Internship Training

At

Aakash Healthcare Private Ltd.

Dwarka, New Delhi

On

"Culture of Patient Safety in a Super Speciality Hospital through learnings from Patient Safety Events"

By

Dr. Apurva Relan

PG/15/014

Under the guidance of

Ms. Kirti Udayai

Assistant Dean,
Academics and Student Affairs

May 2017

Post Graduate Diploma in Hospital and Health Management

2015-17

International Institute of Health Management Research

New Delhi

TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Dr. Apurva Relan**, student of Post Graduate Diploma in Hospital and Health Management (PGDHM) from International Institute of Health Management Research, New Delhi has undergone internship training at **Aakash Healthcare Private Ltd., Dwarka, New Delhi** from **Feb 2017 to April 2017**.

The Candidate has successfully carried out the study designated to her during internship training and her approach to the study has been sincere, scientific and analytical.

The Internship is in fulfilment of the course requirements.

I wish her all success in all her future endeavors.

Dr. A.K. Agarwal
Dean, Academics and Student Affairs
IIHMR, New Delhi

Ms. Kirti Udayai
Mentor
Assistant Dean,
Academics and Student Affairs
IIHMR, New Delhi

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Super Speciality Hospital
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Corporate Office:
G-251-252, Rajapuri Market, Behind Sector-3 Dwarka,
New Delhi - 110 059. Ph.: 011-33581500

The certificate is awarded to

DR. APURVA RELAN

in recognition of having successfully completed her

Internship in the department of

QUALITY

and has successfully completed her Project on

"Culture of Patient Safety in a Super Specialty Hospital

Through learnings from Patient Safety Events"

1st May 2017

Organisation: Aakash Healthcare Private Ltd.

She comes across as a committed, sincere & diligent person who has

a strong drive & zeal for learning.

We wish her all the best for future endeavors

Training & Development

Head-Human Resources

Certificate of Approval

The following dissertation titled **"Culture of Patient Safety in a Super Specialty Hospital through learnings from Patient Safety Events"** at **"Aakash Healthcare, Private Ltd., Dwarka, New Delhi"** is hereby approved as a certified study in management carried out and presented in a manner satisfactorily to warrant its acceptance as a prerequisite for the award of **Post Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation.

Name	Signature
Dr Ashish Roy	
Ms Kusti Ghosh	
Mr. Vinay Tripathi	

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New Delhi - 110 059. Ph.: 011-33581500

Certificate from Dissertation Advisory Committee

This is to certify that **Dr. Apurva Relan,** a graduate student of the **Post- Graduate Diploma in Health and Hospital Management** has worked under our guidance and supervision. She is submitting this dissertation titled "To create a Culture of Patient Safety in a Super Specialty Hospital through learnings from Patient Safety Events" at "Aakash Healthcare Private Ltd. Dwarka, New Delhi" in partial fulfilment of the requirements for the award of the **Post- Graduate Diploma in Health and Hospital Management.**

This dissertation has the requisite standard and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, report or book.

Ms. Kirti Udayai
Assistant Dean,
(Academics and Student Affairs)
IIHMR, New Delhi.

Dr. Aashish Chaudhry
Managing Director
Aakash Healthcare Private Ltd.

INTERNATIONAL INSTITUTE OF HEALTH MANAGEMENT RESEARCH,

NEW DELHI

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled "**Culture of Patient Safety in a Super Specialty Hospital through learnings from Patient Safety Events**" and submitted by **Dr. Apurva Relan**, Enrollment No. PG/15/014 under the supervision of Ms. Kirti Udayai for award of Postgraduate Diploma in Hospital and Health Management of the Institute carried out during the period from Feb 2017 to April 2017 embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other Institute or other similar institution of higher learning.

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G-251-252, Rajapuri Market, Behind Sector-3 Dwarka,
New Delhi - 110 059. Ph.: 011-33581500

FEEDBACK FORM

Name of the Student: Dr. Apurva Relan

Dissertation Organisation: Aakash Healthcare Private Ltd.

Area of Dissertation: To create a Culture of Patient Safety in a Super Specialty Hospital through learnings from Patient Safety Events

Attendance: Puntual

Objectives achieved: 1. Knowledge and Practical Implementation of NABH and JCI Standards.
2. Process of framing the policies for accreditation requirements.

Deliverables:
1. Conducted regular trainings on policies for staff.
2. Actively participated in inculcating Culture of Safety.
3. Framed policies for various standards of NABH + JCI.

Strengths:
Self-motivated, goal-oriented, creative and hard working.

Suggestions for Improvement:
–

Suggestions for Institute (course curriculum, industry interaction, placement, alumni):
–

DOLLY SINGH
Organization Mentor Name
Aakash Healthcare Pvt. Ltd.

Date: 01-05-2017

Place: NEW DELHI

ABSTRACT

Background: Many patients face adverse events during their hospital stay. Preventing errors and the harm that results requires putting systems and procedures in place. To obtain insight into safe hospital care, reliable data about the occurrence, causes, and preventability of adverse events have to be collected and made available. An organizational culture that routinely implements best practices and that avoids blame when mistakes are made is the best environment for safe care. It is very important that healthcare providers and organisations share what they have learned when an investigation has been carried out. It is also important to identify the opportunities of improvement in the processes and policies, to create a closed feedback loop by sharing the information from the analysed events so as to prevent the recurrence of patient safety events in the future and to create a Safety Culture in the organisation.

Aim: The overall aim of this study is to to create a Culture of Patient Safety in a Super Specialty Hospital through learnings from Patient Safety Events

Method: The study was conducted in Outpatient Clinic at Aakash Clinic in Dwarka, New Delhi. A system of patient safety event reporting was established and put in place. The events reported from July 2016 to April 2017 were studied and analysed to determine the system failures and process deficiencies.

A total of 18 patient safety events were reported and analysed in this period.

Results: Out of the total 18 patient safety events that were reported on the patient safety event reporting system, 1 was reported in July 2016, 4 in Jan 2017, 2 in Feb 2017, 7 in March 2017 and 4 in April 2017. Out of these 18 events, 8 were Near Miss events, 9 were adverse events and 1 was a Sentinel event. Different types of events were reported. Most of the errors

were Medication errors. The analysis for all 18 events was done and the process deficiencies and the system failures were identified. The corrective and preventive actions were recommended and improvements in the policies and processes were suggested.

Conclusion: The most important knowledge in the field of patient safety is how to prevent harm to patients during treatment and care. It is important to share what they have learned when an investigation has been carried out. Process deficiencies identified in this study have the potential to enhance patient safety and make the systems strong at Aakash Healthcare so that patient safety events are prevented in future.

ACKNOWLEDGEMENT

I would like to express my gratitude to **Dr. Aashish Chaudhry** (Managing Director), **Dr C.M Bhasin** (COO) for giving me an opportunity to undergo training in their prestigious institute.

I would like to thank **Dr. Tushar Palchodhury** (GM- Quality) **and Ms. Dolly Darshan Singh** (Quality Manager), their valuable encouragement and guidance inspired me to do this study.

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I am highly indebted to my mentor **Ms. Kirti Udayai,** Assistant Dean-Academics and Student Affairs, IIHMR Delhi for her co-operation, help and encouragement on various aspects of this project.

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ABBREVIATIONS

WHO : World Health Organisation

JCI : Joint Commission International

JCAHO : *Joint Commission on Accreditation of Healthcare Organizations*

PSRS : Patient Safety Reporting System

ADE : Adverse Drug Events

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Annexure I: Sample Event Reporting and Analysis forms of different organisations.

Annexure II: Patient safety Event reporting form

Annexure III: Patient Safety Event Analysis Form

INTRODUCTION

Many patients face adverse events during their hospital stay. The occurrence of adverse events varies from 3% to 17% of all hospital admissions worldwide. A significant proportion of these adverse events result in death (5–21%), of which half could be prevented. Medication errors cause at least one death every day and injure approximately 1.3 million people annually in the United States of America alone.

Both health workers and patients can make mistakes that result in severe harm, such as ordering, prescribing, dispensing, preparing, administering or consuming the wrong medication or the wrong dose at the wrong time. But all medication errors are potentially avoidable. Preventing errors and the harm that results requires putting systems and procedures in place to ensure the right patient receives the right medication at the right dose via the right route at the right time.

WHO launched a global initiative on 29th March 2017 to reduce severe, avoidable medication-associated harm in all countries by 50% over the next 5 years.

The Global Patient Safety Challenge on Medication Safety aims to address the weaknesses in health systems that lead to medication errors and the severe harm. It lays out ways to improve the way medicines are prescribed, distributed and consumed, and increase awareness among patients about the risks associated with the improper use of medication.

Patient safety event is a process or act of omission or commission that result in unsafe health care conditions and/or unintended harm to the patient or has a potential to cause harm. An event is identified by a generalized high-level, discrete, auditable term or group of terms.

Adverse Event is an event that results in unintended harm to the patient by an act of commission or omission rather than by the underlying disease or condition of the patient.

Patient safety, medical error and adverse event reporting is becoming a major issue in health care systems in the UK and across the world, particularly the United States of America and Australia.

In 1995, hospital-based surveillance was mandated by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) because of a perception that incidents resulting in harm were occurring frequently. JCAHO employs the term sentinel event in lieu of critical incident, and defines it as follows: An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. As one component of its Sentinel Event Policy, JCAHO created a Sentinel Event Database.

To obtain insight into safe hospital care, reliable data about the occurrence, causes, and preventability of adverse events have to be collected and made available. To evaluate interventions for reducing medical errors and adverse event, effective methods for detecting such events are required. Commonly used methods for analyses of unsafe hospital care and improvement of patient safety include external peer reviews, internal audits, patient safety systems, and performance indicators.

But these systems will perform optimally only if we improve our understanding of the fundamental nature of errors and the ways in which the human mind can naturally, but erroneously, contribute to the problems that we observe.

Health care systems originally adapted PSRS from the systems of aviation and other industries where safety is critical. They introduced PSRS into health care because they wished to achieve the level of resilience and response to error that high-risk industries have achieved

Patient safety event reporting systems are ubiquitous in hospitals and are a mainstay of efforts to detect patient safety events and quality problems. *Incident reporting* is frequently used as a general term for all voluntary patient safety event reporting systems, which rely on those involved in events to provide detailed information. Patient safety event reporting systems is the processes and technology used in standardising, communicating, giving feedback on, analysing, learning about and responding to reported events as well as in making known any lessons learned from such events.

Initial reports often come from the frontline personnel directly involved in an event or the actions leading up to it (e.g., the nurse, pharmacist, or physician caring for a patient when a medication error occurred), rather than management or patient safety professionals. Voluntary event reporting is therefore a passive form of surveillance for near misses or unsafe conditions, in contrast to more active methods of surveillance such as direct observation of providers or chart review using trigger tools.

The objectives of a reporting system emerge from the perceived needs of a patient safety programme. Reporting is a tool for obtaining safety information. To be effective, lessons learnt from the analysis of reports should feed into a mechanism for developing and disseminating changes in policy and practice that improve safety.

If the commitment to improvement is weak, or if there is no infrastructure to implement changes, a reporting system will be of little value. Stating it simply, it is more important to develop a response system than a reporting system.

Most harm arises from systems failures in the way care is organized and coordinated, especially when multiple health providers are involved in a patient's care. An organizational culture that routinely implements best practices and that avoids blame when mistakes are made is the best environment for safe care. It is very important that healthcare providers and organisations share what they have learned when an investigation has been carried out. It is a great opportunity to share lessons learned as widely as possible in order to improve healthcare. It is also important to identify the opportunities of improvement in the processes and policies, to create a closed feedback loop by sharing the information from the analysed events so as to prevent the recurrence of patient safety events in the future and to create a Safety Culture in the organisation.

RATIONALE

Most harm arises from systems failures in the way care is organized and coordinated, especially when multiple health providers are involved in a patient's care.

In this study, we are focussing on studying the types of patient safety events being reported, the process deficiencies and look out for the opportunities of improvement to improve our system and processes, thus creating a culture of patient safety in the organisation.

AIM

- To create a Culture of Patient Safety in a Super Specialty Hospital through learnings from Patient Safety Events

OBJECTIVES

- To define Patient Safety events' in healthcare services.
- To design the Process of Patient Safety event reporting and analysis.
- To identify Process Deficiencies from the analysis of Patient Safety Events
- To identify the Scope of improvements from the learning of Patient Safety Event Analysis
- To recommend corrective and preventive actions to eliminate Process Deficiencies to improve Patient Safety

LITERATURE REVIEW

Patient safety has become a primary focus for healthcare internationally and a prerequisite for the provision of effective quality care (Gardner et al 2002). Recently much of the focus of research in healthcare has been on patient outcomes, and how to ensure that patients experience the best possible outcome as a result of the care provided. This focus has manifested itself in unease for both professionals and the public at large around less than acceptable patient outcomes resulting from care provided (Clarke 2006).(1)

In the USA the publication in 1999 of the Institute of Medicine's (IOM's) report 'To Err is Human: Building a Safer Health System1 highlighted the risks of medical care and the magnitude of medical error related deaths (44,000 to 98,000 deaths and approximately 1 million excess injuries per year). These estimates make medical errors the eighth leading cause of death in the USA. Publication of the report prompted a number of legislative and regulatory initiatives concerned with documenting errors and finding solutions to the problem, along with a federally funded patient safety and medical errors research programme.(2)

In the UK, events in which patient safety is compromised are estimated to occur in 10% of all admissions (Department of Health 2000). International studies indicate that between 4% and 16% of patients admitted to hospital experience adverse events, at least half of which could be prevented (Brennan et al 1991, Wilson et al 1995, Kohn et al 2000, Dept of Health 2000, Baker et al 2004). (1)Nevertheless a very positive result of the recent focus on patient safety has been a move away from the previous tendency to attribute blame for poor patient outcomes, to an approach where systems are examined and modified to prevent recurrence, and where learning, rather than blaming, is the focus. (1)

Many of the accidents that take place are reported to be replicas of earlier ones and it appears that the mechanisms for learning from these experiences are absent or could be greatly enhanced. Building a Safer NHS for Patients sets out the Government's plans for promoting safety and places patient safety in the context of the quality programme.(2)

Drawing on the work of aviation and other high-risk industries, the report specifically recommended adopting nationwide mandatory reporting systems that provide for 'the collection of standardised information by governments about adverse events that result in death or serious harm'. In 2000 the United Kingdom's Department of Health published its own landmark report, *An Organisation with a Memory*, which also recommended creating a national system for reporting and analysing adverse health care events.(3)

PSRS are now one of the most widespread strategies for improving safety in health care. Recommended by international and national bodies as a key method to learn more about risks to patient safety and how to improve it, PSRS are part of health care systems around the world. They operate at various levels – national, regional, within health care organisations and within specialty areas or departments – and in both public and private organisations. Some focus on a specific type of incident or event. Although PSRS adopt various formats, most have the same core operating model.

• Frontline workers submit reports about situations in which a patient was harmed or had the potential to be harmed.

• Reported incidents are investigated.(4)

Studies have documented considerable variation in perceptions of safety culture across organizations and job descriptions. In prior surveys, nurses have consistently complained of the lack of a blame-free environment, and providers at all levels have noted problems with

organizational commitment to establishing a culture of safety. The underlying reasons for the underdeveloped health care safety culture are complex, with poor teamwork and communication, a "culture of low expectations," and authority gradients all playing a role.(5)

Identifying preventability of an adverse event is very challenging, since there is no "gold standard" for determining this. Preventability depends on the specific circumstances related to the occurrence of the event, and is not simply a "yes/no" phenomenon.

Safety culture has been defined and can be measured, and poor perceived safety culture has been linked to increased error rates. However, achieving sustained improvements in safety culture can be difficult. Specific measures, such as teamwork training, executive walk rounds, and establishing unit-based safety teams, have been associated with improvements in safety culture measurements but have not yet been convincingly linked to lower error rates. The culture of individual blame still dominant and traditional in health care undoubtedly impairs the advancement of a safety culture. One issue is that, while "no blame" is the appropriate stance for many errors, certain errors do seem blameworthy and demand accountability. (5)

Member States regulating the reporting of incidents have implemented laws or guidelines to regulate the following: (6)

• the level at which reporting systems operate;

• to determine when it is obligatory and when it is voluntary to report an incident; and who is responsible for reporting;

• the types of incident to be reported;

• who is responsible for acting on reports;

levels of anonymisation and confidentiality concerning the identification of the person reporting and (other) health professionals;

•ensuring that the person reporting is free from sanctions.

Who can report- The RLS should provide a way for all staff of the healthcare providing organisation to be able to report. This should not be limited only to healthcare staff because serious incidents can also happen in technical areas or be witnessed by other staff(6)

Belgium encourages hospitals to make it possible for patients to notify incidents, near-incidents and unsafe situations. They are an important source of information and their input can be relevant to improve patient safety. (6)

United Kingdom: Since 2003, healthcare providers have been able to report using the NRLS eForm. In 2005, an eForm for patients and the general public was made available on the National Patient Safety Agency website to facilitate direct reporting by patients and their carers. Anonymisation and confidentiality can be addressed at different levels: the person reporting (especially a health professional), the data submitted to the system, and the mechanism used to ensure confidentiality.

Several RLSs initially enabled paper reporting in the early stages of their operation. Over time, many of these ended this and now only accept electronic reporting. Paper reporting with later conversion into electronic form could be some benefit in specific care settings or in the early stages of RLS development; however, our general recommendation is to capture the data in electronic form as early as possible. Converting data from paper to electronic form consumes valuable resources that could be better used directly for patient safety(6).

Several sample forms of different organisations are available and were studied to design the patient safety event reporting and analysis form (Annexure I)

Over 6 years of operation, the JCAHO Sentinel Event Database has captured only 1152 events, 62% of which occurred in general hospitals. Two-thirds of the events were self-reported by institutions, with the remainder coming from patient complaints, media stories

and other sources. These statistics are clearly affected by underreporting and consist primarily of serious adverse events (76% of events reported resulted in patient deaths), not near misses.(4)

Medication administration errors and near misses are common including in mental health settings. Nurses should report all errors and near misses so that lessons can be learned and future mistakes avoided. Nurses commonly said they would not report the errors or near misses because there was a good excuse for the error/ near miss, because they lacked knowledge about whether it was an error/near miss or how to report it, because they feared the consequences of reporting it, or because reporting it was too much work. Guidance for nurses indicates that all errors and near misses should be immediately reported in order to facilitate the development of a learning culture. (7)

Most hospitals' incident reporting systems fail to capture the majority of errors and near misses. Studies of medical services suggest that only 1.5% of all adverse events result in an incident report and only 6% of adverse drug events are identified through traditional incident reporting or a telephone hotline. The American College of Surgeons estimates that incident reports generally capture only 5-30% of adverse events. (7)

A 2008 study of over 1600 U.S. hospitals evaluated their event reporting systems using the criteria and concluded that according to these standards, most hospitals do not maintain effective event reporting systems. In addition to lack of physician reporting, most hospitals surveyed did not have robust processes for analyzing and acting upon aggregated event reports. Failure to receive feedback after reporting an event is a commonly cited barrier to event reporting by both physicians and allied health professionals.(8)

Event reports therefore provide a snapshot of safety issues, but on their own, cannot place the reported problems into the appropriate institutional context. One way to appreciate this issue is to observe that some institutions celebrate an increase in event reports as a reflection of a "reporting culture," while others celebrate a reduction in event reports, assuming that such a reduction is due to fewer events.(8)

There are several barriers, though, to improving measurement of safety in outpatient care. Because process measures are most frequently used, there is a need to develop outcome measures that relate directly to care processes in the outpatient setting (and that signify the end product of care).Patients are frequently seen by multiple providers in different outpatient settings, making assessment of the coordination of care difficult. Additionally, patients generally assume greater responsibility for their care in the outpatient setting. (8)

Medication errors and adverse drug events (ADEs) are common, costly, and clinically important problems. Two inpatient studies, one in adults and one in pediatrics, have found that about half of medication errors occur at the stage of drug ordering, although direct observation studies have indicated that many errors also occur at the administration stage. The principal types of medication errors, apart from missing a dose, include incorrect medication dose, frequency, or route. ADEs are injuries that result from the use of a drug. One study of preventable inpatient ADEs in adults demonstrated that 56% occurred at the stage of ordering, 34% at administration, 6% at transcribing, and 4% at dispensing. In this study, the drug class most commonly associated with preventable ADEs was analgesics, followed by sedatives and antibiotics. Even fewer studies have been conducted in the outpatient setting. One recent cross-sectional chart review and patient care survey found an ADE rate of 3% in adult primary care outpatients (8)

Literature around patient safety focused initially on examining the culture of safety in healthcare, and subsequently, the factors which impact of safety outcomes. Clarke (2006) characterised organisational culture as the "accumulation of invisible, often unspoken ideas, values and approaches that permeate organisational life". However although patient safety literature focuses attention on the inevitability of human error, a "prevailing expectation" exists both within healthcare circles, and in the general public, that mistakes in healthcare are unacceptable (Smith and Forster 2000). (1)

A growing body of research indicates that nurse staffing levels are associated with improved patient outcomes. Nurses have a greater opportunity than other healthcare workers, due to their proximity to patients, to witness adverse events (Kingston et al 2004 and Johnson 2007) and therefore to strengthen and support the patient safety culture (Cook et al2004, IOM 2004 and Auffrey 2005). Their role in patient surveillance is acknowledged as crucial to patient safety, with one study suggesting that nurses intercepted 86% of medication errors made by doctors and pharmacists (Hinton Walker et al 2006). The assumption that significantly more nurses are needed to address shortcomings in patient outcomes is not only simplistic, but has implications for funding, recruitment and education. (1)

PATIENT SAFETY EVENTS

1. Defining Patient Safety Events

The most important knowledge in the field of patient safety is how to prevent harm to patients during treatment and care. The quality of care and the safety of patients are core values of The Joint Commission accreditation process. This is a commitment The Joint

Commission has made to patients, families, healthcare practitioners, staff, and healthcare organization leaders. The first obligation of healthcare is to "do no harm."

Patient safety, as defined by the World Health Organization, is the prevention of errors and adverse effects to patients that are associated with healthcare. Safety is what patients, families, staff, and the public expect from Joint Commission–accredited organizations. While patient safety events may not be completely eliminated, harm to patients can be reduced, and the goal is always zero harm.

The fundamental role of patient safety reporting systems is to enhance patient safety by learning from failures of the health care system.

Health-care errors are often provoked by weak systems and often have common root causes which can be generalized and corrected. Although each event is unique, there are likely to be similarities and patterns in sources of risk which may otherwise go unnoticed if incidents are not reported and analysed.

Patient safety event: An event, incident, or condition that could have resulted or did result in harm to a patient. This includes adverse events and near misses.

Adverse event: A patient safety event relating to medical management that resulted in harm to a patient.

The IOM defined an **adverse event** as ‘‘an injury caused by medical management rather than the underlying condition of the patient’’

Medical error as ‘‘the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim’’

‘Near miss’ or ‘close call’. ‘ A near miss’ or ‘close call’ is a serious error or mishap that has the potential to cause an incident, but fails to do so by chance or because it was intercepted.

Sentinel event: A sub-category of Adverse Events, a Sentinel Event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:

- Death
- Permanent harm
- Severe temporary harm

Medical errors occur much more frequently than adverse events and medication errors out number adverse drug events by 100–1

2. Method of Reporting Patient Safety Events

By incident reporting, we specifically mean the voluntary reporting of a medical event by a health care provider. A reporting system can give important information for improvements in Aakash Healthcare, and can be used as an indicator of a good safety culture.

Reporting can help to identify hazards and risks, and provide information as to where systems and processes are weak.

This can help in targeting measures for improvement and put in efforts to improve processes and systems to reduce the likelihood of causing harm to the patients.

The objective of using a reporting system is to use the results of data analysis and investigations to improve healthcare directly and help healthcare professionals to do safer work.

To build the culture of Safety, it was important that the patient safety events be reported and analysed to know the deficiencies in the processes.

A **voluntary patient safety event reporting system** accessible by all health care providers at Aakash Healthcare was implemented. Any employee of Aakash Healthcare who has witnessed the event shall report the event.

Any type of error witnessed during departmental or prescription audits which could cause patient harm or did cause patient harm should also be reported.

A dedicated email-ID was created – event@aakashhealthcare.com for the reporting of the events.

All the events had to be reported to this Email ID by filling the details of the event in the reporting form. The Top management and the Quality Department only had access to and received all the events reported to this Email ID.

Designing Forms

- For reporting of the events, forms were designed, to document the details related to the event. A separate form was designed for the Reporting of all the Patient Safety events.

EVENT REPORTING FORM (Annexure - II)

- The Reporting form included information to be collected related to
    - patient identification;
    - date, time, and location of report and event;
    - type and description of event.

- Reporting forms enabled free-text reporting
- The reporting form had to be filled and mailed to event@aakashhealthcare.com and a hard copy could also be submitted to the Quality Dept in case of difficulty filling the soft copy.

- A separate Analysis form was designed to be used for the documentation after analysis of all the Patient Safety Events by the Quality Department.

EVENT ANALYSIS FORM (Annexure- III)

- Access to Analysis form was only with the Quality Dept.
- The Analysis form included:
    - patient identification;
    - date, time, and location of report and event;
    - type and description of event
    - Important points noted from the event
    - Composition of the Committee
    - Learnings from the event
    - Corrective action
    - Preventive action
    - Closure report

A policy was defined by the Quality Department at Aakash Healthcare on the process of Event Reporting.

The Policy defines the process of

- Reporting,
- Documenting
- Analysing all Patient Safety and Service Events occurring in Aakash Healthcare

All the staff at Aakash Healthcare were periodically trained on the Process of Event Reporting.

- Process of Reporting:

1. **How to report?**

- By filling up the soft copy of Patient Safety Event Reporting Form.
- In case of any difficulty in filling up the soft copy form, a printout should be taken to report the event in hard copy

2. **Where to report?**

- The soft copy or completely filled scanned hard copy shall be sent to event@aakashheathcare.com

3. **When to report?**

- within 12hrs from the occurrence of the event.
- not reported within 12hrs by the employee -responsibility of the Supervisor/ HOD (report within 24hrs)

Analysis

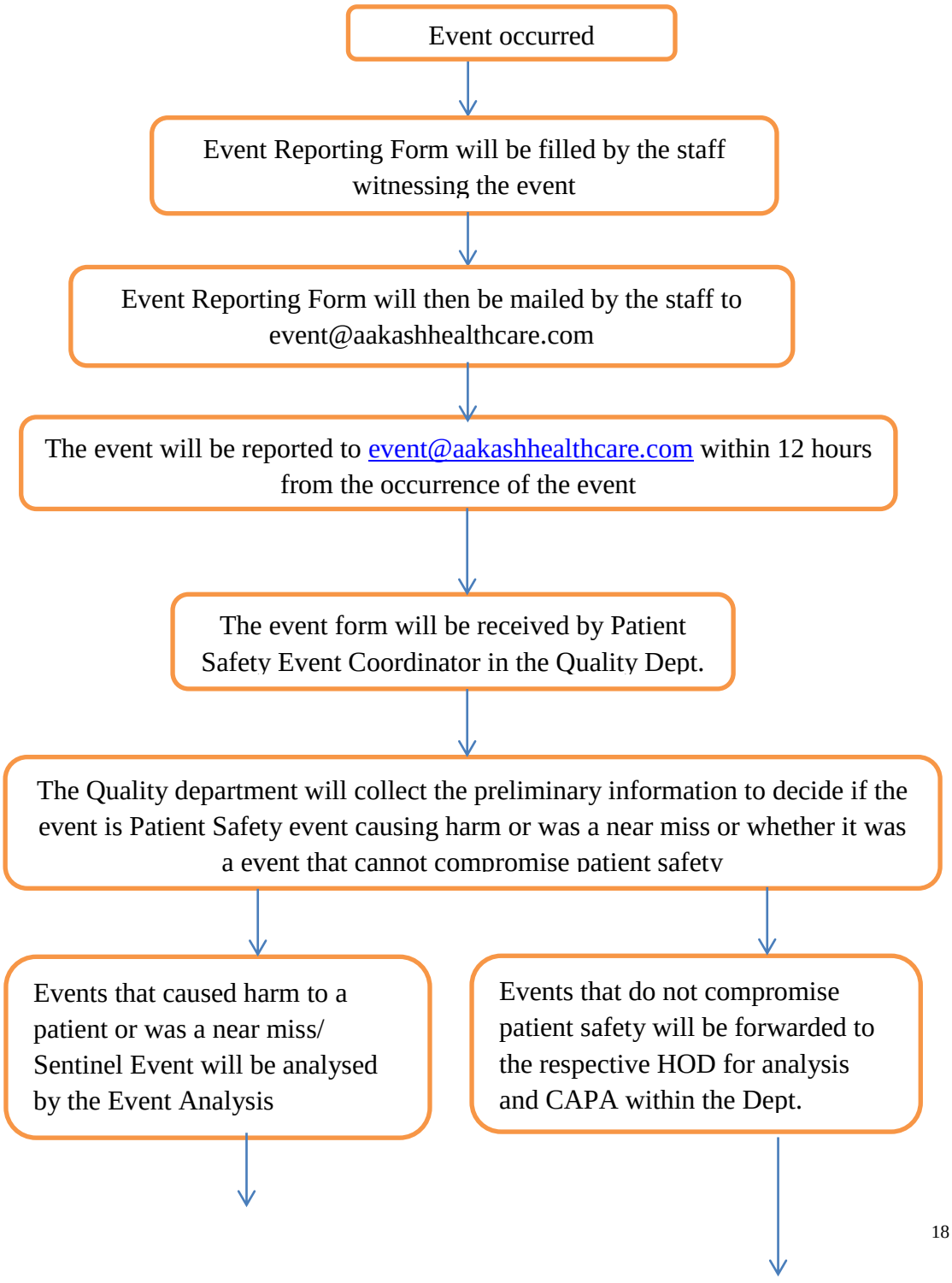
- Incoming incident reports were to be reviewed, anonymised and systematically analysed.
- Preventive recommendations should be disseminated.

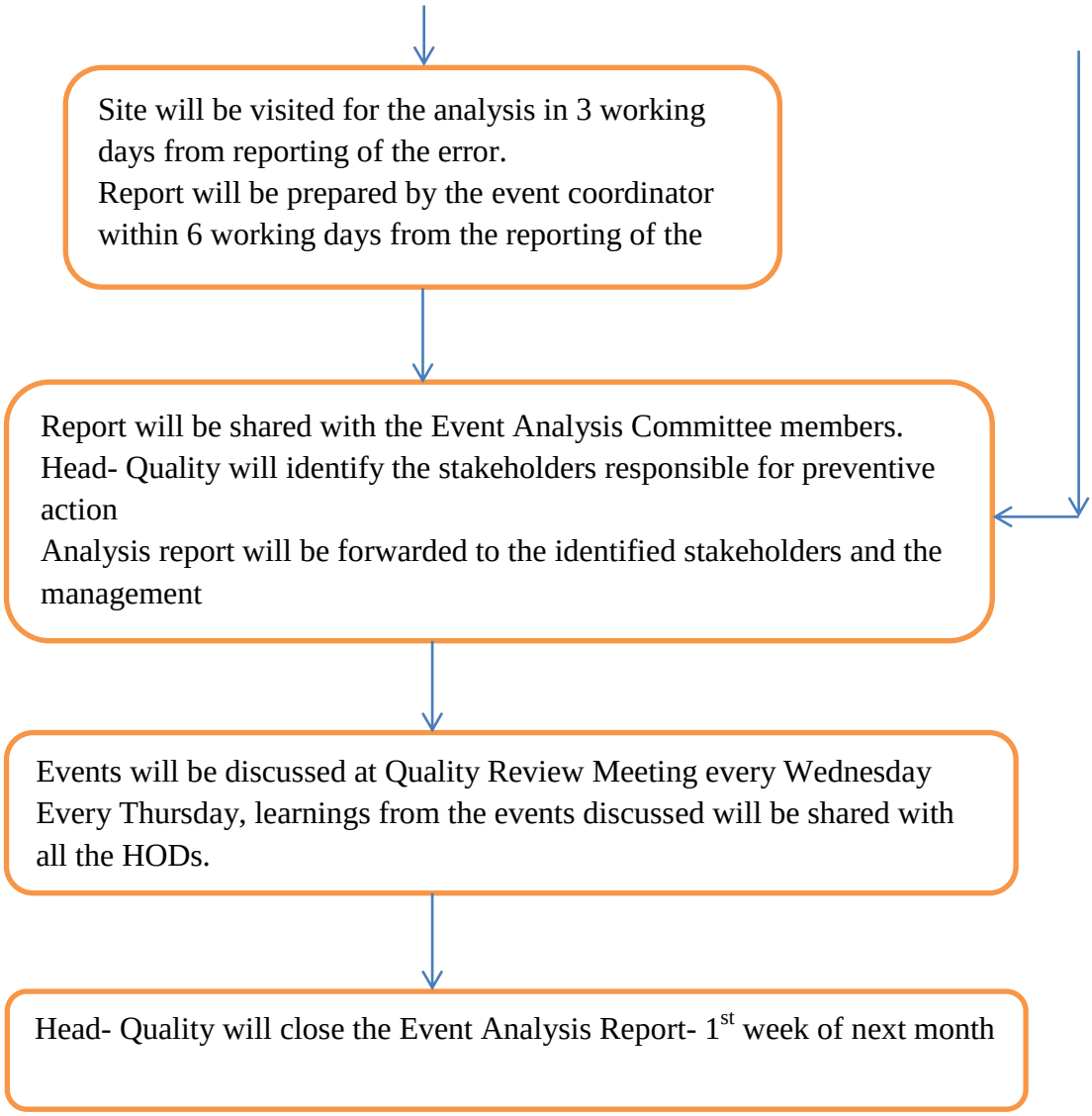
3. Process of Event Reporting

The policy of Event Reporting described the process for the reporting and analysis of patient safety events.

The Process flow is as follows:

Process Flow




Site will be visited for the analysis in 3 working days from reporting of the error.
Report will be prepared by the event coordinator within 6 working days from the reporting of the
Report will be shared with the Event Analysis Committee members.
Head- Quality will identify the stakeholders responsible for preventive action
Analysis report will be forwarded to the identified stakeholders and the management
Events will be discussed at Quality Review Meeting every Wednesday
Every Thursday, learnings from the events discussed will be shared with all the HODs.
Head- Quality will close the Event Analysis Report- 1st week of next month

METHODOLOGY

a. **Study Design:** Descriptive Study

b. **Study Area**: The study was done at Aakash Healthcare Clinic in Dwarka Sector 11, New Delhi

c. **Study Duration:** 3 months (1st Feb to 1st May 2017)

d. **Sample:** A total of 18 Patient Safety Events reported in Aakash Healthcare Clinic from July 2016 to April 2017 were reported and collected to be analysed.

e. **Inclusion Criteria:** All adverse events that could have resulted, or did result, in unnecessary harm to a patient were included in the study.

   Near Miss and Sentinel Events were also included in the study.

f. **Exclusion Criteria:** Events which did not compromise patient safety were excluded from the study.

   Patient Service Events were excluded from the study.

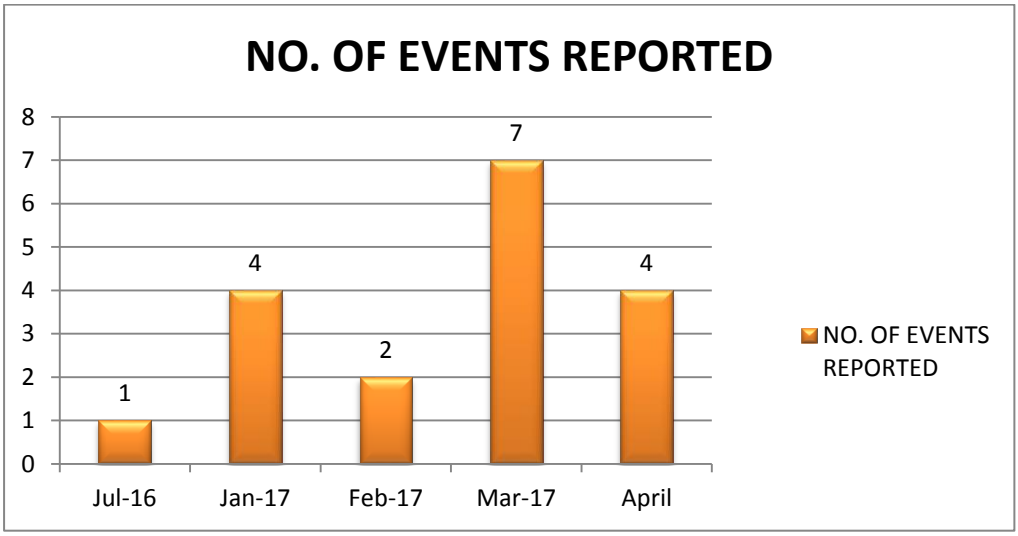
g. **Data collection Tool**: Patient Safety Event Reporting Forms designed were used for the reporting of the patient safety events.

   Patient Safety Event Analysis form designed was used for the documentation of the analysis of Safety events

ANALYSIS AND RESULTS

11.1 Total number of events reported in 2016 and 2017.

S.NO.	MONTH	NO. OF EVENTS REPORTED
1	July 2016	1
2	January 2017	4
3	February 2017	2
4	March 2017	7
5	April 2017	4



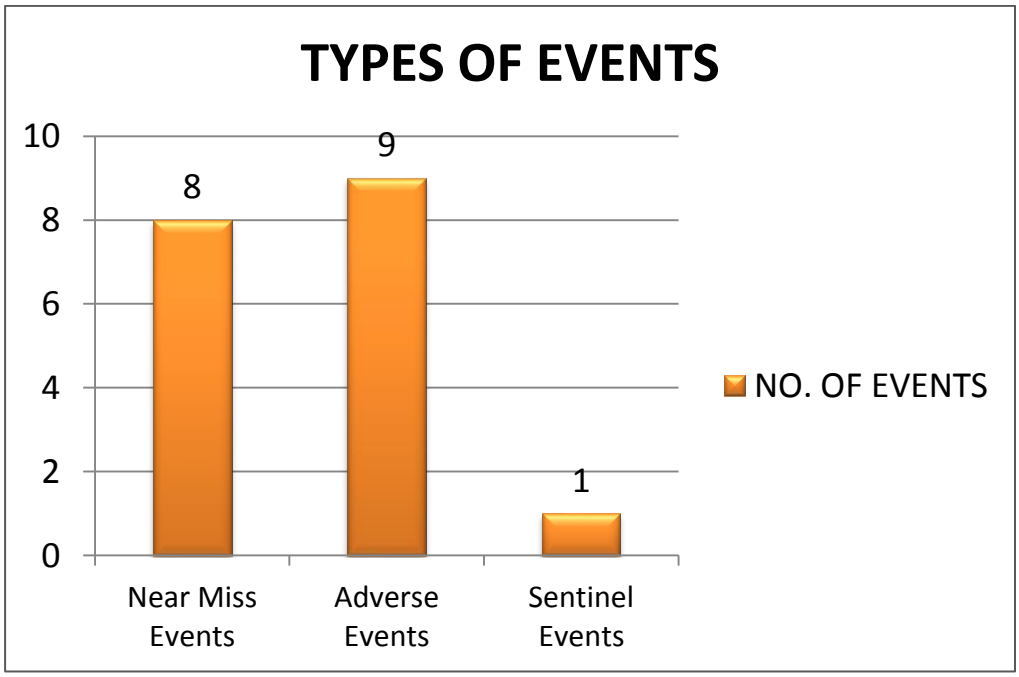
Graphical Representation (Fig. 11.1)

From the table and the graph, we can see that from From July 2016 to Jan 2017, no patient safety event was reported. This clearly shows the absence of a system of reporting of patient safety events.

No of events reported in Jan 2017 were 4, in Feb 2017 were 2, March 2017 were 7 and in April 2017 4 patient safety events were reported.

11.2 Types of Events reported at Aakash Healthcare

S.NO	TYPES OF EVENTS	NO. OF EVENTS
1	Near Miss Events	8
2	Adverse Events	9
3	Sentinel Events	1



Graphical Representation (Fig 11.2)

The type of events that were reported were mostly Adverse events as can be seen from the table and the graph above. 9 out of the 18 reported events were Adverse events and 8 were Near Misses. 1 out of the 18 events was a Sentinel Event.

Types of Patient Safety Events reported at Aakash Healthcare were:

JULY 2016

1. Tab MISOPROST 200 mcg, 20 Tablets dispensed by the pharmacy to a pregnant patient instead of Tab MICROGEST 200mg.

JANUARY 2017

1. Wrong X-Ray attached for a patient in the mail to the Consultant.
2. A RTA patient registered by the wrong name.
3. A child walked out of the Audiology OPD into the car parking.
4. Tab Flagyl 400mg dispensed to the patient by the pharmacy instead of Tab Flagyl 800mg.

FEBUARY 2017

1. Pharmacy dispensed the wrong medication to a patient.
2. Incorrect and delayed reporting by the Lab.

MARCH 2017

1. Verbal order of Inj Tramadol was given to the OT Technician and nurse administered the Inj, without a written prescription.
2. Patient fall in the Opthalmology OPD
3. Male patient catheterization by a male OT technician.

4. Color change in the medication on preparation of the injection before administration.
5. Dislodgement of wall mounted Height measuring scale while measuring the height of a patient.
6. Route of injection administration not mentioned in the prescription.
7. Fault in the BP machine digital monitor

APRIL 2017

1. Sodium hypochlorite splash in the eyes of the patient and the doctor during a dental procedure.
2. Pharmacy dispensed and the nurses administered Inj. Levoflox instead of Inj. Oflox for 2 days.
3. Inj. Tazact 4.5gm IV 8 hourly as advised by the doctor was administered only twice a day at home instead of thrice a day (8 hourly)
4. Vaccine Menectra was administered to a wrong patient who had come for Vaccine for Hepatitis B

DISCUSSION

I. Reporting of all Patient Safety Events

With the introduction of the Policy on the Process of Patient safety event reporting system, it is observed there was an increase in the number of events that were being reported.

From July 2016 to January 2017, no patient safety events were reported.

As the Policy on Patient safety event reporting was introduced and the staff was sensitized on the importance of reporting an event, a sense of responsibility was developed in the staff at Aakash Healthcare creating a Culture of Patient Safety in the organisation. Staff was more aware of the incidents that could be a potential for harm or could cause harm to the patient.

Use of Soft copy form made it easier and time saving for the staff to report an event.

Staff was able to differentiate better between NEAR MISS EVENTS, ADVERSE EVENTS and a SENTINEL EVENTS.

II. Process deficiencies from the analysis of patient safety events

i. Medication errors were due to Illegible handwriting of the prescriptions.

ii. High Risk Medications were not segregated in the Pharmacy.

iii. The X-Ray report was not matched with the patient's name and UHID in OPD before mailing to the doctor.

iv. Patient identification was not done properly.

v. Wrong medication or wrong dosage of a medication dispensed to the patient

vi. Pharmacist did not cross check the medication bill of the patient with the prescription before dispensing the medications.

vii. Verification of lab reports was done by the lab technician and not the Microbiologist.

viii. Verbal order given to OT technician for administration of an injection.

ix. The verbal order was not documented and read back.

x. Incomplete verbal order was passed by a doctor without mentioning the rate of infusion of an injection.

xi. Patient fall in Opthalmology OPD due to patient stools with wheels

xii. Refusal by nurse to do male catheterization.

xiii. Defect in a batch of a medication.

xiv. Height meter wasn't fitted properly on the wall, hence it got dislodged

xv. Incomplete hand written prescription which did not mention the route of administration of an injection.

xvi. Digital BP machine gave incorrect readings.

xvii. The syringe did not snuggly fit with the needle causing the sodium hypochlorite splash into the patient's and the doctor's eyes.

xviii. The prescription did not mention the frequency and duration of the administration of the injection.

xix. Nurse did not cross check the medication with the prescription before administration of the medication

xx. Verbal orders were passed from the doctor to the technician and from the technician to the nurse.

xxi. Patient identification was not done before administering the vaccine and labelling of the syringe of the vaccine wasn't done.

RECOMMENDATIONS

Learning from adverse events and near misses may reduce the incidence of preventable errors.

i. High Risk medications should be stored separately and marked with red colored signage.

ii. High risk medications storage and use policy should be laid down and put to use.

iii. PRESCRIPTIONS:

a. The prescriptions should be written in CAPITAL LETTERS.

b. Prescriptions should be printed using the EMR and hand written prescriptions should be avoided.

c. All prescriptions should be complete with Drug Name, Dose, Route, Rate, Frequency and Duration.

d. Change in prescription to be documented with date.

e. Cutting & over-writing in the prescriptions should be avoided.

iv. DISPENSING:

a. The pharmacy should have a double check system wherein one pharmacist takes the prescription and gets the medication and the other pharmacist should prepare the bill after matching the prescription and the medications.

b. The pharmacy should never dispense the medication based on verbal communication by the nurse or the patient, rather should always ask for a prescription.

c. The pharmacy staff should always get in touch with the consultant and confirm the dosage in case of any confusion.

d. The pharmacist who is billing the medication should countercheck the medication prior to billing.

v. ADMINISTRATION:

a. The nurse should identify the patient as well as the medication brought by him with the doctor's prescription before administration of the medication.
b. The nurse should contact the physician if no prescription is available.
c. All the medications administered should be documented in the Medication Administration Register with the details of patient, medication, time and person giving medication.
d. Labelling of the vaccines and the syringes should be done and cross checked before administration.

vi. VERBAL ORDERS

a. Verbal orders to be given by a physician to another physician only.
b. Verbal orders should be given to nurses in emergency only & will be documented ASAP
c. Verbal orders should always be read back and verified with the doctor before administration.
d. Verbal orders should be documented and countersigned by the doctor.

vii. Chairs with wheel lock / chairs without wheels or examination stool without wheels should be provided for patients in OPD chambers.

viii. HAZARDOUS SPLASHES/ SPILLS

a. Personal Protective equipments should be used for procedures that can cause dangerous splashes.
b. MSDS for all hazardous materials should be available in all the departments

ix. WRONG REPORTS:

a. The X-Ray should be matched with the patient's name and UHID in OPD.
b. Staff should be more careful while sending attachments of Radiographic images through email.

x. Responsibility of checking on child and keeping main door closed should not be given to the housekeeping staff.

xi. LAB REPORTS DELAY:

a. The microbiologist should do the verification of report in all the cases when she is present in the hospital.
b. The microbiologist should not depend on outside report to avoid bias from the outsourced report.

xii. Female nurses are not restricted from doing Male catheterization.

xiii. A technician can perform male catheterization on doctors' orders if he / she is certified to do this based on his competency.

xiv. Pharmacist should not issue the drug of the same batch no. in case any type of complaints like discoloration with any medications.

xv. Use of appropriate methods for fitting of instruments, equipments and gadgets

Corrective and preventive actions to eliminate process deficiencies

The aim of this study was to create a patient safety system in the organisation to prevent the recurrence of incidents in different settings causing harm to patients or putting them at risk from preventable errors. The aim was also to find process deficiencies and to improve them and impart learnings to all staff from the events analysed.

Regular trainings and Changes in Processes and Policies would address all the reasons to prevent recurrence of the events and to reduce the incidence of new events.

i. Policies and Procedures on the following were to be formulated and put in place to prevent the recurrence of the events:
    a. Policy on Patient Identification
    b. Policy on High risk medication storage and use
    c. Policy on Storage, Labelling of Medications
    d. Revised Policy on Dispensing of Medications
    e. Policy on Medication Prescriptions
    f. Policy on Medication Administration
    g. Policy on Recall of Medications
    h. Revised Policy on Medication Order
    i. Policy on fall assessment and prevention

All the staff was to be trained and counselled to follow the processes and protocols.

ii. Regular Counselling and training of the Doctors on the following:
    a. To write name of the medications in Capital Letter

b. To check the completeness of the prescriptions with Drug Name, Dose, Route, Rate, Frequency and Duration
c. Verbal orders to be given to other Doctors only
d. To give Verbal orders to nurses in emergency only & to document them ASAP.
e. Verbal orders should always be documented and signed by the doctor.
f. Any Changes in prescription to be documented with date.
g. Cutting & over-writing to be avoided.
h. To ensure patient identification
i. To ensure use of Personal Protective equipments for procedures that can cause dangerous splashes.
j. The Consultant should ensure that the needle is properly locked with the hub of the syringe before using it for a procedure.

iii. The microbiologist shall be counselled for verification of report in all the cases when she is present in the hospital.

iv. She shall also be counselled that she should not depend on outside report, thereby delaying the entire reporting process and to avoid bias from the outsourced report.

v. Lab Technician shall be counselled to exercise verification option only when Microbiologist is not on duty.

vi. Patient examination chairs with wheels should be replaced with chair without wheels / wheels with lock / examination stool without wheels

vii. The Nursing staff shall undergoing regular trainings on the following:

a. The importance of process of verification prior to administration.

b. Nursing to carry out written orders correctly.

c. Nursing to avoid verbal orders from technicians

d. Nurses should not administer medications without a written/ EMR prescription

e. Staff should not take verbal orders from any technician.

f. Female nurses privileged to do male catheterization (under supervision) after internal certification by our clinicians.

g. Staff nurses counselled not to administer the drug in case of any complaints like discoloration with any medications.

h. To counsel the patient's attendants prior to administration of injection

viii. Counselling of departmental staff for appropriately checking the attachment in the email before sending.

ix. Training of the Front Office staff regarding process of registering patients.

x. All the housekeeping staff shall be appropriately trained and counselled on adverse incidents and measures to be taken to avoid recurrence.

xi. The Pharmacy staff shall be trained on the following:

a. All the pharmacy staff to be counselled and trained on confirming the dosage with the consultant before dispensing in case of confusion.

b. The pharmacist who is billing the medication should countercheck the medication prior to billing.

c. The bill should not be prepared by using the prescription

d. Pharmacists counselled not to issue the drug of the same batch no. in case any type of complaints like discoloration with any medications.

xii. Technicians to have a Training and Competency Certificate signed by AHPL Surgeons/Urologist/OT incharge Clinician/Critical Care incharge certifying his competency in Catheterization (under supervision) which should be available in his Personal File.

xiii. The injection of the same batch no. to be returned back to the vendor along with the discoloured medication.

xiv. The equipment to be re-fixed in appropriate manner by using drilling machine, plastic buffer sticks and screws of appropriate length.

xv. Staff to be trained to wear protective equipment to prevent skin and eye exposure to hazardous material wherever necessary

xvi. Staff trained to check that the needle is properly locked with the hub of the syringe before using it for any procedure.

xvii. MSDS for all hazardous materials to be made available in all the departments.

LIMITATIONS

- Under- reporting of patient safety events
- Fear of reporting
- Lack of clarity between patient safety and service events
- Time pressures
- Difficulty in reporting through soft copy.
- Lack of infrastructure
- Cost and resource limitations

CONCLUSION

The fundamental role of patient safety reporting systems is to enhance patient safety by learning from failures of the health care system.

Sir Liam Donaldson (Chair, World Alliance for Patient Safety)

Health care workers were willing to use the patient safety event reporting system, which yielded a broad range of patient safety data. Patient safety events are multifaceted and often have multiple causal factors. It is essential that we improve the processes and policies in order to ensure that we are measuring the true safety performance of providers, and also that we are targeting our quality improvement efforts at events that most likely can be prevented. Timely, visible and repeatable corrective action and quality improvement processes are necessary in order to sustain a learning culture in the organisation.

All persons reporting an incident should understand their own benefit from reporting, since this will help to avoid the occurrence of incidents that could potentially be damaging to themselves and to the reputation of this organisation. Top management of healthcare systems and providers should spread the message of a 'blame-free and non-punitive objective'. Feedback should be given to healthcare providers on the results of an investigation and preventive measures taken.

Closing the safety feedback loop' means using information from reported incidents to improve the safety of frontline clinical work systems. If feedback is to contribute meaningfully to the overall improvement project, it cannot just involve passively giving out the information. It is better understood as an active process of communication that sustains a continuous cycle of learning, reporting and learning.

An effective safety culture in healthcare is one where adverse events are acknowledged, reported and investigated with the aim of learning from the event in order to prevent recurrence. Such a culture is known to enhance the safety of care provided to patients.

Process deficiencies identified in this study have the potential to enhance patient safety and make the systems strong at Aakash Healthcare so that patient safety events are prevented in future at Aakash Healthcare.

ANNEXURES

I. Sample forms for Reporting and Analysis of patient safety events of different organisations.

A.

MEDICATION ERROR REPORTING FORM

Instruction for filling up the form
The form can be filled by any member of the staff/ patient/attendant
Kindly put the filled form in suggestion box
Disclosure of identity is at person's will
All forms to be collected and sent to Department of Quality Management

Name of the Patient: _____ **Age/Sex:** _____

Diagnosis (Final/Provisional): _____

Bed No. _____ **MRD No.:** _____ **Floor:** _____

Incident Details: _____

_____

Date of Error Occurrence _____ **Time of Error Occurrence** _____

Date of Error Reporting _____ **Time of Error Reporting** _____

Type of Error (Describe): If Medication error, please tick the correct Observation

Prescription error	☐	**Allergy information missing**	☐
Indent error	☐	**Improper storage**	☐
Dispensing error	☐	**Misinterpretation of verbal order**	☐
Administration error	☐	**Charting Discrepancy**	☐

Did error reach to the patient? ☐**Yes** ☐**No** **if yes, Outcome and Harm Stratification**

1. Potential error☐ **2. Error, No harm**☐ **3. Error, Harm**☐ **4. Error, Death**☐

Details of the Harm _____

_____

_____

Name _____ **Designation** _____ **Sign / Date** _____
To be filled by the higher authority

BLK/DQM/18/00/2012

Dr. B. L. Kapur Memorial Hospital, Pusa Road, New Delhi -110005
Tel: +91 11 3040 3040, Ambulance Helpline: +91 11 3065 3030

1. Root cause analysis by the local area in-charge, Nursing Supervisor, CMO, AMS/MS or any one in higher position to them_____

2. Action taken _____

_____

Name _____Designation _____Sign / Date_____

3. Comments and the recommended Corrective and preventive action _____

_____

Name _____Designation _____Sign / Date_____

Definition of Medication error (ref. NCC MERP)

"A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and u"

Types of errors	Category	Result
No error	Category A	Circumstances or events that have the capacity to cause error
Error, No harm	Category B	An error occurred but the medicine did not reach the patient
	Category C	An error occurred that reached the patient but did not cause patient harm
	Category D	An error occurred that resulted in the need for increased patient monitoring but no patient harm
Error harm	Category E	An error occurred that resulted in the need for treatment or intervention and caused temporary patient harm
	Category F	An error occurred that resulted in initial or prolonged hospitalization and caused temporary patient harm
	Category G	An error occurred that resulted in permanent patient harm
	Category H	An error occurred that resulted in near death event (eg, Anaphylaxis, cardiac arrest)

B.

REPORTING FORM FOR ADVERSE EVENT/ADVERSE DRUG REACTION/ADVERSE DRUG EVENT

Fill in this form if you suspect that an adverse reaction has occurred and is suspected to administration of a drug, or a combination of drugs. Report all suspected reactions whether serious or minor.
The form can be filled by any member of the staff / patient / attedant
Kindly put the filled form in suggestion box.
Disclosure of identity is at person's will.
All forms to be collected and sent to Department of Quality Management

Patient's Name: _____ **Age / Sex :** _____

MRD: _____ **IPD :** _____ **D O A :** _____

Room No: _____ **Unit/ Doctor:** _____

Diagnosis (Final/Provisional) : _____

Provide the following information on drug that is suspected to have caused the reaction

Generic Name _____ **Brand Name/Batch Number** _____

Route _____ **Dosage** _____

Date & Time Started _____ **Date & Time Stopped** _____

Description of AE/ADR/ADE/ME and contributing factors _____

_____

_____

_____

Concomitant Medication administered

1 _____ 4 _____

2 _____ 5 _____

3 _____ 6 _____

Suspected reaction (s)

Outcome: ☐ **Recovered** ☐ **Recovering** ☐ **Continuing**

Date Reaction(s) started _____ **Date reaction(s) stopped** _____

Do you consider the reaction to be serious YES/No

Dr. B. L. Kapur Memorial Hospital, Pusa Road, New Delhi -110005
Tel: +91 11 3040 3040, Ambulance Helpline: +91 11 3065 3030

BLK/DQM/19/00/2012

Casual assessment: grade of causation (Mark the appropriate box)

☐ **Certain** : Relief on withdrawal of drug and recurrence of reaction of re-administration Corroborates causation

☐ **Probable** : Relief on withdrawal corroborates causation

☐ **Possible** : Alternate explanations are plausible

☐ **Unlikely** : Time relationships between the drug use and the adverse event makes the Causality improbable

Name_____ **Signature with date**_____

Designation_____

1. **Root cause analysis by the local area in-charge, Nursing Supervisor, CMO, DMS / AMS or any one in higher position to them** _____

Comments and the recommended Corrective and preventive action.

_____

Action Required

Nil ☐ Urgent ☐ Immediate ☐ Policy decision ☐

Name_____ Signature with date_____

Designation_____

2. **Action taken (HOD, Nursing)**

Nil ☐ Urgent ☐ Immediate ☐ Policy decision ☐

Name_____ Signature with date_____

Designation_____

3. **Review by Sentinel Events Committee/Management Review Committee**

Name_____ Signature with date_____

Designation_____

C.

SUSPECTED ADVERSE DRUG REACTION REPORTING FORM

For VOLUNTARY reporting of Adverse Drug Reactions by Healthcare Professionals

INDIAN PHARMACOPOEIA COMMISSION

(National Coordination Centre-Pharmacovigilance Programme of India)
Ministry of Health & Family Welfare, Government of India
Sector-23, Raj Nagar, Ghaziabad-201002
www.ipc.nic.in

FOR AMC/NCC USE ONLY

AMC Report No. :

Worldwide Unique No. :

A. PATIENT INFORMATION

1. Patient Initials ----------

2. Age at time of Event or Date of Birth _____

3. M ☐ F ☐ Other ☐

4. Weight_____Kgs

12. Relevant tests/ laboratory data with dates

B. SUSPECTED ADVERSE REACTION

5. Date of reaction started (dd/mm/yyyy)

6. Date of recovery (dd/mm/yyyy)

7. Describe reaction or problem

13. Relevant medical/ medication history (e.g. allergies, race, pregnancy, smoking, alcohol use, hepatic/renal dysfunction etc.)

14. Seriousness of the reaction (Yes ☐ No ☐)

☐ Death (dd/mm/yyyy) ☐ Congenital-anomaly
☐ Life threatening ☐ Required intervention to Prevent permanent
☐ Hospitalization/Prolonged impairment/damage
☐ Disability ☐ Other (specify)

15. Outcomes

☐ Recovered ☐ Recovering ☐ Not recovered
☐ Fatal ☐ Recovered with sequelae ☐ Unknown

C. SUSPECTED MEDICATION(S)

S.No	8. Name (Brand/Generic)	Manufacturer (if known)	Batch No. / Lot No.	Exp. Date (if known)	Dose used	Route used	Frequency (OD, BD etc.)	Therapy dates		Indication
								Date started	Date stopped	
i										
ii										
iii										
iv										

S.No as per C	9. Action Taken						10. Reaction reappeared after reintroduction			
	Drug withdrawn	Dose increased	Dose reduced	Dose not changed	Not applicable	Unknown	Yes	No	Effect unknown	Dose (if reintroduced)
i										
ii										
iii										
iv										

11. Concomitant medical product including self medication and herbal remedies with therapy dates (Exclude those used to treat reaction)

D. REPORTER DETAILS

16. Name and Professional Address:_____
_____
Pin:_____E-mail_____
Tel. No. (with STD code)_____
Occupation:_____ Signature:_____

17. Causality Assessment:

18. Date of this report (dd/mm/yyyy):

Additional Information:

Confidentiality: The patient's identity is held in strict confidence and protected to the fullest extent. Programme staff is not expected to and will not disclose the reporter's identity in response to a request from the public. **Submission of a report does not constitute an admission that medical personnel or manufacturer or the product caused or contributed to the reaction.**

D.

(CONFIDENTIAL)

ROOT CAUSE ANALYSIS

PLEASE ATTACH THE INCIDENT REPORT FORM

Please do not use this template for RCA of Healthcare Associated Infection, Return to OT / ICU, Readmission and Code Blue.

Incident category (Please tick the desired option)		
Major ☐ May require prolonged hospitalization ☐ Additional treatment/procedure ☐ Intervention required to sustain life ☐ Prolonged or permanent disability ☐ Patient Death	**Minor** ☐ Minor Treatment/test required ☐ No harm to patient, temporary discomfort	**Near Miss** ☐ Event having potential of incurring harm

RISK PRIORITY MATRIX (Please tick the desired option)

Likelihood of recurrence at that severity	Potential Severity (IMPACT: HARM/INJURY TO PATIENT)		
	Major	Minor	Near Miss
Frequent	9	5	2
Occasional	7	4	1
Rare	6	3	1

Interpretation	High Risk > 6	Moderate Risk = between 5 to 2	Low Risk =1

Investigation team (Names, Roles, Dept.'s)	Source of Information & evidence gathered
1. 2. 3.	1. 2. 3.

Chronology of events: background of case, detection, on spot rescue, and actions

Instrumentation

II. Patient Safety Event Reporting Form

Aakash Healthcare Super Specialty Hospital — We care, Rs cares	PATIENT SAFETY & SERVICE EVENT REPORTING FORM

To be filled by Reporting Employee			
Date of Incident		Time of Incident	
Date of Reporting		Time of Reporting	
Exact Location of Incident	☐ OPD ☐ ER ☐ IP- Ward ☐ OT ☐ Cath Lab ☐ Critical Care ☐ Others_____		

Type Of Affected Patient / Person			
☐ Patient	☐ Attendants	☐ Staff	☐ Visitors

Details of the Affected Patient / Person				
Name/Age/Sex	UHID / Emp.ID	IP No./OP No.	Consultant	Department

Description of Patient Safety / Service Event by Reporting Employee	
Name of Reporting Employee	Department
Signature	Employee ID.
Name of the witness	Department
Signature	Employee ID.

Please mail the filled up Softcopy / Scanned Hard Copy of this Reporting Form to event@aakashhealthcare.com

To be filled by Quality Department			
Type of Event	☐ Patient Safety Event ☐ Patient Service Event		
Received on		Received by	
Tracker Number	AHPL/ Patient Safety / Service Event / Year / Month / Serial No		

III. Patient Safety Event Analysis Form

Lebash Healthcare Super Speciality Hospital — We care, He cures	PATIENT SAFETY & SERVICE EVENT ANALYSIS FORM

To be filled by Patient Safety / Service Event Co-ordinator			
Date of Incident		Time of Incident	
Date of receiving		Time Of Receiving	
Tracker Number	AHPL/ Patient Safety / Service Event / Year / Month / Serial No		

Brief Description of the Event by Patient Safety / Service Event Coordinator

Type of Incident			
☐ Near Miss	☐ Safety Event	☐ Service Event	☐ Sentinel Event

Composition of the Safety / Service Event Analysis Committee (Min. Three Members)

Members	Name	Department	Designation
1. Team Leader			
2. Member			
3. Member			
4. Member			
5. Member			
Date & Time of forwarding Safety / Service Event Form to Members of Analysis Committee		Date	Time

Signature:		**Name:**	
Designation:		**Date & Time :**	

Patient Safety / Service Event Analysis Report (To be filled by Patient Safety / Service Event Co-ordinator)			
Important Points noted from the Event			
Learning from the Event			
Corrective Action			
Suggested Preventive Actions			
Action Points		Responsibility	Timeline
Signature:		**Name:**	
Designation:		**Date & Time :**	

Comments of Head –Quality after Verification of Suggested Preventive Actions			
Signature:		**Name:**	
Designation:		**Date & Time :**	

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