Quality & Patient Safety



FOCOS Hospital

HEALTHCARE QUALITY & PATIENT SAFETY ORIENTATION

Presented By: Joy Dede Okrah

ORIENTATION PROGRAM

FOR NEW EMPLOYEES

Hello and a very warm welcome to all our new colleagues! We are absolutely thrilled to have you join the FOCOS family. My name is Joy Dede Okrah, and I am with the Quality unit of FOCOS Orthopaedic Hospital. Today, we're going to embark on a very important journey together: an overview of Healthcare Quality and Patient Safety. This isn't just about rules and regulations; it's about the core of why we are all here: to provide exceptional, safe care for every patient, every time. Let's begin.

LEARNING OBJECTIVES

By the end of this session, participants will be equipped to:

- Perform an improvement using the PDSA cycle.
- Define and categorize incidents.
- Understand the international patient safety goals (IPSG) and its key components.
- Roles and responsibilities of each employee.

OUTLINE

PART 1 – Introduction and Foundations

- Mission and Vision
- Goals of Department
- Framework
- Functions
- Dimensions of Healthcare Quality

PART 2 – A Culture of Safety - Incident Reporting

PART 3 – Global Standards & Our Responsibilities

- International Patient Safety Goals (IPSG)
- JCI Accreditation Preparation - Standards and Policies

PART 4 – Post-Test



PART 1
Introduction and Foundations

MISSION & VISION



This is our mission in the Quality Department. Please take a moment to read it. 'To continuously improve the safety and quality of care in FOCOS'. This word, **'continuously,'** is vital. It means that no matter how good we are, we believe we can always be better. It's a shared responsibility that involves every single one of us, in every role.

And this is our vision. 'For **all** patients to experience the safest, high quality and best-value healthcare.' This is our ultimate goal. It's a promise we make to our community. Whether you interact with patients directly at the bedside or support their care from behind the scenes, your work is integral to making this vision a reality.

OUR CORE GOALS

To ensure continuous improvement of the quality of services rendered to internal and external customers (patients) of FOCOS Hospital.

To **improve patient safety** and **reduce risk** to patients as well as staff



To achieve this mission and vision, our department has specific goals. While the details are many, they all centre on a few key themes: building a robust framework for quality, measuring our performance, and most importantly, fostering a culture where every team member feels empowered to speak up for safety and quality.

FUNCTIONS



So, what does the Quality Department actually do? Our key functions include monitoring performance data, leading improvement projects using the framework we will discuss, preparing for accreditations like JCI, performing risk assessments, enhancing patient safety through auditing, managing the incident reporting system, and most importantly, supporting all of you; our frontline staff in providing safe care.

FRAMEWORK

Our quality efforts are structured within a clear framework. Think of this as the platform that holds up everything we do. Let's briefly explain these pointers in terms you'll see in action during quality improvement projects.

Plan-Do-Study-Act (PDSA) Cycle: This is how we test changes on a small scale.

For example, we might

- **Plan** a new way to schedule patient transport
- **Do** it for one week on one unit
- **Study** the results to see if it reduced wait times, and
- **Act** on what we learned by adopting, adapting, or abandoning the change.



OTHER IMPROVEMENT METHODS



Root Cause Analysis (RCA): When a serious incident occurs, we don't just stop at the **'what.'** We use RCA to dig deep and find the **'why'** – the underlying system failures, so we can fix them for good.



Performance & Quality Measures (Metrics): We measure what matters. This includes hospital-wide data like infection rates, fall rates, and patient satisfaction scores. These metrics tell us if we are succeeding and where we need to focus our improvement efforts. Additionally, every department has its own key performance indicators tailored to their processes and workflow.



Benchmarking: We don't just look internally. We compare our performance data against other top hospitals, WHO, CDC, accrediting bodies like the JCI, to see how we can be even better.

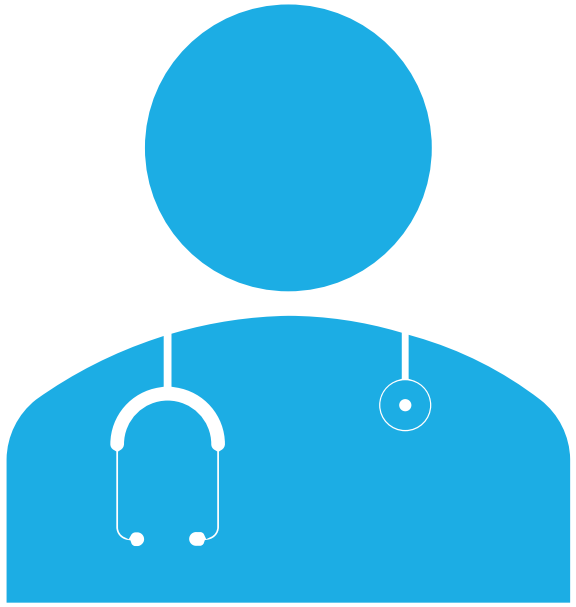


Evidence-Based Practice: Our decisions and procedures are not based on habit; they are based on the best available scientific evidence and clinical guidelines.



This framework ensures we are systematic, not haphazard, in our pursuit of excellence.

HEALTHCARE QUALITY DIMENSIONS



WHAT IS QUALITY OF CARE?

*Now, let's get into the heart of the matter. What do we actually mean by **'quality' in healthcare?** It is more than just being nice. It's a multi-faceted concept, best defined by six key dimensions.*

DIMENSIONS OF HEALTH CARE QUALITY

Dimension	Meaning
1. Safety	Avoiding injuries to patients from the care that is intended to help them.
2. Timeliness	Reducing waits and harmful delays for both those who receive and those who give care.
3. Effectiveness	Providing care that is based on scientific knowledge (evidence-based) and results in improved health outcomes. Avoiding underuse and overuse of care.
4. Efficiency	Delivering care with optimal use of resources, avoiding waste (e.g., of time, supplies, or money).
5. Equity	Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, or socioeconomic status.
6. Patient-Centered	Respecting and responding to patient preferences and needs.



Quality Care, Every Time

The 6 key dimensions of quality healthcare

Right care. Right way. For every patient.

Safety

Avoiding harm to patients.

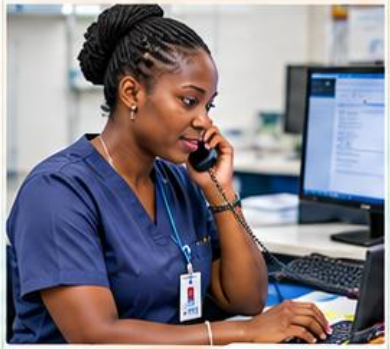


Example:

- Correctly using two patient identifiers to prevent misidentification.
- Housekeeping staff ensuring a wet floor is marked with a sign to prevent a fall.

Timeliness

Reducing waits and harmful delays.

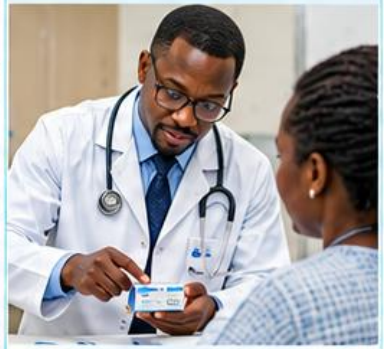


Example:

- A nurse ensuring a critical lab result is communicated to a doctor immediately.
- The registration team at the OPD streamlining the admission process to reduce patient waiting time.

Effectiveness

Providing services based on scientific knowledge.



Example:

- A doctor prescribing the right antibiotic for a specific infection.
- A physiotherapist using proven techniques to help a patient recover mobility.

Efficiency

Avoiding waste.



Example:

- An inventory officer managing supply inventory to prevent over-ordering and expiration.
- A nurse organizing tasks to minimize unnecessary steps during a shift.

Equitable

Providing care that does not vary in quality due to personal characteristics.



Example:

- Providing interpreter services for all patients who need them.
- Ensuring the same high standard of care is given to every patient, regardless of their background.

Patient-centered

Providing care that is respectful of and responsive to individual patient preferences.



Example:

- A nurse taking the time to explain a procedure in a way the patient understands.
- The food service staff accommodating a patient's dietary preferences.

Quality isn't a single action — it's a mindset.

Each of us plays a part in delivering safe, timely, effective, efficient, equitable and patient-centered care.

Better care together



PART 2
A Culture of Safety: Incident Reporting

INCIDENT REPORTING

Incident: An event which happens in the hospital or its grounds, which is not consistent with routine operations and

- May have the potential to negatively affect patient outcome.
- May or may not result in injury
- May result in loss or damage to property or equipment
- May involve loss or damage to the property of a patient, staff or visitors.
- May be behavioral and involve a patient, staff, contractor or visitor.

Safe Care Starts with a Proactive Safety Culture

How we view and report incidents helps us prevent harm, learn, and improve care for everyone.



What is an incident?

An **incident** is any event that happens in the hospital that is not part of routine operations.

This includes events that may involve:

Potential to negatively affect a patient

Even if no one was actually hurt.



Loss or damage to property or equipment



Property of a patient, staff, or a visitor loss or damage



Behavioral incidents involving a patient, staff, a contractor, or a visitor



The key takeaway is that an incident is **any deviation from the norm.**

REPORT • LEARN • PREVENT
A SAFER TOMORROW

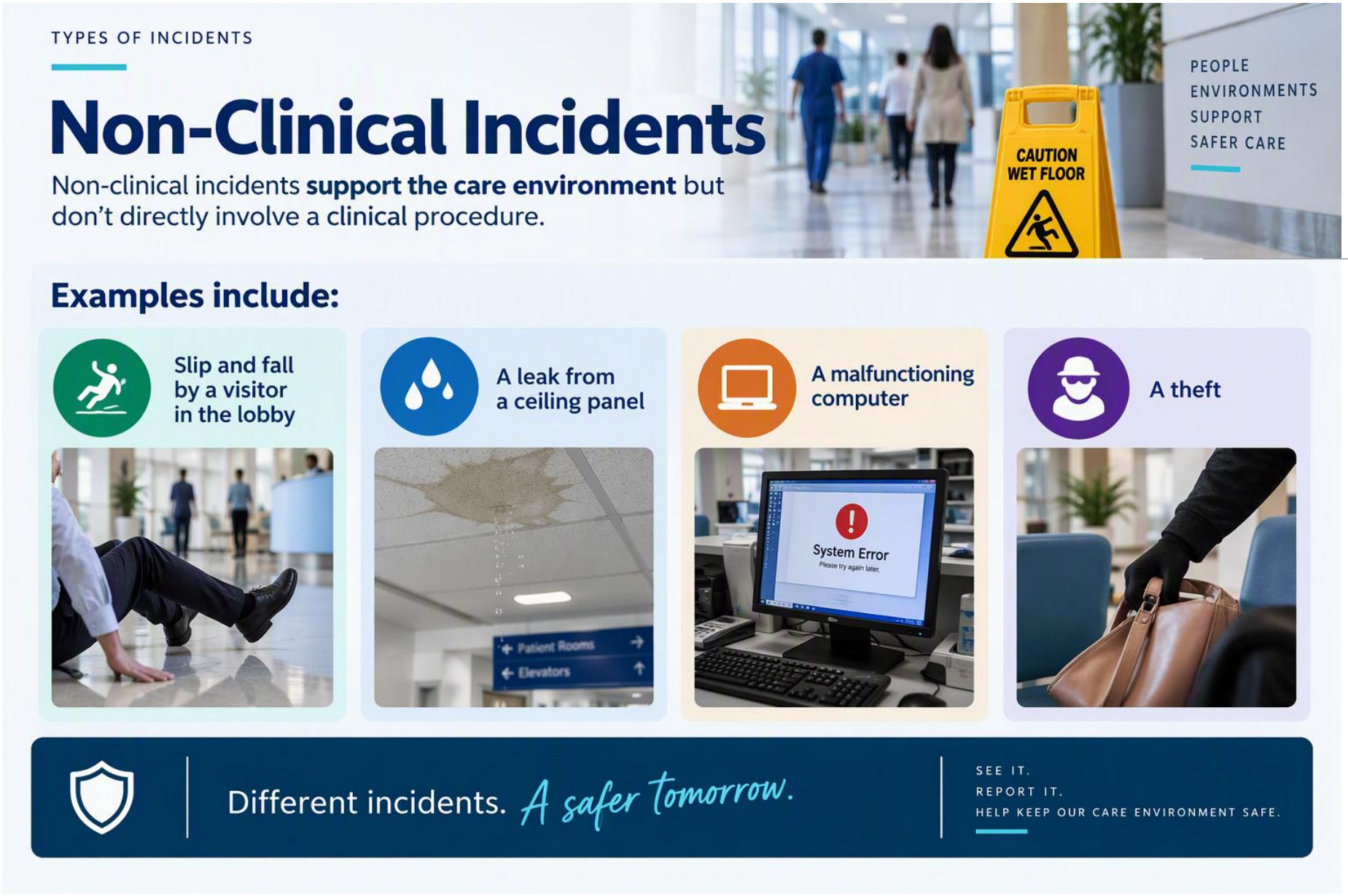
INCIDENT REPORTING TYPES



Clinical Incident

Is an unexpected event in healthcare involving patient care that caused harm, had the potential to cause harm, or reached the patient without causing harm. It can be due to mistakes, system failures, or unforeseen complications.

INCIDENT REPORTING TYPES



Non-Clinical Incident

Is an unplanned event that occurs within a healthcare facility that does not directly involve clinical care but causes, or has the potential to cause harm, injury, damage, disruption, or a security concern, and affects safety, operations, or efficiency.

INCIDENT REPORTING CATEGORIES

Now, let's look at the **four main categories** we use to classify incidents, which helps us analyse them correctly. It's crucial to understand that these categories are about the outcome of the event, and they apply to both clinical and non-clinical situations.



Near Miss

- Any process variation that did not affect an outcome but for which a recurrence carries a significant chance of a serious adverse outcome. Such a “near miss” falls within the scope of the definition of an adverse event.



No-Harm Incident

- Any undesirable event that does reach an individual but does not cause harm to the person.



Adverse Events

- Any serious undesirable patient safety event that resulted in harm to the patient but does not rise to the level of being a sentinel event.



Sentinel Events

- Any unexpected occurrences involving death or serious physical/physiological injury (either temporal or permanent harm).

Categories of Incidents

Different events. A shared opportunity to learn and improve.

A Safer Tomorrow Together

Near Miss

An event that could have harmed a patient, but didn't, either by chance or because it was caught in time.

Example:
A medication was ordered incorrectly, but the pharmacist caught the error before it reached the patient.



No Harm Event

An event that reached a patient, but did not cause any harm.

Example:
A patient received the wrong dose of medication, but experienced no adverse effects.



Adverse Event

An event that resulted in harm to a patient.

Example:
A patient fell in the hospital and sustained a fracture requiring treatment.



Sentinel Event

A serious, often preventable event that results in death, permanent harm, or severe temporary harm.

Example:
A patient undergoes the wrong surgical procedure on the wrong body part.



All incidents provide valuable information.

Report. Learn. Improve. Together.

PEOPLE | SAFETY | BETTER CARE

Note:

- This is the most critical point I want to make about incident reporting. This process exists for systems improvement and to build a just culture. It is primarily not about blaming individuals. We are human, and humans working in complex systems will make errors. When you report an incident, whether it's a near miss or a no-harm event, you are providing us with a precious piece of the puzzle. You are helping us see where our processes are broken, so we can fix the system and prevent it from happening again to any patient, or to any colleague. You are not getting into trouble for reporting; you are being a hero for our patients and our team.

- And please remember this: All staff must report any incident they are involved in or witness. This is not optional; it's a professional responsibility that is fundamental to our ability to learn and improve as an organization.



No incident should be downplayed no matter its severity.

All incidents should be reported within **24-72 hours**, except sentinel events which should be reported within **24-48 hours** as per hospital policy.



PART 3
Global Standards & Our Responsibilities

*Beyond our internal systems, we align with global standards. The **International Patient Safety Goals (IPSG)**, are a set of core protocols recognized worldwide to minimize the most common and high-risk areas of patient care. Let's walk through these critical goals.*

INTERNATIONAL PATIENT SAFETY GOALS (IPSG)

1



IDENTIFY PATIENT CORRECTLY

2



IMPROVE EFFECTIVENESS OF COMMUNICATION

3



IMPROVE THE SAFETY OF HIGH-ALERT MEDICATIONS

4



ENSURE CORRECT-SITE, CORRECT PROCEDURE, CORRECT PATIENT SURGERY

5



REDUCE RISK OF HEALTH CARE-ASSOCIATED INFECTIONS

1 INTERNATIONAL PATIENT SAFETY GOALS (IPSG)

Identify Patient Correctly

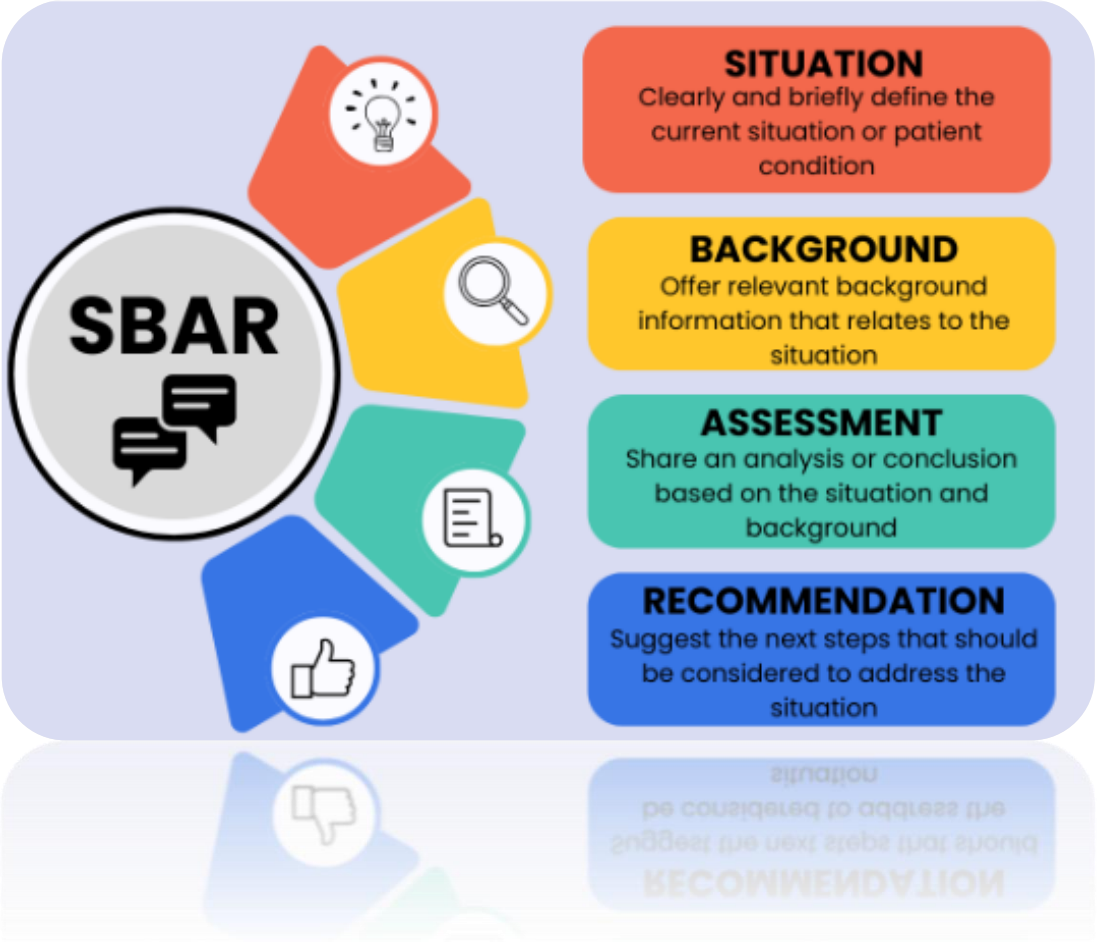
IPSG 1: Identify Patients Correctly. At FOCOS Hospital, we use two patient identifiers: the **patient's full name** and their **date of birth**. You must use both, every single time, before administering medication, taking a blood sample, or providing any treatment or procedure. This is our simplest and most powerful tool to prevent errors.



2 A

INTERNATIONAL PATIENT SAFETY GOALS (IPSG)

Improve Effectiveness Of Communication

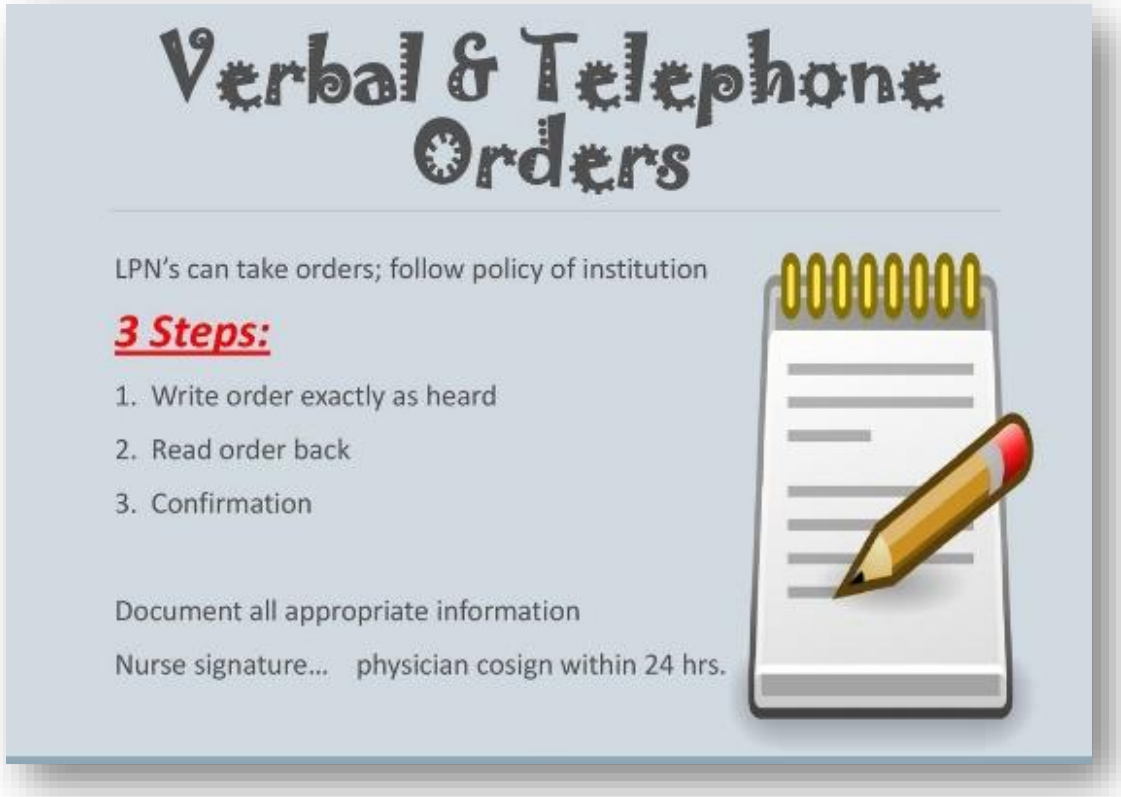


IPSG 2: Improve Effective Communication. Miscommunication is a leading cause of errors. In FOCOS, we standardize this using the **SBAR** tool: Situation, Background, Assessment, Recommendation. This is used during handoffs between shifts or when transferring a patient to another department.

2 B

INTERNATIONAL PATIENT SAFETY GOALS (IPSG)

Improve Effectiveness Of Communication



IPSG 2: Improve Effective Communication. Furthermore, for **verbal and telephone orders**, they must be documented, read back to the prescriber for confirmation, and then carried out. For critical test results, timely communication is key and must be documented by both the sender and the receiver to ensure the loop is closed.

3 INTERNATIONAL PATIENT SAFETY GOALS (IPSG)



Improve The Safety Of High-Alert Medications



IPSG 3: Improve the Safety of High-Alert Medications. High-alert medications are drugs that carry a significantly higher risk of causing serious harm if used incorrectly. Common examples include insulin, anticoagulants like heparin and warfarin, concentrated electrolytes, and opioids. To manage this risk, we have specific protocols: **these medications are stored in standardized, dedicated locations, often with extra red labels**. Their use frequently **requires independent double-checks** by two qualified staff members before administration. It is absolutely vital that everyone involved in the medication process is aware of these high-alert medications and follows the safety procedures meticulously.

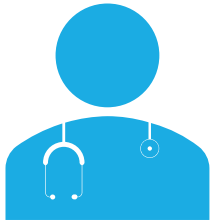
4 INTERNATIONAL PATIENT SAFETY GOALS (IPSG)



Ensure Correct-site, Correct Procedure, Correct Patient Surgery

IPSG 4: Ensure Safe Surgery (Correct Site, Correct Procedure, Correct Patient Surgery). This goal is about making sure we do the correct surgery, on the correct patient, on the correct site. To achieve this, we use a pre-operative verification process, mark the surgical site clearly, and perform a "Time-Out" immediately before starting the procedure. In the **"Time-Out,"** the entire team pauses to verbally confirm the correct patient, procedure, site, and any critical information. This final check is a universal responsibility of everyone in the operating room. Completing our safe surgery protocol is the **Surgical Sign-Out**, a final team briefing after the procedure but before the patient leaves the operating room. This standardized pause ensures the entire team agrees on the procedure that was actually performed, confirms that all instrument and sponge counts are correct, and outlines the key recovery plans. It acts as a vital safety closure for the operation and ensures a clear handoff for the patient's post-operative care.

4 INTERNATIONAL PATIENT SAFETY GOALS (IPSG)



Ensure Correct-site, Correct Procedure, Correct Patient Surgery

WHO checklist

SIGN IN

Anaesthetist and assistant
(Before induction of anaesthesia)

Patient confirmation
- Name
- Procedure
- Site marked

Allergies?

Anaesthetic safety
- Airway plan
- Antibiotics

E-issue blood available?

STOP **Stop before you block**

TIME OUT

Introductions

Team: Confirm patient's
- Name
- Procedure
- Site and side
- Imaging
- Allergies

Surgeon
- Significant blood loss?

Team
- Diathermy on
- Antibiotics given
- Specimen plan
- Warming on
- VTE prophylaxis on

Anyone not happy to start?

SIGN OUT

Whole theatre team
- Procedure recorded as…
- Counts correct
- Specimens labelled
- Packs removed / labelled
- Lines flushed
- Equipment problems

Post op plan
- Specific concerns?
- VTE and antibiotic plan
- Daycase?

5

INTERNATIONAL PATIENT SAFETY GOALS (IPSG)

Reduce Risk Of Health Care-Associated Infections





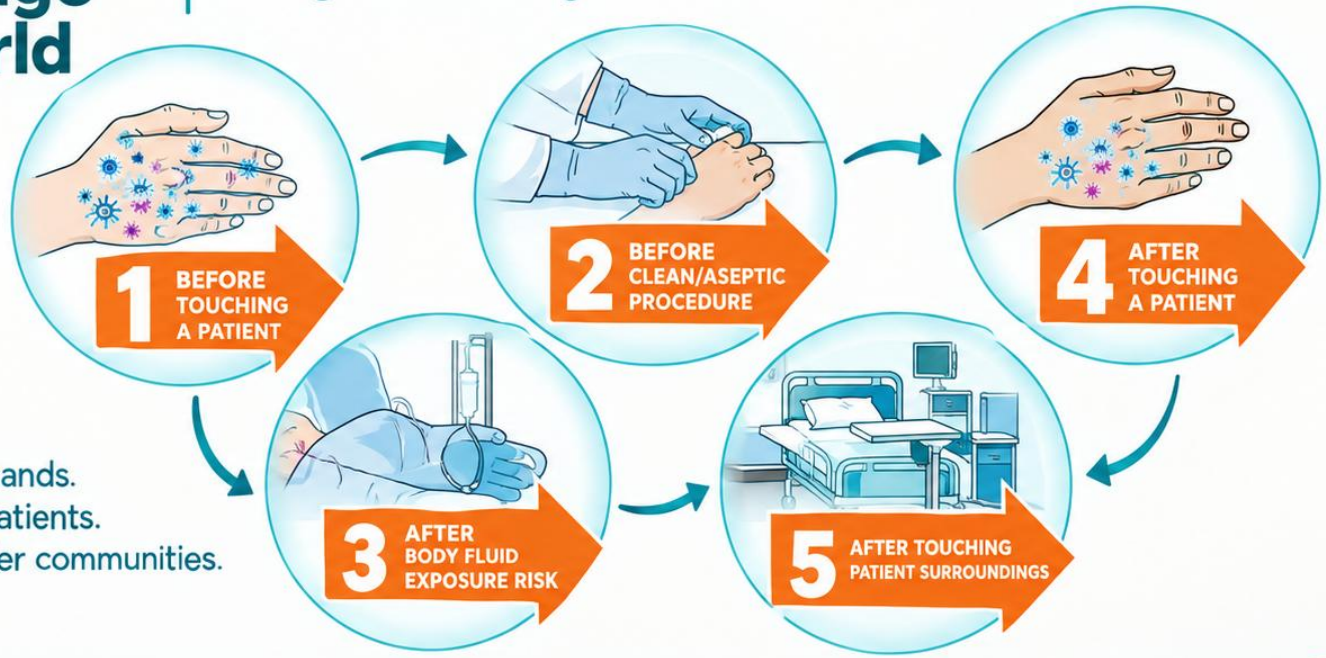
IPSG 5: Reduce the Risk of Health Care-Associated Infections. Hand hygiene is the single most important way to prevent the spread of infections. According to the **WHO's 'My 5 Moments for Hand Hygiene,'** you must clean your hands: before touching a patient, before a clean/aseptic procedure, after body fluid exposure risk, after touching a patient, and after touching patient surroundings. This applies to every single person in this hospital. Additionally, we follow strict protocols for cleaning equipment, managing linens, proper waste segregation and using personal protective equipment (PPE).



It takes just 5 Moments to change the world

Clean your hands, stop the spread of drug-resistant germs!

Clean Hands Safer Care



Clean hands.
Safer patients.
Healthier communities.

World Health Organization

SAVE LIVES
Clean Your Hands

No Action Today
No Cure Tomorrow



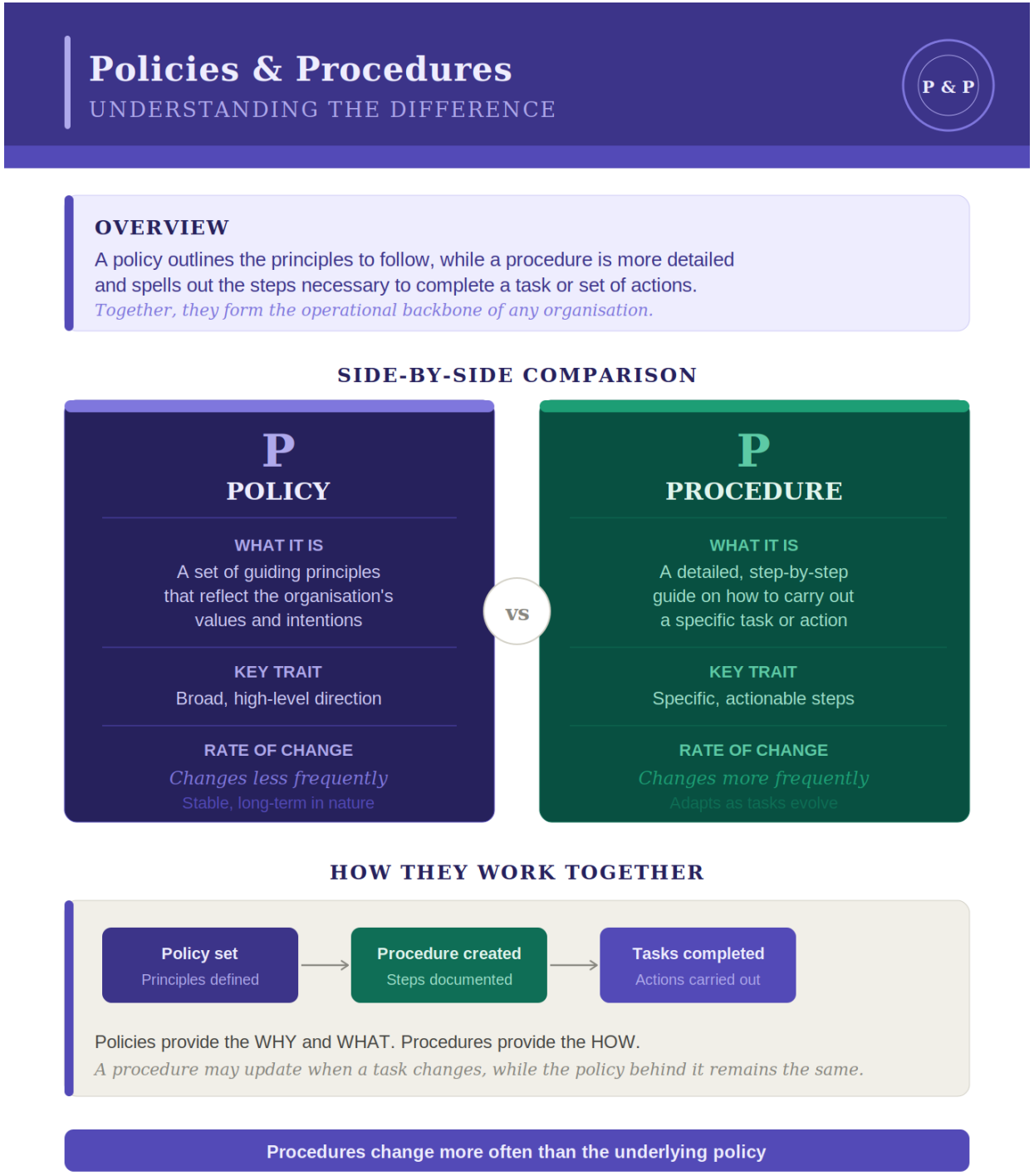
Across all these IPSGs, the message is the same: **patient safety comes first, and it starts with us doing the right thing even when no one is watching.** This means always using two patient identifiers, performing a proper SBAR handoff, double-checking a high-alert medication, speaking up during a Time-Out, and cleaning your hands diligently. These actions are non-negotiable. They are the bedrock of trust that our patients place in us and are fundamental to our accreditation.



JCI ACCREDITATION PREPARATION

Our commitment to these high standards is formally recognized through our pursuit of Joint Commission International (JCI) accreditation. JCI standards are the gold standard globally. They provide a framework for us to measure, assess, and improve our performance. They are the **'what.'** Our hospital's Policies and Procedures are the **'how.'**

Now, what are Policies and Procedures?



JCI ACCREDITATION PREPARATION CONT'D

Policies and Procedures

Compliance with hospital policies, protocols and procedures helps build a safer system for patients and staff and helps prevent patient safety errors and medicolegal issues. They are our playbook, developed from evidence and experience to guide us safely through complex situations. They ensure we are all on the same page, working together cohesively.

And this leads me to a golden rule in healthcare: If it wasn't documented, it wasn't done.

Documentation is not just paperwork; it is a critical part of patient care. It ensures continuity, communicates vital information to the entire team, and serves as a legal record of the care we provided. Your diligent documentation is a professional and ethical responsibility.

JCI ACCREDITATION PREPARATION ROADMAP

Now we'll walk through our comprehensive roadmap for JCI accreditation preparation. This process involves ten strategic steps that will guide us from initial preparation to final readiness.



OUR JCI ACCREDITATION JOURNEY

Ten stages to build readiness, close gaps, and sustain safer care

JCI ACCREDITATION

1

START UP

Understand the standards

Become familiar with JCI accreditation standards and the survey process so everyone understands what accreditation involves and what surveyors will assess.

STAGE 1 OF 10

2

PLAN

Identify the gaps

Compare current practices with JCI standards through a gap analysis, then develop a comprehensive action plan for improvement.

STAGE 2 OF 10

3

PROCESS

Formalize the system

Review and update policies and procedures to align with JCI requirements, turning improvements into documented, consistent systems.

STAGE 3 OF 10

4

FOCUS

Prioritize improvement

Target the specific areas that need improvement and direct resources toward the most critical gaps identified in the analysis.

STAGE 4 OF 10

5

FIX BARRIERS

Enable implementation

Work with staff to remove barriers such as resource constraints, workflow challenges, and resistance to change.

STAGE 5 OF 10

SHARED RESPONSIBILITY • CONTINUOUS IMPROVEMENT • SAFER CARE FOR EVERY PATIENT

OUR JCI ACCREDITATION JOURNEY

Stages 6–10: assess, strengthen, test, and refine our readiness

JCI ACCREDITATION

6

READINESS

Check our progress

Assess our current readiness to confirm we are on track and identify where adjustments are needed.

STAGE 6 OF 10

7

TRAINING

Build staff confidence

Continue staff education and training to support consistent practice and sustainable change.

STAGE 7 OF 10

8

MONITOR & ADJUST

Learn and refine

Review results and feedback regularly, then improve processes based on what we learn.

STAGE 8 OF 10

9

MOCK SURVEY

Test survey readiness

Simulate the JCI survey to uncover remaining gaps and assess how prepared we are.

STAGE 9 OF 10

10

FINAL STAGE

Close the remaining gaps

Make final improvements based on mock survey findings before the actual accreditation survey.

STAGE 10 OF 10

CONTINUOUS IMPROVEMENT • FEEDBACK LOOPS • SHARED COMMITMENT

OUR JOURNEY IS ITERATIVE, NOT LINEAR. EVERYONE PLAYS A ROLE IN SUSTAINING SAFER, HIGH-QUALITY CARE.

In conclusion, every employee is committed to:

Our Commitment

Ensure safe, high-quality, and patient-centered care through continuous improvement in systems, processes, and people.

KEY FOCUS AREAS

- **Quality improvement** & performance monitoring
- **Patient safety** & risk management
- Incident reporting (non-punitive, improvement-focused)
- Compliance with **JCI standards** and international best practices

PATIENT SAFETY ESSENTIALS

- Accurate patient identification (2 identifiers)
- Effective communication (SBAR, read-back of verbal and telephone orders)
- Safe use of high-alert medications
- Correct-patient, correct-procedure surgery
- Infection prevention & proper waste management

STAFF RESPONSIBILITIES

- Follow hospital policies and procedures
- Report all incidents promptly (72 hrs; sentinel events within 48 hrs)
- Participate in training, audits, and continuous improvement efforts.

KEY MESSAGE

Quality and patient safety are everyone's responsibility—reporting, compliance, and teamwork drive safer care and better patient outcomes.

SAFE CARE
We prioritize safety in everything we do.

HIGH QUALITY
We are committed to delivering excellence.

PATIENT-CENTERED
We respect, involve, and care for our patients.

CONTINUOUS IMPROVEMENT
We learn, adapt, and strive to be better every day.



THANK YOU

Thank you for your time and, more importantly, for your commitment to being a part of our quality and safety culture. We are so glad to have you on the team. Together, we will live our mission and make our vision a daily reality for every person who walks through our doors. Welcome.



PART 4
Post-Test