

Incident Analysis From Apollo Hospital, Sheshadripuram, Bangalore

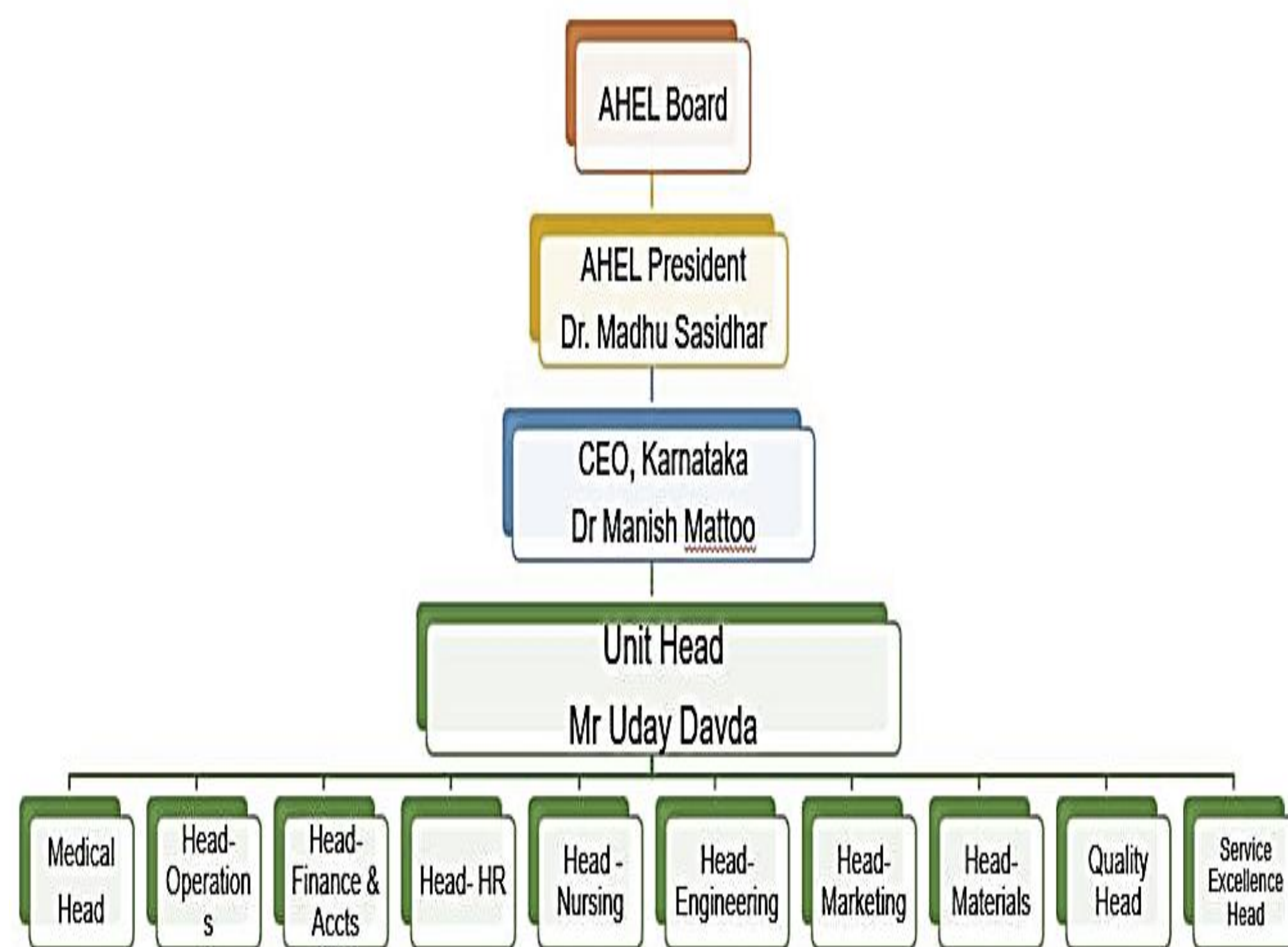
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Introduction

Apollo hospital Sheshadripuram was started on 1st August 2015 in the heart of the garden city of Bangalore, is a NABH-accredited, multi-specialty facility , Offering advanced medical services across key specialties with over 200 beds, it caters to a high volume of outpatient visits and surgical procedures each month. The hospital is known for its robust emergency care, state-of-the-art technology, and skilled medical professionals. With a focus on clinical excellence and patient-centered care, Apollo Sheshadripuram sets benchmarks in quality, safety, and healthcare innovation.

Organisation Structure



Mission

Apollo's mission is to bring healthcare of international standards within the reach of every individual. We are committed to the achievement and maintenance of excellence in education, research and healthcare for the benefit of humanity.

Vision

Apollo's vision for the next phase of development is to *Touch a Billion Lives."*

Swot Analysis

Strength - Strong adherence to NABH standards. - Use of AIRS (Apollo Incident Reporting System) promotes proactive incident reporting. - Structured internal audits and active file reviews. - Digital tools for KPI monitoring and compliance tracking. Well-trained quality team with defined SOPs and checklists.	Weakness - Incomplete or delayed documentation in some departments. - Documentation errors during peak hours - Dependence on manual processes in some areas. - Limited integration of data between departments causing data discrepancies.
Opportunities - Implementation of real-time dashboards and analytics. - Regular training and sensitization sessions to improve quality culture. - Use of automation (e.g., common integrated portal for all the departments reducing data discrepancies). - Patient feedback integration to guide quality improvement plans.	Threats - High competition from other NABH-accredited hospitals in the area - Poor documentation may lead to compliance risks. - Staff burnout or turnover affects continuity in quality efforts. "Breach of patients' trust in the hospital's quality standards due to delayed incident closures or inconsistent care."

Key Learnings

- Gained hands-on experience in monitoring quality indicators such as patient falls, medication errors, and near misses.
- Observed the complete incident reporting and root cause analysis process.
- Participated in internal audits, mock drills, and quality review meetings to understand real-time compliance practices.
- Involved in **pulse checks** and **clinic audits**, helping assess compliance with SOPs and service delivery standards.
- Participated in **ICQUA audit** of other departments, offering broader insight into quality practices hospital-wide.
- Joined **quality review meetings** to discuss reported incidents, analyze contributing factors, and suggest preventive measures.
- Analyzed quality dashboards and KPIs to connect theoretical indicators with practical data interpretation

Difference between Practical exposure at SIP Organization and theoretical understanding from IIHMR University

- Observed interdepartmental coordination challenges, gaining insights into the importance of teamwork in hospital operations.
- Understood the impact of patient behavior and expectations on service delivery, beyond what textbooks cover.
- Applied theoretical concepts like NABH standards and quality indicators in a real hospital setting.
- Gained exposure to hospital policies, SOPs, and compliance audits, bridging academic learning with regulatory practices.
- Witnessed the role of technology integration and its limitations in real-time healthcare settings.

Objective

To study hospital-reported incidents by category and assess the severity of events (harm, no-harm, and near misses) in order to identify key areas for patient safety improvement.

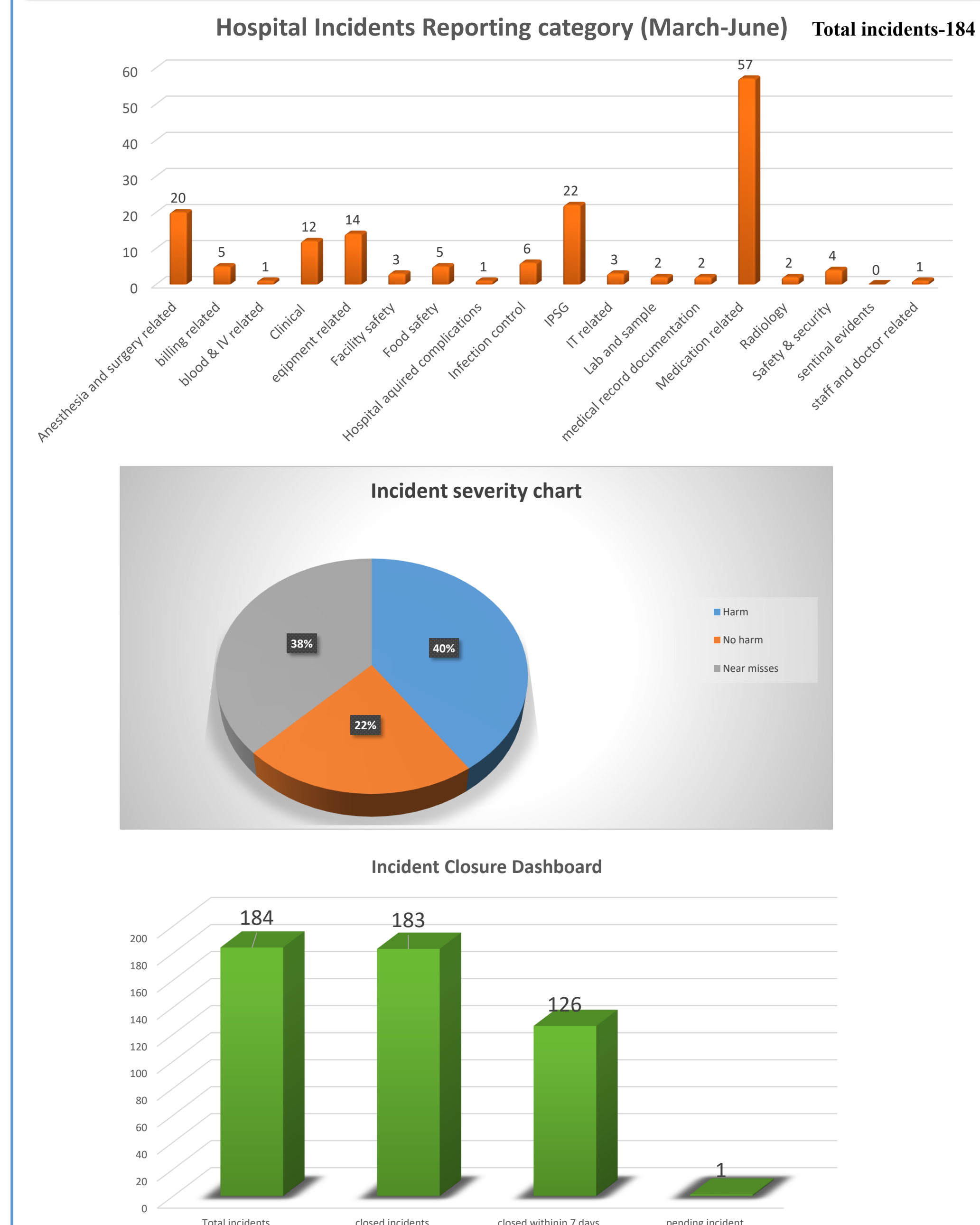
Methodology

•**Study Design:**
This was an **observational study** conducted over a 4-month period (March to June). It involved the review and analysis of reported hospital safety incidents.

•**Data Sources:**
•**Primary data:** Real-time incident reporting process observations, on-site audit(e.g. Active file audits, safety checks and document reviews, notes from daily rounds and safety meetings)
•**Secondary data :**
Incidents were categorized by type (e.g., medication errors, surgery-related, facility issues), and each was assessed based on severity—classified into harm, no-harm, or near-miss categories. The closure rate and resolution timelines of incidents were also analyzed.

•**Tools Used:**
Tools used: **Active file audits, observation checklists, and the AIRS (Apollo Incident Reporting System).**
Data was categorized and analysed by type, severity, and resolution timeline. Confidentiality of patient and staff data was maintained throughout the study. No individual identifiers were used

Analysis and Results



- ❑ From march to June out of 187 reported incident cases medication-related incidents accounted for the highest number of reports (57 cases), signaling significant issues in the prescribing, dispensing, and administration processes. Other notable categories included IPSG related (22) surgery and anaesthesia related incidents (20), facility safety (14), and clinical equipment-related issues (12). The consistently high number of medication errors emphasizes the urgent need for targeted interventions to improve medication safety protocols across the hospital
- ❑ Out of all reported incidents, 40% resulted in actual harm, while 22% were no-harm cases and 38% were near misses. The high percentage (60%) of non-harmful events suggests a proactive reporting culture, which is a positive sign of safety awareness.

- ❑ Out of 184 incidents, nearly all were closed—showing strong follow-up. However, only 69% were resolved within 7 days, which is a key benchmark for timely action. This suggests a need to strengthen internal processes to ensure quicker resolution and maintain momentum in patient safety efforts.

Challenges Faced During Internship

- ❑ Slow HMIS system led to delays in administrative tasks and patient processing.
- ❑ Incomplete incident descriptions making RCA difficult.
- ❑ Delayed response from clinical and non-clinical staff in providing justifications for reported incidents hampers timely investigation and closure.
- ❑ Discrepancies observed between data provided by various departments and that collected independently by the Quality Department, leading to challenges in ensuring data accuracy and consistency.
- ❑ Observed challenges in effective communication between staff and patients, impacting patient understanding and satisfaction

Suggestions

- ❑ Upgrade HMIS infrastructure to improve processing speed and efficiency.
- ❑ Implement token-based systems and optimize appointment scheduling for better patient flow.
- ❑ Strengthen e-prescriptions, barcode verification, staff training, and double-checks to reduce medication errors
- ❑ Conduct regular training sessions on communication skills and local language basics.
- ❑ Increase frequency of housekeeping rounds and perform routine hygiene audits.
- ❑ For IPSG, ensure proper ID band use, clear communication (SBAR), time-outs, and regular safety drills.

