CHAPTER: 18

STUDY ON EVALUATION OF HOSPITAL SAFETY STATUS

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INTRODUCTION

Hospitals extend their significance beyond saving lives during disasters; they serve as potent symbols of social progress and prerequisites for economic development. Therefore, reducing their physical vulnerability demands special attention. The vulnerability of a hospital surpasses a mere medical concern [1]. It is crucial for hospitals to remain operational during emergencies, as people instinctively seek medical assistance at the nearest hospital without considering its functionality. Although there are conventional evaluation methods like Hazard and Vulnerability Analysis, Equipment and Critical Lines Studies, and Organizational/Functional Evaluation, each has its limitations [2].

The Hospital Safety Index not only functions as a tool for technical assessments but also provides a crucial perspective on emergency and disaster risk management in the health sector, highlighting the importance of prevention, mitigation, and preparedness. This quick and cost-effective diagnostic tool allows authorities to promptly identify actions and measures that can enhance safety and evaluate the hospital's capability to respond to emergencies and disasters [2]. A checklist facilitates the evaluation of various items and assigns safety ratings to a hospital. Using a scoring system that determines the relative importance of each item, a numeric value is calculated to assess the hospital's likelihood of surviving and functioning in an emergency or disaster [3].

RESEARCH OBJECTIVES

Objective assessment – Hospital safety Index tool by WHO

1. To assess the hospital's ability to maintain service delivery after an adverse event.
2. To pinpoint areas requiring enhancement in terms of hospital safety.
3. To prioritize interventions by advocating for cost-effective measures with a high impact.

Subjective assessment – Hospital Safety Culture tool by AHRQ

1. To evaluate the current status of patient safety culture,
2. To identify strengths and areas for patient safety culture improvement
3. To conduct comparisons within and across organizations.

RESEARCH METHODOLOGY

The study was structured as a Descriptive Cross-sectional Study and conducted at P.D. Hinduja National Hospital and Medical Research Centre in Mahim, Mumbai. Utilizing a quantitative approach, specifically employing the Likert Scale, the study spanned a three-week period. The research instrument used was the pre-validated and standardized tool from the Agency for Healthcare Research and Quality (AHRQ), developed in collaboration with the Quality Interagency Coordination Task Force (QuIC) Medical Errors Workgroup, with permission obtained from the agency for its use. The AHRQ tool operates on a five-point Likert scale, allowing participants to express their level of agreement or disagreement with statements across six categories. The employed tool, the Hospital Survey on Safety Culture, comprises 44 items grouped into 12 composites, emphasizing aspects related to patient safety, error, and event reporting. Drawing data from a database encompassing results from 630 hospitals globally as of 2018, the survey facilitates benchmarking best practices. Additionally, the survey includes two questions prompting respondents to provide an overall grade on patient safety for their work area/unit and indicate the number of events they reported over the past 12 months.

RESULTS & DISCUSSION

The average percentage of positive responses from Hinduja Hospital (n = 300 participants) was compared with the AHRQ database, consisting of an average of 630 hospitals. The comparison indicated that Hinduja Hospital performs less favorably than the database average in punitive response, events reporting, and staffing, signifying these dimensions as the weaker aspects of the safety culture. However,

Hinduja Hospital exceeds the database average in safety composites such as manager expectations, handoffs, management support, teamwork within units, and organizational learning, identifying these as the stronger elements of the safety culture to be capitalized on. Similar results were observed in the hospital-wide composite analysis. It became evident that punitive response, staffing, and events reporting frequency received the lowest scores in terms of percent positive response as well as the weighted average, designating them as the weaker dimensions of the safety culture at Hinduja Hospital. Conversely, handoffs, management support, teamwork within units, and organizational learning emerged as the stronger dimensions of the safety culture at Hinduja Hospital. Given that organizational learning and teamwork within units are the stronger dimensions, they can be leveraged to fortify the weaker composites.

CONCLUSION

The hospital's safety culture lacks the desired strength, and there are noticeable disparities in safety culture across various departments. The results provide in-depth perspectives on staff attitudes and experiences concerning safety culture within hospitals. It is crucial to foster a positive patient safety culture through the implementation of measures that strengthen all aspects of the safety culture.

REFERENCES

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