



ISQua's 39th International Conference

27th- 30th August | COEX Seoul



IMPROVING PATIENT SAFETY CULTURE WITH INCIDENT REPORTING: CUASE & EFFECT ANALYSIS

DR. MOHINI SAXENA
(Manager - Medical Admin & Quality)

DR. PARIMAL ARYAN
(Sr. Manager - Medical Operations)

DR. MINAL SOLANKI
(Unit Head)

DR. BIREN CHAUHAN
(Group COO)

(Sunshine Global Hospital, Vadodara, Gujarat, India)

P082

INTRODUCTION

- As per WHO estimates 20-40% of global healthcare spending goes waste due to poor quality of care resulting in death of more than 138 millions patients every year.
- Incident Reporting Systems is an important parameter to improve patient safety and quality of care. Incident reporting systems have been identified as the primary method to capture medical errors and harm. At the same time Incidents are rarely reported. We have tried to evaluate the same in our Hospital.

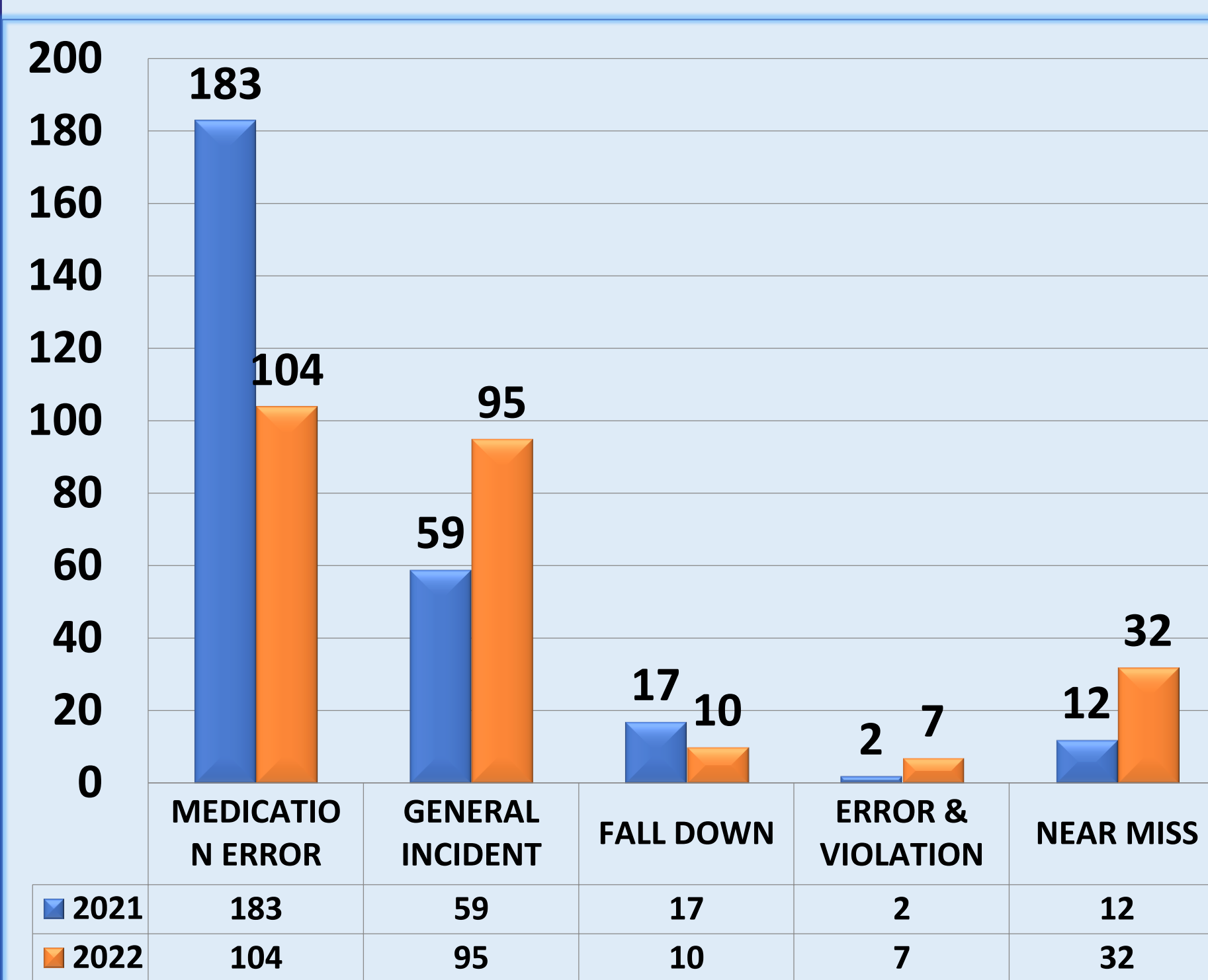
AIM

- To document & analyze maximum number of incidents occurring inside hospital
- To encourage maximum reporting of incidents without any apprehension or biasness across hospital
- To find out scope of improvement to enhance patient safety & quality based of structured incident reporting & analysis.
- To sustain culture of patient safety & quality through incident reporting structure

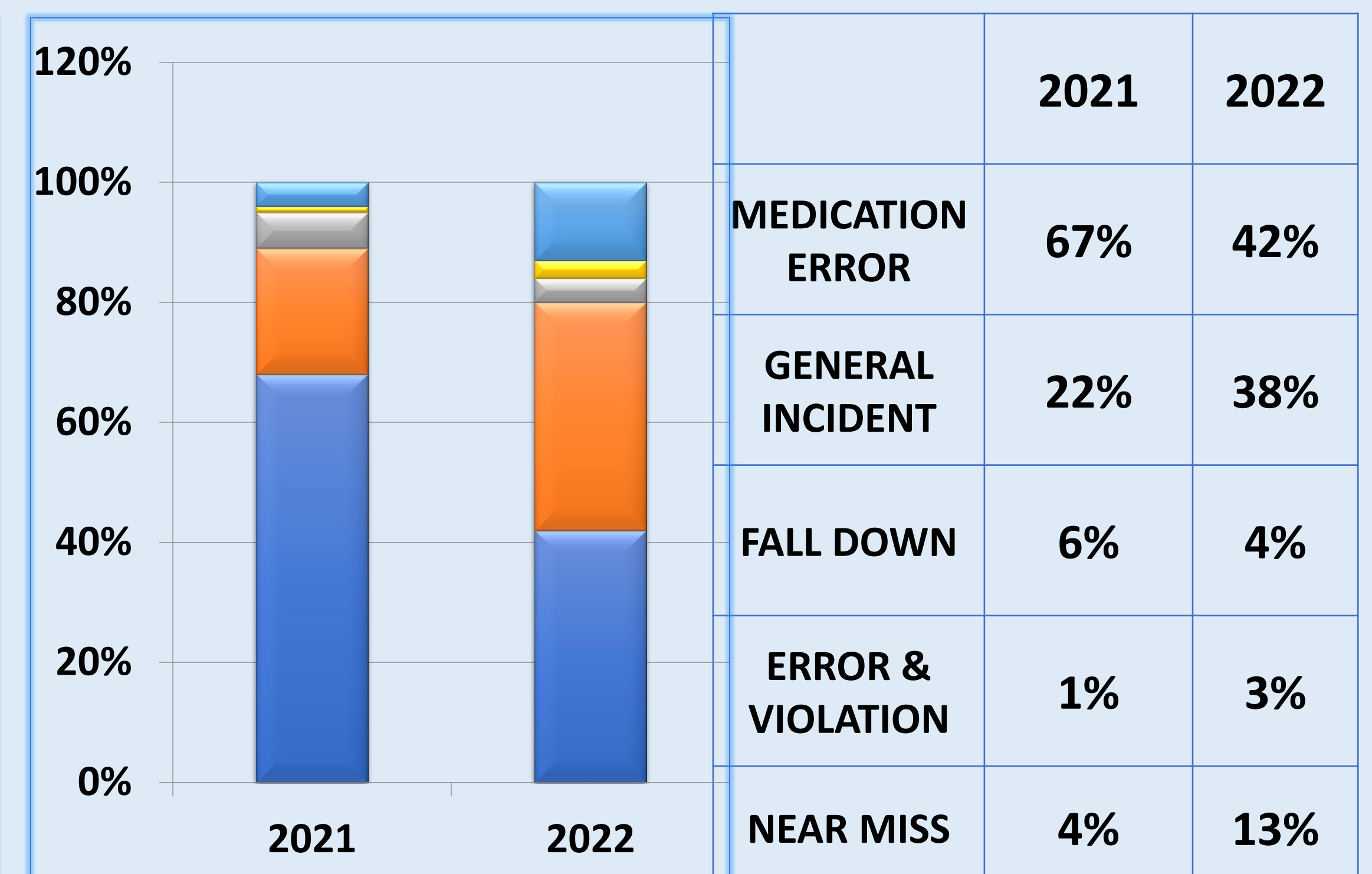
METHOD

- Retrospective mixed methods (qualitative & quantitative) study
- Root Cause Analysis using appropriate Quality Tools
- Organization level analysis using HFACS (Human Factor Analysis and Classification System) to implement effective CAPA (Corrective and Preventive Action) Plan

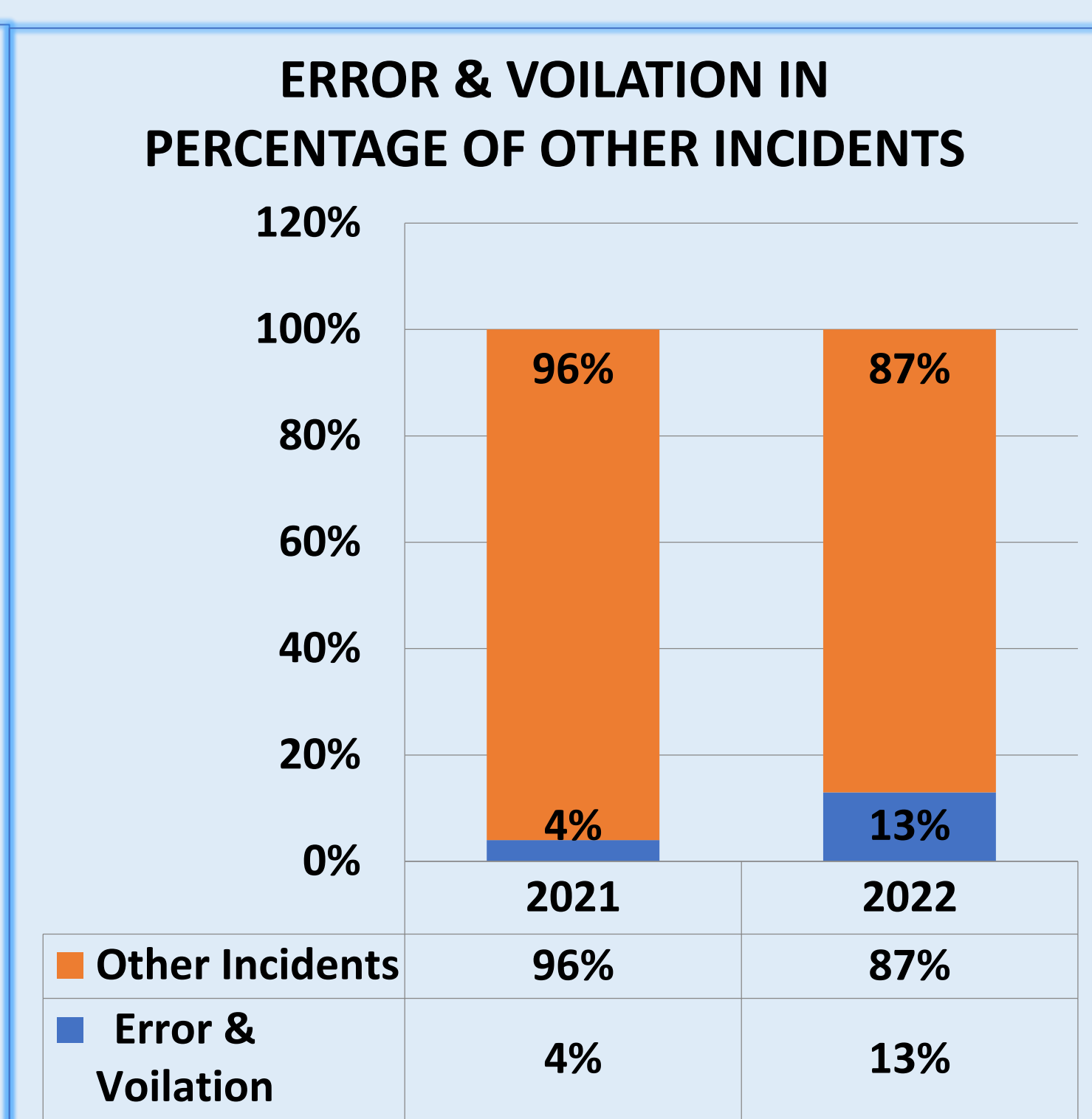
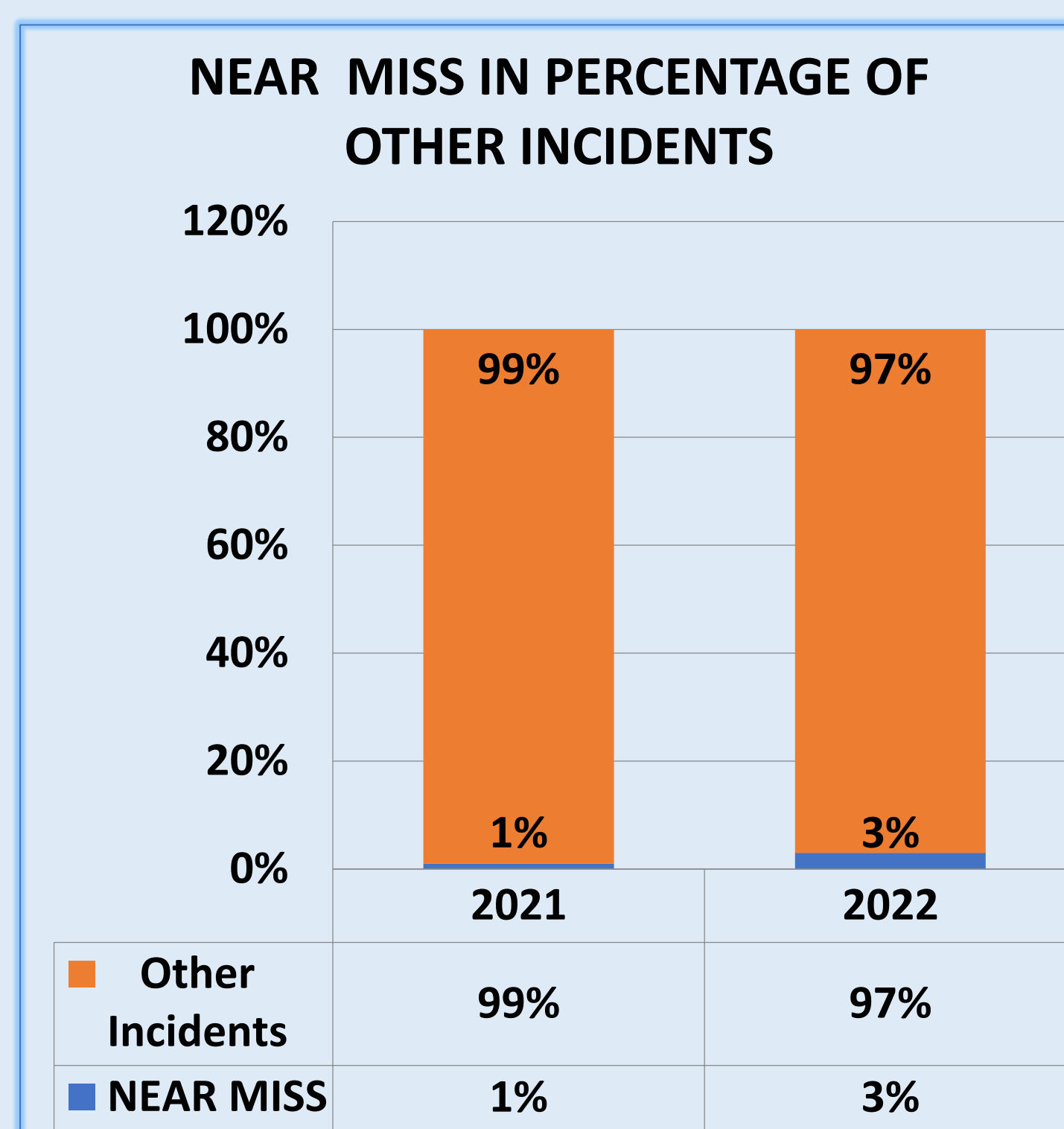
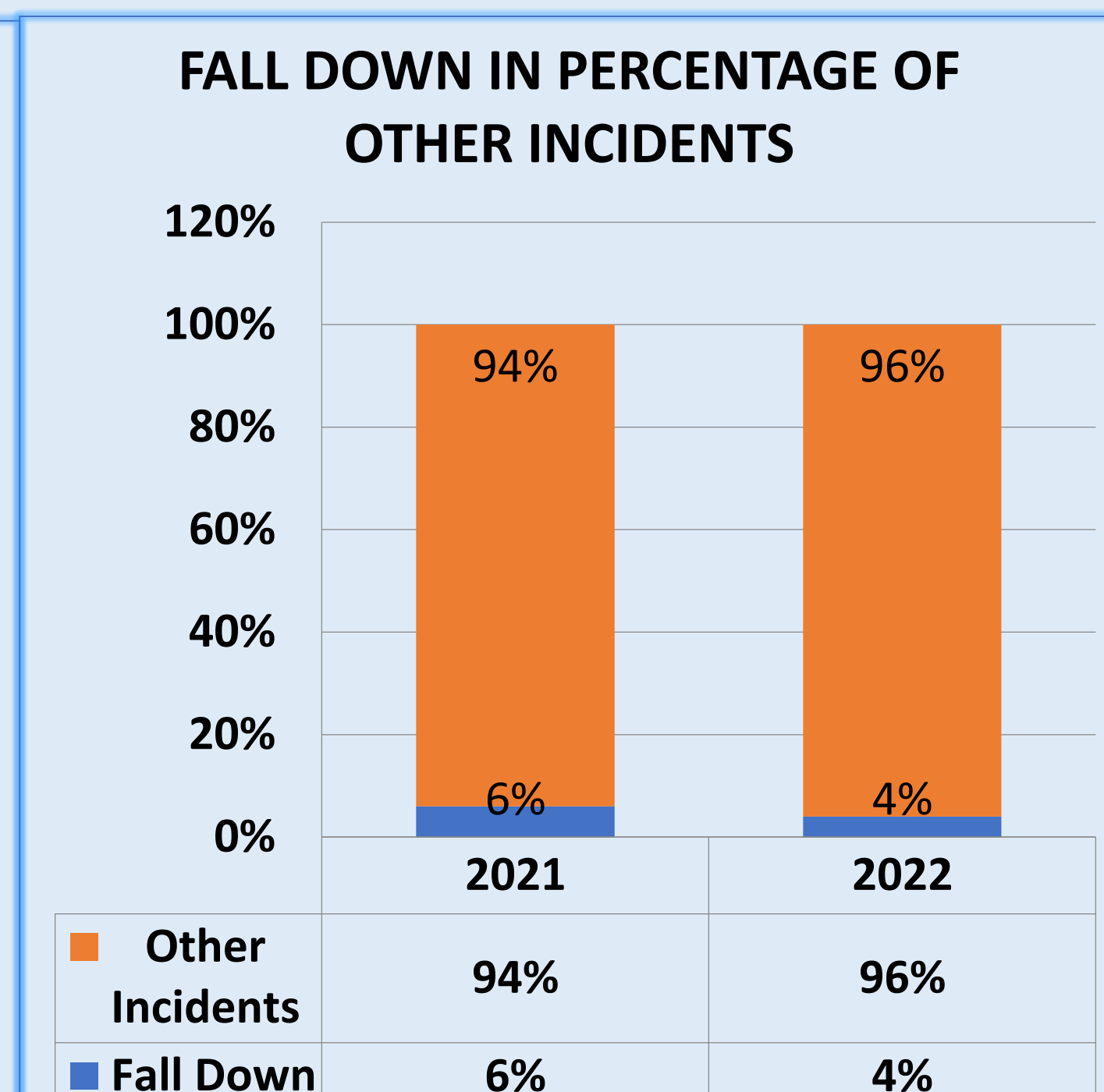
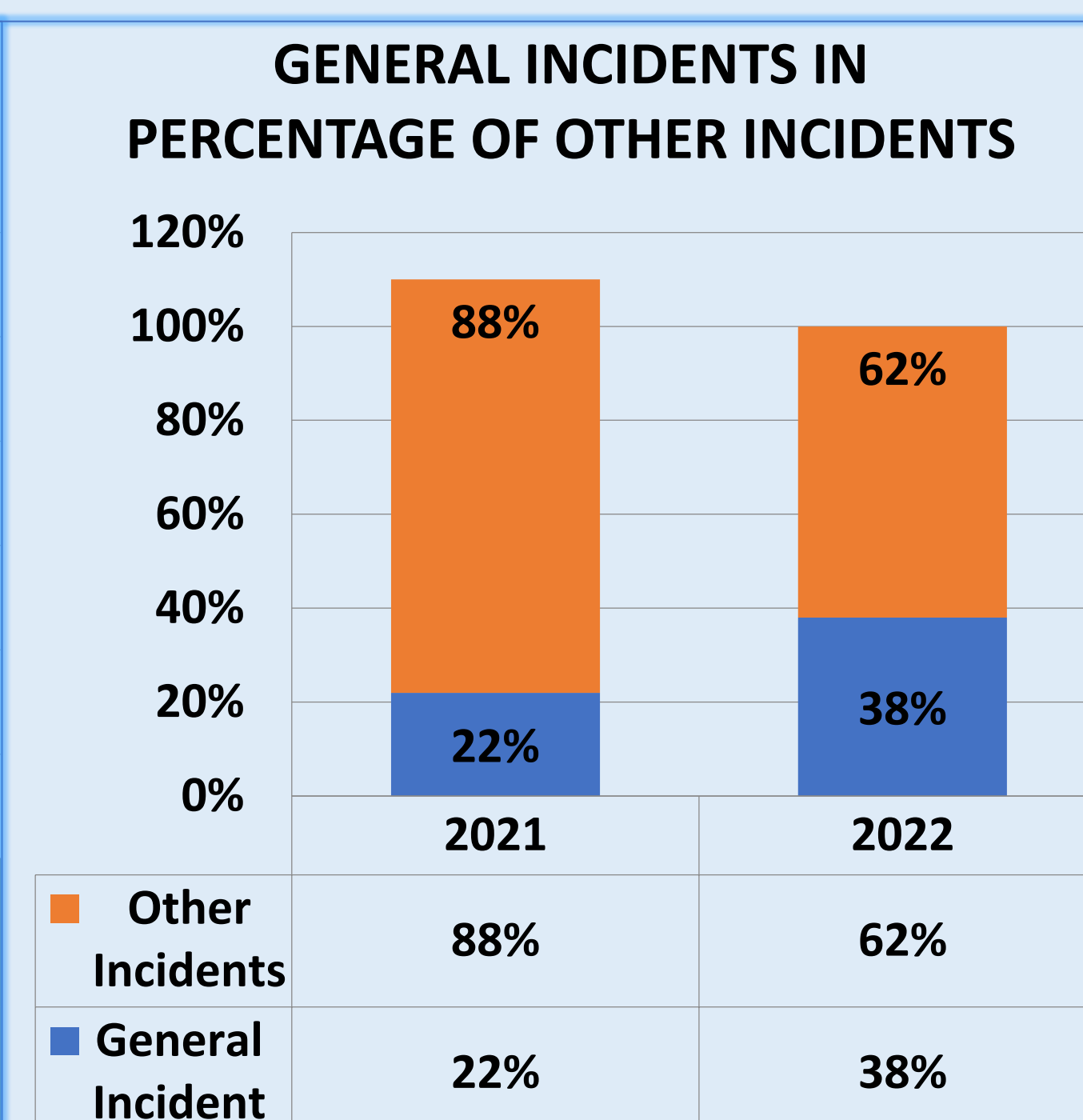
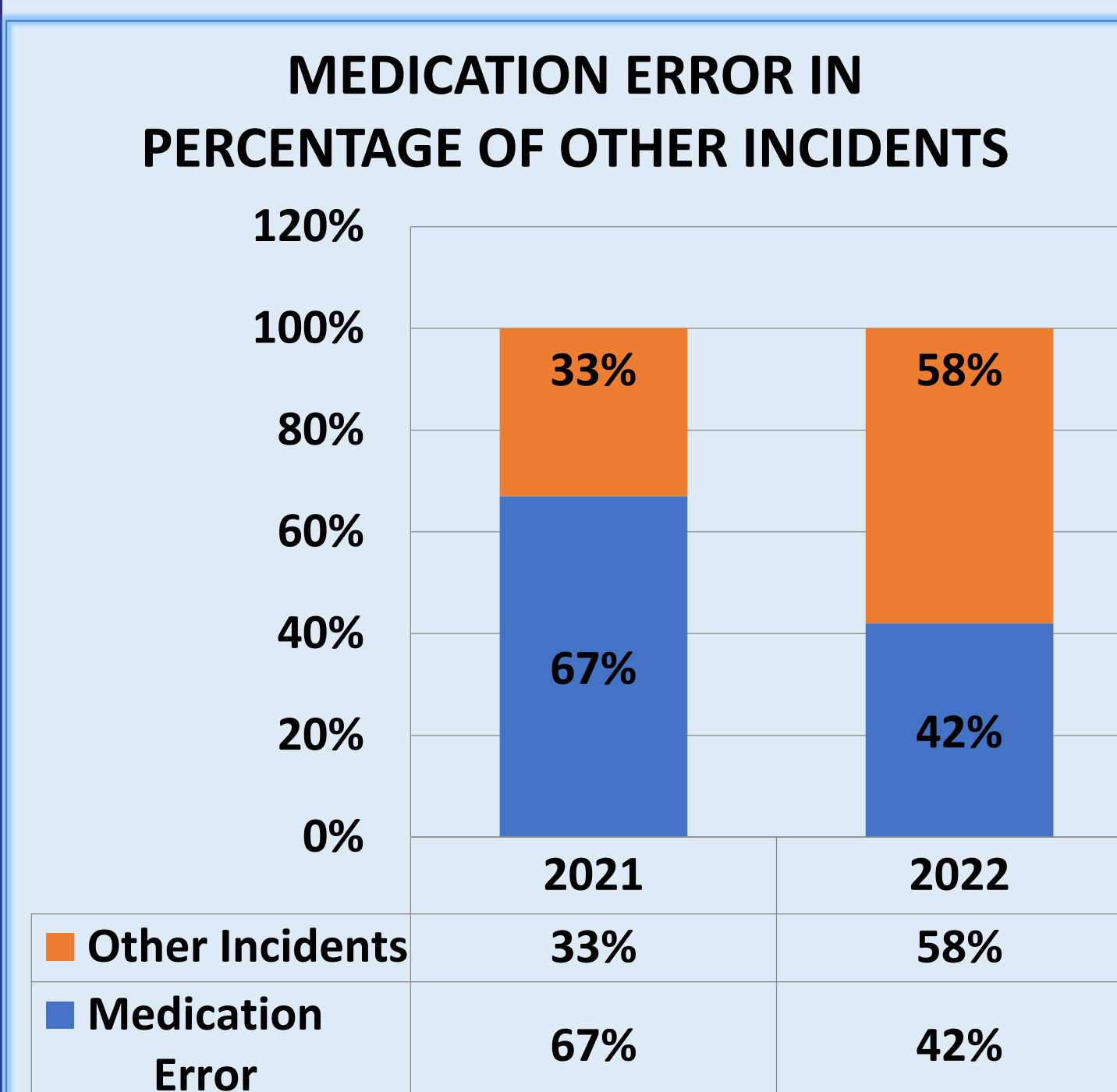
RESULTS



YEAR WISE NUMBER OF ALL CATEGORY OF INCIDENTS



YEAR WISE PRESENTATION OF ALL CATEGORY OF INCIDENTS (%)



CONCLUSIONS

- Post training & sensitization, incident reporting culture is enhanced as we see most of the departments are reporting incidents without any biasness & fear. *Variety of incidents and frequency of incidents has increased significantly after training and sensitization. Focused group discussions, one to one coaching has made this positive impact.*
- Through sound & accurate incident report analysis using appropriate quality tools has been very effective in reducing harm & wastages across the hospital.
- Even for the same nature of incidents, there has been highly personalised CAPA because we are using HFACS classification for every incident occurring in the hospital and involve various stakeholders in this analysis.

ACKNOWLEDGEMENT

Our thanks and gratitude go to every medical and paramedical staff who have actively participated in learning, documenting, reporting, analyzing, designing training modules and imparting effective trainings. Teamwork Always Works.



REFERENCES

- <https://qualitysafety.bmj.com/content/25/2/71.short>
- <https://academic.oup.com/intqhc/article/25/2/141/1855001>
- <https://qualitysafety.bmj.com/content/25/2/92.short>
- <https://journals.sagepub.com/doi/pdf/10.4081/jphr.2013.e27>

CONTACT INFORMATION

Dr. Biren Chauhan
Group COO
Sunshine Global Hospitals
Vadodara | Surat
M: +91 983 389 0515
E: birenc15@gmail.com