

STANDARDIZING THE DATA COLLECTION PROCESS AND TOOLS OF IPSG KEY PERFORMANCE INDICATORS (KPIS) IN THUMBAY UNIVERSITY HOSPITAL

HOSPITAL

(KPIS) IN THUMBAY UNIVERSITY

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Dissertation Presentation

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Roll no : 1332

Course : MBA-HM 2nd year Healthcare
Management

Introduction

Thumbay University Hospital, located in Thumbay Medicity in Al Jurf, Ajman stands out as the is the largest private academic hospital in the Middle East region, with the capacity of **350 beds**.

In 1998 Thumbay moideen from India launches Thumbay group in UAE, with the establishment of Gulf medical college.

Thumbay Hospital prides itself on being the largest network of private academic hospitals in the region. This is one of the most important aspects which differentiate Thumbay Hospitals from the other healthcare providers in the region. In the UAE alone, GMU and its network of pioneering teaching hospitals train around 20 percent of the doctors and 60 percent of the total healthcare professionals.

Background

The World Health Organization (WHO) and other international healthcare organizations created the International Patient Safety Goals (IPSG), a collection of recommendations, to increase patient safety and decrease medical mistakes on a worldwide level. These objectives are created to deal with issues of concern and offer a framework for healthcare professionals to adopt safety procedures.

The IPSG usually concentrates on areas where patient safety problems are more likely to happen or have a big effect.

Goal 1: Identify patients correctly.

Goal 2: Improve effective communication.

Goal 3: Improve the safety of high-alert medications.

Goal 4: Ensure safe surgery.

Goal 5: Reduce the risk of health care-associated infections.

Goal 6: Reduce the risk of patient harm resulting from falls.

► **Based on these International Patient safety goals Existing key performing indicators are:**

1. Compliance to Patient Identification Protocol.
2. Compliance to Nursing handover protocol
3. Percentage Compliance to storage of High alert medications
4. Compliance to Surgical Safety Checklist
5. Percentage Compliance to Hand Hygiene Protocol
6. Patient Fall Rate

Research Objective

1. Primary Objective is to Establish a centralized and standardized data collection tool for IPSG key performance indicators (KPIs) at Thumbay University Hospital Ajman (TUH).
2. Develop a comprehensive framework that ensures consistent monitoring and evaluation of patient safety metrics.
3. Provide recommendations for incorporating new KPIs to enhance patient safety practices at TUH.

PROBLEM STATEMENT

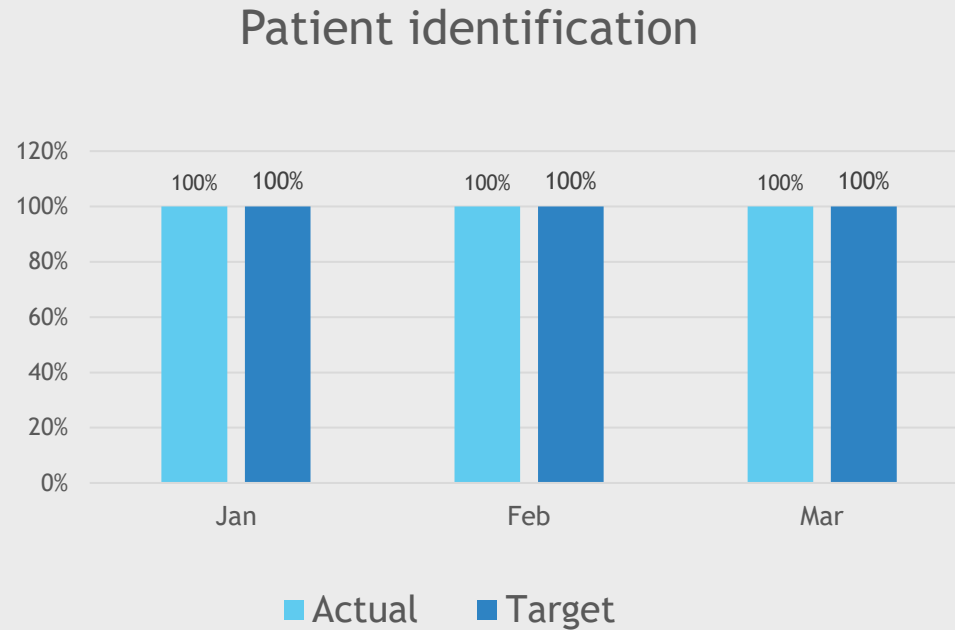
Upon joining the Quality Assurance department on a monthly basis, my role involves receiving data on Key Performance Indicators (KPIs) and analyzing them to enhance the processes of various departments. After thoroughly examining the existing KPI data, it becomes apparent that nearly all the KPIs exhibit a 100% compliance rate.

This scenario can only occur in two circumstances

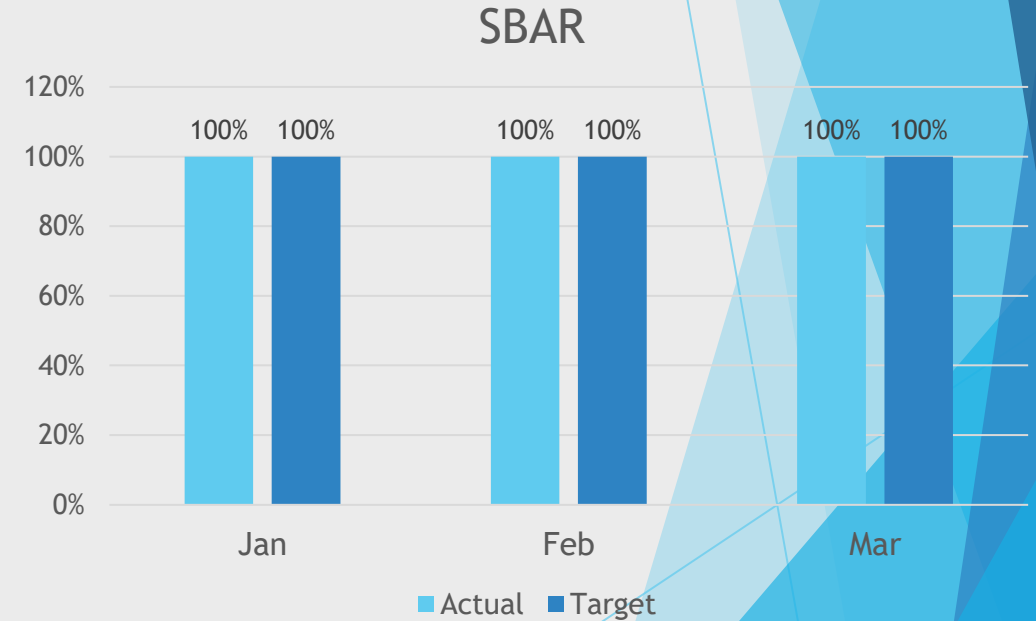
1. A score of 100 might indicate an exceptionally high degree of operational excellence and efficiency, meaning that every part of the organization or process being evaluated is operating at its peak.
2. Different explanation appears, prompting questions regarding the precision and thoroughness of the data gathering procedure.

ANALYSIS OF EXISTING KPI's

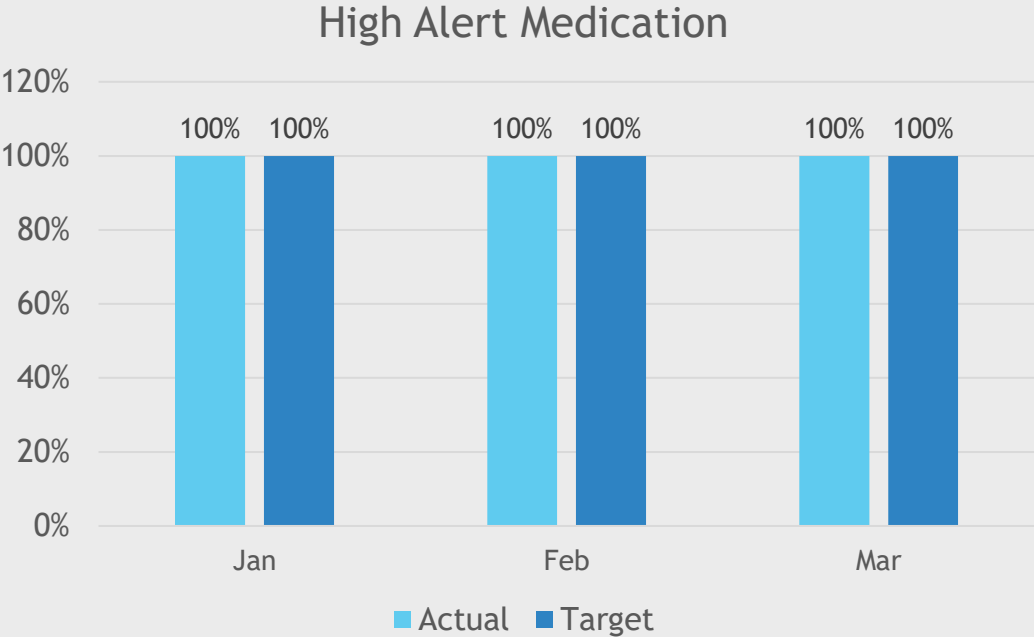
KPI 1-Compliance to Patient Identification Protocol.



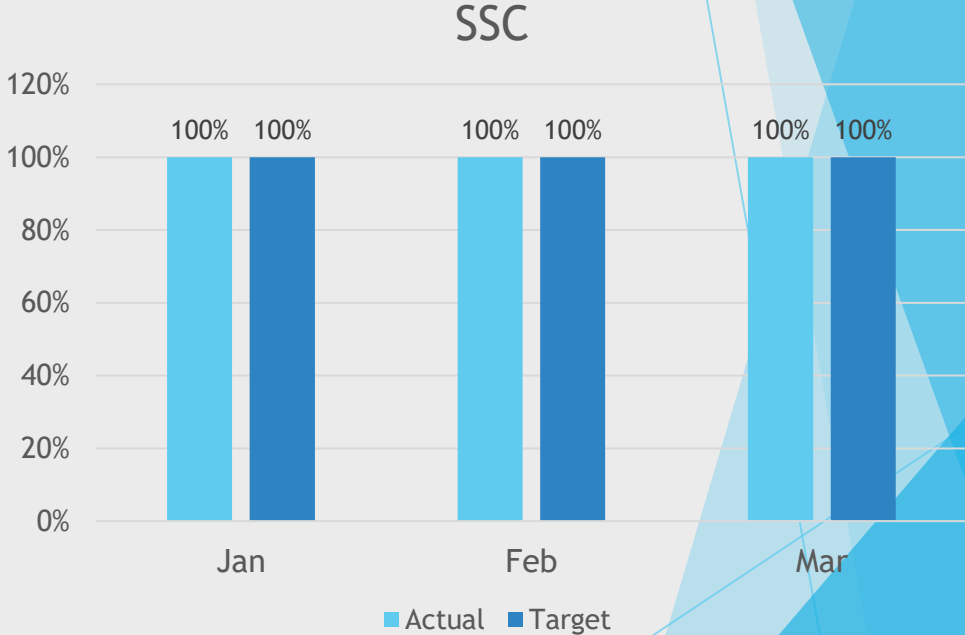
KPI 2-Compliance to Nursing handover protocol



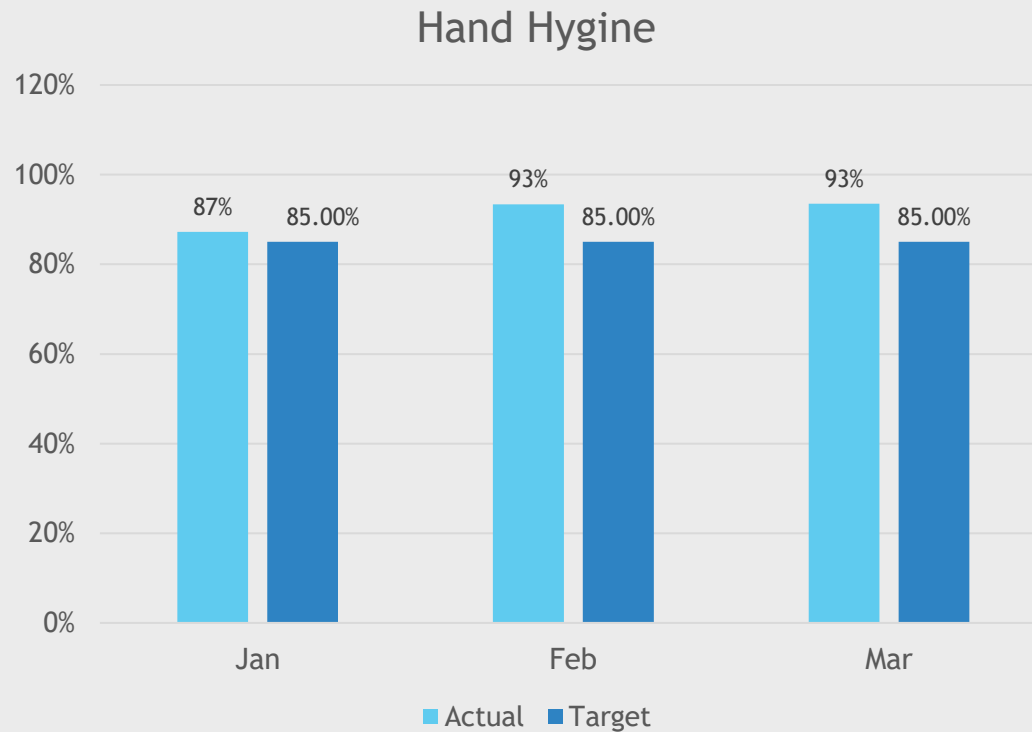
KPI 3-Percentage Compliance to storage of High alert medications



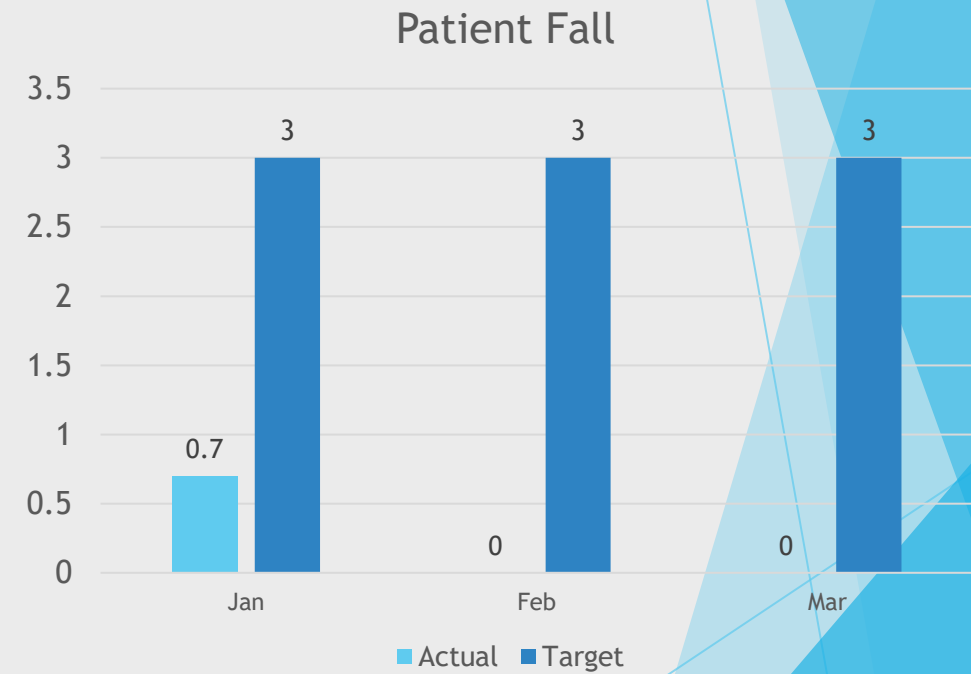
KPI 4- Compliance to Surgical Safety Process



KPI 5-Percentage Compliance to Hand Hygiene Protocol



KPI 6- Patient Fall Rate



Methodology

Research Questions

- ▶ What are the current data collection tool used to collected data of IPSG KPIs?
- ▶ What are current data collection practices?
- ▶ What new KPIs can be developed to align with the IPSGs, to improve patient safety and quality of care?

Research Setting

- ▶ The study was conducted in Thumbay University Hospital (TUH) .

Research Design

- ▶ This is a Qualitative Research approach.

Methodology

Step 1: Reviewing the present data collection tool employed by the infection control, pharmacy, and nursing departments:

Step 2: Understand the current data collection practices from stakeholder.

Step 3: Preparing a new data collection tool in accordance with IPSG objectives.

Step 4: Review and Modification of Newly formed data collection tool.

Results

After reviewing and studying the existing data collection tools and processes, receiving feedback from the team responsible for data collection or Stakeholders (including nurses, medical orderlies, and technicians), and reviewing the best practices for data collection for the identified key performance indicators (KPIs), new data collection tools are being developed.

Goal 2: Improve effective communication.

IPSG 2- Hospital should develop and implement a process to improve effective communication

Indicator 1- Percentage compliance to Verbal/ Telephonic order

Performance Measuring-Nursing								
INDICATOR-Verbal/ Telephonic Order								
Sr. No.	UNITS	Patient Name	Hospital Id	Documentation of Verbal order	Verbal Order READ BACK Evidence	Telephonic Order confirmed by Doctor	Doctor's Acknowledgment within 24 hours	% Compliance

2.1- Hospital should develop and implement a process for reporting critical results of diagnostics tests.

Indicator 2- Percentage compliance to Critical Result.

Performance Measuring-Nursing										
Indicator-Critical Test Result										
Sr. No.	UNITS	Patient Name	Hospital Id	Test result logged as critical	Critical result reported within 30 minutes	Receiving time/whom documented?	Informing time/whom documented?	Action advised by the doctor documented?	Appropriate action taken	% compliance

DATA COLLECTION TOOLS FORMED

Goal 2: Improve effective communication.

2.2- Hospital develop and implements a process of handover communication.

Indicator- Compliance percentage to Nursing handover protocol

Performance Measuring-Nursing											
INDICATOR-Situtation Background Assessment Recommendation											
Sr. No.	UNITS	PT NAME	HOSPITAL ID	Handover Type	Departement of Handover	Situation Documented	Background Documented	Assesment Doucmented	Reccomendation	Overall Compliance %	Audited by

DATA COLLECTION TOOLS FORMED

Goal 3: Improve the safety of high-alert medications

IPSG 3: Hospital should develop and implements a process to improve safety of high alert medication.

3.1- Process to improve the safety of look-alike and sound alike medication.

3.2- Manage the safe you of concentrated electrolyte.

Indicator-Percentage Compliance to storage of High alert medications

Performance Measuring- Pharmacy								
INDICATOR-Storage of High Alert Medication								
Sr. No.	Date	Medication Name	CONCENTRATED ELECTROLYTES AND HIGH ALERT MEDICATIONS STORAGE				% Compliance	Remark
			Restricted access Evidence	Secure storage	Medication Label	Near Expire Label Available		

DATA COLLECTION TOOLS FORMED

Goal 4: Ensure safe surgery.

IPSG 4-Implement a process for the preoperative verification.

4.1- Hospital should implement a time-out and Sign-out process.

Indicator- Percentage Compliance to WHO Surgical Safety Checklist

Performance Measuring-Operation Theater (OT)											
INDICATOR- Surgical Safety Checklist											
				SIGN IN				TIME OUT DOCUMENTED			
S.No.	Pt. Hospital No.	Surgery Date	Surgery/ Procedure done	Pre-op site marking	A pre -operative checklist is utilized to verify correct site,	Known Allergy	Difficulty in respiration	Time Out documented	Verbal confirmation of site and Procedure	Antibiotic prophylaxis within 60 min	VTE prophylaxis been undertaken
SIGN OUT											
Count of the instruments, swabs and sharps confirmed		Specimen is labelled (Including Patient name and UHID)		Equipment problems identified	Key concerns for the recovery and management of post operative patient identified			Surgeon's Name	Circulating Nurse	Compliance %	

DATA COLLECTION TOOLS FORMED

Goal 5: Reduce the risk of health care-associated infections

IPSG 5- Should implement evidence based hand-hygiene guidelines.

Indicator- Percentage compliance to hand hygiene Protocol.

Performance Measuring- Infection control

INDICATOR- Hand hygiene Protocol

Sr. No	Location	Professional Category	Hand Hygiene Moments					HH Action		
			Total	Bef-Pat	Bef-asept	Aft-pat	Aft-sur	HR	HW	Missed

DATA COLLECTION TOOLS FORMED

Goal 6: Reduce the risk of patient harm resulting from falls.

IPSG 6- Implement the process to reduce the risk of patient harm resulting from patient fall

Indicator- Patient fall Rate per 1000 bed days.

Performance Measuring- Nursing										
Indicator- Patient Fall (Outpatient)										
Sr. No.	Date	Patient Name	Hospital ID	Risk of Patient Fall	Precautions	Patient Fall	Corrective Action	Escalation	Remarks	%Compliance

LINK - [KPI \(1\).xlsx](#)

Data definition sheets

Data definition sheets are formed for all the KPIs which includes all the information about the KPIs.

KPI 1-Percentage compliance to patient identification protocol:

Type of Measure: (Tick one)		☐ Structure	☐ Process
☒ Clinical ☐ Managerial		☐ Outcome	☒ Process and Outcome
TITLE OF PERFORMANCE INDICATOR	Percentage compliance to Patient Identification protocol		
DEFINITION OF INDICATOR: <i>Include all important terms, references</i>	Patient identification is the process of recognizing an individual through sets of patient identifiers established by Thumbay enterprise to ensure that the right patient is indeed receiving the right treatment / care. To ensure all patients are correctly identified two patient identifiers are used in the Outpatient Department "Full name of the patient and the Date of Birth", which is available on Patient Visit Record (PVR). The identifiers selected for all In-patients are "full Name of the patient and Hospital Number". Patients are identified in the following conditions (Not Limited to):- • Administration of all medicines • X-rays and imaging procedures • Surgical interventions and any invasive procedures • Blood transfusion • Collection of patient samples/ specimens • Transport/ transfer of the patient • Confirmation of death		
RATIONALE FOR MEASURE COLLECTION	Patient identification during blood transfusion, sample collection transport / transfer of patient, Surgical interventions and any invasive procedures and medication administration is a vital activity to prevent any wrong barcoding/labelling leading to wrong diagnosis and medication error/adverse events.		
INCLUSIONS AND EXCLUSIONS IF ANY	IPD, OPD patients undergoing. • Medication administration • X-rays and imaging procedures • Surgical interventions and any invasive procedures • Blood transfusion • Collection of patient samples/ specimens • Transport/ transfer of the patient		
NUMERATOR & DENOMINATOR <i>If applicable</i>	Numerator: Total number of compliances to patient identification protocol Denominator: Total number of audit (IPD, OPD)		
TARGET / BENCHMARK (WITH REFERENCE): <i>As Applicable</i>	Target: 100 % Benchmark: NA		
DATA COLLECTION PLAN:	Data will be collected by the nursing in-charge by directly observing the nursing staff, physician, pharmacist, Physiotherapist & dietician during Administration of all medicines , X-rays and imaging procedures, Surgical interventions and any invasive procedures, Blood transfusion , Collection of patient samples/ specimens, Transport/ transfer of the patient ,Confirmation of death. The data collection tool (Patient identification observation checklist) shall be filled in by the nursing in-charge during IPD rounds daily for checking patient identification process. The data must be standardized area-wise in order to ensure that all areas of the hospital are monitored for the process.		
DATA COLLECTION METHODOLOGY:	☐ Retrospectively ☒ Concurrently		
DATA SOURCES/ AREA OF MONITORING:	Patient identification observation checklist IPD, OPD		
FREQUENCY OF COLLECTION:	Frequency: ☐ Weekly ☒ Monthly ☐ Quarterly ☐ Others		
RESPONSIBILITY ASSIGNED TO:	For Data Collection: Nursing Supervisor For Data Analysis and Reporting: Enterprise Quality Assurance		

KPI 2.1- Verbal and Telephonic order:

Type of Measure: (Tick one)		☐ Structure	☐ Process
☒ Clinical ☐ Managerial		☒ Outcome	☐ Process and Outcome
TITLE OF PERFORMANCE INDICATOR	Percentage compliance to verbal and telephonic order.		
DEFINITION OF INDICATOR: <i>Include all important terms, references</i>	Verbal order refers to an instruction given orally, without a written document, typically in a face-to-face or direct communication setting. Telephonic order, on the other hand, refers to an instruction given over the phone, where the verbal communication is conducted remotely through a telephone conversation.		
RATIONALE FOR MEASURE COLLECTION	Collecting data on verbal and telephonic orders allows for accurate records, accountability, legal compliance, and analysis of communication patterns, trends, and efficiency for process improvement and decision-making.		
INCLUSIONS AND EXCLUSIONS IF ANY	Inclusions: All patients Exclusions: Complex or high-risk procedure		
NUMERATOR & DENOMINATOR <i>If applicable</i>	☐ NA Numerator: Total number of verbal/telephonic order documented Denominator: Total number of verbal and telephonic order received.		
TARGET / BENCHMARK (WITH REFERENCE): <i>As Applicable</i>	Target: NA Benchmark: NA		
DATA COLLECTION PLAN:	The data shall be collected through an incident reporting portal by the Unit Quality team and will be shared with the enterprise quality assurance department monthly.		
DATA COLLECTION METHODOLOGY:	☒ Retrospectively ☐ Concurrently		
DATA SOURCES/ AREA OF MONITORING:	All patient care area		
FREQUENCY OF COLLECTION:	Frequency: ☐ Weekly ☒ Monthly ☐ Quarterly ☐ Others		
RESPONSIBILITY ASSIGNED TO:	<i>For Data Collection: Nursing</i> <i>For Data Analysis and Reporting: Enterprise Quality team</i>		
DATA ANALYSIS PLAN: <i>Frequency, Graphs / Display</i>	Display : ☐ Report ☒ Graphs (specify: line/bar/pie charts) Frequency: ☒ Monthly ☐ Quarterly ☐ Bi-annual ☐ Annual		
ANALYSED REPORTS: To Whom? Frequency of Reporting?	☐ Head of Department Frequency: ☒ Monthly ☐ Quarterly ☐ Bi-annual ☐ Annual ☐ Others ☐ Hospital Committee, specify: Frequency: ☐ Monthly ☐ Bi-Monthly ☒ Quarterly ☐ Bi-annual ☐ Annual ☐ Hospital Staff Frequency: ☐ Monthly ☐ Bi- Monthly ☒ Quarterly ☐ Bi-annual ☐ Annual ☐ Other/s Frequency: ☐ Monthly ☐ Bi- Monthly ☐ Quarterly ☐ Bi-annual ☐ Annual		

KPI 2.2- Percentage Compliance to hand over communication.

Type of Measure: (Tick one)		☐ Structure	☒ Process
☒ Clinical ☐ Managerial		☐ Outcome	☐ Process and Outcome
TITLE OF PERFORMANCE INDICATOR	Percentage Compliance to hand over communication.		
DEFINITION OF INDICATOR: <i>Include all important terms, references</i>	Patient handovers are the transfer of information and professional responsibility and accountability between individuals and teams. Timely and effective handover of critical information ensure continuity of patient care and safe delivery.		
RATIONALE FOR MEASURE COLLECTION	Breakdowns in communication can occur during any handover of patient care and can result in adverse events. Standardized, critical content for communication between the patient, family, caregiver, and health care providers can significantly improve the outcomes related to handovers of patient care.		
INCLUSIONS AND EXCLUSIONS IF ANY	Inclusions: Shift Handover, patient transfer from one care unit to another, transfer of patient one physician to other. Exclusions: Non-Medical departments		
NUMERATOR & DENOMINATOR <i>If applicable</i>	☐ NA Numerator: Number of handovers complied as per the policy Denominator: Total number of Handovers audited		
TARGET / BENCHMARK (WITH REFERENCE): <i>As Applicable</i>	Target: 100 % Benchmark: NA		
DATA COLLECTION PLAN:	The data will be collected by the Nursing Supervisor monthly by auditing the patient medical record and handover register. The data collected in the data collection tool will be submitted monthly electronically (on excel sheet) to the quality assurance department.		
DATA COLLECTION METHODOLOGY:	☐ Retrospectively ☒ Concurrently		
DATA SOURCES/ AREA OF MONITORING:	Medical Records, Handover Register, SBAR All patient care area		
FREQUENCY OF COLLECTION:	Frequency: ☐ Weekly ☒ Monthly ☐ Quarterly ☐ Others		
RESPONSIBILITY ASSIGNED TO:	For Data Collection: Nursing Supervisor For Data Analysis and Reporting: Quality Assurance		
DATA ANALYSIS PLAN: <i>Frequency, Graphs / Display</i>	Display : ☐ Report ☒ Graphs (specify: line/bar/pie charts) Frequency: ☒ Monthly ☐ Quarterly ☐ Bi-annual ☐ Annual		
ANALYSED REPORTS: To Whom? Frequency of Reporting?	☐ Head of Department Frequency: ☒ Monthly ☐ Quarterly ☐ Bi-annual ☐ Annual ☐ Others ☐ Hospital Committee, specify: Frequency: ☐ Monthly ☐ Bi-Monthly ☒ Quarterly ☐ Bi-annual ☐ Annual ☐ Hospital Staff Frequency: ☐ Monthly ☐ Bi-Monthly ☒ Quarterly ☐ Bi-annual ☐ Annual ☐ Other/s Frequency: ☐ Monthly ☐ Bi-Monthly ☐ Quarterly ☐ Bi-annual		
RELATED FORMS / AUDIT TOOL	Handover Register, SBAR		
COMMENCEMENT DATE	June - 2023		

KPI 2.3- Percentage Compliance to hand over communication

Type of Measure: (Tick one)		☐ Structure	☐ Process
☒ Clinical	☐ Managerial	☐ Outcome	☒ Process and Outcome
TITLE OF PERFORMANCE INDICATOR		Percentage compliance to Critical value reporting.	
DEFINITION OF INDICATOR: <i>Include all important terms, references</i>		Critical values are potentially life-threatening diagnostic results that must be conveyed immediately to the physician or other health care professional so that therapeutic measures can be instituted rapidly. Monitoring of process indicates the timely reporting of the critical values from diagnostics departments.	
RATIONALE FOR MEASURE COLLECTION		Delay information of critical diagnostic tests values can lead to the serious medical issue and sometime may lead to the death of the patient. The timely reporting will provide information to the treating team to take timely therapeutic decisions to improve the patient's medical condition.	
INCLUSIONS AND EXCLUSIONS IF ANY		Inclusions: All critical values identified and approved by the hospital Exclusions: values do not present in the critical value list	
NUMERATOR & DENOMINATOR <i>if applicable</i>		☐ NA Numerator: Number of Critical values reported (Laboratory, Radiology) within the defined time. Denominator: Total number of Critical values reported (Laboratory, Radiology)	
TARGET / BENCHMARK (WITH REFERENCE) <i>As Applicable</i>		Target: 100 % Benchmark: NA	
DATA COLLECTION PLAN:		The data will be collected by the laboratory quality officer and radiology medical secretary monthly. The collected will be shared with the quality assurance monthly.	
DATA COLLECTION METHODOLOGY:		☒ Retrospectively ☐ Concurrently	
DATA SOURCES/ AREA OF MONITORING:		Critical value register Laboratory and Radiology	
FREQUENCY OF COLLECTION:		Frequency: ☐ Weekly ☒ Monthly ☐ Quarterly ☐ Others	
RESPONSIBILITY ASSIGNED TO:		For Data Collection: Lab Quality Officer, Radiology Medical Secretary For Data Analysis and Reporting: Quality Assurance	
DATA ANALYSIS PLAN: <i>Frequency, Graphs / Display</i>		Display : ☐ Report ☒ Graphs (specify: line/bar/pie charts) Frequency: ☐ Monthly ☐ Quarterly ☐ Bi-annual ☐ Annual	
		☐ Head of Department Frequency ☒ Monthly ☐ Quarterly ☐ Bi-annual ☐ Annual ☐ Others	
ANALYSED REPORTS: To Whom? Frequency of Reporting?		☐ Hospital Committee, specify: Frequency: ☐ Monthly ☐ Bi- Monthly ☒ Quarterly ☐ Bi-annual ☐ Annual	
		☐ Hospital Staff Frequency: ☐ Monthly ☐ Bi- Monthly ☒ Quarterly ☐ Bi-annual ☐ Annual	
		☐ Other/s Frequency: ☐ Monthly ☐ Bi- Monthly ☐ Quarterly ☐ Bi-annual ☐ Annual	
RELATED FORMS / AUDIT TOOL		Critical value register	

KPI 3: Percentage Compliance to storage of High alert medications.

Type of Measure: (Tick one)		☐ Structure	☒ Process
☐ Clinical	☒ Managerial	☐ Outcome	☐ Process and Outcome
TITLE OF PERFORMANCE INDICATOR		Percentage Compliance to storage of High alert medications	
DEFINITION OF INDICATOR: <i>Include all important terms, references</i>		High-alert medications are drugs that bear a heightened risk of causing significant patient harm when they are used in error. Although mistakes may or may not be more common with these drugs, the consequences of an error are clearly more devastating to patients. The standardized storage of high alert medication reduces the risk of harm.	
RATIONALE FOR MEASURE COLLECTION		High alert medication can cause heightened effects to patient and can lead to serious adverse drug reactions. Standardized storage reduces the risk form harm.	
INCLUSIONS AND EXCLUSIONS IF ANY		Inclusions: All high alert medication storage areas Exclusions: General medication storage	
NUMERATOR & DENOMINATOR <i>if applicable</i>		☐ NA Numerator: Number of High alert medications stored as per policy Denominator: Total number of High alert medications stored	
TARGET / BENCHMARK (WITH REFERENCE): <i>As Applicable</i>		Target: 100 % Benchmark: NA	
DATA COLLECTION PLAN:		The data will be collected by the pharmacist monthly and data will be shared with the quality assurance on monthly basis.	
DATA COLLECTION METHODOLOGY:		☒ Retrospectively ☐ Concurrently	
DATA SOURCES/ AREA OF MONITORING:		Sub-store Medicines inspection checklist IPD, OPD, Pharmacy	
FREQUENCY OF COLLECTION:		Frequency: ☐ Weekly ☒ Monthly ☐ Quarterly ☐ Others	
RESPONSIBILITY ASSIGNED TO:		For Data Collection: <i>Pharmacist</i> For Data Analysis and Reporting: <i>Quality Assurance</i>	
DATA ANALYSIS PLAN: <i>Frequency, Graphs / Display</i>		Display : ☐ Report ☒ Graphs (<i>specify: line/bar/pie charts</i>) Frequency: ☐ Monthly ☐ Quarterly ☐ Bi-annual ☐ Annual	
ANALYSED REPORTS: To Whom? Frequency of Reporting?		☐ Head of Department Frequency: ☒ Monthly ☐ Quarterly ☐ Bi-annual ☐ Annual ☐ Others ☐ Hospital Committee, <i>specify:</i> Frequency: ☐ Monthly ☐ Bi- Monthly ☒ Quarterly ☐ Bi-annual ☐ Annual ☐ Hospital Staff Frequency: ☐ Monthly ☐ Bi- Monthly ☒ Quarterly ☐ Bi-annual ☐ Annual ☐ Other/s Frequency: ☐ Monthly ☐ Bi- Monthly ☐ Quarterly ☐ Bi-annual ☐ Annual	
RELATED FORMS / AUDIT TOOL		Sub-store Medicine inspection checklist	

KPI 4.1: Percentage compliance to Surgical safety process.

Type of Measure: (Tick one)	
☒ Clinical	☐ Managerial
	☐ Structure
	☐ Outcome
	☐ Process
	☐ Process and Outcome
TITLE OF PERFORMANCE INDICATOR	Overall Percentage Compliance to Surgical safety process
DEFINITION OF INDICATOR: <i>Include all important terms, references</i>	The surgical safety checklist essentially identifies three distinct phases of an operation, each corresponding to a specific period in the normal flow of work: Before the induction of anesthesia before the incision of the skin, and before the patient leaves the operating facility. In each phase, a 'checklist coordinator' must confirm that the surgical team has completed the listed tasks before it proceeds with the procedure.
RATIONALE FOR MEASURE COLLECTION	The wrong patient, wrong site and wrong procedure can lead to serious adverse or sentinel events. Use of surgical safety checklist is important process during surgical procedures to ensure that the operation site, procedure and the patient to be operated are all accurate so as to elude any harm to patients due to surgical errors.
INCLUSIONS AND EXCLUSIONS IF ANY	Inclusions: All Surgical and invasive procedures Exclusions: Non-Invasive Procedure
NUMERATOR & DENOMINATOR <i>if applicable</i>	☐ NA Numerator: Number of Surgical safety Documentation undertaken (IPD, OPD, ER) as per policy Denominator: Total number of Surgical safety documentation audited
TARGET / BENCHMARK (WITH REFERENCE): <i>As Applicable</i>	Target: 100 % Benchmark: NA
DATA COLLECTION PLAN:	The data is collected by the nursing supervisor on a monthly basis by using the standardized data collection tool. The data will be shared with the quality assurance on a monthly basis.
DATA COLLECTION METHODOLOGY:	☐ Retrospectively ☒ Concurrently
DATA SOURCES/ AREA OF MONITORING:	Surgical safety checklist Operation Theater, OPD procedure rooms, Minor OT
FREQUENCY OF COLLECTION:	Frequency: ☒ Weekly ☐ Monthly ☐ Quarterly ☐ Others
RESPONSIBILITY ASSIGNED TO:	For Data Collection: Nursing For Data Analysis and Reporting: Quality assurance department
DATA ANALYSIS PLAN: <i>Frequency, Graphs / Display</i>	Display : ☐ Report ☒ Graphs (specify: line/bar/pie charts) Frequency: ☐ Monthly ☐ Quarterly ☐ Bi-annual ☐ Annual
ANALYSED REPORTS: To Whom? Frequency of Reporting?	☐ Head of Department Frequency ☒ Monthly ☐ Quarterly ☐ Bi-annual ☐ Annual ☐ Others ☐ Hospital Committee, specify: Frequency: ☐ Monthly ☒ Bi- Monthly ☐ Quarterly ☐ Bi-annual ☐ Annual ☐ Hospital Staff Frequency: ☐ Monthly ☒ Bi- Monthly ☐ Quarterly ☐ Bi-annual ☐ Annual ☐ Other/s Frequency: ☐ Monthly ☒ Bi- Monthly ☐ Quarterly ☐ Bi-annual
RELATED FORMS / AUDIT TOOL	Surgical safety checklist, Surgical Safety Compliance checklist

KPI 5.1: Hand Hygiene compliance Rate.

Type of Measure: (Tick one) ☒ Clinical ☐ Managerial	☐ Structure ☐ Outcome ☒ Process ☐ Process and Outcome
TITLE OF PERFORMANCE INDICATOR	Hand Hygiene Compliance Rate
DEFINITION OF INDICATOR <i>Include all important terms, references</i>	Hand hygiene: A general term referring to any action of hand cleansing. Hand rubbing with an alcohol-based hand rub or hand washing with soap and water aimed at reducing or inhibiting the growth of Micro-organisms on hands. Hand hygiene indication: Reason for a hand hygiene action. Hand hygiene opportunity: The opportunity is an accounting unit equivalent to the number of hand hygiene actions required, regardless of the number of indications. Or Moment during health-care activities when hand hygiene is necessary to interrupt germ transmission by hand. Hand Hygiene Action: Probable hand hygiene performed by a HCW against a hand hygiene opportunity. The action may be either negative (not performed) or positive (performed). A positive action indicates compliance; a negative action indicates non-compliance
RATIONALE FOR MEASURE COLLECTION	- To monitor the degree of compliance with hand hygiene among health-care workers. - To avoid any transmission of infection (direct or cross infection) through the employees of the organization to the patients. - To help determine the most appropriate interventions for hand hygiene promotion, education, and training.
INCLUSIONS AND EXCLUSIONS IF ANY	Inclusions: Total number of hand hygiene opportunities for all health care providers Exclusions: A positive action that is not justified by an identified indication that therefore cannot be translated into an opportunity cannot be included when measuring compliance.
NUMERATOR & DENOMINATOR if applicable	☐ NA Numerator: Number of Actions (conformance events) observed Denominator: Total Number of Opportunities (Events: Probable Hand hygiene practice activity)
TARGET / BENCHMARK (WITH REFERENCE): As Applicable	Target: 82.2% Benchmark: NA
DATA COLLECTION PLAN:	The data is collected by the infection control nursing monthly by using the standardized data collection tool. The data will be shared with the quality assurance department monthly.
DATA COLLECTION METHODOLOGY:	☐ Retrospectively ☒ Concurrently
DATA SOURCES/ AREA OF MONITORING:	WHO Hand Hygiene Observation Tool.
FREQUENCY OF COLLECTION:	Frequency: ☒ Weekly ☐ Monthly ☐ Quarterly ☐ Others
RESPONSIBILITY ASSIGNED TO:	For Data Collection: Nursing For Data Analysis and Reporting: Quality assurance department
DATA ANALYSIS PLAN: Frequency, Graphs / Display	Display : ☐ Report ☒ Graphs (specify: line/bar/pie charts) Frequency: ☐ Monthly ☐ Quarterly ☐ Bi-annual ☐ Annual
ANALYSED REPORTS: To Whom? Frequency of Reporting?	☐ Head of Department Frequency: ☒ Monthly ☐ Quarterly ☐ Bi-annual ☐ Annual ☐ Others ☐ Hospital Committee, specify: Frequency: ☐ Monthly ☒ Bi- Monthly ☐ Quarterly ☐ Bi-annual ☐ Annual ☐ Hospital Staff Frequency: ☐ Monthly ☒ Bi- Monthly ☐ Quarterly ☐ Bi-annual ☐ Annual ☐ Other/s Frequency: ☐ Monthly ☒ Bi- Monthly ☐ Quarterly ☐ Bi-annual
RELATED FORMS / AUDIT TOOL	Surgical safety checklist, Surgical Safety Compliance checklist

KPI 6: Fall rate per 1,000 occupied bed days.

Type of Measure: (Tick one) ☒ Clinical ☐ Managerial	☐ Structure ☒ Outcome ☐ Process ☐ Process and Outcome
TITLE OF PERFORMANCE INDICATOR	Fall rate per 1,000 occupied bed days
DEFINITION OF INDICATOR: Include all important terms, references	Fall is a sudden loss of an upright or erect position of the body. The fall did not result from any forcible physical action of another person.
RATIONALE FOR MEASURE COLLECTION	Patient falls are common adverse events that occur in all healthcare environments. Patient falls are a common cause of morbidity ("disability caused by accident") and the leading cause of nonfatal injuries producing trauma-related hospitalizations. Patient fall results in longer hospital stays, increase in medical costs and reduced quality of life for the patients who experience these events. Knowledge of patient fall rates can help focus patient fall prevention efforts.
INCLUSIONS AND EXCLUSIONS IF ANY	Inclusions: All patients Exclusions: None
NUMERATOR & DENOMINATOR if applicable	☐ NA Numerator: Total number of falls in the organization Denominator: Total occupied inpatient days
TARGET / BENCHMARK (WITH REFERENCE): As Applicable	Target: NA Benchmark: 3.44 https://hscmagaz.biosmedcentral.com/articles/10.1186/s12877-019-1368-8?text=National%20benchmark%20of%20rate%20of%20injury%20%5B4%5D
DATA COLLECTION PLAN:	The data shall be collected through an incident reporting portal by the Unit Quality team and will be shared with the enterprise quality assurance department on monthly basis.
DATA COLLECTION METHODOLOGY:	☒ Retrospectively ☐ Concurrently
DATA SOURCES/ AREA OF MONITORING:	Incident reporting portal All patient care area
FREQUENCY OF COLLECTION:	Frequency: ☐ Weekly ☒ Monthly ☐ Quarterly ☐ Others
RESPONSIBILITY ASSIGNED TO:	For Data Collection: Unit Quality team For Data Analysis and Reporting: Enterprise Quality team
DATA ANALYSIS PLAN: Frequency, Graphs / Display	Display : ☐ Report ☒ Graphs (specify: line/bar/pie charts) Frequency: ☒ Monthly ☐ Quarterly ☐ Bi-annual ☐ Annual
ANALYSED REPORTS: To Whom? Frequency of Reporting?	☐ Head of Department Frequency: ☒ Monthly ☐ Quarterly ☐ Bi-annual ☐ Annual ☐ Others ☐ Hospital Committee, specify: Frequency: ☐ Monthly ☐ Bi- Monthly ☒ Quarterly ☐ Bi-annual ☐ Annual ☐ Hospital Staff Frequency: ☐ Monthly ☐ Bi- Monthly ☒ Quarterly ☐ Bi-annual ☐ Annual ☐ Other/s Frequency: ☐ Monthly ☐ Bi- Monthly ☐ Quarterly ☐ Bi-annual ☐ Annual
RELATED FORMS / AUDIT TOOL	Incident report

Discussion

This study provides some valuable insights:-

- ▶ End users have not received adequate training on how to gather the data.
- ▶ Existing IPSG KPI data collecting procedure lacks a common format across all hospital units.
- ▶ Sample size is not taken for any of the KPIs.

Patient identification:

Compliance was checked whether patient name and date of birth is asked or not, whether the correct procedure say's patient should be identified before giving any medication, treatment or any procedure.

Compliance to Nursing handover protocol (SBAR)

SBAR should be documented before shift handover, Internal handover, and External handover but current there is not standardized format for documenting SBAR, only internal handovers are documented in registers.

Compliance to Nursing handover protocol (SBAR)

Compliance is recorded based on whether cabinets containing high-alert medication are checked daily or not, there is no parameter in the data collection tool to check whether, LASA medication are marked or not whether near expire date label checked or not.

Discussion

Compliance to WHO Surgical Safety Process

In the existing data collection tool for Surgical safety process all the parameters under sign in, time out and time out are not documented which ensure safe surgery.

Percentage Compliance to Hand Hygiene Protocol

For hand hygiene protocol data collection was done in standardized format but there is not data collection sheet available for calculation of Hand hygiene compliance, as data is received from entire hospital.

Patient Fall rate

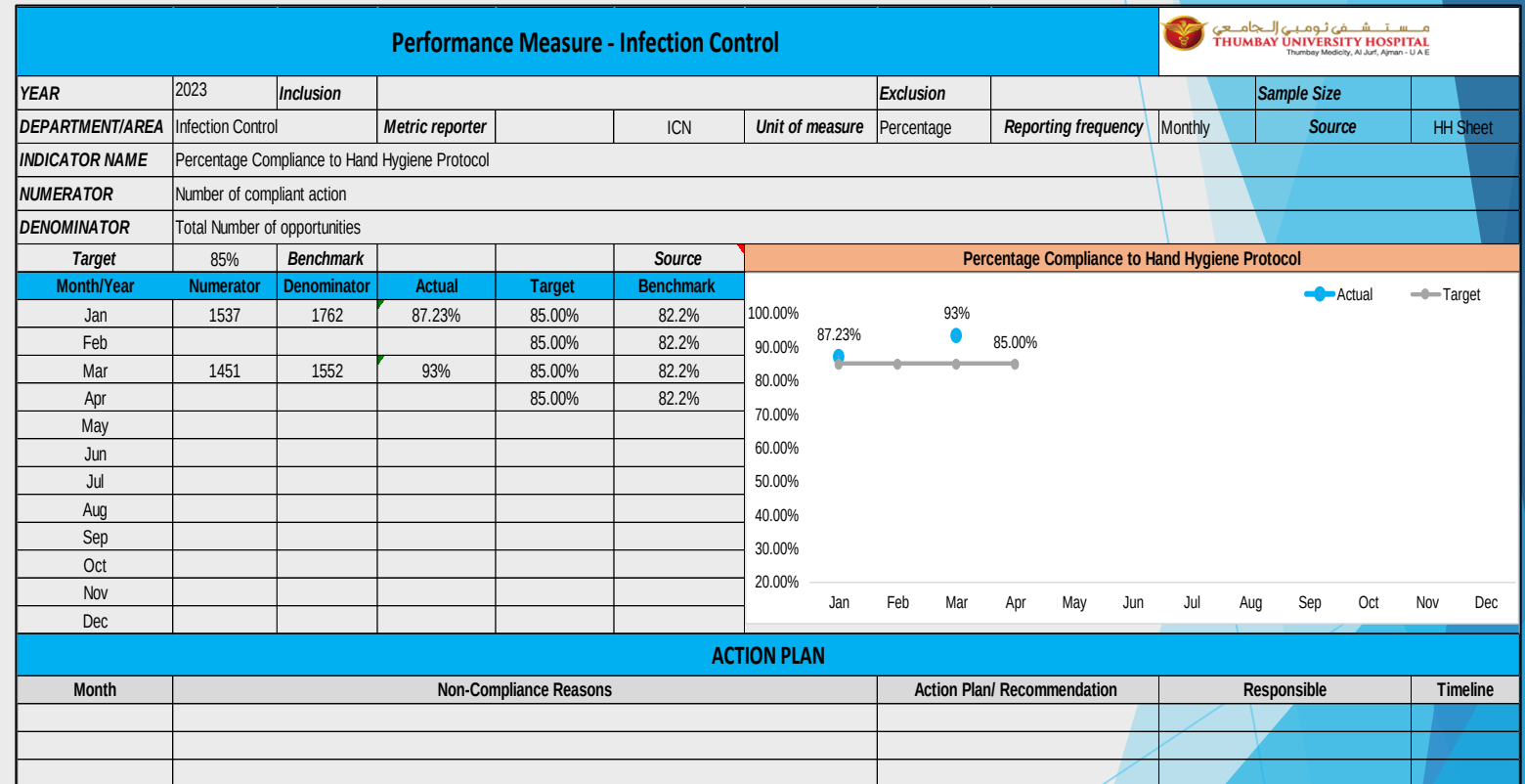
Patient fall should be recorded for all the patient who are at the risk of fall, but currently Patient fall is recorded at the time discharge, it is checked whether the patient is at risk of falling by assessing their fall risk score.

Conclusion

- ▶ To improve patient safety and match with worldwide standards, this study provides a thorough method to standardizing data gathering procedures in healthcare settings.
- ▶ New data collection sheets have been developed for six existing key performance indicators (KPIs), while three additional KPIs have been proposed specifically for the nursing department in alignment with IPSG, aiming to enhance patient safety
- ▶ A standardized data collection tool has been developed to align with the International Patient Safety Goals (IPSG), specifically addressing three departments: nursing, infection control, and pharmacy. Comprehensive training has been provided to all key stakeholders in these departments.

Conclusion

► Comprehensive framework is developed that ensures consistent monitoring and evaluation of patient safety metrics.



THANK YOU