Background Safety of patients in tertiary care hospitals in India was found to be a big problem. 62.9% of unsafe injections are administered every year¹ in India. Estimated risk of HCAI is up to 20 times higher than industrialised countries and is approx 10% and 15–30% in acute care. 77% of all reported cases of counterfeit and substandard drugs are from developing countries. **Methods** A longitudinal study on patient safety practice in 12 (6 public+6 private) multi-specialty hospitals* was conducted by DGHS from 2005–2011 with objective of identifying, analysing and improving the gaps in hospital patient safety system, so that it is compliant to WHO guidelines on patient safety 2005. The study took up safety practice for hand hygiene, surgery, injection, medication, blood transfusion, infection control and hospital waste management as core areas of hospital patient safety system. Data were collected & analysed annually and at the end of study. It provided for annual gap identification and introduction of corrective measure in each core area and also for system development at end of study in areas of advocacy, infrastructure, capacity building and funding for practice of patient safety in hospitals.

Results This study created a patient safety unit in DGHS, a patient safety committee in the hospitals, a targeted advocacy programme, guidelines for survey and root cause analysis, protocols for safety practice in hospitals, training manuals, standard reporting format for adverse events, supportive monitoring system, and annual and study- end evaluation of outcome in terms of mortality and adverse events. Policy and practice changes like introduction of auto-disable syringe in public health (2009), revision of guidelines for disposal and syringe/needle under bio-medical disposal rules (2010), introduction of antibiotic policy in tertiary hospitals, strengthening of pharmaco-vigilance programme took place during this period. Success stories, reports of hospital, study report and technical report were documented. **Conclusions** The study was able to showcase relevance of patient safety system in tertiary hospitals for better quality outcome.

*Safdarjang Hospital, Ram Manohar Lal Hospital, AIIMS, Kalawati Saran Hospital, G. B. Pant Hospital, and GTB Hospital in public Health Sector – 6 National Accreditation Board for Hospital and Healthcare Providers approved private hospitals of Max group

MoHFW – Ministry of Health & Family Welfare
HCAI – Hospital Care Associated Infections

- (CLEN Program Evaluation Network (IPEN) for Department of Family Welfare, MoHFW)

774

FACTORS THAT IMPROVE THE SAFETY OF PATIENT CARE AS EXPERIENCED BY EMERGENCY MEDICAL CARE PROVIDERS

¹Mari Salminen-Tuomaala, ²Päivi Leikkola, ³Riitta Mikkola, ⁴Eija Paavilainen. ¹Seinäjoen University of Applied Sciences, School of Health Care and Social Work, Finland; ²Seinäjoen Central Hospital, Finland; ³University of Tampere, School of Health Sciences, Finland; ⁴University of Tampere, School of Health Sciences, South Ostrobothnia Hospital District

10.1136/injuryprev-2016-042156.774

Background An increasing number of acutely ill patients are not transported to hospital but treated in their homes or another location. Special attention should be paid to factors that affect patient safety (Ministry of Social Affairs and Health 2014.)

Methods The study describes factors that promote the safety of patient care in out-of-hospital emergency medical care, as experi-

enced by care providers. The data were collected by semi-structured interviews (n = 15) with care providers selected by discretionary sampling. The material was analysed using inductive content analysis.

Results Patient safety improves with successful consultation with the emergency physician and with holistic consideration of all factors that affect the patient's coping. Safety is further promoted by the emergency care provider's theoretical, practical and attitudinal competencies and co-operation skills. Situational sensitivity is an important factor intertwined with the care provider's personality, emotional intelligence and discretion. Moreover, safety can be improved by making certain that individual procedures are carried out safely and by ensuring continuity of care and coping with home care. Finally, management practices that aim at workers' wellbeing at work increase patient safety.

Conclusions A study of factors that improve or impair patient safety can help care providers anticipate threats and prevent risks.

775

PATIENT SAFETY IN THE OPERATING ROOM: NURSES' EXPERIENCE AND ATTITUDES IN CYPRUS

¹Petya Trendafilova, ²Elisabeth Michael. ¹Medical University – Sofia, Faculty of Public Health, Sofia, Bulgaria; ²Makarios III Hospital, Nicosia, Cyprus

10.1136/injuryprev-2016-042156.775

Background Effective communication skills in the operating room (OR) promote team behaviour and usually result in good patient outcomes. Communication and collaboration constitutes an integral role during this process both with patients and with inter-professionals when working in such a highly specialised setting as an OR. Patient and staff safety in the OR has never been investigated in Cyprus before.

Methods One of the most often used tools to assess safety culture in an organisation is the Safety Attitudes Questionnaire (SAQ) (The Evidence Centre, 2011 & Sexton et al, 2006). SAQ is a psychometric instrument used for evaluating healthcare providers and especially operating nurses' attitudes regarding patient safety and climate. Six major factors are measured through the use of modified SAQ: teamwork climate, job satisfaction, management perception, safety climate, working conditions and stress recognition. A random sample of 112 OR nurses was studied from Makarios III Hospital which is one of the two major public hospitals in Nicosia.

Results The sample was comprised of 30 males and 82 females: the majority was working as permanent staff in the hospital and their experience varied from 0–25 years both in total as well as in the specific hospital. Overall participants believed that issues related to guidelines, teamwork and patient safety need further improvements. Males have significantly higher scores regarding experience with safety issues in the OR compared to their female counterparts. Interestingly, the lowest scores regarding nurses' notions and opinions regarding OR safety were expressed by the most experienced participants, who had more than 25 years of work experience. This is an indication of the need for further improvements in the in-service training which currently takes place in the Cyprus health system.

Conclusions More experienced staff might be in need for education regarding more recent safety procedures and techniques followed in the OR.