Implementation of WHO International Patient Safety Solutions in Tertiary Care Hospital 525 Bedded

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Introduction

- Worldwide, the delivery of health care is challenged by a wide range of safety problems. The traditional medical oath— “First do no harm”—is rarely violated intentionally by physicians, nurses, or other practitioners, but the fact remains that patients are harmed every day in every country across the globe in the course of receiving health care.
- All patients have a right to effective, safe care at all times.

- In 2005, the World Health Organization (WHO) designated the Joint Commission and Joint Commission International as the WHO Collaborating Centre for Patient Safety Solutions. Working with WHO, and with guidance from an International Steering Committee, the Collaborating Centre developed the first set of nine Patient Safety Solutions
- The basic purpose of the solutions is to guide the re-design of care processes to prevent inevitable human errors from actually reaching patients

Rationale

- Jaypee hospital operations management was mainly concerned about following four patient safety solutions amongst nine WHO solutions as these were the problematic areas and due to which patient safety was at higher risk in the ward level of hospital.

This study was conceptualized for the following four areas:

I. **Patient Identification**: The FDA's own research concluded that correct patient identification will prevent 500,000 adverse drug events and blood transfusion errors over 20 years**.**

(Source:Patient identification, Patient safety solutions volume 1, solution 2/may 2007)

II. **Communication during Patient Hand-Over**: Research world over shows that poor clinical handover is a significant contributing factor to many adverse patient events. It is estimated that 80% of serious medical errors involve miscommunication during the handovers between healthcare professionals. .A review of 3000 sentinel events demonstrated that in 14 communication breakdown occurred 65-70% of the time

II. **Hand Hygiene to Prevent Health Care-Associated Infections**: Hand hygiene reduces the incidence of healthcare associated infections. Each year nearly 2 million patients get an infection in hospitals, and about 90,000 of these patients die as a result of their infection**.**

(Source:Improved hand hygiene to prevent health care associated infections, Patient safety solutions volume 1, solution 9/may 2007)

II. **Assuring Medication Accuracy at Transitions in Care**: Medication errors most frequently occur during prescribing and administering actions.

AIMS AND OBJECTIVES

The aim of this study is to identify gaps and devise required interventions for implementation of patient safety solutions recommended by WHO, to reduce errors of patient safety from the perspective of health care providers.

GENERAL OBJECTIVE

- To identify the gaps in implementation of World Health Organization International Patient Safety Solutions in 525 bedded tertiary care hospital and devise & implement necessary training interventions

SPECIFIC OBJECTIVES

1) To identify the gaps in implementation of International Patient Safety Solutions
2) To devise training interventions of International Patient Safety Solutions to all stakeholders
3) To monitor the change post training interventions
4) To evaluate the outcome of trainings and suggest the recommendations

Research Methodology

Study design: Cross sectional Descriptive study

Study location: In Patient Wards - Jaypee hospital, Noida

Sample population:

- Clinical
- Para - Clinical
- Support staff of In Patient Ward of Jaypee Hospital, Noida

Sample and Sample Design:
Convenience sampling for the staff and Doctors
Sample size 90,
(Ward Nurses =75 & Resident medical officers=15)

It was based on the IPD wards (5^{th} and 6^{th} floor) being allotted for training purposes.

- **Data collection**

1. Primary data:

a. Data was collected from the sample group taken for study (Ward Nurses =75 & Resident medical officers=15) by using the checklist and questionnaires based on WHO IPSS

b. Direct observation

c. Discussions with hospital IPD staff

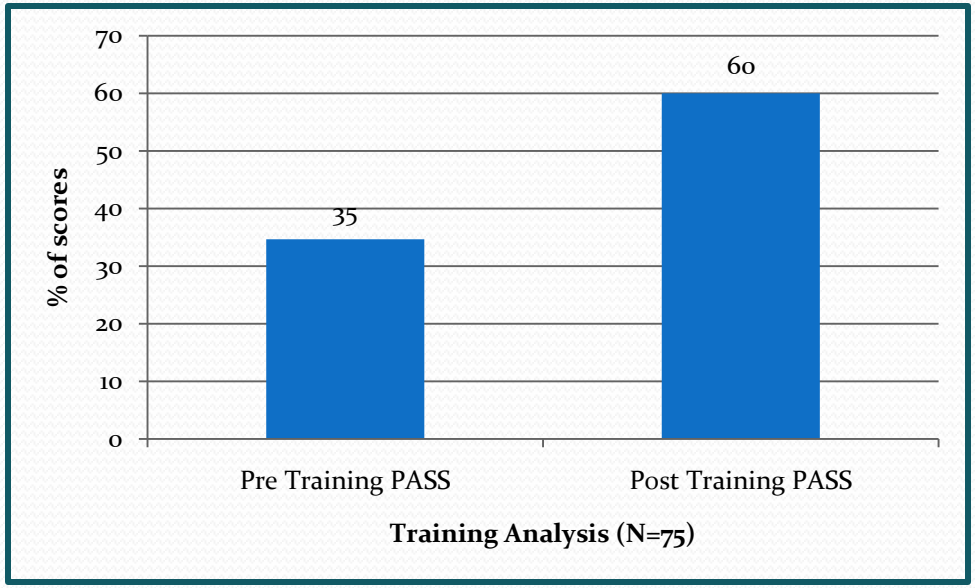
2. Secondary data: Reports, forms and registers of IPD and other relevant records

Steps for developing a training programme for IPSS

1. Depending upon the objectives it was decided which mode of learning is most suitable for reaching the objectives (e.g. checklist tracker list, questionnaires,).
2. A programme outline based on the above was Constructed
3. Assessment of learners to be included pre training was done
4. Knowledge tests such as multiple-choice questions along with practical examples to demonstrate skill was prepared.
5. Post training assessment of learners was calculated.

RESULTS

- **Pre training vs Post training nurses analysis**



Training intervention

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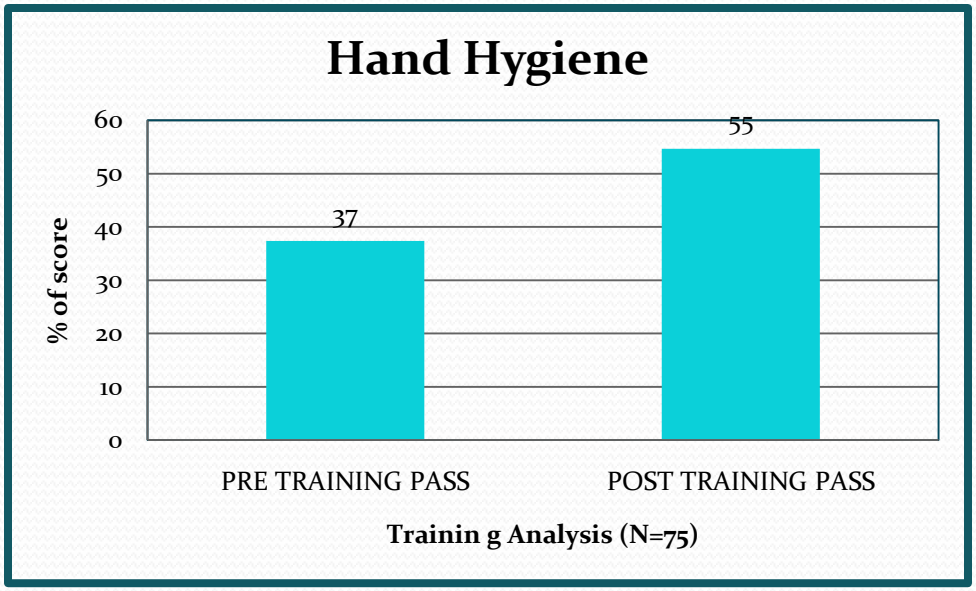
- **Strategies for patient identification**

1) Use of at least 2 identifiers to verify a patient identity upon admission or transfer or prior to the care administration.
2) Use of id bands on which a standardized pattern and specific info could be written.
3) Implement automated systems(e.g. Bar coding) to decrease the potential for identification errors.

Policy	emphasize that health care providers have primary responsibility for verifying a pt. identity, while patients should be actively involved and receive education on importance of correct pt. identification
Admission	upon admission and prior to administration of care ,use at least 2 identifiers to verify a patients identity.
Patient Identification	Standardize the approaches to patient identification among different facilities within a health-care system Develop an organizational protocol for identifying patients with same name
Intervention	Even if they are familiar to the health care provider, check the details of a patient identification to ensure right patient receives the right care
Patient	Involve patients in the process of pt. identification

- Pre training vs. Post training nurses analysis on Hand hygiene

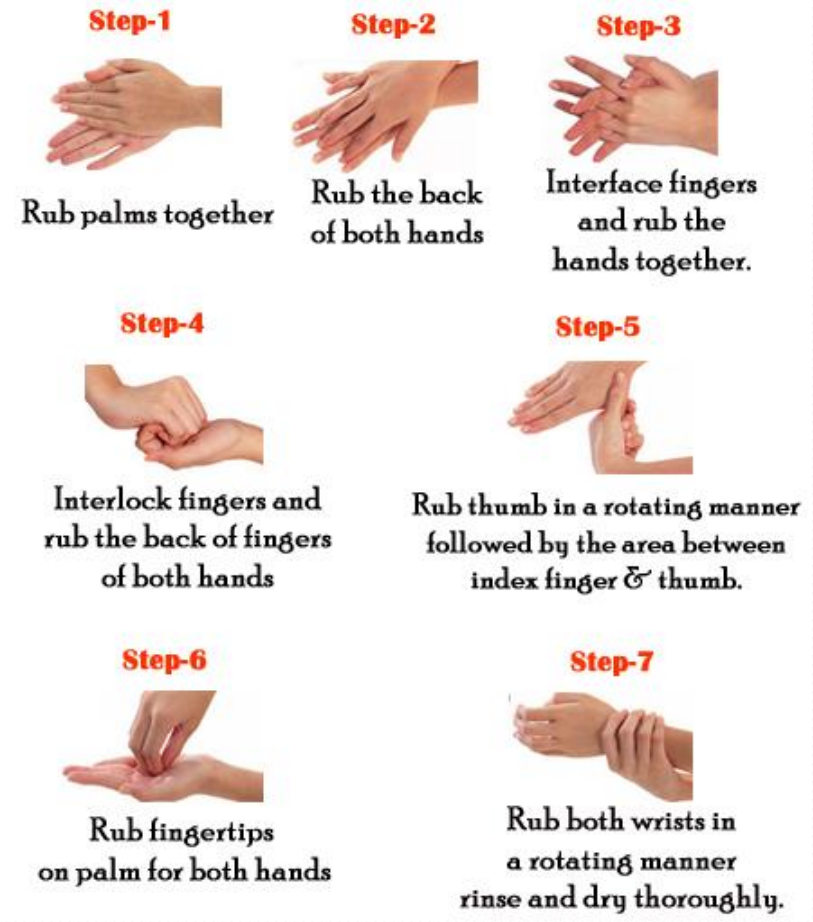


Strategies To Improve Hand Hygiene To Prevent Hospital Acquired Infections

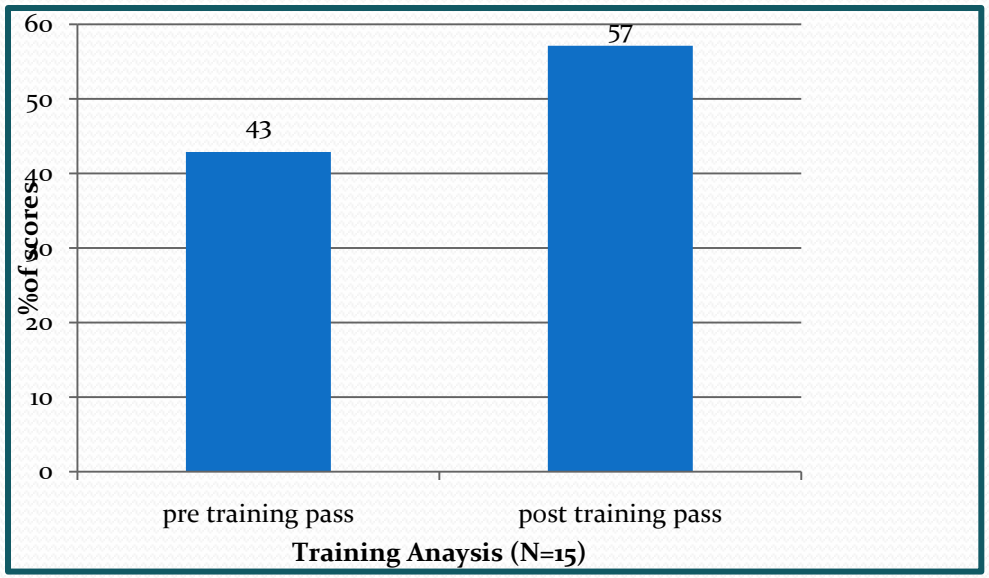
- Provision of readily accessible alcohol- BASED hand rubs at the point of patient care
- Access to safe continuous water supply at all taps and the necessary facilities to perform hand hygiene
- Education of health care workers on correct hand hygiene techniques
- Display of promotional hand hygiene reminders in workplace


Your 5 moments for
HAND HYGIENE
1 BEFORE PATIENT CONTACT
2 BEFORE ASEPTIC TASK
3 AFTER BODY FLUID EXPOSURE RISK
4 AFTER PATIENT CONTACT
5 AFTER CONTACT WITH PATIENT SURROUNDINGS

Hand washing steps



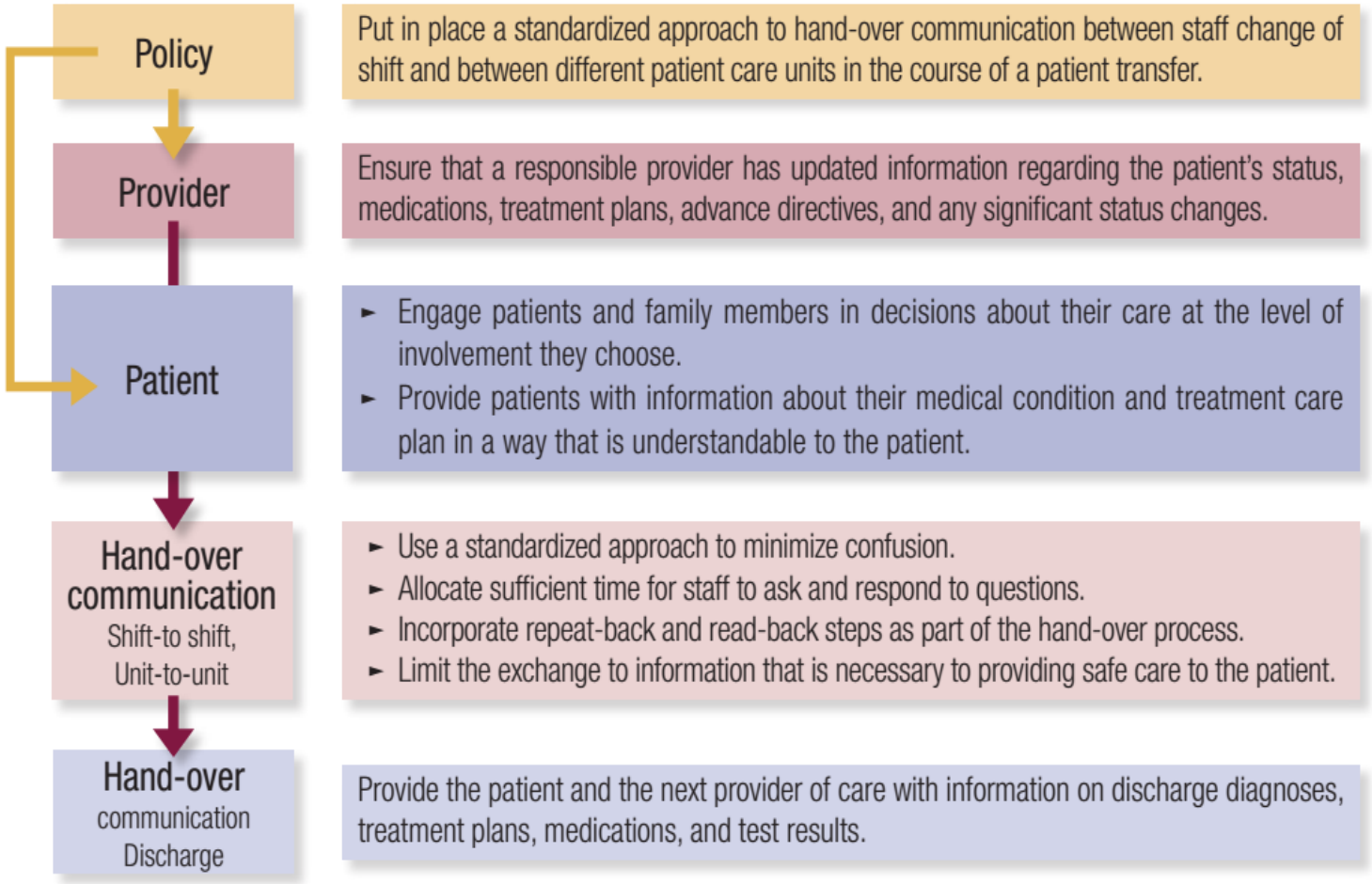
Pre training vs Post training doctors analysis on communication during Patient Hand over



Strategies For Good Communication During Hand-over

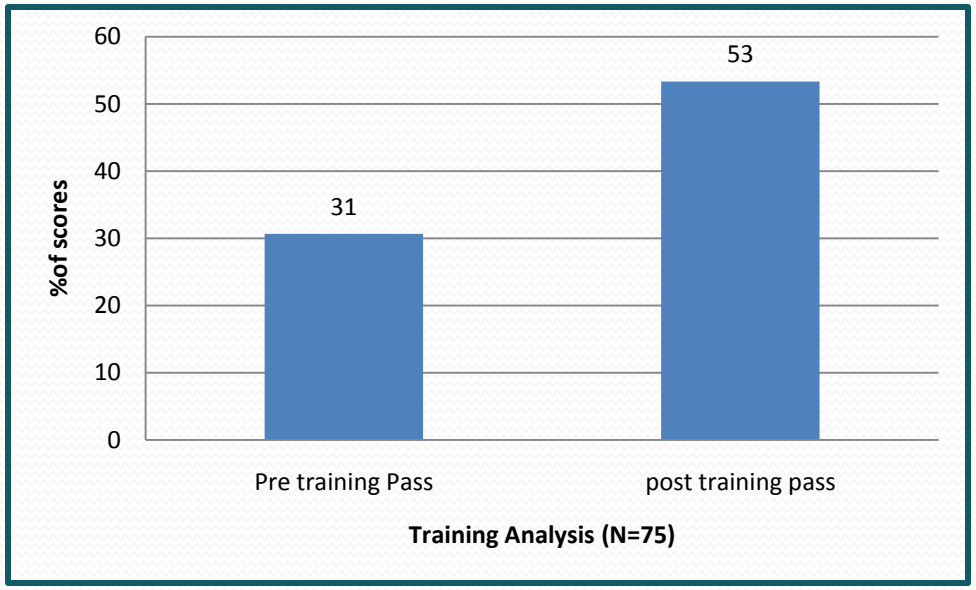
- Doctors and Nurses Communication Hand Over Register is implemented in IPD
- Use of SBAR (Situation, Background, Assessment and Recommendations) technique during communication is to be followed
- Repeat –back and read back steps should be included in the handover

EXAMPLE OF
Communication During Patient Hand-Overs

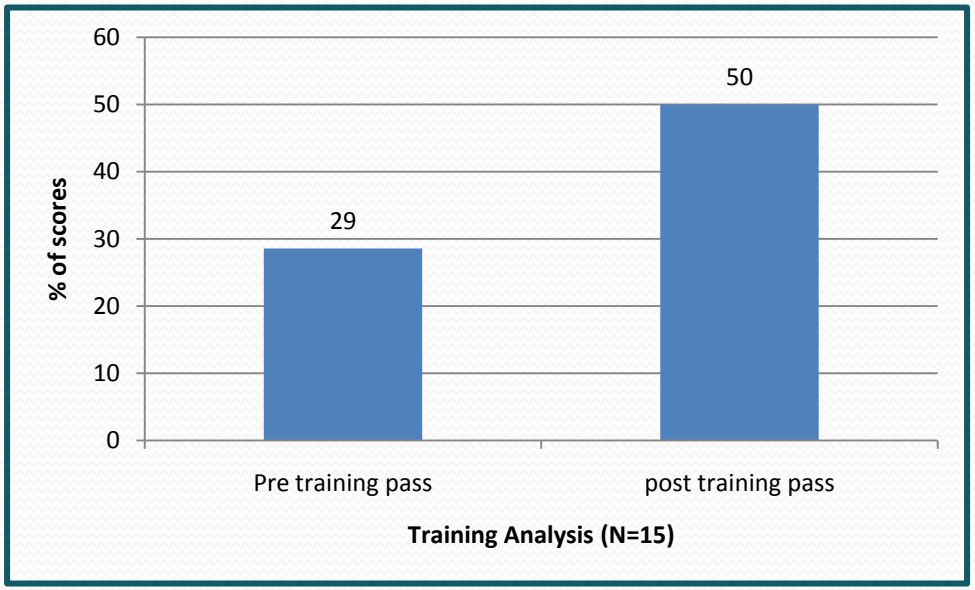


This example is not necessarily appropriate for all health-care settings.

- Post training vs Post training nurses analysis on communication during patient hand over

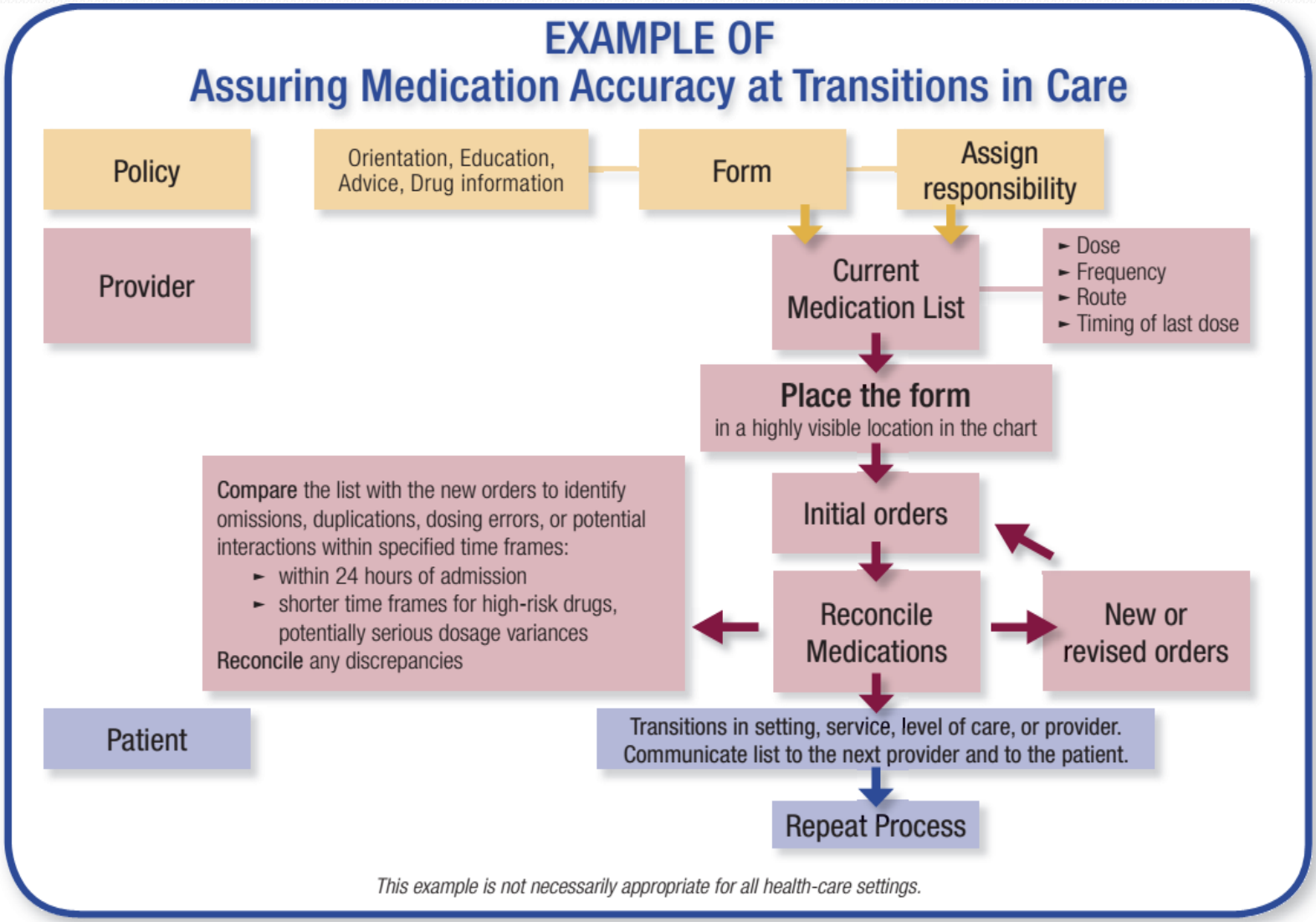


Pre training vs Post training doctors analysis on Medication Accuracy at Transition in Care



INTERVENTION:TRAINING

- Collect and document information about all current medications for each patient and provide the resulting medication list to the next care provider at each care transition point (admission, transfer, and discharge).
- Incorporate training on procedures for reconciling medications into the educational curricula, orientation, and continuing professional development for health-care professionals.


EXAMPLE OF
Assuring Medication Accuracy at Transitions in Care
Policy
Orientation, Education, Advice, Drug information
Form
Assign responsibility
Provider
Current Medication List
► Dose
► Frequency
► Route
► Timing of last dose
Place the form
in a highly visible location in the chart
Initial orders
Compare the list with the new orders to identify omissions, duplications, dosing errors, or potential interactions within specified time frames:
► within 24 hours of admission
► shorter time frames for high-risk drugs, potentially serious dosage variances
Reconcile any discrepancies
Reconcile Medications
New or revised orders
Patient
Transitions in setting, service, level of care, or provider.
Communicate list to the next provider and to the patient.
Repeat Process
This example is not necessarily appropriate for all health-care settings.

SUGGESTIONS

- Formulation of patient safety guidelines in departmental manual-detailed SOPs for the same so that it can be evaluated and edited as per the requirements of top management
- Where available, explore technologies such as electronic medical records, electronic prescribing systems to streamline information access and exchange for Patient Safety
- Consider implementation of automated systems (e.g. electronic order entry, bar coding, radiofrequency identification, biometrics) to decrease the potential for identification errors.
- The missing bilingual (Hindi & English)hand hygiene signage's/posters need to be displayed near all the taps in IPD
- Induction program for the staff to be introduced for patient safety
- Training monitoring records to be maintained on regular basis