"PATIENT SAFETY CULTURE"

A Dissertation Submitted in partial fulfillment of the requirements
For the award of

Post Graduate Diploma in Health and Hospital Management

by

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Certificate of Internship Completion

Date:03-04-2012

TO WHOM IT MAY CONCERN

This is to certify that **Dr. Shweta Singh (PT)** has successfully completed her 3 months internship in our organization from **January 2, 2012 to April 2, 2012.** During her internship she has worked on "**Patient Safety Culture**" under my guidance and team of Bansal Hospital .We appreciate her sincere efforts in making this internship project a success

We wish her good luck for her future assignments.

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Certificate of Approval

The following dissertation titled "**Patient Safety Culture**" is hereby approved as a certified study in management carried out and presented in a manner satisfactory 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

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Certificate from Dissertation Advisory Committee

This is to certify that **Dr. Shweta Singh**, a participant of the **Post- Graduate Diploma in Health and Hospital Management**, has worked under our guidance and supervision. She is submitting this dissertation titled "**Patient Safety Culture**" in partial fulfillment 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.

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Abstracts

"PATIENT SAFETY CULTURE"

Safety in healthcare has received substantial attention often used worldwide since the late 1990s. In recent years, the issues of patient safety have become important topics in health policy and healthcare practice in several countries. Rapid change in healthcare has mandated greater attention to safety, which is essential to the efficient, competent delivery of quality care.

Safety is a condition or state of being resulting from the modification of human behavior and/or designing of the physical environment to reduce hazards, thereby reducing the chance of accidents.

The purpose of this research is to analyze the culture of safety in the organization and to gain understanding of views of clinical staff on various issues related to patient safety.A prospective study was conducted with the help of questionnaires for duration of 3 month. The questionnaires were designed for doctors, nurses and support staff to know their opinion regarding the current culture of the safety in hospital and in order to assess their views regarding the risks associated with jobs. The convenience sampling method was used to select the study subjects. The total frequency for each response was calculated and percentage was obtained for analysis.

Some of the major findings of the study are that 49% of staff speaks freely if they say something negative. 75% of staff had the awareness of the incident reporting system in work area.21% of the staff is discouraged to report any error. Excessive patient load is the major reason for the errors.68% of patient are aware of patient safety policies.73% of the staff are not aware of patient safety goals in hospital.62% of staff believes that their mistakes are held against them. There is a need of improvement of patient safety culture in hospital. Staff needs to be trained regarding it.

Findings from this study provide a description of the current status of patient safety at Bansal Hospital. The findings will not only provide a baseline from which to work, but they will help raise safety awareness throughout the organization and identify areas most in need of improvement. Findings will lead to the development of interventions to improve patient safety in the hospital.

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ACKNOWLEDGEMENT

It gives me pleasure to remember the moments when my teachers and batch mates were extending their support and guidance to me. I feel highly fortunate too. I express my deep sense of gratitude and appreciation to all of them at this moment.

At the outset I feel great pleasure to express my regards to Ms. Anupama Sharma, Assistant professor in IIHMR, New Delhi for his incessant boosting, inspiring encouragement, patience and ever readiness to help. It is my privilege to work under his dynamic Supervision.

I am sincerely thank full to Dr. Misha Bansal(Head Quality) my external guide and Junam Nishi (Quality Manager) who were caring and supported me throughout my training period.

I am thankful to the IIHMR,, New Delhi for having provided me with the invaluable learning experience..

Above all I thank the almighty and my parents for the constant support strength and everything.

Dr.Shweta Singh(PT)

PART 1 –INTERNSHIP REPORT

Part I: Internship Report

Practical exposure is an integral part of our Postgraduate Diploma in Hospital and Health Management (PGDHM). As a part of the curriculum, each student of final year is required to undergo internship and dissertation with a reputed organization for a period of three months.In Internship He/she will assist the administrator / manager in day-to-day operations.Through this process he/she is expected to gain practical knowledge and skill to handle managerial issues related to major departments of the organization.

With the similar objective in mind I joined the Bansal Hospital as a Management trainee on dated 2nd April 2011.

1.1.1.About the Hospital

BANSAL HOSPITAL, located at New Friends Colony, New Delhi, in the vicinity of Holy Family Hospital & Escort Heart Institute. This facility is unique in its kind with functional 50 beds and highly equipped modular Operation Theatres, Labour Rooms, Nursery & ICU. Well qualified doctors, impressive infrastructure, latest technology & excellent facilities is the specialty of **BANSAL HOSPITAL**.

BANSAL HOSPITAL has been serving people for 30 years, helping India to achieve distinction in universal healthcare.

BANSAL HOSPITAL & Dr. Bansal's Stone (UROLOGY & LAPAROSCOPY CENTRE) provide facilities like Laparoscopic & General Surgery, Urology (Lithotripsy, G.I. Endoscopy, Laparoscopic Gynae, Arthroscopy, Joint Replacement Surgery, ENT, Neurology, Gyn. & Obs. , Medicine, Pediatrics, Eye, Dental, Vascular Surgery, Skin & others.

There is well trained, proficient and dedicated staff that takes care of each and every patient with great care. We put forward latest technology and equipment so as to handle ones problem with great care and ease. Treatment of the patients is done with great dignity

and esteem. So one can rely their problems on us.

The infrastructure is impressive, sophisticated and calming one can feel like home. It is outfitted with all safety system and alarms. Their waiting area is stress-free and has enough space where 50 people can be put up at a time. You can get up to date information from our reception.

Their doctors do the same working day and night to serve the nation. Medical stores are also there in hospital premises and diagnostic services are available 24 hours .Patients are kept under strict supervision and dieticians are there to set their diet chart.

Our aim:

• To provide a high quality specialized services
• To include patients and the local people in evaluating our services.
• To increase our knowledge through researches
• To look over the necessities of our patients
• Our aim is not pecuniary but to deliver our services

Outstanding services at Bansal hospital:

• AIR CONDITIONED O.P.D
• 24 hours X-RAY and laboratory
• I.C.U
• WELL EQUIPPED NURSERY
• LABOUR ROOM
• LIFE SAVING RESUSCITATION EQUIPPED AMBULANCE

We also lay emphasis on eco- friendly environment that focuses on quality and well being of the patients and our effort is to give matchless services and security during the stay in hospital.

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BANSAL HOSPITAL has succeeded in giving health care motivation to people which helps in making people of the nation healthy. Seeing our services people came from far off places and we feel delighted as so many people trust on us .We will continue to deliver our services like this only and will serve the nation.

Vision:

"BANSAL Hospital will strive with excellence to fulfill the needs of the community in its chosen field of medical treatment"

Because of our emphasis on teamwork we bring together all the necessary disciplines and skills to serve our patients better and attempt to set the BANSAL Care in a league of its own.

Mission:

"To serve and enrich the quality of life of patients suffering from diseases, through the efficient deployment of technology and human expertise, in a caring and nurturing environment with the greatest respect for human dignity and life."

BANSAL Hospital believe in setting the best practice standards in our services, continuously improving performance and exceeding the expectations of our patients as well as their families. We believe in building and maintaining long-term patient relationships, so as to become an essential resource for their well being.

We believe in:

- **Excellence.** We have a continuous thirst for excellence and are always seeking ways to improve the health of those who count on us.
- **Diversity.** We embrace diversity in people, thought, experiences and perspectives.
- **Integrity.** We have a shared commitment to do what is right.

- **Compassion.** We have genuine concern for those in our community and treat them with respect and empathy.
- **Teamwork.** We work collaborative

1.1.2. FACILITY LAYOUT

HOSPITAL DIRECTORY:

FIRST FLOOR • HDU • WARDS • NURSING STATION	**GROUND FLOOR** • RECEPTION OPD • OPD'S • GYANE CHAMBER • MINOR OT • ICU • LABOUR ROOM • OPD PHARMACY • CASUALITY
SECOND FLOOR • PRIVATE ROOMS • DELUXE ROOM • PRIVATE SUITS	**THIRD FLOOR** • DELUXE ROOMS • NICU • 2 MAJOR OT • AUTOCLAVE ROOM • CSSD
	FOURTH FLOOR • KITCHEN • GENERATORS

1.1.3 Objective of internship-

It is imperative in the field of management to do internship at the end of classroom teaching. It allows hands on experience that is sometimes missing in theoretical knowledge.
Fundamental objective to internship are,

- ✓ To get involved in day to day operations.
- ✓ To comprehend the interdepartmental co-ordination.
- ✓ To find an area in the organization where improvement is required and where management knowledge & skills can be imparted.

1.2Managerial Tasks-

1.2.1. Marketing Department:

- ➢ Meeting with doctors
- ➢ Going for empanelment in various organizations
- ➢ Organization of camps
- ➢ Preparation of patient doctors list
- ➢ Preparing the cheques to be given to doctors
- ➢ Organization of CME'S.

1.2.2. Quality Department

To be a part of NABH core group-
1) Prepare Hospital for assessment of NABH.
3) Making the policies for all department.
3) Preparing training schedule, sending circulars and organizing training for all hospital staff and analyzing the effectiveness of imparted training.

4) Making the hospital committees and then conducting their regular meeting according to annual schedule.

6) To conduct employer & patient satisfaction survey

7) Making quality actions plans.

8) Streamlining of hospital **waste management** system.

9) Departmental audits were organized to keep a check on the working of departments.

1.3Reflective learning

The learning that I extracted from the experience not only enriched me in terms of providing knowledge as to how an established private hospital runs but also gave me insights into my ownself,imparting priceless lessons of patience, dedication and importance of good behavioral communication.

PART 2- DISSERTATION

REPORT

Chapter1-INTRODUCTION

1.1 Introduction

Safety in healthcare has received substantial attention often used worldwide since the late 1990s [1]. In recent years, the issues of patient safety have become important topics in health policy and healthcare practice in several countries. Rapid change in healthcare has mandated greater attention to safety, which is essential to the efficient, competent delivery of quality care [2, 3]

Safety is a condition or state of being resulting from the modification of human behavior and/or designing of the physical environment to reduce hazards, thereby reducing the chance of accidents [4].

The Institute of Medicine (IOM) report that leaders and managers committed to promote a safety culture at all levels of the organization and empowers employees to be defined safety culture as "**an integrated pattern of individual and organizational behavior, based upon shared beliefs and values that continuously seeks to minimize patient harm, which may result from the processes of care delivery".**

The above definition reflects a dynamic, conscious culture of safety in which actions are taken towards reducing harm or risk to the patient. Safety experts believed that the development of safety culture begins with the enforcement of system safety of patients. It has three stages: first is emphasis on complying with regulatory standards and meeting technical requirements. Then safety performance is best seen as in organizational goal and value that is being important. Finally, the culture of safety permeated the organization for emphasis on continuous improvement.

A lot of researchers have generated various dimensions of safety culture. In 2004, the Center of Excellence for Patient Safety Research and Practice at the University of Texas established a conceptual framework to measure culture of patient safety. For the current study, the authors decided to use safety attitude questionnaire (SAQ). Safety attitude questionnaire was derived from the Flight Management and considered as one of the most widely and rigorously questionnaire for measuring six most important dimensions of safety culture safer quality of care. Which are; **stress recognition**, **working conditions**, **safety climate, perceptions of Management, job satisfaction** and **team climate?**

Patient safety is a critical component of health care quality. As health care organizations continually strive to improve, there is growing recognition of the importance of establishing a culture of patient safety. Achieving a culture of patient safety requires an understanding of the

values, beliefs, and norms about what is important in an organization and what attitudes and behaviors related to patient safety are supported, rewarded, and expected

Patient Safety Culture

According to the Institute of Medicine, ‘‘the biggest challenge to moving toward a safer health system is changing the culture from one of blaming individuals for errors to one in which errors are treated not as personal failures, but as **opportunities to improve the system and prevent harm.’’** (1)

A first step is to define safety culture, we use the AHRQ definition from the Health and Safety Commission of Great Britain:

The safety culture of an organization is the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management.[11]

Patient safety and the initiative of developing safety cultures to assure patients from harm have slowly but steadily become one of the central concerns in quality improvement in healthcare both nationally and internationally.

A culture of safety can be defined as ‘an integrated pattern of individual and organizational behavior, based on a system of shared beliefs and values that continuously seeks to minimize patient harm that may result from the process of care delivery.[23]

In Scotland all NHS Boards have a just or no-blame culture embodied in their policy documents. A survey of staff conducted as part of the NHS QIS report *Safe Today- Safer Tomorrow* (2006) found that a large majority agreed that mistakes are seen as learning opportunities (89%) and there is a willingness to raise safety issues (80%). However, a minority considered that blame is still being apportioned

(36%), staff are treated inconsistently (39%) and there is a perception that nothing is done until a problem has recurred several times (33%)

An effective safety culture:

- **sees errors as learning opportunities**
- **motivates individuals to talk about their own experiences by encouraging such experiences to be shared**
- **responds to problems that are identified**
- **does not unfairly penalize those who have made errors**
- **has a reporting system that is seen to uncover the underlying causes of incidents.**

The National Patient Safety Agency has identified seven key steps to patient safety which places promoting a safety culture as the first step:

1. **Build a safety culture:** Create a culture that is open and fair
2. **Lead and support your staff:** Establish a clear and be focus on patient safety throughout your organization
3. **Integrate your risk management activity**: Develop systems and processes to manage your risks and identify and assess things that could go wrong.
4. **Promote reporting:** Ensure your staff can easily report incidents locally and nationally
5. **Involve and communicate with patients and the public:** Develop ways to communicate openly with and listen to patients
6. **Learn and share safety lessons:** Encourage staff to use root cause analysis to learn how and why incidents happen
7. **Implement solutions to prevent harm:** Embed lessons through changes to practice, processes or systems

Characteristics of Safety Culture

- Refers to shared values among organization members, defined at the group level.
- Concerned with formal safety issues.

- Relatively enduring, resistant to change, and stable.
- Emphasizes contribution from people at every level of the organization.
- Impacts member behavior.
- Reflected in the convergence between reward systems and safety structure.
- Reflected in an organization's willingness to learn from errors, accidents, and incidents.[17]

Importance of Patient Safety Culture

- Safety and improvement in Quality of care
- Speedy recovery of the patient at the affordable price
- Staff can learn from their mistakes
- Proper implementation of action plan
- can help minimize medical errors

Implementing a safety culture assessment involves the commitment of staff time and resources. Culture assessments can be used to:-

(1) Diagnose safety culture to identify areas for improvement and raise awareness about patient safety;
(2) Evaluate patient safety interventions or programs and track change over time;
(3) Conduct internal and external benchmarking; and
(4) Fulfillment of regulatory or other requirements.

The usefulness of safety culture assessment data depends on:

– involving key stakeholders;

– selecting a suitable safety culture assessment tool
– using effective data collection procedures
– implementing action planning and initiating change. (1)

1.2 **Scope of study:**

Findings will not only provide a baseline from which to work, but they will help raise safety awareness throughout the organization and identify areas most in need of improvement. Findings will lead to the development of interventions to improve patient safety in the hospital.

1.3 REVIEW OF LITERATURE

A review of the patient safety literature must necessarily begin with the seminal IOM report To Err Is Human: Building a Safer Health System that found medical errors kill between 44,000 and 98,000 people in U.S. hospitals each year. Using the lower estimate, more people die from medical errors in a year than from highway accidents, breast cancer, or AIDS [14]. The IOM committee recommended that health care organizations create an environment in which culture of safety is an explicit organizational goal, becomes a top priority, and is driven by leadership [20].In response to the recommendations of the IOM, health care organizations began the process of improving the widespread deficits in patient safety including a focus on organizational safety culture [12]. This led health care leaders to ask, "how will we know?" when we have created a culture of safety within our hospitals.[21] While it is not difficult to express safety culture in words, actually knowing and understanding the characteristics that define a safety culture and its implications to health care organizations may be more elusive.

In this review, the authors critically examined the literature to identify studies which address the important beliefs, attitudes and behaviors that are integral to a culture of safety in hospitals. Many authors offered a theoretical framework for a safety culture, however, the review supported the concept that a more comprehensive framework could be designed incorporating a broader range of properties. The purpose of this review was to organize the properties of safety culture addressed by many studies and develop and define a conceptual culture of safety model that could be a valuable tool to support hospital leadership in creating or improving an organizational safety culture.

It is clearly being recognized that facilitating a safety culture in which we learn from errors is critical to a safe environment for patients and employees. For example, the Patient Safety and Quality Improvement Act, signed by President Bush in 2005, established federal protections

"against discovery and unauthorized disclosure of data arising from patient safety and quality improvement programs. It also provides for certification of patient safety organizations to which healthcare organizations can report this data. One way that an organization's commitment to safety is manifested is through its values, and these values translate to the organization's safety culture. The safety culture is then observable through the actions and attitudes of management and employees. In this section, a brief discussion of safety culture is provided. While some argue that safety culture is most influential in terms of employee actions and attitudes, others argue that it is the safety climate. Further complicating the issue is the fact that others have argued that there is no difference between the two concepts, and the terms are often used interchangeably.[17]

Based primarily on the research revolving around organizational culture, the term safety culture did not become 'popularized' until the late 1980s following the Chernobyl disaster.[15] It was cited, for the first time, that a poor safety culture contributed to this major catastrophe.[16] The atomic and nuclear power plant industries began the push to define safety culture and were quickly joined by other industries experiencing their own disasters . The Institution of Occupational Safety and Health.[12]Reviewed the many definitions of safety culture and narrowed them down to three. Their findings suggest that the meaning of a safety culture includes or refers to: **(1) aspects of organizational culture that related to safety (e.g., norms, policies), (2) common values, beliefs, attitudes, and behaviors regarding safety, and (3) the joint values, attitudes, competencies, and behaviors of individuals and groups that establishes an organization's commitment to, and style and proficiency of its safety program.** Similarly, Pidgeon (1991) argues that safety culture may be a useful tool in risk management and can be defined under one of three headings: **(1) norms and rules for dealing with risk, (2) attitudes towards safety, and (3) the capacity to reflect on safety practices.** In addition, safety culture can be approached from two perspectives as: (1) something an organization has (i.e., structures, practices, controls, and policies designed to promote safety), or (2)something an organization is (i.e., beliefs, values, and attitudes of organizational members regarding safety.

Finally, safety culture is recognized as a higher-level construct, which ultimately influences safety climate.

Findings

We identified a broad range of safety culture properties which we organized into seven subcultures and defined as:

- **Leadership**: Leaders acknowledge the health care environment is a high risk environment and seek to align vision/mission, staff competency, fiscal and human resources from the boardroom to the frontline.

- **Teamwork**: A spirit of collegiality, collaboration, and cooperation exists among executives, staff, and independent practitioners. Relationships are open, safe, respectful, and flexible.

- **Evidence-Based**: Patient care practices are based on evidence. Standardization to reduce variation occurs at every opportunity. Processes are designed to achieve high reliability.

- **Communication:** An environment exists where an individual staff member, no matter what his job description, has the right and the responsibility to speak up on behalf of a patient.

- **Learning:** The hospital learns from its mistakes and seeks new opportunities for performance improvement. Learning is valued among all staff including the medical staff.

- **Just**: A culture that recognizes errors as system failures rather than individual failures and at the same time, does not shrink from holding an individual accountable for his actions.

- **Patient-Centered**: Patient care is centered around the patient and family. The patient is not only an active participant in his own care, but also acts as a liaison between the hospital and the community.

Action Plan for Improvement

Administering the hospital survey can be considered an "intervention," a means of educating hospital staff and building awareness about issues of concern related to patient safety. But it should not be the only goal of conducting the survey. Administering the survey is not enough. Keep in mind that the delivery of survey results is not the end point in the survey process; it is actually just the **beginning**. Often, the perceived failure of surveys as a means for creating lasting change is actually due to faulty or nonexistent action planning or survey follow-up

Seven steps of action planning are provided to help the hospital go beyond simply conducting a survey to realizing patient safety culture change. The progression is getting survey results, developing an action plan, and implementing the plan and tracking progress.

The seven steps of action planning are:

1. **Understand your survey results.**
2. **Communicate and discuss survey results.**
3. **Develop focused action plan**
4. **Communicate action plans and deliverables.**
5. **Implement action plans.**
6. **Track progress and evaluate impact.**
7. **Share what works.**

Step # 1: Understand the Survey Results

It is important to review the survey results and interpret them before we develop action plans. Develop an understanding of the hospital's key strengths and areas for improvement. Examine the hospital's overall percent positive scores on the patient safety culture composites and items.

After reviewing the survey results carefully, identify two or three areas for improvement to avoid focusing on too many issues at one time.

Step # 2: Communicate and Discuss the Survey Results

Common complaints among survey respondents are that they never get any feedback about survey results and have no idea whether anything ever happens as a result of a survey. It is therefore important to thank all the staff for taking the time to complete the survey and let them know that we value their input. Sharing results from the survey throughout the hospitals, use survey feedback as an impetus for change. .Summarize key findings.

Step # 3: Develop Focused Action Plans

Once areas for patient safety culture improvement have been identified, formal written action plans need to be developed to ensure progress toward change. Hospital wide, department-based, or unit-based action plans can be developed. Major goals can be established as hospital wide action plans. Unit-specific goals can be fostered by encouraging and empowering staff to develop action plans at the unit level.

Encourage action plans that are **"SMART":**

- **Specific**
- **Measurable.**
- **Achievable.**
- **Relevant.**
- **Time bound.**

Step # 4: Communicate Action Plans and Deliverables

Once action plans have been developed, the plans, deliverables, and expected outcomes of the plans need to be communicated. Those directly involved or affected will need to know their roles and responsibilities, as well as the timeframe for implementation. Action plans and goals should also be shared widely so that their transparency encourages further accountability and demonstrates the hospital wide commitments being made in response to the survey results.

Step # 5: Implement Action Plans

Implementing action plans is one of the hardest steps. Taking action requires the provision of necessary resources and support. It requires tracking quantitative and qualitative measures of progress and success that have already been identified. It requires publicly recognizing those individuals and units that take action to drive improvement and it requires adjustments along the way.

Step # 6: Track Progress and Evaluate Impact

Ensure that there is timely communication of progress toward action plans on a regular basis. If you determine that a change has worked, communicate that success to staff by telling them what was changed and that it was done in response to the safety culture survey results. Be sure to make the connection to the survey so that the next time

the survey is administered, staff will know that it will be worthwhile to participate again because actions were taken based on the prior survey's results

Step # 7: Share What Works

Once the hospital has found effective ways to address a particular area, the changes can be implemented on a broader scale to other departments within the hospital and to other hospitals. Be sure to share the successes with outside hospitals and health care systems as well.

1.4 Aims and objectives of the study

AIMS

- To analyze the culture of safety in organization

OBJECTIVES

- To gain understanding of views of clinical staff on various issues related to patient safety.

❖ To make recommendation on the basis of findings.

Chapter 2-METHODOLOGY

Materials and Methods

- **Study Design**

A prospective study was carried out with the help of questionnaires for duration of 3 month.

- **Place of Study**

Bansal Hospital

Department

Quality department

- **Sampling Method**

A prospective study was conducted with the help of questionnaires for duration of 3 month. The questionnaires were designed for doctors, nurses and support staff to know their opinion regarding the current culture of the safety in hospital and in order to assess their views regarding the risks associated with jobs. The convenience sampling method was used to select the study subjects. The total frequency for each response was calculated and percentage was obtained for analysis.

- **Method of Data Collection:** After the official permission obtained from the hospital administrator, the questionnaire was prepared and necessary modifications were done. Distribution of the questionnaire was conducted by researcher(myself). Filling the questionnaire consumed about 10-15 minutes and data collection were completed during the period of one month.

- **Sample Size-** The sample in the present study consists of the hospital staff of Bansal Hospital. The total sample size taken for the study was **106.**

- **Inclusion Criteria**

The survey is best suited for the following-

1. Doctors
2. Nurses
3. Dietician
4. Physiotherapist
5. Lab Technicians
6. Hospital supervisors, managers

.

- **Exclusion Criteria**

1. Housekeeping staff
2. Front Office Staff
3. Security Staff

- **Study Period**

2nd January to 2nd April

- **Study Procedure**

The study was performed via questionnaire investigation which uses a five-point Likert scale.Each question had response in terms of **"Yes", "No"** or "**Never, Rarely, Some-times, Most of the times, Always,** or **"Strongly Disagree, Disagree, Neither Agree, Strongly Agree".**

The incomplete questionnaires were excluded from the study. The total frequency for each response was calculated and percentage was obtained for analysis.

After completing the data collection, data were coded, verified and transferred into a special form to be suitable for computer feeding to utilize for data entry, statistical analysis and presentation of the results

- **Survey**

The study was confined to Patient safety culture in Bansal Hospital only.
.The Purpose of the study was explained to respondents and confidentiality was assured.

They were handed over a questionnaire sheet each and were asked to put their opinion. An adequate time of two days were given to each individual, so that the best opinion can be collected.
All the sheets were collected within one month and a cumulative single sheet was prepared having all the data.
The data was then analyzed in terms of frequency and percentage based on the objectives of the study. The data would be presented in tables, graphs and pie charts.
The tool selected for data collection includes a structured questionnaire with open-ended and closed ended questions.

About the Survey Tool

In response to requests from hospitals interested in comparing their results with those of other hospitals on the Hospital Survey on Patient Safety Culture, **the Agency for Healthcare Research and Quality (AHRQ)** established the Hospital Survey on Patient Safety Culture comparative database. The first annual comparative database report was released in 2007 and included data from 382 U.S. hospitals. The mission of AHRQ is to improve the quality, safety, efficiency, and effectiveness of health care by:

• Using evidence to improve health care.
• Improving health care outcomes through Research.
• Transforming research into practice.

Hospitals do not necessarily administer the hospital patient safety culture survey every year. They may administer it on an 18-month, 24-month, or other cycle.

PURPOSES:

- **Comparison**—To allow hospitals to compare their patient safety culture survey results with those of other hospitals.
- **Assessment and Learning**—To provide data to hospitals to facilitate internal assessment and learning in the patient safety improvement process.
- **Supplemental Information**—To provide supplemental information to help hospitals identify their strengths and areas with potential for improvement in patient safety culture.
- **Trending**—To provide data that describe changes in patient safety culture over time.

Data input & Analysis- Data was entered into SPSS version 17.0 which was used for all statistical purposes. Frequency and proportion were calculated.

Chapter 3-Results

Results

The data of Patient Safety Culture Survey from the Staff of Bansal Hospital

In total, 103 people were surveyed All relevant entries were audited, and the report is published as below:-

The characteristics of study subjects are given in table 1 and Fig 1:-

Table 1 Characteristics of study subjects (n = 106)

Categories	Total
Consultant / Attending Physician	40
Lab Technicians	6
Nurses	37
Physiotherapist	1
OT Technicians	16
Biomedical	1
Quality department	1
Dietician	1
Radiology department	3

All the discussion, opinions and survey questions are discussed in details below with graphical presentation of each Verticals and Items:

COMMUNICATION OPENNESS

The Graphs below shows that 49.% has always spoke freely if they see something that may affect patient care .Next to it 30% has mostly spoken about something that may negatively affect patient care. Declining with result 10% has spoke sometimes and 8% rarely.

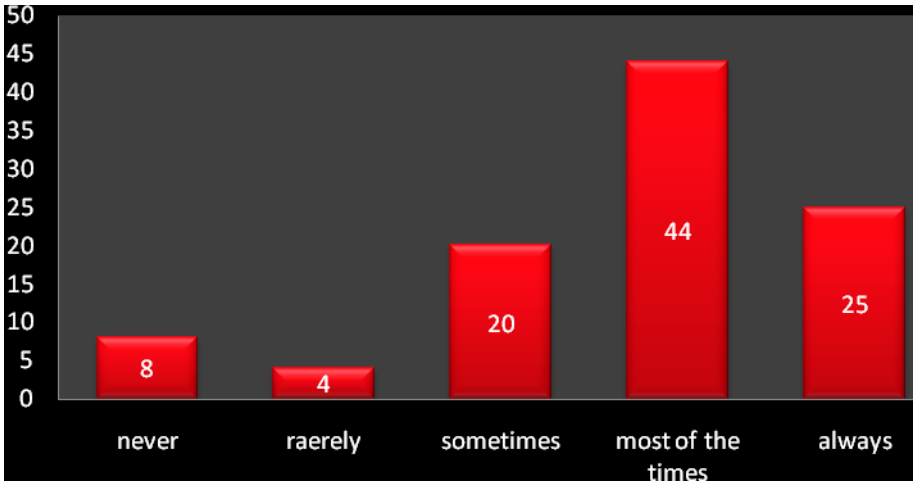
The negative result was shown by 4% who has never spoken up if they see something that which a concern for patient care is really.

The break ups are as follows:-

COMMUNICATION

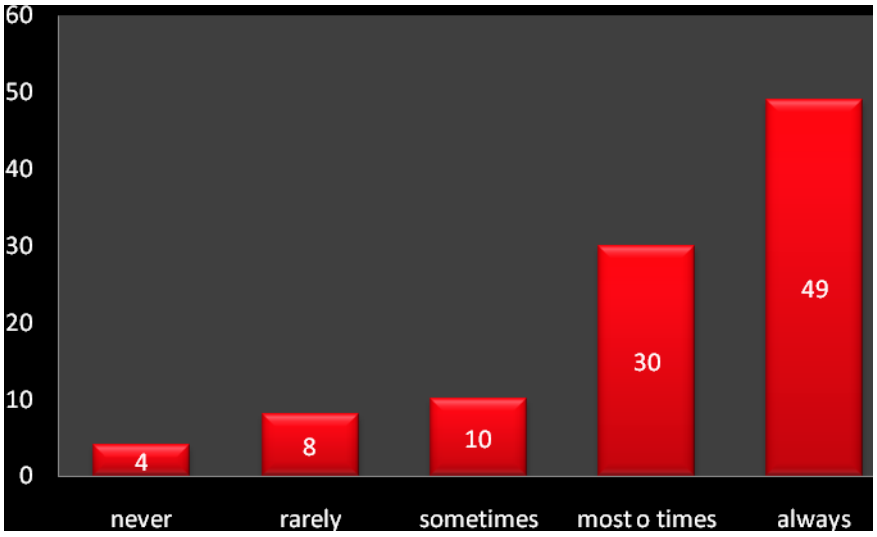
- **Given feedback about changes put into place based on event reports.**

Figure-1.1



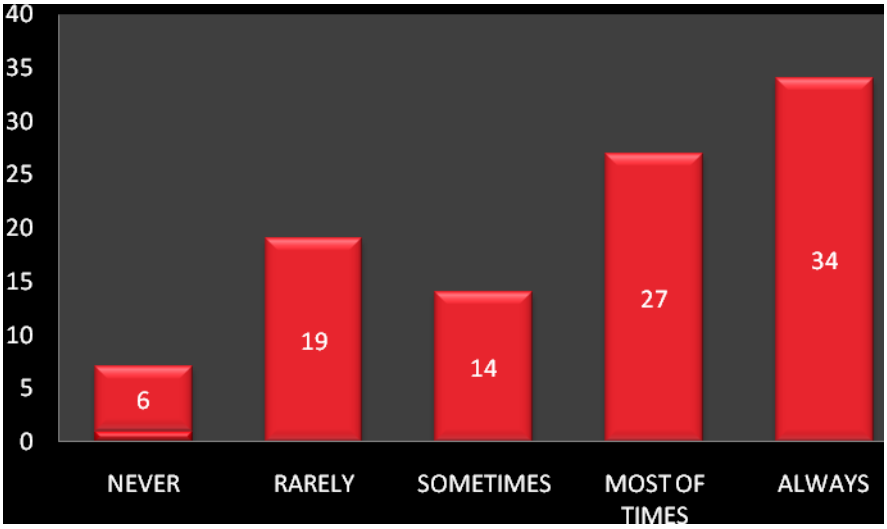
- **Does the staff freely speak up if they see something that may negatively affect patient care?**

Figure-1.2



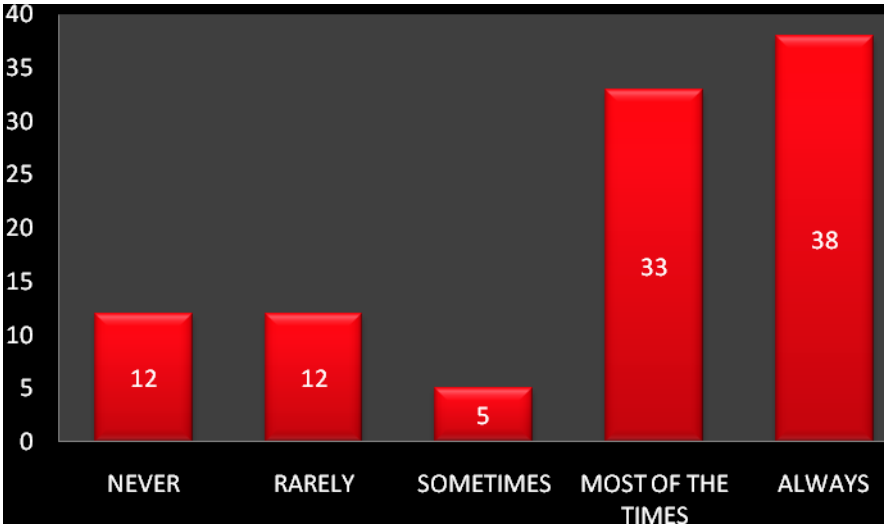
- **How often errors that happen in this unit are informed?**

Figure-1.3



- **How often in this unit, we discuss ways to prevent errors from happening again**

Figure



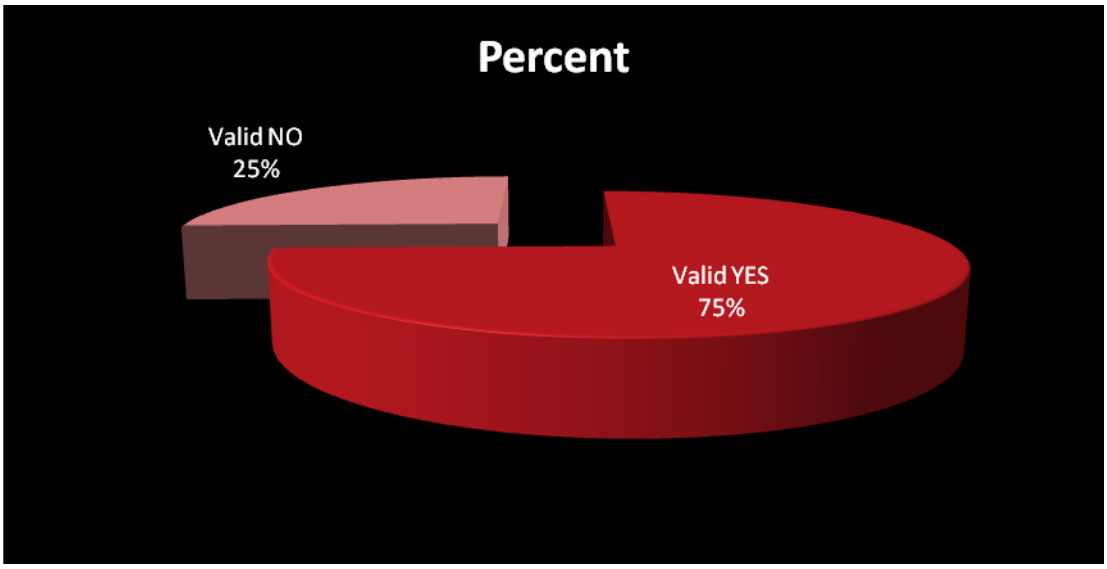
1.4

INCIDENT REPORTING

- **Does the staff had the awareness of the incident reporting system in work area?**

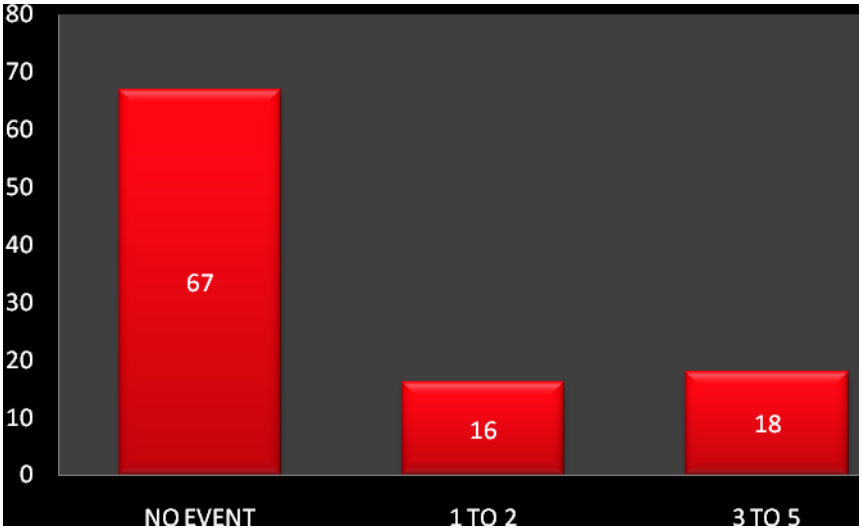
Figure-

2.1



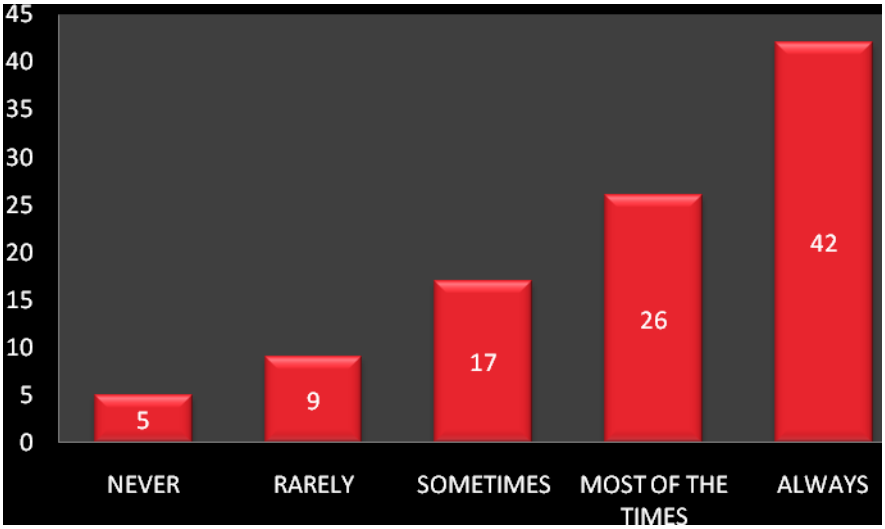
- **In the past 12 months, how many unsafe incidents have you reported?**

Figure-2.2

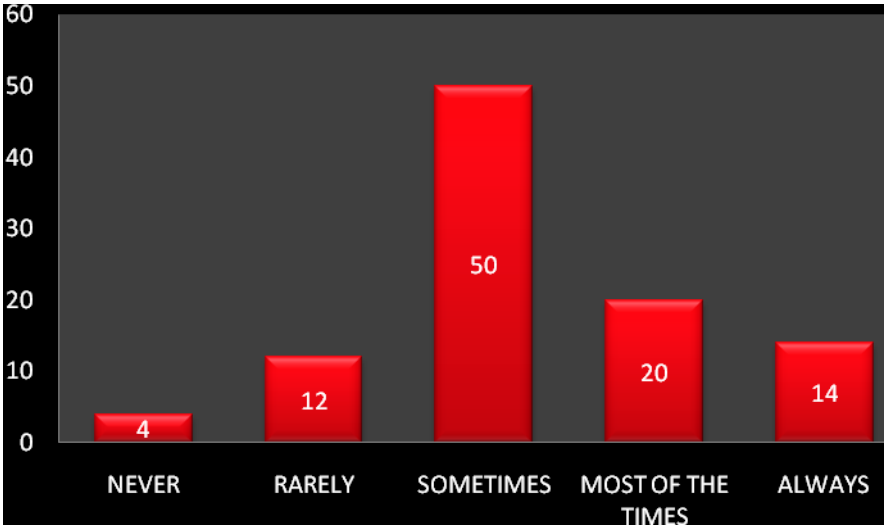


- **How often are they reported when a mistake is made, but is caught and corrected before affecting the patient?**

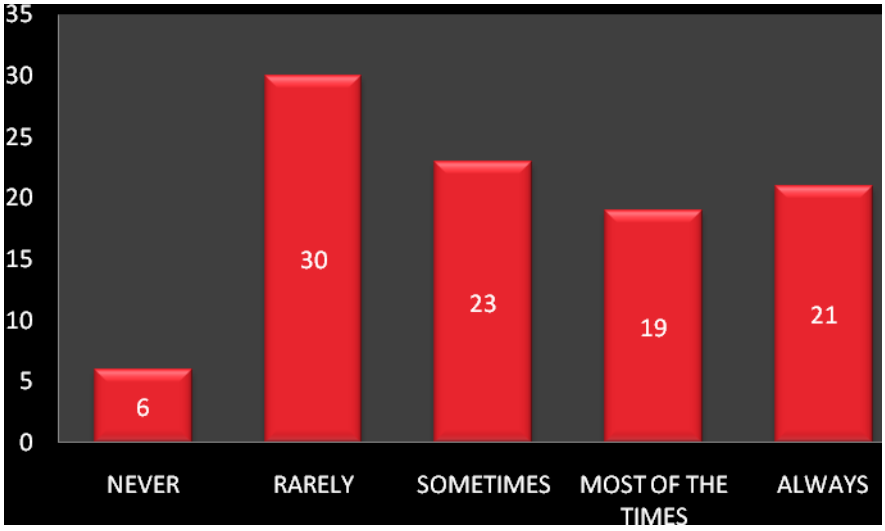
Figure-2.3



- **When a mistake is made that *could harm the patient*, but does not, how often is this reported?**
- **Figure-2.4**

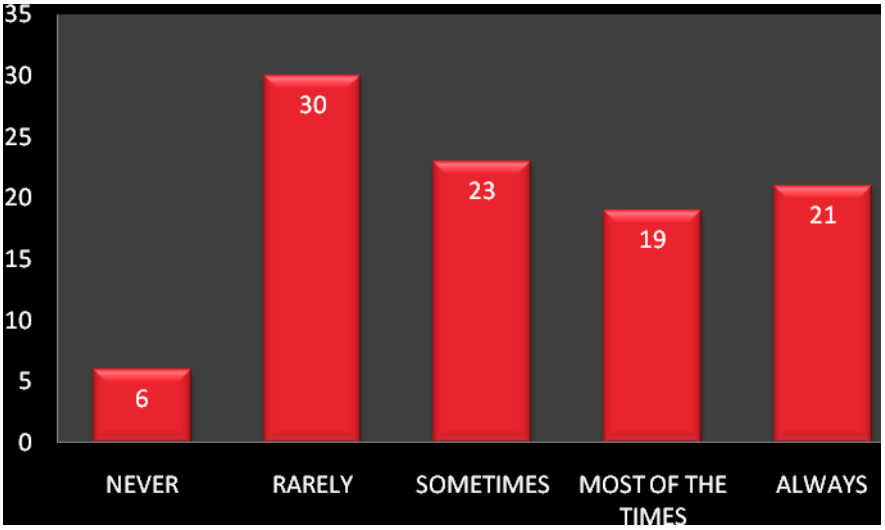


- **When a mistake is made ,but has no potential to harm the patient, how long often is this reported.**
- **Figure-2.5**



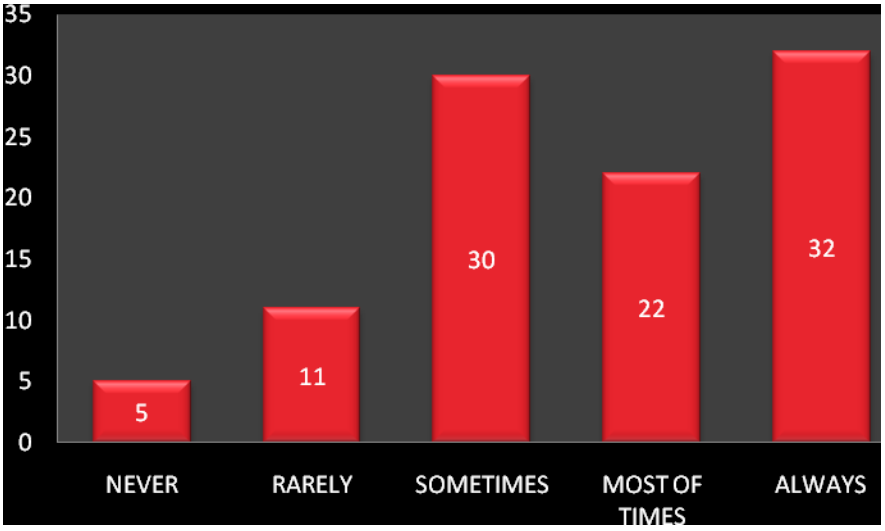
- **Are you discouraged to report any error?**

- **Figure-2.6**



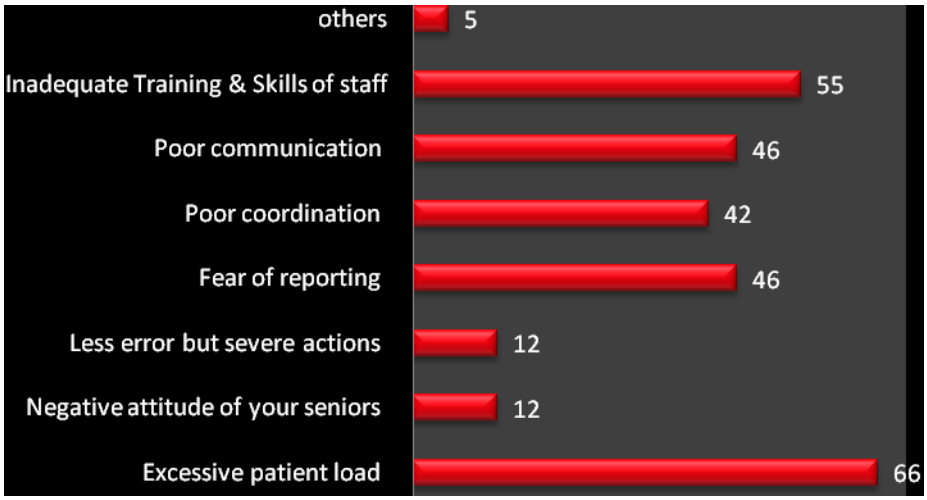
- **Changes are put in place when an adverse event is reported?**

Figure 2.7



Top three factors which are responsible for more errors

Figure-2.7



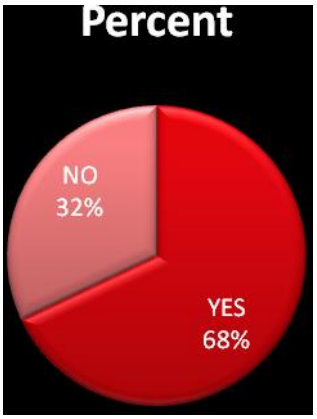
It was found that 66% of the staff believed that Excessive patient load is the main reason for maximum no of errors followed by Inadequate Training & Skills of staff (55%) and fear of reporting and poor communication(46%).

Training- Patient Safety

When the respondent were asked about Patient Safety , which includes patient safety goals, RRT, code blue only 68%of staff were aware of topic ,only 32% were not aware about patient safety policies.

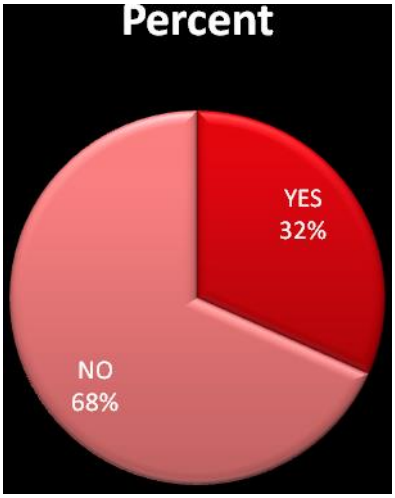
- **Are you aware of any patient safety policies in the hospital?**

Figure-3.1



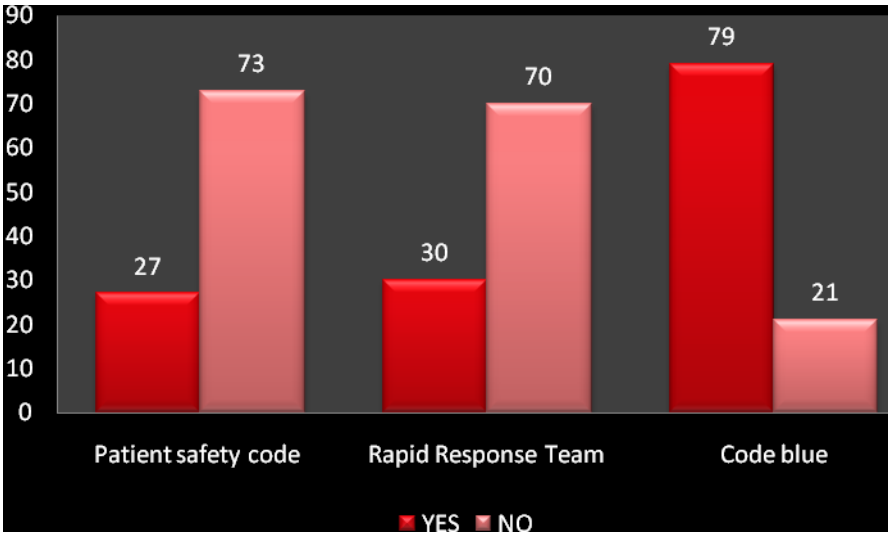
- **Have you attended any training program on patient Safety?**

Figure-3.2



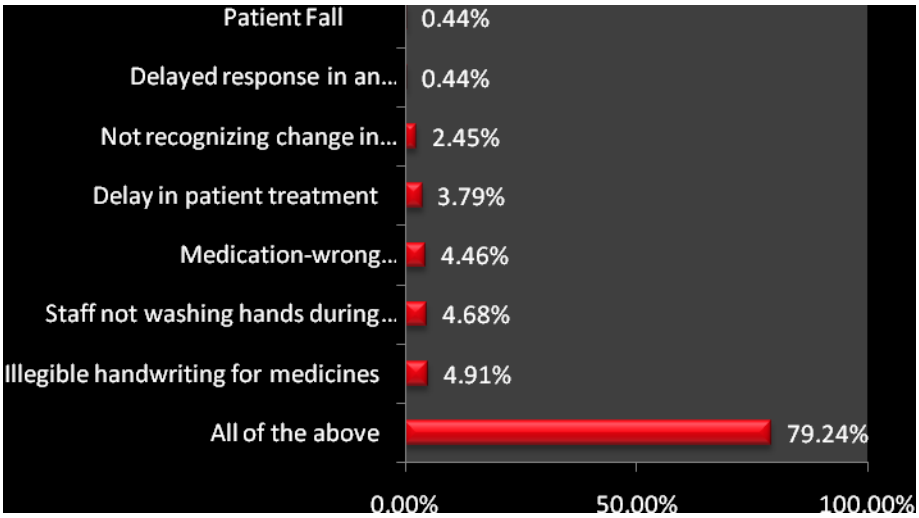
➢ **Awareness regarding the following:**

Figure-3.3



An unsafe action would be

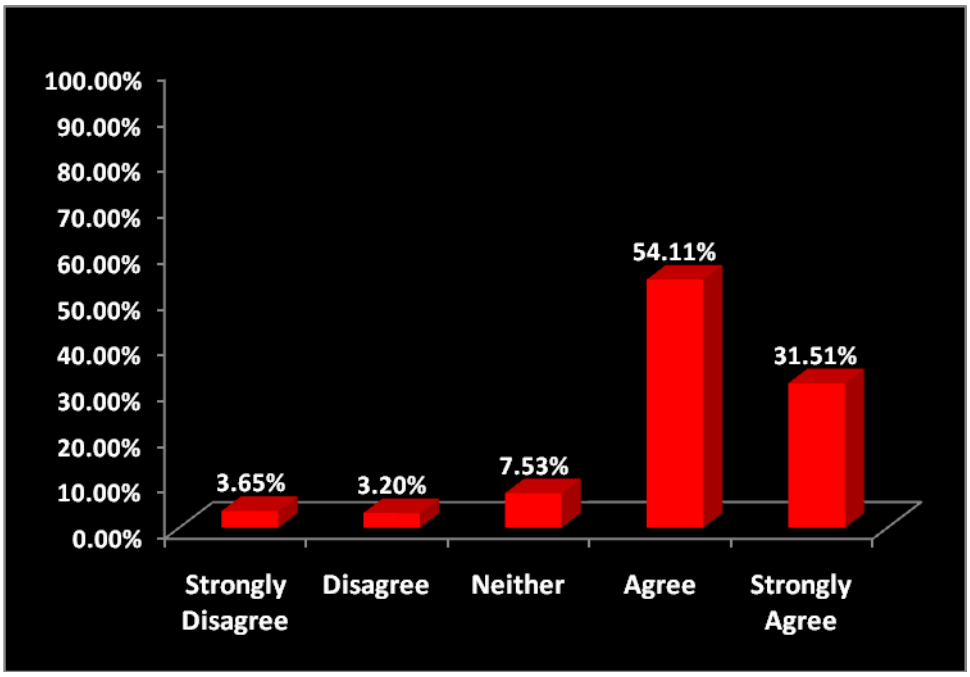
Figure 3.4



About The Department

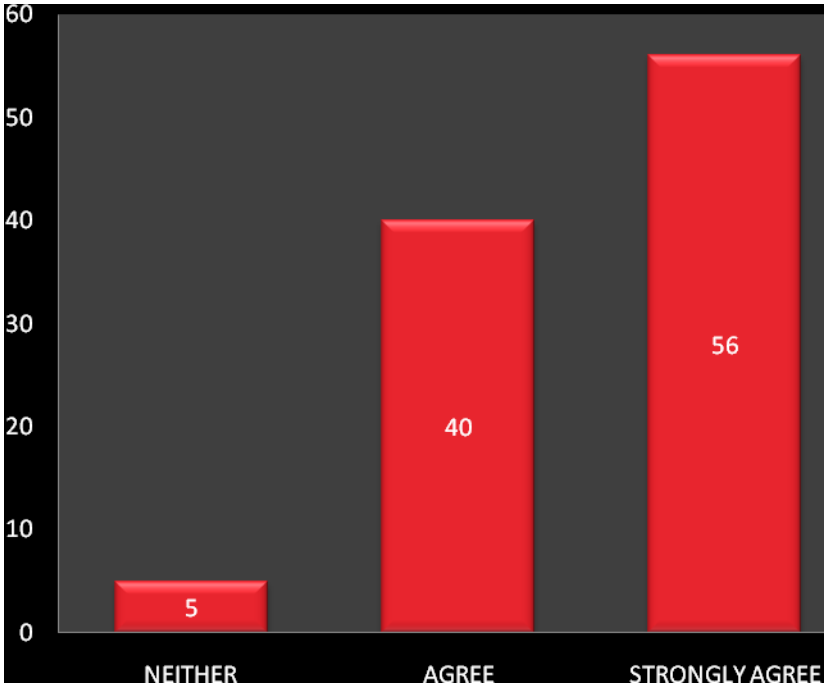
- **Do People support one another in this unit?**

Figure-4.1



- **In this unit, do people treat each other with respect?**

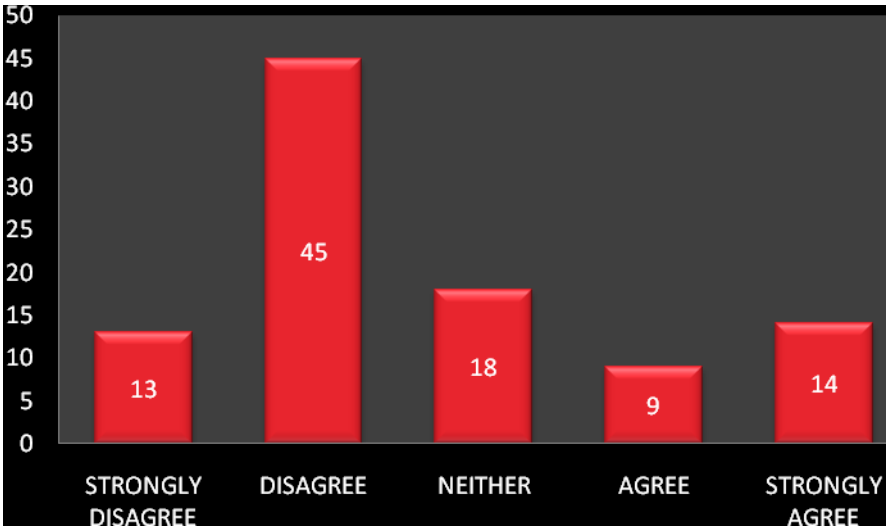
➢ **Figure-**



4.2

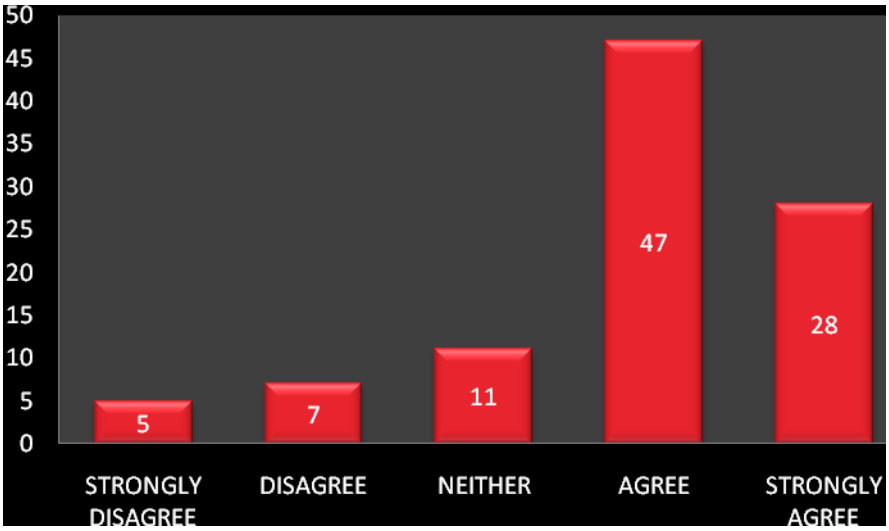
➢ **Do we have enough staff to handle the workload?**

Figure-4.3



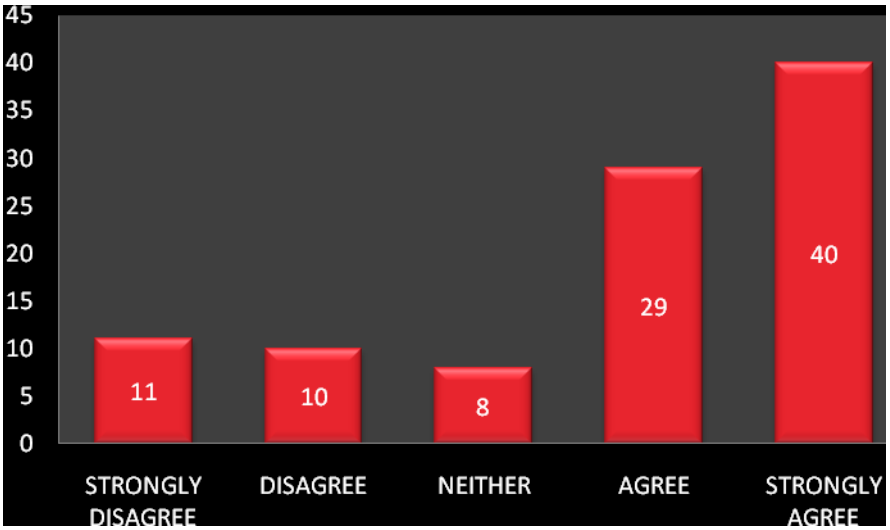
➢ **Do we work in "crisis mode" trying to do too much, too quickly.**

Figure-4.4



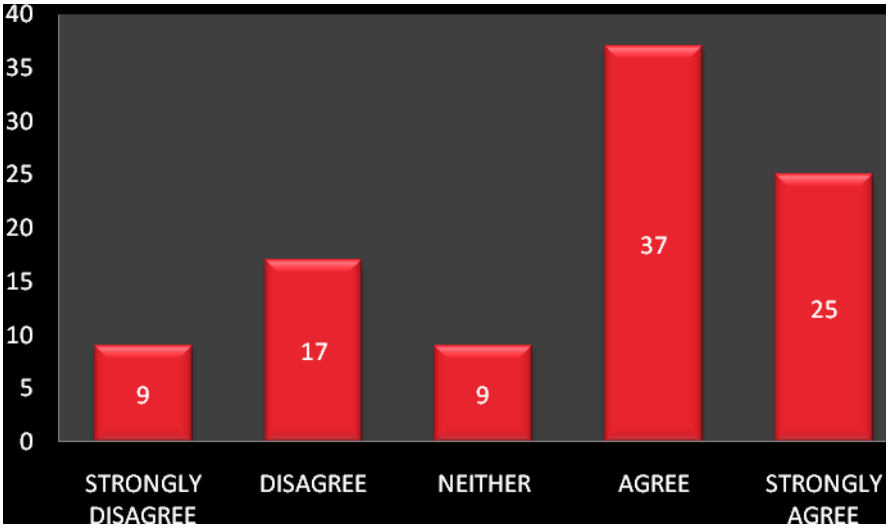
➢ **Are we actively doing things to improve patient safety**

Figure-4.5



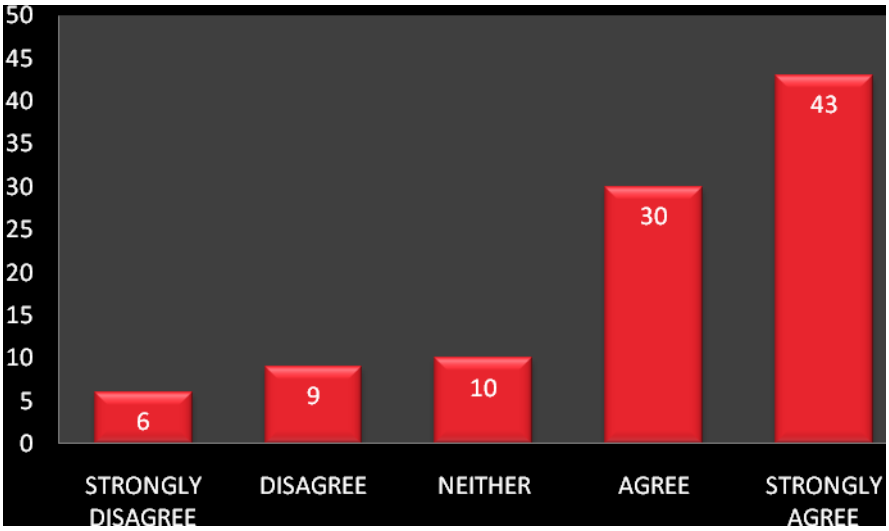
➢ **Do the Staffs feel like their mistakes are held against them**

Figure-4.6



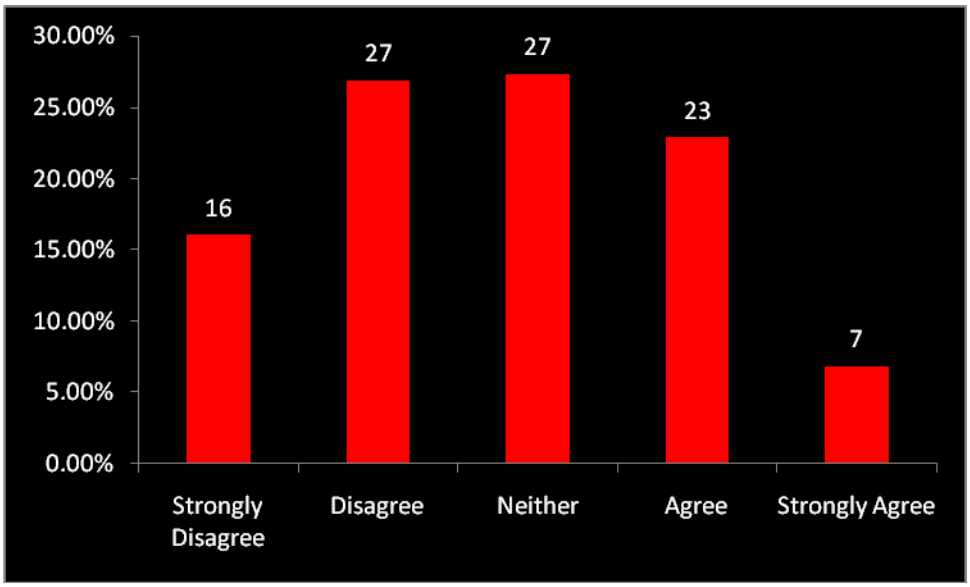
- **Do you agree that mistakes have led to positive changes here?**

Figure-4.7



- **Have you come across any incidence where the patient has sustained any kind off harm as a result safety problems in this unit**

Figure-4.8

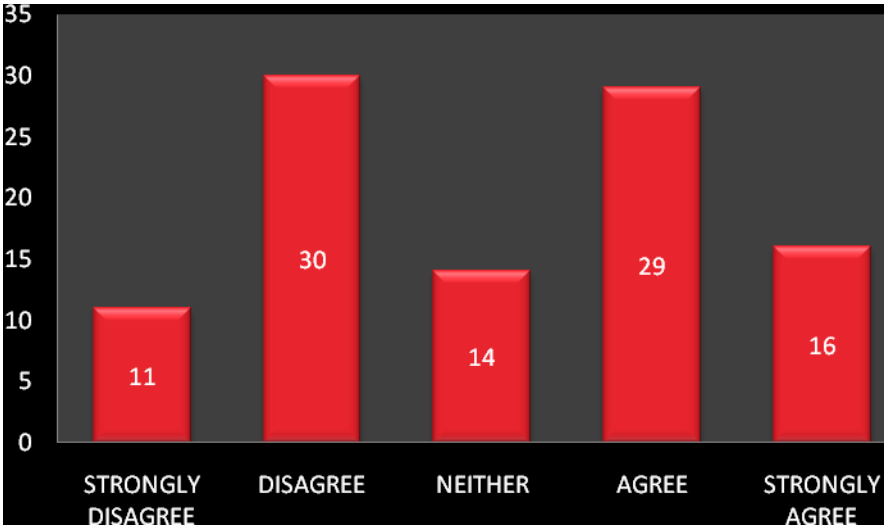


About The Hospital

30% agreeing and 30% of staff disagreeing that hospital work climate is encouraging for patient safety, more than 7 0% also agree that different unit in the hospital work together well to provide best care for patients.

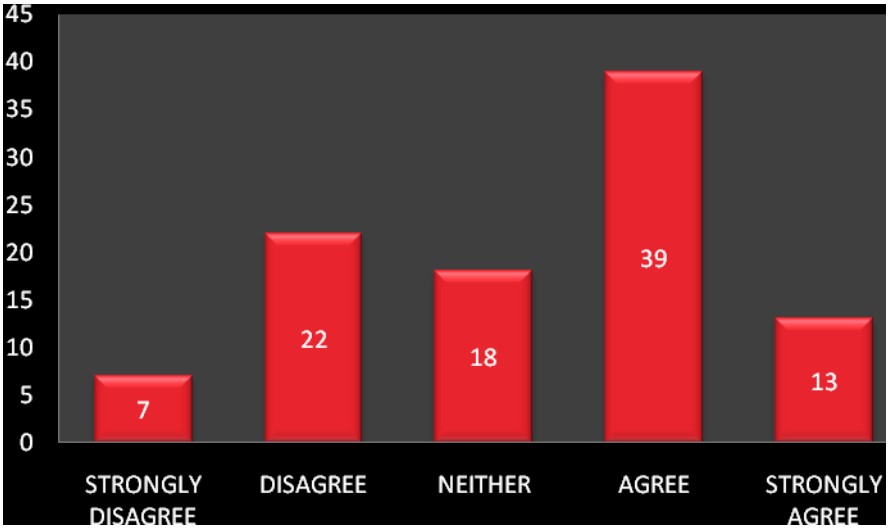
- **Hospital management provides a work climate that promotes patient safety**

Figure-5.1



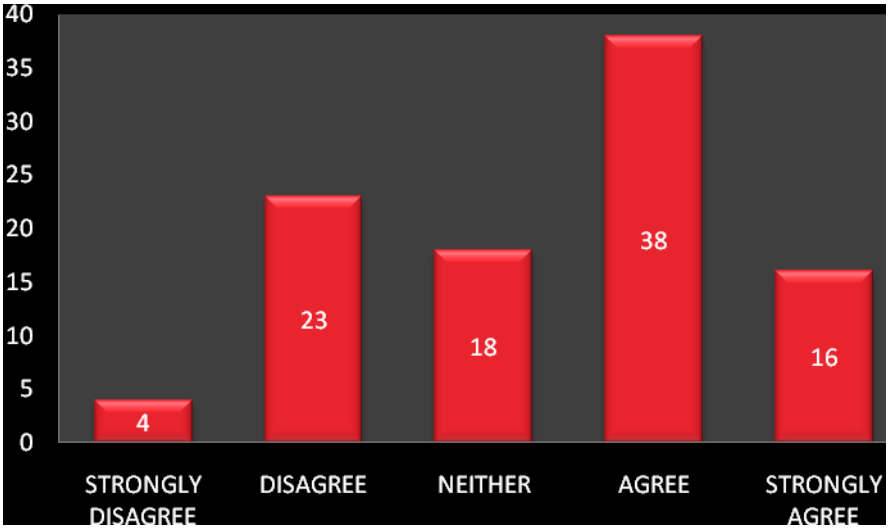
- **Important patient care information is often lost during shift changes**

Figure-5.2



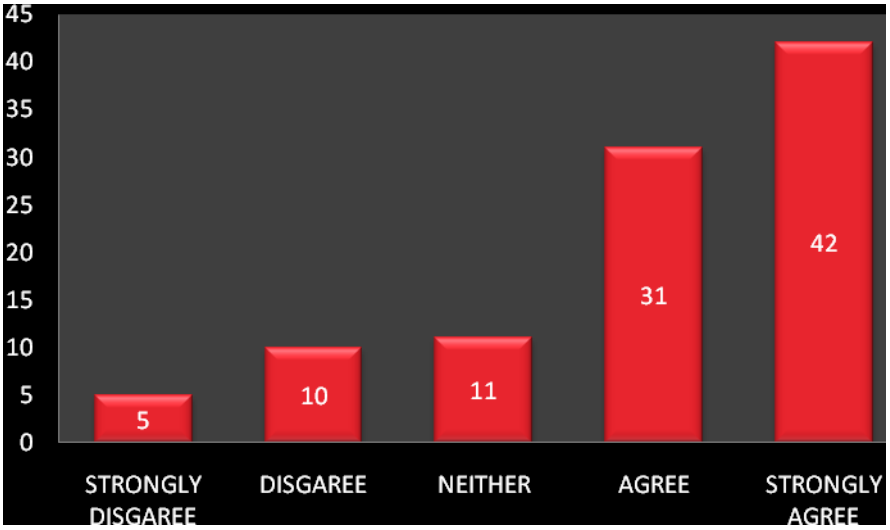
- **Problems often occur in the exchange of information across hospital units**

Figure 5.3



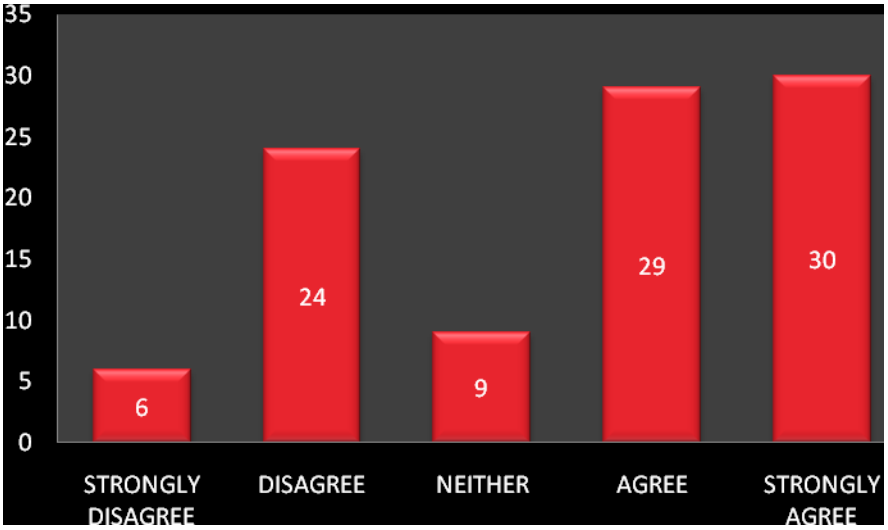
➢ **Hospital units work well together to prvide the best care for patients**

Figure: 5.4



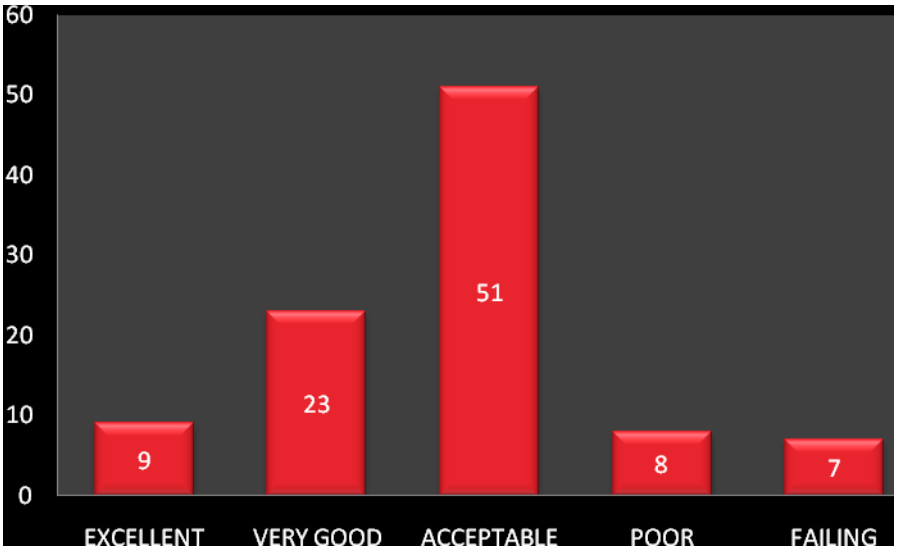
➢ **Our procedures and systems are good at preventing errors from happening**

Figure-5.5



- **Your confidence in our system being highly reliable, safe and efficient**

Figure-5.6



Chapter4- Discussion

4.1 ***Discussion***

The questionare was divided into five section .

Communication openess..

- Out of 106 respondents 49 % of them feels free to speak if they find something negative affecting patient care. Only 34 % of the interviewee supported the fact that in case any error ocuurs in their respective units ,it is informed to the respective authority It seems that the management is not taking serious steps in case of patient safety as there is no formal training or discussion related to prevention of errors ,we can conclude it from the survey result which shows that only 38% of interviewee stated that there often discussion occurs in context to patient safety and prevention of error. Only 44 % of the staff feels that on reporting error the management works on it and some actions are taken place which definitely helps to boost the staff as they feel that their complains are being heard and they add a change in the system.

Incident Reporting.

Majority of staff is aware about the incident reporting system. According to the survey done 77 % of staff says that they have reported 3 to 5 incidents in last twelve months , but as such no records are maintained about the incident reporting system, Most of them are reported verbally to their seniors or the management.Majority of the staff says that they are discouraged in reporting error and it was observed that seniors don’t want them to be blamed for anything and if the staff

do so then ,it was observed from the previous experience that the staffs were asked to leave the organization.

Training and patient safety

Among the total clinical staff only 68 % of them were aware about the patient safety . The hospital does not arrange any formal training for the staff ,majority of the staff .i.e. 68% of the staff did not attend any training program , the staff was not even aware about patient safety goals and rapid response team. The main reason which could be that the staff changes frequently and to hire staff at low wages they go for one who are inexperienced and less qualified for a particular job.

Department:

The staff has good relation with each other. They are supportive and have respect for each other. But due to scaricity of staff they are often loaded with work, due to which they often work in crises mode i.e. trying to do much too quickly. In such a scenario there are often chances of errors occurring while dealing with patient as the staff says that they get both mental and physical fatigue. On finding the reason behind it ,the main reason we got was that management wants to get maximum work done from limited staff employed . It was also found that as the work load was increasing, so instead of increasing the number of nursing staff they increased their working hours from eight to twelve. And 25 % of the employees feels that their mistakes are held against them and they are taken personally which is also a reason due to which the respondents restrict themselves from reporting errors.

Hospital:

These days safety culture is the major issue and is a priority in the hospitals. It's a serious issue for the management to take care of it. In this organization only 20% of the staff feels that hospital provides a work climates that promotes safety. 33 % of the staff says that important patient care information is lost during shift changes and 33 % says that there is problem in exchange of information across the hospital, which is a threat to the patient. Probably the reason could be due to overload of work .

4.2 Recommendations

CORRECTIVE& PREVENTIVE ACTION

- Training infrastructure should be carried for planning of hospital building which should include safety aspects especially engineering controls for infection control, fire etc.
- Business planning and budgeting should take into consideration costs of adequqte staffing levels and skills, material costs for safe medication delivery systems, good quality infection control systems such as disinfectants, disposable gloves etc.

- A safety officer should be nominated to improve the patient safety culture ,there should be safety management team should be set up which will amyalyze risk management . reporting and periodic review of saftey outcomes.

- Physicians should be involved in reviewing " Clinical Safety ".

- There is a need of developing a non punitive culture, with emphasis on reporting to enable root cause analysis, and corrective and preventive analysis in a blame free enviornment .

Recommendations on general patient safety issues

(1) Need to Support the establishment and development of hospital policies and programs on patient safety by:

Patient safety should be the priority issue in the health policies and programmes at hospital as well at wards and ICU levels. Safety standards should be regularly viewed and updated. Specific approach should be taken to promote patient safety practices to prevent the most commonly occurring adverse events such as medication –related

events, healthcare associated infections and complication during or after surgical intervention.

(2) Need to empower and inform citizens and patients by:

There is a need to involve patient organization and representatives in the development of policies and programs on patient safety at all appropriate levels and research should be developed and promoted on patient safety.

(3) Need to support the establishment or strengthen blame-free reporting and learning systems on adverse events that:

Staff should be provided with information on the extent, types and causes of errors adverse events and near misses. Health workers should be encouraged to be actively report through the establishment of a reporting environment which is open, fair and non punitive. Opportunities should be provided for patients, their relatives and other informal caregivers to report their experiences.

(4) Need to Promote, at the appropriate level, education and training of healthcare workers on patient safety by:

Multi-disciplinary patient safety education and training of all health professionals, other healthcare workers and relevant management and administrative staff in healthcare settings should be encouraged. Patient safety should be encouraged in undergraduate and postgraduate education, there should be on job training and the continuing professional development of health professionals. Need to provide and disseminate information to all healthcare workers on patient safety standards, risk and safety measures in place to reduce or prevent errors and harm, including best practices, and promoting their involvement.

(a) Need to provide and disseminate information to all healthcare workers on patient safety standards, risk and safety measures in place to reduce or prevent errors and harm, including best practices, and promoting their involvement**.**

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ANNEXURE

QUESTIONARE

Department: …… ***Date……..***

Designation……..

COMMUNICATION OPENNESS

1. ***Given feedback about change put into place based on event reports***.

Never ☐ rarely ☐ sometimes ☐ most of times ☐ always ☐

2. ***How many of the staff freely speaks up if they see something that may negatively affect patient care***.

Never ☐ rarely ☐ sometimes ☐ most of times ☐ always ☐

3. ***How often errors that happen in this unit are informed?***

Never ☐ rarely ☐ sometimes ☐ most of times ☐ always ☐

4. ***How often in this unit we discuss ways to prevent errors from happening again***

Never ☐ rarely ☐ sometimes ☐ most of times ☐ always ☐

INCIDENT REPORTING

1. ***Does staff had the awareness of the incident reporting system in work area?***

Yes ☐ No ☐

2. ***In the past 12month how many unsafe incidents have you reported***

No event ☐ 1 to 2 ☐ 3 to 5 ☐ 6 to 10 ☐ 11 to 20 ☐ 21 < ☐

3. ***How often are they reported when a mistake is made, but is caught and corrected before affecting the patient***?

   Never ☐ rarely ☐ sometimes ☐ most of times ☐ always ☐

4. ***When a mistake is made, that could harm the patient but does not know how often this is reported.***

   Never ☐ rarely ☐ sometimes ☐ most of times ☐ always ☐

5. ***When a mistake is made ,but has no potential to harm the patient how long often is this reported***

   Never ☐ rarely ☐ sometimes ☐ most of times ☐ always ☐

6. **Are you discouraged to report any error**

   Never ☐ rarely ☐ sometimes ☐ most of times ☐ always ☐

7. ***Changes are put in place when an adverse event is reported***

   Never ☐ rarely ☐ sometimes ☐ most of times ☐ always ☐

8. ***Top three factors which are responsible for more errors.***

   - *Excessive patient load*
   - Negative attitude of your seniors
   - Less error but severe actions
   - Fear of reporting
   - Poor coordination
   - Poor communication
   - Inadequate Training & Skills of staff
   - Other

TRAINING PATIENT SAFTEY

9. Are you aware of any patient safety policies in the hospital?

YES ☐ NO ☐

10. Have you attended NEIT or any other training program on patient safety?

YES ☐ NO ☐

11. Awareness regarding the following

- MHC patient safety goals
- Rapid Response Team
- Code blue

12. ***Unsafe actions would be***

- Patient fall
- Delayed response in an emergency
- Not recognizing change in patient
- Delay in patient treatment
- Medication wrong
- Staff not washing hands during
- Illegible handwriting for medicines
- All of above

ABOUT THE DEPARTMENT

1. ***Do people support one another in unit***

Strongly disagree ☐ ***disagree*** ☐ ***neither*** ☐ agree ☐ strongly agree ☐

2. ***In this unit do people treat each other with respect***

Strongly disagree ☐ disagree ☐ neither ☐ agree ☐ strongly agree ☐

3. ***Do you have enough staff to handle the workload***

Strongly disagree ☐ disagree ☐ neither ☐ agree ☐ strongly agree ☐

4. ***Do you work in "cries mode: trying to do much, too quickly***

Strongly disagree ☐ disagree ☐ neither ☐ agree ☐ strongly agree ☐

5. ***Are we actively doing things to improve patient safety***

Strongly disagree ☐ disagree ☐ neither ☐ agree ☐ strongly agree ☐

6. ***Does the staff feel like their mistakes are held against them***?

Strongly disagree ☐ disagree ☐ neither ☐ agree ☐ strongly agree ☐

7. ***Do you agree that mistake have led positive changes here***

Strongly disagree ☐ disagree ☐ neither ☐ agree ☐ strongly agree ☐

8. ***Have you come across any incidence where the patient has sustained any kind off harm as a result safety problems in this unit.***

Strongly disagree ☐ disagree ☐ neither ☐ agree ☐ strongly agree ☐

ABOUT THE HOSPITAL

1. ***Hospital management provides a work climate that promotes patient safety.***

Strongly disagree ☐ disagree ☐ neither ☐ agree ☐ strongly agree ☐

2. ***Important patient care infection is often lost during shift changes.***

Strongly disagree ☐ disagree ☐ neither ☐ agree ☐ strongly agree ☐

3. ***Problems often occurs in the exchange of information across hospital Units***.

Strongly disagree ☐ disagree ☐ neither ☐ agree ☐ strongly agree ☐

4. ***Hospital units work well together to provide the best care for patient.***

Strongly disagree ☐ disagree ☐ neither ☐ agree ☐ strongly agree ☐

5. ***Our procedure and system are good at preventing errors from happening.***

Strongly disagree ☐ disagree ☐ neither ☐ agree ☐ strongly agree ☐

6. ***Your confidence in our system being highly reliable, safe and efficient.***

Excellent ☐ very good ☐ acceptable ☐ poor falling ☐