

**Summer Training at
Max Healthcare Institute,
New Delhi
(April - June, 2013)**

- 1. ASSESSMENT OF PATIENT SATISFACTION REGARDING THE
COMMUNICATION SKILLS OF DOCTORS**
- &**
- 2. ASSESSMENT OF AWARENESS OF INCIDENT REPORTING
SYSTEM AMONGST THE CLINICIANS**

**By
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**Under the guidance of
Dr. Suresh Joshi**

**Post Graduate Diploma in Hospital and Health Management
2012-2014**



**Institute of Health Management Research,
Jaipur
2013**

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CERTIFICATE

This is to certify that **Dr. Aditi Makkar** student of the 17th batch of the Post Graduate Diploma in Health and Hospital Management (PGDHM) at Institute of Health Management and Research, Jaipur underwent the summer internship at **MAX Super Speciality Hospital, Saket, New Delhi** from April 8th to June 8th 2013 and performed study on:

- 1.) Assessment of patient satisfaction regarding the communication skills of doctors.
- 2.) Assessment of clinician awareness regarding the incident reporting system.

The candidate successfully carried out the study assigned to her during summer training and her approach to the study was sincere, scientific and analytical.

We wish her success in all her future endeavours.



Dr. Ashok Kaushik
Dean (Academics and student affairs)
IIHMR, JAIPUR



Prof. Suresh Joshi
Professor
IIHMR, JAIPUR



Super Speciality Hospital
A Unit of Devki Devi Foundation

CERTIFICATE

TO WHOM IT MAY CONCERN

This is to certify that **Dr. Aditi Makkar**, PGDHM student from Institute of Health Management and Research, Jaipur has successfully completed her project titled **"Assessment of awareness regarding Incident Reporting System amongst clinicians"** at Max Hospital, under our supervision. During her study process, she had the opportunity to visit other hubs of Max Healthcare, to collect data.

To the best of our knowledge, the study mentioned above is her original work.

Dr. Arati Verma
Senior Vice-President
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MAX at a GLANCE

Max Super Specialty Hospital is a part of Max India Limited which is a public limited company founded in 1985 by its current chairman, **Analjit Singh**. It's major shareholders include Singh and the private equity firm Warburg Pincus. Max Super Specialty Hospital under the name Max Healthcare commenced operations in 2001 with the intention to provide comprehensive and world-class healthcare services in India. Max Super Specialty Hospital is the country's first comprehensive provider of standardized, seamless and world-class healthcare services. It is committed to the highest standards of medical and service excellence, patient care, scientific and medical education. Max super specialty operates eight centers in Delhi & NCR, offering services in over 30 medical disciplines. Max Super Specialty Hospital has state of the art tertiary care facilities at Saket in South Delhi, secondary care hospitals at Pitampura, Patparganj, Gurgaon and Noida and an outpatient facility, the Max Med centre and a Specialty centre focused on Eye and Dental care at Panchsheel Park. Max Super Specialty Hospital is located in serene environment of South Delhi, 15 km away from New Delhi railway station and 12 km from domestic airport. It is also easily reachable from satellite town of NCT, Delhi.

Passion-Vision Model:



Observational Learning in Different Departments:

OPD

Every specialty has a decentralized OPD. New patients need to get themselves registered by paying a sum of Rs.100. The registration is done only once and is then valid for lifetime. Registration is done for patient identification by issuing a unique Id and easy retrieval of patient records.

IPD

IPD rooms are available on 2nd, 3rd, 4th and 5th floor of east wing and 2nd, 3rd, 4th, 5th and 6th floor of west wing. There are 5 types of in-patient rooms available depending on patient's choice of stay. The types of rooms are:

- Economy: One room has 4 beds and 2 washrooms
- Twin sharing: 2 patients share one room and there is one washroom
- Single
- Suite
- Deluxe

4th floor of east wing has 2 reverse barrier nursing rooms with positive pressure for immune-compromised patients. Also every nursing station has its own crash cart for emergency purposes.

To prevent medication errors Bar coded medication administration (BCMA) software is used. The software ensures 5 rights of administration which are Right patient, right drug, right dose, right time and right documentation.

Also to ensure easy identification of vulnerable patient the patient file is of green color with a violet sticker on it. Also the door of the patient's room had a red color sticker.

EMERGENCY

25 bedded Emergency comprises of Observational area and Resuscitation area and 1 Resuscitation room. Since Cardiology is a major specialty hence the Emergency is directly connected to ACC (Apex Coronary Care) ICU.

STAFF: 2 Senior Doctors, 4 PG Doctors, 6-8 Nurses and 5-6 GDA's

AMBULATORY SERVICES: All the Hubs of PAN MAX are planning to have a centralized ambulatory service centre which promises to provide an ambulance within 30min of call for request in the NCR region. There are 2 types of ambulances ACLS and BLS. Max Saket has 2 ACLS Ambulances and 5 BLS Ambulances.

The health condition of the patient is enquired over the phone and depending upon the severity the required ambulance is sent. In case the requirement is within the NCR region, the ambulance leaves within 5min of receiving call but in case of an outstation requirement, the ambulance leaves within an hour.

OPERATION THEATRE

There are 20 Operation Theatres in Max, Saket. West Block comprises of 10T complex which has 7OTs on 1st Floor and 1 Labour OT on 3rd Floor. East Block has 12 OTs. West Block OT caters to the specialities like Neurology, Orthopaedics, Paediatrics, Urology, Laproscopy, Gynaecology, Eye and ENT. East Block OTs caters to the specialities like Cardiology, Minimal Access Metabolic Bariatric Surgery, Plastic Surgery and Oncology. For neurology there is a special OT Brain Suite with Installed MRI Machine.

INTENSIVE CARE UNIT

There are 99 beds for ICU in East and South wing and 77 beds in West wing. Every ICU is specialized like CTVS Adult-17 beds, ACC-16 beds, CTVS pediatric- 9beds, Medical ICU, Surgical ICU, Oncology Medical ICU and Surgical ICU, Respiratory ICU, Pediatric ICU, Neonatal ICU.

Every ICU has an Isolation Room apart from onco medical ICU. The beds types include alpha beds, nimbus beds, excel beds and normal beds. Every cubicle has a monitor, oxygen pipelines, vacuum line, a Computer on Wheels (COW) and 22 electric sockets. Ventilators are available on demand. The ICUs have syringe pumps.

Areas: Nursing Station, dirty utility room, medication storage room, washroom, clean utility room and pantry.

Nurse: Bed Ratio is maintained as 1:2 normally and 1:1 for critically ill and ventilator supported patients. 2 duty doctors are available in each shift. Visits by consultants and physiotherapists are made as per requirement.

PHARMACY

The pharmacy is self-owned with Central Pharmacy situated at corporate office, Okhla. There are 2 In-patient pharmacy stores and 2 Out-patient stores in the hospital. The number of narcotic drugs to be issued to the hospital is sanctioned by the Government of Delhi according to the bed occupancy, number of surgeries occurring and other factors.

Inventory is maintained according to categories of ABC Analysis as:

- A Items: 7 days
- B Items: 10 days
- C Items: 15 days

IP Pharmacy maintained inventory of 9 days and OP pharmacy maintained that of 17-20 days. Turnover for IP pharmacy is 6-7 crores per month and OP pharmacy is 2 crore per month.

Medication Dispensing: Orders for medicine dispensing are fed in CPRS. The Stat orders required immediately were dispensed within 30 minutes. The normal order is dispensed within 1 hour and routine order is delivered by 1 round per day. Narcotics are dispensed on indent raised by nursing staff through indent form along with return of broken ampoules of used drugs.

Medication Recall: If a drug is found to be defective, it is reported to the Okhla office where the records for that particular series of drugs dispensed is checked and verified for medication recall.

Room temperature is maintained at 15-30⁰C and refrigerator temperature is 20⁰C for medication storage.

Assessment of Patient Satisfaction regarding the Communication Skills of Doctors



INTRODUCTION

Patient satisfaction is the strongest determinant of effective patient-centered healthcare delivery. It is essential as patients are the primary customers of a hospital and their satisfaction is directly related to the functioning and growth of the organization in healthcare industry (Figure 1). The benefits of ensuring high levels of patient satisfaction include improved profitability, greater patient loyalty, improved compliance and increased productivity. It depends on a number of factors concerning the doctors, nurses and other services provided in the hospital.

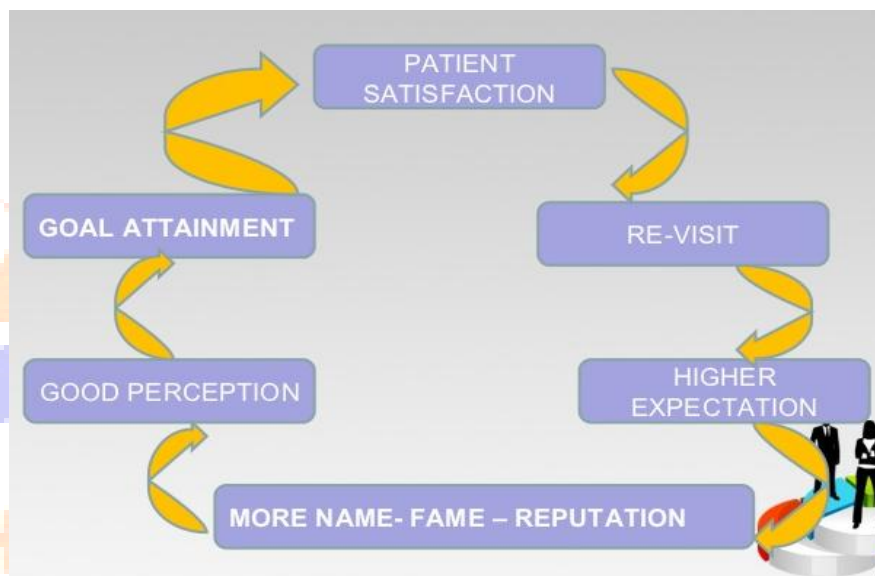


Fig. 1

Effective doctor patient communication is shown to be highly correlated with patient satisfaction from health care services. The way a physician communicates with a patient is a critical part of building a relationship and building trust. A doctor's communication skills encompass the ability to gather information in order to facilitate accurate diagnosis, counsel appropriately, give therapeutic instructions, and establish caring relationships with patients. These are the skills in the practice of medicine, with the ultimate goal of achieving the best outcome and patient satisfaction, which are essential for the effective delivery of health care. Information exchange is the dominant communication model, and the rise in consumerism in health sector has led to the current model of shared decision making and patient-centered communication.¹⁻⁵ Effective doctor-patient communication is determined by the doctors' "bedside manner," which patients judge as a major indicator of their doctors' general competence. The ultimate objective of any doctor patient communication is to improve the patient's health and medical

care. Studies on doctor-patient communication have demonstrated patient discontent even when many doctors considered the communication adequate or even excellent.⁶ Doctors tend to overestimate their abilities in communication, which was demonstrated by a survey conducted by the management in the same hospital. In contrast, the complaints of patients concerning the poor communication from doctors' end are reported frequently. Thus the need to identify the levels of satisfaction amongst the patients regarding the communication skills of doctors was generated.

OBJECTIVE of STUDY

Primary objective: To assess the patient satisfaction levels regarding the communication skills of the doctors.

Secondary Objectives:

- To justify the parameters of doctors' communication skills those are supposed to affect patient satisfaction.
- To identify the order of significance of the factors affecting patient satisfaction.
- To estimate the need for training of doctors related to the attributes lacking in their current communication.

METHODOLOGY

Study type: The study design is a quantitative cross-sectional research.

Technique: Patient Survey in Max Super Specialty Hospital, Saket

Study tool: Questionnaire.

Questionnaire Design: Communication Assessment Tool (CAT) developed and tested by Makoul et al⁷ (see Annexure 1) was used as the study tool. The CAT is a reliable and valid instrument for measuring patient perceptions of physician performance in the area of interpersonal and communication skills. It was developed by engaging in a systematic scale development process to obtain a psychometrically sound assessment tool. This process yielded a 15-item instrument that is written at the employs a five-point

Likert response scale, with 5 = excellent, 4= very good, 3= good, 2= fair, 1=poor. Pilot testing established that the CAT differentiates between physicians who rated high or low on a separate satisfaction scale. A field test was conducted with physicians and patients from a variety of specialties and regions within the US to assess the feasibility of using the CAT in everyday practice. Overall scale reliability was high (Cronbach's alpha = 0.96).

Sample Size

A sample of 100 patients was decided.

Sampling technique

Convenience sampling technique was followed to select a sample of 100 patients in the hospital, who were willing to participate in the survey. Patients were approached both in out-patient and in-patient departments. 25 patients were taken from the OPD and 75 patients were from the IPD. The criteria for this division were: i) the patients interact for a longer time with the doctors in IPD and ii) a greater part of interaction of the patient in IPD is with the junior doctors, whose communication skills are expected to be requiring training more than the senior doctors.

Exclusion criteria:

1. Patients from all facilities were approached except for the following departments:-

- Neurosciences
- Pediatrics
- Oncology

The criterion for exclusion was the concern for unstable mental state of the patients in these facilities, owing to the severity of the diseases.

2. Patients below 18 years of age were not included in the sample.

Data Collection

- OPD patients were approached randomly, depending on their willingness, in the waiting area after completion of their visit with the consultant.
- Patients were explained about the study by the investigator and requested to complete the questionnaire to help improve the quality of healthcare at the hospital.
- The investigator offered the patients to read out aloud the questions and himself / herself record patient responses, if required by the patient.
- Additionally, the patients were told that their refusal or participation would not influence the care provided by the hospital.
- Also each patient was ensured for maintain the confidentiality of their responses, before starting the answering of questions.
- IPD patients with stable conditions, from facilities except the above mentioned excluded departments were approached and the same procedure was followed thereafter.

Fifteen parameters of communication skills considered in the assessment tool were:

1. Initial Greeting: At the first interaction with the patient, the doctor should greet the patient in such a way that the patient is comfortable to give history of illness and inform his/her health concerns.
2. Respect: Patients expect the doctor to treat them respectfully, considering them a human being rather than another disease case.
3. Understanding: The doctor should understand the patient's concerns regarding their health problems.
4. Attention: While communicating with the patient, doctor should not be distracted and should make good eye contact continuously.
5. Listening Skills: The doctor should have good listening skills and allow the patient to express his/her problems without interrupting them.
6. Delivering Information: The doctor should provide the patients and their attendants' sufficient information regarding the disease, its impact, course of treatment, need of investigations and prognosis of treatment.
7. Simple Language: The language used by the doctor should not include much of medical terms, which cannot be understood by the patient.
8. Cross Checking: Doctor should cross check whether the patient has understood whatever he/she has explained.

9. Encourage Doubts: The patient should be encouraged by doctor to ask doubts regarding the disease or treatment.
10. Protect privacy: Prior to examining the patient, doctor is supposed to inform him/her and ensure to protect the privacy of patient.
11. Explain prognosis: The patient should be given details regarding the chances of success of treatment and risks involved in treatment. This should be conveyed verbally by doctor, apart from giving consent forms to be filled by patient.
12. Shared decision-making: Patient should be involved in the decision making for the type of treatment he/she wants to be given, after being provided information of all the possible treatment options by the doctor.
13. Explain Follow-up: Before discharge, the patient should be explained about the medications and self-care to be taken at home and briefed of follow-up plans.
14. Sufficient time: It is the responsibility of the doctor to satisfy the patient, such that patient does not feel rushed up
15. Caring attitude: Doctor should express care and concern for the emotional disturbance patient is undergoing due to state of illness.

DATA ANALYSIS:

The responses from 100 patients were analyzed as follows:

Mean Score

- Question wise mean score calculated
- Overall mean score calculated

Percentage of Ratings

- Question wise
- Overall

Question-wise Analysis:

- Each question was analyzed to calculate the average score given by the respondents, which is the mean score.
- The percentage of respondents who rated the question as 'Excellent', as 'Very good', as 'Good', as 'Fair' and as 'Poor' was calculated.

The Doctor:

1. *'Greeted me in a way that made me feel comfortable'*

Mean score	% as 'Excellent'	% as 'Very Good'	% as 'Good'	% as 'Fair'	% as 'Poor'
3.86	45%	31%	20%	3%	0%

2. *'Treated me with respect'*

Mean score	% as 'Excellent'	% as 'Very Good'	% as 'Good'	% as 'Fair'	% as 'Poor'
3.95	49%	29%	19%	2%	0%

3. *'Understood my main health concerns'*

Mean score	% as 'Excellent'	% as 'Very Good'	% as 'Good'	% as 'Fair'	% as 'Poor'
3.86	45%	36%	15%	3%	1%

4. *'Paid attention to me (looked at me, listened to me carefully)'*

Mean score	% as 'Excellent'	% as 'Very Good'	% as 'Good'	% as 'Fair'	% as 'Poor'
3.85	45%	33%	19%	2%	1%

5. *'Let me talk without interruptions'*

Mean score	% as 'Excellent'	% as 'Very Good'	% as 'Good'	% as 'Fair'	% as 'Poor'
3.78	40%	35%	22%	3%	1%

6. *'Gave me as much information as I wanted'*

Mean score	% as 'Excellent'	% as 'Very Good'	% as 'Good'	% as 'Fair'	% as 'Poor'
3.66	36%	40%	16%	7%	1%

7. *'Talked in terms I could understand'*

Mean score	% as 'Excellent'	% as 'Very Good'	% as 'Good'	% as 'Fair'	% as 'Poor'
3.66	30%	44%	22%	3%	1%

8. *'Checked to be sure that I understood everything'*

Mean score	% as 'Excellent'	% as 'Very Good'	% as 'Good'	% as 'Fair'	% as 'Poor'
3.06	26%	30%	24%	18%	3%

9. *'Encouraged me to ask questions'*

Mean score	% as 'Excellent'	% as 'Very Good'	% as 'Good'	% as 'Fair'	% as 'Poor'
3.06	26%	30%	24%	18%	3%

10. *'Informed me prior to examining me and protected my privacy'*

Mean score	% as 'Excellent'	% as 'Very Good'	% as 'Good'	% as 'Fair'	% as 'Poor'
3.19	24%	33%	32%	11%	1%

11. *'Explained chances of success and likely risks of treatment'*

1	Mean score	% as 'Excellent'	% as 'Very Good'	% as 'Good'	% as 'Fair'	% as 'Poor'
1	3.35	27%	36%	30%	5%	2%
2						

12. *'Involved me in decisions as much as I wanted'*

Mean score	% as 'Excellent'	% as 'Very Good'	% as 'Good'	% as 'Fair'	% as 'Poor'
3.13	22%	36%	26%	13%	3%

13. *'Discussed next steps, including any follow-up plans'*

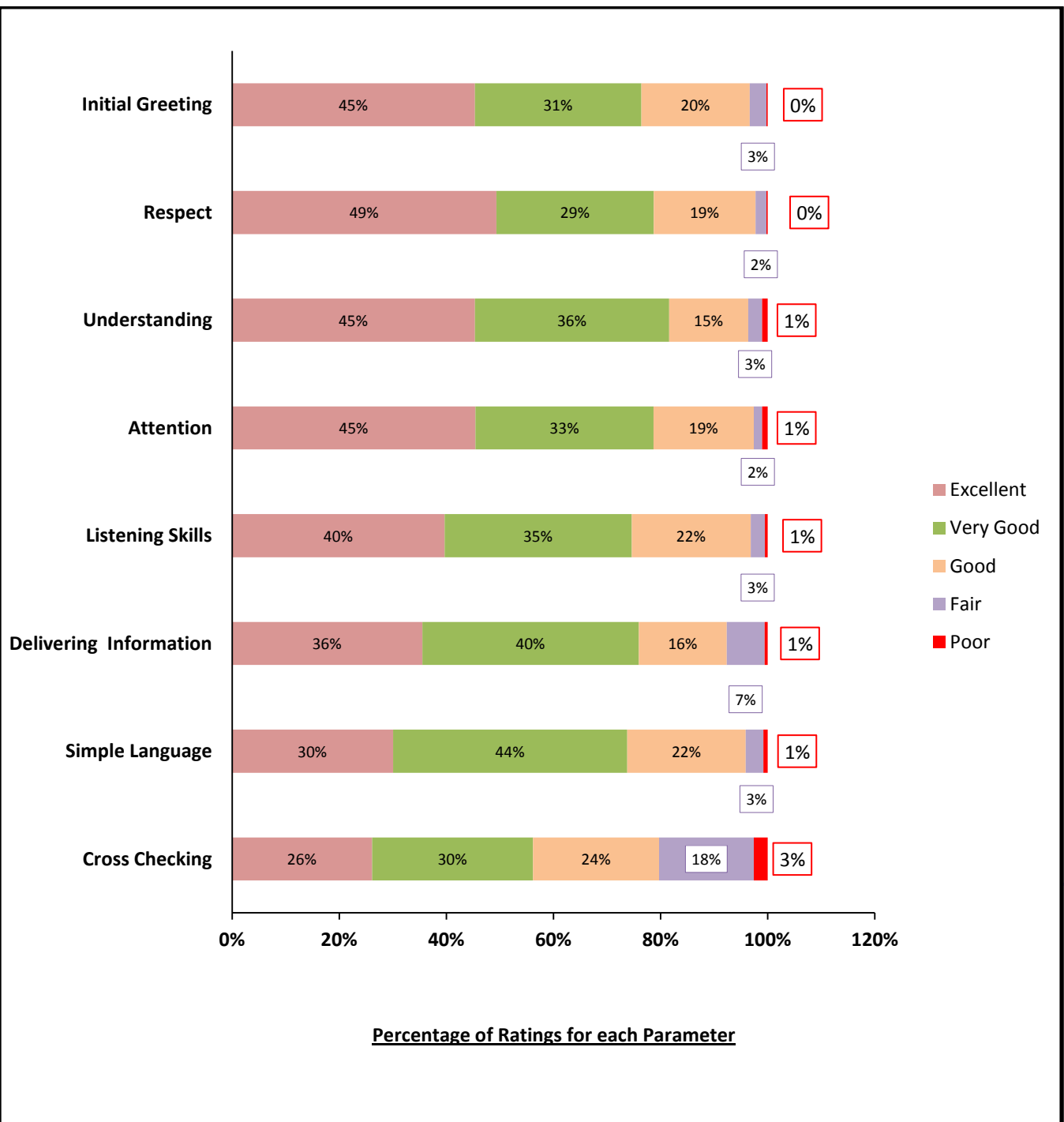
Mean score	% as 'Excellent'	% as 'Very Good'	% as 'Good'	% as 'Fair'	% as 'Poor'
3.44	29%	38%	25%	6%	1%

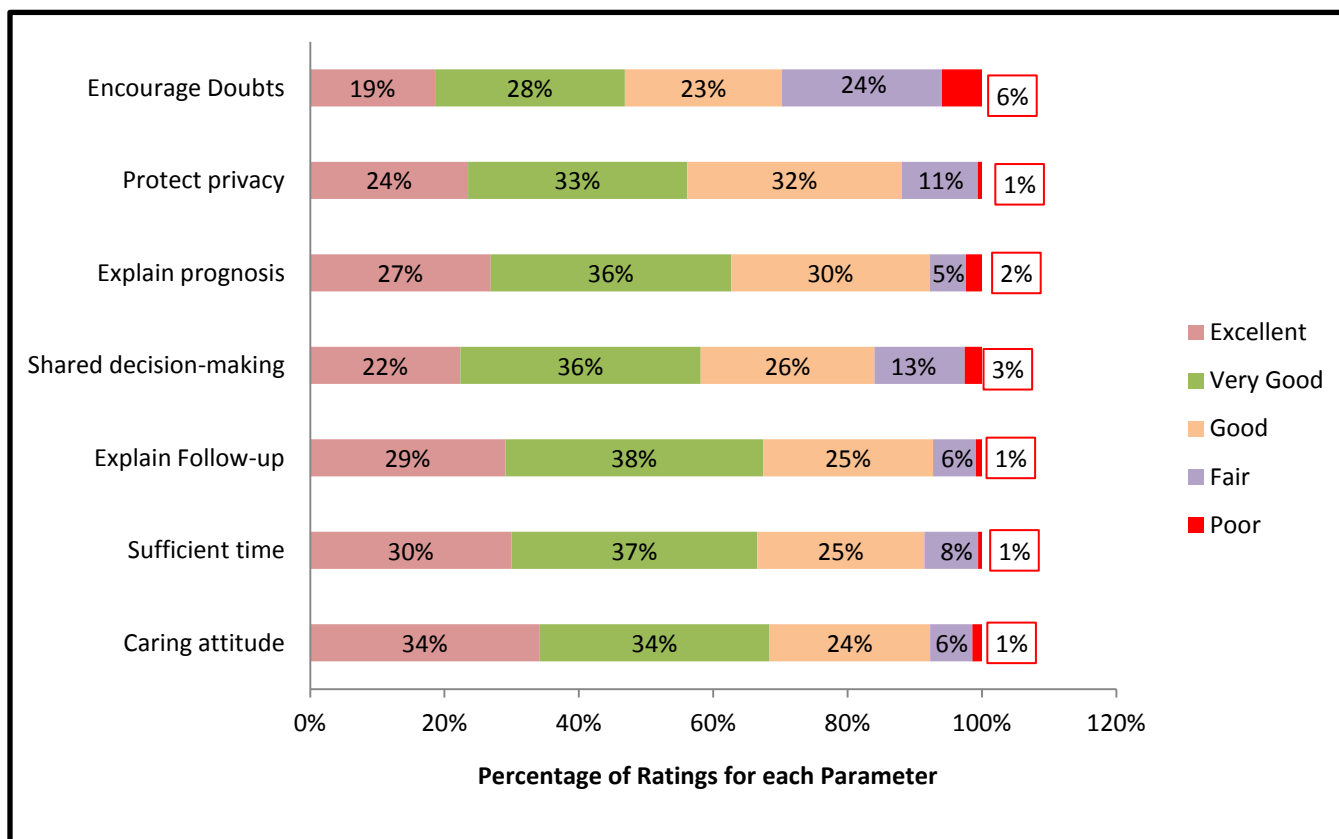
14. *'Spent the right amount of time with me'*

Mean score	% as 'Excellent'	% as 'Very Good'	% as 'Good'	% as 'Fair'	% as 'Poor'
3.5	30%	37%	25%	8%	1%

15. *'Showed care and concern'*

Mean score	% as 'Excellent'	% as 'Very Good'	% as 'Good'	% as 'Fair'	% as 'Poor'
3.51	34%	34%	24%	6%	1%





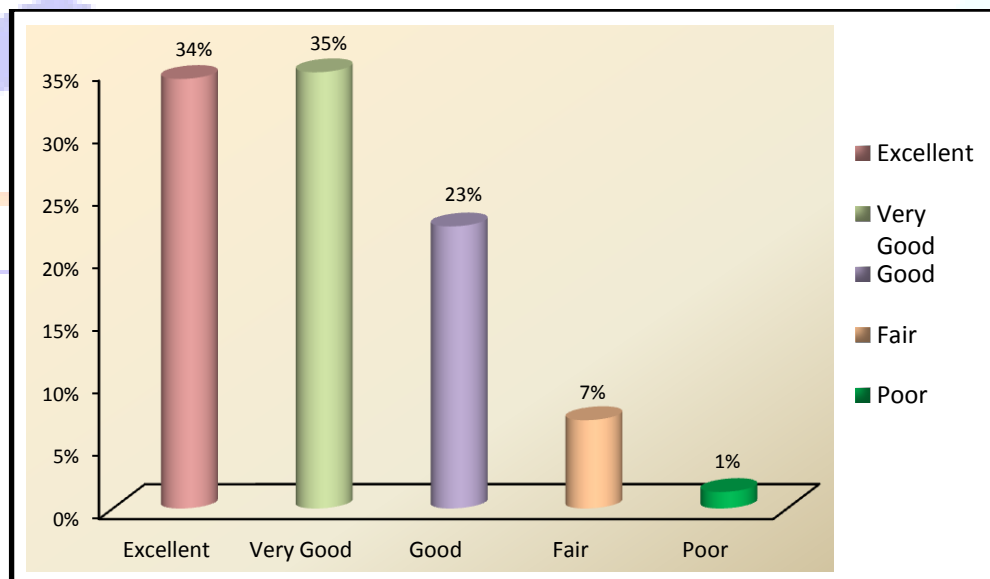
Interpretation:

- From the above analysis, it was found that the lowest percentage rating as 'Excellent' was 19% for the question – *'The doctor encouraged me to ask questions'*. This implies that only 19% of doctors encouraged their patients to clarify doubts, if they had any regarding their illness.
- The next low percentage is 22% for the question *'Involved me in decisions as much as I wanted'*. This indicates that the doctors are not able to make the patient feel a part of decision-making process. Failing this creates insecurity in the patients'/ relatives' mind regarding the authenticity of treatment being provided.
- The other questions with markedly low percentages of 'Excellent' rating were:-
 - 'The doctor informed me prior to examining me'* - 24%
 - 'The doctor checked to be sure that I understood everything'* – 26%
 - 'The doctor explained chances of success and likely risks of treatment'* – 27%

Overall Analysis:

- The overall average (or mean) score was found to be 3.5, with a standard deviation of 0.36.
- The overall percentages of ratings given by the respondents for all 15 items were :-

Rating	Percentage
Excellent	34.29%
Very Good	34.83%
Good	22.52%
Fair	7.05%
Poor	1.31%



Interpretation:

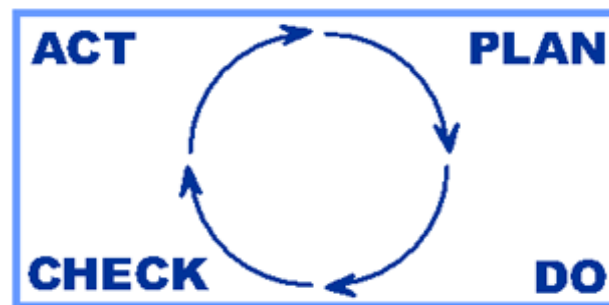
- The overall rating as 'Excellent' is 34% and 'Very good' as 35%.
- The aim is to achieve 100% 'Excellent' rating.
- Thus it can be inferred that there exists a gap of 65% with the current communication skills of doctors in the hospital.

RECOMMENDATIONS:

- **Training Need Identification:** The study analysis can be used as a tool of training need identification, which involves determining organizational objectives and assessing training needs. This can be done through following steps:
 1. Organisational analysis: is done by determining the organizational goals. The primary goal of the organization is to achieve high levels of patient satisfaction regarding the communication skills of doctors. It is aimed to get 100% rating as 'Excellent' for all the parameters surveyed through questions.
 2. Task analysis: Prioritising the tasks in meeting the organizational goals: From the given analysis, the parameters that have lowest percentage ranking as 'Excellent' can be identified as the highest priority tasks during training. Also the questions with high percentage of 'Poor' ranking should be given priority over the rest.
 3. Personnel analysis: Determining whether performance efficiency is the result of lack of knowledge, skill or ability and planning the training according to the needs of the employees.

- **Improvement measures:**

Once the training needs have been identified, the improvement can be implemented using *Deming Cycle* or *PDCA (Plan-do-check-act) Cycle*⁹, used in management for continuous improvement. It is a four stage model for change management to achieve continuous improvement. It is represented as a circle as it requires repeating the same stages over and over to improve the output.



PLAN: Developing a plan for training the doctors involves setting an objective; identifying actions, responsibilities, timeframes; and defining the method and frequency of measurement of improvement.

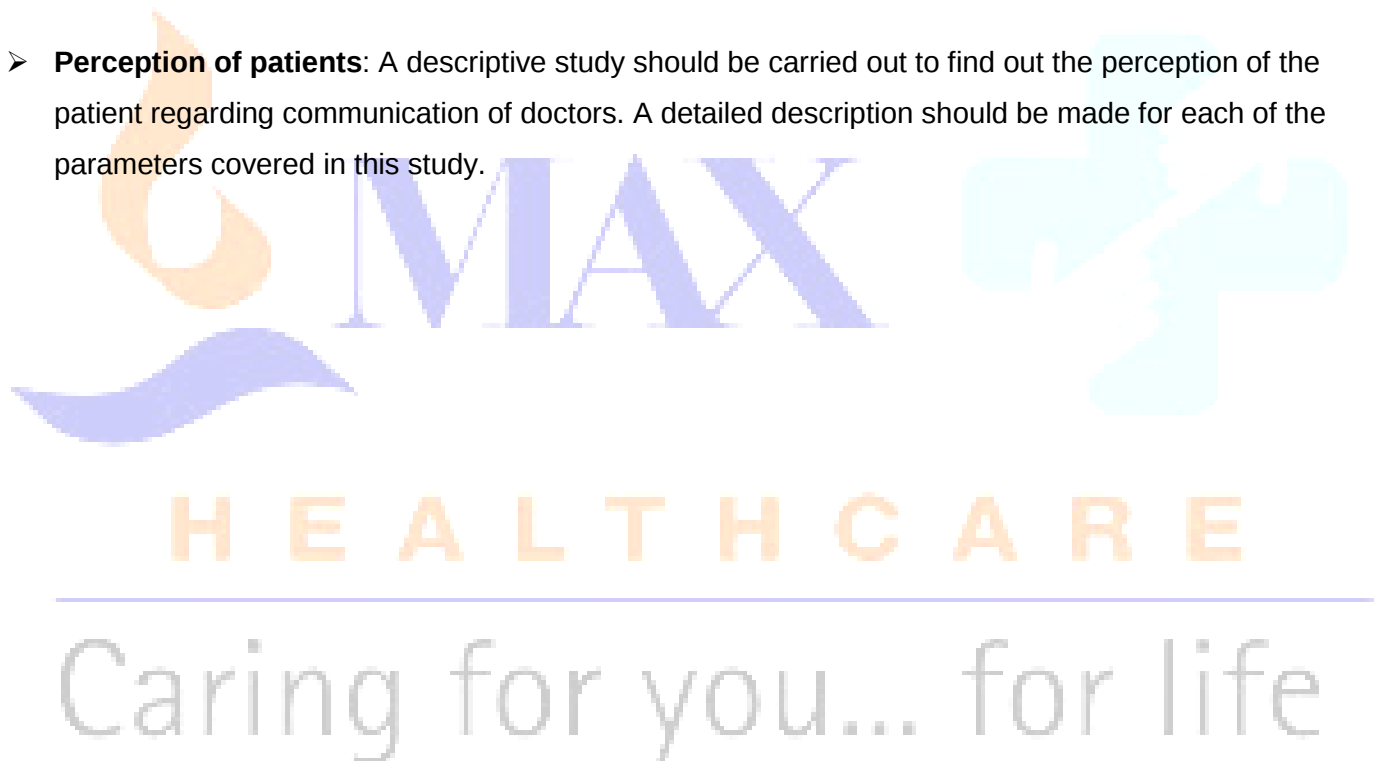
DO: The training team of human resources department in hospital is asked to develop a training module based on the findings of study. Team implements the training module by encouraging the doctors to participate through posters floated on the employee portal of hospital.

CHECK: Training team reviews the change improvement by conducting role plays at the end of the training sessions.

ACT: Based on the results of the check, the team makes some modification in the training pattern and may try another change for further improvement.

Repeat PDCA Cycle: the stages of the cycle are repeated over intervals and results are reviewed for measurement of change.

- **Comparative Analysis:** A comparative analysis of the patient satisfaction from other competitive hospitals could be done to find out the expectations of patients from their treating doctors.
- **Perception of patients:** A descriptive study should be carried out to find out the perception of the patient regarding communication of doctors. A detailed description should be made for each of the parameters covered in this study.



ANNEXURE 1

PATIENT SATISFACTION SURVEY

Date:

1. Name (optional) 2Age (in yrs.) 3. Gender.....
 4. ID Number 5. Your Doctor's Profile

Dear Patient,

We would like to know your views on your interaction with the doctor during this visit. Your feedback will be highly valuable in helping us improve the quality of healthcare provided at our hospital.

Please spend a few moments to answer the following questions. Your responses will be kept confidential.

Please respond with a tick mark to these questions:	Poor	Fair	Good	Very Good	Excellent
The Doctor	1	2	3	4	5
• Greeted me in a way that made me feel comfortable	☐	☐	☐	☐	☐
• Treated me with respect	☐	☐	☐	☐	☐
• Understood my main health concerns	☐	☐	☐	☐	☐
• Paid attention to me (looked at me, listened to me carefully)	☐	☐	☐	☐	☐
• Let me talk without interruptions	☐	☐	☐	☐	☐
• Gave me as much information as I wanted	☐	☐	☐	☐	☐
• Talked in terms I could understand	☐	☐	☐	☐	☐
• Checked to be sure that I understood everything	☐	☐	☐	☐	☐
• Encouraged me to ask questions	☐	☐	☐	☐	☐
• Informed me prior to examining me and protected my privacy	☐	☐	☐	☐	☐
• Explained chances of success and likely risks of treatment	☐	☐	☐	☐	☐
• Involved me in decisions as much as I wanted	☐	☐	☐	☐	☐
• Discussed next steps, including any follow-up plans	☐	☐	☐	☐	☐
• Spent the right amount of time with me	☐	☐	☐	☐	☐
• Showed care and concern	☐	☐	☐	☐	☐

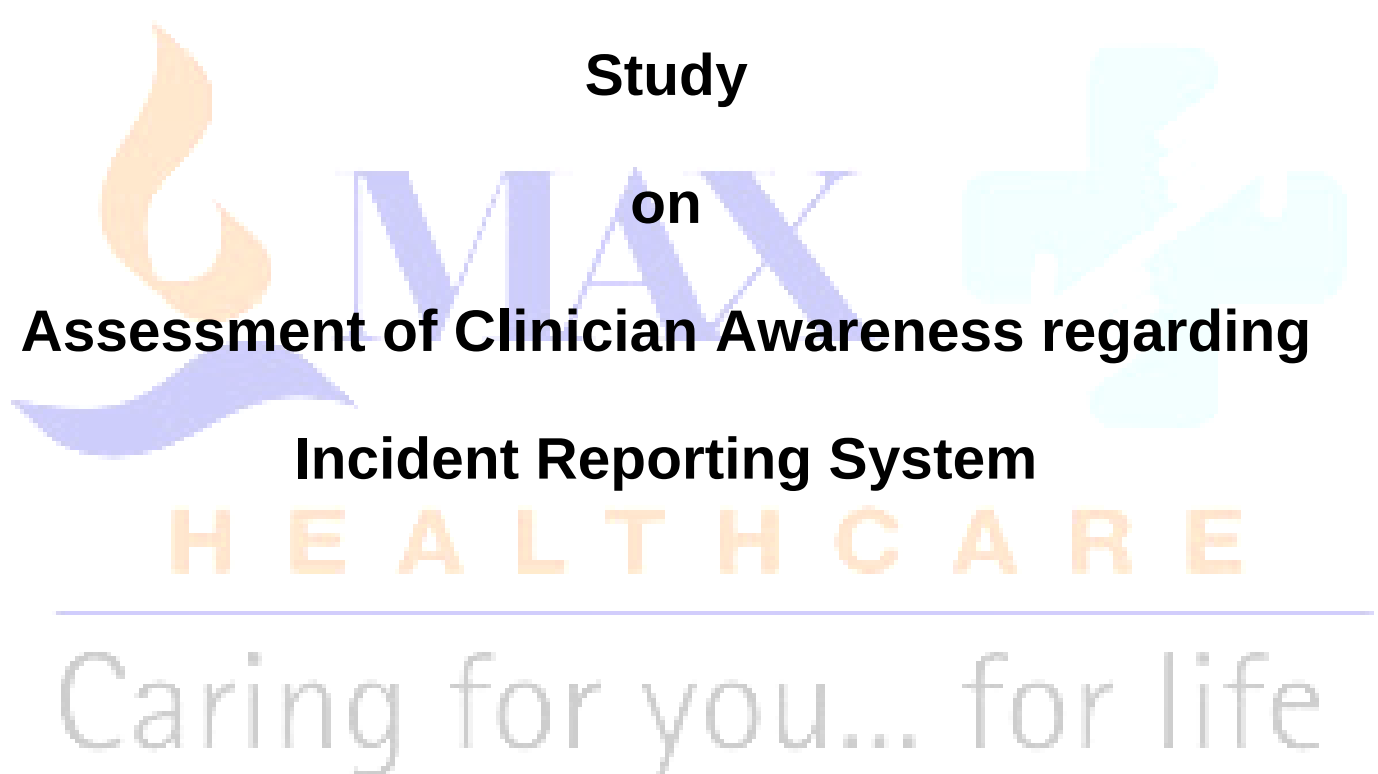
Thank you for taking part in this survey. Your feedback is very important to us.

References:

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H E A L T H C A R E

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Study

on

Assessment of Clinician Awareness regarding

Incident Reporting System

INTRODUCTION

Patient safety has been, and still is, a cause for concern in health-care systems all over the world, including India. It has been increasingly recognized that hospitals can be dangerous places for patients, since medical errors have been shown to cause harm to patients [1], [2]. The standard term for medical errors world-wide is 'Adverse Event'. According to NABH glossary, an adverse event is any injury related to medical management, in contrast to complications of disease. Medical management includes all aspects of care, including diagnosis and treatment, failure to diagnose or treat, and the systems and equipment used to deliver care. Adverse events may be preventable or non-preventable (WHO Draft Guidelines for Adverse Event Reporting and Learning Systems). One of the leading newspapers of the country, dated September 21, 2013, mentions: "India is recording a whopping 5.2 million injuries each year due to medical errors and adverse events. Similarly, approximately 3 million years of healthy life are lost in India each year due to these injuries" [3]. These incidents result in prolonged hospitalization, require life-sustaining intervention, cause permanent disability, or may result in death. In order to identify medical errors, to learn from mistakes and to improve patient safety, the healthcare community has introduced incident reporting systems (IRS).

REVIEW OF LITERATURE

Health-care organizations or individuals benefit from reporting incidents if they receive back useful information gained by generalizing and analyzing similar cases from other institutions. The fundamental role of patient safety reporting systems is to enhance patient safety by learning from failures of the health-care system.[4] Reporting must be safe. Individuals who report incidents must not be punished or suffer other ill-effects from reporting. Reporting is only of value if it leads to a constructive response. At a minimum, this entails feedback of findings from data analysis. Ideally, it also includes recommendations for changes in processes and systems of health care. Meaningful analysis, learning, and dissemination of lessons learned requires expertise and other human and financial resources. The agency that receives reports must be capable of disseminating information, making recommendations for changes, and informing the development of solutions. The objectives of an incident reporting system for learning are first, to identify errors and hazards, and then through investigation to uncover the underlying systems failures, with the goal of redesigning systems to reduce the likelihood of patient injury. The key conceptual point here, and the heart of a non-punitive approach to error reporting, is the recognition that adverse events and errors are symptoms of defective systems, not defects themselves. Reporting, whether retrospective (adverse events and errors) or prospective ("hazards", or "errors waiting to happen") provides the entry point into investigation and analysis of systems' defects, which, if skillfully done, can lead to substantial system improvements.

Types of Incidents/ Adverse Events to be reported :

- Patient Fall
- Medication gap: Prescription, dispensing, administration
- Hospital Acquired Infections: VAP, CRBSI, CLABSI, SSI
- Infection Out break

- Needle Stick Injury
- Readmission within 7 days
- Return to Emergency within 7 days
- Return to OT within 7 days
- Code Blue
- RRT
- Pressure Sores
- Hypoglycemia (Less than 70mg/dl)
- Adverse Drug Reactions
- Return to ICU
- Patient Identification Error
- Acute Limb ischemia
- Discrepancy in Sponge/gauge count
- Cautery Burns
- Needle left inside Porta Cath
- Tubing Error
- Intravascular Air Embolism
- Hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products
- Death in a low risk labor or delivery in a low-risk pregnancy
- (Kernicterus) with failure to identify and treat hyperbilirubinemia in neonates
- Death or serious disability due to Spinal manipulative therapy
- Artificial insemination with the wrong donor sperm or wrong egg

Surgical Events:

- Surgery performed on the wrong body part
- Surgery performed on the wrong patient
- Wrong surgical procedure performed on a patient
- Unintended retention of a foreign object in a patient after surgery or other procedure
- Intra operative or postoperative death within 24 hrs in an ASA Class I patient

Product or Device Events: Patient death or serious disability associated with

- Contaminated drugs, devices, or biologics
- Wrong device use

Patient Protection Events:

- Infant discharged to the wrong person
- Patient death or serious disability associated with patient elopement (disappearance)
- Patient suicide, or attempted suicide, resulting serious disability while being cared for in a healthcare facility

Criminal Events

- Someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
- Sexual assault on a patient
- Physical assault (i.e., battery)

Others

OBJECTIVE of STUDY

Primary Objective: To assess the awareness of clinicians regarding incident reporting system in the super specialty private hospital.

Secondary Objectives:

- To trace the causes of poor incident reporting
- To provide a direction towards improvement of incident reporting, which in turn helps achieve patient safety goals

METHODOLOGY

Study type: The study design is a quantitative cross-sectional research.

Technique: Clinician Survey in 4 hubs of Max Hospital, Delhi

Study tool: Questionnaire.

Questionnaire Design: A questionnaire with 7 items was designed, with 2 closed-ended and 5 open-ended questions (See Appendix 2). The survey tool also recorded the designation of the clinician as junior/ senior resident or consultant and also their date of joining Max Healthcare. The questionnaire checked the awareness of clinicians in the following sequence:

- Occurrence of adverse events in the hospital
- Definition of adverse event
- Types of events
- Existence of reporting system
- Steps of reporting

Sample Size

A sample of 120 clinicians was decided.

Sampling technique

Convenience sampling technique was followed to select a sample of 120 doctors at 4 different hubs of Max Hospitals, namely at Saket, Shalimar Bagh, Gurgaon and Pritam Pura.

Data Collection

The doctors were asked to fill in the survey in the presence of the investigator.

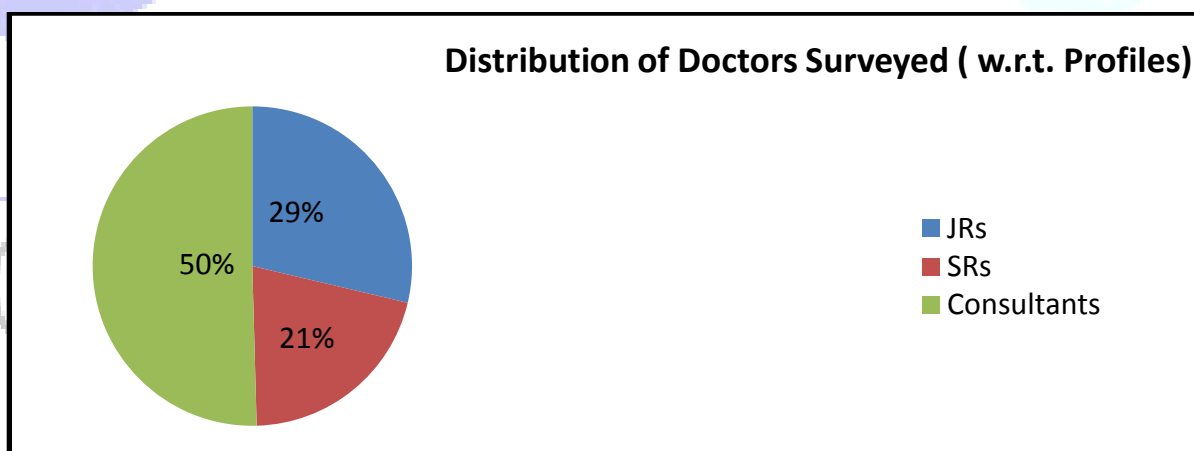
DATA ANALYSIS

Criteria

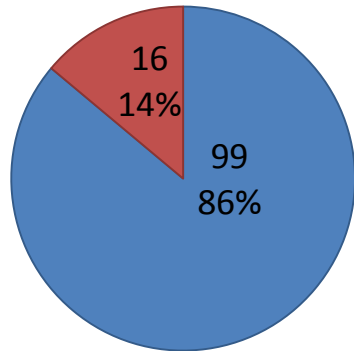
According to NABH standards, the criteria for analysis of questionnaire was as following:

- The answers were marked as 0, 5 and 10.
 - 'Yes' = 10
 - 'No' = 0
- For the open-ended questions, the marking was according to the compliance of the answer with the NABH descriptions.
 - Complete Compliance = 10
 - Partial Compliance = 5
 - No Compliance = 0

RESULTS

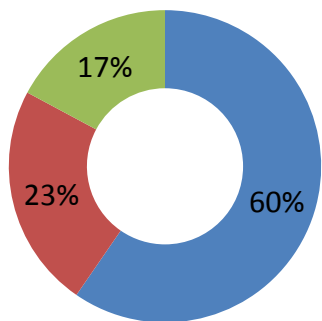


Doctors aware of ADE occurrence



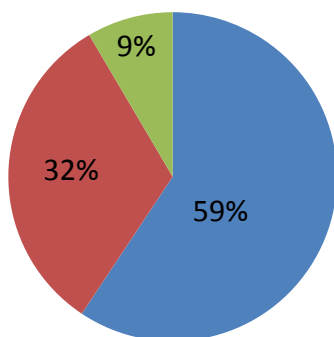
- No. of doctors aware
- No. of doctors not aware

Awareness of term ' Adverse Event' among Aware Doctors



- Completely Compliant
- Partially Compliant
- Not Compliant

Knowledge of types of Adverse Events among the Aware Doctors



- Completely Compliant Examples
- Partially Compliant Examples
- Non Compliant Examples

Profile Distribution of Doctors aware of Incident Reporting System

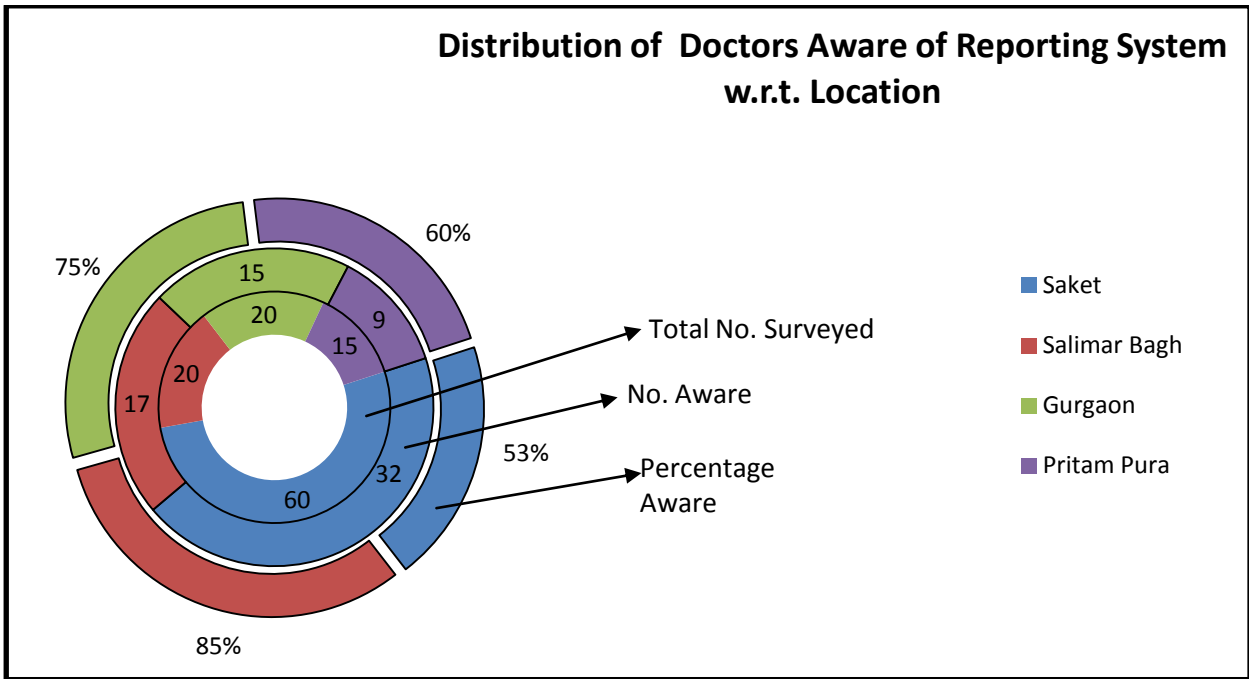


Distribution of Doctors aware of Incident Reporting System w.r.t Work Experience



Doctors Aware of Reporting Form





DISCUSSION

As observed from the pie charts, of all the doctors surveyed, 50% were consultants, 29% Junior residents and 21% were senior residents.

The doctors aware of the occurrence of adverse events were 86%.

Of these 86% aware doctors, 60% could correctly explain the term 'Adverse Event'. 23% of them gave partially compliant answers for the definition of adverse event and 17% gave non-compliant answers.

Amongst the 60% doctors who gave compliant answers to definition of adverse event, 59% gave compliant examples for adverse events and 32% gave partially compliant answers.

The distribution of doctors aware of the reporting system was: 58% consultants, 23% junior residents and 19% senior residents.

Finally, at the different locations the percentage awareness of doctors regarding the incident reporting system was:

- 85% at Shalimar Bagh
- 75% at Gurgaon,
- 60% at Pritam Pura and
- 53% at Saket.

RECOMMENDATIONS

- Education at orientation.[4]
- Ongoing education and use of case studies to highlight reportable events at departmental forums
- Ability to access a reference manual about what to report
- Rename/redesign the form to make it more relevant to medical staff
- Simplify the reporting process — one page being the optimal length
- Option of quicker reporting processes (eg, telephone reporting, online submission)
- Risk-assessment tool to prioritize action for follow-up. Type and timing of feedback given dependent on severity of incident or degree of risk to the organization. Staff informed of follow-up processes
- Confidentiality of the person reporting an incident should be guaranteed.
- Option to report anonymously to an independent body, without fear of being identified and with the option to omit identifiers of either self and/or organization.
- Individual/group feedback of action taken

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2. Kohn KT, Corrigan JM, Donaldson MS (1999) To err is human. Building a safer health system. Washington, DC: National Academy Press.
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ANNEXURE II

Adverse Event Reporting – Assessment of Clinician Awareness – Tool

Designation:	JR	SR	Consultant	Date:
Department/ Location:				Date of Joining MHC:

Dear Clinician(s),

The incidence of adverse events comprises patient safety and quality provided at a hospital. Reporting of such events can help us minimize errors and thus promote better patient safety at our hospital. Kindly spend a few moments to answer the following and help us improve **Incident Reporting** at MHC.

1.	Are you aware about the occurrence of Adverse Events in a hospital? ☐ Yes ☐ No	2.	If yes, what do you mean by the term “Adverse Events”?
3.	List three (3) most common Adverse Events that you come across a. b. c.	4.	Are you aware of the incident reporting system at MHC? ☐ Yes ☐ No
5.	If Yes , what are the 2 steps the clinician should take to report an incident?	6.	What is the time limit within which the adverse event should be reported?
7.	From where can the reporting form be obtained?		

Thanks for your feedback.