International Journal of All Research Education and Scientific Methods (IJARESM),
ISSN: 2455-6211, Volume 12, Issue 11, November-2024, Available online at: www.ijaresm.com

A Study on: Reduce Adverse Impact of Risk and Improve Patient Safety by the Effective Use of Hospital Management

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ABSTRACT

Hospitals deal with the life and health of their patients. Good medical care relies on well-trained doctors, nurses, and high-quality facilities and equipment. Whenever a patient goes to a doctor the patient is treated in several conditions due to this, the chance of increased medical error. As a result, most patients die because of medical mistakes and improper treatment every year. In that case, the hospital administrator oversees various aspects of hospital operations from resource allocation to patient safety. Patient safety is a new healthcare discipline that encompasses reporting, analyzing, and preventing medical errors that often lead to adverse healthcare events.

The field of hospital administration has evolved significantly, adapting to the changing dynamics of the healthcare industry. This study is intended to discuss the role of healthcare professionals in maintaining a culture of safety and also explore critical aspects of patient safety and risk management within healthcare institutions. This paper highlights some technological advantages and strategic methods for reducing the adverse effects of risk and improving patient outcomes. The study concludes with recommendations for enhancing patient safety and risk management through systematic changes and collaborative efforts across all levels of the healthcare industry.

Keywords: Hospital, Patient Safety, Risk, Medical Error.

INTRODUCTION

“First, do no harm" is the most fundamental principle of any healthcare service and there is compelling evidence of a huge burden of avoidable patient harm globally across the developed and developing healthcare system. Over the past 20 years, there has been rapid growth in interventions to improve the safety of people, who receive care. The rapid progress in medical science over the past century has resulted in untold benefits for all. As a result, the need of the persons was changed, and their narrative was not as important as the medical tests and investigations. The organizational structure of the healthcare system has been divided into two parts one is patient safety and another one is risk management. It is increasingly clear that patient safety has become a discipline; complete with an integrated body of knowledge and expertise, and that it has the potential to revolutionize health care, perhaps as radically as molecular biology increased the therapeutic power in medicine. Nowadays, patient safety is recognized in many countries and there continue to be significant challenges to implementing patient safety policies and practices. The important responses to this realization have been the growth of interest in patient safety. On the other hand, risk management in healthcare comprises the clinical and administrative systems, processes, and reports employed to detect, monitor assess, mitigate, and prevent risks. By employing risk management, healthcare organizations proactively and systematically safeguard patient safety as well as the organization's assets, market share, accreditation, reimbursement levels, brand value, and community standing.

LITERATURE REVIEW

A. Fall (2001) has tried to explore the risk managers' role in creating an organizational patient safety strategy. The study reports that improving patient safety could not come at a better time for healthcare risk managers.
B. Kuhn and Youngberg (2002) focus on department-based risk assessment, loss management, and risk financing and finally report that risk managers who accept change and think of new ways to embed risk management principles into their organizations can help create meaningful and sustainable change in the future.
C. Andreasson et al. (2017) have explored the importance of healthcare managers' organizational preconditions and support resources for their appraisal of planned change and its outcomes. Here, researchers report that managers who

perceived strong support from employees, management, and the organizational structure perceived higher levels of healthcare process quality.

D. Fanelli et al. (2021) have investigated how healthcare professionals perceive their level of preparation in managerial skills. The study found that healthcare professionals feel sufficiently prepared in all managerial areas identified.
E. Huda Jalal Jaber et al. (2023) have investigated the association between the perceived patient safety culture and its relationship with horizontal violence among nurses working in Jordan. The study found that despite its low incidence, patient safety culture was found influential to the horizontal violence based on the perspectives of nurses in Jordan.
F. Liberati et al. (2023) have examined the first documented attempt to apply the Safety Case methodology to clinical pathways. The researcher reports that the safety case approach was recognized by those involved in the Safer Clinical Systems.

OBJECTIVES

A. To study the role of healthcare professionals in maintaining a culture of safety.
B. To discuss about the various aspect of patient safety and risk management within the healthcare institution.
C. To explore various strategies adopted to reduce the adverse effects of risk and improving patient outcomes.
D. To study the adaptation of technological advantages for reducing risk.

METHODOLOGY

A descriptive analytical design is used in the study to thoroughly examine the topic. The methodology's main focus is on analyzing and interpreting the available facts to offer a thorough explanation and comprehension of the subject. In order to ensure that the analysis is based on previously collected and documented information, the data collection procedure depends on secondary data sources. This method enables a comprehensive review of previous studies, papers, and other pertinent materials, supporting a solid and perceptive investigation of the research topic.

THE ROLE OF HEALTHCARE PROFESSIONALS IN MAINTAINING A CULTURE OF SAFETY

A culture of safety in a healthcare organization is an environment where safety is a shared value and priority for all, from frontline staff to executive leadership. It reduces the incidence of medical errors, and patient falls, decreases the likelihood of workplace injuries, and equipment-related hazards, and promotes a more positive working environment, which can lead to higher staff retention rates.

In such a culture, every member of the healthcare administration is empowered to speak up about risks and work collaboratively to resolve them. This approach ensures that the safety and well-being of patients and staff are always at the forefront of healthcare delivery. A strong safety culture can improve patient outcomes, enhance the level of trust patients have in their healthcare providers, and can even contribute to the financial stability of healthcare institutions by avoiding the cost associated with preventable errors and accidents. Moreover, this commitment not only enhances the quality of patient care but also ensures a safe working environment for healthcare professionals.

i. Leadership commitment: Top management must actively demonstrate their commitment to safety by allocating resources, setting clear expectations, and leading by example.
ii. Open communication: Encourage staff to voice safety concerns without fear of revenge. Establishing channels for transparent communication promotes a culture of trust and collaboration.
iii. Comprehensive training: Provide ongoing training and education to all staff with the knowledge and skills necessary to uphold standards and respond effectively to potential hazards.
iv. Regular safety audits: Conduct routine assessments to identify potential risks and areas for improvement. Regular audits help to proactively address safety issues before they escalate.
v. Recognition and reward: Recognize and celebrate individuals and teams who demonstrate a commitment to safety. Positive reinforcement desired behaviors and motivates continued adherence to safety protocols and is an important step that shouldn't be overlooked if the patient is looking at how to change safety culture.

VARIOUS ASPECT OF PATIENT SAFETY AND RISK MANAGEMENT WITHIN THE HEALTHCARE INSTITUTION:

Risk management has become an integral part of hospital management in most of the developed countries. Given the rapid changes in all facets of the healthcare industry, there is a need to continually monitor and evaluate risk management and patient safety programs. Following are some needed areas of risk management programs:

i. Safety of female patients: Female patients are supposed to be informed of the procedure of the treatment well before the actual procedure of the treatment takes place. Male and female patients should not be kept in the same ward. During the

routine examination by a male physician, he should be accompanied by the female nurse on his round.

ii. Safety of patient's belongings: If a patient comes to casualty, accident, or emergency department it is the duty of the nurse attending the patient, to keep the jewellery and his other personal belongings in a safe place. As well as there should also be a documented policy, regarding the safety of the patient's personal belongings, hence if unconscious, the sister in charge of the patient looks after his belongings and keeps them safe with a security officer. Such safety policy is conveyed to the patients and their relatives through notice boards.

iii. Safety of the dead bodies: It is very crucial in every healthcare organization. The mortuary department should have a distinct register of the inward and outward of the dead bodies. It should be guarded 24x7 by security personnel. The department should properly name the dead body and kept in cold storage.

iv. Swapping or theft of patients: Psychiatric patients may attempt to run away from the hospital premises if the security is not up-to-mark. In that case activated code pink in the hospital

v. Discharge Against Medical Advice (DAMA): It is very important from the patient's point of view. Hospital clinical teams legally and morally are obliged to provide health care services for patients from admission until the end of the treatment process. The clinical staffs of the hospital sometimes encounter patients who refuse to continue the treatment at the hospital and leave the hospital against the advice of physicians and their desires.

VARIOUS STRATEGIES ADOPTED TO REDUCE THE ADVERSE EFFECT OF RISK AND IMPROVING PATIENT OUTCOMES

Hospital management plays a crucial role in developing a culture of continuous improvement throughout the organization. They can lead an improvement team, encourage staff engagement in quality improvement initiatives, and provide the necessary resources and support. Administrators should also ensure that data-driven decision-making is ingrained in the hospital's culture, make evidence-based adjustments to care processes, and ultimately achieve better patient outcomes. Strategies for improving patient outcomes are as follows:

i. Patient-Centered Care: It reviews healthcare by prioritizing the patient in all decisions and actions. Its tailor's services to individual needs, values, and preferences, enhancing satisfaction and engagement

ii. Enhancing Patient Satisfaction: It includes regular surveys for feedback, personalized care plans, minimizing wait times, effective patient education, respecting dignity, and patient advocacy programs.

iii. Effective Communication: It is a crucial part of every organization with empathy training and shared decision-making.

iv. Collaboration and Interdisciplinary Care: It promotes teamwork among all healthcare professionals from different specialties for comprehensive and effective patient care.

v. Mortality Rate: It is essential to assess the overall effectiveness of clinical care. Hospitals should establish robust mortality review committees that evaluate patient deaths to address this. These committees should analyze the root causes of death and by avoiding the risk take initiatives to prevent avoidable deaths.

vi. Complication Rates: Measuring complication rates related to surgeries, medical interventions, and hospital-acquired infections is essential for patient safety. Comprehensive training and monitoring of healthcare-associated infections are vital for reducing complication rates.

vii. Patient Satisfaction Scores: Gathering patient feedback through standardized surveys. Hospitals should regularly administer patient satisfaction surveys and use the results to identify areas for improvement.

viii. Length of Stay: Hospitals should implement care pathways and protocols that optimize patient flow and resource allocation to address this. Regular performance reviews and process improvement initiatives can help streamline care delivery and reduce unnecessary delays in patient discharge.

ix. Patient Satisfaction Indicators: Hospitals should establish patient safety committees investigating adverse events and near misses to address this. Root cause analyses should be conducted to identify systemic issues, and corrective actions should be implemented. Ongoing staff training on patient safety protocols is essential.

x. Adherence to Clinical Guidelines: Hospitals should establish clinical guidelines committees responsible for developing, disseminating, and promoting adherence to evidence-based protocols. Regular audits and feedback mechanisms should be in place to monitor compliance with clinical guidelines and create continuous improvement.

ADAPTATION OF TECHNOLOGICAL ADVANTAGES FOR REDUCING RISK

Various methods have been developed that will help in diluting medication errors and develop the healthcare system.

i. Electronic Health Record: More advancement in electronic health records includes standard drug dosages, allergy checks, and patient education information. Moreover, clinical guidance for disaster management has demonstrated benefits when accessible within the electronic record during the process of treating the patient.

ii. Computerized Provider Order Entry: Errors in prescription are the largest identified source of preventable errors in hospital. Computerized provider order entry (CPOE) also known as computer physician order entry, reduces medication error by diluting harm to the patient.

iii. Evidence-based Medicine: It includes the experience of the doctor in developing dose preparation and drugs to be used. The clinician uses pertinent clinical research on the accuracy of diagnostic tests and the efficiency and safety of therapy, rehabilitation, and prevention to develop an individual plan of care.
iv. Health Literacy: It is one of the most common and serious safety concerns. Patient's inability to understand the physician and pharmacist counselling also develops patient medication errors.
v. Pay for Performance: This technique seems to be the most promising approach in reducing errors but cases have been reported as avoidance of high-risk patients when payment was linked to outcomes improvements.

RECOMMENDATION

i. Hospitals give serious consideration to implementing or strengthening risk management programs to protect their assets and minimize losses. More scientific research into patient safety improvement is needed, the results and effectiveness of which should be shared across the scientific community worldwide.
ii. It is necessary to advocate the concept of patient safety is not only in the hands of clinicians and nurses but also in the hands of every healthcare worker. All the healthcare organizations have must provide the training of all healthcare workers in specific maters of safety.
iii. Management of patient safety and prevention of injury risks is a collective responsibility of the entire perioperative team. Hospital faced the challenges of a changing healthcare sector in today's age of multi-morbidities, researchers, caregivers and patients should work together to address the current limits of clinical guidelines.
iv. Communication for safety in perioperative settings includes a wide array of protocols and topics to prevent patient harm. The potential of electronic health records and computer ordering system address the communication and transcription challenges in patient safety are still to be realized. They have not overcome communicational issues but offer the opportunity to have better communication and easier pathways, if the implementation is successful.
v. Maintaining fluid and electrolyte balance is a collaborative effort that prevents deficit volume in the surgical patient.
vi. Protection of a patient's personal, ethical and legal rights underlies patient safety and risk management in perioperative settings. Training of patients is the fundamental starting point to develop shared knowledge and implement an active multilevel participation of patients and families for the improvement of quality and safety care.
vii. Major government, regulatory and accrediting agencies and associations address key elements of patient safety.

CONCLUSION

Patient safety is a growing global concern. All the family members, community members are harmed unnecessarily from unsafe care. The healthcare system has only recently begun to approach patient safety in a more systematic way. There is a clear need to improve the quality of care in the medical system. The ultimate goal of patient safety program is that the medical Centre has a safety level that is sufficient to protect patient from harm and preventable complication, disability and mortality during medical management. On the other hand, risk management has become an integral part of hospital management in the most of the developing countries. However, the needed attention to the concept and process of risk management in the developing countries is yet to be given. Healthcare professionals are encouraged to participate actively. Embrace new technologies, engage in continuous learning and contribute to a culture prioritizing patient safety and proactive risk management. The future of patient safety and risk management lies in embracing trends and leveraging technological advancement like telemedicine, AI, data analytics, etc. By doing so, healthcare professionals can play a vital role in shaping a future where patient care is safer, more efficient and responsive to the needs of patients.

ACKNOWLEDGMENT

This paper is not only the fruit of the labor of the authors themselves. Without the dedicated involvement of a number of individuals it would not have been published. The author would like to express their profound gratitude to the person without whose support and encouragement this paper could never be published.I would like to acknowledge the authors and the researches for their valuable information without which my study could not be completed. I would like to convey my gratefulness to my family who inspired me to undertake such a work.

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