treatment so that they have the capacity to obtain, process & understand the basic health information to take the appropriate decisions.
49	Neurology	HOD of Neurology	Operational Risk	Due to non-availability of drugs in the pharmacy store forcing the patients to buy drugs from outside pharmacy leaving bad impression on patients.	Actual	Pharmacy department ensures adequate stock is kept for all the medications to prevent stockouts. However, in case of stock outs cash purchases are made.	3	5	15	1) Selection and formulary management by a multidisciplinary committee. 2) Pharmacy management systems, which provide real-time inventory quantities 3) Electronic traceability system to determine the demand for certain medications to prevent stockouts.
50	Gastroenterology	HOD OF Gastroenterology	Patient Care and Safety	Risk of infection in patients with peripheral IV cannula introduced to susceptible key sites such as hands, as they themselves walk to without any assistance.	Potential	Supervision by nurses.	3	3	9	A patient being nursed should only be transferred between wards for the benefit of that individual's clinical needs under clinical assistance.

51	Gastroenterology	HOD OF Gastroenterology	Patient Care and Safety	Risk of child's finger getting pinched in a door while playing.	Actual	Hinge guards on every door in the facility.	2	3	6	Parents should be counselled regarding playing with instruments which might lead to injury.
52	Orthopaedics	HOD OF Orthopaedics	Employee Safety	Risk for exposure to blood-borne pathogens because of the increased rate of percutaneous injuries caused by needle sticks or sharps.	Potential	1) Standard precautions developed by the Hospital Infection Control team for preventing exposure to pathogens are followed. 2) Using Personal Protective Equipment (PPE).	3	3	9	To wear cut-resistant gloves and changing outer gloves.
53	Orthopaedics	HOD OF Orthopaedics	Employee Safety	Risk of injury because of increased contact with sharp instruments.	Actual	Hospital protocols on handling and disposal of sharp instruments.	3	4	12	1) Sharps to be placed on a neutral zone. 2) Use of a hands-free/ scoop technique is recommended to avoid injury. 3) Recapping of needle should be avoided.
54	Orthopaedics	HOD OF Orthopaedics	Employee Safety	Risk of splash of blood and bone fragments that occur with frequent use of power tools causing mucosal exposure and eye trauma.	Actual	Use of PPE (face mask and goggles) helps in preventing the mucosal exposure and eye trauma.	3	3	9	Risk of contamination can be prevented by using of advanced plastic glasses.
55	Orthopaedics	HOD OF Orthopaedics	Employee Safety	Risk of surgeons getting exposure to radiation during procedures requiring X-ray and C-arm.	Actual	Wearing of Lead aprons and TLD badges during the procedures require X-ray and C-arm.	2	3	6	1) To use low-dose option on C-arms when maximum resolution is not needed.

										2) Using a laser guide to centre the beam to avoid unnecessary off-centre images.
56	Orthopaedics	HOD OF Orthopaedics	Employee Safety	Polymethylmethacrylate can induce skin reactions in susceptible orthopaedic surgeons.	Potential	Standard precautions are adhered to prevent risk of skin reactions.	3	2	6	Avoid direct contact with PMMA and to wear appropriate personal protective equipment, consistent with infection control guidelines.
57	Paediatrics	HOD of Paediatrics	Patient Care and Safety	Risk of the medication error in paediatric patients.	Potential	1) Follow hospital policies and protocols on medication prescription, preparation, dispensing and administration.	4	3	12	1) Computerised physician order entry in paediatric medical wards; a paediatric weight-based dosage calculator and medication dosages checks should be available. 2) Wrong-dosage alerts, drug-drug interaction alerts and allergy alerts on physician's system. 3) Barcode medication administration system.
58	Paediatrics	HOD of Paediatrics	Patient Care and Safety	Risk of injury due to free movement of children.	Actual	Supervision by nurses and facility supervisors.	2	3	6	1) Exit doors near the play area should be locked and supervised.

										2) Provide sufficient and dedicated space for children play area.
59	Paediatrics	HOD of Paediatrics	Patient Care and Safety	Risk of falls/tripping.	Potential	1) All patients, parents/carers are oriented to room and wards. 2) All beds are kept in low height with brakes on. 3) Side rails are always kept raised for all patient groups. 4) Nurse call bell system available 5) Patient undergo fall assessment and patients who are at the risk of fall are educated and fall prevention leaflets are provided.	2	1	2	1) Hourly rounds will support the provision of proactive care such as the need for assistance to the bathroom. 2) Reinforce information and education to parent/carer concerning normal psychological and motor development of small children, which is related to falls risks and other hazards both inside and outside hospital. 3) Appropriate non-slip footwear for ambulating patients.
60	Paediatrics	HOD of Paediatrics	Patient Care and Safety	Risk of infant abduction.	Potential	1) Controlled access to labour and delivery/NICU. 2) Electronic Security Alarm System (Hugs and Kisses) has been installed in the hospital to assist in the protection of infant from abduction. 3) In case of missing child	4	3	12	Regular mock drills for code pink to be conducted and staff to be trained on code pink.

						hospital staff activates code pink.				
61	Endocrinology	HOD of Endocrinology	Patient Care and Safety	Risk of falls is higher in hypoglycaemic patients.	Potential	1) Maintenance of normal glycaemic levels. 2) Oral antidiabetic agents that are least likely to cause hypoglycaemia used as the first choice of therapy. 3) Physician-directed hypoglycaemia treatment protocols can help to limit both the duration and severity of the event.	5	2	10	Nil
62	Endocrinology	HOD of Endocrinology	Employee Safety	Risk of needle stick and sharps injuries and hence resulting in transmission of blood borne diseases.	Actual	1) Policy on safe handling and disposal of sharps. 2) Policies on post exposure prophylaxis. 3) Training on the use of sharps.	3	3	9	1) Needle Stick Injuries- Implement the use of devices with safety features and evaluate their use to determine which are most effective and acceptable. 2) Sharps are placed in neutral zone, no recapping technique is recommended to avoid injury.

63	Endocrinology	HOD of Endocrinology	Patient Care and Safety	Risk of infections due to air contaminants in immunocompromised patients.	Actual	Air ventilation system installed.	3	3	9	To use High Efficiency Particulate Arrestance (HEPA) filters for air filtration.
64	Dermatology	HOD of Dermatology	Employee Safety	Risk for exposure to infectious agents from percutaneous exposures, aerosolized infectious particles (E.g.: in Laser surgery and Dermabrasion, instrumentation and Cryotherapy-spraying of liquid nitrogen).	Potential	1) Use of PPE (face mask and goggles) helps in preventing the exposure to infectious agents. 2) Staff trained on use of PPE.	4	2	8	1) Audits can be conducted for adherence to Personal Protective Equipment usage.
65	Dermatology	HOD of Dermatology	Patient Care and Safety	Post procedural risks include infections, bleeding, change in skin colour.	Actual	1) Evidence based guidelines and practices are adhered. 2) Informed consent obtained from the patient explaining all the possible risks involved in the procedure for post procedural risks.	3	4	12	Staff to be a part of continuous medical and nursing education so as to be updated with current advances in medicine.
66	Dermatology	HOD of Dermatology	Employee Safety	Risks due to laser beam procedure.	Potential	1) Use of lead aprons and goggles. 2) Availability of safety manuals for handling equipment.	3	3	9	1) Development of documentation tools on laser safety. 2) Audits can help in determining compliance with occupational health and safety rules

67	Infection Control Department	HOD of Infection Control Department	Patient Care and Safety	Risks of hospital acquired infections such as CAUTI, CLABSI, SSI, VAE-Pneumonia.	Potential	1) Infection Control Practices are defined and followed during patient stay/visit in the hospital. 2) Aseptic techniques are followed at the time of performing procedure(s) on patient. 3) CSSD ensures effective sterilization of all the instruments being used for patient care. 4) Hand Hygiene is promoted across the hospital and monitored to ensure compliance. 5) Cleanliness is maintained across the units and the cleaning of facilities is ensured by the housekeeping department. 6) Separate dedicated isolation room. 7) Prophylactic Antibiotics administered prior to surgery. 8) Policies regarding the number visitors visiting hospital.	3	3	9	1) Hospital wide trainings should be done to reinforce hand hygiene compliance. 2) Prior to sending items to CSSD, aseptic spraying of instruments in OT/Procedure rooms to be done instead of washing it.
68	Infection Control Department	HOD of Infection Control Department	Patient Care and Safety	Risks of multiple drug resistant organisms.	Potential	Defined policies and protocols for screening, isolation and treatment of MRSA patients.	3	4	12	Nil

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69	Infection Control Department	HOD of Infection Control Department	Patient Care and Safety	Risks of outbreaks.	Potential	1) Policies and guidelines for management of outbreaks and global communicable disease programme in place. 2) Infection control team is responsible for the coordination of the surveillance, subsequent investigation, and control of infection in patients, staff and visitors.	4	2	8	Infection control team should monitor for potential outbreaks.
70	Infection Control Department	HOD of Infection Control Department	Employee Safety	Risk of hospital acquired infection (HAI) to clinical staff due to: 1) sharps/ needles 2) Infectious diseases 3) Staff sickness 4) Environmental cleanliness 5) Lack of proper sterilisation 6) Disposal of infectious waste 7) Spills and body fluids	Potential	1) Use of PPEs (Personal Protective equipment) 2) Ensuring immunization protection for all the clinical staff. 3) Standard precautions and Aseptic techniques are followed at the time of performing procedure(s) on patient. 4) Proper segregation of waste at the point of generation. 5) Adhering to Hospital's guidelines on sterilisation and disinfection 6) Policy on management of spill sand body fluids is	2	3	6	1) Hospital wide trainings to reinforce Hand Hygiene compliance 2) Communication plan for adherence to guidelines.

						followed.				
71	Infection control department	HOD of Infection Control Department	Employee Safety	Risks related to facility/hospital due to cross-contamination of air	Potential	1) Negative pressure Isolation rooms. 2) Laminar air flow in OTs.	4	2	8	1) Tracking of air flow and pressure patterns. 2) Installation of HEPA filters throughout the facility so as to prevent air contamination.
72	Laboratory	Laboratory HOD	Employee Safety	Risk to Lab Staff of biological, chemical and physical injuries while dealing with biological fluids, carrying out assays, handling reagents and hazardous chemicals, and operating analysers/equipment.	Potential	1) Periodic training on existing "Laboratory Safety Policies". 2) Orientation and training of new staff. 3) Use of personnel protective equipment. 4) Safe storage and handling of chemicals, use of closed flammable cabinet. 5) Mechanism for injury	3	2	6	Nil

						reporting/ investigation, and engineering controls like eye wash station/ shower				
73	Laboratory	HOD-Laboratory	Patient Care and Safety	Risk of delay in treatment due to non-availability of blood.	Potential	1) The laboratory stocks two units of blood for each blood type. 2) System in place to procure blood from Sharjah blood bank on an urgent basis (if requirement is more).	4	2	8	Nil
74	Nursing	Chief Nursing Officer	Patient Care and Safety	Risk of not providing quality nursing care due to: 1) Incompetent/ inexperienced nurses recruited 2) Lack of training for the nurses 3) Lack of supervision 4) Lack of motivation 5) Lack of communication skills 6) High attrition/ turnover of nurses	Actual	1) During recruitment two round of interviews are conducted. 2) Nurses are deployed bases on their skills and experience. 3) Well defined and documented departmental orientation programme is conducted for all new staff 4) Develop in - house specialized training programmes such as- Clinical record documentation training programme, HIMS training programmes , soft skill development	2	3	6	1) Conduct speciality based proficiency test during recruitment. 2) Provide regular internal and external CNE programmes for nurses. 3) Schedule a shift in-charge/Senior staff nurse every shift only for supervision.

						programmes etc. 5) Regular meetings are conducted with in-charge nurses. 6) Reward and Recognition for good performers.				
75	Nursing	Chief Nursing Officer	Patient Care and Safety	Risk of patient safety incidents like fall, pressure ulcer, adverse events, sentinel events etc. due to: 1) Non-compliance to the policies and procedures 2) Lack of awareness/training 3) Lack of supervision 4) Negligence 5) Lack of cooperation from the patient/ visitors	Actual	1)Regular trainings to staff on policy and procedures are provided. 2) Proper mix of manpower is ensured (experienced and new/junior). 3) Counselling of errant staff.	3	4	12	1) Follow buddy and mentor system for all new staff. 2) Schedule a Senior staff nurse in every shift only for supervision.

76	Nursing	Chief Nursing Officer	Employee Safety	Risk of staff safety incidents [needle stick, fall, body mechanism, spills] due to: 1) Noncompliance to the policies and procedures 2) Lack of awareness/training 3) Lack of supervision 4) Negligence 5) Lack of availability of advanced resources	Actual	1) For preventing Needle Stick Injuries: • Training to staff on segregation and safe disposal of biomedical waste • Mechanism for reporting and timely follow-up of all needlestick and other sharps-related injuries. • Prompt removal of filled sharps disposal boxes 2) For preventing exposure to radiation use of lead apron while entering radiation zone.	3	4	12	Needle Stick Injuries- Implement the use of devices with safety features and evaluate their use to determine which are most effective and acceptable 1) Use of roller for transferring patient. 2) Provide antiskid footwear for staff. 3) Ergonomic advice to staff to prevent posture related injuries
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77	Nursing	Chief Nursing Officer	Patient Care and Safety Employee Safety	Risk of hospital acquired infections or both staff and patients: 1) Non compliance to the policies and procedures 2) Lack of awareness/training 3) Lack of supervision 4) Negligence	Actual	1) Well defined infection control manual as per Centre for Disease Control's and JCI guidelines is maintained. 2) An infection control committee with regular meeting has been formulated. 3) Training to all staff on infection control protocol is provided. 4) Infection control audit is conducted. 5) Infection related quality indicators (i.e. ventilator associated pneumonia (VAP), urinary tract infection (UTI), surgical site infection (SSI), central line related blood stream infection (CRBI), biomedical waste management (BWM)) are monitored. 6) Hepatitis B vaccination to all new nurses are given. 7) Hand disinfectant/hand rub is provided to all staff. 8) Hand hygiene practices followed.	3	4	12	1) Sponsor nurses to external infection control training programs. 2) Inspect various areas according to a defined calendar. 3) Perform annual health check for all staff.
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78	Nursing	Chief Nursing Officer	Patient Care and Safety	Risk of medication error due to: 1) Noncompliance to the policies and procedures 2) Lack of awareness/training 3) Lack of supervision 4) Negligence 5) Prescription errors 6) Verbal / Telephonic orders 7) Emergency/ Panic situation 8) Non availability of prescribed medication 9) Non formulary/ new medication prescription	Actual	1) A well-defined Policy on medication management and use is available. 2) Training provide to all new staff on medication administration protocol. 3) All first dose medications before administration are reviewed by a clinical pharmacist. 4) Training on high risk and high alert medication policy is defined and provided. 5) Patients on infusion are regularly monitored. 6) Allergies of patients during initial nursing assessment confirmed and monitored. 7) Training to sensitize doctors on prescription related errors is provided. 8) Policies on verbal / telephonic orders is maintained and adhered to. 9) Training to staff on emergency response (e.g. Code Blue) is provided. 10) Escalate to treating doctor for substitute if prescribed drugs are not available. 11) Expiry date of all drugs	3	5	15	Training to sensitize doctors on prescription related errors to be provided monthly basis.
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						in the wards regularly checked. 12) Medications are stored as per storage guidelines. 13) Medical record audit performed regularly. 14) Occurrence and variance reporting and corrective measures are undertaken. 15) Training on sound-alike and look-alike medication.				
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79	Nursing	Chief Nursing Officer	Financial Risk	Risk of mismanagement or improper use of equipment due to: 1) Lack of awareness/training 2) Lack of supervision 3) Negligence 4) Emergency/ Panic situation 5) Interference of patients like aggressive patients	Actual	1) Regular training of staff on equipment is provided. 2) Functionality of equipment is checked daily. 3) Staff on usage of equipment regularly supervised. 4) Training to staff on equipment during emergency situation is provided. 5) Occurrence and Variance reporting is done and corrective measures are taken. 6) Proper placement of equipment is ensured.	2	1	2	Nil
80	Nursing	Chief Nursing Officer	Financial Risk	Risk of mismanagement of ward stock or not being accounted for due to: 1) Error/ Omission 2) Lack of supervision 3) Negligence	Actual	1) Stock control measures are maintained and adhered to. 2) Co stock checks against inventory lists and controlled drug records are checked. 3) Occurrence and Variance reporting done and corrective measures for missing items are taken	2	3	6	Conduct stock take .

81	Nursing	Chief Nursing Officer	Operational Risk	Risk of inaccurate or incomplete documentation due to: 1) Lack of awareness of protocol 2) Shortage of staff 3) Ignorance/Negligence 4) Non availability of computer on time 5) Emergency/ Panic situation 6) Improper hand over	Actual	1) Documentation is done as per departmental protocol 2) Training to all new and existing staff in HIM 3) Adequate staff for every shift 4) Staff supervision on a daily basis 5) Occurrence and Variance reporting done and corrective measures are taken.	3	4	12	To allocate adequate computer station.
82	Nursing	Chief Nursing Officer	Financial Risk	Risk of inaccurate and or incomplete money being charged due to: 1) Lack of awareness of protocol 2) Shortage of staff 3) Ignorance/Negligence 4) Non availability of computer on time 5) Emergency/ Panic situation 6) Improper hand over	Actual	1) All order entries are checked before submitting IP clearance form. 2) Training to all staffs on Hospital Information Management System. 3) Adequate staff for every shift.	2	3	6	Allocate adequate computer station for entering of the procedures.

83	Intensive Care Unit	Nursing incharge of ICU	Patient Care and Safety	Risk of delay in treatment due to unavailability of bed in the critical care area.	Potential	1) Hospital's policy and guidelines on prioritization of admissions is followed. 2) Well defined admission and discharge criteria followed by the Intensive Care Units.	4	3	12	Demand forecasting on the basis of bed days can prevent delay in allocation of bed.
84	Intensive Care Unit	Nursing incharge of ICU	Patient Care and Safety	Risk of non-availability of medications can pose a threat to the life of patient.	Actual	1) Chief Nursing Officer (CNO) and pharmacy in charge maintains [appropriate stock in ICU to prevent any stock outs. 2) The Pharmacy In-charge and CNO are intimated well in advance prior to drugs stock out. 3) Pharmacy department ensures adequate stock is kept for all the medications to prevent stockouts. However, in case of stock outs cash purchases are made.	3	4	12	Reminder pop-ups should be generated on computer system of CNO and pharmacy in charge prior to stock outs for appropriate actions.
85	Intensive Care Unit	Nursing incharge of ICU	Operational Risk	Risk of equipment failure.	Potential	1) Checking of equipment is done by ICU nursing in charge prior to patient admission. 2) Periodic Preventive Maintenance (PPM) of all the equipment is done as per schedule	2	5	10	Biomedical Department to ensure proper functioning of the equipment on regular basis so as to avoid any breakdown.

86	Intensive Care Unit	Nursing in charge of ICU	Employee Safety	Risk of infection if standard protocols are not followed strictly by the staff.	Potential	1) Hand hygiene protocols are followed by staff. 2) Monitoring is done by ICU in charge on adherence to universal hand hygiene practices by the staff before and after touching the patient. 3) Use of Personal Protective Equipment 4) Compliance to Hand Hygiene Protocol is monitored as Hospital Wide Quality Indicator and actions taken for improve the same.	3	3	9	1) Monitor Health Care Workers adherence to recommended hand hygiene practices and provide them with performance feedback. 2) Encourage partnerships between patients, their families and Health Care Workers to promote hand hygiene.
87	Intensive Care Unit	Nursing in charge of ICU	Patient Care and Safety	Risk of infection to immunocompromised patients as the visitors policy is not strictly adhered to.	Potential	ICU has access control to restrict the entry of visitors.	4	3	12	At the time of admission, the In-patient Department to educate patient families/visitors regarding the Hospital Visitors Policy especially in ICU.
88	Physiotherapy & Rehabilitation	HOD OF Physiotherapy & Rehabilitation	Patient Care and Safety	Risk of patient injury in form of sudden shock or burn during delivery of electrotherapy modalities mostly using electrical stimulator.	Actual	Periodic preventive maintenance conducted.	3	4	12	Electrical stimulator to be replaced.

89	Physiotherapy & Rehabilitation	HOD OF Physiotherapy & Rehabilitation	Patient Care and Safety	Risk of patient injury due to falls resulting from: 1) Inadequate lighting 2) Mal-functioning of equipment like treadmills etc.	Potential	1) Watch your steps signages placed throughout the hospital. 2) Caution boards are placed near wet floors. 3) Anti-skid strips are placed at all the ramps. 4) Periodic preventive maintenance of equipment conducted.	4	2	8	1) Reinforce information and education to parent/carer concerning normal psychological and motor movements of patients, which is related to falls risks and other hazards both inside and outside hospital. 2) Appropriate non-slip footwear for ambulating patients. 3) Replacement of faulty equipment.
90	Physiotherapy & Rehabilitation	HOD OF Physiotherapy & Rehabilitation	Patient Care and Safety	Risk of falls resulting from patient transfer(s) from OPD to gym because of: 1) High patient traffic in the area (it being the main hospital OPD entrance). 2) Slippery(tiled) flooring in the corridor. 3) Improper functioning of wheels and brakes of	Potential	Staff accompanying patients at the time of patient transfer to gym.	4	2	8	Flooring of the OPD corridor to be anti-skid.

				recliner couches.						
91	Physiotherapy & Rehabilitation	HOD OF Physiotherapy & Rehabilitation	Patient Care and Safety	Risk of harm to patients safety due to therapeutic intervention being applied to the patient where it is contra-indicated(e.g. chest physiotherapy in patients with pulmonary embolism, pneumothorax, fractured rib etc).	Actual	1) Competent staff recruited for providing rehabilitation services. 2) Evidence based treatment guidelines are adhered to	4	3	12	1) Couches to be replaced. 2) Patient to be educated about the risk before commencing the therapy.
92	Radiology	HOD of Radiology	Patient Care and Safety	Risk of Patient Fall from the CT or MR table: Elderly, trauma or paediatric patients are risk to injury due to fall and need additional care while shifting them on/off the table.	Potential	1) Complete and accurate initial assessment before undertaking any radiological procedure. 2) Assistive ambulation devices provided to the patients on risk of fall.	4	1	4	Nil

93	Radiology	HOD of Radiology	Patient Care and Safety	Risk of ionizing radiation exposure (X-ray and CT) in Pregnant Patients	Potential	1) Radiation is to be avoided in the pregnant patients and all the female patients are asked to declare the possibility of pregnancy prior to undergoing CT or MRI. 2) For the patients unsure of the pregnancy, the referring physician is informed to rule out the pregnancy with the blood tests as and when required.	3	2	6	Additional recruitment of the care takers to assist the patients.
94	Radiology	HOD of Radiology	Employee Safety	Risk of radiation overdose to Radiology staff	Potential	1) Health care staff wearing the TLD badges while working. 2) Radiation dose is being monitored at regular intervals.	1	4	4	Nil
95	In Patient Department	In Patient Manager	Financial Risk	Risk of financial loss /bad debts to the hospital because 1) Money not deposited by the patients who are admitted through accident and emergency 2) Patient transfers to critical care areas from wards but not willing to pay the higher prices	Actual	1) Advance amount taken at the time of admission. 2) Patient signs a Guarantee Of Payment Form. 3) The patients relatives /friends/ employer are contacted in order to settle the outstanding amount. 4) Such cases where patient doesn't pay the bill are forwarded to the legal team for necessary actions.	2	4	8	Nil

				associated with it.						
96	In Patient Department	In Patient Manager	Patient Care and Safety	Risk of delay in patient care(admission) because - patients do not carry the ID proof/documents required for the admission process.	Actual	1) The Emirates ID is scanned in the OPD and made available to the In-patient department at the time of admission. 2) Correct information about the admission procedure is communicated by the nursing staff to the patients(in case the patient bypasses the IPD during admission).	3	5	15	LED display screens informing the patient to bring their ID at the time of admission
97	In Patient Department	In Patient Manager	Employee Safety	Risk of harm to the safety of employees because of violence/abuse by the patients because of -Lack of room availability/delay in admission and discharge. -Mis-communication. -Lapses in the clinical and support services.	Actual	1) Patient counselling on various issues arising during the patient's stay in the hospital. 2) Code white is activated in case of physical threat by patients/Visitors. 3) Four level of Patient complaint handling mechanism in order to address the patients' complaints in an effective and timely manner.	4	3	12	To practice AIDET while communicating with patients.

98	In Patient Department	In Patient Manager	Integrity Risk	Risk of harm to the hospital reputation due to negative media coverage/negative word-of-mouth publicity which can be due to dissatisfaction of patients.	Actual	1) Restricting people to take photos or videos 2) Four levels of Patient complaint handling mechanism in order to address the patients' complaints in an effective and timely manner. 3) VOC (Voice of customer) initiative-As a part of this, patients who do not wish to revisit the hospital/recommend the hospital to others are contacted by the PRO and their grievances are attended to.	3	3	9	Regular monitoring and supervision of existing controls
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99	In-Patient Department	In-Patient Department Manager	Patient Care and Safety	Risk of loss of information or break in continuity of care during the shift change, transfer of patient from one unit to another or during external transfer.	Potential	1.) Handovers are practised during the shift change between the nursing staff and the physicians. 2.) Physician Handover Sheet used by physicians to document their handovers in critical care areas 3.) SBAR tool used by nursing staff for documentation of handovers in critical care areas. 4.) In House Transfer form along with the updated medical records are used during all internal transfers which aids in continuity of care/treatment. 5.) Provision of documenting patient's status in external transfer form in cases of external transfer of the patient 6.) Provision of updating progress of the patient by the physicians and the nurses in the doctor's progress notes and the Nurses Progress Notes respectively which aids in continuity of the care	3	3	9	Nil
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