



A STUDY OF PATIENT
SAFETY EVENT
REPORTING AT KD
HOSPITAL, AHMEDABAD

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1. INTRODUCTION

I.1 Background of the study

Patient safety is a health-care culture that evolved in reaction to the growing complexity of health-care systems and the resulting rise in nosocomial patient harm.

Patient safety incidents are a well-known health-care difficulty and are described as an event or scenario that may have caused, or did cause, avoidable injury to a patient.

A reporting culture refers to the creation of an environment in which hospital employees can report patient safety problems in a fair and blame-free manner.

To improve patient safety, it is crucial to create an environment that encourages the organization to identify errors, evaluate causes and take appropriate actions to improve performance in the future

1. INTRODUCTION

1.2 Significance of the study

- At the moment, incidents are underreported, although the reason for this is unknown. The reluctance of employees to report an incident, whether witnessed or committed, is apparent. The majority of the studies on this topic focus on clinical professionals such as nurses and doctors' reluctance to report incidents, yet incident reporting is everyone's obligation, from ground level staff to administrative staff.
- Hence, this study aimed to examine the culture of incident reporting among clinical as well as non-clinical staff at KD Hospital, and the factors that affect it while eliminating those factors by providing training to enhance incident reporting culture.



1.3 OBJECTIVES



To understand the current incident reporting system and culture at KD hospital.



To identify the factors that influence reporting of incidents.



To explore the factors that would motivate the staff to report an incident.



To assess the impact of training to enhance patient safety event reporting.



1.4 RESEARCH QUESTIONS



What is the current incident reporting practice at KD Hospital, Ahmedabad?

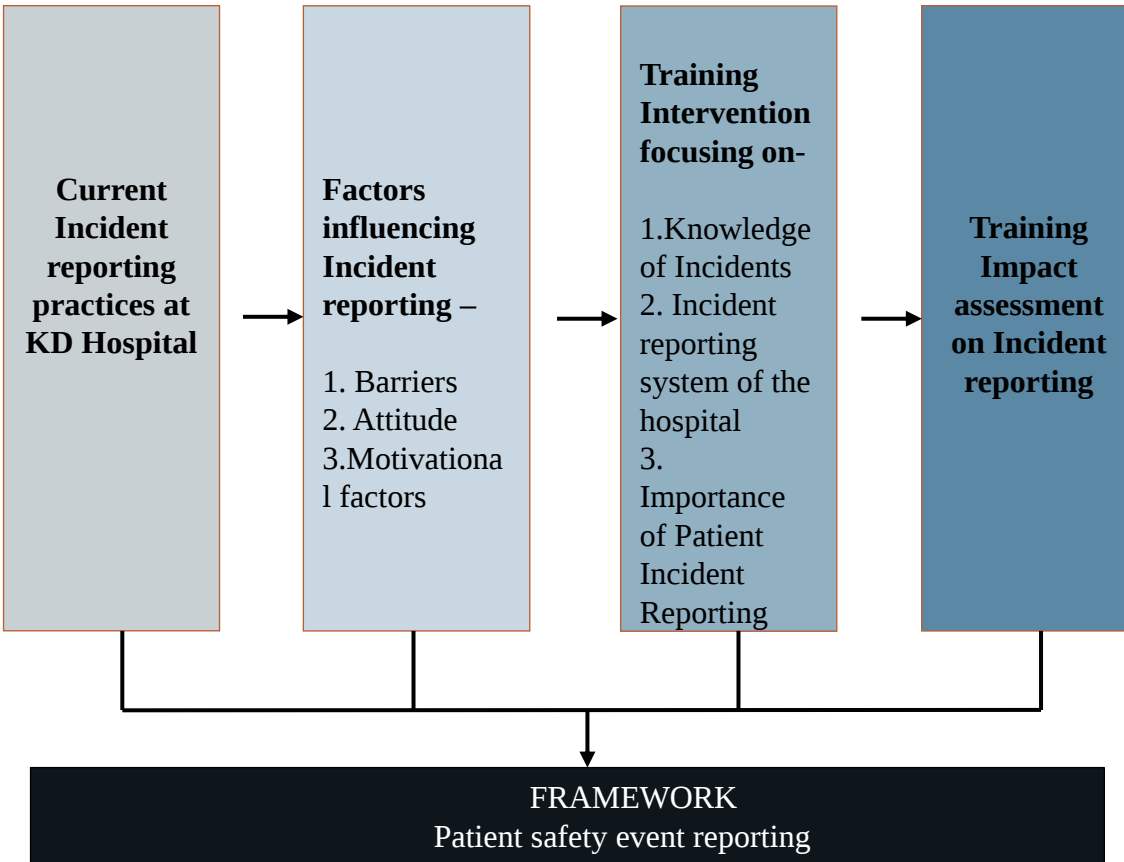


What are the factors that affect the incident reporting behaviour among the staff?



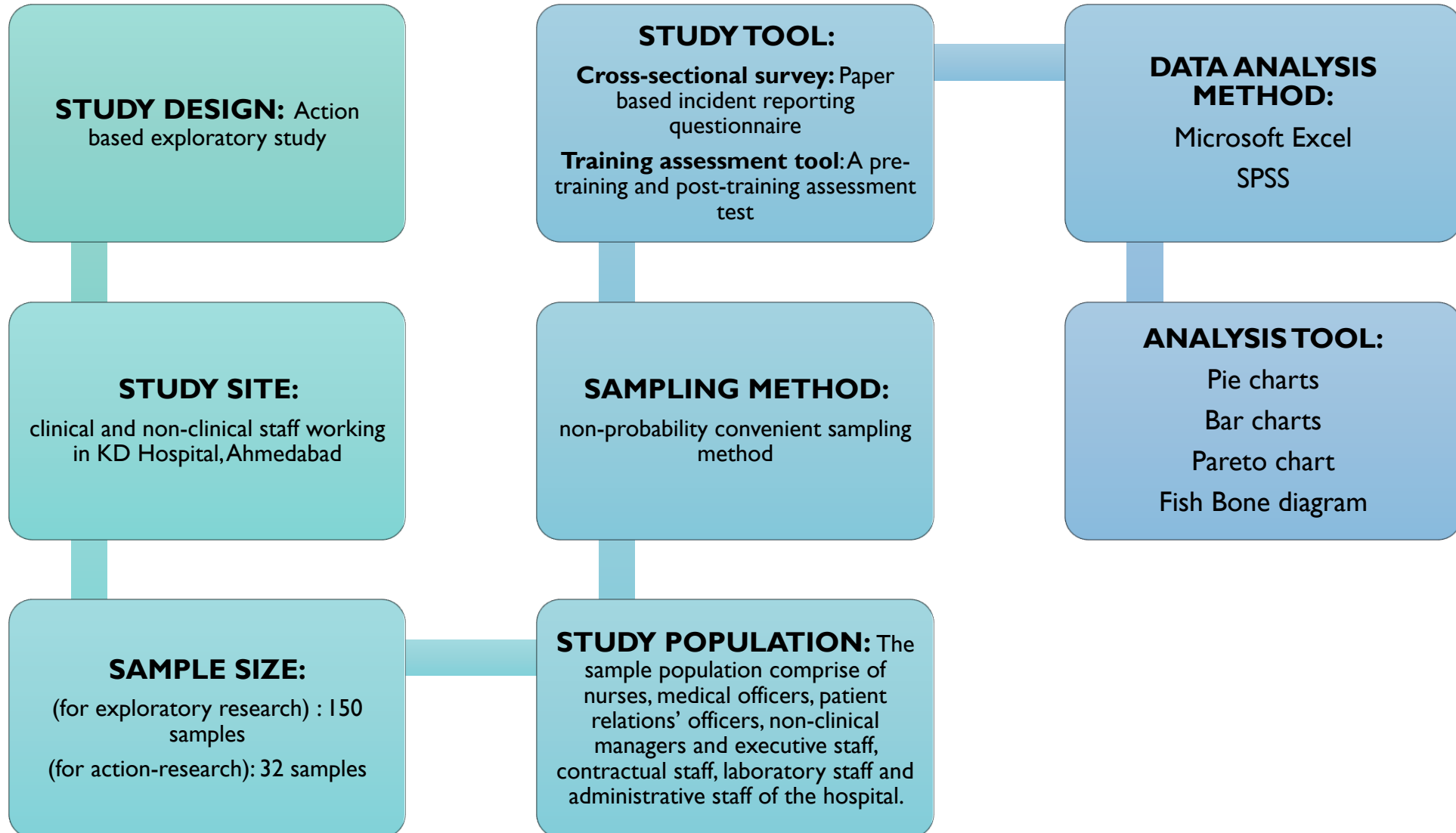
What is the impact of intervention taken to enhance patient safety event reporting culture?

2. CONCEPTUAL FRAMEWORK



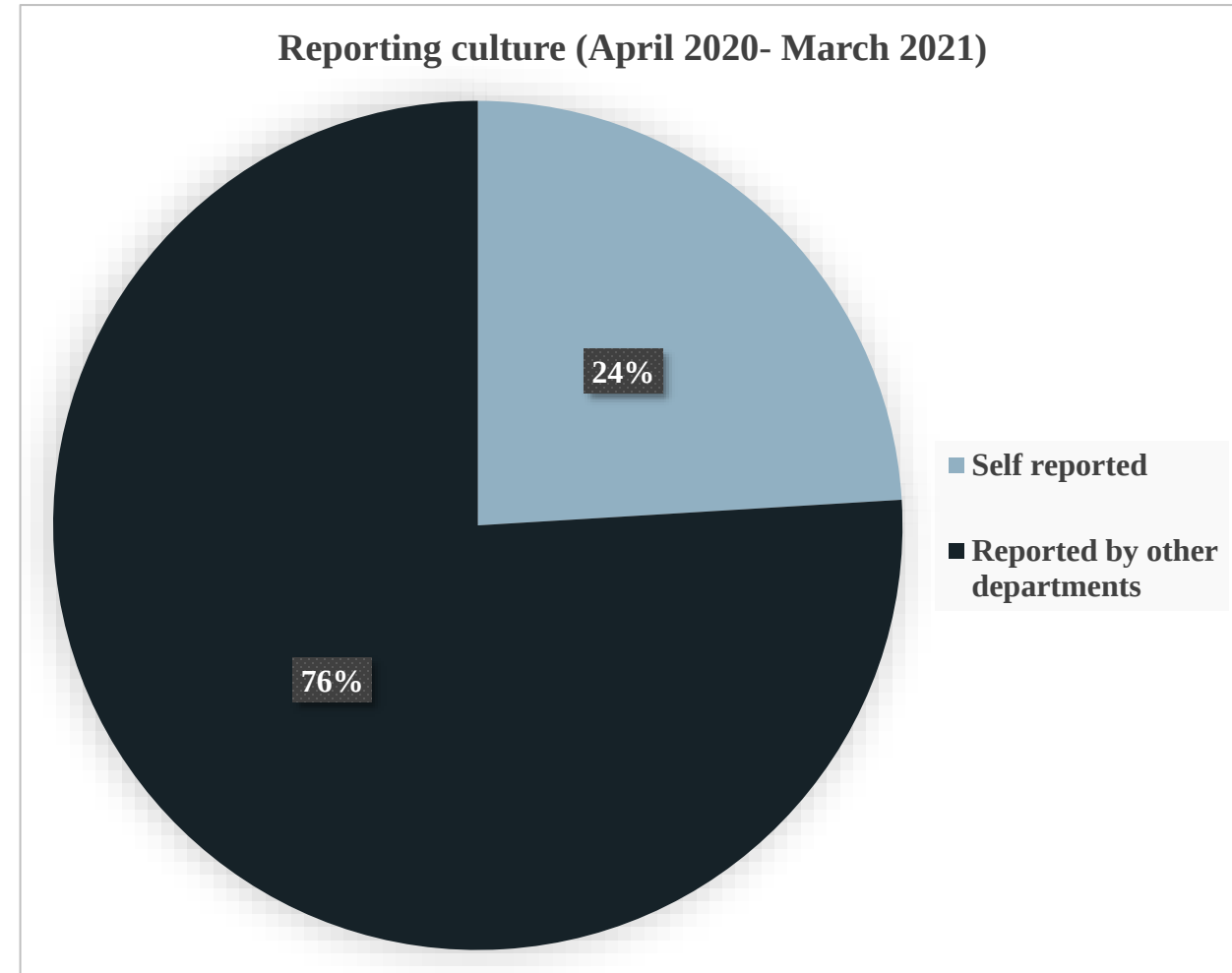
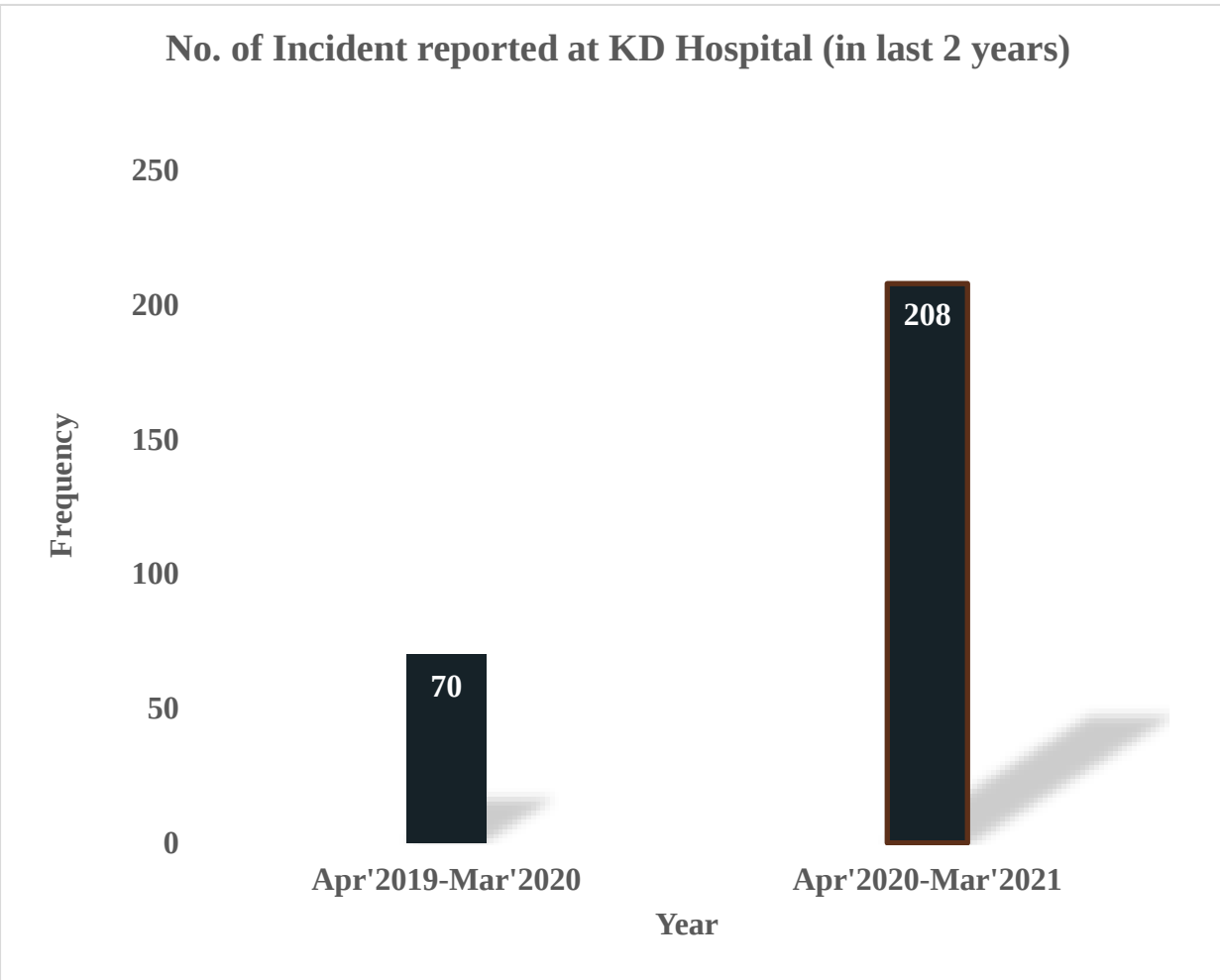
- A study conducted to understand incident reporting practices at KD Hospital in order to enhance patient safety and quality care by using incident reporting as a mechanism.
- Various factors were taken under consideration such as awareness regarding IRS, barriers to reporting, perception towards e-IRS and motivational factors. Training was used as an interventional method to improve IRS, and the results were evaluated.
- The results of the pre- and post-assessment tests were utilised to determine the impact of the training.
- The null hypothesis was formed by comparing pre- and post-assessment test results.
- As a result, the null hypothesis for the training impact was that there was no difference in pre and post assessment test results.

3. RESEARCH METHODOLOGY

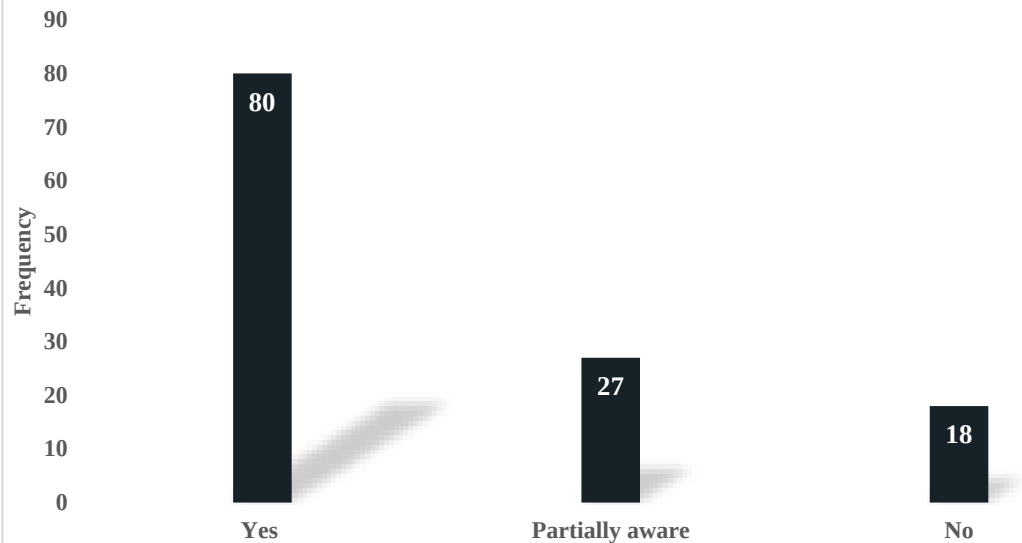


4. RESULTS

4.1 Descriptive Statistics:

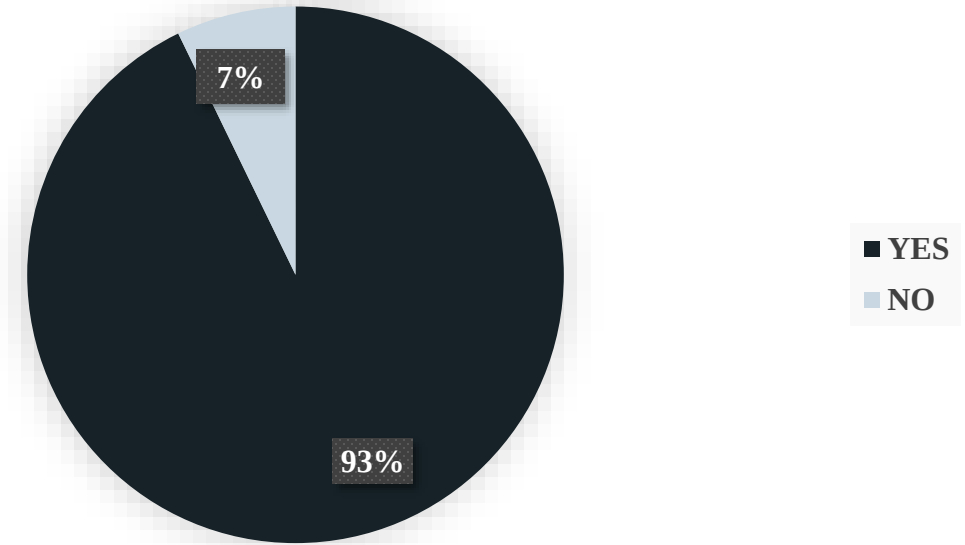


Awareness among staff regarding IRS



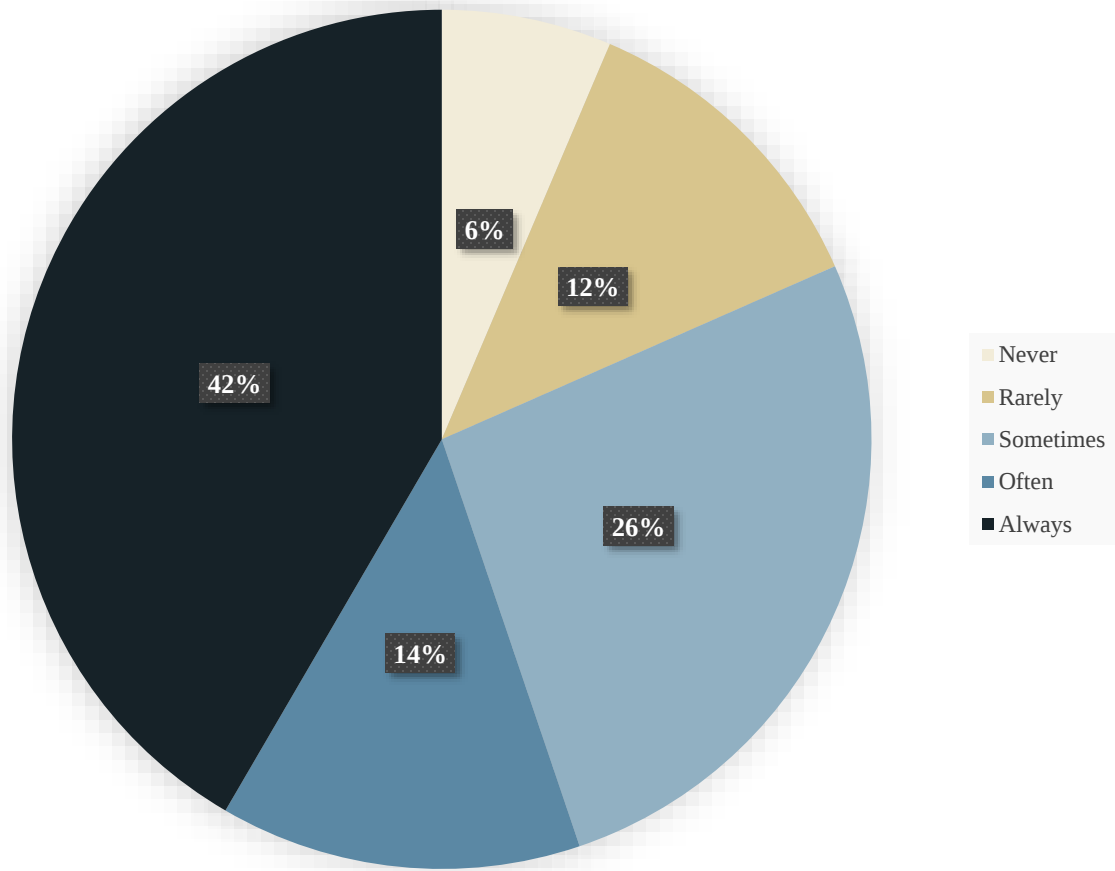
We can see that out of 125 respondents, 80 respondents were aware regarding the hospitals incident reporting system while, 27 respondents were partially aware, and 18 respondents were fully unaware about the hospital's IRS.

Study populations' perception about incident reporting importance

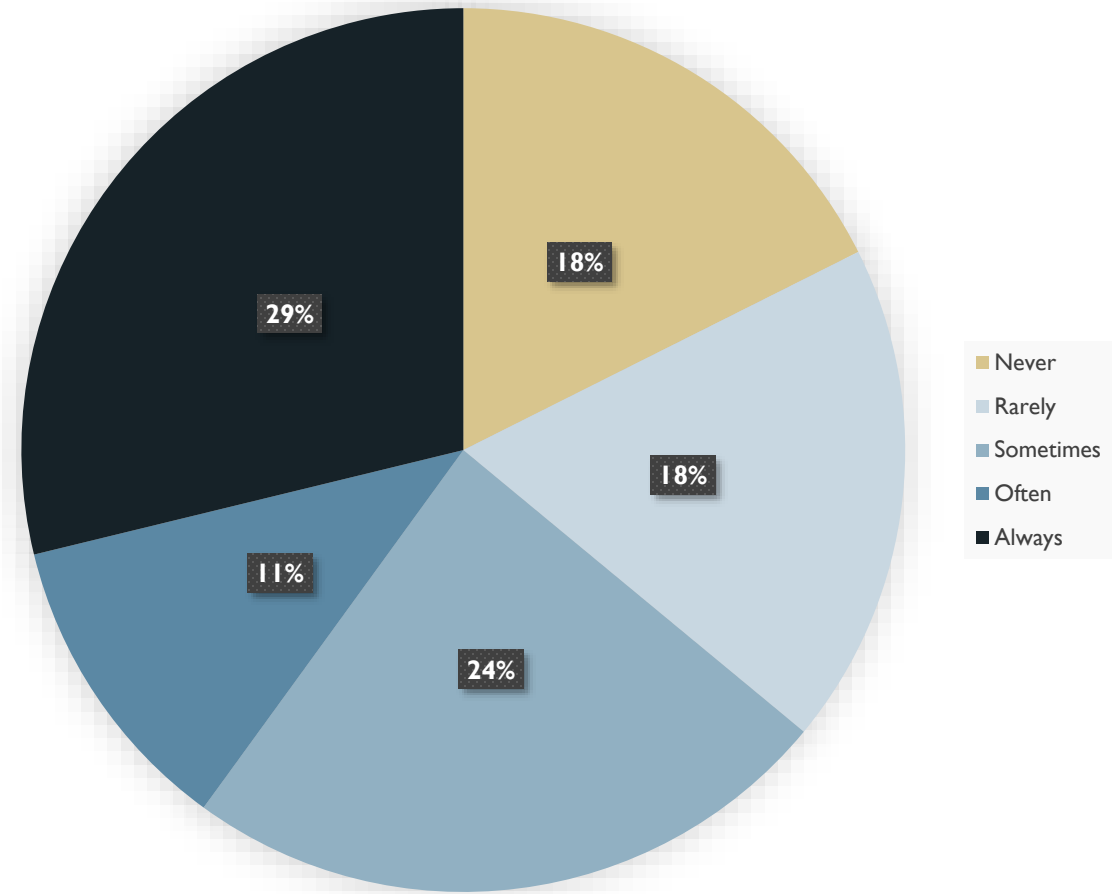


We can note that 93% of the respondents agreed that incident reporting is important in order to enhance patient safety and quality care, while 7% of the respondents denied the importance of incident reporting.

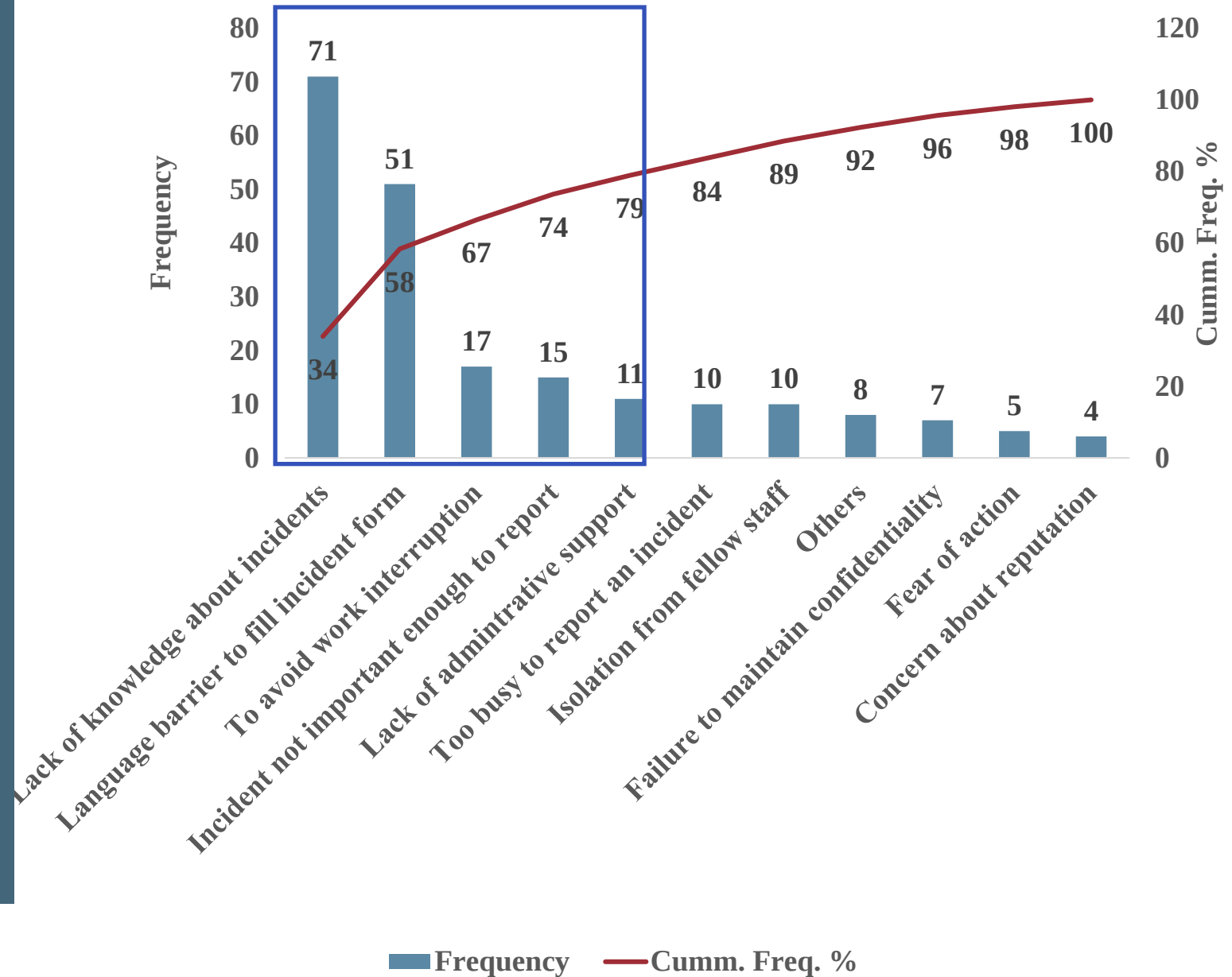
Appropriate action taken post incident reporting

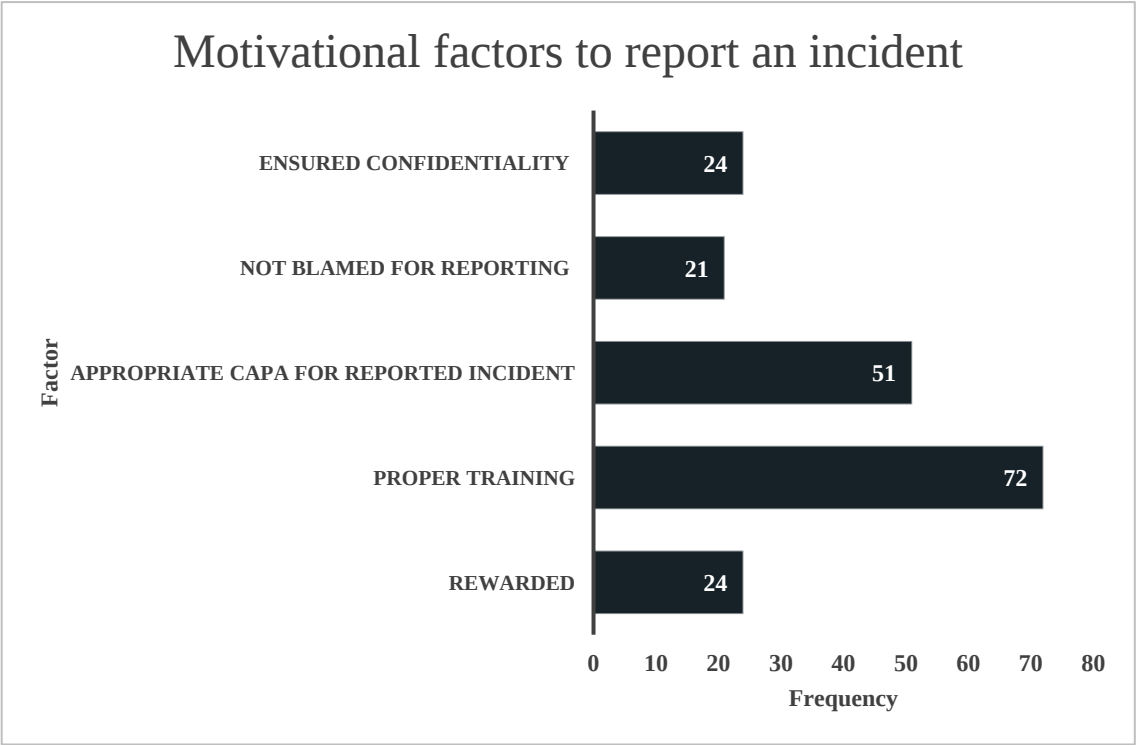


Response to preventive action been intimated to concerned staff

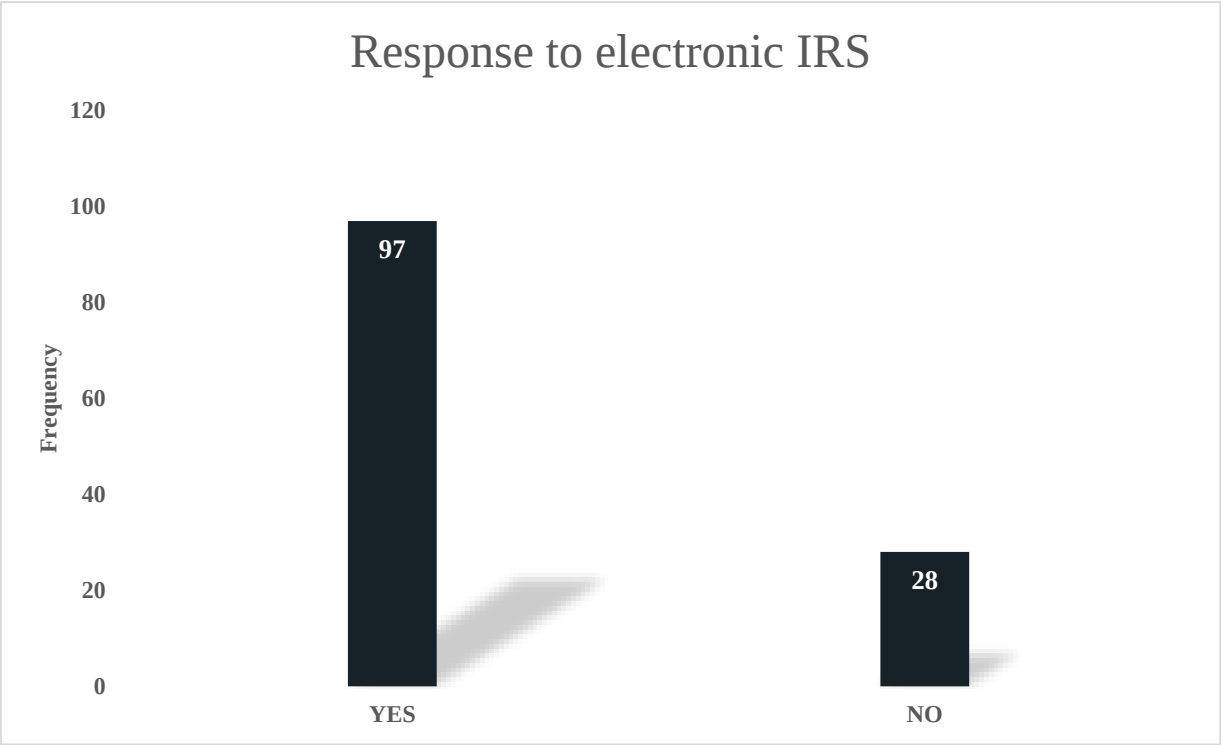


PARETO ANALYSIS FOR THE BARRIERS TO INCIDENT REPORTING





Major respondents (i.e., 72 responses) considered training about incidents and the IRS as an important motivational factor to enhance incident reporting. The respondents who believed that an appropriate CAPA was not taken after reporting an incident (51 responses) agreed that an appropriate CAPA for a reported incident was their motivating factor to report it. Respondents also considered rewards (24 responses), confidentiality (24 responses) and blame free (21 responses) culture as their motivational factors.

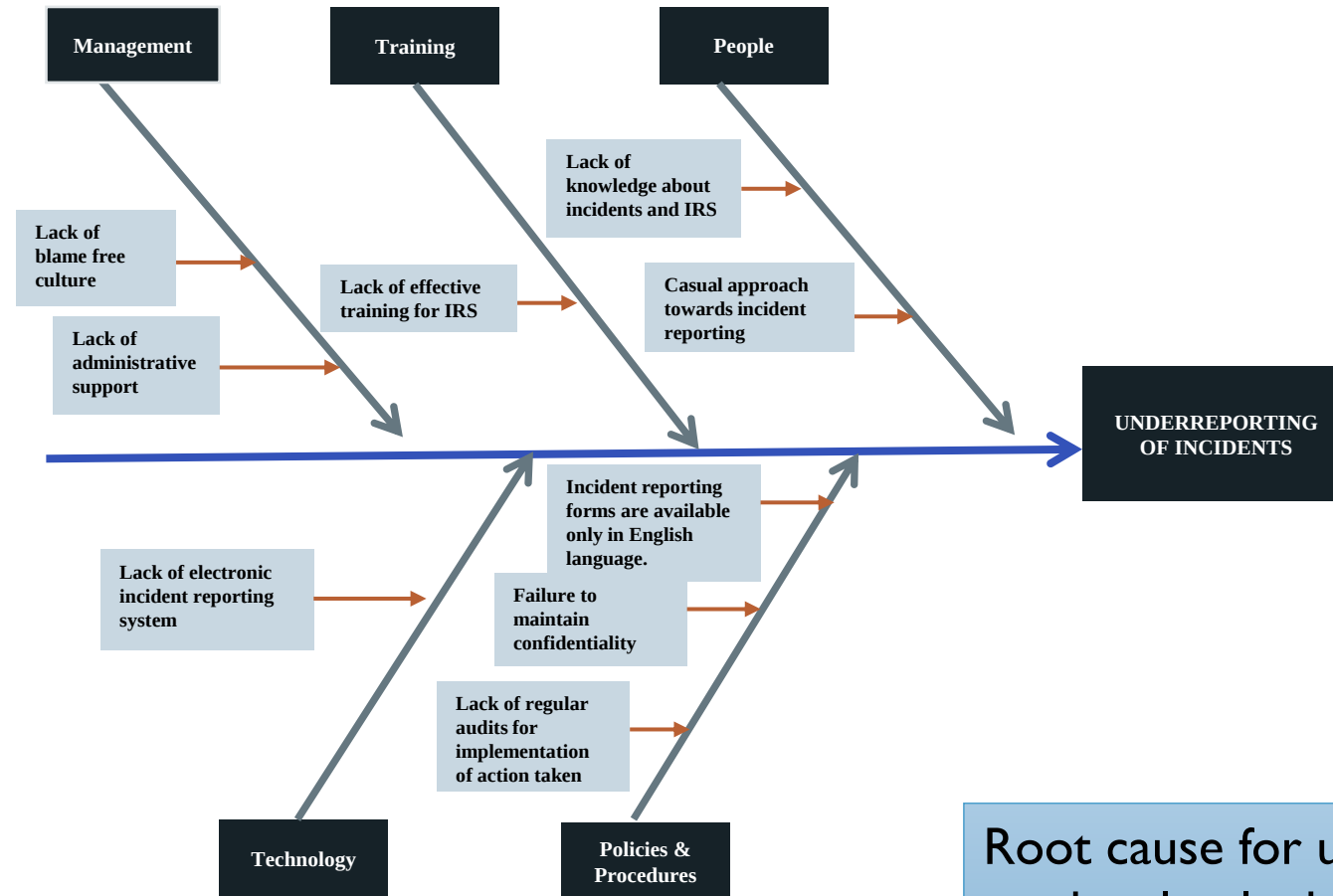


When asked if they thought an electronic incident reporting system would make it easier to report an incident, 97 respondents said yes, while only 28 said no. Hence, we can say that e-IRS can play a major role in enhancing incident reporting system at KD Hospital.

4.2 INFERENTIAL STATISTICS

- Based on the results, we reject our null hypothesis i.e., ‘There is no difference between the pre and post training assessment scores’ and accept our alternate hypothesis i.e., ‘There is difference between the pre and post training assessment scores.’
- Therefore, we can say that training was effective in terms of imparting knowledge regarding incidents and IRS to the staff. However, the impact of training can only be assessed by comparing it with the incident reporting rate after giving training to entire staff of the hospital.

5. DISCUSSION



Root cause for under-reporting can be clearly depicted in the fishbone diagram.

6. CONCLUSION



Currently lower incident reporting rate is observed



Major barriers to reporting identified in the study: Lack of knowledge about incidents and language barrier to fill incident form.



Major motivational factor identified in the study: Training



Positive impact of training

6.1 RECOMMENDATIONS

- Training
- Availability of forms in all the three languages: Hindi, Gujarati, English
- Maintaining anonymity of the person reporting an incident
- e- Incident reporting system
- Reducing the threshold of reporting
- Administrative support
- Regular audits to check for implementation of the actions taken

All accidents must be reported.

... explain exactly
what happened





THANK YOU