Impact Of Weekly Patient-safety Audits On Adherence To Patient Safety

Guidelines at Chtorchia Hospital

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Introduction
In Lebanon, “Patient Safety” is a fairly young concept that has recently been adapted by Lebanese Hospitals during the last national accreditation. Chtorchia Hospital is a 75 bed general hospital, located in Chtorchia-Bekaa, that was reopened in 2011 under a new administration. Its “Patient Safety” program was reestablished towards the end of 2012. In an attempt to spread the patient safety culture extensive training was conducted about this topic in the hospital.

Purpose
To gauge the spread of the patient safety culture, it was decided to conduct extensive auditing on the floors (on site). This on site auditing will provide several advantages:
1. Provide an immediate mean for corrective actions, thus continuously reminding staff members of the basis that they have been taught during their in-service education, until the safe practices are embedded in their everyday processes.
2. Provide a mean for control, so that staff realize that this concept needs to be implemented rather than just memorized for occasional inspections.
3. Provide a mean to assess the number of actual errors that occur in the wards and compare it to the number of reported errors, thus providing a reliable KPI that will help us in assessing the spread of the safety culture in the hospital and fulfill the accreditation requirement for this KPI.

Methodology
The patient safety officer (PSO) was assigned the task of performing at least 2 audits per week on every patient ward over a period of 2 months (July-August 2013). During these audits an audit sheet had to be filled that included the following processes:
• Patient Identification
• Fall Prevention
• Verbal Orders
• Medication administration and Intravenous infusions
• “Safe Surgery” checklist

Procedure
The PSO was instructed to perform rounds on patients’ wards at this stage and observe the above mentioned processes using the guidelines detailed in the adjacent audit sheet. During every round, each process had to be observed 5 times (on 5 different patients) to detect the occurrence of any errors. Each ward was audited at least twice per week.
A baseline audit was conducted during the last week of June (audit 0) then each ward was audited 12 times during July and August. During the audits the PSO was pointing out the errors and explaining the rationale for the correct methodology of the process whenever needed. Also, staff members were reminded to report all the errors that occurred during their shifts on the provided “accident report” form. The errors noted during each audit were documented on the audit sheet and entered on a spread sheet for accumulation of results.

Results
At the baseline audit (0), the total number of errors noted on the wards was 194 errors. This number showed a gradual and steady decline during the subsequent audits during July and early August. However there was a spike of errors during audits 9 and 10 then the total of errors went down during the last 2 audits at end of August. The highest number of errors was noted in the pediatrics floor followed by the ICU then the maternity floor. The types of errors were highest in the procedure of verbal orders followed by medication administration and patient identification.

The rate of error reporting was near zero (1 per week) at the beginning of this intensive audit. Unfortunately, the rate of error reporting did not change throughout the 2 months of this audit, thus we were unable to calculate a variation in the rate of reported to actual errors.

Discussion
As noted, verbal orders is the most problematic area that we encountered, this is mostly due to the fact that as a relatively small community hospital we need the cooperation of doctors to minimize the frequency of phone orders and the adherence of the nursing staff to the proposed procedure (2 nurses to take the order), which is hard to do when the number of verbal orders is very high. The second problematic area of patient identification is mostly encountered in the pediatric floor where the bracelets are frequently removed and identification is not carried out according to procedure. We have been following up on this frequent error and hope for an improvement. As for medication administration the main issue is in the labeling and reporting of medication errors.

As noted the audit succeeded in improving the adherence to the proposed guidelines. Unfortunately, the sudden increase in the number of errors noted during audits 9 and 10 was attributed to the sudden rise in the number of admissions and turnover rate of patients during mid August, which followed the month of Ramadan and the Eid when the patient census was at its lowest of the year. With the rise in patient census, the nursing staff was more likely to commit errors (as it is well known) and to forgo the usual precautionary measures. The lack of reporting is a major issue, and we hope that it will improve once we share these results with all the staff members.

Our hospital is still at the early stages of acknowledging the patient safety culture. So far, the adherence to the patient safety guidelines is considered as an adherence to the accreditation guidelines and not as measures that help in minimizing errors and improving the outcome of patient care. This process will take time. We hope that by sharing these results with the staff with constant feedback in subsequent audits, they will realize the lack of a blame culture and be incited to report errors and compete with other wards to minimize the total number of errors.

References:
Lebanese Accreditation Standards
- JCIA 4th edition Hospital Standards
- Queensland Government Patient Safety Unit: Audit tools for National Safety and Quality Health Service Standards.