UNDERREPORTING OF ERRORS COMPROMISING PATIENT SAFETY"

A dissertation submitted in partial fulfillment of the requirements
For the award of

Post-Graduate Diploma in Health and Hospital Management

By

Richa Mehra
under the guidance of

International Institute of Health Management Research
New Delhi -11007

MAY, 2011

"UNDERREPORTING OF ERRORS COMPROMISING PATIENT SAFETY"

A Dissertation Summary Report for

Post Graduate Diploma in Health and Hospital Management

By

Richa Mehra

Roll No.PG/09/039

Under the guidance of

Dr. Ruchira Solanki.
Director(Operations)
(Hospital)
Tagore Hospital & Research Centre,Jaipur
Jaipur

Anupama Sharma
Assistant Professor
IIHMR,New Delhi

International Institute of Health Management Research

New Delhi -11007

MAY, 2011

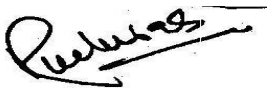
Certificate of Internship Completion

Date:11-04-2011

TO WHOM IT MAY CONCERN

This is to certify that Dr. Richa Mehra has successfully completed his 3 months internship in our organization from January 10, 2011 to April 10, 2011. During this intern he has worked on the projct of "Underreporting of errors-compromising patient safety" under the guidance of me and my team at Tagore Hospital.

We wish him/her good luck for his/her future assignments



Dr. Ruchira Solanki

Director(Operations)

Certificate of Approval

The following dissertation titled "**Underreporting of error-compromising patient safety**" 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

Name	Signature
_____	_____
_____	_____
_____	_____

Certificate from Dissertation Advisory Committee

This is to certify that **Dr. Richa Mehra**, 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 "**Underreporting of error-compromising patient safety** " 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.

Dr. Ruchira Solanki

Director Operations

Tagore Hospital & Research centre,

Jaipur

Ms. Anupama Sharma

Assistant Professor

IIHMR

ABSTRACT

Underreporting of error-compromising patient safety

Patient safety (the avoidance and prevention of patient injuries or adverse events resulting from the processes of health care delivery) has become a major academic and public concern in healthcare. In order to promote and sustain a culture of safety in a healthcare organization, healthcare professionals stress the need to understand both individual and system contributions to error events.

The purpose of this research is to identify the systems factors that nurses perceive as contributing to a culture of patient safety and to study the effects these perceptions have on nurses' participation and engagement in the patient safety culture at Tagore Hospital & Research Centre,Jaipur. Tagore's system was utilized as the theoretical framework for this study.

This study used a quantitative research methodology with a descriptive design. The sample of this study was registered RNs at Tagore,Jaipur. The Hospital Survey on Patient Safety Culture (HSOPSC) instrument was used to measure perceptions of nurses on patient safety culture.

Copies of the surveys were distributed to 80 RNs. A total of 66 questionnaires were returned. Among these returned questionnaires,1 was excluded because they had missing responses on more than one complete section of the questionnaire. The total response rate for this study was 83%.

Overall, 45% of the nurses positively perceived patient safety culture at Tagore Hospital, which is considered an opportunity for improvement for those areas needing improvement. Nurses responded most positively to two dimensions, teamwork within unit and organizational learning. Nurses responded most negatively to the dimensions of hospital handoffs and transitions, communication openness, non-punitive response to error, and frequency of event reporting,staffing in hospital.

There were significant differences between nurses' perceptions of patient safety culture and gender, age, years of experience and length of shift; but astonishingly, for level of education, the results were not significantly correlated to any of the HSOPSC dimensions.

Findings from this study provide a description of the current status of patient safety at Tagore Hospital,Jaipur from the nurses' perspective. 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

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. Ruchira Solanki,Director(Operations),Tagore Hospital & Research Center,Jaipur my external guide who provided me a caring and supporting and throughout my training period.

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

I acknowledge the moral support and encouragement provided by my friends at the every stage of my study.

TABLE OF CONTENTS

PART -1

INTERNSHIP REPORT

Tagore Hospital & Research Centre, Jaipur

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 Tagore Hospital & Research Institude as a quality manager on dated 1st January 2011.

1.1 History of Tagore Hospital & Research Centre :

The Hospital was inaugurated by **H.E Shri Bhairon Singh Ji Shekhawat**, the then The Vice President of India and **H.E Smt. Pratibha Patil Ji**, the then Governor of Rajasthan & now The President of India on 31st march 2006. The Hospital was created with the aim of providing comprehensive medical resources under one roof, while maintaining the highest standards of excellence. Not only have the most renowned specialists been brought together here, but our consistent investment and belief in technology has ensured that anyone who comes to us gets the benefit of very best that medical science can provide.

Company policies & procedures.

(1) MOTTO: AAROGYA – PARMO DHARMAH
(2) OUR MISSION:
(3) TO BE THE LEADING HEALTHCARE ORGANIZATION PROVIDING EFFICIENT AND COST EFFECTIVE HEALTHCARE SOLUTIONS WITH HUMANITARIAN TOUCH.
(4) OUR VISION :
(5) TO PROVIDE HIGH QUALITY & COST EFFECTIVE MEDICAL SERVICE DELIVERED WITH PERSONAL TOUCH.

About Hospital

THRI is a 100 bedded(operational) and 300 beded (proposed) well equipped multi facility hospital to meet the Health Services need of community of Jaipur & Near by villages of Jaipur City. The THRI, Jaipur was established in the year 2006 .It has been functioning under the administrative control of the Director Shri P.D Singh Ji.

Our quality objectives:

(1)To work and propagate for promoting better health amongst the public, and to work for social upliftment of the society.
(2)To arrange for the reception and treatment of persons suffering from illness.
(3)To show the love of god through the care of the patient in his physical, mental and spiritual needs.
(4)To set up, manage and organize hospitals, dispensaries, and such medical institutions for achieving the objectives of the Trust.
To provide training programmes for doctors, nurses and paramedical workers whenever possible.

1.2 Services offered by THRI:-

- Department of Medicine
- Department of Surgery
- Department of Obs. & Gynae
- Department of Paediatrics and Gynaecology.
- Department of Ortho: -
- Department of Critical Care
- Department of Anaesthesiology and critical care
- Department of Dentistry
- Department of Urology

- Department of ENT: -
- Department Of Dermatology
- Department Of Ophthalmology
- Department Of Gastroenterology
- Plastic Surgery
- Department of emergency
- Ambulance Services.

Services not available at THRI

- **I**nvasive Cardiology
- Oncology
- MRI

FACILITY LAYOUT

HOSPITAL DIRECTORY:

BASEMENT	GROUND FLOOR

• Canteen
• Parking
• Gas Manifold
	• OPD:
	  ○ General Surgery
	  ○ General Medicine
	  ○ Gynaecology
	  ○ Paediatrics
	  ○ Dental
	  ○ Dietary
	  ○ Orthopaedics
	• Laboratory
	• Radiology Department
	• Medical Superintendent Office
	• Reception – for OPD & Investigations
	• Investigations report collection counter
	• Physiotherapy
	• Emergency Department

FIRST FLOOR • Administrative Block • Consultant's Rooms • Accounts department • Conference Room • TPA • Research Room • OPDs (Non functioning) • Stores • Medical Records Dept.	SECOND FLOOR • Male Ward • Female Ward & Paediatric Ward • Semi- Deluxe • Deluxe • Super Deluxe • Suite classes • Nursing Supervisor's room • Doctor duty room
THIRD FLOOR • OT 1& 2 • NICU • CSSD • Endoscopy Room • Labour Room • Lithotripsy	FOURTH FLOOR • ICU

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 organisation where improvement is required and where management knowledge & skills can be imparted.

Department Visited-

To execute the dissertation, it was indispensable to visit all the department in the hospital but some of key department are enumerated below-

Clinical-

- OPD
- IPD
- ICU
- Operation Theatre
- Neonatal ICU
- Emergency
- Laboratory
- Radiology
- Knee Clinic

Non clinical-

- CSSD
- Pharmacy
- Medical Record Department

- Store
- Laundry
- Cashless services
- Dietary Department
- Housekeeping
- Security
- Mortuary

1.2Managerial Tasks-

To be a part of NABH core group-

1)Prepare Hospital for final assessment of NABH.

2)To administer the hospital in coordination with medical superintendent & improve the utilization of hospital services.

3)Preparing training schedule,sending circulars and organising training for all hospital staff and analysing the effectiveness of imparted training.

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

5)Documenting the minutes of meeting and preparing the action taken report of all committee meetings.

6) To conduct employer & patient satisfaction survey and then analysing them and send a report to hospital management.

7) To take infection control round with infection control nurse and analysing infection related rates.

8)Human resource files of all nurses and doctors and higher authorities were completed by initially checking for their degrees and adding up their credentials and previliges in each files,hence to complete Human resource file.

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

10)An internal assessment was done and report was made and sent to management and worked on every non-compliance.

11)Collecting Data from all department related to quality indicators and then calculating and analysing it.

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 behavioural communication.

PART 2

DISSERTATION REPORT

2.1INTRODUCTION-

The definition of patient safety has evolved from untoward events related to heath care in hospitals and work around anesthesia error monitoring to a broader content and context, requiring complex interventions. The 1999 report of the United States Institute of Medicine, to err is human, brought patient safety to public and political attention.[2]

It is generally agreed that patient safety can be defined as freedom for a patient from Unnecessary harm or potential harm associated with health care. Medical errors can occur at various stages during the provision of health care, such as during prevention, diagnostics, treatment and follow up. Errors can include communication failures, equipment failures and other system failures. Rather comprehensive taxonomies have been developed due to the difficulty in setting boundaries at the conceptual level[4,]The intricate relationships within the complex environment of health care practices have been further illustrated by the eight direct definitions and seven complementary descriptions using safety as an entry point, identified through the World Health Organization (WHO) International Classification for Patient Safety.

Subsequently, patient safety could be viewed in a practical way as the mechanisms, tools, underlying resources and required actions to reduce and ultimately avoid unintentional harm to patients. These can cover any aspect of care, including organizational factors, health-care personnel, the systems and environments that can contribute to a safety breach (i.e. prevalence of health-care acquired infections, diagnostic and medication errors, addressing more specific risks associated with certain treatments, medicines or devices, etc.).

While patient safety is a complex issue spanning numerous public health and health-care domains, this document adopts a generic understanding of the subject in respect to avoidable harm[8]. As such, most of the patient safety interventions chosen have a general and cross-cutting character and do not include the many complementary and dedicated actions developed at various levels of the health system and beyond. Moreover, as patient safety is constantly developing better ways to respond to health, economic, social and environmental challenges, the

Document is to be seen as a 'snapshot' of the current state of patient safety culture in Tagore Hospital,Jaipur.

Organizational culture is an important determinant of patient safety in healthcare organizations. Research efforts in various countries have focused on assessment safety culture. Dimensions of safety culture have been linked to several healthcare outcomes such as medication errors, device or product event, urinary tract infections, surgical events, criminal events.

2.2Background

National Accreditation Board for Hospitals and Healthcare Providers (NABH) is a constituent board of Quality Council of India, set up to establish and operate accreditation programme for healthcare organizations.

NABH is an institutional member of the International Society for Quality in Health Care (ISQua)

The board while being supported by all stakeholders including industry, consumers, government, has full functional autonomy in its operation. **Patients** are the biggest beneficiaries.Accreditation results in high quality of care and patient safety. The patients get services by credential medical staff. Rights of patients are respected and protected. Patient satisfaction is regularly evaluated.**Hospital** gets stimulated for 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. **Staff** in an accredited hospital is satisfied lot as it provides for continuous learning, good working environment, leadership and above all ownership of clinical processes.It improves overall professional development of Clinicians and Paramedical staff and provides leadership for quality improvement within medicine and nursing. [11]

NABH Standard

Standard is a statement that defines the structures and processes that must be substantially in place in an organization to enhance the quality of care. It has **Objective Element.** It is a measurable component of a standard. Acceptable compliance with objective elements determines the overall compliance with a standard. To develop standards one need to organize around important functions

- Focus on patient and staff safety
- Set standards that all organizations must pass
- To be revised periodically and raise the “bar”
- Achieve International recognition

The standards provide framework for quality assurance and quality improvement for hospitals.

For ensuring NABH standards should be implemented and integrated in the hospital functioning, patient safety is one of the issues. The following section discusses about the need of event reporting and reasons for underreporting..

As Tagore Hospital is going for NABH accreditation,according to NABH the standard of 6th chapter of nABH that is Continous Quality Improvement(CQI) demands that sentinel events are reprted by hospital.The standard of the chapter is as follows:

“Sentinel Events are intensively analyzed”

Measurable Elements of the standard:

- The organization has defined sentinel event.
- The organization has established process for intense analysis of such events.

2.3Significance of Study

My observation of last 3 months as a Quality Manager of Tagore Hospital,Jaipur is that There is a problem of practice whereby errors are not reported. Errors can be differentiated as an incident, mistake, and event. An “incident” is an action which can result in an unexpected consequence. A “mistake” refers to using wrong judgment. An “event” is the resulting outcome of an error. For the purposes of this study,
Incident, mistakes and events are collectively referred to as errors.

Fig.2.3(a) Number of Sentinel Event

We can easily figure out from the below diagram that in the entire period of 6 months only 3 sentinel events were reported in MAY-2010.

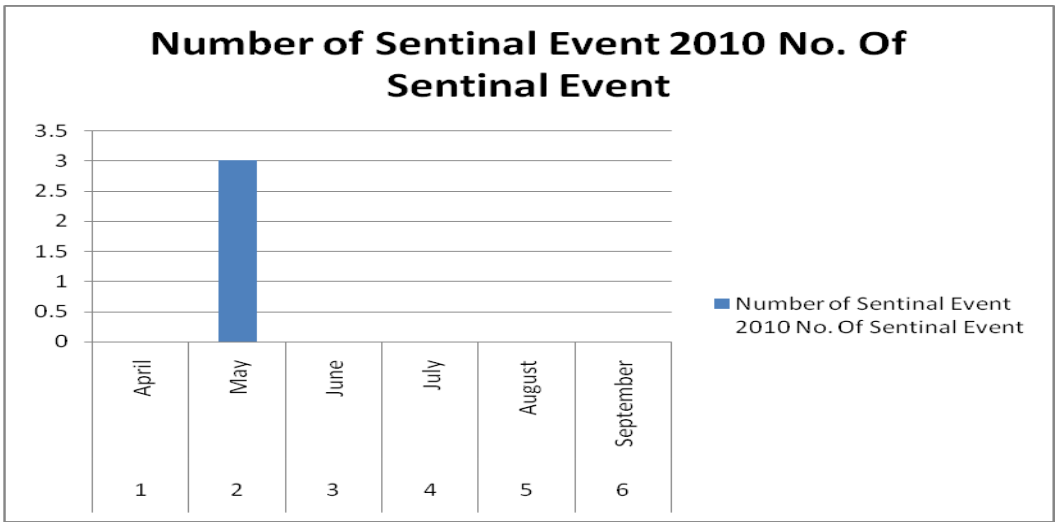
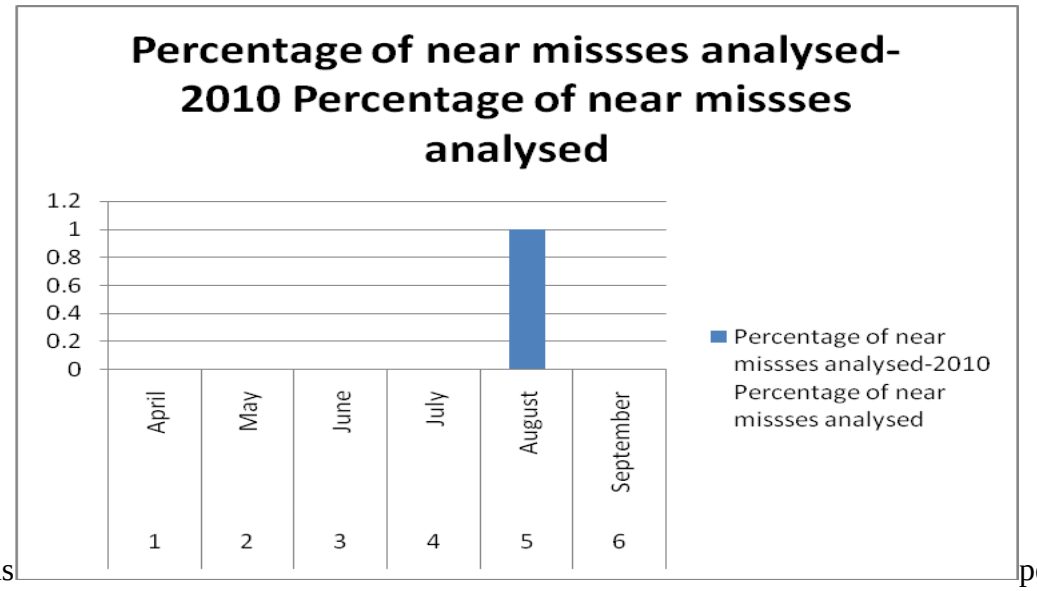


Fig-2.3(b) **no. of near miss event**

This graph depicts the underreporting practice of error in Tagore hospital.Only 1 near miss error was reported in 6



months period.

Purpose of analyzing sentinel events-

Having established process for intense analysis of sentinel events comprehensively describe the hospital's commitment to patient safety.

Health Alert: There is a problem of practice whereby errors are not reported. Unreported errors and misattribution of errors not only affect patient safety and health, but may increase the risk for patient harm in the future. For example, the British Journal of Healthcare Computing & Information Management published an article describing two patients whom died in a Los Angeles hospital, reportedly because the alarms on monitors failed to sound an alert. The monitor data logs documented the sequence of events that led to the alarm failures. Both patients were physically disconnected from the monitor for more than eight hours. Although these adverse medical events were originally attributed to equipment failures, during the discovery phase of litigation the actual cause was proven to be human error. The information originally reported markedly differed from the actual event.[5]

As this case demonstrates, often there is a significant discrepancy between what is reported and what actually happens. Errors appear to be attributed to another source inappropriately or not reported at all. This gap impedes the error epidemiology process and raises additional questions on how errors are defined and reported.

This study addresses the following questions:

1. What are the barriers to reporting patient error?
2. Why is error reporting necessary?
3. knowledge, skill, practices, systems of patient safety culture in Tagore hospitalSeveral initiatives have been implemented to improve safety mainly through establishing standards and initiating accreditation schemes. Despite the rising emphasis on patient safety, little is known about safety culture in hospitals, and few attempts have been made to evaluate the extent to which safety is a strategic priority or that organisational culture supports patient safety. Thus, the purpose of this study is to evaluate the extent to which organisation culture supports patient safety in Tagore hospital and the extent to which safety is a strategic priority.

2.4The Problem Statement"-There is a problem of underreporting of errors in Tagore Hospital. Unreported errors and misattribution of errors not only affect patient safety and health, but may increase the risk for patient harm in the future.

The connection to reporting and analyzing data from sentinel events needs to be linked to improvement in patient safety. Motivating staff to report involves feedback, acknowledgement and positive reinforcement of the value of the event report.

How patient errors are defined and reported can provide insight on why errors continue to occur in high numbers.

2.5The Research Problem & Research questions:

- What are the barriers of reporting patient error in hospital which compromise patient safety?

2.6 Objectives

The **general objective** of this study is to

To find out the barriers in event reporting and thus improving the quality of services provided at hospital on basis of Patient safety survey. To improve patient safety and quality of care through implementation of safety systems and creating a culture of safety.

The **specific objectives** are:

- To analyze the reporting level in different areas of hospital.
- The study was conducted to assess the need for developing a system & encourage error reporting in indoor patient.
- Attempt to explain why errors are underreported or barriers of underreporting.

- To assess and understand the issues at the time of delivery of care to patient.

- To develop a strategic plan to improving the patient safety standards.

The ultimate objective of the study is to identify opportunities for improvement and to establish baseline for assessing future improvement efforts.

2.7Review of Literature

Patient safety is a serious concern all over the world, as a consequence of increased awareness of the issue. While health care has become more effective it has also become more complex, with greater use of new technologies, medicines and treatments. Health services are treating older and sicker patients who often present with significant co-morbidities requiring increasingly difficult decision-making in health care prioritization. Economic constraints are leading to often overloaded and besieged health-care environments. Reduced revenues and increasing expenditures in times of financial crisis are likely to increase pressure on the health systems to further contain costs, and thus affect service quality and patient safety.[3] Evidence has shown that health systems must be strengthened to face current and future challenges in maintaining and increasing the health status of populations and their quality of life. Weak legal and regulatory oversight of health service delivery, inappropriate infrastructure, including outdated or overused technologies, insufficiently distributed, trained or simply exhausted health-care personnel, uninformed patients/consumers, are all factors which usually converge in various proportions towards the occurrence of safety failures. Unexpected/ unwanted events might take place in all settings where health care is delivered. Medical errors and health-care related adverse events occur in between 8% and 12% of Hospitalizations. For example, the United Kingdom Department of Health, in its 2000 report, An organization with a memor, estimated that there were approximately 850,000 adverse events a year (10% of hospital admissions), while Spain in its National Study of Adverse Events, France and Denmark have presented incidence studies with similar results.[1]

What Are The Barriers to Reporting Patient Errors?

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) supports patient safety standards that encourage a culture of safety . To that end, Liang (2000) emphasizes JCAHO's policy to encourage organizations to voluntarily report sentinel events.

"A sentinel event is defined as an unexpected serious patient adverse event resulting in death or having a serious 6 psychological affect or physical injury including the loss of a limb or physical function (ABS Consulting, 2004).

JCAHO's attempt to mandate disclosure of sentinel events is of great concern to the medical community. They fear error data will be used to **blame** rather than to improve patient delivery care and these same concerns resonate within hospital cultures. This is sometimes referred to as the "name, blame, and shame" culture (Jeffe et al., 2004 p. 475). Jeffe et al. (2004) conducted a study on barriers to patient error reporting. Their research focused on identifying perceived barriers to reporting. Like the Jeffe et al. (2004) study, a study by Uribe et al. (2002) focused on contributing factors to the underreporting of medical errors and the perceived barriers to reporting. Wakefield et al. (1999) focused their study on the 'why' question to answer why patient errors are not reported.[10]

Safety problems are believed to arise from safety violations and unintentional errors and mistakes. Studies show that the majority of errors and adverse events more accurately stem from a complex chain of events that jointly contribute to the cause rather than human errors. Efforts to minimize these injuries have led to the patient safety movement, and the generally accepted definition of patient safety is the prevention and reduction of adverse outcomes or injuries stemming from the processes of health care.

Underreporting can be attributed to various organizational and individual factors that "Ultimately prevent individuals from generating a formal report. In their search to answer the "why' question for not reporting, (Wakefield, Wakefield, UdenHolman, & Blegen, 1996) found the staff **lacked an understanding of the organization's** reporting process. Errors went unreported if the staff didn't **have access to the report** forms or to the computers to file a report. When the staff did not recognize that an error occurred, believed the error was a nonissue, felt embarrassed, or if they feared punitive action, reports were not submitted

(Wakefield, Wakefield, UdenHolman,& Blegen, 1996)[9]. Using paper reporting forms can also be problematic.

The reporting process starts when an adverse event occurs involving a patient. The unit staff reports an error following policies, procedures, and guidelines on who, what, when and how to report errors provided by the hospital. As of 2001, 73% of the hospitals represented at the second annual Partnership Symposium had not automated their error reporting systems and were still using a paper reporting system. The paper reporting process could take up to six months to filter through the organization before it reached the quality assurance and risk management departments. Once the paper report was received by the quality and risk management departments, the information was entered into a computer for analysis.[6]

This process adds additional barriers. First, the forms are processed through the organization slower than if an electronic reporting system is used.

Second, the information in the reports is sometimes illegible and/or incomplete.

Third, since patient data is confidential, the paper processing system can inadvertently pose a security problem.

Fourth, reports can get lost, misplaced, or photocopied.

The process of completing a report is perceived as taking too much out of the Caregiver's time. The Jeffe et al. study (2004) supports this point of view. Their study Indicates providers feel patient care prerequisites take priority over completing error reports. This is similar to the findings of Uribe et al. (2002) that healthcare providers are focused on providing patient care and do not have the time to file a report.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 The Research Design:

The study design- This study used a descriptive & quantitative research methodology. Type of study is Cross Sectional Study (Quantitative). The present study was carried out in the Tagore Hospital,Jaipur in the period of 3 month from 10th Jan. to 10th April 2011

The Hospital Survey on Patient Safety Culture (HSOPSC) instrument was used to measure perceptions of nurses on patient safety culture.The instrument contains 42 items which will measure 12 dimension.AHRQ(Agency for health care research and quality) tool was used for data entry and its analysis.

The entire study was conducted in following steps-

Primary Data-

- Incident Reporting
- Questionnaire
- Informal discussion

Secondary Data-

- Web sites
- Literature review

Sample Size-includes all registered nurses working in clinical areas of Tagore hospital.It was 100% coverage of staff and thus sample size is 100% representative of staff.Copies of the surveys were distributed to 80 RNs. A total of 66 questionnaires were returned. Among these returned questionnaires, 1 was excluded because they had missing responses on more than one complete section of the questionnaire. The total response rate for this study was 83%.

3.2Safety Culture Dimensions Measured in the Survey

The survey places an emphasis on patient safety issues and on error and event reporting. The survey measures **seven unit-level** aspects of safety culture:

- Supervisor/Manager Expectations & Actions Promoting Safety (4 items),
- Organizational Learning—Continuous Improvement (3 items),
- Teamwork Within Units (4 items),
- Communication Openness (3 items),
- Feedback and Communication About Error (3 items),
- Nonpunitive Response to Error (3 items), and
- Staffing (4 items).

In addition, the survey measures **three hospital-level** aspects of safety culture:

- Hospital Management Support for Patient Safety (3 items),
- Teamwork Across Hospital Units (4 items), and
- Hospital Handoffs and Transitions (4 items).

Finally, four outcome variables are included:

- Overall Perceptions of Safety (4 items),
- Frequency of Event Reporting (3 items),
- Patient Safety Grade (of the Hospital Unit) (1 item), and
- Number of Events Reported (1 item).

3.3Data Collection The sample includes all registered nurses working in clinical areas of Tagore hospital shows 100% coverage of staff.A survey questionnaire was distributed hospital-wide in all patient care areas to .registered nurses. A total of 42 items were there in designed questionnaire. To each & every nurse, depending on the hospital size, 80-85 copies of the questionnaire were sent to staff members, usually the master trainer, along with instruction on distribution and collection of survey instrument.It was said to master trainers to encourage staff to participate in the study. . Once completed, all surveys were collected and picked up from the 2 master trainer(nursing supervisors).

3.4 The data analysis-

- Statistical tool used is AHRQ.

The survey includes 42 items that measure 12 dimensions of patient safety culture: communication openness, feedback and communication about errors, frequency of events reported, handoffs and transitions, management support for patient safety, non-punitive response to error, organisational learning—continuous improvement, overall perceptions of patient safety, staffing, supervisor/manager expectations and actions promoting safety, teamwork across units and teamwork within units. The questionnaire was kept in its original language (English), as English is the main language of communication in Hospital. Scores were expressed as the percentage of positive answers towards patient safety for each dimension.

The two lowest response categories have been combined (Strongly Disagree/Disagree and Never/Rarely) and the two highest response categories have been combined (Strongly Agree/Agree and Most of the time/Always). The midpoints of the scales are reported as a separate category (Neither or Sometimes). The percentage of answers corresponding with each of three response categories then is displayed graphically.

We define patient safety strengths as those positively worded items that about 75 percent of respondents endorsed by answering “Strongly Agree/Agree” or “Always/Most of the time” (or those negatively worded items that about 75% of respondents disagreed with). The 75 percent cutoff is somewhat arbitrary, and your hospital may choose to report strengths using a higher or lower cutoff percentage. Similarly, areas needing improvement are identified as those items that 50 percent or fewer respondents did not answer positively (they either answered negatively or “Neither” to positively worded items, or they agreed with negatively worded items). The cutoff percentage for areas needing improvement is lower, because if half of the respondents are not expressing positive opinions with regard to a safety issue, there probably is room for improvement.

The survey items are grouped into dimensions of safety culture, and then calculate one overall frequency for each dimension that is to create a composite frequency of the total percentage of positive responses for each safety culture dimension. Thus,Composites can be computed for or for the hospital as a whole.

3.5 Calculation Formulae-

- **Calculating Your Response Rate**

$$\frac{\text{Number of complete, returned surveys}}{\text{Number of surveys distributed} - (\text{ineligibles} + \text{incomplete surveys})}$$

(Minus) (Plus)

- **Composite Frequency**

$$\frac{\text{Number of positive responses to the items in the dimension}}{\text{Total number of responses to the items (positive, neutral, and negative) In the dimension}}$$

CHAPTER 4

RESULTS AND FINDINGS

After all data was collected, the next step is analyzing the data thoroughly for each dimension.

The Hospital Survey on Patient Safety Culture is designed to measure the following:

1) Two overall patient safety outcomes:
   1. Number of events reported
   2. Overall patient safety grade

   Twelve dimensions of culture related to patient safety:
   1. Teamwork Within Units
   2. Supervisor/Manager Expectations & Actions Promoting Patient Safety
   3. Organizational Learning--Continuous Improvement
   4. Management Support for Patient Safety
   5. Overall Perceptions of Patient Safety
   6. Feedback & Communication About Error
   7. Communication Openness
   8. Frequency of Events Reported
   9. Teamwork Across Units
   10. Staffing
   11. Handoffs & Transitions
   12. Nonpunitive Response to Error.

   The two lowest response categories have been combined (Strongly Disagree/Disagree and Never/Rarely) and the two highest response categories have been combined (Strongly Agree/Agree and Most of the time/Always). The midpoints of the scales are reported as a separate category (Neither or Sometimes). The percentage of answers corresponding with each of three response categories then are displayed graphically.

   - We define patient safety strengths as those positively worded items that about 75 percent of respondents endorsed by answering "Strongly Agree/Agree" or "Always/Most of the time" (or those negatively worded items that about 75% of respondents disagreed with).
   - Similarly, areas needing improvement are identified as those items that 50

percent or fewer respondents did not answer positively (they either answered negatively or "Neither" to positively worded items, or they agreed with negatively worded items.

4.1 Respondent Demographics –

Shows overall stats of who responded to the survey.

Respondent Demographics for Tagore Hospital & Research centre Jaipur

Your Hospital Completed Survey Data Collection	May-11

4.1(a)Survey Administration Statistics

Number of completed surveys (response rate numerator)	66
Number of surveys administered (response rate denominator)	80
Response rate	83%

4.1(b)Work Area/Unit (Survey Item: Ai)

	N	**%**
Many different units / No specific unit	22	33%

Medicine (non-surgical)	12	18%
Surgery	11	17%
Obstetrics	5	8%
Pediatrics	4	6%
Emergency department	4	6%
Intensive care unit (any type)	8	12%
Psychiatry / mental health	0	0%
Rehabilitation	0	0%
Pharmacy	0	0%
Laboratory	0	0%
Radiology	0	0%
Anesthesiology	0	0%
Other	0	0%
Total	66	100%
Missing	0	

4.1(c)Staff Position (Survey Item: H4)

H4)	**N**	**%**
Registered nurse	66	100%
Physician assistant / Nurse practitioner	0	0%
LVN / LPN	0	0%
Patient care asst / Aide / Care partner	0	0%
Attending / Staff physician	0	0%
Resident physician / Physician in training	0	0%
Pharmacist	0	0%
Dietician	0	0%
Unit assistant / Clerk / Secretary	0	0%
Respiratory therapist	0	0%
Physical, occupational, or speech therapist	0	0%

Technician (e.g., EKG, Lab, Radiology)	0	0%
Administration / Management	0	0%
Other	0	0%
Total	66	100%
Missing	0	

4.1(d)Interaction with Patients (Survey Item: H5)	**N**	**%**
YES, I typically have direct interaction or contact with patients	66	100%
NO, I typically do NOT have direct interaction or contact with patients	0	0%
Total	66	100%
Missing	0	

4.1(e)Time Worked in the Hospital (Years) (Survey Item: H1)	**N**	**%**
Less than 1 year	42	64%
1 to 5 years	24	36%
6 to 10 years	0	0%
11 to 15 years	0	0%
16 to 20 years	0	0%
21 years or more	0	0%
Total	66	100%
Missing	0	

4.1(f)Time Worked in Their Current Hospital Work Area/Unit (Years) (Survey Item: H2)	**N**	**%**
Less than 1 year	32	48%

1 to 5 years	29	44%
6 to 10 years	4	6%
11 to 15 years	1	2%
16 to 20 years	0	0%
21 years or more	0	0%
Total	66	100%
Missing	0	

4.1(g)Typical Hours Worked Per Week (Hours) (Survey Item: H3)	**N**	**%**
Less than 20 hours per week	5	8%
20 to 39 hours per week	2	3%
40 to 59 hours per week	54	82%
60 to 79 hours per week	4	6%
80 to 99 hours per week	0	0%
100 hours per week or more	1	2%
Total	66	100%
Missing	0	

4.1(h)Time Worked in Their Current Specialty or Profession (Years) (Survey Item: H6)	**N**	**%**
Less than 1 year	13	20%
1 to 5 years	42	64%
6 to 10 years	8	12%
11 to 15 years	3	5%
16 to 20 years	0	0%
21 years or more	0	0%
Total	66	100%
Missing	0	

4.2Composite-Level Scores - Shows the average percentage of positive responses for each patient safety culture area. Composite level scores are not calculated when an item in a composite has fewer than 3 respondents.

Composite results or scores measure 12 different areas of patient safety culture. They are calculated for each dimension by averaging the percent positive response on the items within a composite. For example, for a 3-item composite, if the item-level percent positive responses were 50 percent, 55 percent, and 60 percent, the hospital's composite-level percent positive response would be the average of these three percentages or 55% positive.

4.2(a)Composite-Level Results for Tagore Hospital & Research centre Jaipur

Patient Safety Culture Composites

This above graph depicts that Overall, 45% of the nurses positively perceived patient safety culture at Tagore Hospital, which is considered an opportunity for improvement for those areas needing improvement. Nurses responded most positively to two dimensions, teamwork within unit and organizational learning. Nurses responded most negatively to the dimensions of hospital handoffs and transitions, communication openness, non-punitive response to error, and frequency of event reporting,Staffing.

4.3 Item-Level Results

Now we are going in detail of all the 12 dimensions by calculating positive,Negative & Neutral response for each and every item.

DEFINITIONS OF POSITIVE, NEUTRAL & NEGATIVE

1) **Positive** is the percentage of responses that were rated a 4 or 5 (Agree / Strongly agree or Most of the Time / Always) for positively worded questions, or a 1 or 2 (Disagree / Strongly Disagree or Rarely / Never) for negatively worded questions.
2) **Neutral** is the percentage of responses that were rated a 3 (Neither or Sometimes) for any question.
3) **Negative** is the percentage of responses that were rated a 1 or 2 (Disagree / Strongly Disagree or Rarely / Never) for positively worded questions, or a 4 or 5 (Agree / Strongly agree or Most of the Time / Always) for negatively worded questions.

4.3Item-Level Results for Tagore Hospital & Research centre Jaipur

Number of responses=66

Fig.4.3-1. Teamwork Within Units

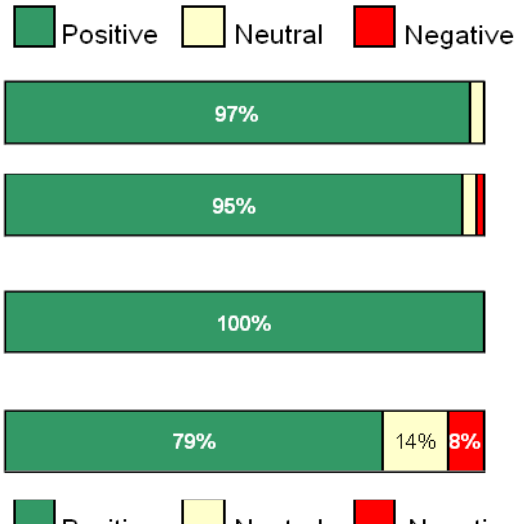


Fig.4.3-2. Supervisor/Manager Expectations & Actions Promoting Patient Safety

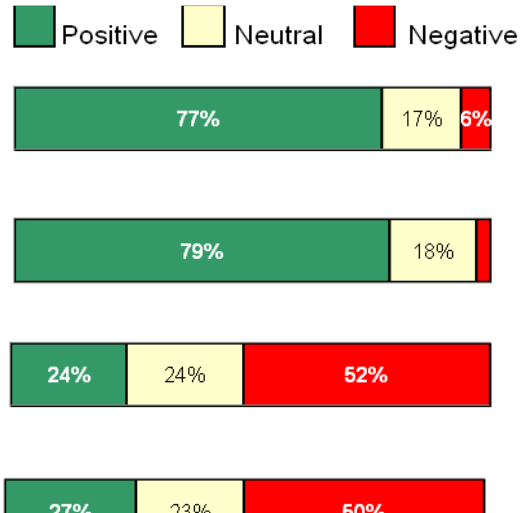


Fig.4.3-3. Organizational Learning—Continuous Improvement

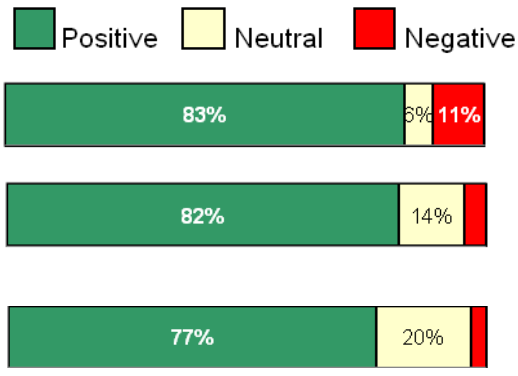
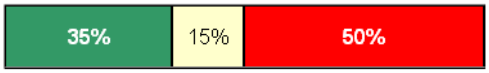


Fig.4.3-4. Management Support for Patient Safety

1. Hospital management provides a work climate that promotes patient safety. (F1)

2. The actions of hospital management show that patient safety is a top priority. (F8)

3. Hospital management seems interested in patient safety only after an adverse event happens. (F9R)



Note: 1) “R” = a negatively worded item; 2) Chart totals exclude missing & may not sum to 100% due to rounding; 3) M
= % of respondents with missing data; 4) Item data not displayed for fewer than 3 respondents; 5) % not displayed for
less.

Fig.4.3-5. Overall Perceptions of Patient Safety

1. It is just by chance that more serious mistakes don’t happen around here. (A10R)

2. Patient safety is never sacrificed to get more work done. (A15)

3. We have patient safety problems in this unit. (A17R)

4. Our procedures and systems are good at preventing errors from happening. (A18)

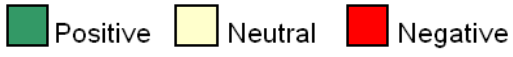
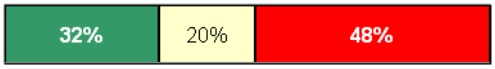
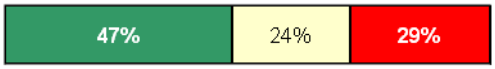


Fig.4.3- 6. Feedback and Communication About Error

1. We are given feedback about changes put into place based on event reports. (C1)



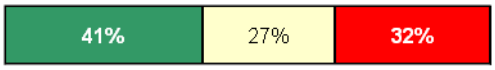
2. We are informed about errors that happen in this unit. (C3)



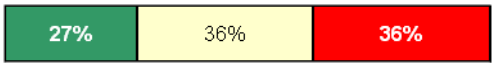
3. In this unit, we discuss ways to prevent errors from happening again. (C5)

Fig.4.3- 6. Feedback and Communication About Error 7. Communication Openness

1. Staff will freely speak up if they see something that may negatively affect patient care. (C2)



2. Staff feel free to question the decisions or actions of those with more authority. (C4)



3. Staff are afraid to ask questions when something does not seem right. (C6R)

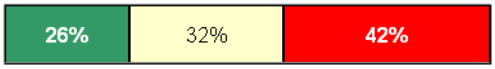
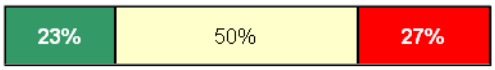
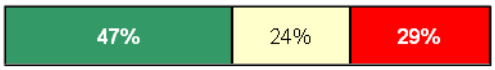


Fig.4.3-8. Frequency of Events Reported

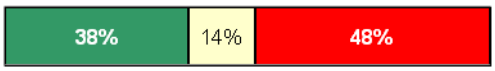
1. When a mistake is made, but is caught and corrected before affecting the patient, how often is this reported? (D1)



2. When a mistake is made, but has no potential to harm the patient, how often is this reported? (D2)



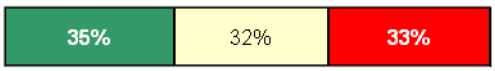
3. When a mistake is made that could harm the patient, but does not, how often is this reported? (D3)



Note: 1) “R” = a negatively worded item; 2) Chart totals exclude missing & may not sum to 100% due to rounding; 3) I
% of respondents with missing data; 4) Item data not displayed for fewer than 3 respondents; 5) % not displayed for 5

Fig.4.3-9. Teamwork Across Units

1. Hospital units do not coordinate well with each other. (F2R)



2. There is good cooperation among hospital units that need to work together. (F4)

3. It is often unpleasant to work with staff from other hospital units. (F6R)

4. Hospital units work well together to provide the best care for patients. (F10)

Fig.4.3-10. Staffing

1. We have enough staff to handle the workload. (A2)

2. Staff in this unit work longer hours than is best for patient care. (A5R)

3. We use more agency/temporary staff than is best for patient care. (A7R)

4. We work in “crisis mode” trying to do too much, too quickly. (A14R)

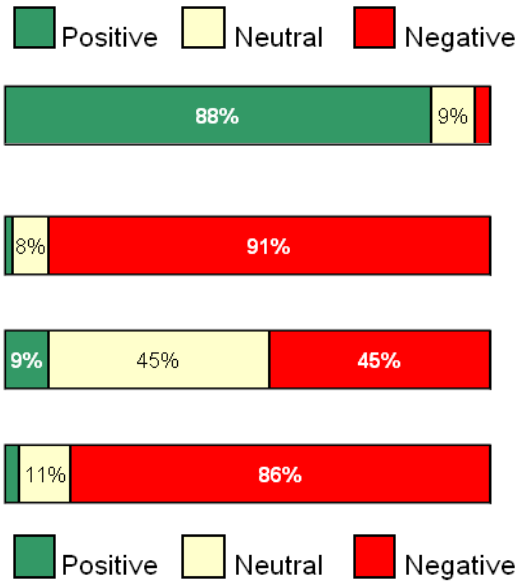


Fig.4.3-11. Handoffs & Transitions

1. Things “fall between the cracks” when transferring patients from one unit to another. (F3R)

2. Important patient care information is often lost during shift changes. (F5R)

3. Problems often occur in the exchange of information across hospital units. (F7R)

4. Shift changes are problematic for patients in this hospital. (F11R)

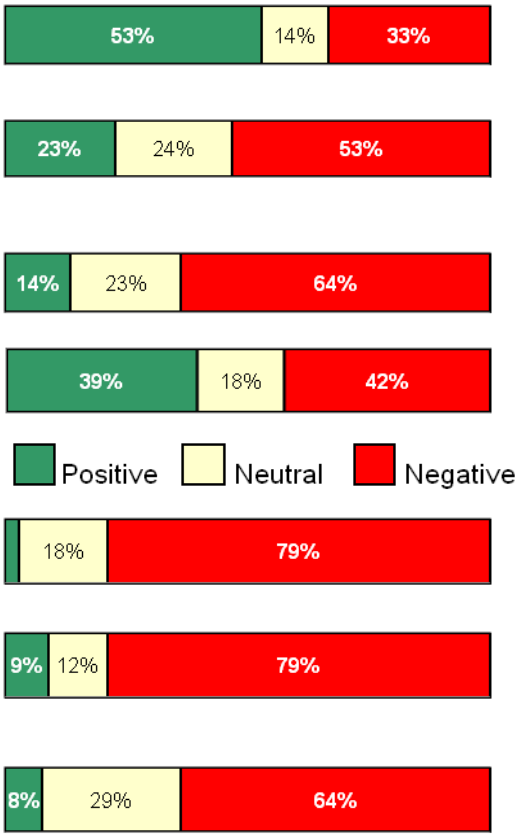


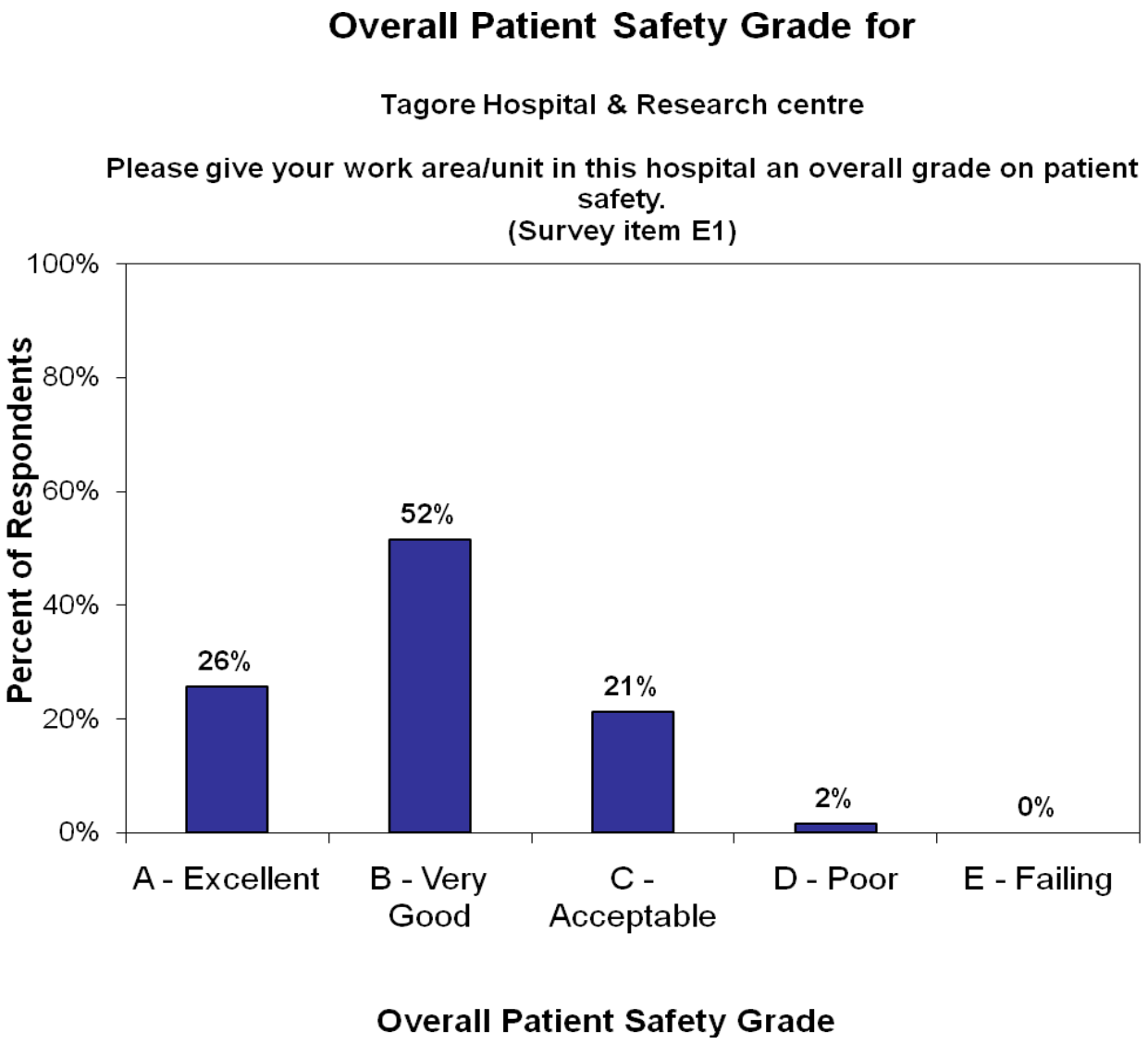
Fig.4.3-12. Nonpunitive Response to Error

1. Staff feel like their mistakes are held against them. (A8R)

2. When an event is reported, it feels like the person is being written up, not the problem. (A12R)

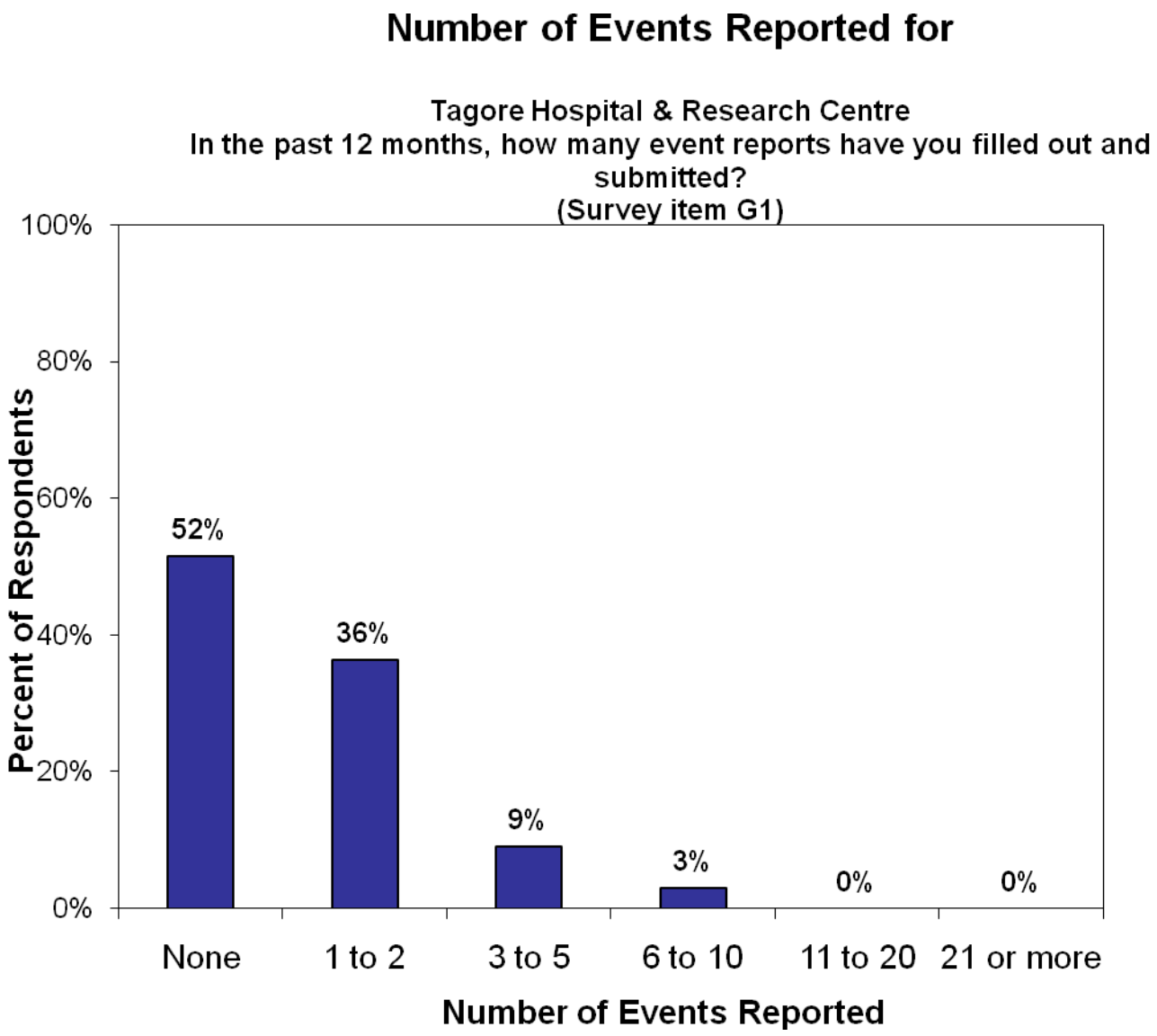
3. Staff worry that mistakes they make are kept in their personnel file. (A16R)

Note: 1) “R” = a negatively worded item; 2) Chart totals exclude missing & may not sum to 100% due to rounding; 3) M
= % of respondents with missing data; 4) Item data not displayed for fewer than 3 respondents; 5) % not displayed for
less.



4.4 Overall Patient Safety Grade-

Fig3.4(a)Above graph explains that 52% staff feel that the hospital is very good in terms of overall patient safety.This is a patient safety strength for Tagpre Hospital.



3.5 Number of Events Reported

Fig3.5(a) This graph shows that in the past two months 52% staff haven't filled out any report yet which is a patient safety weakness of Tagore hospita

3.6Patient Safety Strength & weakness based on data analysis-

(a)Strengths of Tagore Hospital

- Tagore has great teamwork within units.
- 97% nurses agree that People support one another in this unit
- 95% staff give positive response to when a lot of work needs to be done quickly, we work together as a team to get the work done
- 100% people treat each other with respect in hospital
- 79% staff believe that when one area in this unit gets really busy, others help out.
- 77% staff give positive response that supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures.
- 79% staff say that supervisor/manager seriously considers staff suggestions for improving patient safety.
- 83% nurses say that we are actively doing things to improve patient safety.
- 82% staff accept that mistakes have led to positive changes here
- After we make changes to improve patient safety, we evaluate their effectiveness, 77% staff agrees to it.
- 86% staff feel that hospital management provides a work climate that promotes patient safety
- 50% nurses feel that hospital management seems interested in patient safety only after an adverse event happens,
- 77% staff accept that our procedures and systems are good at preventing errors from happening
- 82% staff believe that there is good cooperation among hospital units that need to work together.
- 94 % nurses find that hospital units work well together to provide the best care for patients.

- 88% staff agree that We have enough staff to handle the workload
- 77% staff disagree that important patient care information is often lost during shift changes
- Shift changes are never problematic in Tagore Hospital.

(b)Weaknesses-

- 52% staff feel that whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts and supervisor/manager overlooks patient safety problems that happen over and over
- 68% staff complain that we are not given feedback about changes put into place based on event reports
- 53% staff disagree that we are informed about errors that happen in this unit.
- 60% staff feel that Staff will not freely speak up if they see something that may negatively affect patient care
- Only 27% nurses give positive response that staff feel free to question the decisions or actions of those with more authority
- 58% staff accept that staff are afraid to ask questions when something does not seem right
- Frequency of event reporting is not up to the mark in Tagore hospital. Only 27% staff report , . when a mistake is made, but is caught and corrected before affecting the patient.
- 55% staff say that hospital units do not coordinate well with each other.

- More than 50% staff complain that things “fall between the cracks” when transferring patients from one unit to another
- 97% Staff feel like their mistakes are held against them.
- When an event is reported, it feels like the person is being written up, not the problem,90% staff agree to it.
- 92% staff is worry that Staff worry that mistakes they make are kept in their personnel file.

CHAPTER -5

CONCLUSION

AND

RECOMMENDATIONS.

Overall, 45% of the nurses positively perceived patient safety culture at Tagore Hospital, which is considered an opportunity for improvement for those areas needing improvement. Nurses responded most positively to two dimensions, teamwork within unit and organizational learning. Nurses responded most negatively to the dimensions of hospital handoffs and transitions, communication openness, non-punitive response to error, and frequency of event reporting, Staffing.
The results from the survey can be used to diagnose the current status of patient safety culture; raise staff awareness about patient safety; evaluate the impact of patient safety interventions

Organizations with a positive safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures.

5.1Recommendation-

Patient safety culture, a specific aspect of an organization's overall culture, has received growing attention as a focus on patient safety in healthcare organizations has become an international priority.
So after listing down all the patient safety strengths and weakness of Tagore Hospital based on data analysis, now I am recommending a strategic plan for next one year to achieve the positive safety culture.

1) To establish a well defined error reporting system in hospital which is not only easy to follow but also have easy access to reporting formats from every department.
2) The reporting process starts when an adverse event occurs involving a patient.

To train and develop an understanding in staff about reporting an error following policies, procedures, and guidelines on who, what, when and how to report errors provided by the hospital.

3) To start a new system of giving "THANK YOU CARD" to staff on every error reporting and in the end of every month, who has maximum no. of cards will be given GIFT VOUCHER. It will encourage and motivate staff for error reporting.
4) To instruct supervisor to give in written if they find shortage of staff in any unit and should not build pressure on units if workload suddenly increases.
5) To conduct training of all unit incharges and informed them about errors that can happen in their unit.
6) To eliminate the "name, blame, and shame" culture because Staff fear that error data will be used to **blame** rather than to improve patient delivery care and these same concerns resonate within hospital cultures.

   For this management needs to take regular meetings and honour staff infront of everyone in the meeting if they report any sentinel event.

7) HR department should facilitate teamwork and interdiversity discipline among employees of different unit.
8) HR department can conduct different game sessions on particular day which will give employee a chance to know each other.
9) To instruct staff to come 15 minutes prior to given time so that they can take patient over in details and asks their doubts regarding patients.

   To introduce new patient over register which comprises all details of patient condition?

(10) Examine and address through education and training those behaviors that inhibit open communication between senior and subordinates and between physicians and nurses that put care at risk.

(11)Medical audit is a must to reduce errors and absolutely essential if we talk and mean about patient's safety and Quality care.

5.2 Conclusion-

Patient safety is a critical component of health care quality. As health care organizations continually strive to improve, there is a growing recognition of the importance of establishing a culture of safety. Achieving a culture of 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 expected and appropriate

This study determined that the patient safety culture dimensions and items included in the AHRQ Hospital Survey on Patient Safety Culture are overall sound for use by hospitals interested in assessing patient safety culture .

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

5.3Limitation of the study-

In hospital,patient safety concerns each and every healthcare worker but due to time constraint we could not cover overall staff working for patient care.

CHAPTER 5

REFERENCES

1.Pascal Carayon(2007) Handbook of human factor & ergonomics in health care Pages 152 – 185

2. John Sandars , Gary Cook (July 2007)ABC of patient Safety Pages 27-34

3. John Wiley & Sons: Hoboken, NJ(2010)Patient Safety Quality Digest,Second Edition page 110-143

4.Garry null(2004),Death by medicine,Page 322-467

5.A.H. Gibson(2004),Health Alert-underreporting of errors,402-449 vol2

6.Z.R. Wolf (2008),Error Reporting and Disclosure.

7. Russell and Taylor (2005). Operations Management – Quality and Competitiveness in a Global Environment. Fifth Edition. John Wiley and Sons .

8.NHSN manual,Patient safety protocol,JAN 2009.

9. Srinivasab AesV. managing & modern hospital, Response books A Division of sage publishers India (P) Ltd., New Delhi"(2000)Pg 53-69

10.Barriers of underreporting & patient safety culture seen on www.patientsafety.com.

11.Standards of NABH and introduction was seen on www.qci.org

Annexures

ANNEXURE-1

Hospital Survey on Patient Safety

Instructions

This survey asks for your opinions about patient safety issues, medical error, and event reporting in your hospital and will take about 10 to 15 minutes to complete.

If you do not wish to answer a question, or if a question does not apply to you, you may leave your answer blank.

*An **"event"** is defined as any type of error, mistake, incident, accident, or deviation, regardless of whether or not it results in patient harm.*

***"Patient safety"** is defined as the avoidance and prevention of patient injuries or adverse events resulting from the processes of health care delivery.*

SECTION A: Your Work Area/Unit

In this survey, think of your "unit" as the work area, department, or clinical area of the hospital where you spend *most* of your work time or provide *most* of your clinical services.

What is your primary work area or unit in this hospital? Select ONE answer.

☐ a. Many different hospital units/No

specific unit

☐ b. Medicine (non-surgical)
☐ c. Surgery
☐ d. Obstetrics
☐ e. Pediatrics
☐ f. Emergency department
☐ g. Intensive care unit (any type)
☐ h. Psychiatry/mental health
☐ i. Rehabilitation
☐ j. Pharmacy
☐ k. Laboratory
☐ l. Radiology
☐ m. Anesthesiology
☐ n. Other, please specify:

Please indicate your agreement or disagreement with the following statements about your work area/unit.

Think about your hospital work area/unit…	**Strongly Disagree** ▼	**Disagree** ▼	**Neither** ▼	**Agree** ▼	**Strongly Agree** ▼
1. People support one another in this unit	☐1	☐2	☐3	☐4	☐5
2. We have enough staff to handle the workload	☐1	☐2	☐3	☐4	☐5
3. When a lot of work needs to be done quickly, we work together as a team to get the work done	☐1	☐2	☐3	☐4	☐5
4. In this unit, people treat each other with respect	☐1	☐2	☐3	☐4	☐5
5. Staff in this unit work longer hours than is best for patient care	☐1	☐2	☐3	☐4	☐5

SECTION A: Your Work Area/Unit (continued)

Think about your hospital work area/unit…	**Strongly Disagree** ▼	**Disagree** ▼	**Neither** ▼	**Agree** ▼	**Strongly Agree** ▼

6. We are actively doing things to improve patient safety..	☐1	☐2	☐3	☐4	☐5
7. We use more agency/temporary staff than is best for patient care	☐1	☐2	☐3	☐4	☐5
8. Staff feel like their mistakes are held against them.....	☐1	☐2	☐3	☐4	☐5
9. Mistakes have led to positive changes here	☐1	☐2	☐3	☐4	☐5
10. It is just by chance that more serious mistakes don't happen around here	☐1	☐2	☐3	☐4	☐5
11. When one area in this unit gets really busy, others help out.....	☐1	☐2	☐3	☐4	☐5
12. When an event is reported, it feels like the person is being written up, not the problem	☐1	☐2	☐3	☐4	☐5
13. After we make changes to improve patient safety, we evaluate their effectiveness	☐1	☐2	☐3	☐4	☐5
14. We work in "crisis mode" trying to do too much, too quickly.....	☐1	☐2	☐3	☐4	☐5
15. Patient safety is never sacrificed to get more work done.....	☐1	☐2	☐3	☐4	☐5
16. Staff worry that mistakes they make are kept in their personnel file.....	☐1	☐2	☐3	☐4	☐5
17. We have patient safety problems in this unit	☐1	☐2	☐3	☐4	☐5
18. Our procedures and systems are good at preventing errors from happening.....	☐1	☐2	☐3	☐4	☐5

SECTION B: Your Supervisor/Manager

Please indicate your agreement or disagreement with the following statements about your immediate supervisor/manager or person to whom you directly report.

	Strongly Disagree ▼	Disagree ▼	Neither ▼	Agree ▼	Strongly Agree ▼
1. My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures	☐1	☐2	☐3	☐4	☐5
2. My supervisor/manager seriously considers staff suggestions for improving patient safety	☐1	☐2	☐3	☐4	☐5
3. Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts	☐1	☐2	☐3	☐4	☐5
4. My supervisor/manager overlooks patient safety problems that happen over and over	☐1	☐2	☐3	☐4	☐5

SECTION C: Communications

How often do the following things happen in your work area/unit?

Think about your hospital work area/unit…	Never ▼	Rarely ▼	Some-times ▼	Most of the time ▼	Always ▼
1. We are given feedback about changes put into place based on event reports	☐1	☐2	☐3	☐4	☐5
2. Staff will freely speak up if they see something that may negatively affect patient care.....	☐1	☐2	☐3	☐4	☐5
3. We are informed about errors that happen in this unit.....	☐1	☐2	☐3	☐4	☐5
4. Staff feel free to question the decisions or actions of those with more authority	☐1	☐2	☐3	☐4	☐5

5. In this unit, we discuss ways to prevent errors from happening again	☐1	☐2	☐3	☐4	☐5
6. Staff are afraid to ask questions when something does not seem right	☐1	☐2	☐3	☐4	☐5

SECTION D: Frequency of Events Reported

In your hospital work area/unit, when the following mistakes happen, *how often are they reported?*

	Never ▼	**Rarely** ▼	**Some-times** ▼	**Most of the time** ▼	**Always** ▼
1. When a mistake is made, but is *caught and corrected before affecting the patient*, how often is this reported?	☐1	☐2	☐3	☐4	☐5
2. When a mistake is made, but has *no potential to harm the patient*, how often is this reported?	☐1	☐2	☐3	☐4	☐5
3. When a mistake is made that *could harm the patient*, but does not, how often is this reported?	☐1	☐2	☐3	☐4	☐5

SECTION E: Patient Safety Grade

Please give your work area/unit in this hospital an overall grade on patient safety.

☐	☐	☐	☐	☐
A	**B**	**C**	**D**	**E**
Excellent	Very Good	Acceptable	Poor	Failing

SECTION F: Your Hospital

Please indicate your agreement or disagreement with the following statements about your hospital.

Think about your hospital…	Strongly Disagree ▼	Disagree ▼	Neither ▼	Agree ▼	Strongly Agree ▼
1. Hospital management provides a work climate that promotes patient safety.....	☐1	☐2	☐3	☐4	☐5
2. Hospital units do not coordinate well with each other	☐1	☐2	☐3	☐4	☐5
3. Things "fall between the cracks" when transferring patients from one unit to another.....	☐1	☐2	☐3	☐4	☐5
4. There is good cooperation among hospital units that need to work together	☐1	☐2	☐3	☐4	☐5

SECTION F: Your Hospital (continued)

Think about your hospital…	Strongly Disagree ▼	Disagree ▼	Neither ▼	Agree ▼	Strongly Agree ▼
5. Important patient care information is often lost during shift changes.....	☐1	☐2	☐3	☐4	☐5
6. It is often unpleasant to work with staff from other hospital units	☐1	☐2	☐3	☐4	☐5
7. Problems often occur in the exchange of information across hospital units	☐1	☐2	☐3	☐4	☐5
8. The actions of hospital management show that patient safety is a top priority.....	☐1	☐2	☐3	☐4	☐5
9. Hospital management seems interested in patient safety only after an adverse event happens.....	☐1	☐2	☐3	☐4	☐5
10. Hospital units work well together to	☐1	☐2	☐3	☐4	☐5

provide the best care for patients .....

11. Shift changes are problematic for patients in this hospital ..... ☐1 ☐2 ☐3 ☐4 ☐5

SECTION G: Number of Events Reported

In the past 12 months, how many event reports have you filled out and submitted?

☐ a. No event reports ☐ d. 6 to 10 event reports

☐ b. 1 to 2 event reports ☐ e. 11 to 20 event reports

☐ c. 3 to 5 event reports ☐ f. 21 event reports or more

SECTION H: Background Information

This information will help in the analysis of the survey results.

1. How long have you worked in this hospital?

☐ a. Less than 1 year ☐ d. 11 to 15 years

☐ b. 1 to 5 years ☐ e. 16 to 20 years

☐ c. 6 to 10 years ☐ f. 21 years or more

2. How long have you worked in your current hospital work area/unit?

☐ a. Less than 1 year ☐ d. 11 to 15 years

☐b. 1 to 5 years ☐ e. 16 to 20 years

☐ c. 6 to 10 years ☐ f. 21 years or more

3. Typically, how many hours per week do you work in this hospital?

☐a. Less than 20 hours per week ☐d. 60 to 79 hours per week

☐ b. 20 to 39 hours per week ☐ e. 80 to 99 hours per week

☐c. 40 to 59 hours per week ☐ f. 100 hours per week or more

SECTION H: Background Information (continued)

4. What is your staff position in this hospital? Select ONE answer that best describes your staff position.

- ☐ a. Registered Nurse
- ☐ b. Physician Assistant/Nurse Practitioner
- ☐ c. LVN/LPN
- ☐ d. Patient Care Asst/Hospital Aide/Care Partner
- ☐ e. Attending/Staff Physician
- ☐ f. Resident Physician/Physician in Training
- ☐ g. Pharmacist
- ☐ h. Dietician
- ☐ i. Unit Assistant/Clerk/Secretary
- ☐ j. Respiratory Therapist
- ☐ k. Physical, Occupational, or Speech Therapist
- ☐ l. Technician (e.g., EKG, Lab, Radiology)
- ☐ m. Administration/Management
- ☐ n. Other, please specify:

5. In your staff position, do you typically have direct interaction or contact with patients?

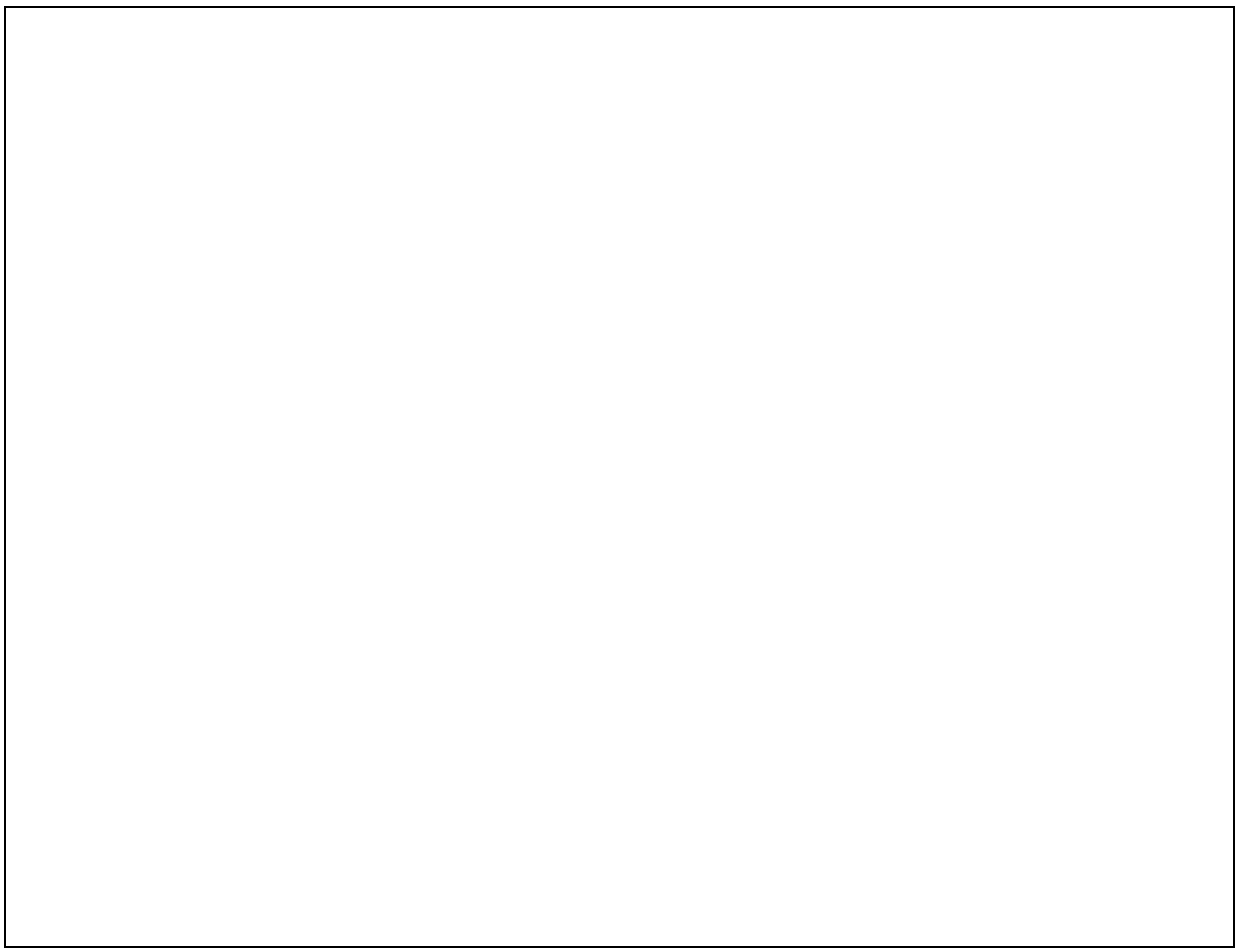
- ☐ a. YES, I typically have direct interaction or contact with patients.
- ☐ b. NO, I typically do NOT have direct interaction or contact with patients.

6. How long have you worked in your current specialty or profession?

- ☐a. Less than 1 year
- ☐ b. 1 to 5 years
- ☐ c. 6 to 10 years
- ☐ d. 11 to 15 years
- ☐ e. 16 to 20 years
- ☐ f. 21 years or more

SECTION I: Your Comments

Please feel free to write any comments about patient safety, error, or event reporting in your hospital.



Annexure-2

Sentinel event policy of Tagore Hospital.

I. Sentinel Events

In support of its mission to continuously improve the safety and quality of health care provided to the public, the Risk Management Committee reviews organizations' activities in response to sentinel events in its accreditation process, including all full accreditation surveys and random unannounced surveys and, as appropriate, for-cause surveys.

• A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

• Such events are called "sentinel" because they signal the need for immediate investigation and response.

• The terms "sentinel event" and "medical error" are not synonymous; not all sentinel events occur because of an error and not all errors result in sentinel events.

The purpose of the Sentinel Event Policy is to define the process for identification, reporting, investigation and management of sentinel events that occur in both public and licensed private health care facilities across hospital.

II. Goals of the Sentinel Event Policy

The policy has four goals:

1. To have a positive impact in improving patient care, treatment, and services and preventing sentinel events
2. To focus the attention of an organization that has experienced a sentinel event on understanding the causes that underlie the event, and on changing the organization's systems and processes to reduce the probability of such an event in the future
3. To increase the general knowledge about sentinel events, their causes, and strategies for prevention
4. To maintain the confidence of the public and accredited organizations in the accreditation process

III. Reportable sentinel events

Sentinel events are rare events that lead to catastrophic patient outcomes. The hospital board endorsed a list of sentinel events (see below).

Reporting of sentinel events is mandatory for all service staff. This includes both salaried and non-salaried visiting medical practitioners

Assessment should be based on clinical judgment, circumstances and context of the incident. Please see Attachment 1 for greater detail on the events outlined above. This list should be widely distributed throughout hospital.

IV. Reporting requirements

All level of staff is required to report sentinel events to the Risk Management Committee via the nursing of the unit within seven (7) working days of the event occurring.

Sentinel events must be reported using the Incident Reporting Form (Refer to Risk Management Guidelines) and include all relevant details as mentioned.

V. Investigation of sentinel events

Sentinel events often signal serious breakdowns in care systems and require thorough investigation and response. The investigation of a sentinel event should involve a comprehensive and systematic analysis of the facts to identify contributing factors. Recommendations and strategies should be developed and implemented to minimize the occurrence of similar events in the future. Hospital is committed to follow the standard for investigating high and extreme risk clinical incidents.

The principles of natural justice must be followed in every sentinel event investigation. Natural justice encompasses various rules of procedural fairness to achieve two basic principles:

i) persons involved in an incident must be given adequate opportunity to present their case, and

ii) decision-makers hearing the case must be unbiased.

There are a number of methodologies that can be used for investigating sentinel events. Root Cause Analysis (RCA) is one investigation methodology recommended.

Root Cause Analysis

Root cause analysis is a process for identifying the basic or causal factors that underlies variation in performance, including the occurrence or possible occurrence of a sentinel event.

A root cause analysis focuses primarily on systems and processes, not on individual performance. It progresses from special causes* in clinical processes to common causes† in organizational processes and systems and identifies potential improvements in processes or systems that would tend to decrease the likelihood of such events in the future or determines, after analysis, that no such improvement opportunities exist.

* Special cause is a factor that intermittently and unpredictably induces variation over and above what is inherent in the system. It often appears as an extreme point (such as a point beyond the control limits on a control chart) or some specific, identifiable pattern in data.

† Common cause is a factor that results from variation inherent in the process or system. Redesigning the process or system can reduce the risk of a common cause. In selecting an example, the organization may choose a "closed case" or a "near miss" to demonstrate its process for responding to a sentinel event.

Action Plan

The product of the root cause analysis is an action plan that identifies the strategies that the organization intends to implement in order to reduce the risk of similar events occurring in the future. The plan should address responsibility for implementation, oversight, pilot testing as appropriate, time lines, and strategies for measuring the effectiveness of the actions. Following an investigation, the Sentinel Event Final Report is to be forwarded to the Risk Management Committee within 45 working days of initial notification.

VI. Management of sentinel events

As a result of a sentinel event there are a number of actions that need to be taken. Hospital is committed to develop management pathways for the immediate care and management of patients involved and considers staff and families who may be distressed by these events.

ATTACHMENT 1

List of sentinel events

Sentinel event: An unexpected incident, related to system or process deficiencies, which leads to death or major and enduring loss of function for a recipient of health care services.

1. Surgical events

   a) Surgery performed on the wrong body part
   b) Surgery performed on the wrong patient
   c) Wrong surgical procedure performed on the wrong patient
   d) Retained instruments in patient discovered after surgery/procedure
   e) Patient death during or immediately post surgical procedure
   f) Anesthesia related event

2. Device or product events Patient death or serious disability associated with:

   a) the use of contaminated drugs, devices, products supplied by the organization
   b) the use or function of a device in a manner other than the device's intended use
   c) the failure or breakdown of a device or medical equipment
   d) intravascular air embolism

3. Patient protection events

   a) Discharge of an infant to the wrong person
   b) Patient death or serious disability associated with elopement from the health care facility
   c) Patient suicide, attempted suicide, or deliberate self-harm resulting in serious disability
   d) Intentional injury to a patient by a staff member, another patient, visitor, or other
   e) Any incident in which a line designated for oxygen or other came to be delivered to a patient and contains the wrong gas or is contaminated by toxic substances
   f) Nosocomial infection or disease causing patient death or serious disability

4. Environmental events

   Patient death or serious disability while being cared for in a health care facility associated with:

a) a burn incurred from any source
b) a slip, trip, or fall
c) an electric shock
d) the use of restraints or bedrails

5. Care management events

a) Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products
b) Maternal death or serious disability associated with labour or delivery in a low-risk pregnancy
c) Medication error leading to the death or serious disability of patient due to incorrect administration of drugs, for example:
    i. omission error
    ii. dosage error
    iii. dose preparation error
    iv. wrong time error
    v. wrong rate of administration error
    vi. wrong administrative technique error
    vii. wrong patient error
d) Patient death or serious disability associated with an avoidable delay in treatment or response to abnormal test results

6. Criminal events

a) Any instance of care ordered by or provided by an individual impersonating a clinical member of staff
b) Abduction of a patient
c) Sexual assault on a patient within or on the grounds of the health care facility
d) Death or significant injury of a patient or staff member resulting from a physical assault

Annexure 3

Table- Task Timeline for Project Planning:

Task Timeline for Project Planning	Preparation Planning	week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8
Prepare survey material		✓							
Prepare data collection scheduled		✓							
Distribution of survey material			✓						
Collecting data from source 2				←	—	—	→		
Collecting data from source 2							✓		
Data analysis								←	→