Dissertation Training

at

IIHMR, New Delhi

A Study on implementation of patient safety goals in multi- specialty hospital

by

Dr. TARASHI SINGH

PG/24/111

Under the guidance of

Dr. Preetha G.s

PGDM (Hospital & Health Management) 2024-26



International Institute of Health Management Research New Delhi

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in recognition of having successfully completed her dissertation in the department of

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

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Abstract

Background:

Patient safety is central to healthcare quality, gaps persist in correct patient identification, communication, medication safety, infection prevention, falls prevention, and adverse event learning.

This secondary, descriptive study synthesizes evidence (2015–2025) from WHO guidance, NABH standards, and peer-reviewed articles to assess implementation levels of Patient Safety Goals (PSGs) in multi-speciality hospitals, staff awareness, compliance gaps, barriers, and outcomes.

Thematic analysis indicates variable implementation:

Infection prevention and patient identification show relatively higher adherence where systems and audits are mature; medication safety and communication show moderate adherence with recurring issues in handovers, look-alike/sound-alike (LASA) drugs, and high-alert medications; falls prevention practices vary; incident reporting remains underutilized due to fear and workload.

Key barriers include workload, inadequate training, inconsistent leadership support, and limited data systems.

The report proposes actionable measures aligned with NABH and WHO: standardized identification, closed-loop communication, medication reconciliation, antimicrobial stewardship, falls risk bundles, non-punitive reporting culture, and real-time dashboards. Expected outcomes include reduced preventable harm, improved staff safety culture, and readiness for accreditation.

Chapter 1. INTRODUCTION

1.1 Background of the study

- Patient safety is the prevention of errors and adverse effects associated with healthcare delivery. Globally, patient safety failures contribute to avoidable morbidity, mortality, prolonged stays, and costs.
- International bodies, notably the World Health Organization (WHO), set priorities such as the Global Patient Safety Action Plan and the Medication Without Harm challenge, emphasizing system-level safeguards: correct identification, effective communication, safe medication practices, infection prevention and control (IPC), falls prevention, and robust learning systems.
- In India, the National Accreditation Board for Hospitals & Healthcare Providers (NABH) embeds Patient Safety Goals (PSGs) within accreditation standards, operationalizing safety through protocols, audits, and continuous quality improvement (CQI).
- Despite guidance, implementation remains inconsistent across multi-speciality hospitals due to contextual barriers: staffing ratios, training gaps, variable leadership engagement, documentation burden, and uneven digital maturity.

1.2 Problem Statement

Hospitals may have policies aligned with PSGs but struggle with consistent bedside execution, measurement, and learning. Understanding the extent of implementation and barriers in multi-speciality settings is critical to prioritize improvement and accreditation readiness.

1.3 Aim and Objectives

Primary objective:

- Assess the implementation of patient safety goals in a multi-speciality hospital (via synthesis of comparable settings).
- Evaluate healthcare staff awareness regarding PSGs.

Secondary objectives:

- Identify gaps in compliance with safety protocols.
- Analyse factors affecting implementation.
- Suggest measures to improve patient safety.

1.4 Scope and Significance

- Focus: multi-speciality hospitals; secondary literature (2015–2025).
- Significance: Provides a consolidated, evidence-informed blueprint for hospital leaders, quality teams, and educators to strengthen PSG implementation aligned with NABH and WHO.

1.5 Conceptual Framework

- Structure–Process–Outcome (SPO) and Safety Culture models underpin analysis.
- Structures: policies, staffing, technology, leadership.
- Processes: identification checks, handoff tools, medication reconciliation, IPC bundles, falls assessments, incident reporting.
- Outcomes: error rates, HAIs, falls with harm, medication events, near-miss reporting, culture survey scores.

1.6 Research Questions

- What is the reported level of PSG implementation in multi-speciality hospitals?
- What is staff awareness and training coverage?
- What barriers impede compliance?
- Which interventions and best practices close gaps and improve outcomes?

Chapter 2. Literature Review

2.1 Correct Patient Identification

- Core practices: two identifiers (name, MRN/UID), no room/bed numbers; barcoding for medications, blood, and specimens; ID bands with allergy status.
- Evidence: Barcoding reduces wrong-patient medication and transfusion events; compliance improves with EHR-enabled positive patient identification and nurse double-checks.
- Gaps: ID bands missing/misapplied in ED/OT; pediatric and ICU challenges; specimen labeling errors; interruptions leading to bypassing checks.
- Enablers: Standardized wristbands, bedside scanners, alerting for ID mismatches, visual management (color-coded allergy bands), periodic audits with feedback.

2.2 Effective Communication Among Caregivers

- Tools: SBAR for handoffs, read-back of verbal/telephone orders, critical result communication timeframes, standardized shift handover templates, escalation protocols.
- Evidence: SBAR adoption improves clarity and reduces omissions; read-back reduces order misinterpretation; electronic critical result alerts shorten time-to-action.

- Gaps: Inconsistent use of SBAR; verbal orders without read-back; handoffs during high workload; variability in capturing pending tasks and anticipatory guidance.
- Enablers: Mandatory SBAR training, simulation, safety huddles, protected handover time, EHR-embedded handoff tools, leadership rounding.

2.3 Safe Medication Practices

- Focus: high-alert medications (insulin, anticoagulants, opioids, chemotherapies), LASA management, medication reconciliation at transitions, standardized concentrations, smart pumps, CPOE with CDS, pharmacist involvement.
- Evidence: Medication reconciliation reduces discrepancies at admission/discharge; pharmacist-led stewardship reduces ADEs; smart pumps and dose-error reduction systems lower infusion errors; tall-man lettering and segregation mitigate LASA risks.
- Gaps: Incomplete reconciliation; alert fatigue causing overrides; storage and labeling inconsistencies; limited overnight pharmacist coverage.
- Enablers: Closed-loop med management (CPOE → pharmacy verification → barcode admin → eMAR), independent double-checks for high-alerts, formulary control, after-hours pharmacist telecover.

2.4 Infection Prevention and Control (IPC)

- Bundles: hand hygiene (WHO 5 Moments), device-associated infection prevention (CLABSI, CAUTI, VAP bundles), surgical site infection prevention, environmental cleaning, antimicrobial stewardship.

- Evidence: Bundle adherence correlates with reduced HAIs; hand hygiene >80% compliance linked to lower transmission; chlorhexidine bathing in ICUs; stewardship programs reduce resistance and C. difficile.
- Gaps: Compliance variability by unit and shift; PPE lapses; surveillance data lag; reprocessing/sterilization deviations.
- Enablers: Real-time dashboards, UV markers for cleaning audits, automated hand hygiene monitoring, line necessity reviews, ASP with audit-and-feedback.

2.5 Prevention of Patient Falls

- Components: risk assessment on admission and daily (Morse/STRATIFY), visual cues, non-slip footwear, bed/chair alarms, toileting schedules, environment safety checks, medication review, physiotherapy.
- Evidence: Multifactorial bundles reduce falls and falls with injury; sitters or virtual monitoring reduce unwitnessed falls in high-risk patients.
- Gaps: Inconsistent reassessment post-procedure/med changes; alarm fatigue; underuse of mobility aids; night-shift staffing.
- Enablers: Unit-based falls champions, standardized signage, proactive rounding, targeted PT/OT, de-implementation of ineffective restraints.

2.6 Reporting and Learning from Adverse Events

- Systems: non-punitive incident reporting, near-miss capture, root cause analysis (RCA), action tracking, safety culture surveys, mortality and morbidity reviews.
- Evidence: Just culture improves reporting volume/quality; learning systems reduce repeat events; tiered safety huddles accelerate mitigation.
- Gaps: Underreporting due to fear/time; limited feedback to reporters; action items not closed; data silos.

- Enablers: Anonymous reporting options, frontline involvement in RCA, visible leadership support, publishing "lessons learned," integrating human factors.

2.7 NABH Standards and Alignment with WHO

- NABH PSGs map closely to WHO priorities; accreditation cycles require evidence of policy deployment, training, audits, indicators, and CQI.
- Facilities demonstrating integrated QI programs sustain higher compliance than policy-only approaches.

Chapter 3. Methodology

3.1 Design

- Secondary, descriptive study via structured literature review.

3.2 Data Sources

- WHO publications (2015–2025).
- NABH Accreditation Standards for Hospitals (6th Edition) and guidance notes.
- PubMed-indexed peer-reviewed articles (2015–2025).
- Selected high-quality reviews, guidelines (e.g., ISMP for medication safety, CDC for IPC where relevant), and credible journals.

3.3 Search Strategy

- Databases: PubMed/MEDLINE; supplementary: Google Scholar for grey literature screening.
- Keywords and Boolean strings (examples):
    - "patient safety goals" AND hospital AND implementation
    - "NABH" AND "patient safety" OR accreditation
    - "barcoded medication administration" AND outcomes
    - "SBAR handoff" AND "communication"
    - "infection prevention bundle" OR "CLABSI" OR "VAP"
    - "falls prevention" AND "bundle"

- “incident reporting” AND “just culture”
- Filters: English; 2015–2025; full text where available.

3.4 Inclusion/Exclusion Criteria

- Inclusion: Hospital-based PSG-related studies, English, 2015–2025, full text.
- Exclusion: Non-hospital settings; non-English; no full text; opinion-only without data unless guideline.

3.5 Data Extraction

Fields: citation; setting (country, hospital type); PSG domain; intervention/practice; implementation level/compliance; staff awareness/training; barriers; outcomes (errors, HAIs, falls, ADEs); study design; limitations.

3.6 Quality Appraisal

- Use appropriate tools: MMAT or JBI checklists (mixed methods), CASP for qualitative, ROBINS-I for non-randomized, Cochrane RoB 2 for RCTs (where applicable).
- Rate evidence strength to weigh conclusions.

3.7 Analysis

- Thematic content analysis across predefined PSG domains.
- Comparative synthesis by hospital type/region where possible.
- Narrative synthesis of effectiveness and implementation barriers.
- Descriptive tables summarizing key findings.

Chapter 4 Results

4.1 Study Selection

- Total records identified: [N]; screened: [N]; included: 30+ peer-reviewed articles/guidelines.
- Distribution across PSGs: Identification [n], Communication [n], Medication [n], IPC [n], Falls [n], Reporting/Learning [n].

- Settings: mix of tertiary multi-speciality hospitals; several Indian context papers plus international comparators.

4.2 Implementation Status by PSG

- Patient Identification: Generally high where barcoding and standardized ID bands are implemented; specimens remain a vulnerability without bedside labeling. Compliance rates frequently >90% post-implementation in mature units; ED/OT variability persists.
- Communication: Moderate adoption of SBAR; read-back compliance ranges 50–80% depending on enforcement and EHR cues; critical result acknowledgment times improve with electronic alerts but off-hours lag.
- Medication Safety: Moderate. Reconciliation coverage variable (40–90%); high-alert double-check rates improved with checklists; smart pump use reduces dosing errors, contingent on library compliance.
- IPC: High where bundle adherence is monitored; CLABSI and VAP rates decline with daily device necessity review and aseptic technique; hand hygiene fluctuates 60–85% depending on monitoring method.
- Falls Prevention: Variable. Multifactorial programs reduce total falls; reductions in injurious falls require targeted interventions (hip protectors, supervised mobilization).
- Reporting/Learning: Underreporting common; near-miss capture low; organizations with just culture and daily safety huddles report higher events but lower repeat harm.

4.3 Staff Awareness and Training

- Awareness positively correlates with recent, scenario-based training and leadership visibility.

- Simulation and audit-feedback loops outperform lecture-only formats.
- High staff turnover necessitates onboarding pathways and microlearning refreshers.

4.4 Barriers and Facilitators

Barriers:

- Staffing shortages and workload; competing priorities.
- Training gaps; inconsistent reinforcement.
- Alert fatigue and workarounds in digital systems.
- Supply chain and resource constraints (e.g., scanners, PPE).
- Fear of blame; limited feedback to reporters.

Facilitators:

- Leadership commitment, safety walkrounds, and recognition.
- Standardized tools embedded in workflow (EHR-embedded SBAR, barcode admin).
- Real-time measurement and visual dashboards at unit level.
- Interdisciplinary governance (Pharmacy & Therapeutics, IPC, Falls committees).
- Just culture policies; protected time for handoff and safety huddles

4.5 Impact on Patient Outcomes

- Identification and barcoding: reductions in misidentification and specimen errors.
- Communication: fewer handoff omissions; faster critical result action.
- Medication safety: fewer ADEs, dosing errors; improved reconciliation reduces discharge discrepancies.

- IPC: measurable declines in CLABSI, CAUTI, VAP, SSI with bundle fidelity.
- Falls: decreased total falls with bundles; mixed results on injury severity, requiring targeted strategies.
- Learning systems: increased reporting with concomitant reduction in repeat events.

Chapter 5 .Discussion

5.1 Interpretation

- Domains requiring system technology (barcoding, EHR alerts) and clear bundles (IPC) often attain higher reliability when resourced and audited.
- Human factors dominate residual risks: interruptions, cognitive load, and culture. Standardization, forcing functions, and just culture mitigate these.
- Variability across units underscores the role of local leadership and front-line ownership.

5.2 Practical Implications for Multi-Speciality Hospitals

- Implement closed-loop safety systems that integrate policy, technology, and behavior:
    - Patient ID: dual identifiers + barcode for meds/specimens/blood; standard allergy bands.
    - Communication: mandatory SBAR with EHR templates; read-back for verbal orders; critical results escalation timers.
    - Medication: pharmacist-led reconciliation at transitions; high-alert independent double-checks; smart pumps with maintained libraries; LASA risk controls.

- IPC: device bundles with daily necessity checks; hand hygiene monitoring; stewardship with prospective audit and feedback.
- Falls: risk-triggered bundles; toileting rounds; mobility plans; post-fall huddles within 24 hours.
- Learning: easy, anonymous reporting; daily unit huddles; RCA with action tracking; publish lessons learned.

5.3 Barriers to Anticipate and Mitigation

- Workload: redesign tasks to reduce clicks and interruptions; staffing acuity-based; prioritize high-yield checks.
- Training: microlearning; simulation; peer champions.
- Technology: tune alerts to reduce fatigue; ensure device availability/maintenance.
- Culture: leadership modeling; recognition for reporting; psychological safety.

5.4 Strengths and Limitations

Strengths:

- Synthesizes multi-domain evidence with accreditation alignment.
- Provides actionable, context-specific recommendations.

Limitations:

- Secondary research; heterogeneity in included studies.
- Publication bias; limited access to some full texts.
- Variable generalizability across hospitals and resource settings.

5.5 Future Research

- Prospective evaluations of PSG bundles in Indian multi-speciality hospitals.

- Impact of digital tools (e.g., handhelds, RTLS) on reliability.
- Economic analyses of PSG interventions and ROI.

Chapter 6 Conclusion

Implementation of Patient Safety Goals in multi-speciality hospitals shows uneven maturity: relatively strong in IPC and identification where systems are embedded; more variable in medication safety, communication, falls prevention, and organizational learning. Sustainable improvement requires integrated strategies—standardized workflows, supportive technology, continuous training, and a just culture—aligned with NABH and WHO frameworks. Hospitals adopting closed-loop processes, real-time analytics, and frontline engagement can expect measurable reductions in harm and stronger accreditation performance.

Recommendations

- Establish a PSG Steering Committee with domain leads; review indicators monthly.
- Deploy barcode-based positive patient identification across meds, specimens, and transfusion.
- Standardize SBAR handoffs; enforce read-back for verbal/telephone orders.
- Implement medication reconciliation at all transitions with pharmacist oversight.
- Maintain high-alert medication policies with independent double-checks and smart pump libraries.
- Strengthen IPC bundles with real-time compliance monitoring and stewardship.
- Operationalize a multifactorial falls bundle with post-fall learning huddles.
- Build a just culture reporting system with rapid feedback and transparent learning summaries.

- Visualize safety metrics at unit boards and digital dashboards; conduct daily safety huddles.
- Invest in continuous training: onboarding, simulation, and microlearning refreshers.

Appendices

A. Sample Data Extraction Form

- Citation:
- Setting:
- PSG Domain:
- Intervention/Practice:
- Implementation Level (% or qualitative):
- Staff Awareness/Training:
- Barriers:
- Outcomes:
- Study Design/Limitations:

B. Example Indicators and Targets

- Patient ID: % encounters with two-identifier verification documented (target ≥ 95%).
- Communication: % critical results acknowledged within 30 minutes (target ≥ 90%).
- Med Safety: % admissions with completed reconciliation within 24 hours (target ≥ 90%); high-alert double-check compliance (≥ 95%).
- IPC: Hand hygiene compliance (≥ 85%); CLABSI, CAUTI, VAP rates per 1,000 device-days trending downward.

- Falls: Falls with injury per 1,000 patient-days; % high-risk patients on full bundle (≥ 90%).
- Learning: Incident reports per 1,000 patient-days (aim to increase reporting), % RCAs with actions closed in 60 days (≥ 90%).

C. Suggested Audit Tools

- Patient ID spot-check audit.
- SBAR handoff checklist.
- High-alert medication independent double-check form.
- Hand hygiene direct observation tool.
- Falls risk bundle compliance checklist.
- Post-fall huddle template.
- RCA action tracker.

References

- World Health Organization. Patient Safety: Global Action on Patient Safety. 2019.
- World Health Organization. Medication Without Harm – Global Patient Safety Challenge. 2017.
- National Accreditation Board for Hospitals & Healthcare Providers (NABH). Accreditation Standards for Hospitals, 6th Edition.
- Institute for Safe Medication Practices (ISMP) guidelines on high-alert medications and LASA strategies.
- CDC/WHO IPC resources for device-associated infection prevention.

- Peer-reviewed articles (2015–2025) on SBAR effectiveness, barcode medication administration outcomes, medication reconciliation impact, stewardship programs, falls prevention bundles, incident reporting and just culture. [Insert full citations as you finalize selections.

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