

**TO ANALYZE COMPLIANCE FOR INTERNATIONAL
PATIENT SAFETY GOALS IN MONILEK HOSPITAL,
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INTRODUCTION

- Patient Safety is the absence of preventable harm to a patient during the process of health care.
- It has been defined as the reduction and mitigation of unsafe acts within the healthcare system, as well as through the use of best practices shown to lead to optimal patient outcomes.
- The purpose of International Patient Safety Goals is to improve patient safety. The goals focus on problems in healthcare, safety and how to solve them.

INTERNATIONAL PATIENT SAFETY GOALS

- Why patient safety goals.

- List of the goals.

PATIENT SAFETY GOALS



Why patient safety goals

- To improve specific improvement in patient safety.
- To focus on problems in health care safety and how to solve them.

List of International patient safety goals

- 1) Identify patients correctly.
- 2) Improve effective communication
- 3) Improve the safety of high alert medications
- 4) Ensure correct site, correct procedure, correct patient surgery
- 5) Reduce the risk of health care – associated infections.
- 6) Reduce the risk of patient harm resulting from falls.

Identify patients correctly

- To reliably identify the individual as the person for whom the service or treatment is intended.
- To match the service or treatment to that individual.
- The identifiers can be:
 - 1) Patient complete name.
 - 2) Patient medical record number.
 - 3) Birth date
- Patients are identified before providing treatments and procedures/diagnostics, administering medication, serving restricted diet, during time out- before a procedure, etc.

Improve effective communication

- Process of conveying critical information in a way that is timely, accurate, complete, clear and understood by recipient.
- Complete verbal and telephone test results from wards must be **“read back”** by recipient and must be confirmed by the conveyor.
- Standardize abbreviation, acronyms, and symbols used throughout the organization, including a list of those not to be used.

Improve the safety of high alert medications

- **HAM-** High alert medications are those which are involved in a high percentage of errors and/or sentinel events, medications that carry higher risk for adverse outcomes as well as look alike, sound alike medications (LASA).
- High alert categories/ HAM list should be available on the notice board in each clinical department.
- High alert medicines are kept in separate, secured cabinet and labeled by special warning label.

Ensure correct site, correct procedure, correct patient surgery

- Use a checklist, including a “**Time-out**” just before starting a surgical procedure, to ensure the correct patient, procedure and body part.
- Develop a process or a checklist to verify that all documents and equipment needed for surgery are on hand and correct and functioning properly before surgery begins.
- Mark the precise site where the surgery will be performed. Use a clearly understood mark and involve the patient in doing this.

Reduce the risk of healthcare associated infections

- Comply with current published and generally accepted hand hygiene guidelines.
- Implement an effective hand hygiene program.
- Develop policies and procedures that address reducing the risk of health care associated infections.

Reduce the risk of patient harm resulting from falls

- Develop and implement a process to reduce the risk of patient harm resulting from fall.
- The risk of patient harm resulting from falls can be reduced by assessing and reassessing all inpatients and those out patients whose condition diagnosis, situation or location identifies them as at high risk for fall.

Aim: To prevent harm and focused on quality of patient's care

Objective:

- To analyze compliance to patient safety goals.
- Represent proactive strategies to reduce the risk of medical error.
- To provide clear priorities and solutions for improving patient safety.

METHODOLOGY

- **Study type:** Descriptive observational study
- **Study area:** Clinical and non-clinical departments of Monilek Hospital & Research Centre.
- Duration of study: 1st February 2018- 4th May 2018
- Data collection: primary data was collected with the help of checklist enumerating different types of parameters for patient safety namely,
 - 1) Patient with ID band
 - 2) Verbal order registers
 - 3) Handover Registers
 - 4) Legible handwriting
 - 5) No abbreviation

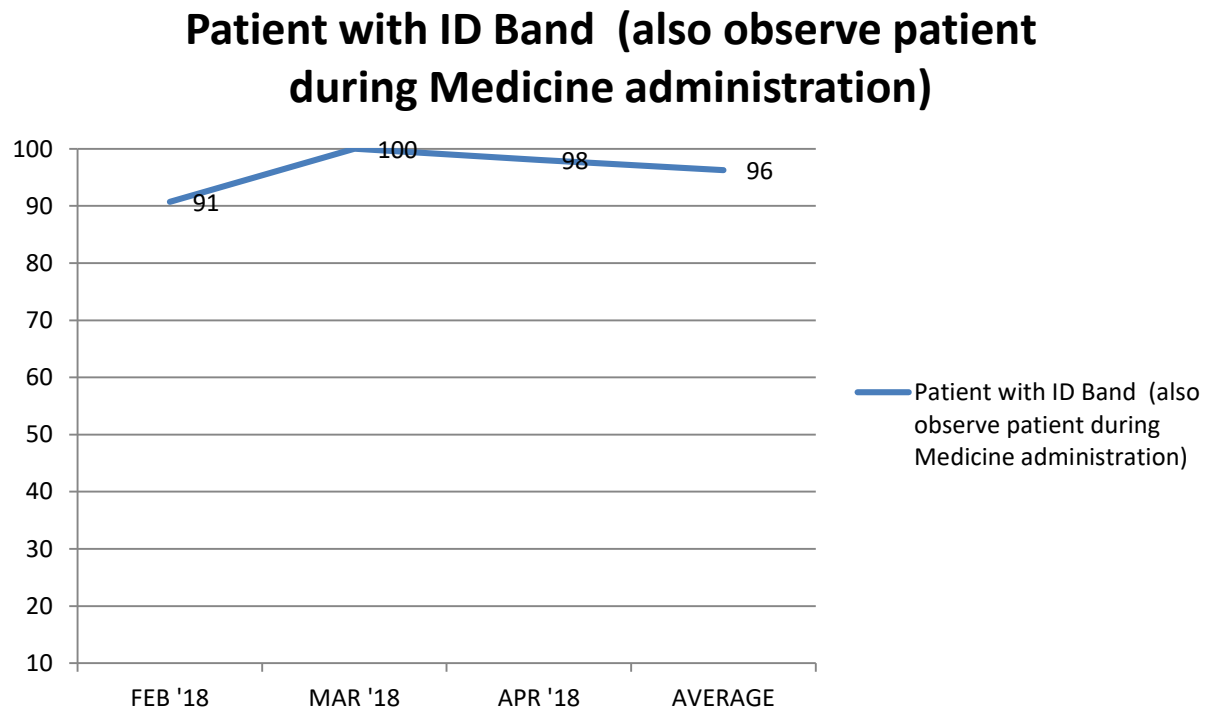
- 6) High risk medicine with inventory
- 7) All other medications with inventory
- 8) Opened bottles labeled with date/time
- 9) Side rails
- 10) WHO surgical safety checklist
- 11) Hand hygiene practice

The scoring pattern for the analysis used was 1 for compliance, 0 for non-compliance. It means if any of the given parameters was found complying, the score was given. On the other hand, if it was not complying then 0 was given.

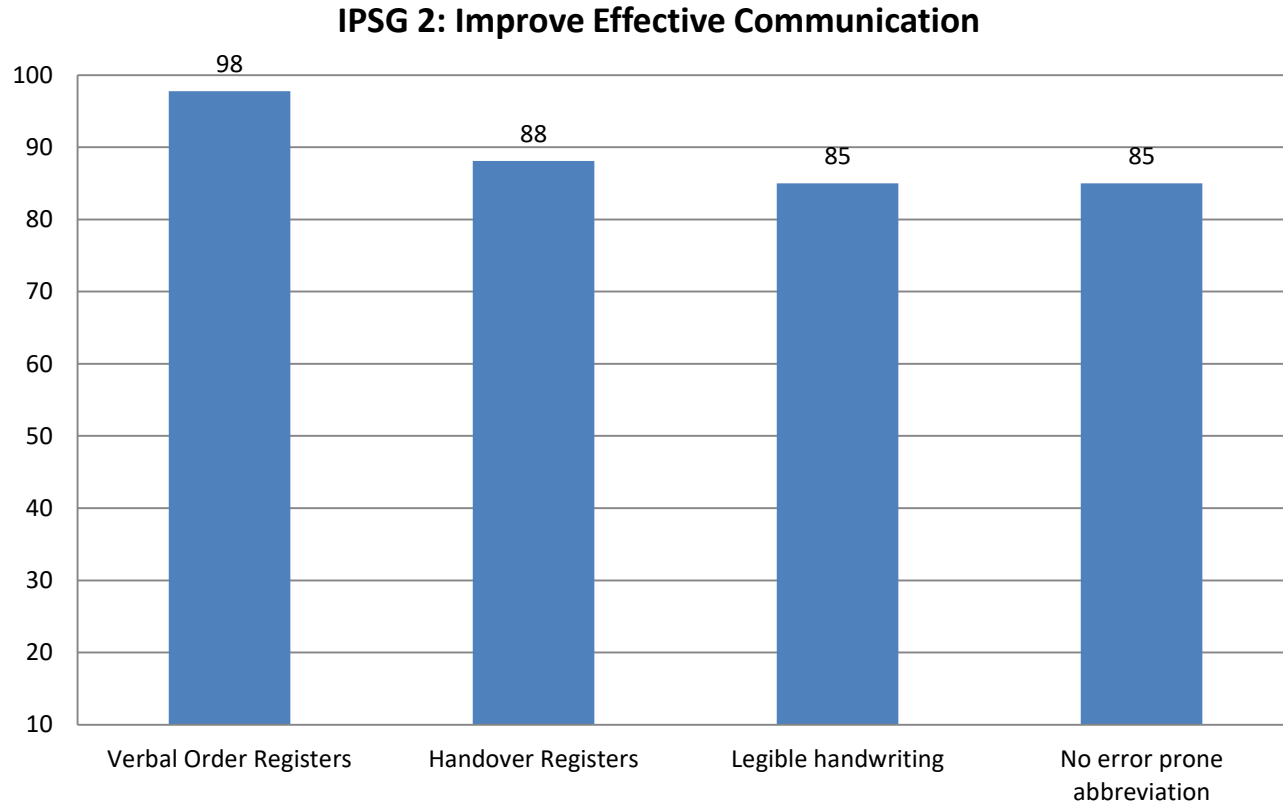
		Ward	Lab	Radiology	Endoscopy	Blood Bank	Store	Pharmacy	Emergency	OPD	FW	MW	Dialysis	LDR	NICU	Pvt Room	ICU	OT	Cath lab	TPR	Total applicable	Total compliance	% compliance
S.no.	IPSG	Checklist																					
1	IPSG 1 - Identify patient correctly	Patient with ID Band (also observe patient during Medicine administration)	NA			NA	NA	NA		NA													
2	IPSG 2 - Improve effective communication	Verbal Registers	NA	NA	NA	NA	NA	NA		NA				NA					NA				
		Handover Registers		NA	NA	NA	NA	NA	NA	NA				NA	NA				NA	NA			
		Legible handwriting	NA	NA	NA	NA	NA	NA		NA			NA	NA	NA			NA	NA	NA			
		No prone abbreviation	NA	NA	NA	NA	NA	NA		NA			NA	NA	NA			NA	NA	NA			
3	IPSG 3- Improve safety of high alert medication	High Risk Medicine maintained with Inventory	NA				NA			NA													
		All other medication managed with Inventory	NA				NA			NA													
		Opened bottles labelled with date/time of opening & expiry					NA	NA		NA													
		If patient medicine in refrigerator it should have Reg No. & Patient Name	NA	NA	NA	NA	NA	NA		NA									NA				
		Labeling of loaded syringe - Pts. Name, Medicine name, Date of loading Name & Signature of staff	NA	NA	NA	NA	NA	NA		NA													
4	IPSG 4 -Ensure correct patient, correct site, correct procedure	WHO Surgical Safety Checklist	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		NA	NA			
		Medical record audit	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA			
5	IPSG 5 - Reduce risk of Hospital Acquired Infection	Compliance of Hand Hygiene Practice																					
6	IPSG 6 - Reduce Patient harm resulting from fall	Side Rails used	NA	NA		NA	NA	NA		NA													
		Fall Risk Assessment done	NA	NA	NA	NA	NA	NA	NA	NA			NA	NA	NA			NA	NA				

DATA ANALYSIS

A total of 18 departments were analyzed.



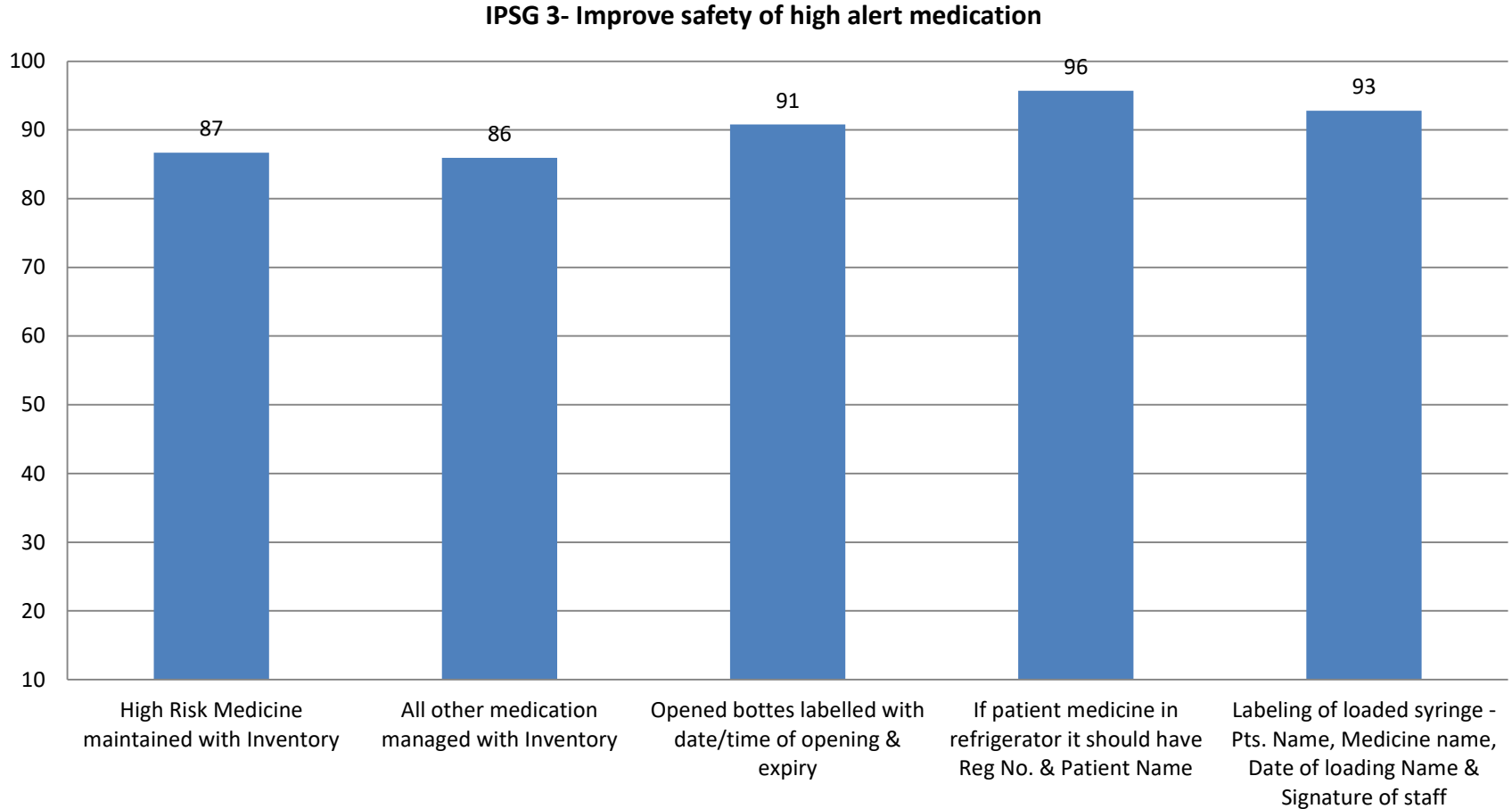
IPSG 2: Improve effective communication



Based on the data collected, it was observed that:

- Communication issues with doctors was one of the contributing factors as verbal orders were given.
- Handoff communication among caregivers.
- Content was not consistently complete and accurate as doctors were not using block letters in prescription.
- Abbreviations were used.

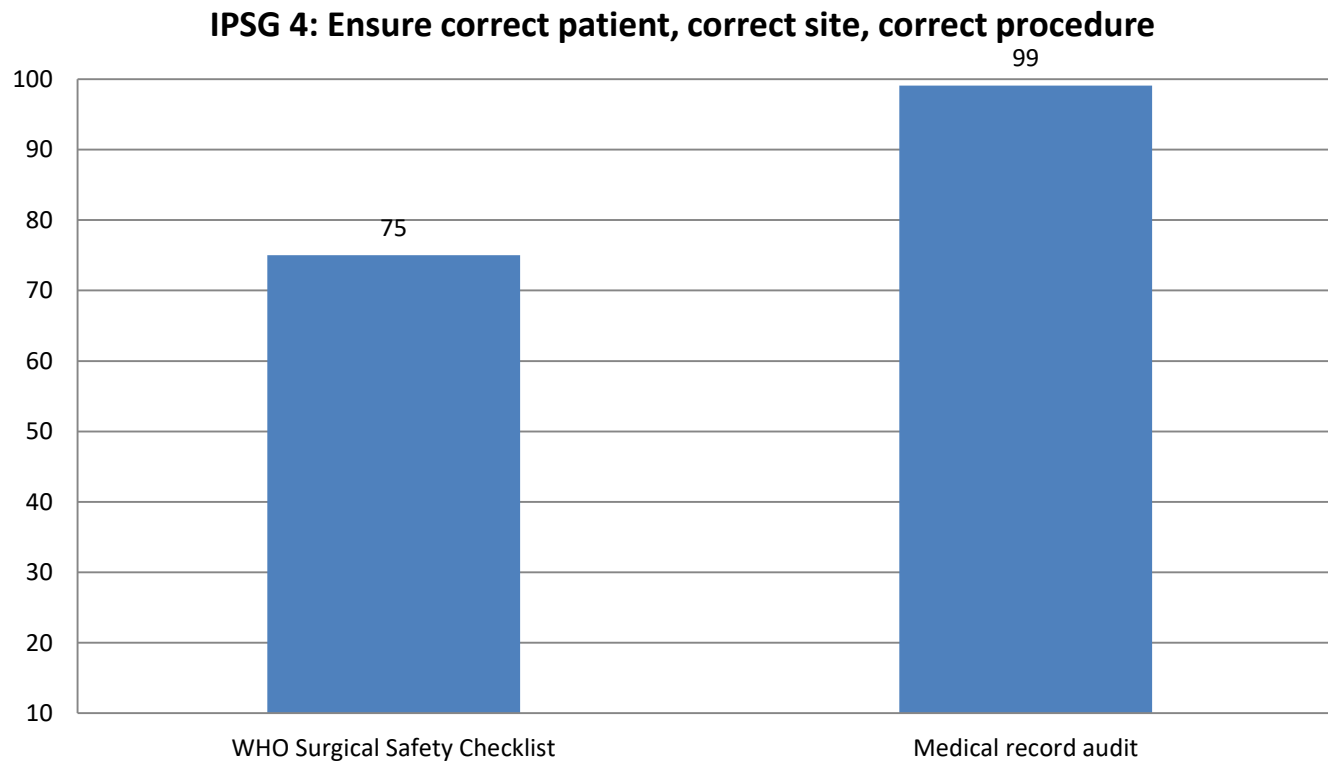
IPSG 3: Improve safety of high alert medication



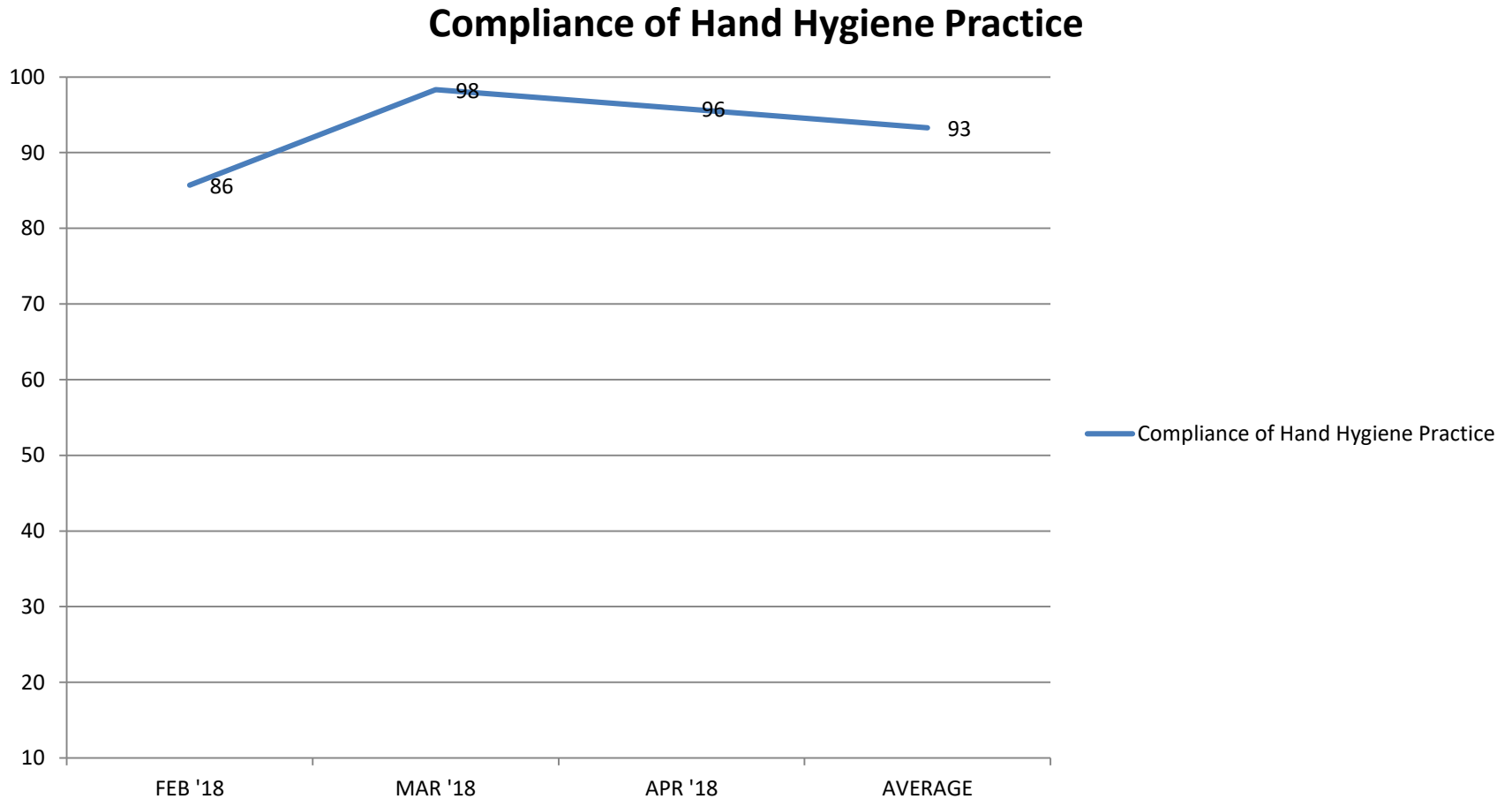
Based on the data collected, it was observed that:

- There was no inventory for high risk medicines and other medicines.
- The medicines were not labeled.
- Medicines were not kept separated from look alike sound alike medicines (LASA).

IPSG 4: Ensure correct patient, correct site, correct procedure

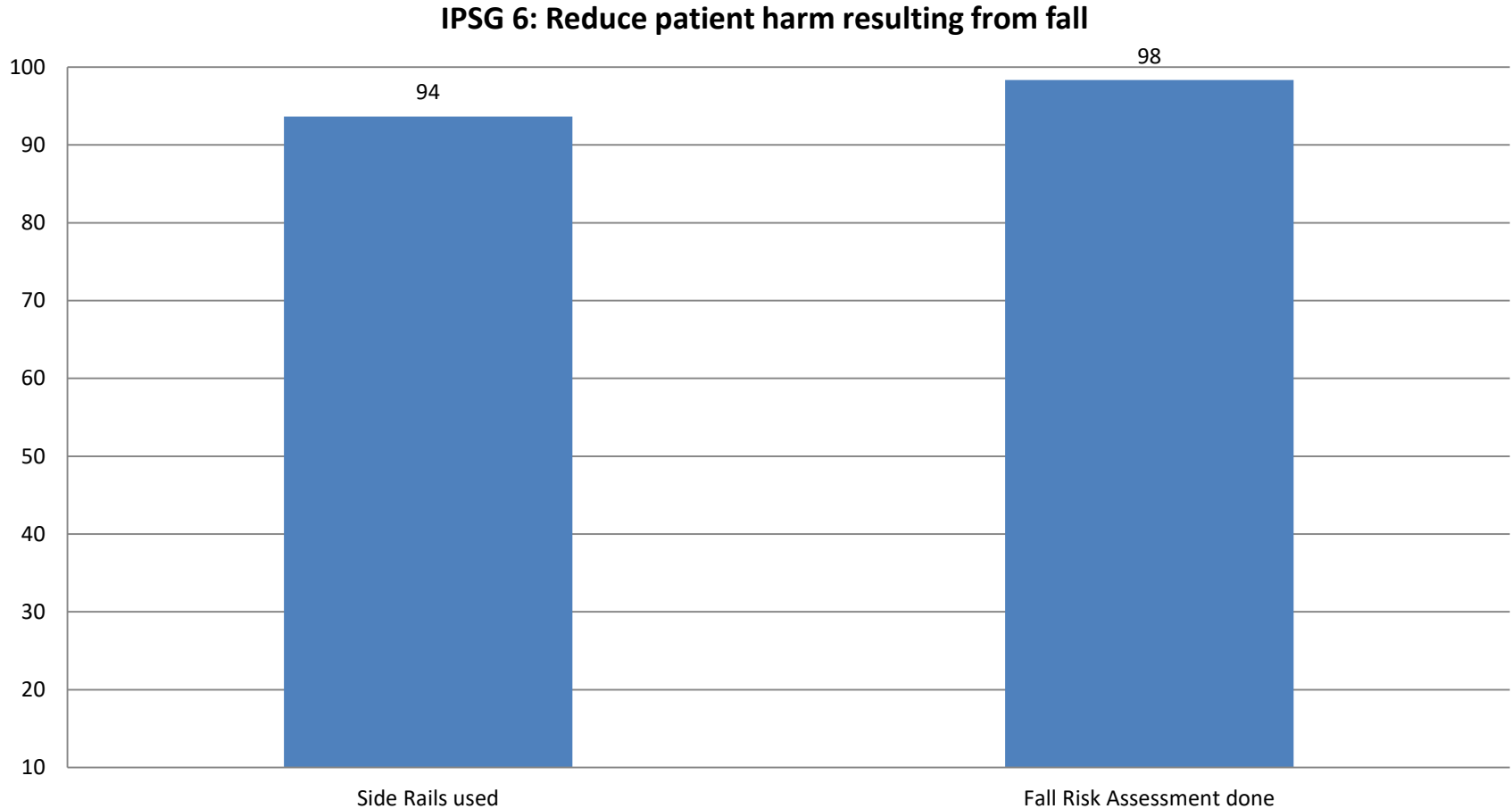


IPSG 5: Reduce risk of hospital acquired infection



- The nursing staff was not following the hand hygiene practices as they were not well trained about the hand hygiene and hand washing movements.
- They were not aware about that when should hand hygiene practice should take place.
- They were not aware about the six steps of hand washing.
- Signages were not displayed.

IPSG 6: Reduce patient harm resulting from fall



- It can be depicted that side rails and belts were not used while transferring the patients from one place to another on stretcher as well as on wheel chairs. The main problem was observed during the transfer of vulnerable patients who were unconscious and needed extra care. The gap was found because the staff was not trained on this matter.

International patient safety goals



GAPS

- Ineffective communication between healthcare providers
- High risk medicines inventory were not maintained separately.
- Fall assessment was not done properly
- Hand hygiene compliance rate was not up to the benchmark.

RECOMMENDATIONS/ SUGGESTIONS

Identify Patient Correctly

- To use two patient identifiers during and before any procedure or treatment which are Name and the Registration Number.
- To compare the two identifiers with the arm band to ensure the correct patient receives the correct treatment.

Improve Effective Communication

- “To get the important test results to the right people timely.”
- “Documentation of who called and the time for all the critical values.”
- “To conduct bedside shift reports.”
- “To ensure that verbal order registers are signed by the Doctor by whom the order was received.”

Improve safety of high alert medication

- To label all the medicines, syringes with proper labels and stickers.
- To use bedside scanning of patient reports and medication charts for confirming the medicines.
- To complete the medication history.

Ensure correct patient, correct site, correct procedure

- To follow universal protocol policy (correct patient and the correct site)
- To ensure that the physician marks the correct site on the patients body prior to surgery/ procedure.

Reduce risk of Hospital Acquired Infection

- Following hand cleaning guidelines to improve hand cleaning.
- Displaying the signages of hand washing step and hand hygiene movements on each and every nursing station.

Reduce patient harm resulting from fall

- Screening of patients to determine which patient is more vulnerable and needs extra care.
- Arranging appropriate transferring methods to ensure patient safety and to reduce patient harm from the fall.
- Ensuring that every bed and wheelchair is with side rails and belts so that while transferring a patient, they can be handled with care.

CONCLUSION

- Patient safety is the cornerstone of high quality health care. Nurses are critical to the surveillance and coordination that reduce such adverse outcomes. Much work remains to be done in evaluating the impact of nursing care on positive quality indicators, such as appropriate self-care and other measures of improved health status.

