

# Factors Which Delay the Emergency Obs/Gynacological Services at Govt. General Hospital Samanabad, Faisalabad

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## **ABSTRACT:**

**OBJECTIVE:** Personal care and quality treatment is highly demanding thing now a day especially when is it about medication and medical facilities. The aim of this research study is to highlight the “factors which delay the emergency of Gynecological services at G.G.H.S.F, Faisalabad.” Gyne is vast field of study and this study provides you detail insight about different aspects of gynecological services. Researcher also elaborates the role of nurses they play at the time of emergency and how much their efficient services are necessary at the time of emergency. Timely provision of medication and care services in case of Gyne is sometime difficult to maintain due to delay in different factors.

To check the validity and reliability of this research study research develop structured questionnaire for data collection. Target population of this research study was those 200 patients who visited the hospital for emergency cases. Researcher use SPSS to maintain the reliability of results and analysis for this research study. The research study would be beneficial to remove the barriers which create immense trouble in provision of quality services at the time of emergency cases.

**MATERIAL AND METHOD:** Sample of the study consisted of n=200, aged 16-45.

**STUDY DESIGN:** Descriptive study design.

**PLACE AND DURATION OF STUDY:** The sample was taken from Govt. General Hospital Samanabad, Faisalabad. The duration of study was Feb 2017 to May 2017. After getting data, the result was tabulated and analyzed using SPSS version 20.

**RESULTS:** In the results section, we have summarized our findings about the factors that influence the obstetric care in the Government General Hospital Samanabad (GGHS). It is about the factors that are responsible for 3<sup>rd</sup> delay in the delivery of the pregnant females in this hospital.

### **Age Distribution:**

Age is an important factor for the health of a pregnant women. Our results indicate that only 30.5% females were under the age of 30 years while admitted for obstetric care. And 69.5% belong to the 30> year group. It could be attributed that most of the females might be getting delivered for more than first time.

**Age**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid <30	61	30.5	30.5	30.5
>30	139	69.5	69.5	100.0
Total	200	100.0	100.0	

### **Number of average gynae cases handled in one day?**

Obstetric care in the gynae department is largely influenced by the patient turn over on each day. It is cleared from the results that 89.5% cases handled in GGHS were more than 20 each day. This is high value for a comparatively small hospital. There is a small ratio (10.5%) of the cases that were handled less than 20 each day. Higher rate of patient is a limiting factor in the obstetric care.

### **Number of gynae specialist/s available at a time?**

Availability of specialist doctor is a key factor that influence the careful delivery of a pregnant female. Our results show that 80.5% it happens that 2-5 experts are present in the gynae department at the same time. It is a better ratio but a department which handles more than 20 cases each day it not able to provide complete care which could ultimately be a cause of 3<sup>rd</sup> delay. Only 12% cases are reported when 5-10 experts were present to handle multiple cases.

**Number of gynae specialist/s available at a time**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 2-5	161	80.5	80.0	80.5
5-10	24	12.0	12.0	92.5
15-20	15	7.5	7.5	100.0

**CONCLUSION:**

Present research was conducted in the gynae department of GGHS in the district Faisalabad. Aim of the study was to assess the various factor that cause the 3<sup>rd</sup> delay in emergency services. We have conducted a survey of 200 pregnant women that were randomly selected. Ethical standards were also followed carefully. Results have revealed that major cause of delay in the emergency services was delay in the management of operating equipment, delay in fluid management, delay in blood transfusion and limited staff with multi cases at a single time. This study will help to understand the patient’s problem in a hospital with limited space and staff.

**RECOMMENDATIONS:**

Although most of the patient were satisfied with the performance of the emergency department but a limiting factor in the hospital is the limited number of beds, that is urgently required to be updated. Moreover huge number of patient also require to induce more physicians and working staff.

**INTRODUCTION:** Introduction Patient satisfaction is considered as an important indicator of quality care provided in Gyne departments (GDs).

Everyone has a duty to behave in an acceptable and appropriate manner. Staff have the right to work, and patients have the right to be treated, free from the fear of assault or abuse in an environment that is safe and secure.

The causes of conflict and aggression in the Government General Hospital Samanabad (GGHS) are multifactorial and complex.

This article highlights the problem, with reference to nonphysical and physical assaults on staff in the GGHS, and outlines formal procedures to deal with it.

Examining surveys of patients' experiences and complaints can reveal some of the causes of patient dissatisfaction and conflict.

We discuss possible preventative and management strategies surrounding conflict with patients, particularly those relevant to obstetrics and gynecology.

Government General hospital Samanabad (GGHS) is a small progressing hospital of district Faisalabad. It is situated in the periphery of the main city along the industrial belt of Samundri road. Hence, it is acting as a hub for nearby rural populations and city dwellers as well. It was constructed on experimental basis in 2012 with the capacity of 50 beds only. However, it was aimed to facilitate the patients with every type of treatment. This hospital has been equipped with the state of the art Medical, surgical, orthopedic, gynae and emergency departments. Moreover, patients are provided with free medicine of all types. All type of treatment is almost free of cost. Free ambulance service is available for 24 hours. Its labs are well developed with latest instrumentation that can be used for X-rays, Ultrasound and detection of multiple homeostatic disorders. Due to devotion of the administration and the staff, this hospital has gained vast popularity within short duration of time. It could be estimated from a huge number of patient out turn leading to the shortage of space and facilities. This could be resulting into the lack of patient satisfaction. Hence, to gain the maximum patient satisfaction, city government has decided to extend the hospital up to 250 beds as soon as possible. This work is going to be inaugurated soon in mid-2017.

This report has been designed to get the insight of patient satisfaction level that are visiting the emergency department of GGHS on daily basis. This will help to understand the physical demands of hospital and psychological needs of the visiting patients.

### **How much time Doctor / physician provided to the patient?**

Patient satisfaction is more focused on the doctor's intention and proper time given to understand the problem. Even the post analytical treatment is slightly delayed, the role of doctor is considered as key to the patient satisfaction. 53.5% of the patient gave good remarks about the

time they get for their treatment. While 26.6% responded very good remarks for the proper time they got from their doctor. This indicated that majority of the patient get satisfactory time period.

**How much time Doctor / physician provided to the patient?**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid V poor	5	1.7	1.7	1.7
Poor	6	2.0	2.0	3.7
Better	31	10.4	10.4	14.1
Good	159	53.5	53.5	67.7
V good	79	26.6	26.6	94.3
<u>Execptional</u>	17	5.7	5.7	100.0
Total	297	100.0	100.0	

**METHODOLOGY:**

This chapter expresses different tools and techniques which are used for data collection, analysis and interpretation of data relating to research under the study. Methodology is a system of principles and methods of organization, constructing theoretical and practical activity and also teaching about the system. Faisalabad, the third largest city and the Manchester of Pakistan is the universe of this study.

Faisalabad lies from 30 - 42 to 31 - 47 north latitudes and 72 – 40 to 73 – 40 east longitudes. This district lies in Rachna Doab’s lower part at middle side. The total Population of Faisalabad district was 5,429,547 as enumerated in March, 1998. City Faisalabad comprises of 04 administrative Hospitals, all the 04 Hospitals (Allied Hospital, DHQ Hospital, G.G Hospital G.M Abad, G.G Hospital Samanabad) was selected as sampling for the data collection. Analysis of data is done with the help of computer software. Qualitative data is analyzed with the help of tabulation and also evaluated in descriptive writing. In the present study, researchers used the SPSS software to analyze the data taken from the field.

**RESULTS AND DISCUSSIONS:**

**Moral Implications of ED Crowding and patient satisfaction:**

Even though few experts agree on the specific definition of ED crowding, significant consensus exists regarding the moral consequences resulting from this phenomenon. Most obviously,

crowding in the emergency department leads to problems in upholding the moral principles most medical practitioners embrace in patient treatment: no maleficence, beneficence, autonomy, and justice. Some of the relevant moral issues result from crowding alone, while many issues are intrinsic to EDs, but are exacerbated by an increase in patient volume. The six complications outlined in the rest of this chapter highlight the ethical dilemmas EDs face due to crowding, and demonstrate how crowding contributes to negative health outcomes. Patients in dire need of medical assistance, and even those whose circumstances are not quite that urgent, see a decrease in positive health outcomes when the amount of time before treatment begins is prolonged (Cowan and Trzeciak 2004). As the ED patient population increases, but the number of medical, nursing, and other professional staff remains the same, providing the care their patients require becomes more difficult. However, when the health care providers perform rapid 11 evaluation and treatment in order to expedite the process, efficiency and effectiveness may be compromised as a result. When the likelihood of good health outcomes decreases, all parties involved suffer moral consequences: the patient fails to receive safe, timely, and effective treatment, and clinicians fail to honor their commitment to provide beneficial care. When —crowding blocks access to emergency care...[it further] induces stress in providers and patients alike, and can lead to errors and impaired quality of care (IOM, 2006).

### **INCREASED WAIT TIMES:**

ED crowding leads to longer wait times for patients to see a physician; increasing input, that is, patients presenting to the ED for treatment, while space and resources for treatment remain constant, creates a bottleneck to patient —flow, or access to care. It is important to point out that waiting for ED services is not a novel concept: —emergency departments are places of waiting. Patients wait in triage, to be seen by care providers, wait for tests, and wait for explanations (Agrawal, 2007). Even though waiting may not be new to EDs, crowding has exacerbated this problem. While the primary purpose of EDs is to provide timely treatment in unforeseen emergencies, the majority of patients seeking care in the ED do not have emergent or life-threatening conditions (IOM, 2006). Because the ED responds first to patients with serious emergency conditions, those with less urgent complaints often experience increased wait times. These protracted wait times lead to delay in diagnosis and in alleviation of pain and suffering (IOM, 2006). Thus, denying patients the opportunity to receive timely treatment leads to poorer

health outcomes, most notably prolonged suffering and increased risk of ineffective treatment when dealing with time-sensitive cases (which may lead to increased risk of more invasive treatment). In their 2011 article, Sills et al found that ED crowding correlated with a decrease in timely delivery of pain medicine to children presenting with bone fractures, with a 47% decrease in probability of receiving analgesics in a timely manner and a 17% increase in the risk of receiving less effective care (in this case whether or not pain medication was given).

In response to the problem of increased wait times, EDs have extended their resources far past their ideal capacity by placing stretchers in hallways, adding fast-track services, and even attempting to restructure triage protocols to accommodate more patients in a more efficient and timely manner (IOM, 2006). Many of these changes, however, have 13 compounded the bottleneck resulting from increased input, as they have not addressed the issue of —output, that is, moving patients out of the ED to a more appropriate location for continuing treatment, or after appropriate treatment has been administered. Regardless of the severity of the condition causing a patient’s presentation to the ED, delays in diagnosis and treatment may also compromise patient safety and inhibit positive health outcomes. In more serious complaints, such as —acute coronary syndrome, stroke, surgical emergencies, and septic shock...impediments to prompt critical care recognition and delivery in the ED setting could potentially represent a threat to patient safety|| (Cowan and Trzeciak, 2004). Extended wait times also result in patients leaving without being seen by a physician. In these cases, the patient does not receive the care he or she seeks, and the patient may suffer serious health consequences as a result.

One ED physician comments —these patients can languish in the ED for hours—or days (Agrawal 2007). Not only is the boarded patient not receiving the medical care best suited to her condition while she remains in the ED, she is also consuming ED resources and occupying a bed that could be used for other patients. Although initial decisions about diagnosis and the need for inpatient care have been made, the patient still remains in the ED and must be monitored and treated as necessary, even if definitive treatment will typically not be administered until transfer to an inpatient unit has occurred. Continuing this care taxes the ED staff that much further, making an already stressful environment all the more primed for —errors, delays in treatment, and diminished quality of care (IOM, 2006). Although a major role of hospital-based EDs is to provide critical care, it is largely only to the extent of stabilization and not longer-term care. In

fact, many EDs —do not have ICU-level resources for optimal longitudinal critical care delivery (Cowan and Trzeciak 2005). These patients require one-on-one round the clock care from the nursing staff, expertise in critical care (and potentially in additional subspecialties), and invasive monitoring, which ED staff are simply not equipped to offer (Cowan and Trzeciak 2005). Liu et al describe epidemiologic points of boarding as a public health hazard with their 2009 study reviewing the outcomes of patients boarded in the ED of a level 1 trauma hospital. They report three main findings: 27.8% of boarded patients experience an —undesirable event (i.e., a missed ED treatment, missed home 15 medication, or missed laboratory check), preventable adverse events were experienced by 3.3% of boarded patients, and elderly patients and individuals with comorbidities had a higher likelihood of experiencing an undesirable event (Liu et al 2009). Boarding not only denies timely access to adequate medical care, but also prevents the delivery of patient-centered care, due to the limitations of the nursing staff and the excessive demands they face to provide care to numerous patients.

#### **AMBULANCE DIVERSION:**

The increase in the number of patients presenting to the ED not only creates longer wait times, but also leads to a practice called —ambulance diversion. Once a crowded ED reaches the point where it cannot receive new patients without compromising the safety of existing patients, as well as incoming patients, it may resort to sending patients to alternative health care sites. If an ED cannot perform at reasonable standards, —inbound ambulances may be diverted to alternative hospitals to allow patients to obtain the proper care. At one point a rare occurrence, ambulance diversion has become all too common in the past decade. In fact, in 2003 approximately once per minute an ambulance was diverted in the United States, totaling to 501,000 ambulances diverted that year (IOM, 2006). While done in the attempt to provide appropriate emergency care in times of great stress, ambulance diversion often compromises basic moral norms. Ambulance diversion poses threats to principles of non-maleficence and autonomy. Patient safety is compromised by ambulance diversion, since it may increase the time to treatment. When an ambulance must transport a patient to another hospital (one that is most likely more distant than the original destination), that ambulance will probably take a longer time to arrive at the second hospital, thus delaying treatment. In the interim, the health issues the patient suffers from continue and may even get worse. For time-sensitive conditions, ambulance



diversion correlates directly with an increased mortality rate. One study found that when an ED experienced ambulance diversion "the patient experienced a higher death rate by about 3 percentage points than when that same ED was not on diversion" demonstrating an increase in 30-day mortality rate corresponding to ED crowding (Shen and Ilesia 2011).

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