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Assessment of existing patient safety practices at Obstetrics Wards in DMH Sri Lanka and develop strategies to enhance patient safety concerning WHO six safety goals[IPSGs]

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I.Executive Summary

Patient safety is the avoidance, prevention, and amelioration of adverse outcomes or injuries stemming from the processes of healthcare. These events include ‘errors’, deviations, and ‘accidents’ (i.e., Zero Harm or No Harm to the patient).

This hospital is popularly known as the De Soysa Lying-in-Home [DMH] or De Soysa Maternity Hospital for women (Teaching). It was opened on 9th December 1879 through the generosity of Charles Henry De Soysa, a great philanthropist of the era. It is the first Maternity hospital in Sri Lanka and the 2nd oldest Maternity hospital in Asia. It is a training institute for all categories of staff in Maternity care. The hospital is headed by a Director and consists of 868 staff members including 11 Consultants. The hospital has 7 Obstetrics wards and 3 Gynaecology wards. The bed strength is 277, BOR:78.73% and BTOR:62.43% (Annual Report 2022, De Soysa Hospital for Women).

The methods used for the assessment were a self-administered structured questionnaire [SAQ] for doctors, nurses and midwives who work at obstetrics wards, key informant interviews [KIIs] with consultants, Special Grade Nursing Officers, Nursing sisters, document reviews and direct observation. The prioritized problem was Inadequate Patient Safety Practices. The prioritized root causes to be addressed are inadequate training on safety practices for healthcare staff, lack of a standardized protocol, insufficient monitoring, auditing, and feedback mechanisms to address safety issues. The recommendation is to develop and implement comprehensive training for all staff about patient safety practices and the implementation and rollout of the patient safety protocol.

II.Introduction

This case study investigates the current patient safety practices within the Obstetrics Wards at DMH and outlines strategies for improvement in alignment with the World Health Organization's (WHO) six international patient safety goals[IPSGs). DMH is dedicated to providing high-quality care to expectant mothers and their newborns, and ensuring patient safety is a top priority. The WHO has established six IPSGs to promote patient safety across healthcare settings. They are as follows:

1) Ensure accurate patient identification.
2) Improve effective communication.
3) Improve the safety of high-alert medications.
4) Ensure safe surgery: ensure the correct patient, correct site, and correct surgery.
5) Reduce the risk of healthcare-associated infections.
6) Reduce the risk of patient harm resulting from falls.

These goals serve as a framework to assess and enhance patient safety practices in healthcare facilities and the key standards to be met by a hospital in order to get certified by the Joint Commission International (JCI). These goals are designed to address common healthcare challenges and reduce the risk of adverse events that may occur during medical care.

In this case study, I tried to explore the significance and impact of the IPSGs through a real-world example of their implementation. The study took me on a journey through the world of healthcare systems and showcased the efforts made by healthcare providers to create a safer environment for patients. This case study emphasized the importance of IPSGs in promoting global healthcare quality and safety.

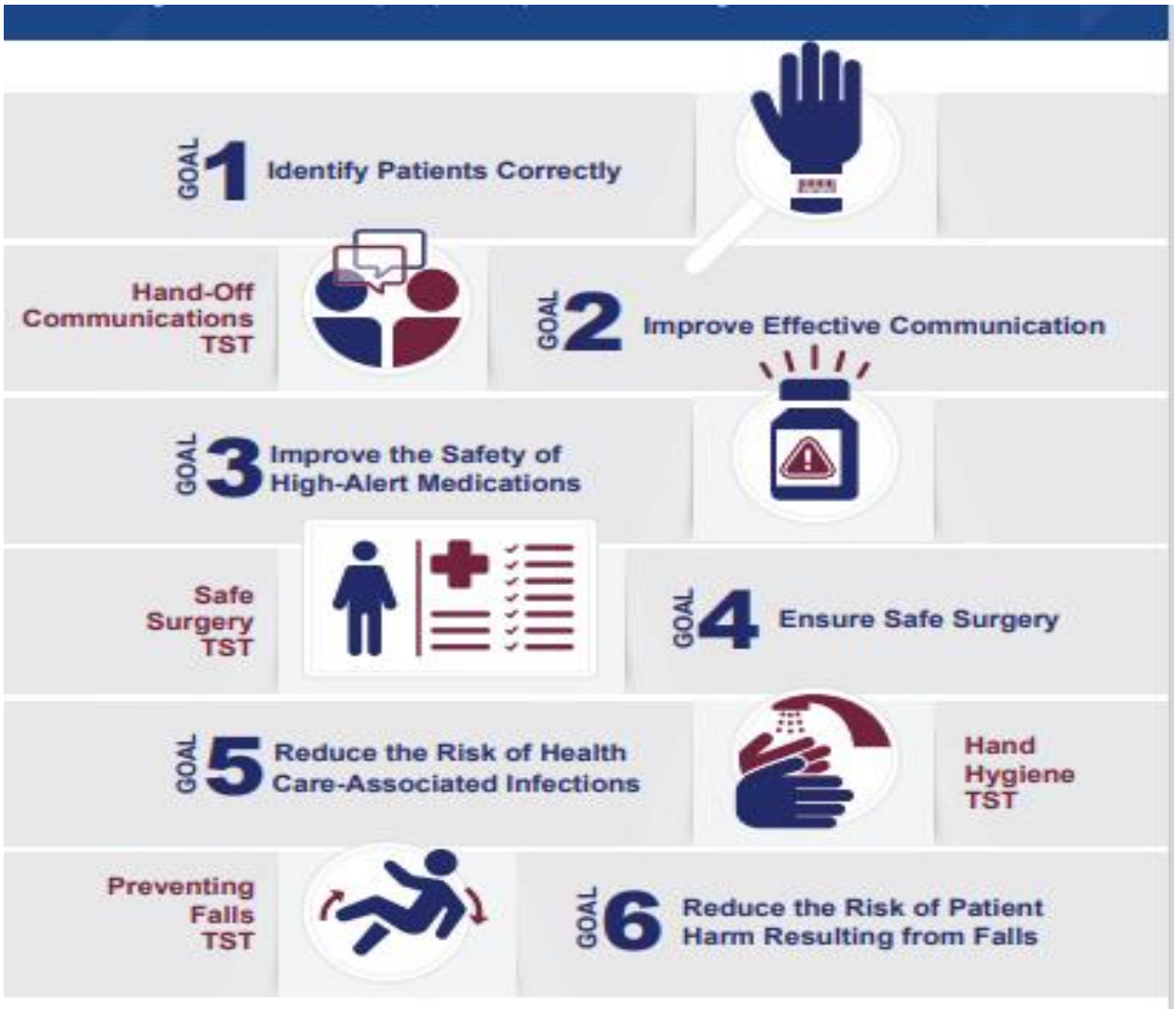

Figure 1: International Patient Safety Goals (IPSGs)-(TST-Targeted Solutions Tool)

These goals are designed to address common safety issues that patients might face during their medical care, irrespective of the country or healthcare system they are in. The IPSGs typically target a range of safety issues, and each goal is associated with specific action items which are called targeted solution tools. e.g.,

a) Patient identification bands
b) Communication handoff tools
c) Electronic Medication Records (EMR)
d) Infection control protocols
e) Fall risk assessment tools
f) Surgical safety checklists
g) Patient education materials

Objectives of the case study

1) To assess the existing patient safety practices at Obstetrics Wards in DMH
2) To identify areas to be improved patient safety practices at Obstetrics Wards in DMH
3) To develop strategies to enhance patient safety practices at Obstetrics Wards in DMH

Methodology

This case study design was mainly a qualitative approach.

- Key informant interviews (KIIs) were carried out with consultants, Special Grade Nursing Officers and Nursing sisters. These interviews provided insights into the process, challenges faced, and outcomes.
- A self-administered structured questionnaire [SAQ] in Google form was shared with doctors, nurses and midwives to obtain their perceptions and suggestions.
- Direct observation by the Principal Investigator [PI] on how the practices are carried out at Obstetrics wards in DMH.
- Document reviews were carried out by the PI.
- Analyzed the collected data and arranged brainstorming sessions. Furthermore, qualitative data analysis was carried out (interview transcripts and documents) using thematic analysis to identify recurring themes related to IPSGs, challenges, and successes.
- Based on the findings from the analysis, practicability and feasibility made the recommendations to improve patient safety practices at Obstetrics wards in DMH through a literature review as well as brainstorming with 3 senior registrars and 2 registrars in medical administration. Moreover, considered triangulation by using multiple sources of data (interviews, documents, and observations) to ensure the validity and reliability of findings.

Problem prioritation

Problem prioritisation was conducted using the nominal group technique with 2 senior registrars and 2 registrars in medical administration, MO/Planning, 1 MO, 1 sister and 1 NO at Obstetrics wards in DMH.

Table 1: Priority Matrix for problems in Patient safety practices at DMH

Priority Matrix for Training Needs Prioritization	Problems	Number of votes received		Total Votes	Final Priority
	Problems in patient safety practices at Obstetrics Wards in De Soysa Hospital For Women (DMH)	1st Round eight votes for each of six members [48votes]	2nd Round six votes for each of the six members [36 votes]		
	1. Inadequate Communication among Staff	2	2	4	-
	2. Inadequate Patient Safety Practices	13	12	25	1
	3. Lack of Proper Medication Reconciliation Practices	3	2	5	-
	4. Inadequate Infection Control:e.g., hand hygiene	2	1	3	-
	5. Lack of Standardized Protocols	6	5	11	3
	6. Inaccurate Patient Records	2	1	3	-
	7. Staff Fatigue and Burnout	4	2	6	-
	8. Inadequate Fetal Monitoring	1	-	1	-
	9. Equipment Failures	2	1	3	-
	10. Patient Identification Issues	2	2	4	-
	11. Inadequate Training and Education	11	8	19	2
	12. Inadequate Response to Obstetric Emergencies	-	-	-	-

III. Problem Analysis

The prioritized problem in patient safety practices at Obstetrics Wards in De Soysa Hospital For Women was inadequate patient safety practices at DMH. The root causes for it were identified by a literature search and brainstorming sessions with 3 senior registrars & 2 registrars in medical administration, 1 Senior registrar,1 registrar and 1 MO at Obstetrics wards in DMH. It is illustrated below.

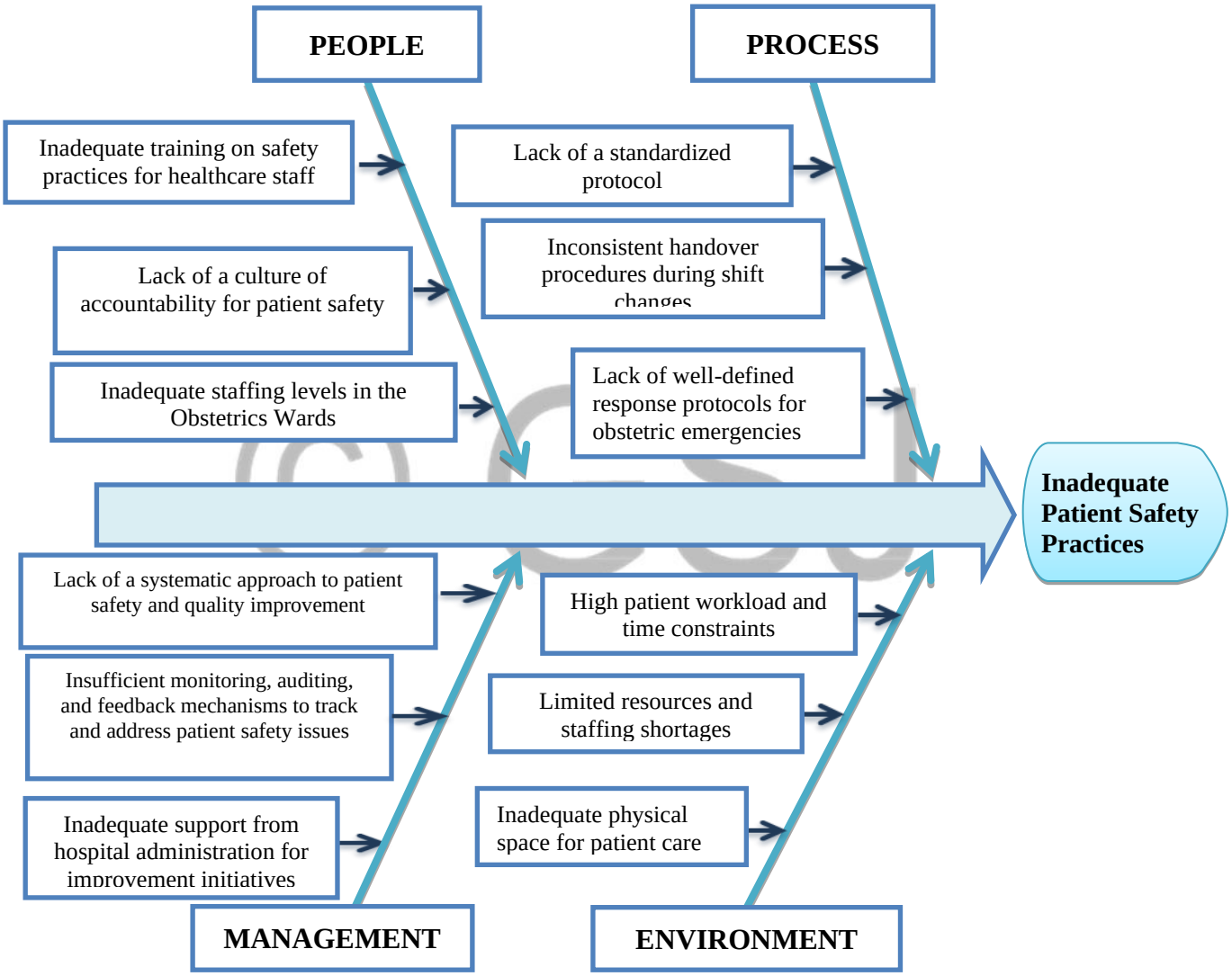

Figure 2: Ishikawa chart - Root cause analysis

These root causes were prioritized considering;

- The feasibility to address - technical, administrative, financial, and practicability.
- The impact of the root cause.
- The time factor to introduce interventions.

Table 2: Priority Matrix for Root Cause Prioritization for Inadequate Patient Safety Practices in De Soysa Hospital For Women [DMH]

Priority Matrix for Root Cause Prioritization	Root Causes	Number of votes received		Total Votes	Final Priority
	Root Causes for Inadequate Patient Safety Practices in DMH	1st Round [Eight votes for each of six members] [48 votes]	2nd Round [six votes for each of six members] [36 votes]		
	1. Lack of a standardized protocol	10	7	17	2
	2. Inconsistent handover procedures during shift changes	3	1	4	
	3. Lack of well-defined response protocols for obstetric emergencies	4	2	6	
	4. Inadequate training on safety practices for healthcare staff	12	13	25	1
	5. Lack of a culture of accountability for patient safety	1	-	1	
	6. Inadequate staffing levels in the Obstetrics Wards	1	-	1	
	7. Lack of a systematic approach to patient safety and quality improvement	2	3	5	
	8. Insufficient monitoring, auditing, and feedback mechanisms to address patient safety issues	7	5	12	3
	9. Inadequate support from hospital administration for improvement	2	1	3	
	10. High patient workload and time constraints	4	3	7	
	11. Limited resources and staffing shortages	2	1	3	
	12. Inadequate physical space for patient care	-	-	-	-

The root cause prioritisation was carried out using the nominal group technique with 3 senior registrars and 2 registrars in medical administration, MO/Planning, 1 MO and 1 NO at Obstetrics wards in DMH.

According to the number of votes received by each root cause, they are arranged in descending order. Afterwards, using Microsoft Office 365 Excel, a Pareto chart was created.

Table 3: Root Causes Arranged in Descending Order

4. Inadequate training on safety practices for healthcare staff	25
1. Lack of a standardized protocol	17
8. Insufficient monitoring, auditing, and feedback mechanisms to address safety issues	12
10. High patient workload and time constraints	7
3. Lack of well-defined response protocols for obstetric emergencies	6
7. Lack of a systematic approach to patient safety and quality improvement	5
2. Inconsistent handover procedures during shift changes	4
9. Inadequate support from hospital administration for improvement	3
11. Limited resources and staffing shortages	3
5. Lack of a culture of accountability for patient safety	1
6. Inadequate staffing levels in the Obstetrics Wards	1
12. Inadequate physical space for patient care	0

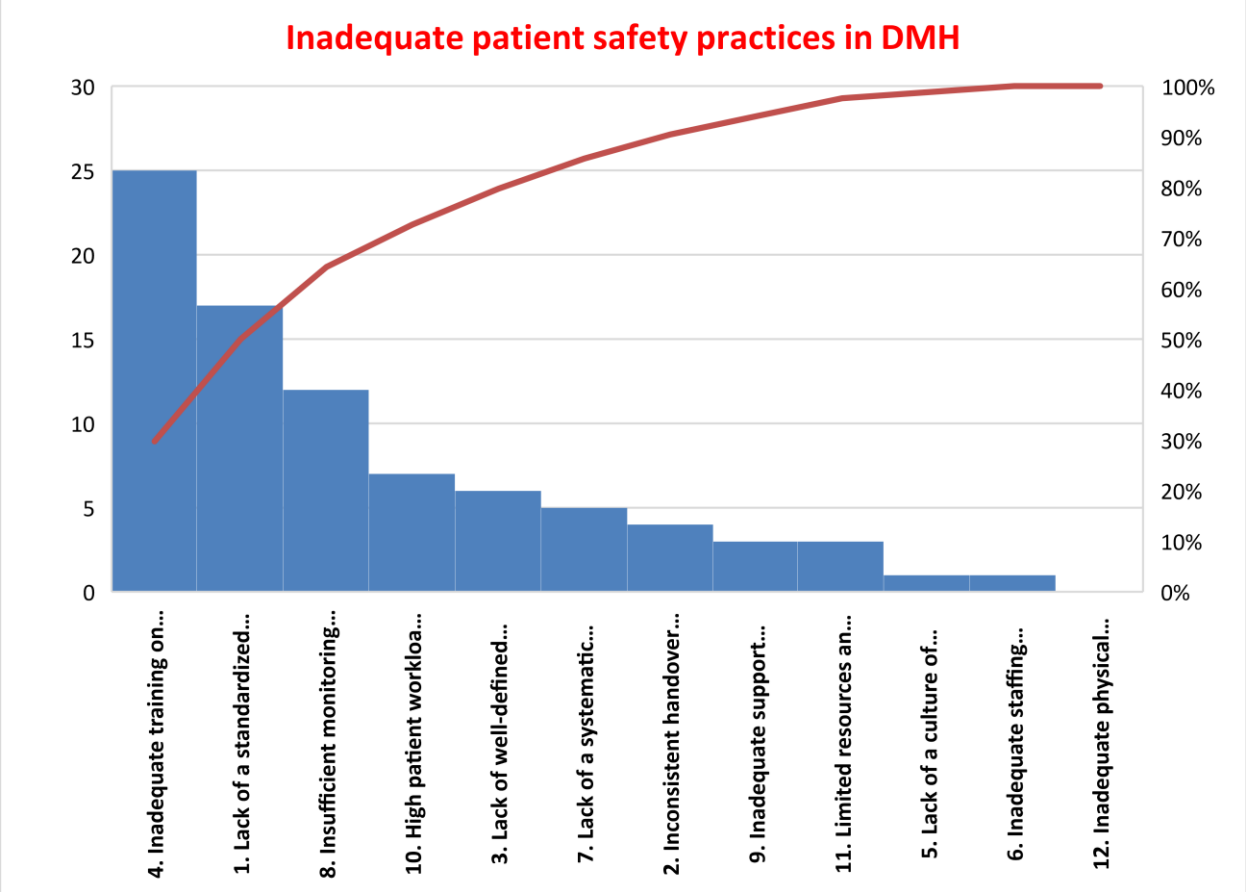

Figure 3 :Pareto Chart for Root Causes

IV.Proposals

Solutions for the vital root causes were identified through SAQ, literature search and brainstorming sessions. According to the Pareto analysis following are the vital few root causes.

1) Inadequate training on safety practices for healthcare staff
2) Lack of a standardized protocol
3) Insufficient monitoring, auditing, and feedback mechanisms to address safety issues

The aforementioned root causes can be addressed by implementing the following solutions and suggestions. Here are some proposals for patient safety practices at Obstetrics Wards in DMH.

Ensuring correct patient identification is crucial for patient safety in a hospital setting. Here are proposals for identifying the correct patient

01.IPSG-1

I. **Use two unique identifiers**: Implement a policy that requires the use of at least two unique patient identifiers, such as the patient's full name and date of birth, when verifying the patient's identity. This helps reduce the risk of mistaken identity.

II. **Patient wristbands:** Ensure that every patient admitted to the hospital, or any care unit, is provided with an identification wristband that includes their name and a unique patient identifier. Verify wristband information before any procedures or medication administration.

III. **Verify information at every interaction:** Healthcare providers should verify the patient's identity at every interaction, whether it's administering medication, performing a procedure, or taking vital signs. This includes asking the patient to state their name and date of birth.

IV. **Patient photo identification:** In cases where confusion is possible, such as shared rooms, consider using a patient's photograph alongside other identifiers. This extra visual cue can help confirm the correct patient.

V. **Electronic Health Records (EHRs):** Leverage EHRs that require staff to log in using unique identifiers and passwords. This can help prevent unauthorized access to patient records and enhance the accuracy of patient information.

VI. **Barcode scanning:** Use barcode scanning technology to verify patient identity when administering medication, collecting specimens, or conducting lab tests. Scanning can reduce the risk of medication errors.

VII. **Universal protocol for surgery:** Implement a universal protocol before any surgical or invasive procedure. This protocol includes verification of the patient's identity, site, and procedure, and it ensures that the entire surgical team is on the same page.

VIII. **Surgical site marking:** If the patient is undergoing surgery, clearly mark the surgical site while the patient is awake and involved in the verification process. This step is crucial for preventing wrong-site surgeries.

IX. **Patient involvement:** Encourage patients to participate actively in their own care by verifying their identity, medications, and treatment plans. Patients can serve as a vital double-check in the identification process.

X. **Training and education:** Provide regular training and education to all staff on the importance of patient identification and the procedures for verifying patient identity. Include examples of adverse events related to misidentification.

XI. **Near-miss reporting:** Establish a system for reporting near misses or incidents related to patient misidentification. Use these reports as opportunities for learning and process improvement.

XII. **Checklists and guidelines:** Develop and distribute checklists and guidelines that healthcare providers can reference during patient interactions. These resources can serve as quick reminders for proper identification procedures.

XIII. **Auditing and quality assurance:** Conduct regular audits to assess compliance with patient identification protocols and provide feedback to staff. Use these audits to identify areas for improvement.

XIV. **Cultural emphasis:** Promote a culture of safety where patient identification is a top priority. Encourage staff to question and verify patient information without hesitation.

By implementing these recommendations, hospitals can significantly reduce the risk of incorrect patient identification, which is essential for ensuring patient safety and delivering the right care to the right person.

02.IPSG-2

Effective communication with patients is crucial for providing high-quality healthcare and ensuring patient satisfaction. Here are proposals for improving communication with patients:

I. **Active Listening**: Pay close attention to what the patient is saying and show that you are actively listening. Maintain eye contact, nod, and provide verbal cues to indicate your understanding.

II. **Empathy and Compassion:** Approach each patient with empathy and compassion. Recognize their emotions and validate their concerns. Show that you care about their well-being.

III. **Use Plain Language:** Avoid medical jargon and use plain, easy-to-understand language when explaining medical conditions, procedures, and treatment plans. Ensure that the patient comprehends the information.

IV. **Open-Ended Questions:** Encourage patients to share their thoughts and concerns by asking open-ended questions. These questions invite more detailed responses and promote dialogue.

V. **Ask for the Patient's Perspective**: Inquire about the patient's perspective on their condition, treatment options, and goals. This helps you tailor care to their needs and preferences.

VI. **Educational Materials:** Provide written or visual educational materials to complement verbal explanations. These materials can reinforce information and serve as references for patients.

VII. **Repetition and Summarization:** Repeat important information and summarize discussions to reinforce key points. Check with the patient to ensure they have understood the information correctly.

VIII. **Use of Visual Aids:** Utilize visual aids, such as diagrams, models, or charts, to help explain medical concepts or procedures. Visual aids can enhance patient understanding.

IX. **Cultural Competence:** Be culturally competent and sensitive to the patient's cultural background and beliefs. This includes respecting their preferences and understanding their cultural context.

X. **Time and Patience**: Allocate sufficient time for patient interactions. Rushed conversations can lead to misunderstandings and dissatisfaction. Patients appreciate it when they don't feel hurried.

XI. **Digital Communication:** Use secure digital platforms to communicate with patients, such as through patient portals, email, or telemedicine. Ensure that digital communication is compliant with privacy regulations.

XII. **Interpreter Services:** If the patient has limited proficiency in the primary language, provide professional interpreter services to ensure accurate communication. Avoid using family members or friends as interpreters.

XIII. **Non-Verbal Communication**: Be aware of your own non-verbal cues, such as body language and tone of voice. Ensure that your non-verbal communication aligns with your verbal messages.

XIV. **Clarify Next Steps:** Clearly communicate the patient's next steps, including follow-up appointments, prescribed medications, and any lifestyle changes. Provide written instructions when necessary.

XV. **Patient Feedback:** Encourage patients to provide feedback on their communication experience. Use feedback to improve communication practices.

XVI. **Team Communication:** Foster effective communication among the healthcare team to ensure consistent and coordinated care. Share relevant patient information with other team members.

XVII. **Patient Involvement:** Involve the patient in the decision-making process regarding their care and treatment options. Ensure they understand their role and responsibilities in managing their health.

XVIII. **Conflict Resolution Skills:** Develop conflict resolution skills to handle situations where patients or their families may have concerns or complaints. Address these issues professionally and empathetically.

Effective communication with patients not only enhances the quality of care but also contributes to patient satisfaction, trust, and better health outcomes. Practising these recommendations can improve the patient experience and strengthen the doctor-patient relationship.

03.IPSG-3

High-alert drugs are medications that have a higher risk of causing significant patient harm when used incorrectly. To ensure the safe use of these drugs, healthcare institutions and professionals should follow specific guidelines and best practices. Here are proposals for the safe use of high-alert drugs:

I. **Identify High-Alert Drugs:** Establish a list of high-alert drugs that are widely available and regularly updated. This list should be easily accessible to all healthcare providers.

II. **Double Check Orders**: Require an independent double check of high-alert drug orders by two healthcare professionals to reduce the risk of medication errors. This is particularly crucial during prescribing and administration.

III. **Use Standardized Concentrations**: Standardize the concentrations of high-alert drugs whenever possible to minimize the potential for dosing errors. Limit the number of available concentrations.

IV. **Reduce Look-Alike/Sound-Alike Drugs**[LASA]: Identify and minimize the use of high-alert drugs with names, packaging, or labelling that may be confused with other medications.

V. **Limit Access and Storage:** Restrict access to high-alert drugs to authorized personnel only. Keep them securely stored in a locked cabinet or area.

VI. **Labelling and Packaging:** Ensure that high-alert drugs have distinct packaging and labelling to prevent mix-ups. Use tall-man lettering (e.g., Digitoxin vs. Digoxin) for differentiation.

VII. **Standardized Protocols:** Develop and implement standardized protocols for the prescribing, preparation, and administration of high-alert drugs. Ensure that these protocols are clear and easy to follow.

VIII. **Patient and Medication Verification:** Verify the patient's identity and confirm the medication name, dose, and route before administration. This includes using at least two patient identifiers.

IX. **Reduce Interruptions:** Minimize interruptions during the preparation and administration of high-alert drugs to prevent distractions that may lead to errors.

X. **Barcoding and Scanning:** Implement barcode scanning technology to verify the accuracy of medication administration. Scan the patient's wristband, medication, and the patient's chart.

XI. **Staff Training and Education:** Provide comprehensive training on high-alert drugs and their safe use to all healthcare providers. Ensure that staff are aware of the risks associated with these medications.

XII. **Regular Competency Assessments:** Conduct regular competency assessments to ensure that healthcare providers are proficient in handling high-alert drugs. Ongoing education and evaluation are critical.

XIII. **Error Reporting and Analysis:** Encourage a culture of reporting near misses and adverse events involving high-alert drugs. Analyze reported errors to identify root causes and implement preventative measures.

XIV. **Involvement of Clinical Pharmacists:** Engage clinical pharmacists in medication management, including dose verification, drug interactions, and patient education for high-alert drugs.

XV. **Continuous Quality Improvement:** Establish a continuous quality improvement program that regularly evaluates the safety of high-alert drug processes and protocols.

XVI. **Patient and Family Education**: Educate patients and their families about the high-alert drugs they are receiving, their potential side effects, and the importance of reporting any adverse events.

XVII. **Regular Audits and Inspections:** Conduct routine audits and inspections to ensure compliance with safety practices related to high-alert drugs.

XVIII. **National Guidelines and Resources:** Stay informed about national guidelines and resources related to the safe use of high-alert drugs and incorporate these recommendations into your healthcare institution's policies and procedures.

The safe use of high-alert drugs demands a systematic and multi-faceted approach that includes strong leadership, staff education, standardized processes, and ongoing monitoring. Following these recommendations can significantly reduce the risk associated with these medications and improve patient safety

04.IPSG-4

Ensuring the correct patient, correct site, and correct surgery is a fundamental aspect of patient safety in healthcare. The World Health Organization (WHO) has established a Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery. Here are proposals to adhere to this protocol and prevent errors in these critical areas:

1. Verify Patient Identity:

- Confirm the patient's identity by using at least two unique identifiers (e.g., full name, date of birth, medical record number).
- Ask the patient to state their name and date of birth as part of the verification process.

2. Use Patient Wristbands:

- Ensure that all patients have wristbands with accurate identification details. Verify wristband information before any procedures.

3. Confirm Procedure:

- Verify the specific procedure to be performed with the patient and their consent. Make sure the patient fully understands the procedure they are about to undergo.

4. Surgical Consent:

- Review the informed consent document with the patient to confirm their understanding and consent for the procedure. Ensure that they are informed about potential risks.

5. Surgical Site Marking:

- Clearly mark the surgical site while the patient is awake and involved in the verification process. Involve the patient in the marking process when possible.

6. Universal Protocol Checklist:

- Use a Universal Protocol checklist that includes items for patient identification, procedure verification, surgical site marking, and other safety checks.

7. Preoperative Briefing:

- Conduct a preoperative briefing with the surgical team to review the patient's identity, procedure, and specific details related to the surgery.

8. Time-Out Procedure:

- Before the start of the surgery, perform a "time-out" with the entire surgical team to verify the patient, procedure, and surgical site. This is an opportunity for everyone to confirm that they are on the same page.

9. Prevent Distractions:

- Minimize distractions and interruptions during the time-out and surgery to maintain the focus on patient safety.

10. Confirm Surgical Instruments: - Verify that the surgical instruments and equipment match the planned procedure and the patient's records.

11. Intraoperative Verifications: - Continuously verify the patient's identity, the procedure being performed, and the surgical site during the operation.

12. Documenting the Procedure: - Document the procedure accurately in the patient's records, including any deviations from the original plan.

13. Involvement of Support Staff: - Encourage the active involvement of all surgical team members, including nurses and anaesthetists, in verifying patient identity and surgical details.

14. Culture of Safety: - Foster a culture of safety within the surgical team that encourages open communication and the reporting of safety concerns.

15. Quality Improvement: - Establish a mechanism for reporting and analyzing near-miss events and errors related to patient identity, procedure, or site.

16. Continuous Training: - Provide ongoing training to all surgical team members to reinforce the importance of correct patient, correct site, and correct surgery.

17. Regular Audits: - Conduct regular audits and reviews to assess the compliance of surgical teams with the Universal Protocol and safety practices.

Adhering to these recommendations, along with the Universal Protocol established by WHO, is essential for ensuring the correct patient, correct site, and correct surgery. These measures help prevent catastrophic errors and enhance patient safety in surgical settings.

05.IPSG-5

The safe use of antibiotics is critical to prevent antibiotic resistance, minimize adverse drug reactions, and provide effective treatment. Here are proposals for the safe use of antibiotics in healthcare settings:

1. **Appropriate Antibiotic Selection:**
    - Prescribe antibiotics only when there is a clear indication for their use. Follow established guidelines for antibiotic selection based on the type of infection, pathogens, and patient characteristics.
2. **Empirical Therapy:**
    - When starting antibiotics before a definitive diagnosis is made, choose the most appropriate empiric therapy based on local resistance patterns and patient-specific factors.
3. **De-escalation:**
    - Re-evaluate antibiotic therapy regularly and de-escalate to narrower-spectrum antibiotics when possible. Avoid using broad-spectrum antibiotics longer than necessary.

4. **Dose and Duration:**
    - Administer the correct antibiotic dose and duration based on the type and severity of the infection. Avoid overuse or underuse.
5. **Allergy Documentation:**
    - Ensure accurate documentation of patient allergies to antibiotics in their medical records to prevent allergic reactions.
6. **Antibiotic Stewardship Program:**
    - Establish and implement an antibiotic stewardship program that includes guidelines for appropriate antibiotic use, audits, and feedback to healthcare providers.
7. **Infection Control:**
    - Implement infection control practices to prevent the spread of infections within healthcare facilities, reducing the need for antibiotics.
8. **Therapeutic Drug Monitoring:**
    - Monitor serum antibiotic levels when appropriate, especially for drugs with a narrow therapeutic window (e.g., vancomycin, aminoglycosides).
9. **Patient Education:**
    - Educate patients on the importance of antibiotic adherence. Instruct them to complete the full course of antibiotics as prescribed.
10. **Proper IV to Oral Conversion:**
    - Switch from intravenous to oral antibiotics when the patient's condition stabilizes to reduce the risk of complications and adverse effects associated with intravenous therapy.
11. **Prevent Drug Interactions:**
    - Be aware of potential drug interactions when prescribing antibiotics. Check for contraindications and consult with a clinical pharmacist if needed.
12. **Antibiotic Review:**
    - Review antibiotics in patients with prolonged therapy or when conditions change. Consider discontinuation if no longer indicated.
13. **Use of Narrow-Spectrum Antibiotics:**
    - Choose narrow-spectrum antibiotics over broad-spectrum ones whenever possible to reduce the risk of resistance.

14. **Culture and Sensitivity Testing:**
    - Whenever feasible, obtain cultures and sensitivity testing to identify the most appropriate antibiotic for the specific pathogen causing the infection.
15. **Antibiotic Allergies and Reactions:**
    - Promptly assess and document any allergic reactions or adverse effects of antibiotics. Update the patient's allergy list and avoid using the same class of antibiotics in the future.
16. **Multidisciplinary Collaboration:**
    - Foster collaboration between healthcare providers, pharmacists, and infection control teams to ensure the proper use of antibiotics.
17. **Documentation and Communication:**
    - Maintain clear, concise documentation of antibiotic orders and patient information, and communicate effectively among healthcare providers regarding antibiotic therapy.
18. **Regular Training and Education:**
    - Provide ongoing training and education for healthcare providers on the principles of antibiotic stewardship and safe antibiotic use.
19. **Public Awareness:**
    - Raise public awareness about the importance of appropriate antibiotic use, including not demanding antibiotics for viral infections.

By adhering to these recommendations and implementing antibiotic stewardship practices, healthcare institutions can significantly contribute to the safe and effective use of antibiotics while mitigating the risks associated with antibiotic misuse and resistance.

06.IPSG-6

Preventing patient falls in healthcare settings is crucial to ensuring patient safety. Falls can result in injuries, increased healthcare costs, and extended hospital stays. Here are proposals for fall prevention:

1. Comprehensive Fall Risk Assessment:

- Conduct a thorough fall risk assessment for each patient upon admission. Use standardized assessment tools to identify risk factors, including age, medical conditions, medications, and mobility limitations.

2. Individualized Care Plans:

- Develop individualized care plans for patients at risk of falling. Tailor interventions are based on their specific risk factors and needs.

3. Medication Review:

- Review and adjust medications that may contribute to dizziness, sedation, or impaired balance. Consult with a pharmacist if necessary.

4. Multidisciplinary Approach:

- Involve a multidisciplinary team, including nurses, physicians, physical therapists, and occupational therapists, in fall prevention efforts.

5. Patient and Family Education:

- Educate patients and their families about the risk of falls and strategies to prevent them. This includes understanding the call system for assistance.

6. Encourage Mobility:

- Encourage ambulation and mobility as appropriate for the patient's condition. Include physical therapy in the care plan to maintain or improve mobility.

7. Use Assistive Devices:

- Provide and encourage the use of appropriate assistive devices, such as canes, walkers, or handrails, to support safe mobility.

8. Safe Environment Design:

- Ensure that patient care environments are free from hazards, including clutter, wet floors, and obstacles. Use non-slip mats and appropriate lighting.

9. Bed Alarms and Sensors:

- Consider using bed alarms, chair alarms, or sensor systems that alert staff when a patient attempts to get out of bed.

10. Hourly Rounds: - Implement regular, hourly rounds by nursing staff to check on patients and assist with toileting or repositioning as needed.

11. Call Bell Accessibility: - Ensure that call bells are within easy reach of the patient and instruct them on how to use the call system to request assistance.

12. Bed and Chair Alarms: - Use bed and chair alarms for patients at high risk for falls to alert staff when the patient attempts to leave the bed or chair.

13. Personalized Fall Prevention Interventions: - Implement personalized interventions for high-risk patients, such as using a low bed, and placing non-slip socks or footwear.

14. Safe Transfers: - Ensure that staff receive training in proper techniques for transferring patients from the bed to a chair or the bathroom and use two-person assistance when necessary.

15. Environmental Design: - Design the physical environment with safety in mind, including the layout of furniture and fixtures, handrails in hallways, and non-slip flooring.

16. Regular Reassessment: - Continuously reassess patient fall risk throughout their hospital stay, particularly when there is a change in their condition.

17. Post-Fall Review: - Conduct a post-fall review for every patient who experiences a fall. Analyze the contributing factors and adjust the care plan accordingly.

18. Reporting and Feedback: - Encourage staff to report near-miss events or potential fall situations. Use reported incidents as opportunities for learning and improvement.

19. Data Tracking: - Maintain records of fall incidents and regularly analyze the data to identify trends and areas for improvement.

20. Leadership Support: - Ensure that hospital leadership supports and prioritizes fall prevention efforts. Allocate resources and training to reduce fall risks.

Preventing patient falls is an ongoing and multifaceted process that requires the commitment of healthcare providers and institutions. By implementing these recommendations, healthcare facilities can significantly reduce the risk of patient falls and enhance patient safety.

V.Recommendations

However, considering the feasibility of addressing technical, administrative, financial and practicability; I will suggest the following recommendation for obstetrics wards of the DMH.

1) Provide comprehensive training to all staff about patient safety practices
2) Implementation and Rollout of the patient safety protocol

VI.Implementation

Implementation of aforementioned recommendations could be done at DMH through following strategies.

Table 4:Implementation-Strategy,Activities and Responsibility

Strategy	Activities	Responsibility
1. Training and Education	I. Provide comprehensive training to all staff about patient safety practices II. Ensure that they understand the protocol [importance and potential effect on patient safety] III. Post-training assessment using **"Kirkpatrick"** evaluation tool	Director Deputy Director VOGs ET&RUnit of MoH MO/Planning SGNOs NO/HE Ward Sisters
2. Implementation and Rollout of the protocol	I. Implement the protocol in one Obstetrics ward I. Identify any issues or challenges before full-scale implementation II. Establish mechanisms to monitor the implementation of the protocol continuously	Director Deputy Director VOGs MO/Planning SGNOs Ward Sisters

VII.Conclusion

The case study highlighted the importance of patient safety practices at obstetrics wards in DMH to enhance patient safety. By implementing training programmes, standardized protocols, promoting better communication, and leveraging health information technology, the DMH could reduce medication errors, optimize patient care, and ensure smooth care transitions for patients in obstetrics wards.

VIII.References

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