Dissertation

IN

Shalby hospital, Ahmadabad

(March 5th -may 17th, 2014)

Awareness and implementation of international patient safety goal

By

Swati kumari

PG/12/099

Dissertation Report submitted in partial fulfilment of the requirements

For the award of

Post Graduate Programme in Hospital & Health Management

2012-2014

International Institute of Health Management Research

New Delhi -110075

May, 2014

This certificate is awarded to

Swati kumari

In recognition of having successfully completed his

Internship in the department of

Quality

And has successfully completed his project on

AWARENESS AND IMPLEMENTATION OF INTERNATIONAL PATIENT SAFETY GOALS

5/03/2014 to 17/05/2014

Shalby Hospital, Ahmadabad

She comes across as a committed, sincere & diligent person

Who has a strong drive and zeal for learning

We wish him all the best for future endeavors

Training & Development

Zonal Head- Human Resource

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IIHMR DELHI, DWARKA 2014

TO WHOM SO EVER MAY CONCERN

This is to certify that **Swati Kumari** 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 Shalby Hospital, Ahmedabad From 05/03/2014 to 17/05/2014.

The Candidate has successfully carried out the study designated to him during internship training and his approach to the study has been sincere, scientific and analytical. The Internship is in fulfillment of the course requirements. I wish him all success in all his future endeavors.

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Dean, Academics and Student Affairs
IIHMR, New Delhi

Dr. D C Jain
Associate Professor,
IIHMR, New Delhi

Certificate of Approval

The following dissertation titled **"Awareness and implementation of international patient safety goal"** at **"Shalby Hospital, Ahmadabad"** 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.

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Name	Signature
DR. D. C. JAIN	
Dr. Radhika S. Adholeya	

Certificate from Dissertation Advisory Committee

This is to certify that **swati kumari;** 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 **"Awareness and implementation of international patient safety goals"** at **"Shalby Hospital"** in partial fulfillment of the requirements for the award of

the **Post- Graduate Diploma in Health and Hospital Management.**

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

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CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled **Awareness and implementation of international patient safety goal at Shalby Hospital, Ahmadabad** and submitted by **swati kumari** Enrollment No. PG/12/099 under the supervision of Dr.D.C.JAIN , Asst. Professor, IIHMR, Delhi for award of Postgraduate Diploma in Hospital and Health Management of the Institute carried out during the period from 05/03/2014 to17/05/2014 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.

Swati
21/05/2014
Signature

FEEBACK FORM

Name Of the student: Swati Kumari

Dissertation Organization: Shalby Hospital, Ahmadabad.

Area of dissertation: Quality

Attendance: - Full.

Objectives Achieved: Yes.

Deliverables: Yes.

Strengths: Hard working & Sincere.

Suggestions for Improvement:

Signature of the office in charge\organization Mentor (Dissertation)

Date: 17/05/14
Place: Ahmadabad.

SHALBY
HOSPITALS

Hereby certifies that

Ms. Swati Kumari

Student of PGD-HHM at International Institute of Health Management Research, Delhi

has successfully completed her dissertation in the

Quality Department

as a part of academic curriculum during the period of

5th March 2014 to 17th May 2014

at our Organization

VIKRAMSINH MAHIDA
Sr. Vice President- HR & ADMIN.
Issued on: 17/05/2014

PREFACE

This is very crucial for the PGDHHM. student to learn process of hospital and has some research on that related to efficiency and effectiveness of current process which help to student to development analytical skill and evaluation of current process by providing conclusion in terms of recommendation and suggestion which shows how student has understood particular process that helps him/her in future.

This project report is consider as first step of student in the practical world because he/she is sole responsible to prepare and execute entire project and this helps him/her at time of joining various organization after the completion of this course because in this time student come across with various standard of departments and get the valuable knowledge regarding hospital grant policies and various norms. It provides some very good experience on our part as we are able to understand some real life situations in this globalization which help me in future.

The basic objective of the research is to learn a process thoroughly to get the mastery in that process and along with that develop various analytical skill which are the essential part of a manager for better medical, administrative and financial functions of the hospital.

ACKNOWLEDGEMENT

The present project was begun under the instructions of DR Bhavesh Patel, Deputy G. manager of Shalby hospital, Ahmadabad. The Asst. manager of quality Dr. Jasmin baldha guided us consistently on the tasks needed to be done.

I am pleased to record my gratitude and indebtedness to Dr. Jasmin baldha physiotherapist and quality associate of shalby hospital, Ahmadabad. He was always ready to help us on our project and on the changes which were required in the hospital as per the required standards.

Last, but not the least, I am extremely grateful to my mentor Dr. D.C.Jain, and my Dean Dr. A.k agrawal who always helped and guided me whenever any assistance was needed. I would like to express my special gratitude and thanks to industry persons for giving me such attention and time. My thanks and appreciations also go to my colleague in developing the project and people who have willingly helped me out with their abilities. I owe a great many thanks to a great many people who have helped and supported me during the completion of my report.

All praise belongs to my family and friends who motivated and inspired me on this project.

- swati kumari
IIHMR, Delhi.

DECLARATION

I, swati kumari hereby declare that the project work titled ‘Awareness and implementation of international patient safety goal ’ submitted in the partial fulfilment of the requirement for the 4th semester of Master of Hospital and Health Management, is a work done by me under guidance of our department faculty and Hospital authorities. This project is only and only STUDY purpose, not for publication or any other means. Use of any content of this project without permission of authorities will be considered illegal and actionable.

Acronyms/ Abbreviations

These are the following Acronyms/Abbreviations which are used in the project report-

- AC- Air Conditioner
- AERB- Atomic Energy Regulatory Body
- AHU- Air Handling Unit
- BMW- Bio Medical Waste
- BMWM- Bio Medical Waste Management
- CCU-critical care unit
- CSSD- Central Sterile Supply Department
- CT scan- Computerized Tomography scan
- CPG –clinical practice guideline
- HIV - Human immunodeficiency virus
- ICU- Intensive Care Unit
- IPD- In Patient Department
- MD- Managing Director
- MO- Medical Officer
- MLT- Medical Lab Technician
- MRD- Medical Record Department
- NABH- National Accreditation Board of Hospital and Healthcare Providers
- NOC- Non-Objection Certificate
- OPD- Out Patient Department
- OT- Operation Theatre.
- MICU-Medical Intensive Care Unit.
- PFPS- Patients for Patient Safety
- SICU-Surgical Intensive Care Unit
- WHO- World Health Organization

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HOSPITAL PROFILE

INTRODUCTION

Shalby is the leading multi-speciality tertiary care healthcare institutions in Western India. We provide world class treatment for all types of diseases at the most affordable rates. Patients come from all over India and the world for treatment in Shalby Hospitals.

Modest Beginning:

Shalby began its journey as a Joint Replacement Centre in 1994 by Dr.Vikram Shah. It has made tremendous progress in this field, as can be seen by the fact that **the highest number of joint replacement surgeries done in a single hospital anywhere in the world are done in Shalby Hospitals' S G Road, Ahmedabad Unit [Main Branch]**. Till date, over 40,000 joint replacement surgeries of different types have been done by the in house surgeons of Shalby Hospitals.

Quality:

We render the best patient care through a professional approach. We believe in continual improvements in quality of our services. We implement quality improvement programs across all the departments of our hospitals with the aim of offering the best services to our patients.

The quality of our healthcare services has been certified by accreditations bodies like the **NABH, NABL and ISO 9001:2008** and recognised by most prestigious awards like the **Rajiv Gandhi National Quality Award**, the **FICCI award** and many more.

Dental Cosmetic &Implantology Centre:

Shalby's 'Dental Cosmetic and Implantology Centre' established in 1995 is a state of the art unit in the field of dental implants and all other comprehensive dental treatments. It offers world class dental care in all aspects of dentistry. People from all over the world regularly visit Shalby's dental clinic for high end procedures, especially dental implants.

Expansion:

Shalby now has multi-speciality hospitals in Ghuma [Ahmedabad], Vapi [Gujarat] and Mapusa [Goa]. The 30 bed hospital where Shalb ybegan now houses a state of the art Assisted Reproductive Technologies [IVF] centre.

Shalby offers OPD services in all major cities of India like Mumbai, Delhi, Kolkatta, Surat, Vadodara, Jaipur, Jodhpur, Indore and in African countries like Kenya [Nairobi].

Future -It is the vision of Shalby to continually improve and grow and fulfill its mission **'TO PRESERVE AND SUSTAIN QUALITY HUMAN LIFE'.**

Chairman's Message

Our objective is to provide high quality healthcare to people across the world. We aim to improve the quality of life of patients through compassion and dedication. We are geared to offer the best of healthcare services at competitive costs to people from across the globe. We are proud to have put Ahmedabad on the medical tourism map.

Vision

To be among the best Joint Replacement centres of the world, and a preferred medical institution for treatment of Cardiac, Spine, Oncology, Trauma and other medical conditions through world class technology, human expertise and highest professional standards at competitive costs.

Mission

To preserve and sustain quality human life as humanely as it can be done through painless processes, facilitation of speedy recovery, and indigenization of medical technology and to promote wellness & awareness through best practices at the highest value for all concerned.

THE CORE DIGNITARIES

- DR.Vikkram Sah- chairman
- Dr. Darshani –Director
- Shyamal Joshi-Director
- Dr Bharat Gajjiar –Director Outpatient services worldwide
- Mr Ravi Bhandari- CEO
- Mr.Bhavesh Upadhyay- Group COO
- Dr.Medhavni Avachit- Medical Superintendent

DESIGN OF HOSPITAL

The structure of hospital is in vertical from which contains 10 floors and two basements. There are mainly two main entrances one is common for all and other for emergency services.

DEPARTMENT IN SHALBY HOSPITAL

Arthroscopy	Neuro surgery
Bariatric Surgery	Nephrology
Cardiology	Nutritional diet
Cardio thoracic Surgery	Orthopaedics
Critical care	Oncology
Cosmetic surgery & cosmetology	Onco surgery
Dental science	Ophthalmology
Dermatology	Pain clinic
Dialectology	Pathology
Eyes, Nose & Throat surgery	Physiotherapy
Endoscopy & Laparoscopy	Pulmonology
Kidney transplant	Plastic surgery
General surgery	Gynaecology & obstetrics
Gastroenterology	Rheumatology
G.I. Surgery	Radiology
Joint Replacement surgery	Spine surgery
Internal medicine	Trauma surgery
Infectious disease	Urology
Minimal invasive surgery	Vascular surgery
Neurology	

AUXILIARY SERVICES

Ambulance Services

Emergency Services

Health check-up service

CSSD

Linen Services

Stores

Medical gases

Security

Kitchen & Cafeteria

Bio-medical Engineering

Maintenance& Engineering

Mortuary services

Medical Record Department

Administrative Services

Hospital Management Information system

Clinical Research

Bio-medical Waste Management

Hospital infection control

Pharmacy

LAYOUT OF HOSPITAL

Conference hall, Library, Doctor's lounge, Clinical Research room, Kitchen, Cafeteria, Cosmetic OPD	9th floor
Premier Room	8th floor
VIP suite, Deluxe Room	7th floor
Premier Rooms	6th floor
AC twin Room,	5th floor
Twin room, Cafeteria	4th floor
OT,MICU,OPD	3rd floor
Corporate Block ,CSSD	L floor
OT,SICU	2nd floor
OPD,CCU, Cath lab	1st floor
Ortho OPD, Dental OPD, Reception, Admissions, Mediclaim ,OP pharmacy, Prayer room, Billing, Corporate help desk, Travel desk, Cafeteria, Ophthalmology OPD, other OPD	Ground floor
ER , Radiology, Pathology, Health check-up, Dialysis, ER Billing	Basement 1
Bio-medical engineering, Mortuary, Medical Records department, Linen Store, General store, IP pharmacy	Basement 2

EXECUTIVE SUMMARY

National Board of Hospitals and Healthcare Providers (NABH) is governed by Quality Council of India. It has certain healthcare standards which are useful in improving the healthcare quality. .

Making plan, development, implementation of patient safety initiatives and programs in shalby hospital after analyze the observation. It is a cross-sectional observational study. This study started from 5th march 2014 and ended on 17th may. It was a three month study. Shalby hospital is a 170 bedded hospital

The first part of the project is introduction of hospital and after that project report is starts with proper light on the significance of project and analysis along with my observation.

Purpose of Project

The purpose behind conducting such project is to awerness and implementation of international patient safety goal in shalby hospital .this project helps to improve quality and services of the hospital.

INTRODUCTION

Patient safety and the quality of care have been major healthcare issues in past years and studies show that safety and quality problems are common in a number of healthcare systems. Patient safety may be defined as "freedom for a patient from unnecessary harm or potential harm associated with healthcare. The work on patient safety has focused on mapping the nature and extent of risk, errors and adverse events and on developing strategies to prevent and handle harm and potential harm.

These strategies have mainly aimed at changing and improving work routines for clinical personnel and learning from adverse events. For the most part studies on patient safety and strategies to prevent adverse events in health care have focused on hospitals and the risks of inpatient-care. Gradually, this focus has broadened and today there is an increasing interest in the safety of primary care. For instance, in 2008 WHO argued for a stronger emphasis on primary care in patient safety research because the majority of health care is delivered in primary care facilities rather than in hospitals?

Over that last decade the patient has gradually come to play a part in patient safety work and re-search. This may partly be due to a more general focus on patient centred care but is also a realisation that all actors in health care are needed to contribute to the improvement of patient safety.

Patient safety is increasingly recognized as one of the most important issues in health care around the world. As patient safety is addressed and discussed in many ways in the literature, one of the challenges in conducting the literature review was the lack of consensus of a universally accepted definition of Patient Safety. The literature review was the lack of consensus of a universally accepted definition of patient safety. In approaching the identification and analysis of literature to address the specific questions on patient safety This review used the Agency for HealthCare Research and Quality (AHRQ) definition of patient safety which Is defined as "freedom from accidental or preventable injuries or harm produced medical care".

Many of these processes emphasize the importance of an organization's commitment to quality and safety and the value of implementing programs in these areas. Improvements in the availability and quality of information at the hospital level and within other healthcare delivery organizations have led to a push for the more active involvement of boards and management teams in the review of quality and safety measures.

It is important to note that while there is an extensive literature that discusses patient safety and a burgeoning literature on consumer involvement and engagement in health policy, it is only in the last 10 years that there has been an interest in determining intersections between these arenas at the organization and system levels.

Composition of NABH

The NABH is comprised of 10 Chapters, 102 Standards and 636 Objective elements. The10 different chapters are as follows-

Chapter1. Access, assessment and continuity of care

Chapter2. Care of patients

Chapter3. Management of medication

Chapter4. Patient right and education

Chapter5. Hospital infection control

Chapter6. Continuous quality improvement

Chapter7. Responsibility of management

Chapter8. Facility management and safety

Chapter9. Human resource management

Chapter10. Information management systems

Assessment criteria and Fee structure of NABH

Size of Hospital	Pre-assessment	Assessment	Surveillance	Application Fee	Annual Fee
Up to 100 beds	Four man-days	Six man days (3x2)	Four man days (2x2)	Rs. 40000/-	Rs. 150000/-
101-300 beds	Four man-days	Nine man days (3x3)	Six man days (3x2)	Rs. 75000/-	Rs. 225000/-
301-500 beds	Six man-days	Twelve man days (4x3)	Nine man days (3x3)	Rs. 100000/-	Rs. 325000/-

NOTE: The man days given above for assessment and surveillance are indicative and may change depending on the facilities and size of the hospital.

Service Tax: With effect from 01.04.2012 a service tax of 12.36% is being charged on all the above fees.

BENEFITS OF NABH

Patients are the biggest beneficiary among all the stakeholders. Accreditation results in high quality of care and patient safety. The patients are serviced by credential medical staff. Rights of patients are respected and protected. Patients' satisfaction is regularly evaluated.
Accreditation to a hospital stimulates continuous improvement. It enables hospital in demonstrating commitment to quality care. It raises community confidence in the services provided by the hospital. It also provides opportunity to healthcare unit to benchmark with the best.
The personnel of accredited hospitals get continuous learning, good working environment, leadership and above all ownership of clinical processes. It improves overall professional development of Clinicians and Para Medical Staff and provides leadership for quality improvement with medicine and nursing.
Finally, accreditation provides an objective system of empanelment by insurance and other third parties. Accreditation provides access to reliable and certified information on facilities, infrastructure and level of care.

CHALLENGES & ISSUES OF NABH

- The NABH Accredited Hospital requires high maintenance; this increases the expenditure of the hospital. As India is a developing country therefore shortage of funds is always an issue. If hospitals will start implementing these standards then it will increase their cost. Increase in price decreases the demand. So, patients may also not prefer to come in an expensive hospital which will hamper the functioning of the hospital.
- Doctors, Para- medicals, Pharmacist etc are the stake holders of the hospital. To work efficiently an accreditated hospital needs cooperation and commitment of all the stakeholders. This becomes a big challenge because human error or negligence can happen from any side.
- To integrate all the departments, effective communication is required. Bromide i.e. failure in communication can lead to many problems. Both oral and written communication does not guarantee the correctness of the delivered and send message.

GOVERNING BODY

Quality Council of India (QCI) controls and manages NABH. QCI is registered as a non-profit society with its own Memorandum of Association. Chairman of QCI is appointed by the Prime Minister on recommendation of the industry to the government. Vision of QCI is to be among the world's leading national apex quality facilitation, accreditation and surveillance organisations, to continuously improve the climate, systems, processes and skills for total quality. Mission is to help India achieve and sustain total quality and reliability, in all areas of life, work, environment, products and services, at individual, organisational, community and societal levels.

RATIONALE OF STUDY

Large numbers of patients come to the shalby hospital for treatment. It becomes important for shalby Hospitals to have appropriate healthcare standards. As shalby Hospital of Ahmadabad is undergoing the awareness and implementation of international patient safety goal so it had to work upon it .An observational cross sectional study was required to be done which can assess the short-comings of the hospital and then can help in implementing the desired changes as per the standards.

It is cross sectional because it was done in a particular time period i.e. 5th march to 17 may 2014. It is also an observational study because hospital condition was observed to identify its present status. This study will help in guiding about the standards and their implementation.

REVIEW OF LITERATURE

***Rachel E. Davis et al. Patient involvement in patient safety: Health Expectations 10, pp. 259-267*, 2007**

Delineates factors that may affect patient participation in quality and safety issues.
Literature review of patient involvement in health care, both direct evidence from safety contexts, and indirect evidence from patient participation in treatment decision-making. Further, a conceptual framework is developed that illustrates known and putative factors that could affect participation and practical implications of patient involvement in safety is discussed . Safety is considered dependent on the interplay of above factors, and likewise, patient involvement requires a positive safety culture. Medication errors and hand washing proved effective participation interventions. The potential for engaging patients in safety is considerable, but further research is needed. The authors also stress that patient involvement is but a small part of safety and that patients should not carry the responsibility of their own health care, but only function as a safety buffer, so that not participating does not result in sub-standard treatment.

Vikki A. Entwistle et al. Speaking up about safety concerns: multi-setting qualitative study of patient"s views and experiences, Quality and Safety in Health Care 19, pp. 1-7 ,2010

Explores patients‟ and family members‟ experiences of and views on speaking up about safety issues in health care.
128 findings of safety risks were uncovered, including unacknowledged deterioration of condition; missed diagnoses; delays in referral and treatment; errors in prescription; dispensation and administering of medicine; errors in technical testing and treatment procedures; omissions or mistakes in communication; shortfalls in hospital accommodation and cleanliness; exposure to threats from other patients; and deficiencies in inpatient nursing. It is noted that some concerns raised by patients do not pose substantial threats. Findings were strikingly consistent across patient groups.
It is concluded that the patient-professional relationship and health professionals' attitudes shape pa-tients' confidence in speaking up and raising concerns and thus whether some patient safety issues are ignored or go undetected. Apart from a potential adverse event not being addressed, this can also lead to significant emotional harm of the patient. Concurrently with speaking up campaigns, listening up campaigns for health care workers is suggested.

Sander Gaal et al. What do primary physicians and researchers consider the most important patient safety improvement strategies? BMC Health Services Research 11(102), pp. 1-6,2010

Identifies the most effective patient safety strategies as considered by an international panel of primary care physicians.

Web-based surveys undertaken by 58 individual physicians and researchers (convenience sample) from eight primarily European countries with a strong primary care system (Austria, Denmark, France, Germany, the Netherlands, New Zealand, Slovenia, UK). The questionnaire considered 38 patient safety strategies based on previous studies (among them Gaal et al. 2010, see below) and telephone interviews with five international experts. The guide was subsequently reviewed by three experts. It considered current use and potential of the 38 patient safety strategies as estimated by respondents. 46/58 respondents were practicing GPs.

According to the authors, many definitions of patient safety exist, the shortest being to do no harm to patients. Among health care staff, patient safety is broadly perceived. The survey considered five themes: practice facilities, patient safety management, communication and collaboration, generic condictions for patient safety and education on patient safety.

Of the 38 strategies the respondents ranked an up-to-date electronic medical record and good telephone access to the practice as most important and considered these strategies widely present. Ac-accordingly ranked on importance (but not current use) were standards for record keeping, learning culture, vocational training on patient safety for GPs and availability of patient safety guidelines.

Jill Hall et al. ‚Effectiveness of interventions designed to promote patient involvement to enhance safety: a systematic review Quality and Safety in Health Care 19, pp. 1-7 ,2010

Systematically compiles interventions involving patients in patient safety . A systematic literature search was conducted up to August 2008 of databases, report databases, con-ference proceedings, grey literature, on-going research, patient safety organisations and a hand-search of two journals (not specified). There were no language restrictions. Over 22,000 references were retrieved, but only 14 studies and one systematic review met the criteria; no on-going studies were identified. Of the 14 studies, two emanated from Europe (Belgium and the UK) and three in a GP setting. The review was from the UK. In interventions, participants were primarily English-speaking literate adults and elderly. It is noted that the methodological quality of the included studies was poor.

The authors note that little is known about patients‟ willingness and ability to adopt patient safety promoting behaviours and that patients are rarely included in the development of interventions. Fu-ture research should focus on areas other than medication safety, consider appropriate research de-sign for the intervention and include qualitative methods.

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Susan Kirk et al. Patient safety culture in primary care: developing a theoretical frame-work for practical use .Quality and Safety in Health Care 16, pp. 313-320 ,2007.

The study develops and tests a framework for making the concept of safety culture meaningful and accessible to managers and frontline staff. 8 dimensions of a patient safety culture in primary care are identified: 1) overall commitment to qual-ity, 2) priority given to patient safety, 3) perceptions of the causes of patient safety incidents and their identification, 4) Investigating patient safety incidents, 5) Organisational learning following a patient safety incident, 6) communication about safety issues, 7) personnel management and safety issues, 8) staff education and training about safety issues, 9) Team working around safety issues. Organisational descriptions were developed for how these dimensions may be characterised at five levels of organisational maturity. The resulting framework aids clinicians‟ and managers„ understanding of patient safety culture and promotes discussions with teams about their safety culture maturity.
There was debate about whether patient involvement should be a separate dimension, but most inter-viewees argued that patient involvement was a component of all the dimensions and would be more evident in organisations with a mature safety culture.

Yves Longtin et al. Patient Participation: Current Knowledge and Applicability to Patient Safety Mayo Clinic Proceedings 85(1), pp. 53-62 ,2010

Current trends in patient participation include questioning health care workers, the initiative of WHO‟s World Alliance for Patient Safety, networks of patients and consumers to promote participation, advocacy and dialogue. The authors identify a shift from a paternalist care model, where the patient was a passive spectator, to the patient being a key player in its own health and in improving the system by demanding quality and lodging complaints. However, despite abundant literature, it is noted that the concept of patient participation is poorly defined and can relate to diverse aspects such as decision making, self-medication and -monitoring, patient education, goal setting and taking part in physical care.
Factors influencing participation are found in the reviewed studies to be acceptance of new patient role; level of health literacy; level of confidence in own capacities; type of decision making required; stakes of the proposed outcome; type of illness and co morbidity; age; sex; socioeconomic level; ethnicity; use of alternative medicine; health care worker professional specialty. Specific obstacles to par titivation on the part of the patient is thus the patient's refusal; low health literacy Obstacles to participation on the part of the professional are a desire to maintain control; time; type of illness; personal beliefs; professional specialty; ethnicity; training in participation. More specifically barriers were seen in health care worker's attitudes; withholding information; exercising paternalistic power over patients; lack of time; primary physicians more willing than specialists; Caucasian more than non-white.
Improvement of patie

OBJECTIVES

- GENERAL OBJECTIVE

  To make aware and implement international patient safety goal.

- SPECIFIC OBJECTIVE

  The specific objectives of the study are as follows-

1. To understand the NABH standard reguarding patint safety
2. To determine the basic status of patient safety goal in shalby hospital.
3. To implement the changes required as per NABH standards in shalby hospital.

METHODOLOGY

STUDY AREA

The study was conducted in the Shalby Hospital, Ahmadabad

STUDY DESIGN

Cross sectional and descriptive study

STUDY PERIOD

5th march to 17th may 2014

STUDY POPULATION

IPD patients

Sample size:- 100

Type of sampling

Randomly convenient sampling

TOOLS

Questionnaire, check list

TECHNIQUES

Observation, interview

CONTAINENT VALIDITY

The tool was given to some of the expert to contain validity based on their suggestion and recommendation tool was modified.

DATA COLLECTION METHOD

Primary data

Observation, interview

VARIABLES

The variables for the study were-

1. Observed Status of patient safety after the implementation of NABH standards.
2. Implementation of the required changes in the hospital as per NABH standards

Outline of International patient safety goal

1. Identify patient correctly.
2. Improve effective communication.
3. Improve the safety of high alert medication.
4. Ensure correct site, correct procedure, and correct patient surgery.
5. Reduce the risk of health care associated infection.
6. Reduce the risk of patient harm resulting from falls.

Goal 1: Identify Patients Correctly (IPSG.1)

The organization develops an approach to improve accuracy of patient identifications.

Intent

Wrong-patient errors occur in virtually all aspects of diagnosis and treatment. Patients may be sedated, disoriented, or not fully alert; may change beds, rooms, or locations within the organization; may have sensory disabilities; or may be subject to other situations that may lead to errors in identification. The intent of this goal is twofold: first, to reliably identify the patient as the person for whom the service or treatment is intended; second, to match the service or treatment to that individual patient.

Policies and/or procedures are collaboratively developed to improve identification processes—in particular, the processes used to identify a patient when giving medications, blood, or blood products; taking blood or other specimens for clinical testing; or providing any other treatments or procedures. The policies and/or procedures require at least two ways to identify a patient, such as the patient's name, identification number, birth date, or other ways. The patient's room number or location cannot be used for identification. The policies and/or procedures clarify the use of two different identifiers in different locations within the organization, such as in ambulatory care or other outpatient services, the emergency department, or operating theatre. Identification of the comatose patient with no identification is also included. A collaborative process is used to develop the policies and/or procedures to ensure that they address all possible identification situations.

Goal 2: Improve Effective Communication (IPSG.2)

The organization develops an approach to improve the effectiveness of communication among caregivers.

Intent

Effective communication—which is timely, accurate, complete, unambiguous, and understood by the recipient— reduces errors and results in improved patient safety. Communication can be electronic, verbal, or written. The most error-prone communications are patient care orders given verbally and those given over the telephone, when permitted under local laws or regulations. Another error-prone communication is the reporting back of critical test results, such as the clinical laboratory telephoning the organization to report the results of a critical lab value. The organization collaboratively develops a policy and/or procedure for verbal and telephone orders that includes the writing down, legibly (or entering into a computer), the complete order or test result by the receiver of the information; the receiver reading back the order or test result; and the confirmation that what has been written down and read back is accurate. The policy and/or procedure identify permissible alternatives when the read-back process may not always be possible, such as in the operating theatre or in emergency situations in the emergency department or intensive care unit.

Goal 3: Improve the Safety of high-Alert Medications (IPSG.3)

The organization develops an approach to improve the safety of high-alert medications

Intent

When medications are part of the patient treatment plan, appropriate management is critical to ensuring patient safety. High-alert medications are those medications involved in a high percentage of errors and/or sentinel events, medications that carry a higher risk for adverse outcomes, as well as look-alike, sound-alike medications. Lists of high-alert medications are available from organizations such as the World Health Organization or the Institute for Safe Medication Practices. A frequently cited medication safety issue is the unintentional administration of concentrated electrolytes (for example, potassium chloride [equal to or greater than 2 mEq/mL concentrated], potassium phosphate [equal to or greater than 3 mmol/mL], sodium chloride [greater than 0.9% concentrated], and magnesium sulfate [equal to or greater than 50% concentrated]). Errors can occur when staff are not properly oriented to the patient care unit, when contract nurses are used and not properly oriented, or during emergencies. The most effective means to reduce or eliminate these occurrences is to develop a process for managing high-alert medications that includes removing the concentrated electrolytes from the patient care unit to the pharmacy.

Goal 4: Ensure Correct-Site, Correct-Procedure, Correct-Patient Surgery (IPSG.4)

The organization develops an approach to ensuring correct-site, correct-procedure, and correct-patient surgery.

Intent

Wrong-site, wrong-procedure, wrong-patient surgery is an alarmingly common occurrence in health care organizations. These errors are the result of ineffective or inadequate communication between members of the surgical team, lack of patient involvement in site marking, and lack of procedures for verifying the operative site. In addition, inadequate patient assessment, inadequate medical record review, a culture that does not support open communication among surgical team members, problems related to illegible handwriting, and the use of abbreviations are frequent contributing factors.

The essential processes found in the Universal Protocol are

- marking the surgical site;
- a preoperative verification process; and
- a time-out that is held immediately before the start of a procedure

Marking the surgical site involves the patient and is done with an instantly recognizable mark. The mark should be consistent throughout the organization, should be made by the person performing the procedure, should take place with the patient awake and aware, if possible, and must be visible after the patient is prepped and draped. The surgical site is marked in all cases involving laterality, multiple structures (fingers, toes, lesions), or multiple levels (spine).

The purpose of the preoperative verification process is to

- verify the correct site, procedure, and patient;
- ensure that all relevant documents, images, and studies are available, properly labeled, and displayed.
- verify any required special equipment and/or implants are present

The time-out permits any unanswered questions or confusion to be resolved. The time-out is conducted in the location the procedure will be done, just before starting the procedure, and involves the entire operative team. The organization determines how the time-out process is to be documented.

Goal 5: Reduce the Risk of Health Care–Associated Infections (IPSG.5)

The organization develops an approach to reduce the risk of health care–associated infections.

Intent

Infection prevention and control are challenging in most health care settings, and rising rates of health care–associated infections are a major concern for patients and health care practitioners. Infections common to many health care settings include catheter-associated urinary tract infections, bloodstream infections, and pneumonia (often associated with mechanical ventilation). Central to the elimination of these and other infections is proper hand hygiene.

Internationally acceptable hand hygiene guidelines are available from the World Health Organization (WHO), the United States Centers for Disease Control and Prevention (US CDC), and various other national and international organizations. The organization has a collaborative process to develop policies and/or procedures that adapt or adopt currently published and generally accepted hand hygiene guidelines and for the implementation of those guidelines within the organization.

Goal 6: Reduce the Risk of Patient Harm Resulting from Falls (IPSG.6)

The organization develops an approach to reduce the risk of patient harm resulting from falls.

Intent

Falls account for a significant portion of injuries in hospitalized patients. In the context of the population it serves, the services it provides, and its facilities, the organization should evaluate its patients' risk for falls and take action to reduce the risk of falling and to reduce the risk of injury should a fall occur. The evaluation could include fall history, medications and alcohol consumption review, gait and balance screening, and walking aids used by the patient. The organization establishes a fall-risk reduction program based on appropriate policies and/or procedures. The program monitors both the intended and unintended consequences of measures taken to reduce falls. For example, the inappropriate use of physical restraints or fluid intake restriction may result in injury, impaired circulation, or compromised skin integrity. The program is implemented.

CHECK LIST FOR INTERNATIONAL PATIENT SAFTEY GOAL

1.Identify the patient correctly (using two identifiers)					
a) Patient ID band is checked.					
b) . Patient Id no. and name on patient bed is cheeked.					
c) verbal communication to the patient for his /her name.					
2.Improve effective communication (and handover between care givers)					
a) Hand over written in over book					
b) Care plan written in nursing notes(transfer notes)					
c) Verbal information transfer on patient ‘s treatment plan					
3.Improve the safety of high alert medication (ensure double cheek of sound alike and look alike medication)					
a) Awareness about high alert medication including sound alike and look alike medication.					
b) Double cheek high alert medication for date ,name, dose, route ,frequency etc					
c) Segregation of sound alike and look alike medication					
4. Ensure correct site, correct procedure,					

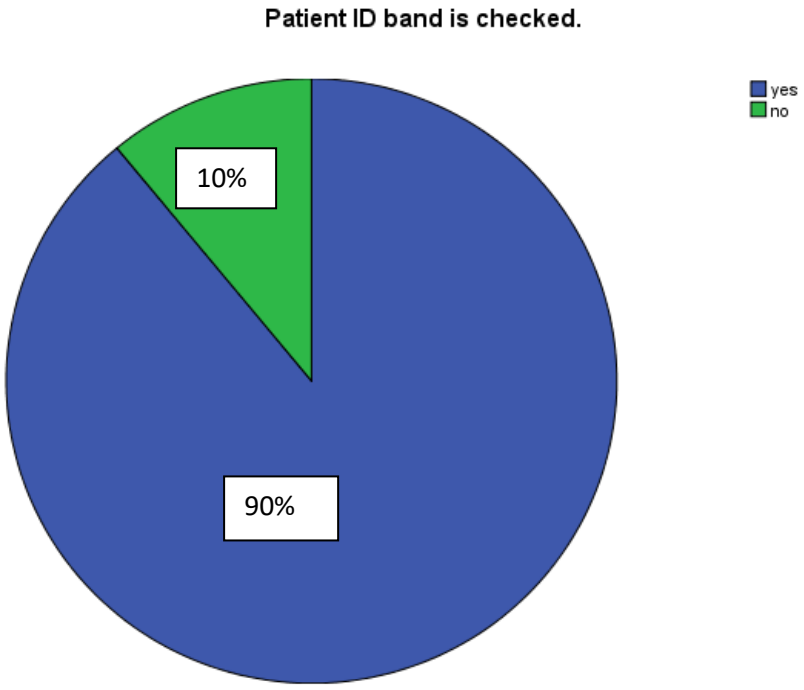
and correct patient surgery.					
a) WHO surgical safety checks list filled and available in medical records.					
b) Goal 1 is adequately is followed.					
c) Site marking for surgery on patient's body **5. Reduce the risk of healthcare associated infection (HAI).**					
a) Awareness about correct hand hygiene practices and other infection control protocols.					
b) Correct hand hygiene technique used for hand hygiene.					
c) PPE used prior to patient care					
6.Reduce the risk of patient falls.(ensure accurate initial assessment and re assessment of the patient for fall risk ensure adequate safety measure are taken)					
a) Nursing initial assessment is done including fall risk assessment.					
b) Patient vulnerability is identified.					
c) Safety measures are available to patient e.g. side rails to bed, safety belt to wheelchair , antiskid,etc.					
Floor					
Name of sis/brother.					
Name of auditor.					

Data Validation and Analysis

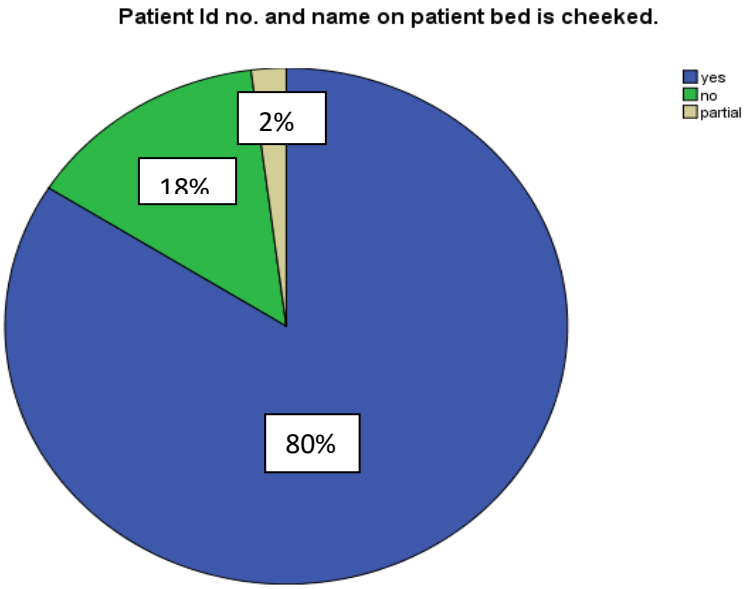
Data validation exercise was conducted for all the data collected. This included cross-checking and matching the data from hard copies in to the soft copies and clarifications with the respective investigator. Then, data was compiled and analyzed based on the objectives of the study, leading to preparation of charts for inclusion into the report. Data were analyzed using the software SPSS- 16th version.

FINDINGS

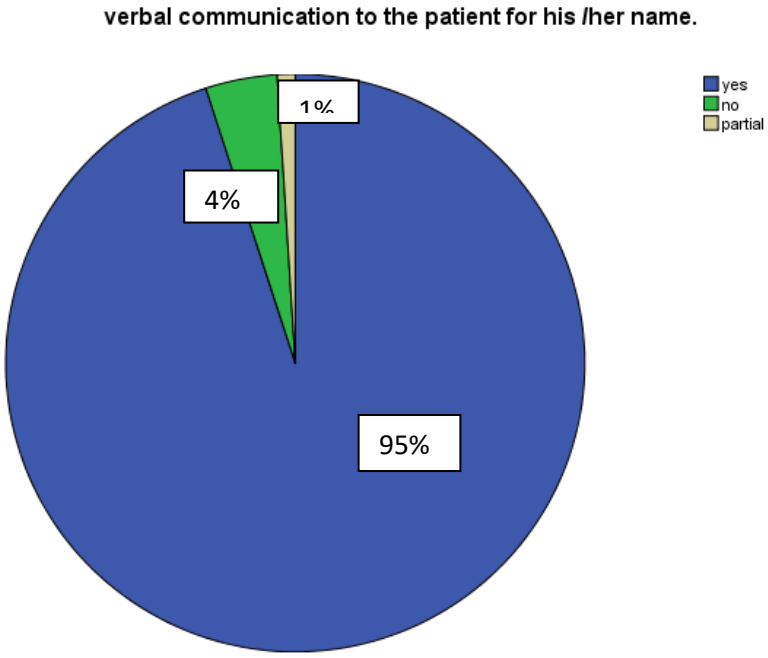
1. Identify the patient correctly



90% patient having ID band and 10 % not having ID band.

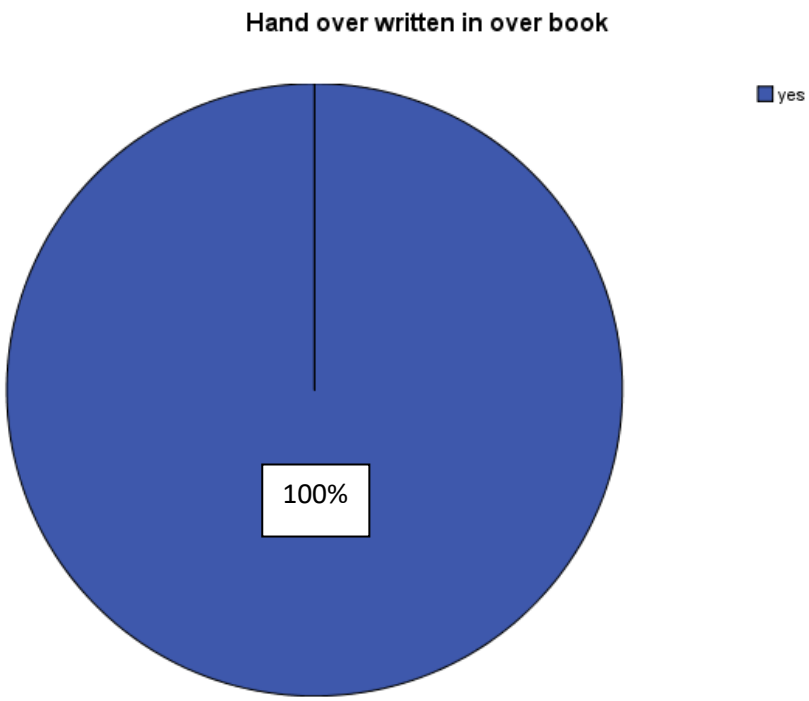


80% patient having ID and name on his bed 18% not having & 2% was partial.

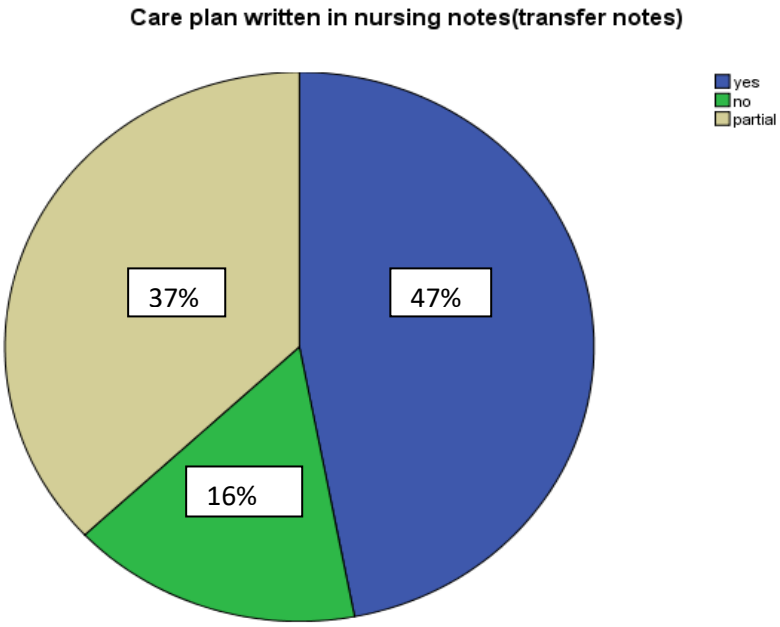


Verbal communication to patient by name was 95% and 4% is not communicate by name and 1 5 is partial .

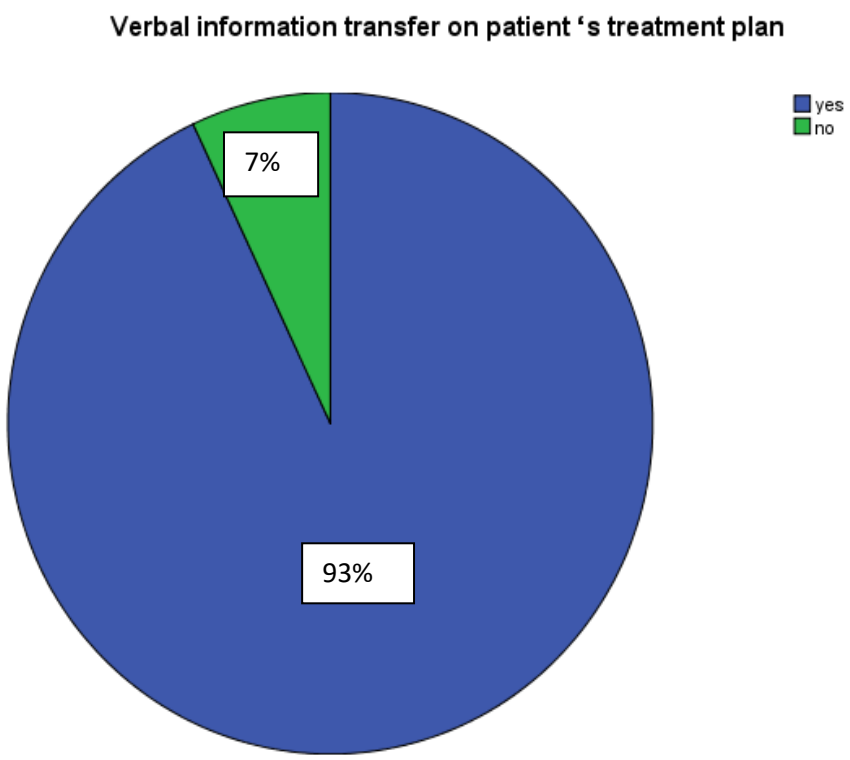
2. Improve effective communication (and handover between care givers).



Hand over written in over book and verbally both followed 100%.

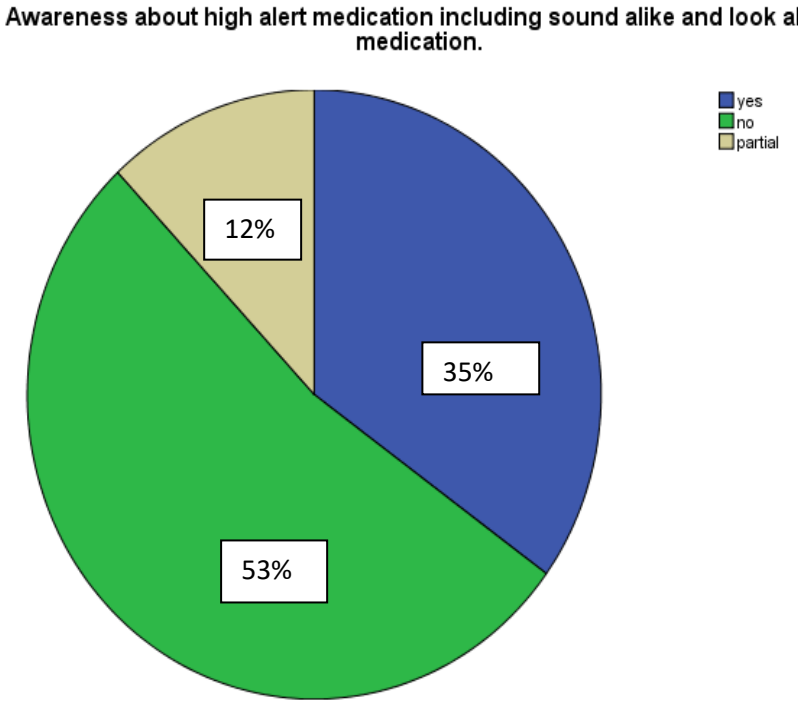


In 47% of patient file care of plan is available in 16% care of plan is not available and in 37% file care of plan is partially maintained.

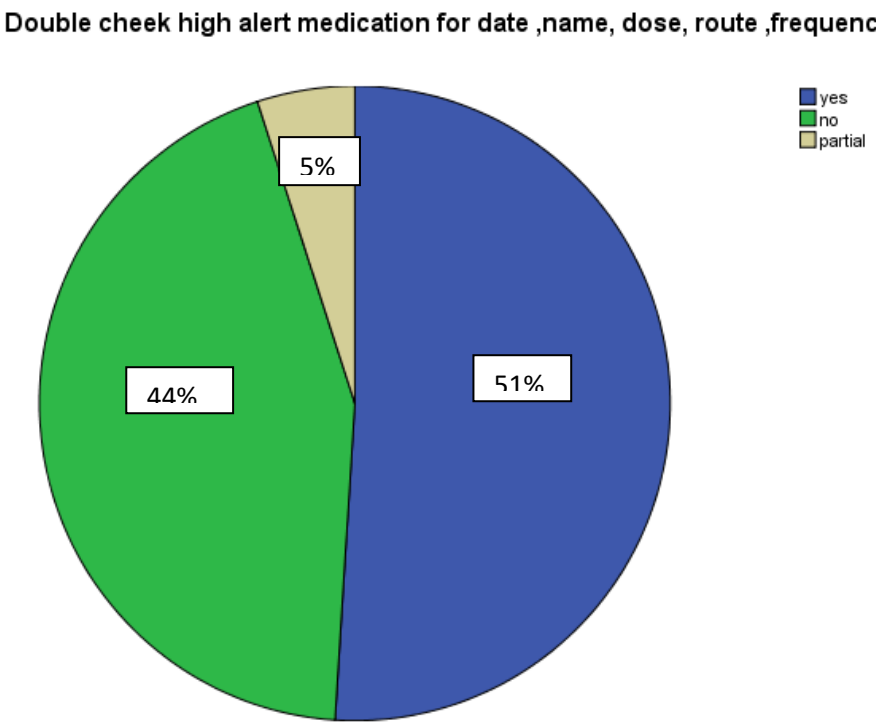


Verbal information on patient’s treatment plan is sucefully in 93% of patient file and 7 % not followed.

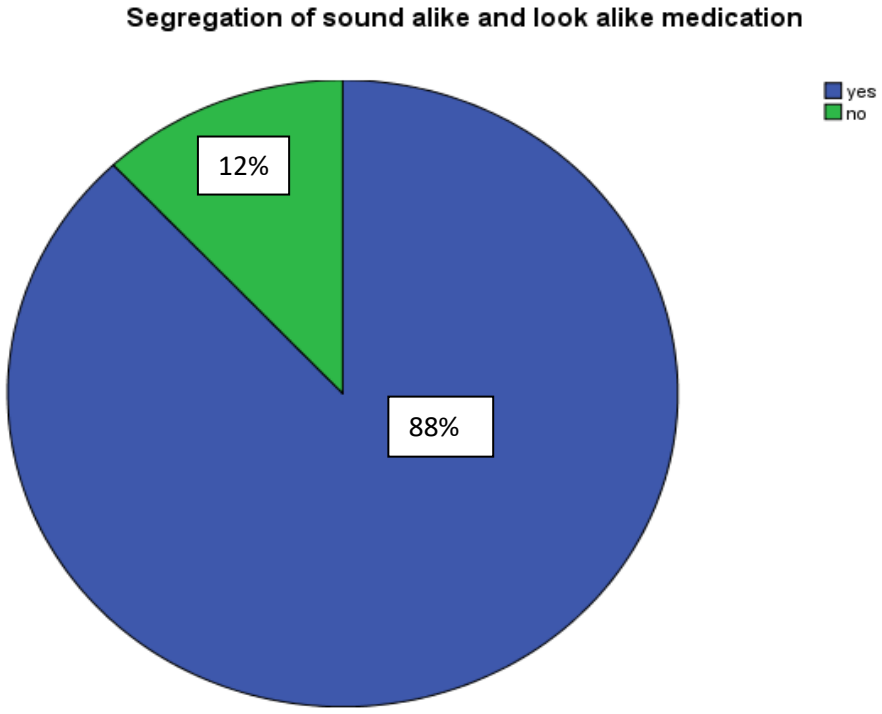
3. **Improve the safety of high alert medication (ensure double cheek of sound alike and look alike medication).**



Awareness about high alert medication including sound alike and look alike medication is 35% and 53 % are not aware and 12% are partially aware.

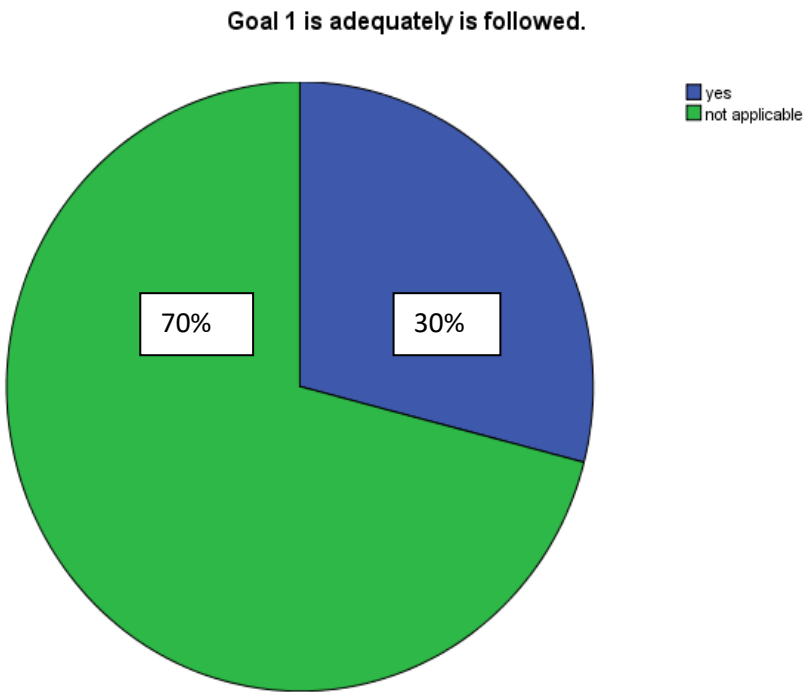


Double checking of high alert medication is followed by 51% staff and 44% not followed and 5% partially followed.

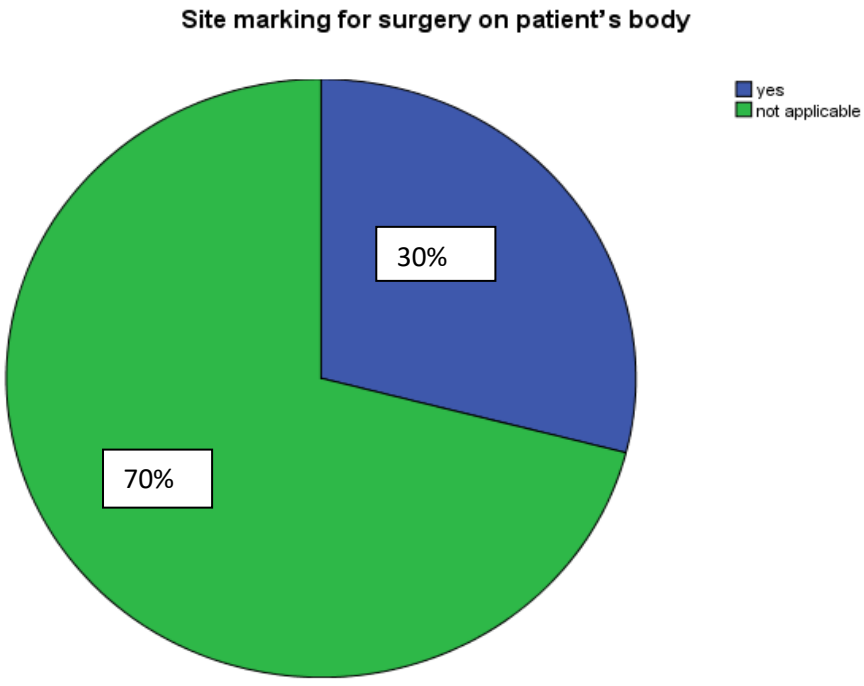


Segregation of sound alike and look alike medication are followed by 88% staff and 12% are not followed

4. Ensure correct site, correct procedure, and correct patient surgery.

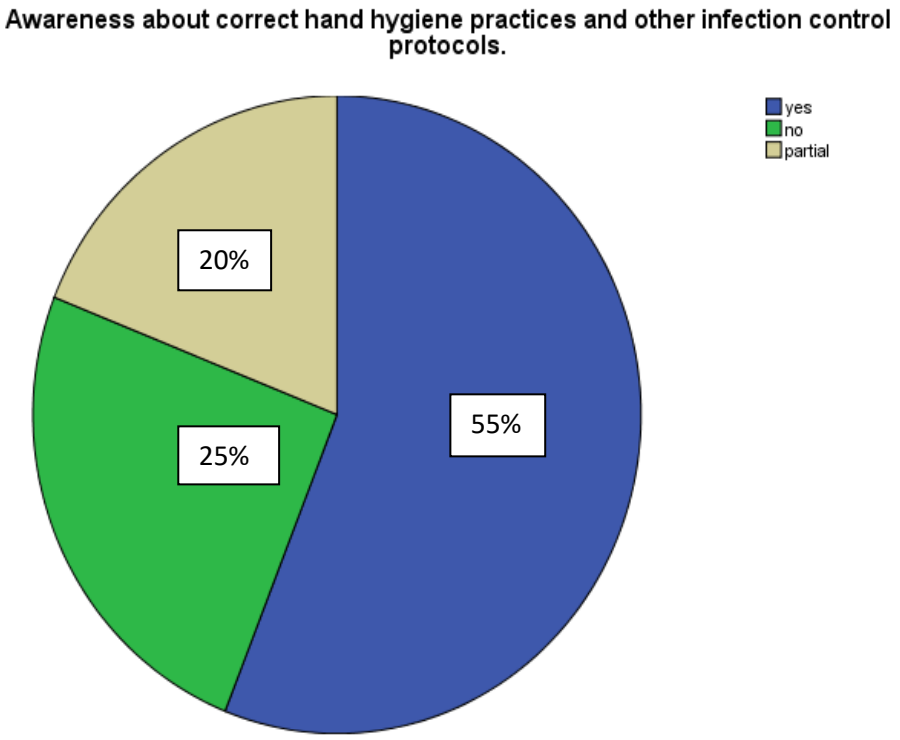


Goal 1 is followed in 30% of patient file and 70% patient are out of surgical process (not applicable)

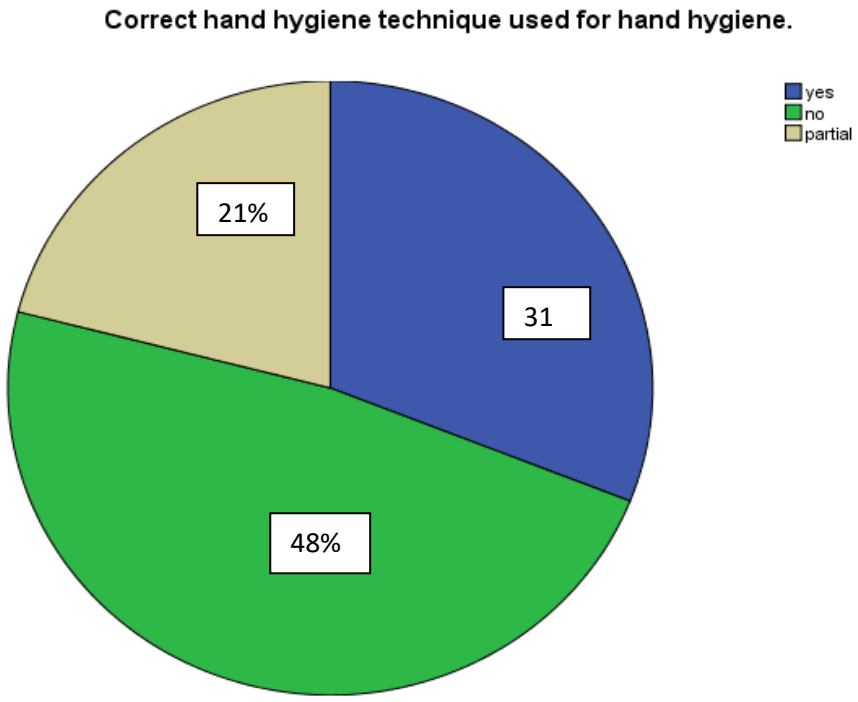


30% patient is marked before surgery and 70% are not applicable bcz. of non surgical process.

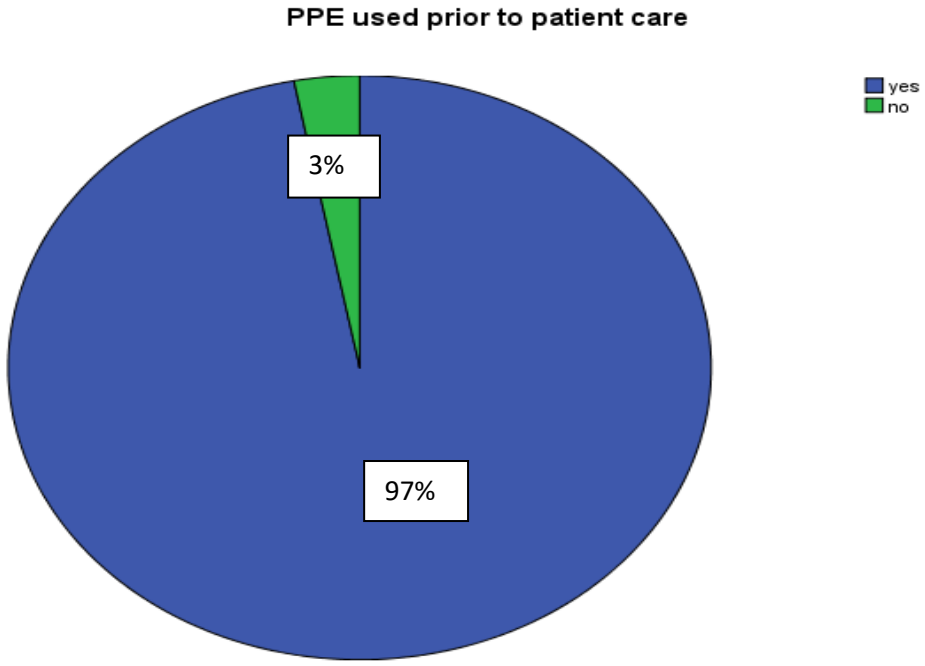
5. Reduce the risk of healthcare associated infection (HAI).



55% of staff are aware about hand hygiene process and 25 % staff are not aware and 20% are partially aware

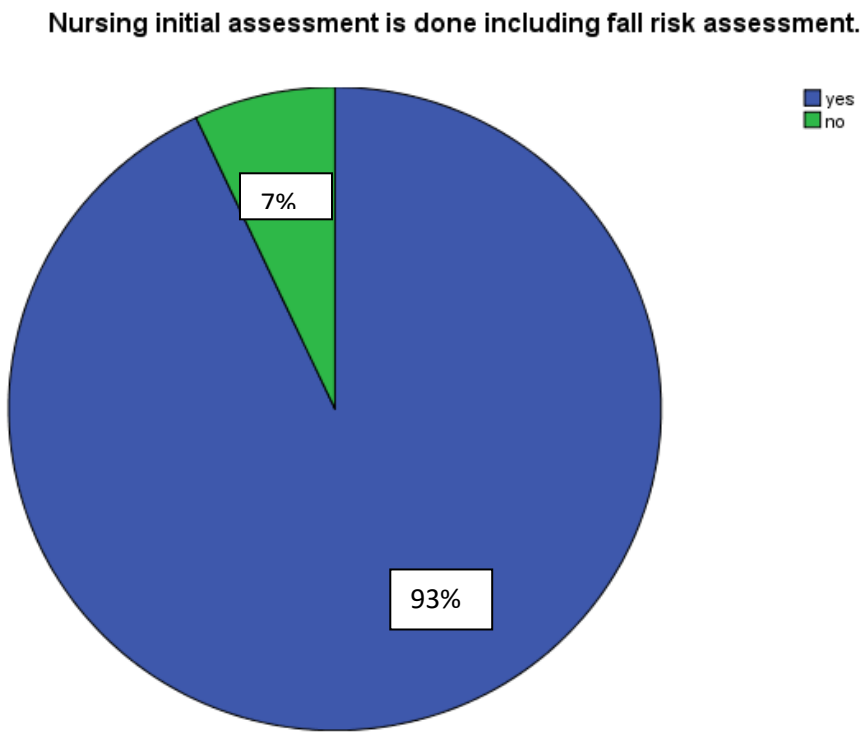


31% are used correct hand hygiene techniques and 48% are not followed correct hand hygiene techniques 21% are partially followed hand hygiene techniques.

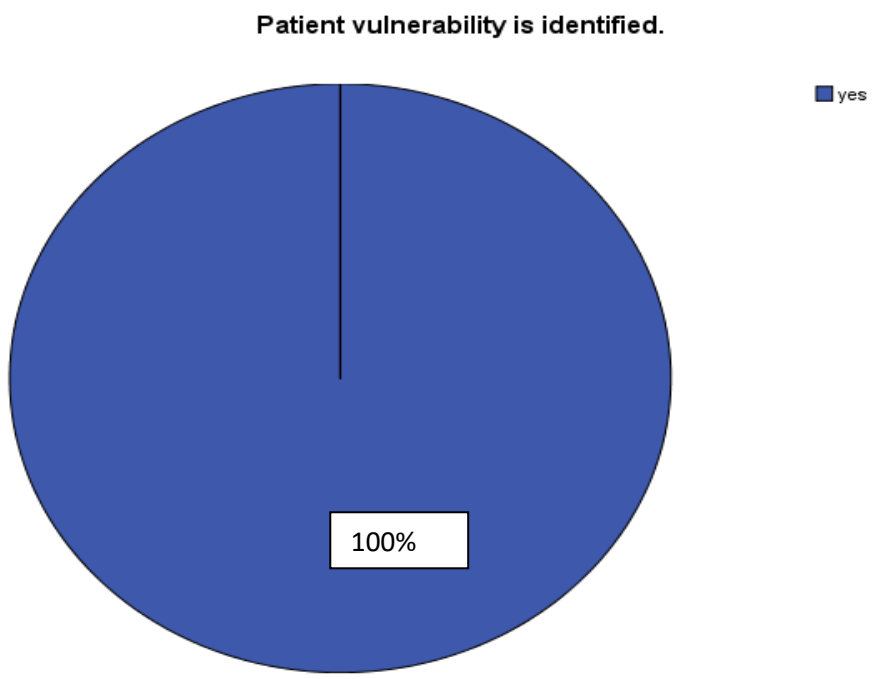


PPE is used by 97% of staff and 3% are not used properly.

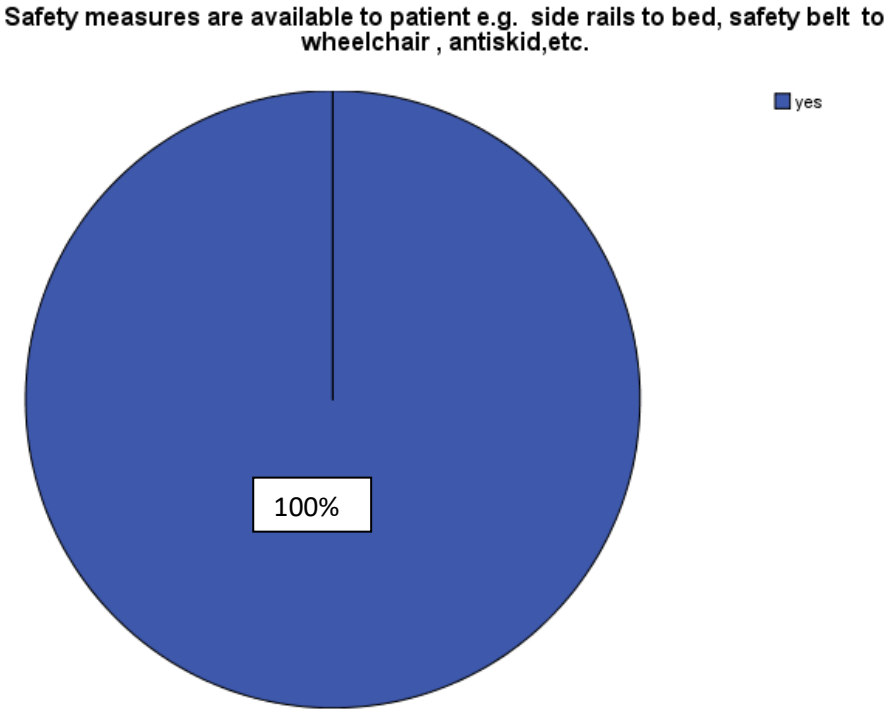
6. Reduce the risk of patient falls.(ensure accurate initial assessment and re assessment of the patient for fall risk ensure adequate safety measure are taken).



93% patient files having initial assessment including fall risk assessment and 7% patient file not having initial assessment including fall risk assessment .



Patient vulnerability is defined 100% in file



Safety measures are available to patient like wheelchair, bed rails in all floors, ICU etc..

Conclusion

This study was conducted in Shalby Hospital, Ahmadabad .It described about the" Awareness and implementation of patient safety goal". Here we discussed about the patient safety goal.

The safety goal is in accordance to the rules and regulation of the accreditation bodies. They are the number of people and department involved in the safety goal, as far by my study to find gaps during this it was concluded to :-

- **The main reason for not aware of sound like or look like medicine is some are following**:-

1. Not receive proper training related high risk medicine.
2. Some are new jonnie.
3. Because of work load not attend training properly.

- **The main reason for not aware about hand hygiene technique and not followed steps of hand washing. Are followed:-**

1. Lack of time.
2. over work load.
3. Not received proper training.
4. New joinee.

- **And lastly not fill plan of care properly.**

1. Lack of awareness.
2. Carelessness.
3. Not strict rules are over there.

RECOMMENDATIONS

- Comprehensive Plane of care should be filled in all files.
- Frequently training facility for all new joiner as well as old.
- Frequently monitoring for hand washing technique.
- Use technology for decrease work load.
- By followed strict rule and regulation..
- By proper monitoring, survey.

LIMITATION

- It is yet hard to monitor the entire safety goal at limited time. We have to do our work as well as our project .So it becomes quite difficult to achieve our target at limited time.
- Staffs are busy with their schedule so most of the time we have to wait for their response.

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