Rawalpindi Medical University

Putting **Patients** First

A Project by Rawalpindi Medical University
for
Improving Patient Care

RMU

PUTTING PATIENT FIRST PROGRAM

A PROJECT BY RAWALPINDI MEDICAL UNIVERSITY

FOR

IMPROVING PATIENT CARE

MISSION STATENMENT

EVERY PATIENT MUST RECEIVE THE BEST POSSIBLE CARE, TREATED WITH DIGNITY AND RESPECT IN SAFE AND CLEAN ENVIRONMENT

MESSAGE BY PROFESSOR MUHAMMAD UMAR

VICE CHANCELLOR

The main function of university is to create knowledge, disseminate knowledge and do research for education and training. Ultimately this knowledge and research provides evidence for strengthening of health care delivery system and good clinical practice to treat patients. In many countries, medical universities are not only doing research, teaching and training but also responsible for providing community based healthcare for general public and research based quality care to patients in university hospital.

In true sense, there is no public sector university hospital in Pakistan except Agha Khan Hospital, Karachi which is a business model. Rawalpindi Medical University is now AN established university, working on a model to provide university level care in its affiliated hospitals as well as in community.

We have started a project with THE name of "**PUTTING PATIENT FIRST PROGRAM**" in emergency department of Holy Family Hospital. This comprise of three components;

1. Life basics
2. Patient safety and quality care
3. Pharmacovigilance

1. Life basics

This means that every staff member (specialists, postgraduate trainees, house officers, nurses and paramedical staff) of emergency department must be trained in resuscitation of patients with life threatening emergencies. For this purpose we have prepared curriculum, training and implantation model.

2. Patient safety and quality care.

This is backbone of Putting Patient First (PPF) program. Different key performance indicators (KPI) were made along with standards in light of Punjab Health Care Commission and international guidelines regarding patient safety and quality care.

3. Pharmacovigilance

Prof of pharmacology and hospital pharmacists have evolved check list to enforce the appropriate use of medicine and monitoring of any event related to drug interaction/ adverse reaction , abuse/misuse and lack of efficacy.

Few other salient features of this program are:

- Patient and attendant counseling is done by emergency staff. For monitoring of patient and attendants satisfaction, a feedback preform is being filled and later analyzed for purpose of improvement.
- Multispecialty approach is being observed in ER for better care of patients.
- A mechanism for internal audit of PPF model has been evolved based on data collection and analysis.

I also appreciate efforts of Dr. Usman Qureshi, Associate Professor of Surgery and Dr. Abdul Naeem, Assistant Professor of Emergency Medicine to formulate the program and wish great success to the noble mission.

Prof. Muhammad Umar

Vice chancellor

Rawalpindi medical university

PREFACE

It is critical to make sure that health services are safe for the people they serve. In Pakistan over burden in public sector hospitals, insufficient human resources and financial constraints have led to increased dissatisfaction of patients regarding services and violence against the healthcare professionals. Looking at the above scenario some of the specific challenges for Pakistan's healthcare system are lack of national healthcare guidelines, policies, procedures and key performance indicators on healthcare quality and patient safety. Unsafe care usually happens because of problems with the system and nonprofessional attitude of health workers including doctors. This situation highlights the need to develop a culture of quality and safety in our hospitals.

Putting Patient First is a concept to transform hospital services for the better outcome. It's a continuous process of improvement within existing processes and pathways that leads to measurable improvements for our patients and staff.

Rawalpindi Medical College was established in 1974. Three years back it was upgraded to Rawalpindi Medical University. Holy Family Hospital, Benazir Bhutto Hospital and District Headquarter Hospital are tertiary care hospitals affiliated with university as teaching hospitals. All these three hospital have very busy emergency departments. These hospitals are referral centers for upper Punjab, Azad Kashmir and KPK. Due to poor primary and secondary health systems, most of emergency patients are directly referred to these hospitals without proper management. Keeping in view above mentioned scenario, university has decided to launch patient first program in emergency of holy family hospital as a piolet project. This program consists of three components including patient safety and quality care, life basic and pharmacovigilance. It will help to overcome issues regarding gaps in delivery of quality health services, capacity building in essential life support services (BLS, BTLS, ACLS) and medication related issues (misuse, prescription errors, adverse reaction etc). A step wise strategic plan has been designed for smooth and sustainable change in outcome of health services in our emergency department. Successful execution of this program will open new opportunities to implement patient first program in rest of hospitals and departments of university.

DR USMAN QURESHI

Edited by

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1-PUTTING PATIENT FIRST PROGRAM

1.1- INTRODUCTION

PUTTING PATIENT FIRST is an approach to transform hospital services for the better outcome and experience of patients in our hospital. Whether it's small steps or complex change, it's a continuous process of improvement within existing processes and pathways that leads to measurable and sustainable improvements for our patients. (1)

Broadly it's about two big ideas.

- Mostly our attitude towards day to day issues is not problem solving. Too often people say, 'That's a problem. Somebody should fix it.' Here in patient first program concept is, 'That's a problem. How can I help fix it?'
- The other is that little everyday things are important. Big transformational programs can take a long time to show results. Instead, if we focus on daily problem solving at workplace in hospitals, that adds up to a huge impact on outcome.

We all say we put patients first, but do we really? Most of us put ourselves first. This is natural – but it's not patient-focused. Putting patient's first means placing them at the center of what we do. To improve patient experience, health care needs a culture change from one where we too often treat patients as though we are doing them a favor to a culture that places their needs at the center of everything we do. This may sound complicated, but it really isn't rocket science. Small changes can make a big difference. It is important to understand what matters to our patients, what their hospital journey might feel like, and recognize what we can do to make their experience as positive as possible. Patient first program is an innovative programme that will enables to positively change patients' experience of being in hospitals.

Putting Patient First approach is driven by 5 key principles: (2)

- The patient at the heart of every element of change
- Cultural change across the organization
- Continuous improvement of our services through small steps of change
- Constant testing of patient pathway to find new opportunities for better outcome
- Encouraging front-line staff to lead the redesigning processes

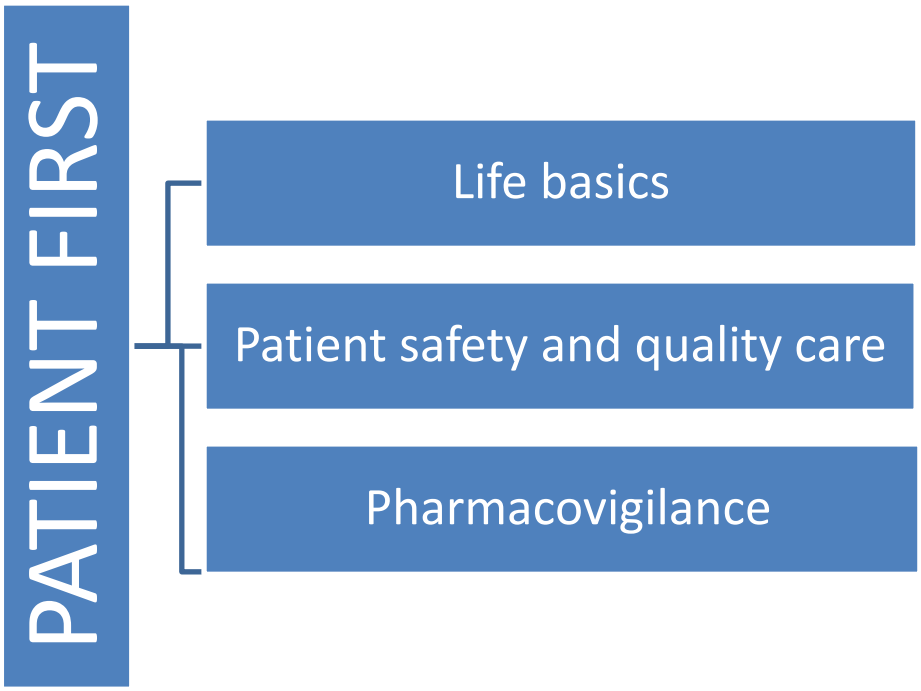
1.2- PATIENT FIRST PROGRAM IN RMU

Rawalpindi Medical College was established in 1974. Two years back it was upgraded to Rawalpindi Medical University. Holy Family Hospital, Benazir Butto Hospital and District Headquarter Hospital are tertiary care hospitals affiliated with university as teaching hospitals. All these three hospital have very busy emergency departments. These hospitals are referral centers for upper Punjab, Azad Kashmir and KPK. Due to poor primary and secondary health systems, most of emergency and elective patients are directly referred to these hospitals without proper management.

In spite of spending huge amount of budget and utilizing large number of human resources, patient dissatisfaction regarding health care services in emergency department is still a big issue. Rawalpindi medical university has launched patient first program in emergency department as a piolet project. The purpose of this program is to provide safe and effective health services in emergency department. This program initially has three components.

1. Patient safety and quality care
2. Life basic
3. Pharmacovigilance

COMPONENTS OF PATIENT FIRST PROGRAM IN RMU



2. Life Basics

2- LIFE BASIC PROGRAM

2.1- OBJECTIVE

Training and capacity building for providing essential life support and trauma management within hospital.

2.2- INTRODUCTION

Cardiac arrests and life-threatening traumatic emergencies are crucial public health issues, where fast recognition and a skilled response can prevent potentially devastating outcomes. Competence in providing immediate life support and cardiopulmonary resuscitation (CPR) is outlined as a prerequisite for all doctors. However, there is a growing concern about the lack of emphasis placed on teaching and reinforcing basic life support (BLS) skills within the undergraduate medical curriculum. With current training, would medical students confidently be able to provide basic cardiac and trauma life support? We propose that the lack of competency may be due to ineffective training and poor retention of skills. Same issue is faced among newly qualified doctors. In Pakistan BLS and BTLS is not part of any undergraduate medical curriculum. Most of young doctors after graduating from medical college may have theoretical knowledge of the lifesaving skills but practical skills are not up to mark. Most of these young doctors start their carrier as house officer and often have to manage critical life situations and are expected to apply BLS and BTLS skills. Therefore, the issue of low confidence in resuscitation skills among medical students and young doctors needs to be addressed. Keeping in view above mentioned scenario it is need of time to train our young doctors in above mentioned skills before start of house job. Rawalpindi medical university has decided to launch an **ESSENTIAL LIFE SUPPORT TRAINING PROGRAM** for undergraduate and postgraduate medical students. This early introduction of BLS and BTLS training in the medical curriculum will solve above mentioned issues. This curriculum is developed to cover all necessary aspects of BCLS and BTLS, chocking and management of mass casualties. It will also cover professional aspects including communication skills, team work and leadership, critical thinking and decision making.

2.3- COMPONENTS OF TRAINING PROGRAM

- BASIC LIFE SUPPORT
- BASIC TRAUMA LIFE SUPPORT
- DAISASTER MANAGEMENT AND TRIAGE

2.4- SCOPE OF LIFE BASIC PROGRAM

- TRAINING OF UNDERGRADUATE MEDICAL STUDENTS
- TRAINING OF HOUSE OFFICERS **(Internship life basic program)**
- TRAINING OF MEDICAL OFFICERS/ CMOs
- TRAINING OF PARAMEDICAL STAFF

2.5- LEARNING OUTCOMES OF LIFE BASIC PROGRAM

	BLS	BTLS/DISASTER MANAGEMENT
KNOWLEDGE	• Know the core knowledge required for BLS • Recognize the signs of someone needing CPR. • List the steps required to safely operate an AED. • Differentiate between adult and pediatric guidelines for CPR. • Explain how to apply the various first aid interventions for adults • Describe how to apply the various pediatric first aid interventions. • Describe the importance of teams in multi-rescuer resuscitation.	• Is able to demonstrate knowledge of mechanisms of common injuries understands the concept of damage control resuscitation and surgery • Understands the principles of haemorrhage control and haemostatic resuscitation • Understands the principles of spinal protection and appropriate immobilization • Knows the principles of management of head injury and prevention of secondary brain injury • Is able to hand over patient to relavent department • Understands the management of large numbers of patients that may occur as a result of a significant or prolonged incident. • Understands the key elements of effective major incident management including command and control, communication, coordination and information management (including documentation)

SKILL	• Able to recognize life-threatening situations • Able to offer vital assistance before more experienced help arrives • Demonstrate how to provide rescue breathing alone for an adult, child & infant who show signs of circulation but have inadequate or not breathing, • Select the correct order of interventions for the victim of cardiopulmonary arrest • Perform high-quality CPR for an adult, Child, infant.(single person/two person) • Perform as an effective team member during multi-rescuer CPR	• Is able to establish an 'AMPLE' history • Is able to conduct a primary survey in a trauma patient (adult and children) utilising the principles of ATLS • Can safely remove a patient from immobilisation/spinal board • Is able to identify those patients with potentially life-threatening cranial/maxilla-facial injury leading to airway compromise • Is able to identify patients with potentially life-threatening thoracic injuries • Is able to identify those patients with potentially life-threatening abdominal and pelvic injuries • Is able to recognize , head injury, spinal injury and critical limb injury • Be able to initiate a systematic secondary survey in a trauma patient (adult and children) utilizing the principles of ATLS • Is able to accurately triage multiple casualties if required to do so
ATTITUDE	• understands roles and responsibilities in the resuscitation team and demonstrates effective communication and team work; • Communicates in a calm and reassuring manner with conscious patients, • Communicates effectively with seniors and specialist teams, including when inter-hospital transfer is required (referral/hand-over)(ISBAR) •	• Attends promptly when required, understands roles and responsibilities in the trauma team and demonstrates effective communication and team work; taking initial leadership role where required to initiate life-saving measures in a timely manner • Communicates in a calm and reassuring manner • Communicates effectively with seniors and specialist teams, including when inter-hospital transfer is required (referral/hand-over) •

2.6- IMPLEMENTATION PLAN

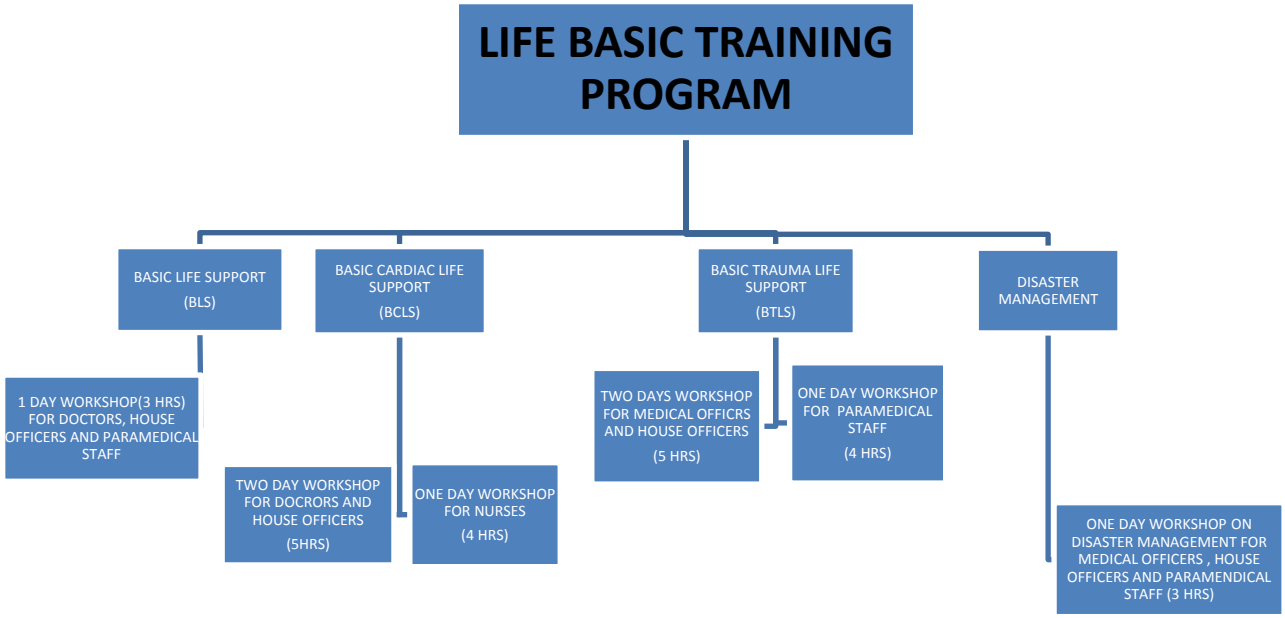
2.6-a- WHO WILL BE TRAINED

Target trainees are divided in following groups

1- Medical officers (CMO/PGT working in ER)
2- House officers
3- Nurses/paramedical staff

2.6-b- HOW WILL BE TRAINED

A set of workshops will be designed for training of doctors and paramedical staff. Content and learning outcomes of workshops will be decided as per target audience.



2.6-c- WHO WILL RUN LIFE BASIC PROGRAM

Faculty for life basic program (APPENDIX-1)

1- Director life basic program
2- Associate director life basic program
3- Assistant directors life basic program
4- Coordinator life basic program
5- Manager life basic program
6- Visiting faculty life basic program
7- Chief facilitator BLS/BCLS/ACLS
    a. Facilitators BLS/BCLS/ACLS (4-6)
8- Chief facilitator BTLS/Disaster management
    a. Facilitators BTLS/Disaster management(4-6)

2.6-d-FORMAT OF WORKSHOPS

- Mini lectures / Videos
- Sessions of Hands on practice

2.6-e- ASSESSMENT

- Pre workshop knowledge assessment- 25 MCQs test
- Formative assessment during workshop (40%)
    - Interaction during Mini lectures
    - Attendance / punctuality
    - Knowledge of subject
    - Attitude
- Summative assessment at end of workshop (60%)
    - DOPs
    - CBD (scenario based)
    - Post workshop MCQs test (25 MCQs)

2.6-f- CERTIFICATION

Certificate of successful completion will be issued by Rawalpindi Medical University. CME points will be awarded by RMU.

Unsuccessful students will be provided one opportunity in Remedial assessment.

2.6-g- REFRESHER COURSES

Initial certification of above mentioned courses will be for three years. Refresher courses will be mandatory for validity of certificates.

3. Patient Safety & Quality Care

PATIENT SAFETY AND QUALITY CARE

3.1- WHAT IS PATIENT SAFETY AND QUALITY CARE?

Patient Safety is a health care discipline that emerged with the evolving complexity in health care systems and the resulting rise of patient harm in health care facilities. World Health Organization's (WHO) International Classification for Patient Safety defines patient safety as, "the reduction of risk of unnecessary harm associated with healthcare to an acceptable minimum. (3)

It aims to prevent and reduce risks, errors and harm that occur to patients during provision of health care. A cornerstone of the discipline is continuous improvement based on learning from errors and adverse events. (4)

Patient safety is often considered a component of quality, thus, practices to improve patient safety improve the overall quality of care. Accreditation Canada defines quality as "the degree of excellence; the extent to which an organization meets client's needs and exceeds their expectations". According to the Health Council of Canada Annual Report (2006) entitled '**Clearing the Road to Quality'** found that patient safety, information management, quality councils and performance reporting are four key strategies to improve the quality of healthcare. (5)

3.2- KEY FACTS

- The occurrence of adverse events due to unsafe care is likely one of the 10 leading causes of death and disability in the world (6).
- In high-income countries, it is estimated that one in every 10 patients is harmed while receiving hospital care (7). The harm can be caused by a range of adverse events, with nearly 50% of them being preventable (8).

- Each year, 134 million adverse events occur in hospitals in low- and middle-income countries (LMICs), due to unsafe care, resulting in 2.6 million deaths (9).
- Globally, as many as 4 in 10 patients are harmed in primary and outpatient health care. Up to 80% of harm is preventable. The most detrimental errors are related to diagnosis, prescription and the use of medicines (10).
- Investments in reducing patient harm can lead to significant financial savings, and more importantly better patient outcomes (7). An example of prevention is engaging patients, if done well, it can reduce the burden of harm by up to 15% (10).

3.3- THE SPECTRUM OF HARM TO PATIENTS

Every year, millions of patients suffer injuries or die because of unsafe and poor-quality health care. Many medical practices and risks associated with health care are emerging as major challenges for patient safety and contribute significantly to the burden of harm due to unsafe care. Below are some of the patient safety situations causing most concern.

- **Medication errors** are a leading cause of injury and avoidable harm in health care systems: *(10).*
- **Health care-associated infections** occur in 7 and 10 out of every 100 hospitalized patients in high-income countries and low- and middle-income countries respectively *(11).*
- **Unsafe surgical care procedures** cause complications in up to 25% of patients. Almost 7 million surgical patients suffer significant complications annually, 1 million of whom die during or immediately following surgery *(12).*
- **Unsafe injections practices** in health care settings can transmit infections, including HIV and hepatitis B and C, and pose direct danger to patients and health care workers *(13).*

- **Diagnostic errors** occur in about 5% of adults in outpatient care settings, more than half of which have the potential to cause severe harm. Most people will suffer a diagnostic error in their lifetime *(14).*
- **Unsafe transfusion practices** expose patients to the risk of adverse transfusion reactions and the transmission of infections *(15).* Data on adverse transfusion reactions from a group of 21 countries show an average incidence of 8.7 serious reactions per 100 000 distributed blood components *(16).*
- **Radiation errors** involve overexposure to radiation and cases of wrong-patient and wrong-site identification *(17).* A review of 30 years of published data on safety in radiotherapy estimates that the overall incidence of errors is around 15 per 10 000 treatment courses *(18).*
- **Sepsis** is frequently not diagnosed early enough to save a patient's life. Because these infections are often resistant to antibiotics, they can rapidly lead to deteriorating clinical conditions, affecting an estimated 31 million people worldwide and causing over 5 million deaths per year *(19).*
- Venous thromboembolism (blood clots) is one of the most common and preventable causes of patient harm, contributing to one third of the complications attributed to hospitalization. Annually, there are an estimated 3.9 million cases in high-income countries and 6 million cases in low- and middle-income countries (20).

3.4- DOMAINS OF QUALITY HEALTH CARE

Key attributes of high quality healthcare systems, as defined by Professor Donald Berwick include following components.(21)

3.5- PATIENT SAFETY AND QUALITY IMPROVEMENT PROGRAM IN RMU

RMU has started patient safety and quality improvement program as a component of putting patient first program. Our mission is that every patient must receive the best possible care, and treated with dignity and respect in safe and clean environment.

We are committed to put quality care at the center of everything we do and have rigorous systems in place to ensure that performance is closely monitored and immediate action can be taken to rectify any issues affecting the quality of our services.

To promote the culture of patient safety and quality care in RMU and allied hospitals, a strategic plan has been prepared to modernize our approach to continuous improvement. The

aim of the strategy is to provide a uniform way for all our staff to think about quality of services.

3.6- CAPACITY BUILDING OF STAFF FOR IMPLIMENTATION OF PATIENT SAFETY AND QUALITY CARE

A series of training workshops will be arranged for staff working in emergency department. It will help to enhance capacity of staff regarding patient safety and quality improvement.

3.6-a- CERTIFICATION

Certificates of participation in workshop will be awarded by university along with CME points.

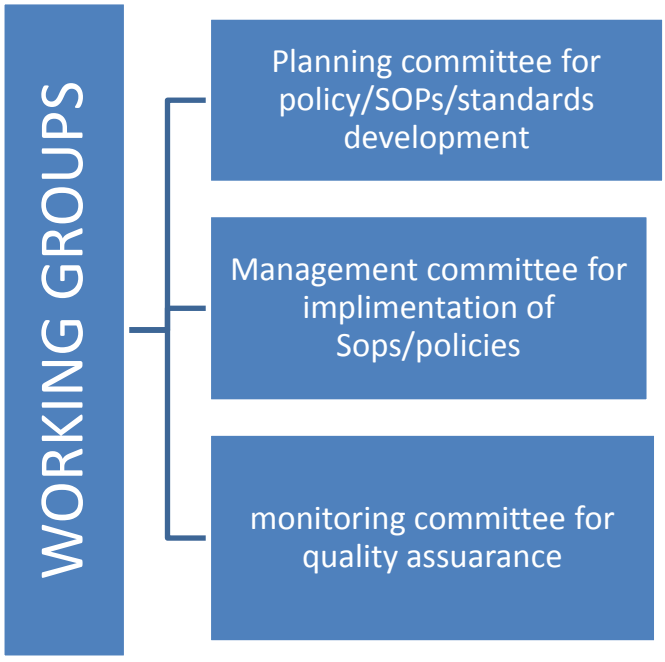
3.7-STRATEGIC FRAME WORK FOR PATIENT SAFETY AND QUALITY CARE

3.7-a- FORMINING A PRJECT TEAM

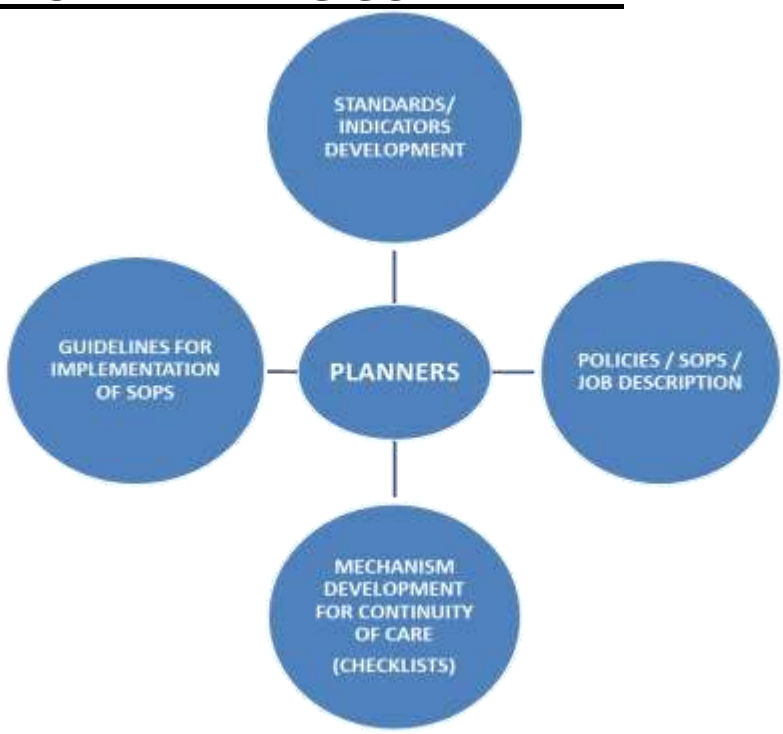
In order to implement change in healthcare organizations it usually requires involvement of several individuals that bring unique expertise and abilities that enable change to take place. It is extremely rare that a single individual can ever manage significant and sustainable change within complex organization.

WORKING GROUP for implementing patient safety and quality improvement will consist of following three committees. These committees will include members from organizational leadership, technical experts and day-to- day leadership.

(APPENDIX-2, APPENDIX-3, APPENDIX-4)

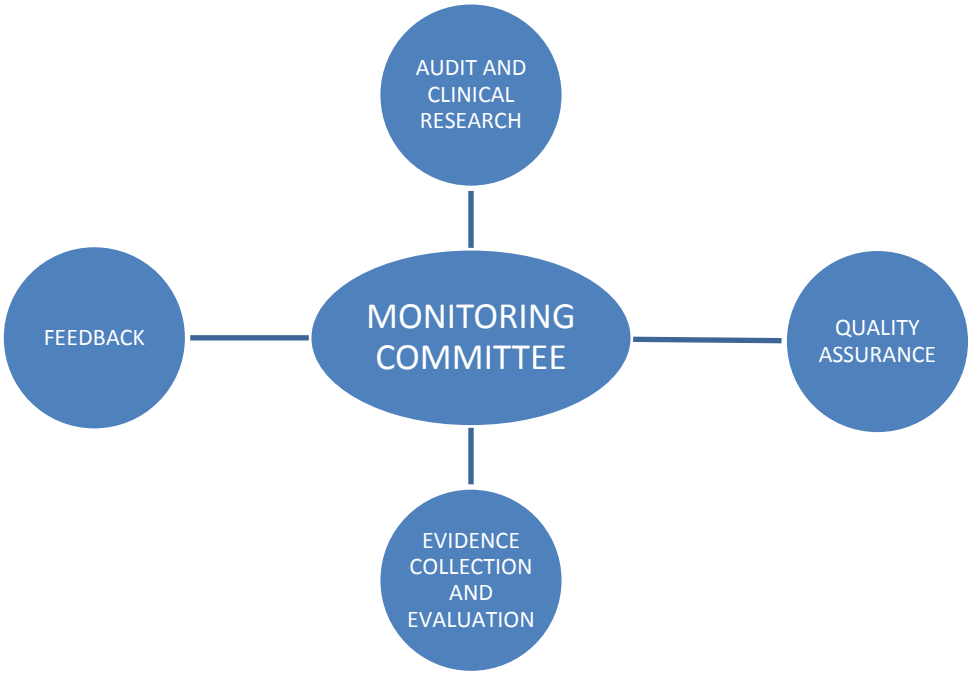


3.7-b- SCOPE OF PLANNING COMMITTEE



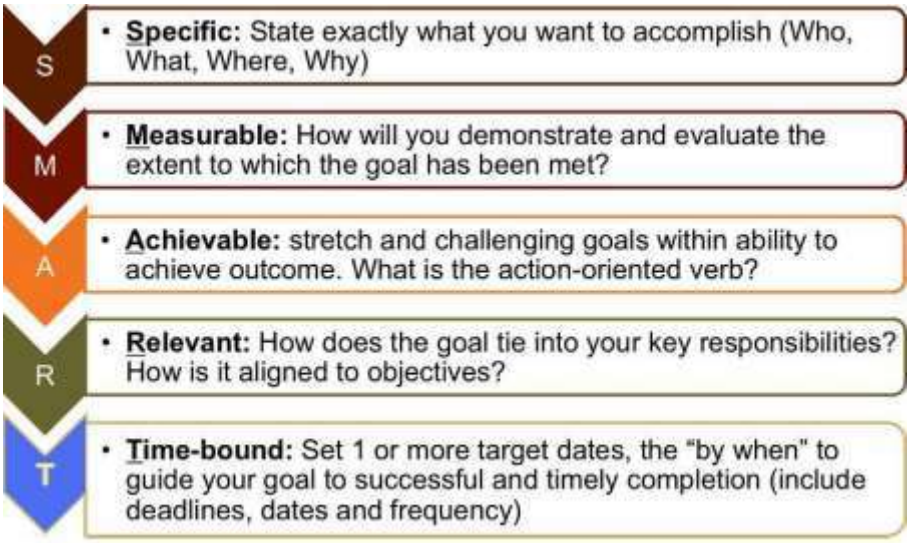
3.7-c- SCOPE OF MANAGEMENT COMMITTEE

3.7-d- SCOPE OF MONITORING COMMITTEE



3.7-e- SETTING AIMS AND OBJECTIVES

Make your aims and objectives in **SMART** format**.**



An aim statement should take into account the following concerns:

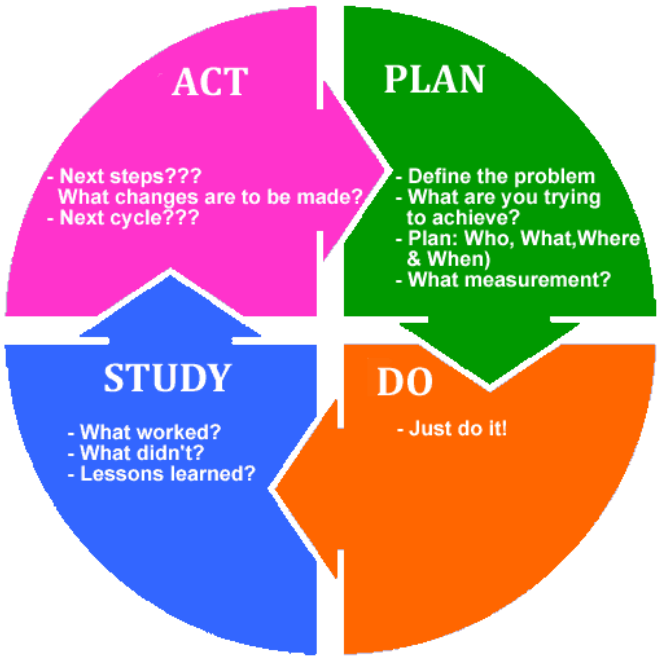
- What are we trying to accomplish?
- Why is it important?
- Who is the specific target population?
- When will this be completed?
- How will this be carried out?
- What is/are our measurable goal(s)?

3.7-f- PDSA CYCLE. A MODEL FOR QUALITY IMPROVEMENT

It is one of the most commonly used QI methodology. It breaks down the process of improvement into three initial queries:

- **Setting the aims/objectives,**
- **Taking necessary measures**
- **Recheck changes/measures for further improvement**

These changes are then tested out in short '**PDSA- Plan, Do, Study, Act' cycles** to see if the changes result in the anticipated outcome and to amend plans as you learn.(22)



Key Tips

- Think **small** steps that you can try in the next few weeks or even days
- Split out the work into several PDSA cycles that will run in parallel

3.7-g- IDENTIFYING POTENTIAL BARRIERS TO YOUR PROJECT

- When carrying out initial planning it is useful to try and anticipate issues that are likely to help or hinder your success.
- This allows you and your team to anticipate or utilize these issues as part of the project plan.
- Identifying these issues can take time but is worth considering at the start of your project as it may save your considerable time and frustration and mean success or failure in the end.

There are different types of barriers

- ***The Initiative/ project itself-*** the evidence base, the usability of interventions, the fit with healthcare processes
- ***Individuals*** –skills and attitudes, staff resistance or enthusiasm, leadership or lack of teamwork.
- ***Organization-*** culture and stability, management support, time availability, funds availability, available data
- ***Wider health system-*** Healthcare culture, stability, partnerships, incentives and funding

3.7-h- CONDUCT A STAKEHOLDER ANALYSIS

Identifying stakeholders during a change is important. Not involving staff or patients in the change that may impact them or their work will often lead to resistance and failure to implement the planned change.

This process include following three steps.

- IDENTIFYING STAKEHOLDERS
- PRIORITIZE YOUR STAKEHOLDERS
- UNDERSTAND YOUR KEY STAKEHOLDERS

Step-1, Identifying Key Stakeholders

Stakeholders can affect or be affected by the organization's actions, objectives and policies .Identifying the key stakeholders are extremely important to the success of the project. The implementation and development of effective occupational **health care** within an organization requires support from several key **stakeholders**. Based on the resources available, the working group should decide on the maximum number of stake-holders. The major **stakeholders in the healthcare** system are patients, physicians/ employers and government.

Step 2: Prioritize Your Stakeholders

Stakeholder analysis is a process of systematically gathering and analyzing qualitative information to determine whose interests should be taken into account when developing

and/or implementing a policy or program. Once you have your list, then it is important to prioritize the stakeholders according to their interest and influence.

High Power	**Satisfy** *Opinion formers. Keep them satisfied with what is happening and review your analysis of their position regularly*	**Manage** *Key stakeholders who should be fully engaged through full communication and consultation*
Low Power	**Monitor** *This group may be ignored if time and resources are stretched*	**Inform** *Patients often fall into this category. It may be helpful to take steps to increase their influence by organising them into groups or taking active consultative work*
	Low impact/stake holding	***High impact/stake holding***

Step 3: Understand Your Key Stakeholders

You now need to discover how your key stakeholders feel about your project. You also need to work out how best to engage them, and how to communicate with them.

3.8 - KEY PERFORMANCE INDICATORS (KPI) (23)

Initially three areas of performance in emergency department are included for monitoring.

1. **PATIENT FACILITATION**
    - Patient transport facilities at reception of emergency
    - Medical staff in triage area (doctor, nurse, guard, medical attendant)
    - Registration counter (staff/ computer operator, computers and printers)
    - Security guards (guards on main gate/ medical ER/Surgical ER/ OT /Indoor)

- One patient one attendant policy
- Facilities at attendants waiting area
- Facilitation desk for patients/ attendants (staff)
- General cleanliness (wards/ wash rooms, triage areas, waiting areas)

2. INFRASTRUCTURE AND EQUIPMENT

- Availability of medicine and surgical supplies
- Surgical Equipment and electro medical equipment in Minor OT
- Portable x-rays
- Cardiac Monitors
- Defibrillators
- ECG machines
- BP Apparatus (triage room/ nursing station/red zone/ bedside)
- CCTV
- Washrooms (medial ER/surgical ER (functional status and cleanliness)
- Electricity/ lights/ fans/ ACs/ heaters etc.

3. CLINICAL CARE AND DOCUMENTATION

- Vitals recorded in triage room (B.P, temperature, RBS)
- Patient seen/ triaged & advised (history/examination/diagnosis/ treatment)
- Signature of doctor along with stamp/time
- Medicolegal cases handled as per SOPS
- If discharged then discharged follow up plan
- Documentation in register appropriately
- If retained , seen by PGT with documentation ER & Register

- If admitted , seen by PGT/ SR & documented appropriately
- Rounds of emergency department by senior consultants
- If discharged , seen by PGT/SR & discharge treatment & Follow up advised.
- Serious patients shifted to red zone immediately, seen and managed by PGT/SR appropriately.

For above mentioned indicators, standards will be designed by planning committee according to local needs and requirements.

4. PHARMACOVIGILANCE

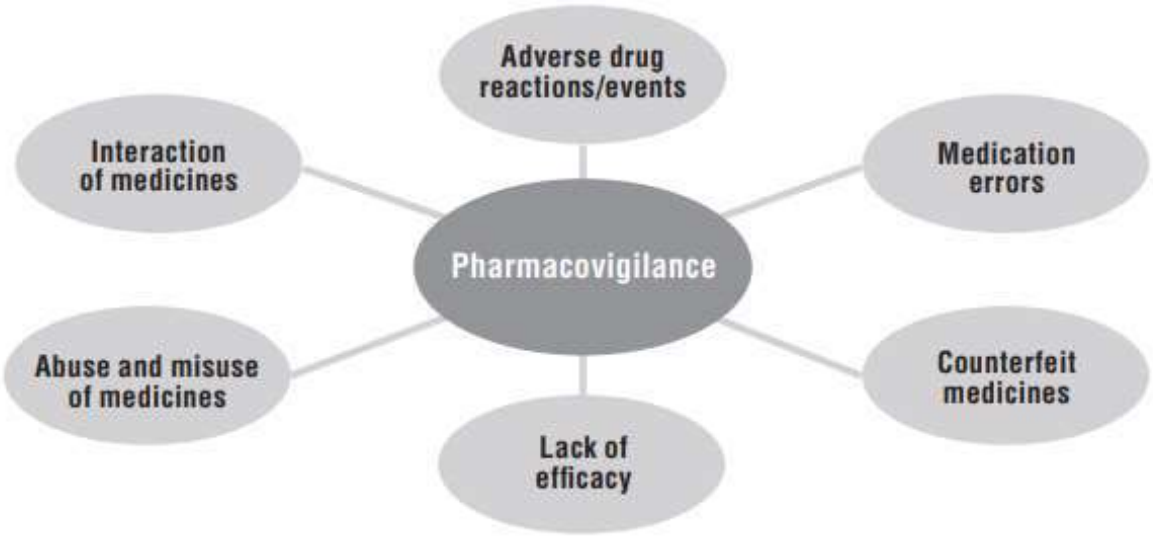
4 - PHARMACOVIGILANCE

4.1- INTRODUCTION

Pharmacovigilance is instrumental in helping to ensure patient safety for both newly released drugs and those that are well established in the market. Pharmacovigilance is defined by WHO as "the science and activities related to the detection, assessment, understanding and prevention of adverse drug effects or any other possible drug-related problems" It is a dynamic clinical and scientific discipline. It provides reliable, balanced information for the effective assessment of the risk/benefit profile of medicines. Under-reporting remains the corner stone that hinders pharmacovigilance activities.

4.2- SCOPE OF PHARMACOVIGILANCE:

The scope of pharmacovigilance has grown remarkably in recent times and is now considered to include the following domains.



4.3- PHARMACOVIGILANCE IN RMU

Pharmacovigilance department has been established in Rawalpindi Medical University. A committee has been constituted in this regard. This committee will work under supervision of Pharmacology department. Committee is working to develop key performance indicator and SOPs for pharmacovigilance. Our main objective is to monitor the efficacy of drugs by monitoring their adverse effects, encouraging the safe rational and cost-effective use of drugs; promoting understanding, education and clinical training in pharmacovigilance. Initially a proforma has been designed for monitoring and data collection.(APPENDIX-5)

5-PUTTING PATIENT FIRST PROGRAM IN RMU

MONITORING TOOLS

5.1- Tool 1: WEEKLY PROFESSOR/HOD ROUND

Evening Rounds Are Done in Emergency Department by Different Head of departments as per schedule.

FACULTY OF SURGERY

1. Prof. Idress Anwar – Dean of Surgery & HOD Surgery Unit II, HFH
2. Prof. Jahangir Sarwar Khan – HOD Surgery Unit I, HFH
3. Prof. Ashraf Mahmood – HOD Neurosurgery Department, HFH
4. Prof. Jawad Zaheer – HOD Anesthesia Department I, HFH
5. Dr. Husnain Khan – HOD Burn & Plastic Surgery Department, HFH
6. Dr.Mudasar Gondal – HOD Pediatric Surgery Department, HFH
7. Dr.Zubair Javed – HOD Orthopedic Department, HFH

DAY	PROF/HOD NAME
Monday	Dr. Mudassar Gondal
Tuesday	Dr. Husnain Khan
Wednesday	Prof. Ashraf Mahmood
Thursday	
Friday	Prof. Jhangir Sarwar Khan
Saturday	Dr. Zubair Javed
sunday	

FACULTY OF MEDICINE

1. Prof. Muhammad Khurram – Dean of Medicine & HOD Medical Unit II, HFH
2. Dr. Prof. Saima Ambreen – HOD Medical Unit I, HFH
3. Dr. Abdul Naeem – HOD Emergency Medicine, HFH
4. Dr. Mujeeb Khan – HOD Department of Infectious Diseases, HFH
5. Dr. Abrar Akbar – HOD Department of Critical Care, HFH
6. Dr. Naveed Sarwar – HOD Multi Organ Failure Department, HFH
7. Dr. Tanveer Ahmed – HOD Department of Gastroenterology, HFH

DAY	PROF/HOD NAME
Monday	Dr. Abdul Naeem
Tuesday	Dr. Abrar Akbar
Wednesday	Dr. Saima Ambreen
Thursday	Prof.M. Khurram
Friday	Dr.Mujeeb Khan/ Dr.Tanveer
Saturday	Dr.Naveed Sarwar Khan

During visit of consultants, Relevant picture and documentary evidence are required to be collected and submit by whatsapp at 0332-9178014

5.2- Tool 2: Attendant Control Status

Faculty Name: _____

Date:_____Time: _____

Stations	Attendants on bedside			
Medical ER	**1**	**2**	**3**	**>3**
Medical Station 05				
Blue Zone				
Yellow Zone				
Green Zone				
Red Zone				
Surgical ER	**1**	**2**	**3**	**>3**
Surgical Station 04				
Minor OT				
Male beds				
Female beds				
Burn room				
CT scan Room				
Ultrasound Room				
X-rays Room				
Emergency OT				

NOTE:

Please take relevant picture and whatsapp at 0332-9178014

5.3- Tool 3: SECURITY SITUATION

Date: _____	Availability/Presence of Security guard					
	01	**02**	**03**	**04**	**05**	**06**
Name of Security Guard						
Time						
Location						
Working attitude						

Name of DMS			**Shift**	
Time		**Remarks**		

NOTE:

Please take relevant picture and whatsapp at 0332-9178014

5.4 - Tool 4: PATIENT FACILITATION

Faculty Name: _____

Date:_____Time: _____

Base	Total No.	Functional	Non-functional
Wheelchairs			
Stretchers			
ED Staff	**Total No.**	**Present**	**Absent**
Porter			
Security staff			
Facilitation desk (Supervisor)			
Registration counter staff			
Sample collector			
Triage staff (CMO & Nurse)			
Injection room nurse			
ECG Technician			
Pharmacy Technician			

NOTE:

Please take relevant picture and whatsapp at 0332-9178014

Sign:_____

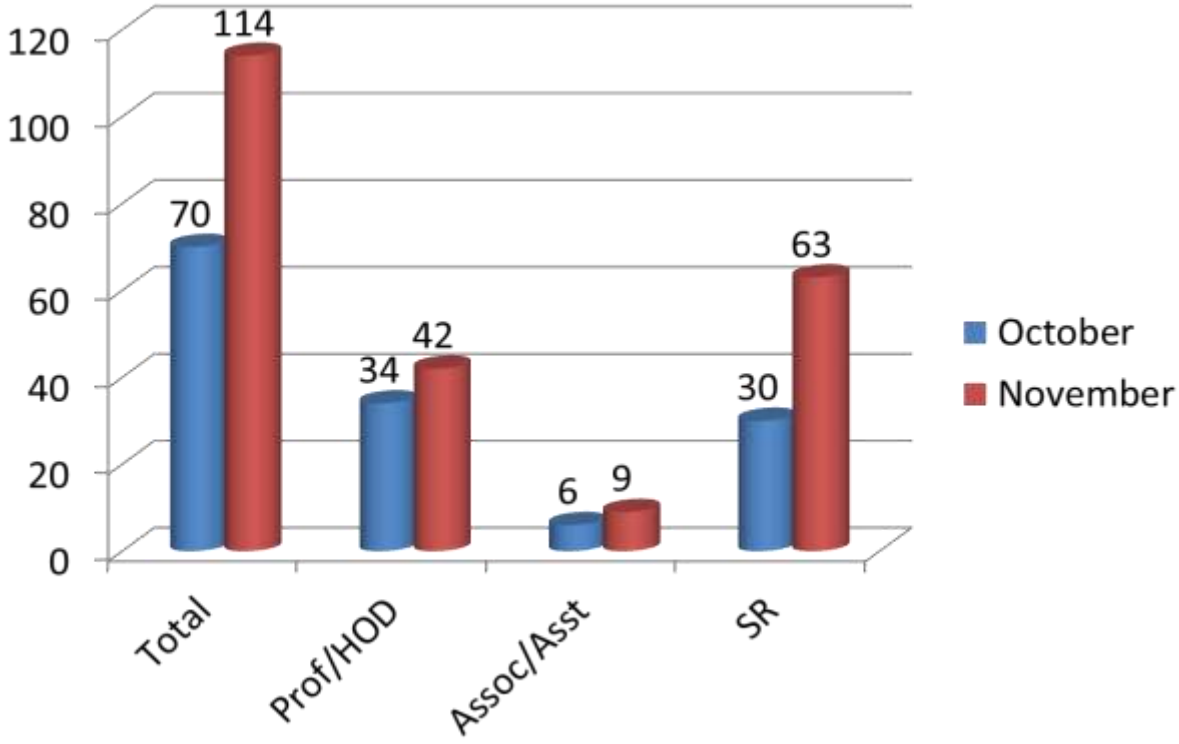
6 - PUTTING PATIENT FIRST PROGRAM

AUDIT REPORT

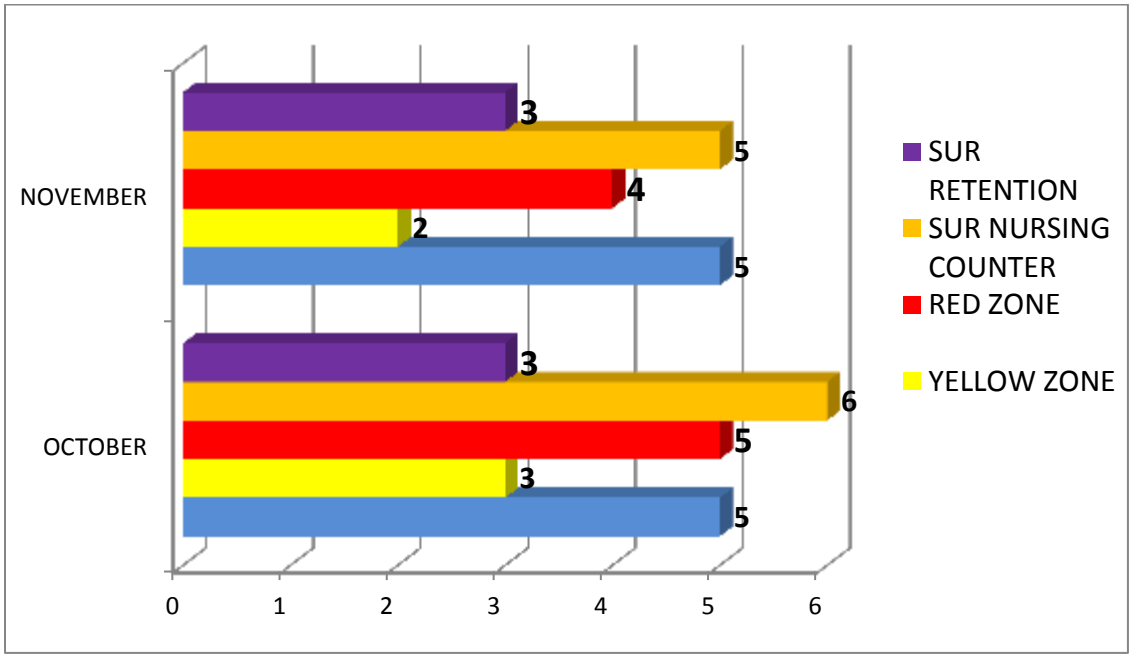
DEPARTMENT OF EMERGENCY, HOLY FAMILY HOSPITAL

OCTOBER - NOVEMBER 2020

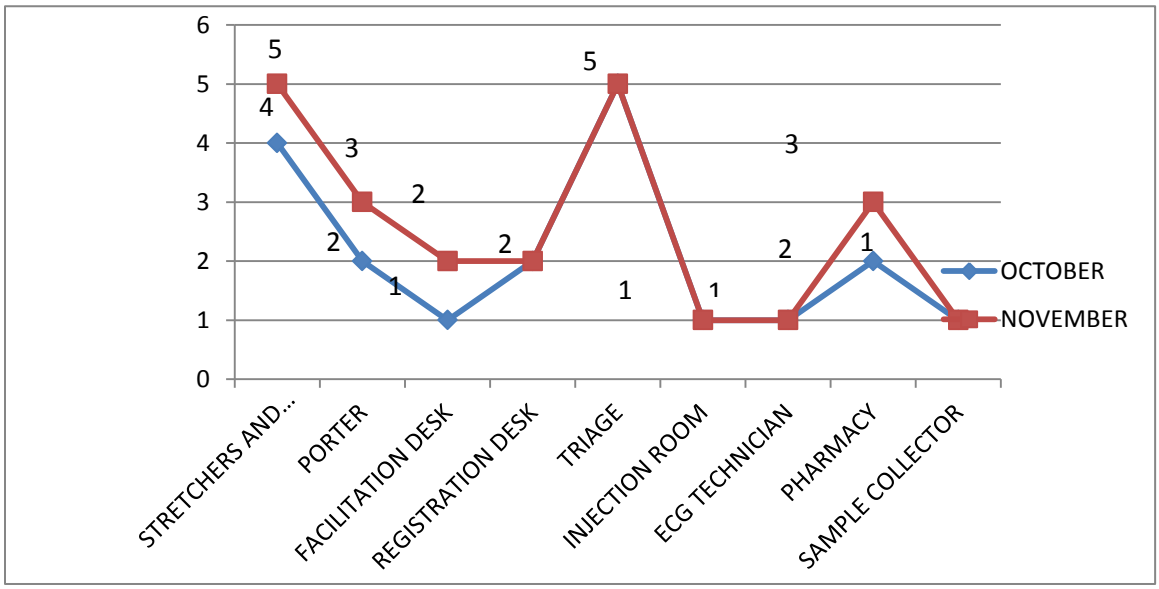
6.1- FACULTY ROUNDS



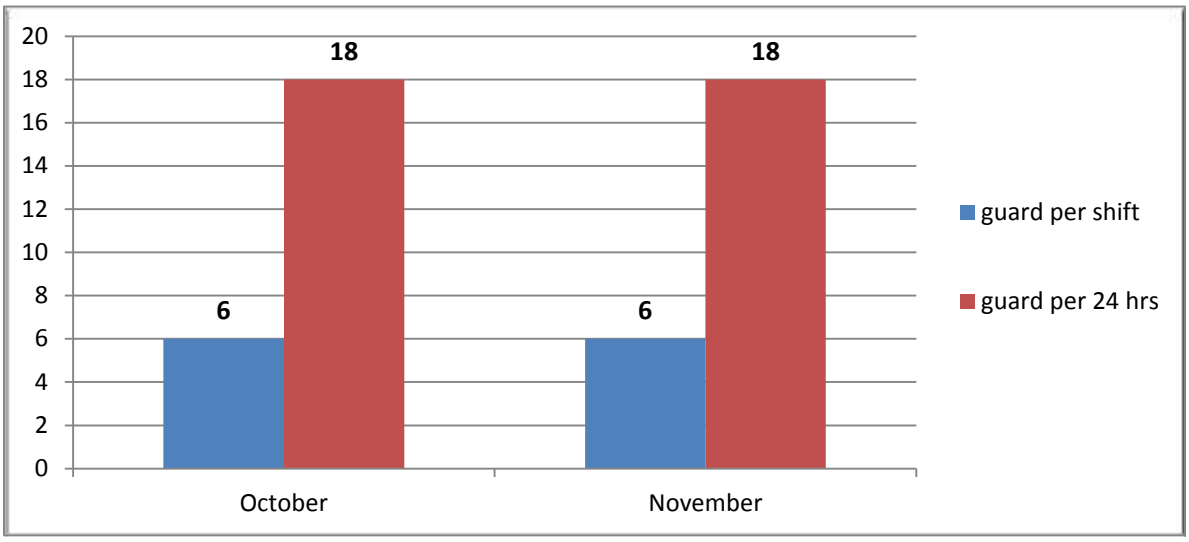
6.2- ATTENDANT CONTROL



6.3- PATIENT FACILITATIONS



6.4- SECURITY STATUS



7- CAPACITY BUILDING AND TRAINING OF NURSING STAFF IN ER

In-service training of nurses plays an indispensable role in improving the quality of patient care. Need to enhance the effectiveness of in-service training of nurses is an inevitable requirement. RMU has designed a comprehensive training program for nursing staff in emergency department. (APPENDIX-6). It will help to improve nursing care of patients presenting in emergency department.

TOPICS FOR TRAINING OF NURSES

1. Encephalopathy and its nursing care
2. Pain control in ER
3. Nursing care of stroke patients
4. Communication skills
5. Intravenous cannulation
6. I/V fluids types and requirements
7. Shock and its management
8. Management of acute asthma in ER
9. DKA presentation and its management in ER
10. Acute kidney failure and its management in ER
11. Patients with chest pain in ER
12. Upper GI bleed and its management
13. Trauma and its assessment in ER
14. COVID-19 management in ER
15. Burn management in ER
16. Ascites and its monitoring
17. Pneumonia and nursing care in ER
18. Meningitis and its care and management in ER

8 - REFRENCES

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4- https://www.stgeorgehospital.org/news/143/patient-safety

5
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April 8, 2016 Written by mbayer
http://theleanconsultinggroup.com/emergency-department-key-performance-indicators-kpi

APPENDIX-1

PALNNING COMMITTEE

INCHARGE

DR USMAN QURESHI

MEMBERS

- DR. ABDUL NAEEM
- DR.MUHAMMAD NAEEM
- Dr. MUBASHIR CHAUDRY
- DR RAMLA GHANZAFAR
- DR. SOBIA KAMRAN
- DR. ANBREEN YOUYSUF
- DR. MAHJABEEN
- NURSING HEAD: STAFF HANFIA BANO

APPENDIX-2

IMPLEMENTATION COMMITTEE

INCHARGE

DR MUHAMMAD NAEEM

MEMBERS

- DR MUBASHIR CHAUDRY
- DR.SALEEM MURTAZA
- DR.JAMIL AHMED JANJUA
- DR.ASAD CHAUDRY
- NURSING INCHHARGE: STAFF AYESHA
- SECURITY INCHARGE: IDRESS
- SUPERVISORS: ANWAR SATTI

APPENDIX-3

MONITORING COMMITTEE

INCHARGE

DR ABDUL NAEEM

MEMBERS

- DR MUBASHIR CHAUDRY
- DR.IRUM ARSHAD
- DR.SOBIA KAMRAN
- DR.MISBAH REHMAN
- NURSING HEAD: STAFF HABFIA BANO
- SECURITY INCHARGE: M. IDRESS
- SUPERVISOR: ANWAR SATTI

APPENDIX-4

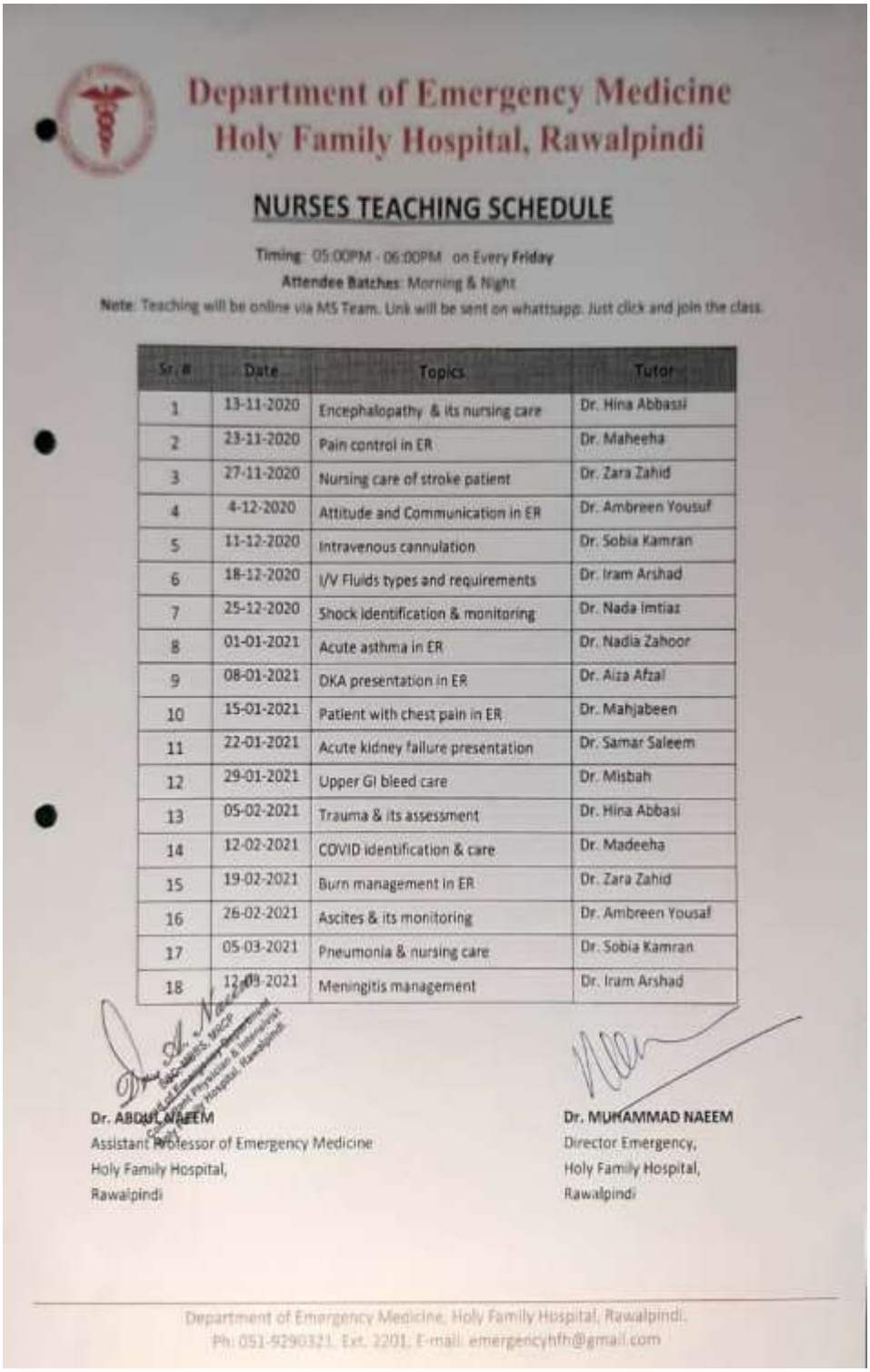
FACULTY FOR LIFE BASIC PROGRAM

1- Director life basic program
   a. PROF JHANGIR SARWAR KHAN
2- Associate director life basic program
   a. DR USMAN QURESHI
3- Assistant directors life basic program
   a. DR ABDUL NAEEM
   b. DR.
4- Coordinator life basic program
   a.
5- Manager life basic program
   a.
6- Visiting faculty life basic program
   a. DR
   b. DR
   c. DR
   d. DR
7- Chief facilitator BLS/BCLS/ACLS
   a. DR.

a. Facilitators BLS/BCLS/ACLS (4-6)
   a. DR
   b. DR
   c. DR
   d. DR
8- Chief facilitator BTLS/Disaster management
   a. DR

a. Facilitators BTLS/Disaster management(4-6)
   a. DR
   b. DR
   c. DR
   d. DR

APPENDIX-5



Department of Emergency Medicine
Holy Family Hospital, Rawalpindi

NURSES TEACHING SCHEDULE

Timing: 05:00PM - 06:00PM on Every **Friday**

Attendee Batches: Morning & Night

Note: Teaching will be online via MS Team. Link will be sent on whattsapp. Just click and join the class.

Sr. #	Date	Topics	Tutor
1	13-11-2020	Encephalopathy & its nursing care	Dr. Hina Abbassi
2	23-11-2020	Pain control in ER	Dr. Maheeha
3	27-11-2020	Nursing care of stroke patient	Dr. Zara Zahid
4	4-12-2020	Attitude and Communication in ER	Dr. Ambreen Yousuf
5	11-12-2020	Intravenous cannulation	Dr. Sobia Kamran
6	18-12-2020	I/V Fluids types and requirements	Dr. Iram Arshad
7	25-12-2020	Shock identification & monitoring	Dr. Nada Imtiaz
8	01-01-2021	Acute asthma in ER	Dr. Nadia Zahoor
9	08-01-2021	DKA presentation in ER	Dr. Aiza Afzal
10	15-01-2021	Patient with chest pain in ER	Dr. Mahjabeen
11	22-01-2021	Acute kidney failure presentation	Dr. Samar Saleem
12	29-01-2021	Upper GI bleed care	Dr. Misbah
13	05-02-2021	Trauma & its assessment	Dr. Hina Abbasi
14	12-02-2021	COVID identification & care	Dr. Madeeha
15	19-02-2021	Burn management in ER	Dr. Zara Zahid
16	26-02-2021	Ascites & its monitoring	Dr. Ambreen Yousaf
17	05-03-2021	Pneumonia & nursing care	Dr. Sobia Kamran
18	12-03-2021	Meningitis management	Dr. Iram Arshad

Dr. ABDUL NAEEM
Assistant Professor of Emergency Medicine
Holy Family Hospital,
Rawalpindi

Dr. MUHAMMAD NAEEM
Director Emergency,
Holy Family Hospital,
Rawalpindi

Department of Emergency Medicine, Holy Family Hospital, Rawalpindi.
Ph: 051-9290321, Ext. 2201, E-mail: emergencyhfh@gmail.com

APPENDIX-6

Proforma For Pharmacovigilance