**Table 9 Characteristics of Selected Tertiary Hospitals in the National Capital Region (Location)**

| Characteristics of Hospitals | Total Hospitals | NCR Central | NCR South | NCR North |
|---|---|---|---|---|
| **Bed Capacity, %** | | | | |
| Less than 100 beds | 14 (8/56) | 5 (1/21) | 21 (3/14) | 19 (4/21) |
| 100 to 199 beds | 27 (15/56) | 33 (7/21) | 21 (3/14) | 24 (5/21) |
| 200 to 299 beds | 32 (18/56) | 33 (7/21) | 43 (6/14) | 24 (5/21) |
| Greater than 300 beds | 27 (15/56) | 29 (6/21) | 14 (2/14) | 33 (7/21) |
| **Ratio of Nurses to Patients Admitted** | | | | |
| In-patients | 1:11 | 1:11 | 1:10 | 1:14 |
| Patients for surgery | 1:11 | 1:12 | 1:9 | 1:11 |
| **Patient safety was articulated in the hospital's mission and/or vision statements, %** | 79 (42/53) | 70 (14/20) | 77 (10/13) | 90 (18/20) |
| **Availability of adverse event reporting system, %** | 93 (51/55) | 100 (20/20) | 86 (12/14) | 91 (19/21) |

**Table 10 Quality Assurance Activities in Selected Tertiary Hospitals in the National Capital Region (Location)**

| Quality Assurance Activities of Hospitals | Total Hospitals (n=56) | NCR Central (n=21) | NCR South (n=14) | NCR North (n=21) |
|---|---|---|---|---|
| **Quality Improvement Activities, %** | | | | |
| Clinical Practice Guidelines | 89 (50) | 91 (19) | 79 (11) | 95 (20) |
| Complaints Analysis | 89 (50) | 95 (20) | 93 (13) | 81 (17) |
| Morbidity and Mortality Meetings | 89 (50) | 91 (19) | 93 (13) | 86 (18) |
| Medical Audits | 89 (50) | 91 (19) | 86 (12) | 91 (19) |
| Credentialing and Clinical Privileging | 86 (48) | 91 (19) | 71 (10) | 91 (19) |
| Expanded Incident Monitoring | 79 (44) | 100 (21) | 71 (10) | 62 (13) |
| Utilization Review | 63 (35) | 52 (11) | 57 (8) | 76 (16) |
| Sentinel Event Monitoring | 54 (30) | 38 (8) | 79 (11) | 52 (11) |
| Clinical Pathways | 52 (29) | 52 (11) | 64 (9) | 43 (9) |
| Variance Reporting and Analysis | 39 (22) | 48 (10) | 43 (6) | 29 (6) |
| **Staff Trainings on Patient Safety Issues, %** | 96 (54) | 100 (21) | 86 (12) | 100 (21) |
| **Average number of safety programs,** Mean (± SD) | 4 (±2) | 5 (±2) | 2 (±1) | 4 (±3) |
| Min-Max | 1-12 | 1-8 | 1-4 | 1-12 |

**Table 11 Adverse Event Monitoring System in Selected Tertiary Hospitals in the National Capital Region (Location)**

| Presence of the Following within the Hospital | Total Hospitals | NCR Central | NCR South | NCR North |
|---|---|---|---|---|
| **A. Adverse Events, %** | | | | |
| Clear definition & examples of adverse events | 48 (27/56) | 48 (10/21) | 50 (7/14) | 48 (10/21) |
| Safety programs to protect patients | 96 (53/55) | 100 (21/21) | 93 (13/14) | 95 (19/20) |
| Periodic survey to detect and report events | 67 (37/55) | 67 (14/21) | 62 (8/13) | 71 (15/21) |
| Incident monitoring forms | 79 (44/56) | 86 (18/21) | 79 (11/14) | 71 (15/21) |
| Sentinel event monitoring | 56 (30/54) | 52 (11/21) | 69 (9/13) | 50 (10/20) |
| Compilation of reports on adverse events | 91 (50/55) | 95 (20/21) | 92 (12/13) | 86 (18/21) |
| **B. Personnel, %** | | | | |
| Personnel handling adverse events | 59 (33/56) | 62 (13/21) | 64 (9/14) | 52 (11/21) |
| Committee, team or structure handling adverse events | 89 (50/56) | 91 (19/21) | 86 (12/14) | 91 (19/21) |
| **C. Steps Taken by Hospital, %** | | | | |
| Feedback provision to concerned medical staff | 100 (56/56) | 100 (21/21) | 100 (14/14) | 100 (21/21) |
| Incentive provision for staff who reports | 21 (12/56) | 24 (5/21) | 21 (3/14) | 19 (4/21) |
| Implementation of prevention/reduction strategies | 95 (52/55) | 100 (21/21) | 92 (12/13) | 91 (19/21) |
| **D. Complaints, %** | | | | |
| Complaints filed concerning patient safety | 66 (36/55) | 70 (14/20) | 79 (11/14) | 52 (11/21) |
| Any legal proceeding or litigation about adverse event | 32 (17/53) | 35 (7/20) | 39 (5/13) | 25 (5/20) |

**Table 12 Clinical Decision Support System Provided in Selected Tertiary Hospitals in the National Capital Region (Location)**

| Clinical Decision Support System | Total Hospitals (n=56) | NCR Central (n=21) | NCR South (n=14) | NCR North (n=21) |
|---|---|---|---|---|
| **Presence of clinical decision support systems, %** | 16 | 14 | 29 | 10 |
| **Clinical Decision Support System, %** | | | | |
| pharmacy computer system | 39 (22) | 38 (8) | 50 (7) | 33 (7) |
| drug dosing calculators | 16 (9) | 10 (2) | 36 (5) | 10 (2) |
| computerized physician order entry system | 7 (4) | 5 (1) | 14 (2) | 5 (1) |
| wireless PDA | 5 (3) | 0 | 7 (1) | 10 (2) |
| others | 18 (10) | 10 (2) | 21 (3) | 24 (5) |

**Table 13 Adverse Event Monitoring System in Selected Tertiary Hospitals in the National Capital Region (Government vs. Private Hospitals)**

| Presence of the Following within the Hospital | Total Hospitals (n=56) | Government (n=28) | Private (n=28) |
|---|---|---|---|
| **A. Adverse Events, %** | | | |
| Clear definition & examples of adverse events | 48 (27) | 50 (14) | 46 (13) |
| Safety programs to protect patients | 95 (53) | 93 (26) | 96 (27) |
| Periodic survey to detect and report events | 66 (37) | 57 (16) | 75 (21) |
| Incident monitoring forms | 79 (44) | 72 (20) | 86 (24) |
| Sentinel event monitoring | 54 (30) | 54 (15) | 54 (15) |
| Compilation of reports on adverse events | 89 (50) | 89 (25) | 89 (25) |
| **B. Personnel, %** | | | |
| Personnel handling adverse events | 59 (33) | 68 (19) | 50 (14) |
| Committee, team or structure handling adverse events | 89 (50) | 96 (27) | 82 (23) |
| **C. Steps Taken by Hospital, %** | | | |
| Feedback provision to concerned medical staff | 100 (56) | 100 (28) | 100 (28) |
| Incentive provision for staff who reports | 21 (12) | 32 (9) | 11 (3) |
| Implementation of prevention/reduction strategies | 93 (52) | 89 (25) | 96 (27) |
| **D. Complaints, %** | | | |
| Complaints filed concerning patient safety | 64 (36) | 61 (17) | 68 (19) |
| Any legal proceeding or litigation about adverse event | 31 (17) | 36 (10) | 25 (7) |

**Table 14 Characteristics of Selected Tertiary Hospitals in the National Capital Region (Training vs. Non-Training Hospitals)**

| Proportion of Hospitals | Total Hospitals (n=56) | Training Hospital (n=44) | Non-Training Hospital (n=12) |
|---|---|---|---|
| **Bed Capacity, %** | | | |
| Fewer than 100 beds | 14 (8) | 5 (2) | 50 (6) |
| 100-199 | 27 (15) | 23 (10) | 42 (5) |
| 200-299 | 32 (18) | 39 (17) | 8 (1) |
| Above 300 | 27 (15) | 34 (15) | 0 |
| **Ratio of Nurses to Patients Admitted** | | | |
| In-patients | 1:12 (55) | 1:13 (44) | 1:6 (11) |
| Patients for surgery | 1:11 (49) | 1:12 (40) | 1:6 (9) |
| **Patient safety was articulated in the hospital's mission and/or vision statements, %** | 75 (42) | 75 (33) | 75 (9) |
| **Availability of adverse event reporting system, %** | 91 (51) | 91 (40) | 92 (11) |

**Table 15 Quality Assurance Activities in Selected Tertiary Hospitals in the National Capital Region (Training vs. Non-Training Hospitals)**

| Quality Assurance Activities of Hospitals | Total Hospitals (n=56) | Training Hospital (n=44) | Non-Training Hospital (n=12) |
|---|---|---|---|
| **Quality Improvement Activities, %** | | | |
| Clinical Practice Guidelines | 89 (50) | 98 (43) | 58 (7) |
| Complaints Analysis | 89 (50) | 91 (40) | 83 (10) |
| Medical Audits | 89 (50) | 98 (43) | 58 (7) |
| Morbidity and Mortality Meetings | 89 (50) | 98 (43) | 58 (7) |
| Credentialing and Clinical Privileging | 86 (48) | 89 (39) | 75 (9) |
| Expanded Incident Monitoring | 79 (44) | 84 (37) | 58 (7) |
| Utilization Review | 63 (35) | 68 (30) | 42 (5) |
| Sentinel Event Monitoring | 54 (30) | 57 (25) | 42 (5) |
| Clinical Pathways | 52 (29) | 55 (24) | 42 (5) |
| Variance Reporting and Analysis | 39 (22) | 46 (20) | 17 (2) |
| **Staff Trainings on Patient Safety Issues, %** | 96 (54) | 98 (43) | 92 (11) |
| **Average number of safety programs, Mean (± SD)** | 4 (±2) | 4 (±2) | 2 (±2) |

**Table 16** **Adverse Event Monitoring System in Selected Tertiary Hospitals in the National Capital Region (Training vs. Non-Training Hospitals)**

| Presence of the Following within the Hospitals | Total Hospitals (n=56) | Training Hospital (n=44) | Non-Training Hospital (n=12) |
|---|---|---|---|
| **A. Adverse Events, %** | | | |
| Clear definition & examples of adverse events | 48 (27) | 50 (22) | 42 (5) |
| Safety programs to protect patients | 95 (53) | 93 (41) | 100 (12) |
| Periodic survey to detect and report events | 66 (37) | 73 (32) | 42 (5) |
| Incident monitoring forms | 79 (44) | 84 (37) | 58 (7) |
| Sentinel event monitoring | 54 (30) | 59 (26) | 33 (4) |
| Compilation of reports on adverse events | 89 (50) | 91 (40) | 83 (10) |
| **B. Personnel, %** | | | |
| Personnel handling adverse events | 59 (33) | 59 (26) | 58 (7) |
| Committee, team or structure handling adverse events | 89 (50) | 93 (41) | 75 (9) |
| **C. Steps Taken by Hospital, %** | | | |
| Feedback provision to concerned medical staff | 100 (56) | 100 (44) | 100 (12) |
| Incentive provision for staff who reports | 21 (12) | 25 (11) | 8 (1) |
| Implementation of prevention/reduction strategies | 93 (52) | 96 (42) | 83 (10) |
| **D. Complaints, %** | | | |
| Complaints filed concerning patient safety | 64 (36) | 66 (29) | 58 (7) |
| Any legal proceeding or litigation about adverse event | 30 (17) | 32 (14) | 25 (3) |

**Table 17 Clinical Decision Support System Provided in Selected Tertiary Hospitals in the National Capital Region (Training vs. Non-Training Hospitals)**

| Clinical Decision Support System | Total Hospitals (n=56) | Training Hospital (n=44) | Non-Training Hospital (n=12) |
|---|---|---|---|
| **Presence of clinical decision support system, %** | 16 (9) | 21 (9) | 0 |
| **Clinical Decision Support System, %** | | | |
| pharmacy computer system | 39 (22) | 48 (21) | 8 (1) |
| drug dosing calculators | 16 (9) | 16 (7) | 17 (2) |
| computerized physician order entry system | 7 (4) | 9 (4) | 0 |
| wireless PDA | 5 (3) | 7 (3) | 0 |

**Table 18** **Characteristics of Selected Tertiary Hospitals in the National Capital Region (Ratio of Total Manpower and Bed Capacity)**

| Proportion of Hospitals | Total Hospitals (n=56) | 1 Personnel per Bed (n=28) | 2 Personnel per Bed (n=20) | 3 Personnel per Bed (n=7) | 7 Personnel per Bed (n=1) |
|---|---|---|---|---|---|
| **Bed Capacity, %** | | | | | |
| Fewer than 100 beds | 14 (8) | 14 (4) | 5 (1) | 43 (3) | 0 |
| 100-199 | 27 (15) | 29 (8) | 35 (7) | 0 | 0 |
| 200-299 | 32 (18) | 25 (7) | 45 (9) | 29 (2) | 0 |
| Above 300 | 27 (15) | 32 (9) | 15 (3) | 29 (2) | 100 (1) |
| **Ratio of Nurses to Patients Admitted** | | | | | |
| In-patients | 1:12 (55) | 1:15 (28) | 1:8 (19) | 1:8 (7) | 1:6 (1) |
| Patients for surgery | 1:11 (49) | 1:13 (25) | 1:9 (17) | 1:6 (6) | 1:6 (1) |
| **Patient safety was articulated in the hospital's mission and/or vision statements, %** | 75 (42) | 75 (21) | 80 (16) | 71 (5) | 0 |
| **Availability of adverse event reporting system, %** | 91 (51) | 86 (24) | 100 (20) | 86 (6) | 100 (1) |

**Table 19** **Quality Assurance Activities in Selected Tertiary Hospitals in the National Capital Region (Ratio of Total Manpower and Bed Capacity)**

| Quality Assurance Activities of Hospitals | Total Hospitals (n=56) | 1 Personnel per Bed (n=28) | 2 Personnel per Bed (n=20) | 3 Personnel per Bed (n=7) | 7 Personnel per Bed (n=1) |
|---|---|---|---|---|---|
| **Quality Improvement Activities, %** | | | | | |
| Clinical Practice Guidelines | 89 (50) | 89 (25) | 90 (18) | 86 (6) | 100 (1) |
| Complaints Analysis | 89 (50) | 89 (25) | 90 (18) | 86 (6) | 100 (1) |
| Medical Audits | 89 (50) | 86 (24) | 90 (18) | 100 (7) | 100 (1) |
| Morbidity and Mortality Meetings | 89 (50) | 82 (23) | 95 (19) | 100 (7) | 100 (1) |
| Credentialing and Clinical Privileging | 86 (48) | 86 (24) | 85 (17) | 86 (6) | 100 (1) |
| Expanded Incident Monitoring | 79 (44) | 79 (22) | 75 (15) | 86 (6) | 100 (1) |
| Utilization Review | 63 (35) | 64 (18) | 60 (12) | 71 (5) | 0 |
| Sentinel Event Monitoring | 54 (30) | 50 (14) | 55 (11) | 71 (5) | 0 |
| Clinical Pathways | 52 (29) | 43 (12) | 60 (12) | 57 (4) | 100 (1) |
| Variance Reporting and Analysis | 39 (22) | 29 (8) | 55 (11) | 43 (3) | 0 |
| **Staff Trainings on Patient Safety Issues, %** | 96 (54) | 100 (28) | 95 (19) | 86 (6) | 100 (1) |
| **Average number of safety programs,** Mean (± SD) | 4 (±2) | 4 (±2) | 4 (±3) | 4 (±2) | 4 |

**Table 20 Adverse Event Monitoring System in Selected Tertiary Hospitals in the National Capital Region (Ratio of Total Manpower and Bed Capacity)**

| Presence of the Following within the Hospitals | Total Hospitals (n=56) | 1 Personnel per Bed (n=28) | 2 Personnel per Bed (n=20) | 3 Personnel per Bed (n=7) | 7 Personnel per Bed (n=1) |
|---|---|---|---|---|---|
| **A. Adverse Events, %** | | | | | |
| Clear definition & examples of adverse events | 48 (27) | 43 (12) | 50 (10) | 71 (5) | 0 |
| Safety programs to protect patients | 95 (53) | 96 (27) | 90 (18) | 100 (7) | 100 (1) |
| Periodic survey to detect and report events | 66 (37) | 61 (17) | 75 (15) | 71 (5) | 0 |
| Incident monitoring forms | 79 (44) | 71 (20) | 85 (17) | 86 (6) | 100 (1) |
| Sentinel event monitoring | 54 (30) | 43 (12) | 60 (12) | 71 (5) | 100 (1) |
| Compilation of reports on adverse events | 89 (50) | 86 (24) | 95 (19) | 86 (6) | 100 (1) |
| **B. Personnel, %** | | | | | |
| Personnel handling adverse events | 59 (33) | 54 (15) | 55 (11) | 100 (7) | 0 |
| Committee, team or structure handling adverse events | 89 (50) | 89 (25) | 85 (17) | 100 (7) | 100 (1) |
| **C. Steps Taken by Hospital, %** | | | | | |
| Feedback provision to concerned medical staff | 100 (56) | 100 (28) | 100 (20) | 100 (7) | 100 (1) |
| Incentive provision for staff who reports | 21 (12) | 18 (5) | 25 (5) | 14 (1) | 100 (1) |
| Implementation of prevention/reduction strategies | 93 (52) | 89 (25) | 100 (20) | 86 (6) | 100 (1) |
| **D. Complaints, %** | | | | | |
| Complaints filed concerning patient safety | 64 (36) | 57 (16) | 80 (16) | 43 (3) | 100 (1) |
| Any legal proceeding or litigation about adverse event | 30 (17) | 25 (7) | 40 (8) | 14 (1) | 100 (1) |

**Table 21 Clinical Decision Support System Provided in Selected Tertiary Hospitals in the National Capital Region (Ratio of Total Manpower and Bed Capacity)**

| Clinical Decision Support System | Total Hospitals (n=56) | 1 Personnel per Bed (n=28) | 2 Personnel per Bed (n=20) | 3 Personnel per Bed (n=7) | 7 Personnel per Bed (n=1) |
|---|---|---|---|---|---|
| **Presence of clinical decision support system, %** | 16 (9) | 7 (2) | 35 (7) | 0 | 0 |
| **Clinical Decision Support System, %** | | | | | |
| pharmacy computer system | 39 (22) | 18 (5) | 70 (14) | 43 (3) | 0 |
| drug dosing calculators | 16 (9) | 7 (2) | 30 (6) | 14 (1) | 0 |
| computerized physician order entry system | 7 (4) | 4 (1( | 15 (3) | 0 | 0 |
| wireless PDA | 5 (3) | 0 | 15 (3) | 0 | 0 |

**Table 22 Characteristics of Selected Tertiary Hospitals in the National Capital Region (Hospital Bed Capacity)**

| Proportion of Hospitals | Total Hospitals (n=56) | Fewer than 100 beds (n=8) | 100-199 beds (n=15) | 200-299 beds (n=18) | Above 300 beds (n=15) |
|---|---|---|---|---|---|
| **Ratio of Nurses to Patients Admitted** | | | | | |
| In-patients | 1:12 (55) | 1:6 (7) | 1:9 (15) | 1:11 (18) | 1:18 (15) |
| Patients for surgery | 1:11 (49) | 1:4 (5) | 1:11 (15) | 1:11 (16) | 1:13 (13) |
| **Patient safety was articulated in the hospital's mission and/or vision statements, %** | 75 (42) | 75 (6) | 87 (13) | 72 (13) | 67 (10) |
| **Availability of adverse event reporting system, %** | 91 (51) | 75 (6) | 93 (14) | 89 (16) | 100 (15) |

**Table 23 Quality Assurance Activities in Selected Tertiary Hospitals in the National Capital Region (Hospital Bed Capacity)**

| Quality Assurance Activities of Hospitals | Total Hospitals (n=56) | Fewer than 100 beds (n=8) | 100-199 beds (n=15) | 200-299 beds (n=18) | Above 300 beds (n=15) |
|---|---|---|---|---|---|
| **Quality Improvement Activities, %** | | | | | |
| Clinical Practice Guidelines | 89 (50) | 63 (5) | 93 (14) | 94 (17) | 93 (14) |
| Complaints Analysis | 89 (50) | 88 (7) | 87 (13) | 100 (18) | 80 (12) |
| Medical Audits | 89 (50) | 63 (5) | 93 (14) | 94 (17) | 93 (14) |
| Morbidity and Mortality Meetings | 89 (50) | 63 (5) | 93 (14) | 94 (17) | 93 (14) |
| Credentialing and Clinical Privileging | 86 (48) | 75 (6) | 87 (13) | 94 (17) | 80 (12) |
| Incident Monitoring | 79 (44) | 50 (4) | 80 (12) | 89 (16) | 80 (12) |
| Utilization Review | 63 (35) | 63 (5) | 53 (8) | 61 (11) | 73 (11) |
| Sentinel Event Monitoring | 54 (30) | 50 (4) | 33 (5) | 61 (11) | 67 (10) |
| Clinical Pathways | 52 (29) | 38 (3) | 53 (8) | 44 (8) | 67 (10) |
| Variance Reporting and Analysis | 39 (22) | 13 (1) | 33 (5) | 50 (9) | 47 (7) |
| **Staff Trainings on Patient Safety Issues, %** | 96 (54) | 88 (7) | 100 (15) | 94 (17) | 100 (15) |
| **Average number of safety programs, Mean (± SD)** | 4 (±2) | 3 (±2) | 3 (±2) | 5 (±3) | 4 (±2) |

**Table 24** **Adverse Event Monitoring System in Selected Tertiary Hospitals in the National Capital Region (Hospital Bed Capacity)**

| Presence of the Following within the Hospitals | Total Hospitals (n=56) | Fewer than 100 beds (n=8) | 100-199 beds (n=15) | 200-299 beds (n=18) | Above 300 beds (n=15) |
|---|---|---|---|---|---|
| **A. Adverse Events, %** | | | | | |
| Clear definition & examples of adverse events | 48 (27) | 38 (3) | 53 (8) | 39 (7) | 60 (9) |
| Safety programs to protect patients | 95 (53) | 100 (8) | 93 (14) | 94 (17) | 93 (14) |
| Periodic survey to detect and report events | 66 (37) | 50 (4) | 67 (10) | 67 (12) | 73 (11) |
| Incident monitoring forms | 79 (44) | 63 (5) | 73 (11) | 89 (16) | 80 (12) |
| Sentinel event monitoring | 54 (30) | 25 (2) | 27 (4) | 67 (12) | 80 (12) |
| Compilation of reports on adverse events | 89 (50) | 63 (5) | 93 (14) | 89 (16) | 100 (15) |
| **B. Personnel, %** | | | | | |
| Personnel handling adverse events | 59 (33) | 63 (5) | 53 (8) | 56 (10) | 67 (10) |
| Committee, team or structure handling adverse events | 89 (50) | 75 (6) | 73 (11) | 100 (18) | 100 (15) |
| **C. Steps Taken by Hospital, %** | | | | | |
| Feedback provision to concerned medical staff | 100 (56) | 100 (8) | 100 (15) | 100 (18) | 100 (15) |
| Incentive provision for staff who reports | 21 (12) | 0 | 13 (2) | 33 (6) | 27 (4) |
| Implementation of prevention/reduction strategies | 93 (52) | 63 (5) | 100 (15) | 94 (17) | 100 (15) |
| **D. Complaints, %** | | | | | |
| Complaints filed concerning patient safety | 64 (36) | 63 (5) | 60 (9) | 67 (12) | 67 (10) |
| Any legal proceeding or litigation about adverse event | 30 (17) | 13 (1) | 20 (3) | 33 (6) | 47 (7) |

**Table 25** **Clinical Decision Support System Provided in Selected Tertiary Hospitals in the National Capital Region (Hospital Bed Capacity)**

| Clinical Decision Support System | Total Hospitals (n=56) | Fewer than 100 beds (n=8) | 100-199 beds (n=15) | 200-299 beds (n=18) | Above 300 beds (n=15) |
|---|---|---|---|---|---|
| **Presence of clinical decision support system, %** | 16 (9) | 0 | 20 (3) | 28 (5) | 7 (1) |
| **Clinical Decision Support System, %** | | | | | |
| pharmacy computer system | 39 (22) | 13 (1) | 33 (5) | 61 (11) | 33 (5) |
| drug dosing calculators | 16 (9) | 25 (2) | 13 (2) | 17 (3) | 13 (2) |
| computerized physician order entry system | 7 (4) | 0 | 7 (1) | 11 (2) | 7 (1) |
| wireless PDA | 5 (3) | 0 | 7 (1) | 6 (1) | 7 (1) |

**Table 26** **Characteristics of Selected Tertiary Hospitals in the National Capital Region (Specialty vs. Non-Specialty Hospitals)**

| Characteristics of Hospitals | Total Hospitals (n=56) | Specialty Hospital (n=9) | Non-Specialty Hospital (n=47) |
|---|---|---|---|
| **Bed Capacity, %** | | | |
| Fewer than 100 beds | 14 (8) | 11 (1) | 15 (7) |
| 100-199 | 27 (15) | 0 | 32 (15) |
| 200-299 | 32 (18) | 33 (3) | 32 (15) |
| Above 300 | 27 (15) | 56 (5) | 21 (10) |
| **Ratio of Nurses to Patients Admitted** | | | |
| In-patients | 1:12 (55) | 1:17 (9) | 1:11 (46) |
| Patients for surgery | 1:11 (49) | 1:8 (6) | 1:11 (43) |
| **Patient safety was articulated in the hospital's mission and/or vision statements, %** | 75 (42) | 67 (6) | 77 (36) |
| **Availability of adverse event reporting system, %** | 91 (51) | 100 (9) | 89 (42) |

**Table 27** **Quality Assurance Activities in Selected Tertiary Hospitals in the National Capital Region (Specialty vs. Non-Specialty Hospitals)**

| Quality Assurance Activities of Hospitals | Total Hospitals (n=56) | Specialty Hospital (n=9) | Non-Specialty Hospital (n=47) |
|---|---|---|---|
| **Quality Improvement Activities, %** | | | |
| Clinical Practice Guidelines | 89 (50) | 100 (9) | 87 (41) |
| Complaints Analysis | 89 (50) | 78 (7) | 91 (43) |
| Medical Audits | 89 (50) | 100 (9) | 87 (41) |
| Morbidity and Mortality Meetings | 89 (50) | 100 (9) | 87 (41) |
| Credentialing and Clinical Privileging | 86 (48) | 78 (7) | 87 (41) |
| Expanded Incident Monitoring | 79 (44) | 78 (7) | 79 (37) |
| Utilization Review | 63 (35) | 44 (4) | 66 (31) |
| Sentinel Event Monitoring | 54 (30) | 67 (6) | 51 (24) |
| Clinical Pathways | 52 (29) | 44 (4) | 53 (25) |
| Variance Reporting and Analysis | 39 (22) | 33 (3) | 40 (19) |
| **Staff Trainings on Patient Safety Issues, %** | 96 (54) | 89 (8) | 98 (46) |
| **Average number of safety programs, Mean (± SD)** | 4 (±2) | 4 (±2) | 4 (±2) |

**Table 28 Adverse Event Monitoring System in Selected Tertiary Hospitals in the National Capital Region (Specialty vs. Non-Specialty Hospitals)**

| Presence of the Following within the Hospital | Total Hospitals (n=56) | Specialty Hospital (n=9) | Non-Specialty Hospital (n=47) |
|---|---|---|---|
| **A. Adverse Events, %** | | | |
| Clear definition & examples of adverse events | 48 (27) | 67 (6) | 45 (21) |
| Safety programs to protect patients | 95 (53) | 100 (9) | 94 (44) |
| Periodic survey to detect and report events | 66 (37) | 56 (5) | 68 (32) |
| Incident monitoring forms | 79 (44) | 78 (7) | 79 (37) |
| Sentinel event monitoring | 54 (30) | 78 (7) | 49 (23) |
| Compilation of reports on adverse events | 89 (50) | 100 (9) | 87 (41) |
| **B. Personnel, %** | | | |
| Personnel handling adverse events | 59 (33) | 67 (6) | 57 (27) |
| Committee, team or structure handling adverse events | 89 (50) | 100 (9) | 87 (41) |
| **C. Steps Taken by Hospital, %** | | | |
| Feedback provision to concerned medical staff | 100 (56) | 100 (9) | 100 (47) |
| Incentive provision for staff who reports events | 21 (12) | 44 (4) | 17 (8) |
| Implementation of prevention/reduction strategies | 93 (52) | 89 (8) | 94 (44) |
| **D. Complaints, %** | | | |
| Complaints filed concerning patient safety | 64 (36) | 56 (5) | 66 (31) |
| Any legal proceeding or litigation about adverse events | 30 (17) | 44 (4) | 28 (13) |