SUMMER INTERNSHIP AT MAX HOSPITAL
(INCIDENT REPORTING ANALYSIS WITH THE GOAL TO IMPROVE PATIENT SAFETY AND QUALITY CARE)

HISTORY : Max Healthcare opened its first medical center in South Delhi's Panchsheel Park in 2000. The organization opened two other secondary care centers in Pitampura in North West Delhi and eastern Delhi suburb of Noida in 2002. In 2004, the company commissioned the East Block of its flagship tertiary care Hospitals called Max Hospital, Saket in South Delhi. Max Healthcare ventured into Gurgaon, the South Western suburb of Delhi with a secondary care hospital in 2007

VISION :
To be the most well regarded healthcare provider in India committed the highest standards of clinical excellence & patient care, supported by latest technology and cutting edge research.

MISSION :
- To achieve professional excellence in delivering quality care
- To ensure care with integrity and ethics
- To push frontiers of care through research and education.
- To adhere to National and global standards in healthcare.
- To provide healthcare to all sections of society.

METHODOLOGY

Prospective Research design
- All the incidents reported during the 2 months duration were identified and the data was collected and documented . (Different categories of incidents happened in the last 2 months, total incidents reported- 9.)
- Detailed discussion, conversations and interviews were done with the patients, nurses, doctors and other staff involved in the incident.
- Thereafter, the RCA and CAPA strategies for all major and repetitive incidents provided by the quality personnel were analysed.
- On the basis of incident data, RCA and CAPA analysis, gaps in the hospital system were identified and documented.
- Based on gaps found in the system, interventions were devised and suggested so that they can be implemented in order to prevent those incidents from recurring and finally to improve patient safety and care quality.

INCIDENT REPORTING PROCESS –

Step 1 :-
Inform about the event

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Step 2 :-
Establish what happened

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Step 4 :-
In Depth Enquiry & Risk Management

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Step 4 :-
Safety online system report completion

THEORITICAL INSIGHTS AND PRACTICAL OBSERVATIONS

Management of accreditations
Concept of hospital accreditation was theoretically known. But how the two main accreditations that is NABH and JCI, are accreditated to the hospital by implementing the policies made by quality team is practically seen. This is done in order to improve the hospital's compliance to match with the pre established standards.

Reactive risk analysis
Theoretically it is the identification of risks, so that the recurrence of errors can be prevented after an incident occurs. Practically we have seen that how RCA is used as one of the methods to find out the root cause of the incident occurring in the hospital.

Patient safety
Theoretically we studied about the patient safety measures that are taken in hospitals. Practically how these measures are implemented followed by ensuring of these implementations with the help of audits was seen as well as executed.

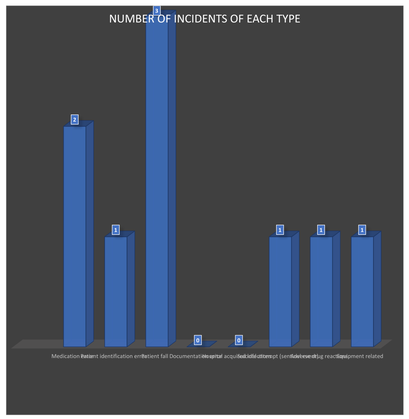
CHALLENGES FACED DURING THE INTERNSHIP

1) Being a non medico while working in medical quality dept. As, interaction with the nurses and doctors (beside patients) and understanding their terms was a pre requisite.

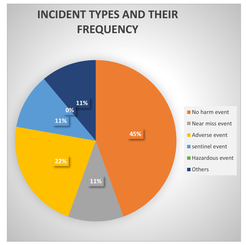
2) Another challenge was having interviews with patients and other staff involved in the incident and its reporting.

USEFULNESS OF INTERNSHIP

Gained the basic knowledge of different departments of hospital
Gained the good clarity of how different departments in a hospital works in an effective way.
Developed team working skills
Developed professional communication skills
Developed self organization skills
Developed time management skills
Learnt about how to tackle gaps and find out solutions. (It was a good opportunity to understand how one can approach a problem in a structured way.)



Incident types	Number of incidents
Medication error	2
Patient identification error	1
Patient fall	3
Documentation error	0
Hospital acquired infections	0
Suicidal attempt (sentinel event)	1
Adverse drug reactions	1
Equipment related	1



Incident types	Number of incidents
No harm event	4
Near miss event	1
Adverse event	2
sentinel event	1
Hazardous event	0
Others	1

No harm event :
1 Medication error,
3 Patient falls

Near miss event :
1 Patient identification error

Adverse event :
1 Medication error,
1 Adverse drug reaction

Sentinel event :
1 Suicidal attempt

Others :
1 Equipment failure event

SWOT ANALYSIS

STRENGTH
1. Experienced and skilled workforce.
2. Regular training to nurses, doctors and other staff.
3. Brand
4. NABH and JCI Accrediation
5. Experienced business units.
6. Prompt services separate de for all like renal, cardio, gynecc dept, etc

WEAKNESS
1. Some departments are under staffed.
2. Not have presence in suburban areas.

OPPORTUNITIES
1. Medical tourism
(Medical treatment at cheaper rates for international patients)
2. Increasing demand (due to growing health concern, awareness and diseases)

THREATS
1. Increasing cost of raw materials.
2. Government regulations
3. Tax changes
4. Presence of competitors Apollo hospital, Fortis and Medanta

GAPS IDENTIFIED IN THE SYSTEM ON THE BASIS OF INCIDENTS OCCURRED IN THE HOSPITAL IN LAST 2 MONTHS.

Multiple root causes or gaps found could contribute to single incident.
1) Failure to communicate.
- Which contributed to majority of incidents, that is, patient identification error, adverse drug reaction and medication error.
2) Failure to plan / absence of proper knowledge in nurses
- Which contributed to adverse drug reaction and medication error.
3) Failure to care
- Which contributed to Suicidal attempt incident.
4) Failure to rescue/ respond
- Which contributed to patient fall incident.
5) Failure to recognise- identification
- Which contributed to patient identification error.

OTHER OBSERVATIONS AND GAPS NOTICED IN THE SYSTEM -

- Limited degree of direct involvement of patient and care staff in discussing and seeking solutions.
- Paper based reporting - Reporting is labour intensive and too paper based for staff who are already dealing with very high workloads.
- Under reporting because of Absence of blame free environment in incident reporting.

PROPOSED SOLUTION

1.Immediate response- It basically involves the care, support, and communication actions that take place immediately following an incident to mitigate or cease further patient harm and ensure the safety of patients. Immediate response continues throughout the incident management process to promote healing, recovery and learning.
2. **Continuous training programs** – Orientation and reorientation of hospital staff on effective patient assessment, patient care and patient safety.

3. Simulation training - It is a growing practice in healthcare, and has potential in help preventing FTR (failure to recognise), by allowing to identify and review contributing factors and practice skills to prevent FTR. Additionally, teamwork strategies practiced in these trainings help nurses to see the whole picture in a determined situation, and communicate within hierarchical structures..

4. **Proper and effective communication** – Between nurses, doctors and other staff and among nurses themselves there must be an effective communication of the complete information related to patient in order to avoid incidents.

5. Proper identification – Frail and vulnerable patients should be identified during their initial assessment and it should be communicated in all departments of hospital without fail.

6. Staff should be more **careful & vigilant** and on duty 24*7 specifically for those patients who have been found frail and vulnerable in initial assessment or have been identified for self harming tendency

7. Proper documentation of all the incidents happening in the hospital so that remedial measures can be taken towards them and to make sure they are not repeated in future. It will help in planning the training sessions to prevent the recurring of those incidents.

8. No blame environment - Non- punitive incident reporting by staff. Creation of no blame environment for incident reporting.

.9. Share learning – Sharing what was learnt from the analysis of the system, both within the organization and beyond it, in order to make patient care safer, prevent the recurrence of similar incidents, and to promote trust and healing

LEARNING DURING INTERNSHIP

1) Learnt the difference between the policy measures and how they are practically implemented.
2) How different type of audits are conducted, which includes-
   i) Patient safety audit : with reference to JCI standards of QPS (Quality improvement and Patient Safety)
   ii) Medical records audit : with reference to JCI standards of MOI (Management Of Information)
   iii) ICN audit : with reference to JCI standards of PCI (Prevention & Control of Infections)
   iv) ER audit : with reference to JCI standard
3) Updating of policies of hospital quality with reference to latest guidelines of JCI

4) During my project-
INCIDENT REPORTING ANALYSIS WITH THE GOAL TO IMPROVE PATIENT SAFETY AND CARE QUALITY
i) Learnt different type of incidents that occur in hospital and how that data is analyzed and comprehended to find gaps?
ii) Learnt how to do Root Cause Analysis and CAPA?
iii) While working on my project I identified some gaps in current practices and proposed some interventions to counter the problem.

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