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ORIGINAL RESEARCH PAPER

Hospital Administration

"A STUDY ON PATIENT SAFETY PRACTICES IN VARIOUS IN-PATIENT UNITS OF A TERTIARY CARE HOSPITAL"

KEY WORDS:

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ABSTRACT

Objective of the Study:
1. To study the patient safety practices in various in-patient units of a Tertiary Care Hospital.
2. To evaluate the patient safety practices with respect to National Patient Safety Goals (2018).

Methods and Materials:
Cluster sampling method was used in this study, since patient safety practices in all the in-patient units were observed. All the 45 in-patient units were considered as clusters of the population. **Results:** This study reveals that among 8 goals none of them were found Non-Compliant which shows that patient safety is given priority in various in -patient units. And also the units are improving in compliance with respect to National Patient Safety Goals in reducing patient harm resulting from falls (64.4%), pressure ulcers (35.6 %) and accuracy of Patient identification (28.9%). **Conclusion:** There should be blame free system for identifying threats to patient safety, sharing information, proper documentation and learning from events. In addition they should provide their health professionals with comprehensive training on patient safety practices, concepts, tools, and implementations.

INTRODUCTION

Hippocrates had stated several centuries ago "DO NO HARM."[1] This aspect was not given much attention in the past. However, since about two decades the fact that several patients are being harmed or die due to preventable medical errors has been getting global attention. With this heightened focus, patient safety has emerged as an important crux of National Patient Safety Goals (NPSG 2018) of Joint Commission International. Every process in the care-giving contains a certain degree of inherent unsafe element. Adverse events may result from problems in practice, products, procedures or systems.

Patient safety is a serious global public health issue. In recent years, countries have increasingly recognized the importance of improving patient safety. In 2002, World Health Organization (WHO) member states agreed on patient safety in a World Health Assembly resolution.

Estimates show that in developed countries, one in 10 patients is harmed in receiving hospital care. It is therefore imperative for all healthcare providers to understand concepts and practices of patient safety, and integrate them into their patient care and leadership responsibilities.

Assessing the existing safety in the hospital is the first stage of developing a safety. Patient safety assessments, required by international accreditation organization, allow healthcare institutions to obtain a clear view of the patient safety aspects which require urgent attention. Healthcare giving units identify their existing patient safety problems and bench mark their scores with other hospitals.

Over and above there are several challenges facing organizations to meet the basic requirements of patient care. The reality on ground is far from an ideal system. Staff training levels are the biggest challenge. Lack of availability of skilled staff without training in safety practices is a gap across the world.

Surgical care errors contribute to a significant burden of disease despite the fact that 50% of complications associated with surgical care are avoidable. Communication and training across the organization must be ensured. Taking frequent rounds of the hospital to check on safety aspects is important. Any change in a process, new program development or civil works, must go through a safety check, so that there is no compromise on the safety of patients.

Objective of The Study

1. To study the patient safety practices in various in-patient units of a Tertiary Care Hospital.
2. To evaluate the patient safety practices with respect to National Patient Safety Goals (2018).

MATERIALS AND METHODS

The study design was a descriptive study, describes and interprets the patient safety practices and tried to evaluate the practices with respect to Joint Commission's National Patient Safety Goals (2018). This descriptive research includes collection of information from the observation made on patients through a checklist.

An administrative permission was obtained from Medical College Hospital authorities concerned for the collection of data. Ethical clearance was given by the Institute Ethical Committee. The checklist for was developed based on Joint commission's NPSG 2018. The tool was given to the experts for content validity. Based on their suggestions and recommendations, the tool was modified.

The study was conducted at Medical College and Hospital, with 1350 bedded.

Cluster sampling method was used in this study, since patient safety practices in all the in-patient units were observed. Various in-patient units were considered as clusters of the population. Patient admitted in all the 45 in-patient Units during the study period were included. As the study setting has 45 in patient units and all are considered as inclusion criteria; there are no exclusions. The entries were filled up in the NPSG (2018) self assessment checklist after reviewing the elements of all NPSG Goals for documentation, implementation and evidence of the same.

RESULTS AND FINDINGS

This study reveals that among 8 goals none of them were found non compliant which shows that patient safety is given priority in various in -patient units. And also the units are improving in compliance with respect to National Patient Safety Goals in reducing patient harm resulting from falls (64.4%), pressure ulcers (35.6 %) and accuracy of Patient identification (28.9%). In addition they should provide their health professionals with comprehensive training on patient safety practices, concepts, tools, and implementations. This in turn will improve patient experiences, patient outcome and will promote patient safety.

CONCLUSION

The study which has been carried out in all the inpatient units of the hospital, gave valuable insight to know the prevalent status of patient safety practices with respect to patient safety Goals 2018. There should be blame free system for identifying threats to patient safety, sharing information, proper documentation and learning from events. In addition they should provide their health professionals with comprehensive training on patient safety practices, concepts, tools, and implementations.

Our result also shows that the move to prioritize patient safety by health care systems through accreditation is important. It is important to strengthen the new accreditation chapter on patient safety by supporting hospitals in training their staff, especially the less experienced ones, on patient safety competencies and about effective implementation of the new standards. Senior policy makers, managers and leaders are the ones who are able to create the culture and commitment needed to identify and resolve underlying systemic causes related to patient safety.

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