

To Evaluate The Hospital Service Quality And Standard From A Patient Safety Perspective

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I. Introduction

Accreditation is “A public recognition of the achievement of accreditation standards by a healthcare organization, demonstrated through an independent external peer assessment of that organization’s performance in relation to the standards”ⁱ. Accreditation proves to be the best parameter for the quality standards of the hospital and it gives access to reliable and valid information about the facilities, the level of care and treatment as well as the infrastructure in a healthcare facility. The place where healthcare is provided to the population to fulfill the social needs should be a safety umbrella. Failure while identifying the errors of patient safety issues leads to increase in error events.ⁱⁱ

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 standards for healthcare organizations in Hospitals. NABH Accreditation is a beneficial level of standard for all stake holders. Patients are the major stakeholders which takes the advantage from the accreditation. Accreditation results in matching the desired standard and helps in comparing the actual performance and the desired performance of the healthcare provider and ensuring high quality of treatment and facilities. NABH helps to protect the rights of patients and helps in evaluating the satisfaction level of patients. The staffs working in an accredited hospital is satisfied and it provides continuous learning process under good working environment, strong leadership and above all ownership of clinical processes. To comply with these standards, the hospital should have standard operating procedure and protocols in all aspects of activities that takes place in the hospital, starting from enquiry, registration, admission, any operating procedures and post-operative treatment till the follow up of the patient when he originally starts to recover. The policies should be transparent enough for all the stakeholders and protocols should be followed properly. NABH have total of 10 chapters out of which 5 have patient centric approach and 5 are having management centric approach with 102 standards and 683 objective elements. Origin of Patient Safety Concept (Hippocratic Oath) – I will prescribe regimens for the good of my patients according to my ability and my judgments and “never do harm” to anyone. Improvement in the measures/aspects of patient safety reduces harm. Hospitals have its primary function to keep people safe and ensure a comfortable stay. The main objective of patient safety is to prevent harm occurring to patients. The safety of the patients is of paramount important. Patient safety has always been the priority in healthcare organizations. Implementation of patient safety has improved the hospital and patients both clinically and non-clinicallyⁱⁱⁱ. There are national guidelines given on patient safety and International Standards with respect to patient safety given for maintaining safety in healthcare facility, this helps in enhancing the relationship with the stake holders. To improve patient safety, error must be prevented, rectified or at least minimized. To ensure the patient safety devices (grab bars, bed rails, sign posting, safety belts on stretchers and wheel chairs, alarms both visual and auditory where applicable, warning signage’s like radiation or biohazard, call bells, fire safety devices etc.) should be installed in the healthcare facility and should be inspected periodically.^{iv}

Patient Safety can be of these types:

- Information Safety
- Communication Safety
- Medication Safety
- Diagnostic Safety
- Treatment Safety
- Environmental Safety

The patient consciousness level must be monitored to prevent any possible danger of falling for patients during sleep precautions like side rail, decreasing bed height must be taken, call bells as well as other patient safety devices which are responsible for preventing any mishappening in the organization with the

patient. Patient safety devices and Infrastructure are installed across the organization and inspected periodically. Provisions are made available for periodically challenged/vulnerable person as per regulatory requirement example special toilet for physically challenged.^v

International Patient Safety Goals (IPSG) help accredited organizations address specific areas of concern in some of the most problematic areas of patient safety.^{vi}

Goal 1: Identify patients correctly

Goal 2: Improve effective communication

Goal 3: Improve the safety of high-alert medications

Goal 4: Ensure safe surgery

Goal 5: Reduce the risk of health care-associated infections

Goal 6: Reduce the risk of patient harm resulting from falls

Types of Errors while maintaining patient safety:

1. **Adverse Event** – Any event or omission arises during treatment which causes physical and psychological injury to patient.
2. **Health care near misses** – Situation in which an event arising during clinical care falls to develop further, whether as the result of compensating action, thus preventing injury.
3. **Sentinel event** – Any unanticipated or unpredicted event in healthcare which is responsible or death or any serious harm to patients and is not related to natural illness of patient.
4. **Adverse Drug Reaction** – Unwanted effect caused by the administration of drugs.
5. **Medication Error** – Any prevented event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of healthcare profession patient or consumer.

Patient safety covers both employees and patient in a healthcare facility. It is a managerial and organizational concern in healthcare. Patient safety is directly proportional to the quality of the hospital. Patient safety also includes the reporting and prevention of medication errors which can cause further to adverse drug reaction of adverse drug event. Most of the events which can increase the chances of harm to patient safety are preventable and can be stopped if continuously monitored. Sometimes the cause of infection can be the poor management. The study carried out was hospital based cross sectional study conducted in one of the multi-speciality hospitals with under graduates, Post Graduated and other allied staff persons. All permanent front-line health care workers servicing in the hospital for more than 6 months of time period were included as a part of the study^{vii}. A questionnaire for survey in the hospital was developed by Agency Healthcare Research Quality from United State of America. After taking consent from people, the questionnaire was filled with the help of randomly selected participants. The main outcome variable “perception regarding patient safety culture” was assessed through the modified questionnaire. A 5-point Likert scale was used in the questionnaire (1-strongly disagree, 2-disagree, 3-neither agree or nor disagree, 4-agree, 5-strongly agree). Information such as age, gender, experience and occupation of the patient was also collected. The result of the study almost concluded like, the overall response rate in the study was around 91%. The dimensions “teamwork within the Unit” “organizational learning and continuous improvement” and “supervisor or officer – in-charge expectation” have shown the highest positive responses. And this paper has given an answer for the research question like, what are the patient safety devices in a hospital and evaluating them considering the guidelines given by NABH and International standards for patient safety.

HYPOTHESIS

Patient safety devices in the hospital are appropriate and maintained time to time by the hospital.

OBJECTIVE: To know about the patient safety device in one multi specialty hospital and also to analyze the following patient safety device according to the International Patient Safety Goals –

- Patient identification
- Nursing call bell
- Stretchers
- Wheel chairs
- Bed (Side Rails)
- Proper Disclaimer in Washroom
- Electrical Boards
- Emergency call bell
- Fire Extinguishers
- Refrigerator
- **Patient Identification:** Throughout the healthcare industry, the failure to correctly identify patients continues to result in medication errors, transfusion errors, testing errors, wrongperson procedures, and the discharge of infants to the wrong families. The practice of having the patient involved in identifying

themselves and using “two patient identifiers” is essential in improving the reliability of the patient’s identification process. The use of two identifiers also helps ensure that a correct match is made between the service or treatment and the individual. This process will help eliminate errors and enhance patient care.

METHODOLOGY and PROJECT DESIGN: - The project design used in this study is “**description**”.

SAMPLING: -Convenient Random Sampling

DATA COLLECTION:- The data is collected form Primary Source (Direct Observation)

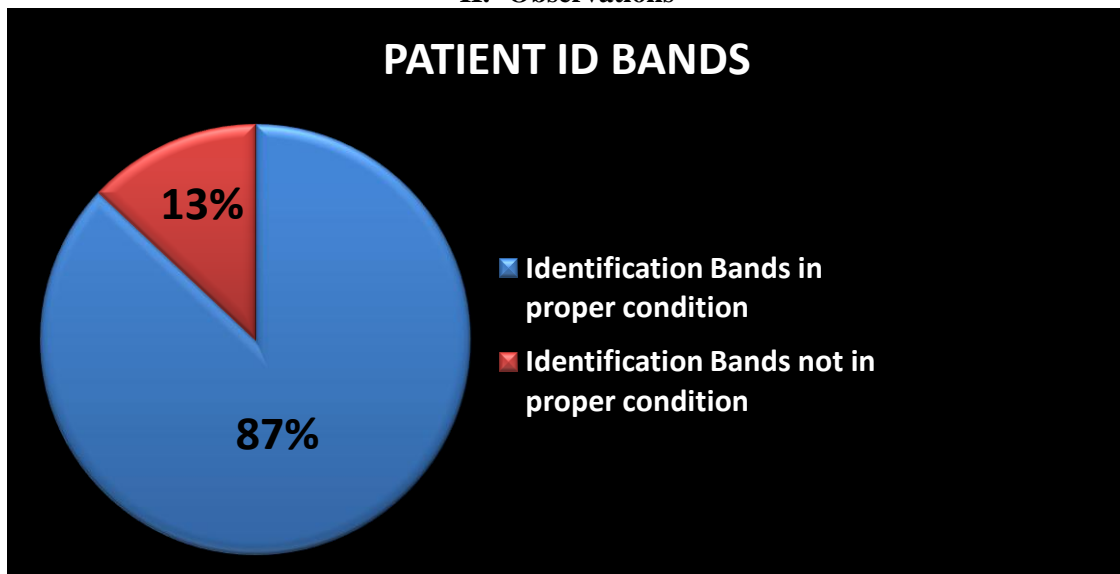
TYPE OF DATA: -Real time Data

STUDY DURATION: -7 weeks

INSTRUMENT: -A structured checklist has been used for collection of the data from various department of the hospital.

STATISTICAL TOOL: -MS-Excel is used to analyze the data.

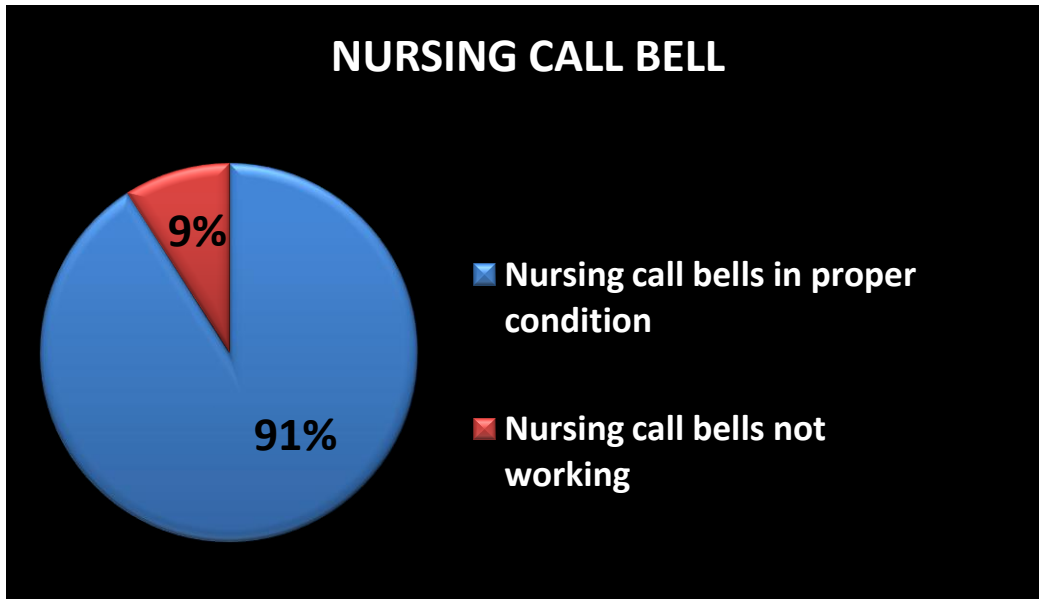
II. Observations



Compliance in Patient ID Bands

Patient ID bands	Total(50)
Proper condition	7
Improper condition	43

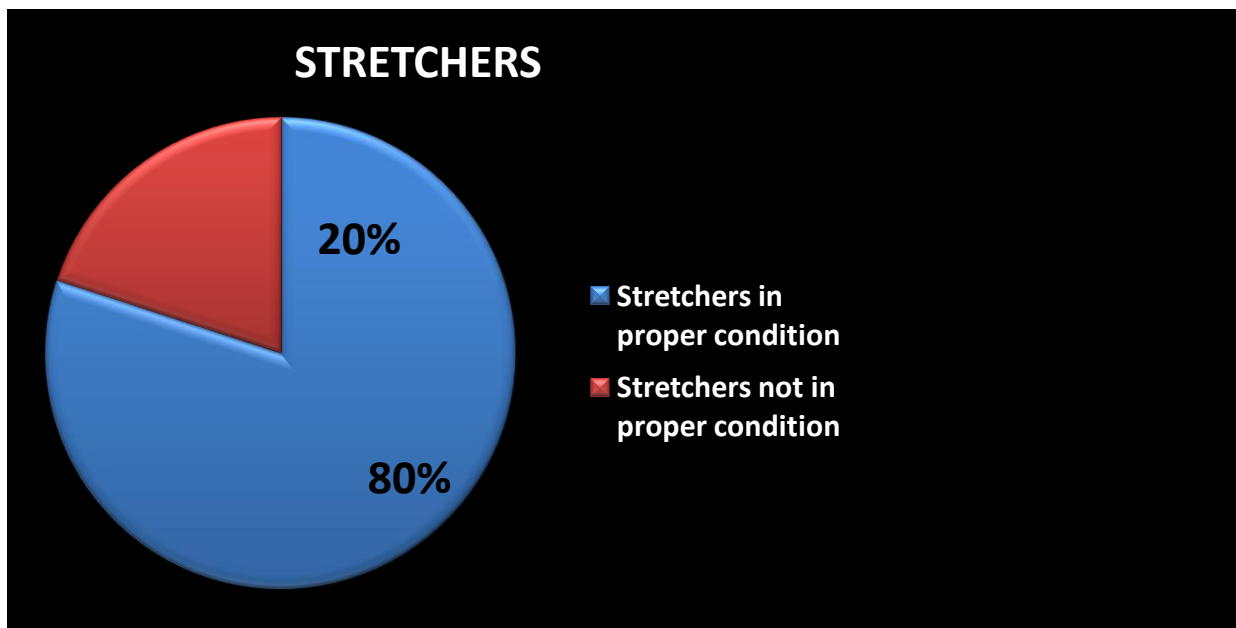
Interpretation: It is found that 13% of the patient are having proper identification band and rest 87% are not having proper identification band.



Compliance in Nursing Call Bells

Nursing call bell	Total(50)beds
Proper condition	5
Not working condition	45

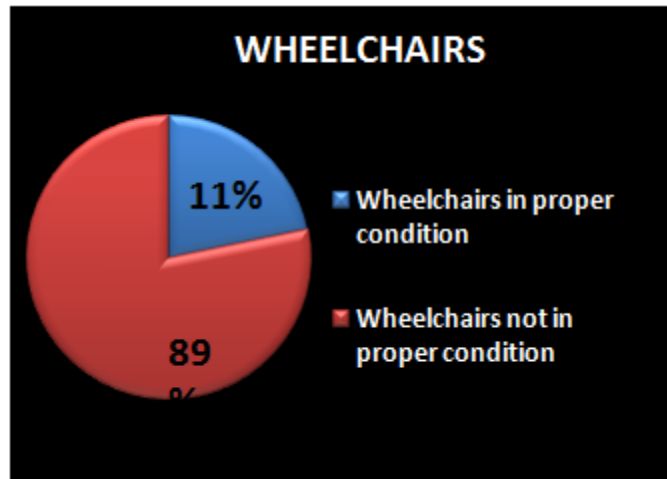
Interpretation: It is found that only 9% nursing call bell are in proper condition and rest 91% call bells are not working.



Compliance in Stretchers

Stretchers	Total(50)
Proper Condition	10
Improper Condition	40

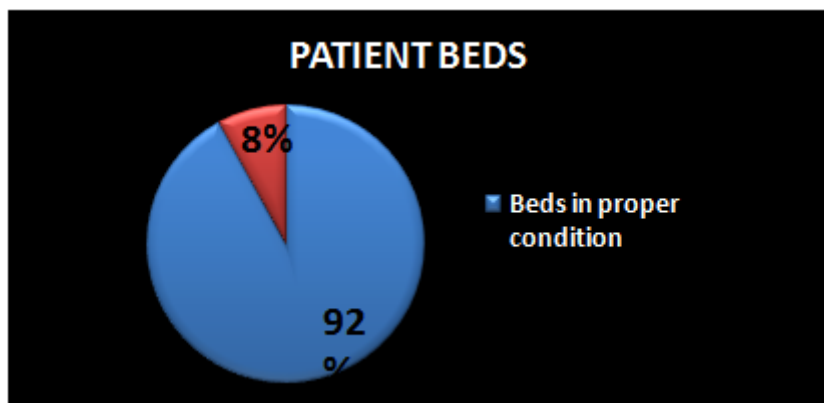
Interpretation: It was found that only 20% stretchers are in proper condition and rest 80% are not in proper condition.



Compliance in wheelchair

Wheelchair	Total(50)
Proper condition	6
Improper condition	44

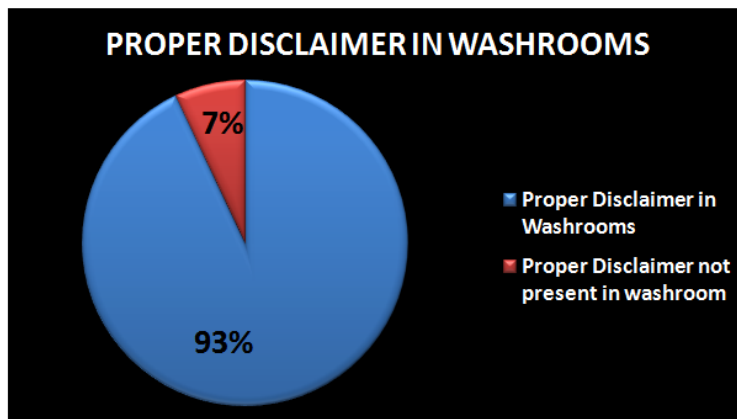
Interpretation: It was found that 11% of the wheelchairs are in proper condition and rest 89% are not in proper condition.



Compliance in Patient Beds

Beds condition	Total (50)
Proper condition	4
Improper condition	46

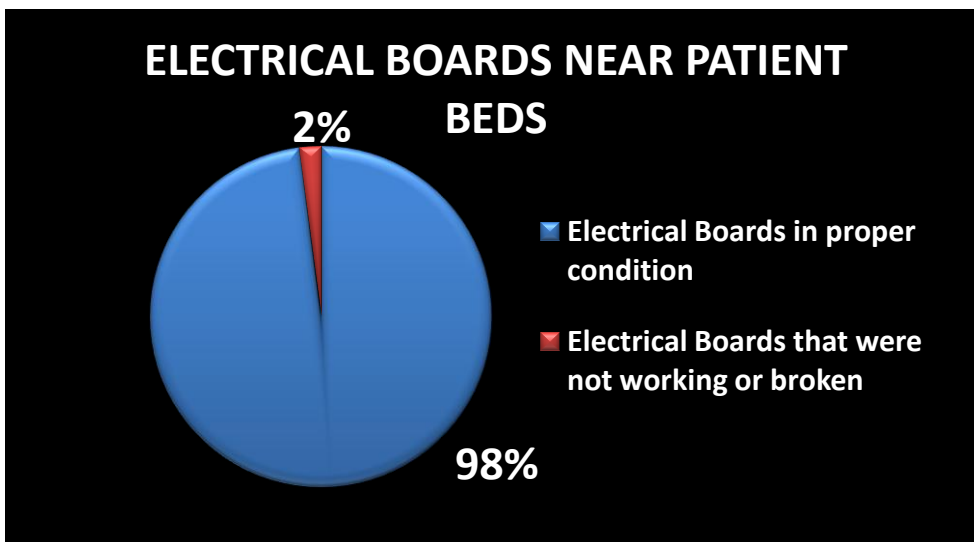
Interpretation: It was found that only 8% are beds are in proper condition and rest 92% beds are not in proper condition.



Compliance in Disclaimer in Washrooms

Total (12)	
Proper condition	1
Improper condition	11

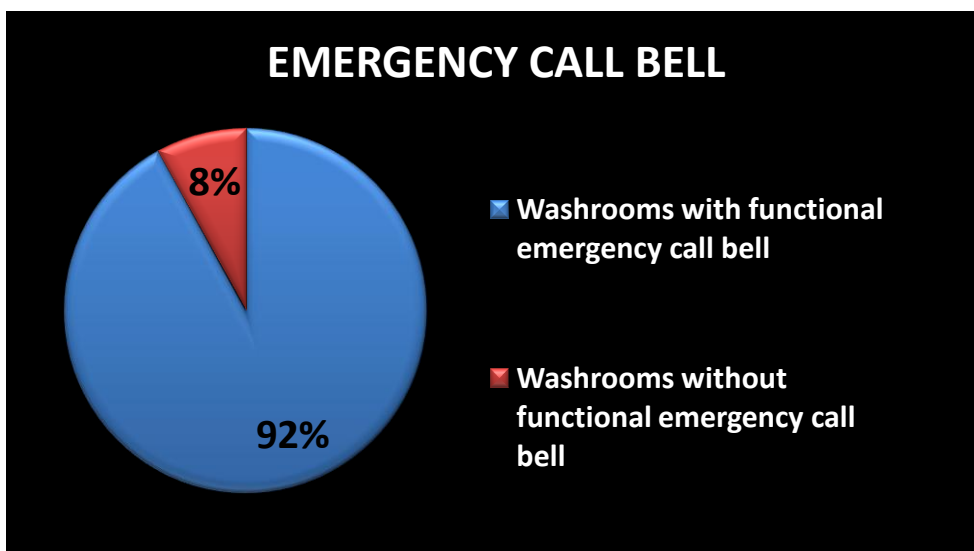
Interpretation: It was found that 7% disclaimer in washrooms are in proper condition, rest 93% are not in proper condition.



Compliance in Electrical Boards

Electrical boards	Total (50)
Proper condition	1
Non working condition	49

Interpretation: It was found that 2% electrical boards are working rest 98% are damaged or not working.

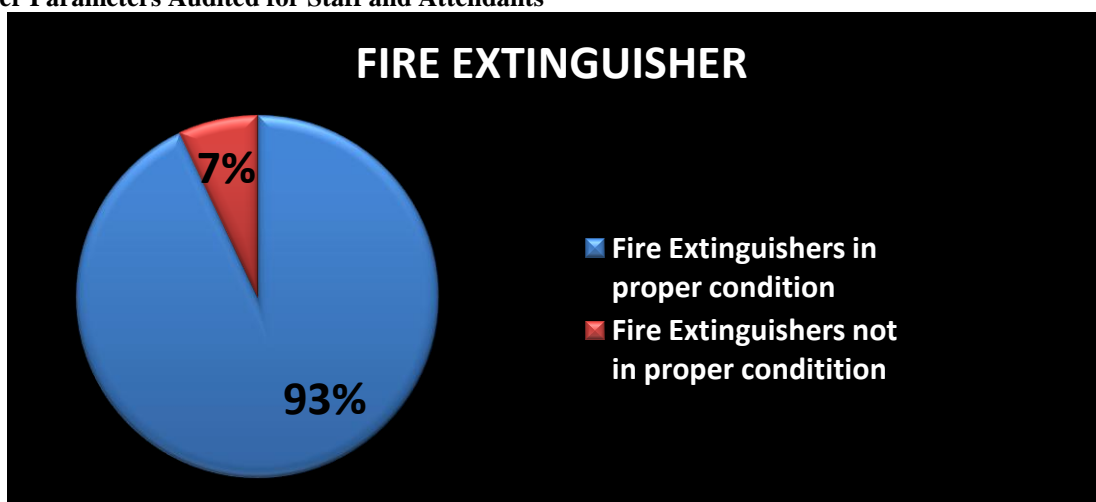


Compliance in Call Bells in Washroom

Emergency call bell in washroom	Total(12)
Proper condition	1
Not in proper condition	11

Interpretation – It was found that 8% emergency call bell in washroom are working rest 92% are not working.

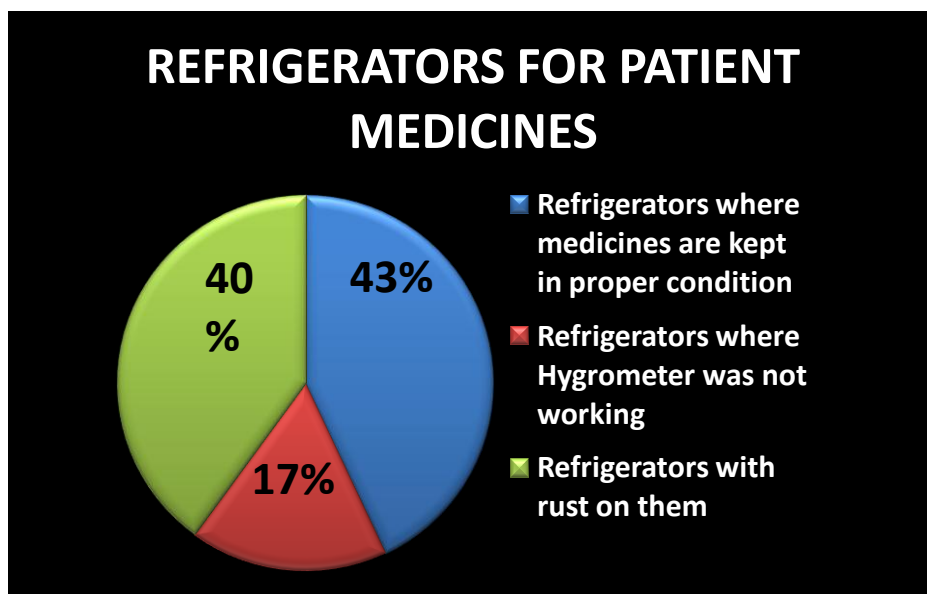
Other Parameters Audited for Staff and Attendants



Compliance in Fire Extinguishers

Fire Extinguisher	Total (16)
Proper condition	1
Improper condition	15

Interpretation: It was found 7% fire extinguishers are working and rest 93% are not working.



Compliance in Refrigerators

Refrigerators for patient	Total(10)
Proper condition	5
Improper condition	5

Interpretation : It was found that 43% refrigerators are kept in proper condition, 17% hygrometer were not working and rest 40% refrigerators are with rust on them.

III. Conclusion

The audits should be done on frequent basis as it will help the organization to maintain the quality and standards they have promised to be delivered and Three times the caution for slippery floors were not kept during the time of mopping of floor which can create mishappening. The disabled patient’s washroom didn’t have any call bell in case of emergency and Stretchers and wheelchairs should be available at each floor near to GDA transport desk and should have identification of maintenance or any other purpose.

There were lots of issues in the identification of patients as some of the Id bands were found to be blurred or the name and details were not clear on the band and there were issues with the stretchers and

wheelchairs as some of them were damaged and rusted which was reported to the concerned persons. The critical care department as well as nursing staff should be well versed with the importance of patient safety and should be aware of preventing it and the audit should be carried out on daily basis to check the non-compliance of IPD files and should get corrected at the same time. The closures of the non-compliance should be done as soon as possible after the audit.

Healthcare organizations are now focusing on the importance on organizational environment for patient safety. Safe environment has been priority for various hospitals with respect to the patients as well as the staff. This study analysis was done for improving the patient safety. All the audited parameters were related to the patient and work staff safety. After auditing, measures were taken to keep a check on the patient safety devices in the hospital.

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