Summer Training at
Care Hospitals, Banjara Hills, Hyderabad
(April 3 to June 2, 2017)

- **Direct Observation of the Compliance with the Surgical Safety Checklist**
- **Evaluate Extent to the compliance of Checklist Completion and Documentation**

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CERTIFICATE

This is to certify that **Alisha Eqbal** has undergone summer training in **Care Hospital, Hyderabad** from **3rd April to 2nd June 2017**.

The candidate herself completed the project assign to her during summer training. Her approach to the project was sincere and proactive. This summer training is in partial fulfillment of the course requirement recommended for the award of MBA in Hospital and Health Management.

I wish her success in all her future endeavors.

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TO WHOM SO EVER IT MAY CONCERN

This is to certify that **Ms. Alisha Eqbal** a student of IIHMR University, Jaipur has done project on **"1.Adherence to Surgical Safety Checklist as per WHO patient safety goal", "2.Documentation compliance on Doctor's OPD prescription as per NABH Standards", "3.Documentation compliance of patient's consents being taken as per statutory requirements", and "4.Data validation of Quality indicator as per NABH requirements -1) Modification of Anesthesia plan 2) Time of initial assessment"** in the department of Quality from 03-04-2017 to 02-06-2017.

During the above period her performance and conduct were found to be good.

We wish her all the best in her future endeavors.

For QUALITY CARE INDIA LIMITED,

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Acknowledgement

I bring taken exertions in this project. However, it might not have been conceivable without those sorts backing Furthermore help of numerous people and organization. I also want to extend my earnest on account of every one of them.

I am exceptionally obligated to (Name of your Organization Guide) for their direction and consistent supervision and also to provide important data with respect to the project and likewise for their support in finishing the project.

I also want to offer my thanks towards the members from (Organization Name)for their kind co-operation and consolation which helped me in the fruition of this project.

I also want to offer my extraordinary thanks and on account of industry people for giving me such consideration and time.

My thanks and appreciations go to my co-intern in building up the project and individuals who have enthusiastically bailed me out with their capacities.

Thank You!

Alisha.

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Abbreviations / Acronyms

- WHO – World Health Organization
- NABH - National Accreditation Board for Hospitals & Healthcare Providers
- SSC – Surgical Safety Checklist

INTRODUCTION

This report is based on a study on the Adherence to Surgical Safety Checklist in Care Hospitals. It has secured the essential introduction of both organization and surgical safety checklist, aim, and objectives, study design, data source or research methodology, concluded with the findings and recommendations to improve the utilization of surgical safety checklist in Care Hospitals (Outpatient, Banjara Hills).

About Care Outpatient Center, Banjara Hills

Purpose
To provide care
that people trust

Vision
To be a trusted, people-centric,
integrated healthcare system
as a model for global health

Values

The practice of honesty fortifies character. Integrity means doing right at all times and willingness to live by the standards and beliefs of the organization.
Teamwork
A collaborative work ecosystem, where the collective efficiencies are harnessed for delivering the best possible care.
Citizenship
Good governance and appropriate working relationship with all stake- holders, based on compliance to laws and ethical practices.
Empathy & Compassion
The ability to understand the feelings of patients as well as employees, so that the services delivered are humane and in a supportive work environment.
Equity
Mutual trust based on fair and impartial consideration of all professional matters so that it fosters positive contribution towards the institutional purpose.

Education
Continuous learning for the creation of a sustainable healthcare system, where employees and the organization can grow together.

Dignity & Respect
Treat all with utmost regard and esteem so that it enhances respect and, in turn, a sense of belonging.

The Group's leader CARE Hospitals, Banjara Hills, Hyderabad - a super claim to fame healing center - started quite care conveyance at the CARE Outpatient Center in October 2012. Situated in the heart of the city, a km far from the in-patient doctor's facility, it is India's biggest incorporated outpatient focus with 65 beds.

Mind Outpatient Center offers meeting in all super claims to fame in Hyderabad, with a best-in-class climate of global norms for the comfort of patients. The clinic is spread crosswise over 6 stories, covering an aggregate zone of 1,85,000 square feet and offers the best restorative care in an office tweaked to convey the most elevated nature of administration.

The CARE Outpatient Center was formally initiated on fourth February 2013 by Late Dr. A. P. J. Abdul Kalam, previous President of India. Talking about the event, Dr. Abdul Kalam stated, "At the CARE Outpatient Center I feel sympathy and seek after the patient. This is a place which passes on solace to the debilitated heart. Mind Hospitals dependably endeavors to serve the general population and is quiet in its approach." Dr. Kalam was Chief Mentor for the doctor's facility chain.

The CARE Outpatient Center offers a wide exhibit of super force administrations at a devoted office enhanced for the outpatient meeting. One of the highlights is mobile or day mind surgery administrations, where post-agent perception is uneventful. Such surgeries have turned out to be conceivable because of enhanced innovation and are an acknowledged technique for treatment for some patients, where overnight doctor's facility stay is not required.

The CARE Outpatient Center is firmly coordinated with the Group's leader in-patient super claim to fame healing facility (with normal transport administrations accessible), safeguarding the basic hospitalization connect for offering complete and far-reaching consideration to patients.

The CARE group has numerous firsts amazingly:

1st Prospective randomized trial of inflatable valvotomy versus mitral valve substitution on the planet

1st Coronary Angioplasty in India

2nd Balloon Valvuloplasty in India

1st Cardiac MRI in India

1st Atrial Fibrillation Clinic in India

1st Beating Heart Surgery in Andhra Pradesh

1st Heart Transplant Performed in a level 2 town (Visakhapatnam)

Surgical Safety Checklist (fig: 1)

In 2009, the World Health Organization (WHO) published the Surgical Safety Checklist (SSC) as part of their Safe Surgery Saves Lives campaign. The WHO Surgical Safety Checklist was made by a universal gathering of specialists accumulated by the WHO with the objective of enhancing the security of patients experiencing surgical methodology around the globe. Input from anesthesiologists, attendants, specialists, persistent wellbeing specialists, patients, and different experts was utilized as a part of the improvement of this instrument.

The point of this agenda is to strengthen acknowledged wellbeing practices and cultivate better correspondence and cooperation between clinical orders. The agenda is planned as an apparatus for use by clinicians inspired by enhancing the wellbeing of their operations and decreasing superfluous surgical mortality and inconveniences. Its utilization has been evidently connected with huge diminishments in confusion and demise rates in different clinics and settings, and with upgrades in consistency to essential benchmarks of care.

The agenda has been intended to be easy to utilize and pertinent in numerous settings. It is right now in dynamic use in operating rooms the world over.

(Figure 1: Surgical Safety Checklist)

Rationale

The point of utilizing the Surgical Safety Checklist and Briefings and Debriefings is to enhance the quality and wellbeing of medicinal services administrations given to patients experiencing surgery and to help forestall unfriendly occasions, by enhancing correspondence and collaboration within the surgical group.

The Surgical Safety Checklist advances correspondence and cooperation and advances the association's patient wellbeing endeavors.

The surgical safety checklist (SSC) is intended to improve tolerant security however investigations of its effect struggle. This review investigated consistency and components that impacted SSC adherence to propose how its consistency could be streamlined.

Data on the compliance of surgical checklists are scarce in the study area. Therefore, this study would help in evaluating compliance of checklist completion and its barrier for utilization at the Care Hospitals, Banjara Hills, Hyderabad.

The checklist consists of three phases:

1) **Sign In**: before induction of anesthesia - before the patient is anesthetized where patient's ID, procedure, consent are confirmed, the site is marked, and discuss any potential issues or necessary equipment, medication, risks of difficult airway or aspiration and blood loss.

2) **Time Out** –after induction and before the patient is prepped and draped/surgical incision, is the final verification of the correct patient, procedure, and site by engagement and communication among all members of the surgical team where the surgeon, anesthesiologist, and nurse verbally confirm the patient's ID, the procedure, the site of the procedure, etc. before skin incision.

3) **Sign Out** - before the patient leaves the operating theater, where the entire team reviews the procedure, completion of instruments, sponges, and needles and discuss the key concern for patient recovery and management.

Aim: To evaluate adherence to surgical safety Checklist

Objective: 1. direct observation of the Compliance with the Surgical Safety Checklist

2. Evaluate extent to the compliance Of Checklist Completion and documentation

Research Methodology

Study Area: The study was conducted in operation theatres of Care Outpatient center,

Banjara Hills, Hyderabad under quality department

Type of Study: Evaluative Study which is defined as a type of study that uses standard social research methods for evaluative purposes, as a specific research methodology, and as an assessment process that employs special techniques unique to the evaluation of social programs.

Duration: 30 Days

Type of Data: The data for checking practical implementation has been collected by the observant

itself Inside the operation theatres therefore, it is primary data.

The data for the documentation compliance was collected from the active surgical

Case Sheets therefore, it is secondary data

Sampling Technique: Purposive Sampling

Tool for Data Collection: An instrument (fig: 2) created for research was based on the checklist, used by the hospital.

Sample Size: 30 different surgical cases were taken for direct observation

And

210 different active surgical case sheets were taken for documentation auditing As per the NABH Standard which is 33% of the total footfall i.e. 636 per month

DATA SOURCE

For practical implementation

Data were collected by means of non-participant observation in the operation theater for Vascular, ENT and Gynecology surgeries.

For completion and documentation

By auditing the completion and documentation of Surgical Safety Checklist from the active case sheets

Sl. No..	Description	1	2	3	4	5	6	7	8	9	10
	IP/OP NUMBER										
	CLINICIAN NAME										
	BEFORE INDUCTION OF ANAESTHESIA										
1	Patient conirmed ID, site, procedure, consent										
2	Site marked										
3	Anaesthesia machine and medication check complete										
4	Pulse oximeter on patient and function										
5	Patient have known allergy										
6	Patient have risk of difficult airway and aspiration										
7	Patient have risk if >500 ml blood										
	BEFORE SKIN INCISION										
1	All members confirm themselves by name and role										
2	Confirm patient's name, procedure and incision site										
3	Antibiotic given within 1 hour										
4	Anticipated critical events										
a	To surgeon										
(i)	critical or non routine steps										
(ii)	duration of case										
(iii)	anticipated blood loss										
b	to anaestetist										
(i)	patient speific concern										
c	to nurse										
(i)	sterility is confirmed										
(ii)	equipment issue or any concern										
5	Essential imaging displayed										
	BEFORE PATIENT LEAVES O.T										
1	Nurse verbally confirms										
a	procedure name										
b	completion of instruments, sponges, needles										
c	labelled specimen										
d	any equipment problem										
2	To surgeon, anaesthetist and nurse key concern for patient recovery and management										
	SIGNED										
a	Nurse										
b	Anaesthetist										
c	Surgeon										

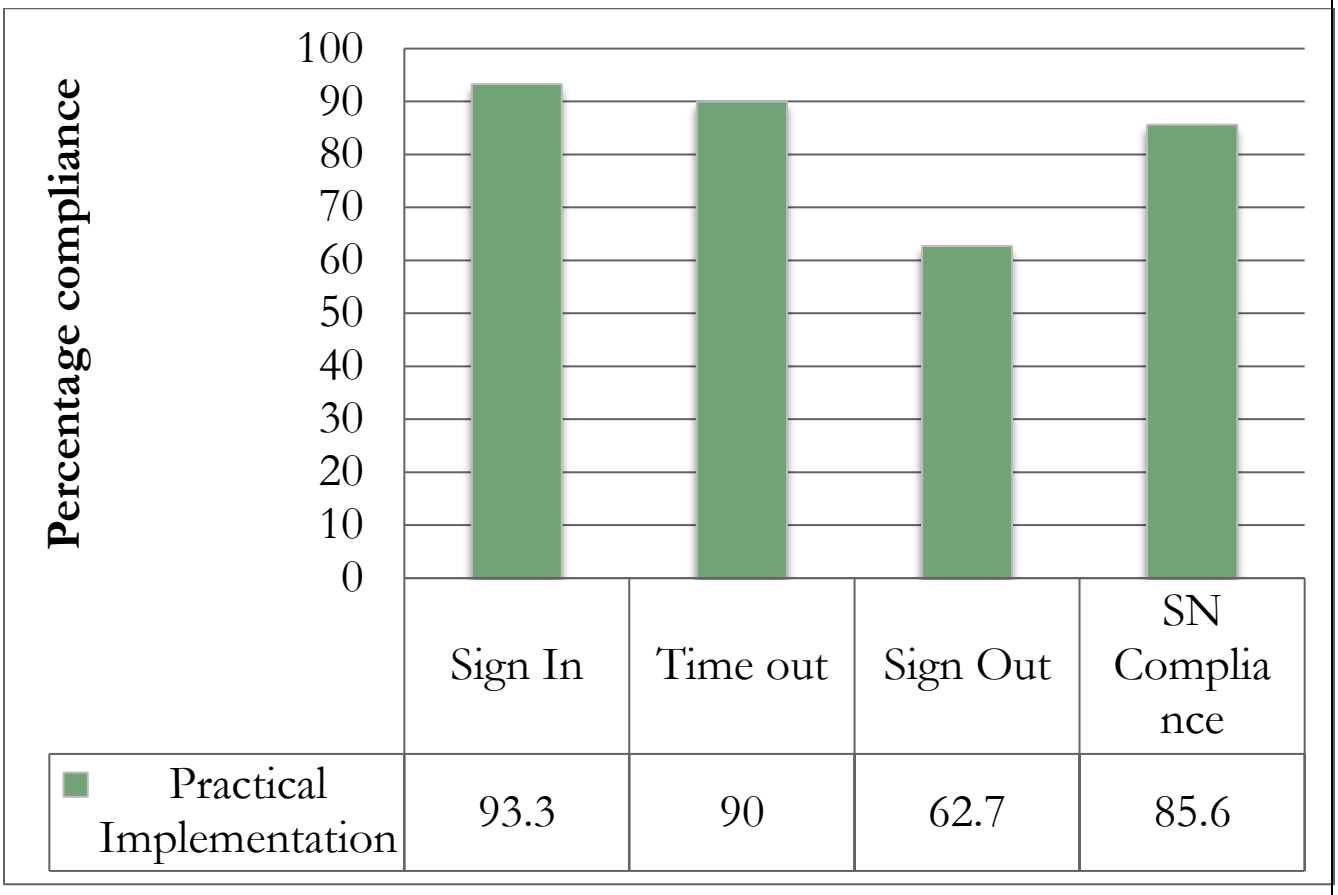
Figure 2: Instrument

DATA ANALYSIS

For analysis of the data frequency or percent distribution analysis will be applied. Percentage compliance to the Practical Implementation and Documentation was calculated separately based on four divisions which are as follows:

- Sign in : Before Induction of Anesthesia
- Time out: Before Skin Incision
- Sign out : Before Patient Leaves Operation Theater
- SN (Signature & Name): Signature and name of circulating nurse, anesthesiologist and the surgeon

Figure 3: Percentage compliance to the Practical Implementation

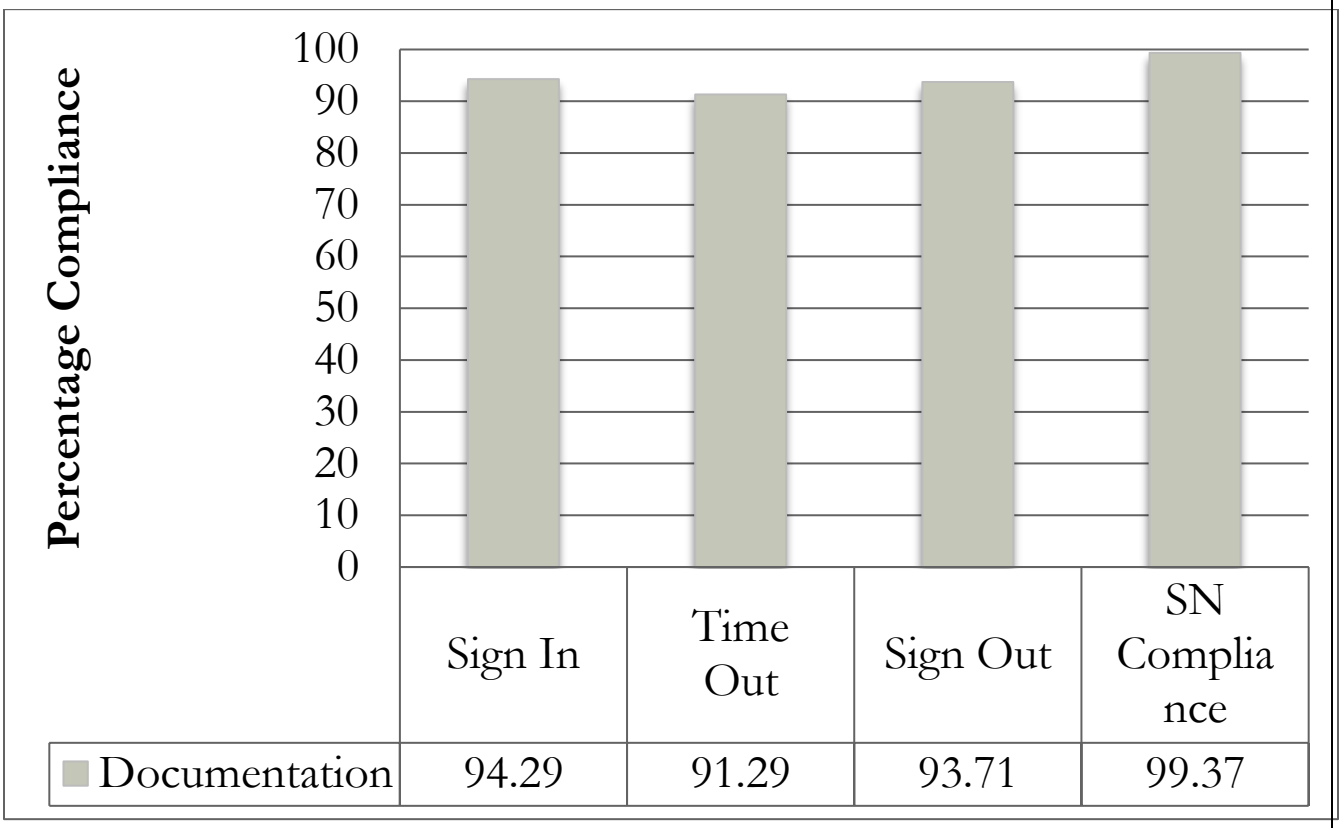


Sl. No..	Description	Total Count	Total Compliance	Average
IP/OP NUMBER				
CLINICIAN NAME				
	BEFORE INDUCTION OF ANAESTHESIA			
1	Patient confirmed ID, site, procedure, consent	30	30	100
2	Site marked	30	24	80
3	Anesthesia machine and medication check complete	30	26	86.7
4	Pulse oximetre on patient and function	30	30	100
5	Patient have known allergy	30	29	96.7
6	Patient have risk of difficult airway and aspiration	30	29	96.7
7	Patient have risk if >500 ml blood	30	28	93.3
	BEFORE SKIN INCISION	**Sign In**		**93.3**
1	All members confirm themselves by name and role	30	13	43.3
2	Confirm patient's name, procedure and incision site	30	29	96.7
3	Antibiotic given within 1 hour	30	30	100
4	Anticipated critical events			
a	To surgeon			
(i)	critical or non-routine steps	30	29	96.7
(ii)	duration of case	30	26	86.7
(iii)	anticipated blood loss	30	27	90.0
b	to anesthetist			
(i)	patient specific concern	30	27	90.0
c	to nurse			
(i)	sterility is confirmed	30	30	100
(ii)	equipment issue or any concern	30	30	100
5	Essential imaging displayed	30	29	96.7
	BEFORE PATIENT LEAVES O.T	**Time Out**		**90**
1	Nurse verbally confirms			
a	procedure name	30	17	56.7
b	completion of instruments, sponges, needles	30	18	60.0
c	labeled specimen	30	13	43.3
d	any equipment problem	30	17	56.7
2	To surgeon, anesthetist and nurse key concern for patient recovery and management	30	29	96.7
	SIGNED	**Sign Out**		**62.7**
a	Nurse	30	27	90.0
b	Anesthetist	30	25	83.3
c	Surgeon	30	25	83.3
TOTAL COMPLIANCE = 84.9		**SN Compliance**		**85.6**

Figure 4: compliance of each separate provision under practical implementation

For the 30 surgical cases which were directly observed, the Sign In Compliance was calculated 93.3 % making it highest among all, the Time Out Compliance was calculated 90, the Sign Out Compliance was calculated 62.7, the lowest of all and the SN Compliance was calculated 85.6 %

Figure 5: Percentage compliance to the documentation



For the 210 surgical cases for which the documentation and completion audit was done, compliance was closely varied.

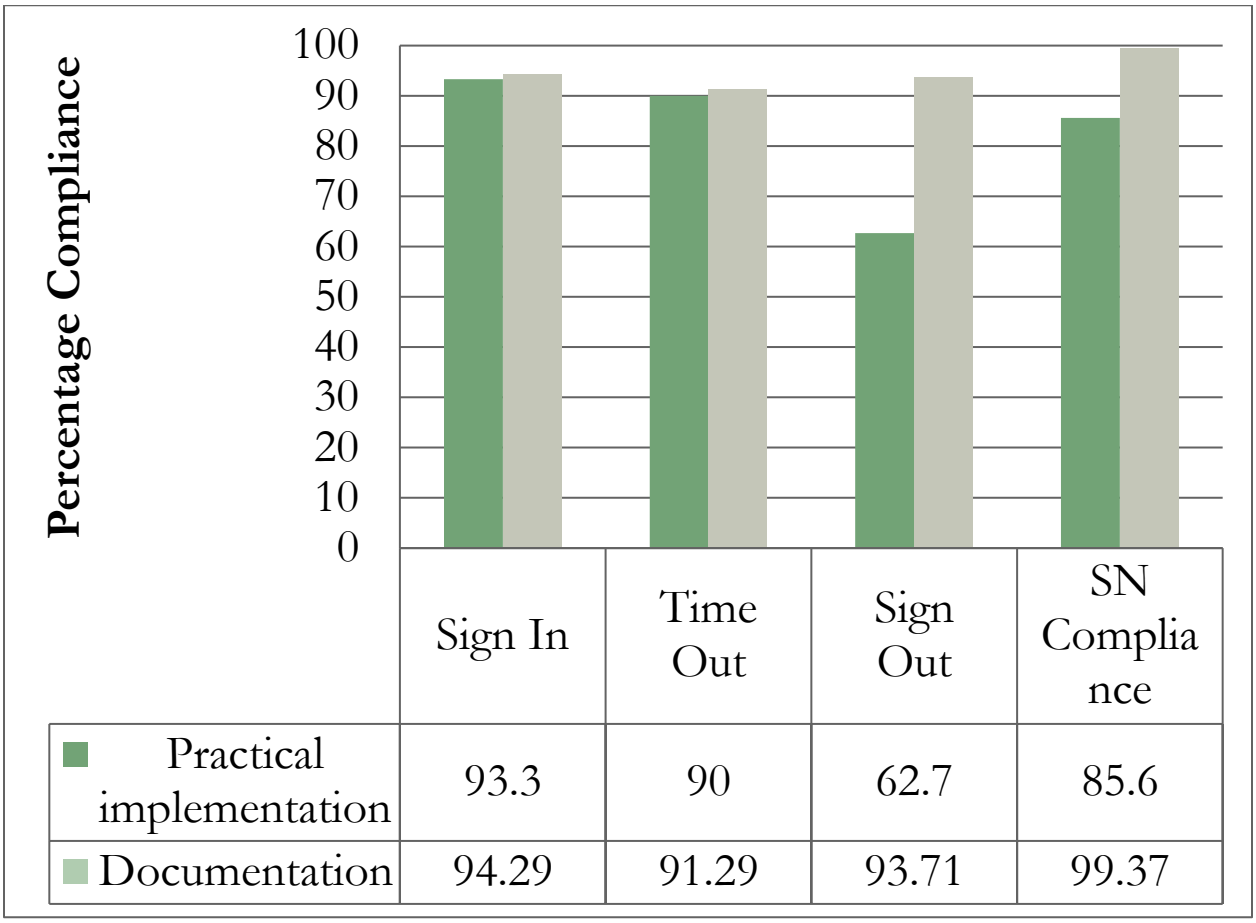
The Sign In Compliance was calculated 94.29 %, the Time Out Compliance was calculated 91.29 % which was the lowest, the Sign Out Compliance was calculated 93.71 % and the SN Compliance was calculated 99.37 % also the highest among all.

Sl. No..	**Description**	Total Count	Total Compliance	Average
	IP/OP NUMBER			
	CLINICIAN NAME			
	BEFORE INDUCTION OF ANAESTHESIA			
1	Patient confirmed ID, site, procedure, consent	210	208	99.0
2	Site marked	210	206	98.1
3	Anesthesia machine and medication check complete	210	209	99.5
4	Pulse oximetre on patient and function	210	209	99.5
5	Patient have known allergy	210	205	97.6
6	Patient have risk of difficult airway and aspiration	210	175	83.3
7	Patient have risk if >500 ml blood	210	174	82.9
	BEFORE SKIN INCISION	**Sign In**		**94.3**
1	All members confirm themselves by name and role	210	203	96.7
2	Confirm patient's name, procedure and incision site	210	190	90.5
3	Antibiotic given within 1 hour	210	204	97.1
4	Anticipated critical events			
a	To surgeon			
(i)	critical or non-routine steps	210	183	87.1
(ii)	duration of case	210	200	95.2
(iii)	anticipated blood loss	210	200	95.2
b	to anesthetist			
(i)	patient specific concern	210	147	70.0
c	to nurse			
(i)	sterility is confirmed	210	198	94.3
(ii)	equipment issue or any concern	210	188	89.5
5	Essential imaging displayed	210	204	97.1
	BEFORE PATIENT LEAVES O.T	**Time Out**		**91.29**
1	Nurse verbally confirms			
a	procedure name	210	200	95.2
b	completion of instruments, sponges, needles	210	193	91.9
c	labeled specimen	210	193	91.9
d	any equipment problem	210	193	91.9

2	To surgeon, anesthetist and nurse key concern for patient recovery and management	210	205	97.6
	SIGNED	**Sign Out**		**93.71**
a	Nurse	210	210	100
b	Anesthetist	210	210	100
c	Surgeon	210	206	98.1
TOTAL COMPLIANCE = 93.58		**SN Compliance**		**99.37**

Figure 6: documentation compliance of each separate provision under

Figure 7: Comparison of the Compliances for both directly observed and audited surgical cases



If both the above data is compared, it can be seen that the practical implementation compliance for each division is less than the documentation compliance.

The compliance with the surgical safety checklist practical implementation had wide variations i.e. (62.7%- 93.3%) whereas the compliance with the completion and documentation of surgical safety checklist had narrow variations i.e. (91.29%-99.37%).

FINDINGS AND CONCLUSION

- The observations showed that the items on the checklist were verified nonverbally inside Operation Theatres. Although the each item in the Surgical Safety Checklist is supposed to be read aloud or confirmed verbally, the circulating nurses used to simply mark the items by confirming nonverbally.

- For the 30 direct observation cases,
    - There were total 22 such cases in which the nurses lacked training i.e. 73.3 % cases were covered by the nurses who were not trained for the implementation of Surgical Safety Checklist.
    - There were total 13 cases which lacked the cooperation from the surgical team i.e. 43.3% of the total cases

- There were 11 General Anesthesia cases requiring anesthesia team support. Out of 11 cases, there were 6 cases which lacked the cooperation from the anesthesia team

- Only 36.6% of observations reported active participation by physicians i.e. 11 cases

- Only 23.3% of observations reported that “the majority did not pay attention” i.e. 7 out of 30 cases which includes all the members of surgical team, anesthesia team and the circulating nurse.

- Only 26.6% of the total observations reported that the team was “just going through the motions” i.e. 8 out of 30 cases.

- For the documentation compliance, out of 210 audited surgical case files, 63 case files missed the section for patient specific concern with local anesthesia cases (30 %), although the provision for "Not Applicable" has to be marked.

- Risk of difficult airway and >500 ml blood loss for patient were not documented (16.9 %).

Recommendations

- In this report, the taskforce has suggestions for substantially more noteworthy consistency focusing on three topics:

- Institutionalize – The advancement of abnormal state national benchmarks of working office rehearse that will bolster all suppliers of NHS-funded care to create and keep up their own particular more definite institutionalized neighborhood methods. The report additionally suggests the foundation of an Independent Surgical Investigation Panel to remotely survey chose genuine episodes;

- Instruct – Consistency in preparing and instruction of all staff in the working theaters, advancement of a scope of mixed media apparatuses to bolster execution of gauges and support for surgical Safety Training including human elements; and

- Blend – Consistency in revealing and distributing of information on genuine incidents, dissemination of gaining from genuine occurrences and concordance with neighborhood and national measures considered through control.

- Recommendations included continuing education, time for pilot-testing, and engaging all staff in Surgical Safety Checklist review.

- Supplementary training and attention to actual checklist used to improve communication.

- Conducting regular audit of checklist utilization is also recommended.

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