

Study on the Compliance of International Patient Safety Goals
among the Doctors and Nurses of Max Hospital, Shalimar
Bagh

By

Priyanka

*Dissertation submitted for the partial fulfillment of the
MBA Hospital and Health Management*

Academic year, 2016-2018



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TO WHOMSOEVER MAY CONCERN

This is to certify that **Dr. Priyanka** student of MBA Hospital and Health Management from The IIHMR University, Jaipur has undergone internship training at **MAX SUPER SPECIALITY HOSPITAL , SHALIMAR BAGH, DELHI** from **1st Feb 2018 to 4th May 2018**.

The Candidate has successfully carried out the study designated to her during internship training and her approach to the study has been sincere, scientific and analytical.

The Internship is in fulfillment of the course requirements.

I wish her all success in all her future endeavors.



(Col.) Dr. Ashok Kaushik

Dean, Academics and Student Affairs

The IIHMR University, Jaipur



Dr. Neetu Purohit

Associate Professor

The IIHMR University, Jaipur

The certificate is awarded to

DR. PRIYANKA

In recognition of having successfully completed her
Internship in the department of

MEDICAL ADMINISTRATION

and has successfully completed her Project on

**COMPLIANCE OF INTERNATIONAL PATIENT SAFETY GOALS AMONG ALL THE
STAFF IN THE HOSPITAL**

FROM 1ST FEB 2018 TO 4TH MAY 2018

AT

MAX SUPERSPECIALITY HOSPITAL, SHALIMAR BAGH, NEW DELHI

She comes across as a committed, sincere & diligent person who has a strong
drive and zeal for learning

We wish her all the best for future endeavors



**ASSISTANT MEDICAL
SUPERINTENDENT**



**DEPUTY MEDICAL
SUPERINTENDENT**

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CERTIFICATE BY SCHOLAR

This is to certify that the dissertation **A STUDY ON THE COMPLIANCE OF INTERNATIONAL PATIENT SAFETY GOALS AMONG THE DOCTORS AND NURSES OF MAX HOSPITAL ,SHALIMAR BAGH** submitted by **DR. PRIYANKA** Enrollment No- **IIHMR-U/01/2016-18/0473** under the supervision of **DR.NEETU PUROHIT** for award of MBA in Hospital and Health of the University carried out during the period from **1st FEBRUARY 2018** to **4th MAY 2018** embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other institute or other similar institution of higher learning.


Signature

DECLARATION

I do hereby declare that I am a student of 2nd year, MBA in Hospital and Healthcare Management, IIHMR University, Jaipur, Rajasthan session 2016-2018.

I would like to state that I have done the project on “Compliance of International Patient Safety Goals among all the staff of the hospital” under the guidance of Dr. Archana Bajaj (Medical Superintendent) at Max Super Speciality Hospital, Shalimar Bagh, New Delhi for the partial fulfilment for the degree of MBA in Hospital and Healthcare Administration.

This project work is my own and has not been submitted to any of the other Institute or University for the purpose of award of any degree or diploma.

Dr. Priyanka

IIHMR University

(2016-2018)

ACKNOWLEDGMENT

I take this opportunity to express my profound sense of gratitude and indebtedness to all those who helped me throughout the duration of the project.

I would like to acknowledge, First and foremost Dr. Archana Bajaj (Medical Superintendent) for showing confidence in me and giving me such a wonderful topic to do my project without her support and guidance it would not have been possible. Also I would like to thank Dr. Suchismita Adhikari (Deputy Medical Superintendent) for her guidance, motivation and encouragement throughout the completion of Project & Dr. Sandeep Dhilupudi (Assistant Medical Superintendent) whose support was very essential in the completion of my project.

I would also like to thank my faculty at IIHMR-Jaipur and specially my Mentor- Dr. Neetu Purohit (Associate Professor) for being my support all through the internship.

I would also whole heartedly thank the entire staff at Max, Shalimar Bagh for being so supportive and helpful and taking out some time from their hectic schedules and giving all the required information, regarding the project.

At the end, I am thankful to God and my heartfelt gratitude to my parents and friends who supported me throughout the course.

THANK YOU ALL

Dr. Priyanka

IIHMR

(2016-2018)

INTERNSHIP CERTIFICATE FROM MAX SHALIMAR BAGH

This is to certify that Dr. Priyanka, a student of IHMR – Jaipur MBA-HM-21 has carried out a project on the topic “Compliance of International Patient Safety Goals among all the staff members of Max, Shalimar Bagh, New Delhi”.

This project work has been prepared by the student herself with utmost sincerity and this work has not been presented earlier for any academic activity.

I wish her all the very best & success in her further future endeavours.

Dr. Suchismita Adhikari

Deputy Medical Superintendent

Dr. Archana Bajaj

Medical Superintendent

CHAPTER 1 - INTRODUCTION

INTRODUCTION

approach to managing quality of an organization and in a hospital context is through the implementation of accreditation, which involves the assessment of work and organizational practices against predefined standards, conducted by multidisciplinary clinical and support service teams.

The level of compliance against standards is then evaluated by the external teams of surveyor and on that basis accreditation rating is arrived at for the organization. Joint Commission International (JCI) is an international body issuing healthcare standards following the principles of Total Quality Management to improve quality and patient safety.

Patient centered standards:

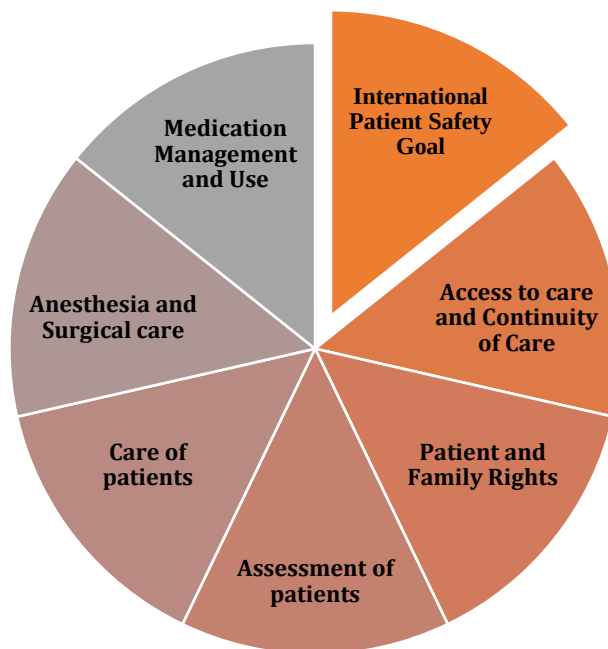


Figure 1 : Patient centered standards

INTERNATIONAL PATIENT SAFETY GOALS (IPSG): 2017-18

Let us ensure 100% Compliance to Safe Processes and Target 'Zero Incidents'

IPSG 1

Identify Patients Correctly:

- Patients are identified using "two" patient identifiers
- Patients are identified before:
 - Performing diagnostic procedures
 - Providing treatments and other procedures.
- Patient identification of comatose patients and newborns



IPSG 2

Improve Effective Communication:

- Verbal/ Telephonic Orders: Read Back, Confirm and Record
- Critical Results of diagnostic tests – Define critical values, Report & Document
- Handover Communication for both "doctors & nurses" during shift handovers and patient transfers



IPSG 3

Improve the Safety of High-Alert Medications:

- High Alert Medications
- Look Alike Sound Alike medications
- Concentrated electrolytes – Identification, labeling, storage and proper use (Prevent inadvertent administration)



IPSG 4

Ensure Correct-Site, Correct-Procedure, Correct-Patient Surgery:

- Site Marking to be done by the person performing the procedure (with involvement of Patient)
- Time Out (OT & invasive Procedures) by full surgical team
- WHO Surgical Safety Check list
- Use of "Procedure Safety Checklist" for medical & dental procedures (performed outside OT)



IPSG 5

Reduce the Risk of Health Care Associated Infections

- Compliance to hand hygiene guidelines
- Evidence-based practices to prevent HAI's
- Follow VAP, Central Line & Catheter Care Bundles.
- Compliance to Antibiotic Policy



IPSG 6

Reduce the Risk of Patient Harm Resulting from Falls

- Fall Risk Assessment (All Inpatient, Outpatient, Adult & Pediatric)
- Screening outpatients for falls
- Initial, ongoing & reassessments of patients identified at risk of falls
- Implementation & monitoring of fall risk reduction measures



Figure 2

There are in total 6 IPSG:

1. Identify Patients Correctly
2. Improve Effective Communication
3. Improve the Safety of High-Alert Medications
4. Ensure Correct-Site, Correct-Procedure, Correct Patient Surgery
5. Reduce the Risk of Health Care-Associated Infections
6. Reduce the Risk of Patient Harm Resulting from fall

IPSG.1 Identify Patients Correctly

- Using two patient identifiers, not including patient's room or location
 - Before administering medications, blood, or blood products
 - Before taking blood and other specimens for clinical testing
 - Before providing treatments and procedures

IPSG.2 Improve Effective Communication

- The complete verbal and telephone order or test result is written down by the receiver of the order or test result.
- The complete verbal and telephone order or test result is read back by the receiver of the order or test result.
- The order or test result is confirmed by the individual who gave the order or test result.
- The complete verbal and telephone order or test result is written down by the receiver of the order or test result.
- The complete verbal and telephone order or test result is read back by the receiver of the order or test result.
- The order or test result is confirmed by the individual who gave the order or test result.

IPSG.3 Improve the Safety of High-Alert Medications

- **High-Alert Medications** are
 - "I Medications involved in a high percentage of errors and/or sentinel events
 - Medications that carry a higher risk for adverse outcomes
 - Look-alike/sound-alike medications
- Policies and/or procedures are developed to address the identification, location, labeling, and storage of high-alert medications.
- The policies and/or procedures are implemented.

- Concentrated electrolytes are not present in patient care units unless clinically necessary, and actions are taken inadvertent administration in those areas where permitted by policy.
- Concentrated electrolytes that are stored in patient care units are clearly labeled and stored in manner that restricted areas.

IPSG.4 Ensure Correct-Site, Correct Procedure, Correct-Patient Surgery

- Uses an instantly recognized mark for surgical-site identification and involves the patient in the marking process.
- The full surgical team conducts and documents a time-out procedure just before starting a surgical procedure.
- Policies and procedures are developed that support uniform process to ensure the correct site, correct procedure, and correct patient, including medical and dental procedures done in settings other than the operating theatre.

IPSG.5 Reduce the Risk of Health Care-Associated Infections

- The organization has adopted or adapted currently published and generally accepted hand-hygiene guidelines
- The organization implements an effective hand-hygiene program.
- Policies and/or procedures are developed that support continued reduction of health care-associated infections.

IPSG.6 Reduce the Risk of Patient Harm Resulting from fall

- Implements a process for the initial assessment of patients for fall risk and reassessment of patients when indicated by a change in condition or medications, among others.
- Measures are implemented to reduce fall risk for those assessed to be at risk.

CHAPTER 2- LITERATURE REVIEW

LITERATURE REVIEW:

Literature review done for the study is presented under the following heading.

1. Studies related to International Standards on patient safety.
2. Studies related to patient safety measures on safe administration of medications.

1. Studies related to International Standards on patient safety

Improved information and data systems are needed to support efforts to make patient safety a standard of care in hospitals, in doctors' offices, in nursing homes, and in every other health care setting. All health care organizations should establish comprehensive patient safety systems by providing immediate access to complete patient information and decision support tools and capturing information on patient safety by reporting adverse events and near misses.

A research study was done on International standards of patient care in King Hussain Cancer Center, Jordan .The purpose of the study was to explain rapid changes on international standards. Sources including personal interviews, document review and on-site observations were combined to conduct a robust examination of KHCC's rapid changes. The changes which occurred at the KHCC during its formation and leading up to its Joint Commission International (JCI) accreditation can be understood within the conceptual frame of the transformational leadership model. Interviewees and other sources for the case study suggest the use of inspirational motivation, idealized influence, individualized consideration and intellectual stimulation, four factors in the transformational leadership model, had significant impact upon the attitudes and motivation of staff within KHCC. As a result it achieved improved levels of quality, expanded cancer care services and achieved Joint Commission International accreditation under new leadership over a three-year period (2002–2005).[1]

A study was done on risk factors for falls as stroke patients are high risk for falling. The purpose of the study was to identify physical and social factors that predispose stroke patients to falls may reduce further disability and life-threatening complications, and improve overall quality of life.

They used 5 biennial waves (1998-2006) from the Health and Retirement Study to assess risk factors associated with falling accidents and fall-related injuries among stroke survivors. They abstracted demographic data, living status, self-evaluated general health, and comorbid conditions. We analyzed the rate ratio (RR) of falling and the OR of injury within 2 follow-up years using a multivariate random effects model. As a result they identified factors such as poor general health, urinary incontinence, motor impairment, living alone, impaired hearing, and etc. are the risk factors. In conclusion this study demonstrates the high prevalence of falls and fall-related injuries in stroke survivors, and identifies factors that increase the risk. Modifying these factors may prevent falls, which could lead to improved quality of life and less caregiver burden and cost in this population.[2]

A study was conducted on sign-out practices among internal medicine house staff, to identify contributing factors to sign-out quality. Prospective audiotape study design was used on eight internal medicine house staff teams from medical ward of an acute teaching hospital. Quantitative and qualitative assessments of sign-out content, clarity of language, environment, and factors affecting quality and comprehensiveness of oral sign-out etc. was done on different sessions. Five factors were associated with a higher rate of oral content inclusion: familiarity with the patient, sense of responsibility for the patient, only one sign-out per day, presence of a senior resident, and a comprehensive written sign-out. Findings suggest that several changes may be required to improve sign-out quality, including standardizing key content, minimizing sign-outs that do not involve the primary team, , emphasizing the role of sign-out in maintaining patient safety, and fostering a sense of direct responsibility for patients among covering staff. The quality of sign-out process shows the standard of the organization.[3]

A study was done about the complexities of the health care system potentially causing significant unintended adverse effects. The purpose of patient safety issue project is to report indications and to recommend potential patient safety issues .A 4 pronged strategies was developed to collect data that is background literature review, structured clinical panel reviews, expert review of ICD code in candidate of patient safety issue, and empirical analysis of potential candidate of patient safety issue. A review of previously reported measures in the literature and of medical coding manuals resulted in identification of over 200 ICD CM codes representing potential patient safety problems.[4]

A study was done on medication errors and patient safety in 2006. The study focused on the word error has drawn attention to prevention and what can be done to minimize mistakes and improve patient safety. The study says the word error means an act that through ignorance, deficiency, or accident, departs from or fail to achieve what should be done. As a result, the researcher says all health care institutions to follow 5 RIGHTS of medication administration to avoid medication errors thus improve patient safety.[5]

This study was done on medication safety in the Australian acute care setting. The study was done to examine the extent and causes of medication incidents and adverse drug events in acute care. A literature search was conducted to identify Australian studies, published from 2002 to 2008, on the extent and causes of medication incidents and adverse drug events in acute care. Results of incident reporting from hospitals show that incidents associated with medication remain the second most common type of incident after falls. Omission or overdose of medication is the most frequent type of medication incident reported. Studies conducted on prescribing of renal excreted medications suggest that there are high rates of prescribing errors in patients requiring monitoring and medication dose adjustment. Research published since 2002 provides a much stronger Australian research base about the factors contributing to medication errors. Team, task, environmental, individual and patient factors have all been found to contribute to error. To conclude, medication-related hospital admissions remain a significant problem in the Australian healthcare system. Medication incidents remain the second most common type of incident reported in Australian hospitals.[6]

A study was done on drug-related problems, arising despite the use of a computerized physician order entry (CPOE) system. The aim of the study was to identify and estimate the drug-related problems, identified by clinical pharmacists during their routine medical rounds. They identified that common drug-related problems are non-conformity to guidelines or contra-indication, improper administration, drug interaction and over dosage. In conclusion drug-related problems are very common even after the implementation of computerized physician order entry.[7]

A study conducted on reporting of incidents and near misses in NHS-London.. The purpose of the study was to find out the cases of under reporting of incidents and near misses as it is still a problem in NHS There were 974000 patient safety incidents and near misses in 2004-2005 reported, but as per National Patient Safety Agency, they failed to get accurate information on

serious incidents and death .The investigating body found that doctors are less likely to report incidents than other group of health care providers. To top it all, the NHS simply has no idea how many people die each year from patient safety incidents. The report concludes that sufficient progress has been made to achieve the Department's plan to guarantee a safer NHS for patients.[8]

2. Studies related to patient safety measures on safe administration of medications.

A study on safety promotion has traditionally focused on the safety of patients and also included systems, environments, and organizations. Safety promotion programs are designed to support community health initiatives taking a bottom-up approach. The aim of this study was to try to empirically identify factors that promote sustainability in the structures of programs that are managed and coordinated by the local government. Four focus group sessions with local government politicians and administrators in designated Safe Communities were conducted and analyzed using qualitative content analysis. Participants reported an increase in cross-disciplinary collaboration among staff categories. Support from the politicians and the county council was seen as a prerequisite. Participants reported an increased willingness to share information between units, which, in their view, supports sustainability. A regular flow of information to policy-makers, residents, and staff was needed in order to integrate safety programs into routines. In contrast to injury prevention, which focuses on technical solutions, safety promotion tries to influence attitudes.[1]

A study was conducted on review of literature on measures of patient safety in developing and emerging countries to identify patient safety measures used in this country and to propose a method of measurably improving patient safety measurements in these countries. They used the medicine data base for 1998-2007 and identified and reviewed 23 English language articles. The outcome included 12 studies that prospectively measured patient safety and 11 studies that retrospectively measured safety .As a result the measurement of patient safety in developing countries have been infrequent and limited in scope. Establishing fundamental safe patient practices is necessary prerequisites to measuring and monitoring progress towards safe patient care in emerging and developing countries.[2]

A cross-sectional study was conducted to explore and compare hospital and home care nurses' assessment of their information management at patients' discharge from hospital to home care before and after the hospital implemented an electronic nursing discharge note. This paper draws on the concept of inter-organizational continuity of care, and specifically addresses the contribution of the implementation of an electronic patient record. The studies have a prospective descriptive design. A questionnaire addressing the information that hospital and home care nurses exchange when patients need continuing care after hospitalization was developed and used. Hospital and home care nurses differed in the way they assessed the structures and content of the information they exchanged, both before and after the electronic patient record implementation. There is a need to take account of the different organizational contexts within which the two nursing groups work. The organizational context (hospital versus home care) has implications for the nurses' assessment of the information they exchange. In further development of electronic patient record, it is therefore essential to clarify the context-related information needs of the various health care provider groups as part of the commitment to patient safety.[3]

A comparative study was conducted on safety culture scores to determine the scores for nursing homes and compare these results with existing data from hospitals. Data were collected from a nationally representative sample of nursing homes. From these nursing homes, administrators completed The Hospital Survey on Patient Safety Culture (HSOPSC). Subscale scores from the nursing home sample were considerably lower than the benchmark hospital scores. In addition, almost all item scores from nursing homes were considerably lower than the benchmark hospital scores. The results clearly showed that the patient safety culture scores of nursing homes are considerably lower than those of hospitals. Residents of nursing homes may be at risk of harm as a result of patient safety errors.[4]

A study was done on Hospital Acquired Infections as these infections are significant cause of mortality and morbidity. The aim of the study is to investigate the incidence and prevalence of hospital acquired infections in patients admitted to departments of internal medicine. The study involved seven departments and was designed as a cohort study based on reviews of medical records. Except for patients who had previously been admitted within the preceding 30 days, the study included all patients admitted for more than 48 hours during the 45-day study period. HAI was defined according to the criteria established by the Center for Disease Control and Prevention,

USA. In conclusion the incidence of hospital acquired infections was relatively constant during the initial 14-day-period of hospitalization, suggesting that shortening the period will have no major impact on the incidence of hospital acquired infections.. The prevalence was 9.7%, which is in line with results from prior studies.[5]

A study was done to measure patient safety climate considered predictive of health outcomes have begun to emerge. The study done by systematic literature review nine surveys were found that measured the patient safety climate of an organization. All used Likert scales; all covered five dimensions of patient safety leadership, policies and procedures, staffing, communication and reporting. The strength of psychometric testing varied. In conclusion achievement of a culture conducive to patient safety may be an admirable goal in its own right, but more effort should be expended on understanding the relationship between measures of patient safety climate and patient outcome.[6]

This study was done to determine the cost of healthcare-associated bloodstream infections (HA-BSI) in adult patients admitted to an Auckland City Hospital. A matched cohort study was performed with a 1:2 or 1:1 match in which all patients admitted between January and June 2005 who had HA-BSI were included. Controls were selected from patients admitted between July 2004 and December 2006. Patients with haemodialysis, central line-related HA-BSI were not matched with controls as the admission was related purely to that episode of infection. As a result there were 106 episodes of HA-BSI in 99 patients. Fifty-five patients were able to be matched 1:1 or 1:2 with controls, group 1. Nineteen BSI episodes were in patients undergoing renal replacement therapy by haemodialysis and the patients were admitted as a consequence of this episode of infection, group 2. An episode of healthcare-associated bloodstream infections increased the length of the hospital stay by 9.7 days and 7.9 days in group 1 and group 2, respectively. The excess cost associated with an episode of healthcare-associated bloodstream infections was \$20,394 in group 1 and \$11,139 in group 2. In conclusion there are substantial costs associated with healthcare associated bloodstream infections. A proportion of these infections can be reduced by effective infection control measures.[7]

**CHAPTER 3- NEED OF THE STUDY, OBJECTIVE,
RESEARCH METHODOLOGY AND DATA
COLLECTION**

NEED OF THE STUDY

Safe administration of medication is one of the goal or concern for Joint commission international. Nurses in large part expressed having suffered from mental problems of medication error events. Hospital's risk management should concentrate on organizational deficit and positive error cultures. Making system improvements for safer medication use in hospital requires leadership from the top of the organization. Individual staff in every discipline are also in a position to make significant contribution to safety in the system as a whole. Given the complexity and range of services being offered, hospitals are launching numerous improvement initiatives in all clinical care and support areas. Joint commission international and other voluntary agencies helping organizational leaders to better understand, organize and prioritize patient quality, and safety issues

Medication errors constitute a significant public health problem and are recognized as such nowadays among healthcare professionals, societies, authorities and international organizations. This has led to seeking and implementing effective practices focused on improving medication use safety. These safety improvement initiatives are based upon progressively developing an institutional culture of safety and on establishing practices designed to reduce errors or detect them in time, thus avoiding adverse effects to patients. Among these recent initiatives are the safety practices approved by the National Quality Forum, and the National Patient Safety Goals that the Joint Commission on Healthcare Accreditation has required since 2003. Also mentioned are several strategies that have been offered to facilitate the application of these practices, among which are the Pathways to Medication Safety, the development of collaborative projects among hospitals and organizations of experts, and the inclusion of a medication safety specialist in

hospitals as a support figure overseeing the application of safety measures. The challenges inherent in putting these preventive measures into real patient's care needs to be discussed. The barriers confronting this step must obviously be faced if improvements in patient safety are truly to be achieved. Patient falls and related injuries are serious problems in hospitals. Some hospitals started to apply Fall Tips to prevent patient falls by translating routine nursing fall risk assessment into a decision support intervention that communicates fall risk status and creates a tailored evidence based plan of care that is accessible to the care team patients and family members. Patient education handouts can be given to patients and relatives to enhance their knowledge on prevention of falls and fall related injuries. Joint Commission International recommends assessment and periodic assessment of patient to identify patients under risk for fall. Such patient's needs to be monitored closely and falls can be prevented.⁶

Ineffective communication is the most frequently reported cause of sentimental events in most of the hospitals. Examining hospital process and systems of communication and standardizing communication practices can reduce the risks to patients in the acute care environment. Joint Commission International recommends all hospitals to implement a process or procedure for taking verbal or telephonic order in emergency situations. In this aspect the person who takes the order or information have to read back the order to make it clear and to avoid mistakes, ultimately patient safety will be improved. Effective communication is the one of the skill required for the nurses to practice as a professional nurse.

JCI Program is designed to create a culture of safety and quality within a health care facility and ensure that it strives to continuously improve patient care process and results for patients. The IPSGs are fundamental to achieve high quality health care standards and the optimal level of patient's safety. The foundation of quality patient care is a proactive program of patient safety. As patient is the main customer of health care facility, the prime aim of the organization should direct towards patient safety.

Meeting these goals helps health care facilities to ensure that a safe health care environment is provided for the patient. Compliance with standards and each International Patient Safety Goals is a requirement of JCI Accreditation too. This study is aimed towards the further awareness regarding IPSP among health care professionals. Common communication problem within the

health care team and between the health care professionals can be reduced by achieving the goal 2-improve effective communication.

Also IPSGs help to establish National Reporting systems and response mechanisms that are integral components of quality assurance program. Implementing evidence based interventions reduce patient harm and improve safety. Meeting IPSGs helps to create or implement policies and legislations conducive to sustainable health oriented solutions. It helps to establish systems that respect the rights of both patients and health care providers. It also provides strong technical leadership and support to health care professionals.

The risk of health care associated infections is estimated to be 2-20 times higher in developing countries. Adhering to IPSG goal 5 reduces health care associated infections by promoting hand washing among health care providers. Unsafe practices include reuse of syringes and needles in the absence of sterilization and poor collection and disposal of dirty injection equipments which expose health care workers and the community to the risk of needle stick injuries.

The health workers and staff nurses have very little knowledge about international patient safety goals, so, the investigator felt the need to prepare self instructional module regarding international patient safety goal to enhance knowledge among nurses.

OBJECTIVE:

- To check the compliance level of International Patient Safety Goals as per JCI guidelines among the staff (Doctors, Nurses) of Max Hospital, Shalimar Bagh (New Delhi) in various departments.
- . To identify the gaps and issues in all processes and procedures that corresponds to JCI standards for IPSG chapter (International Patient Safety Goals).

METHODOLOGY:

Study Design: Descriptive Study

Setting: Max Hospital, Shalimar Bagh, New Delhi.

Sample: Total population (Doctors, Nurses)

Sample size: 100

Period of Study: February 2018 to May 2018.

Study Population:

- Doctors
- Nurses

Study Tool:

- Checklist as per IPSC guidelines

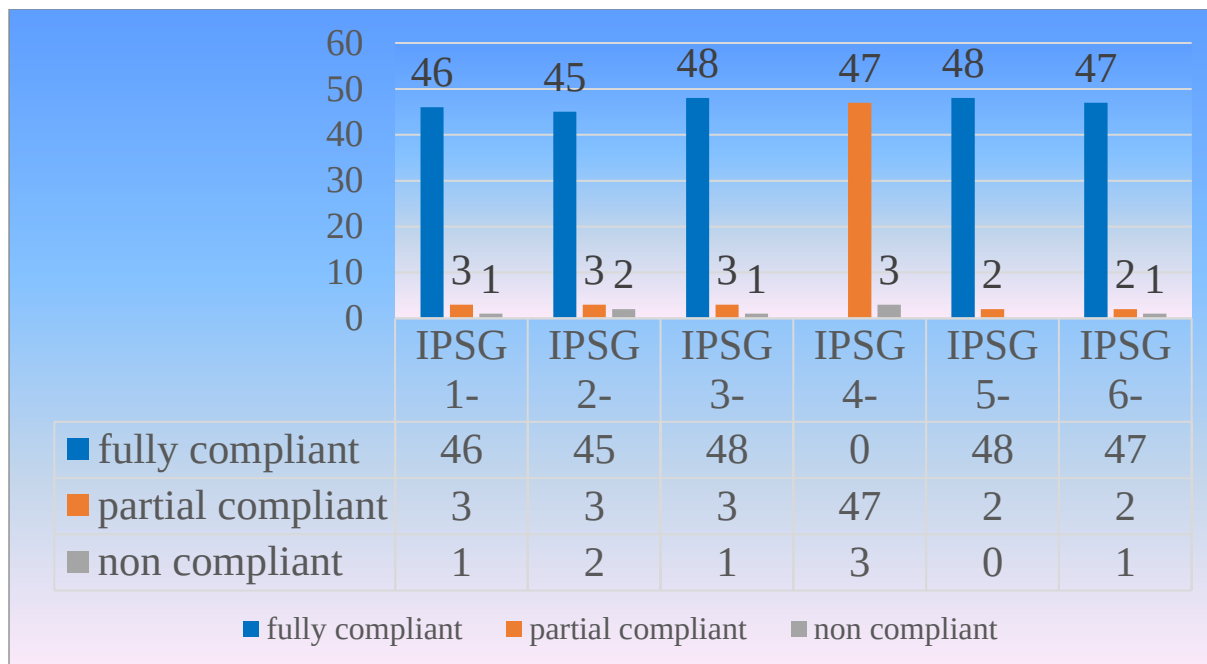
Data Collection Method:

- These included:
 - Emergency department,
 - Radiology department,
 - ICU
 - Labor room and
 - Wards
- The observations were noted in checklists and compared with the existing policies for the same.

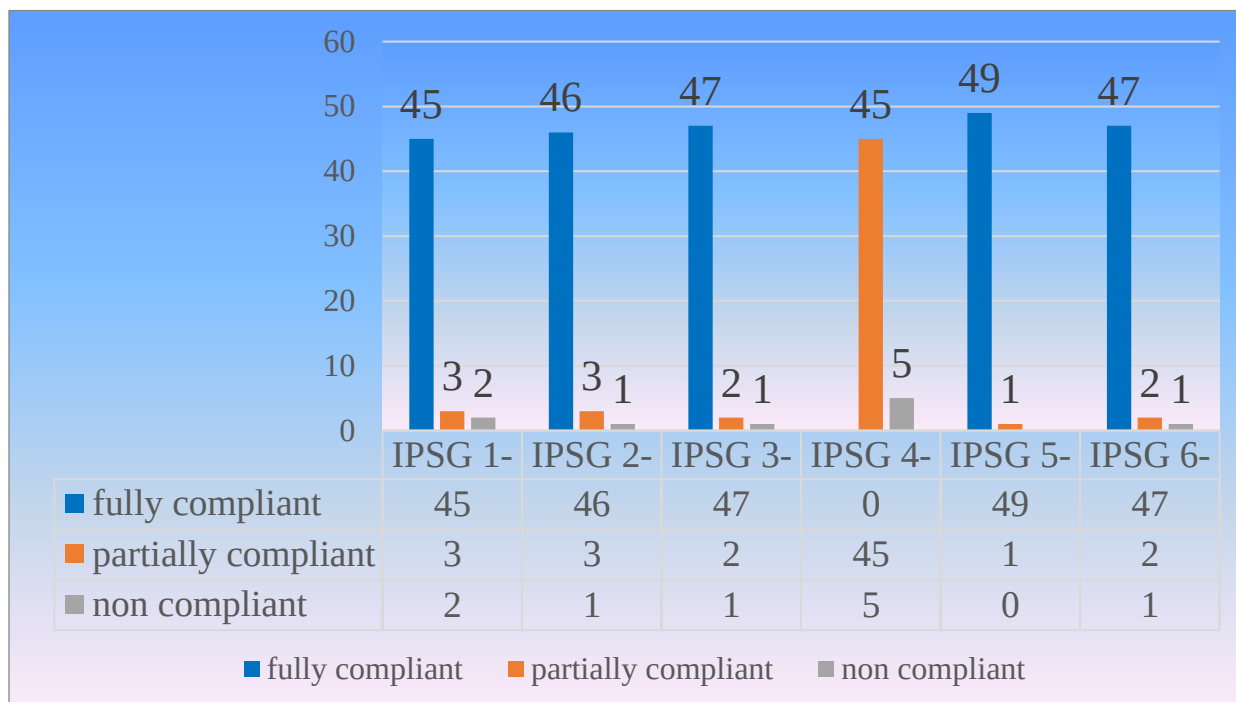
DATA ANALYSIS AND INTERPRETATION:

1-ICU

	Nurse (N-50) (percentage)	Doctors (N-50) (percentage)
IPSG 1-Identify patients correctly	92	90
IPSG 2-Improve effective communication	90	92
IPSG 3-Improve the safety of high alert medications	96	94
IPSG 4- Ensure correct site, correct procedure, correct patient surgery	NA	NA
IPSG 5-Reduce the risk of health care associated infections	96	98
IPSG 6-Reduce the risk of patient harm resulting from falls	94	94



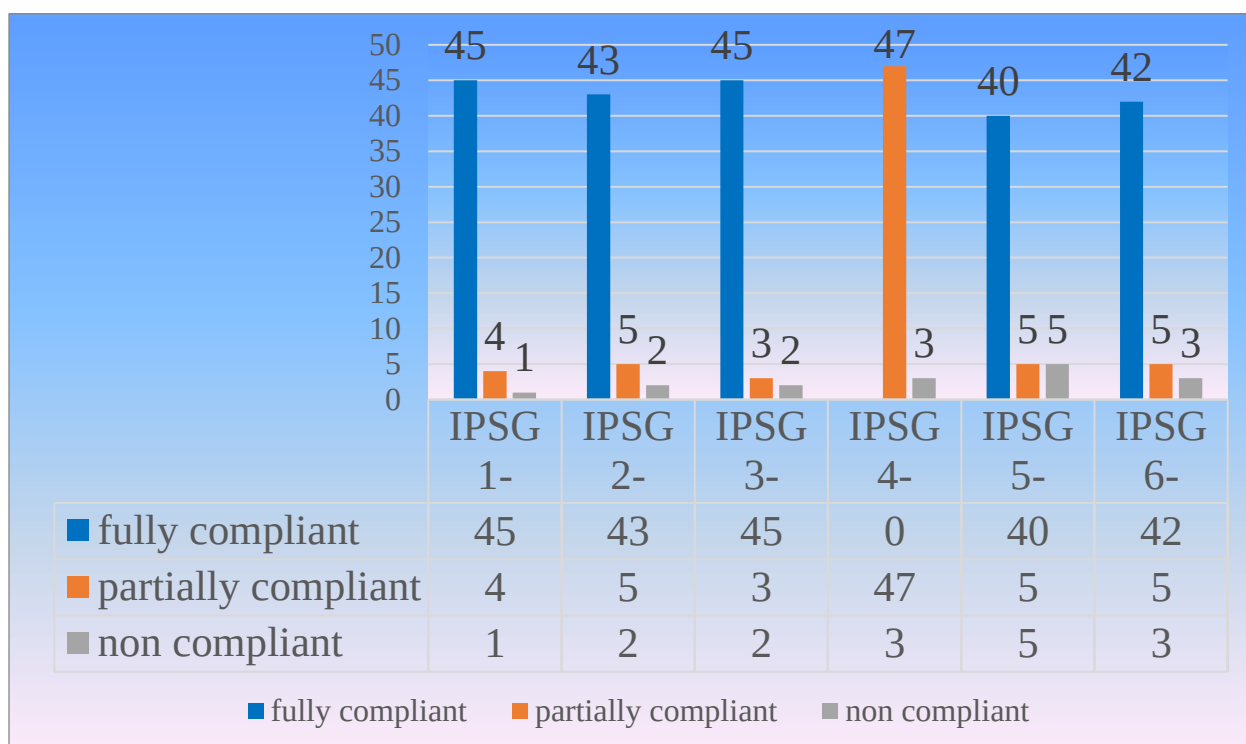
COMPLIANCE OF NURSES IN ICU (in Numbers)



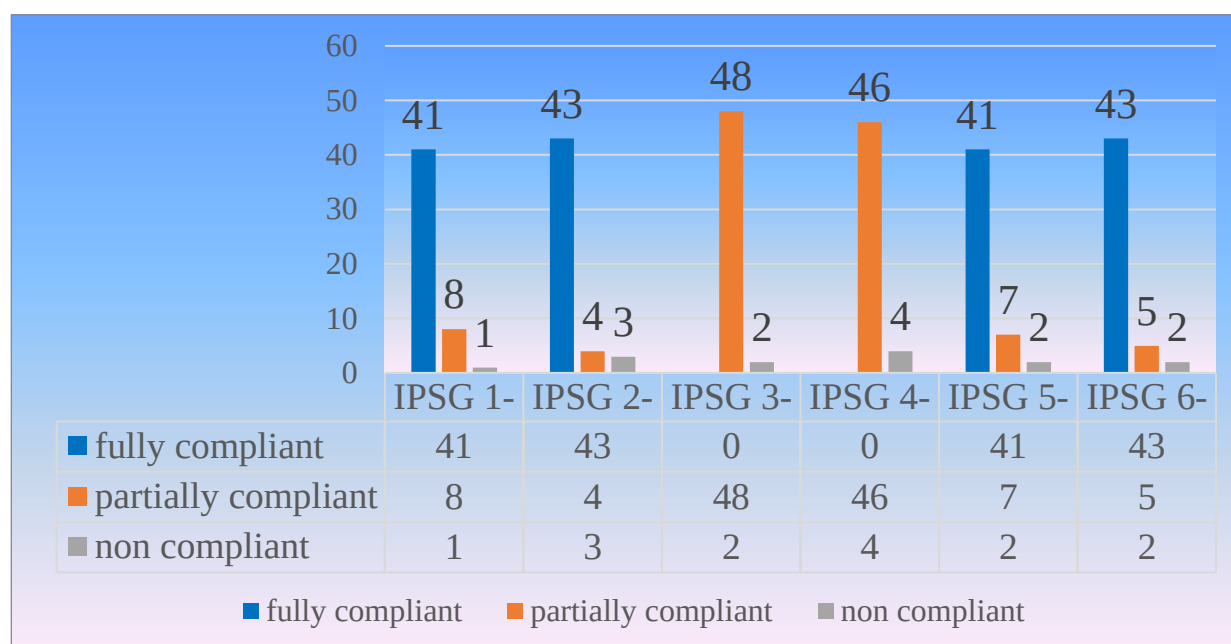
COMPLIANCE OF DOCTORS IN ICU (in Numbers)

2EMERGENCY

	Nurse (N-50) (percentage)	Doctors (N-50) (percentage)
IPSG 1-Identify patients correctly	90	90
IPSG 2-Improve effective communication	86	82
IPSG 3-Improve the safety of high alert medications	90	90
IPSG 4- Ensure correct site, correct procedure, correct patient surgery	NA	NA
IPSG 5-Reduce the risk of health care associated infections	80	82
IPSG 6-Reduce the risk of patient harm resulting from falls	84	80



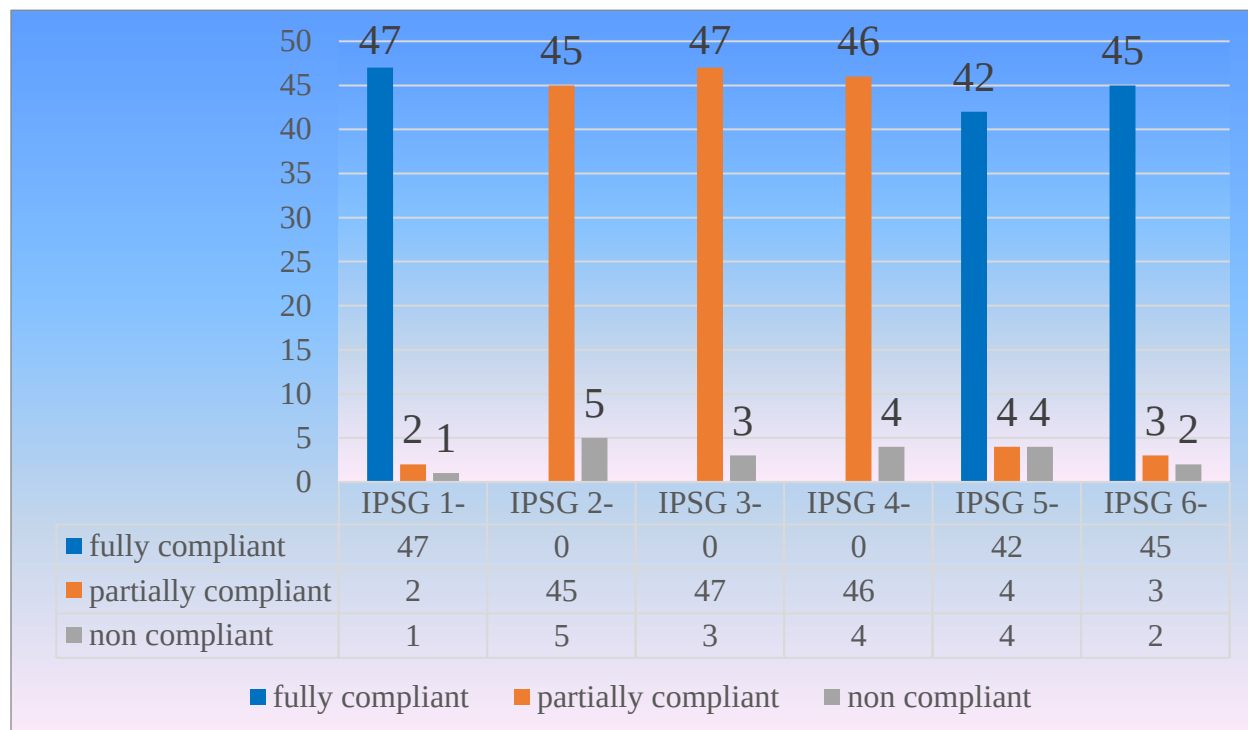
COMPLIANCE OF NURSES IN EMERGENCY DEPARTMENT(in Numbers)



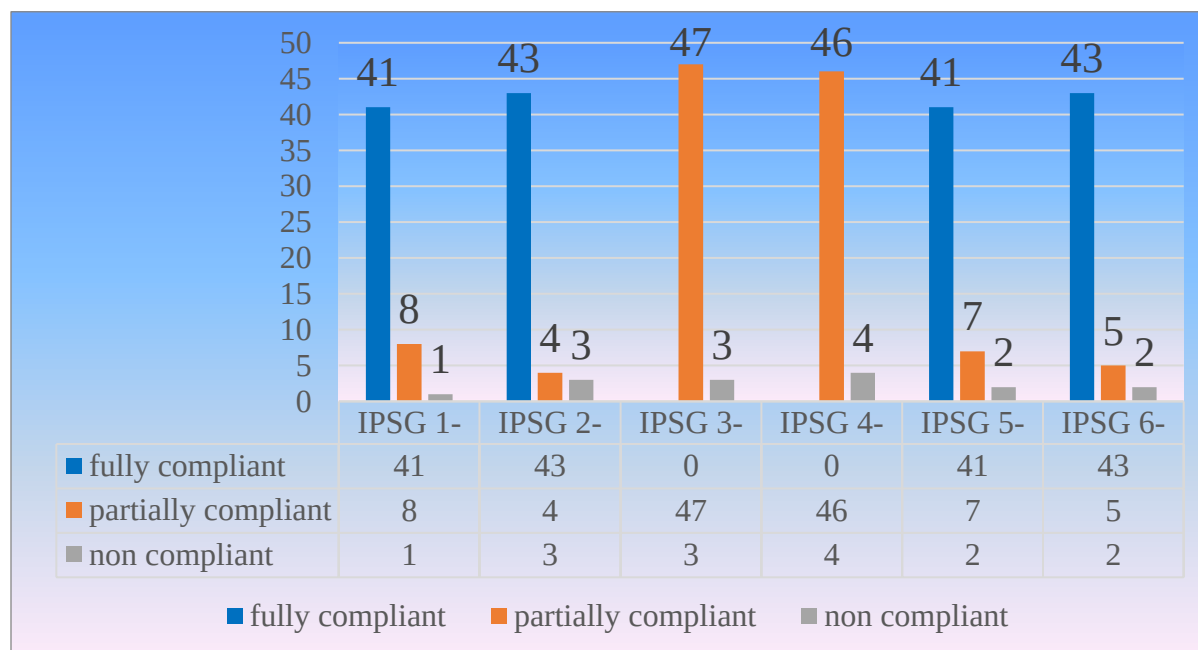
COMPLIANCE OF DOCTORS IN EMERGENCY DEPARTMENT (in Numbers)

3.RADIOLOGY DEPARTMENT:

	Nurse (N-50) (percentage)	Doctors (N-50) (percentage)
IPSG 1-Identify patients correctly	94	82
IPSG 2-Improve effective communication	NA	86
IPSG 3-Improve the safety of high alert medications	NA	NA
IPSG 4- Ensure correct site, correct procedure, correct patient surgery	NA	NA
IPSG 5-Reduce the risk of health care associated infections	84	82
IPSG 6-Reduce the risk of patient harm resulting from falls	90	86



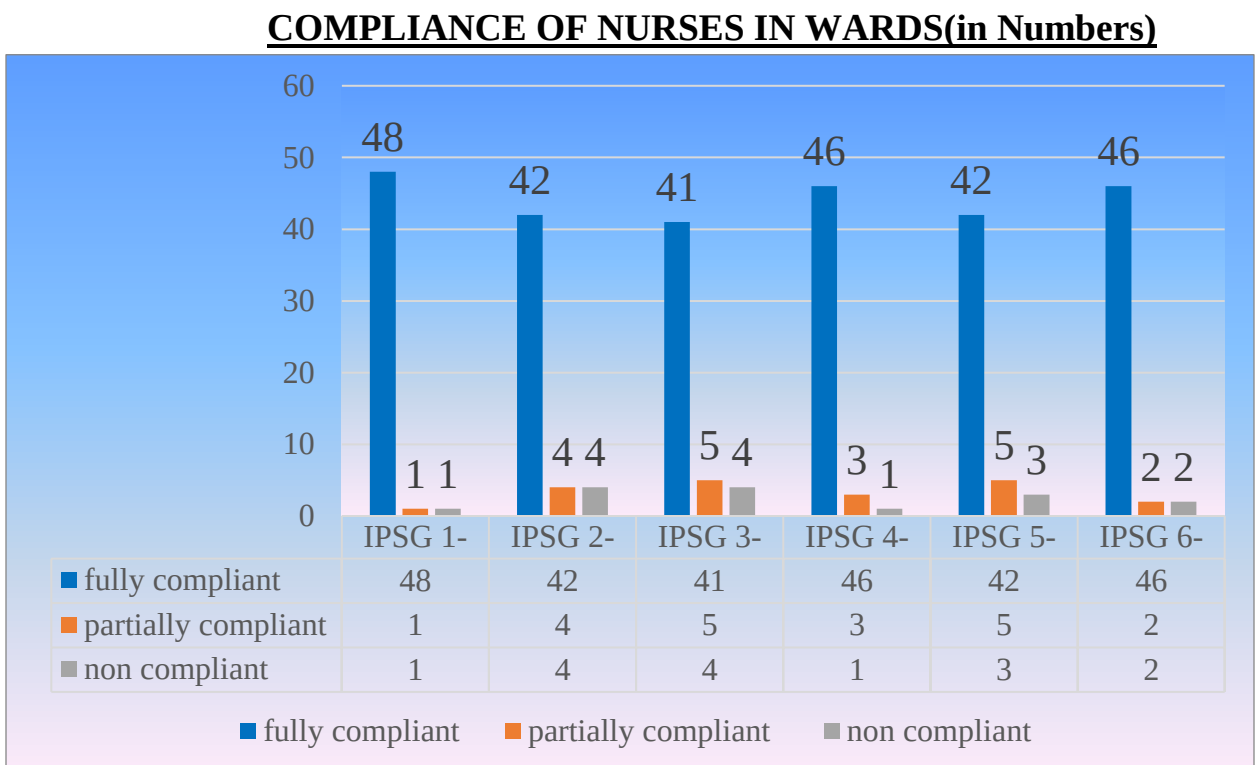
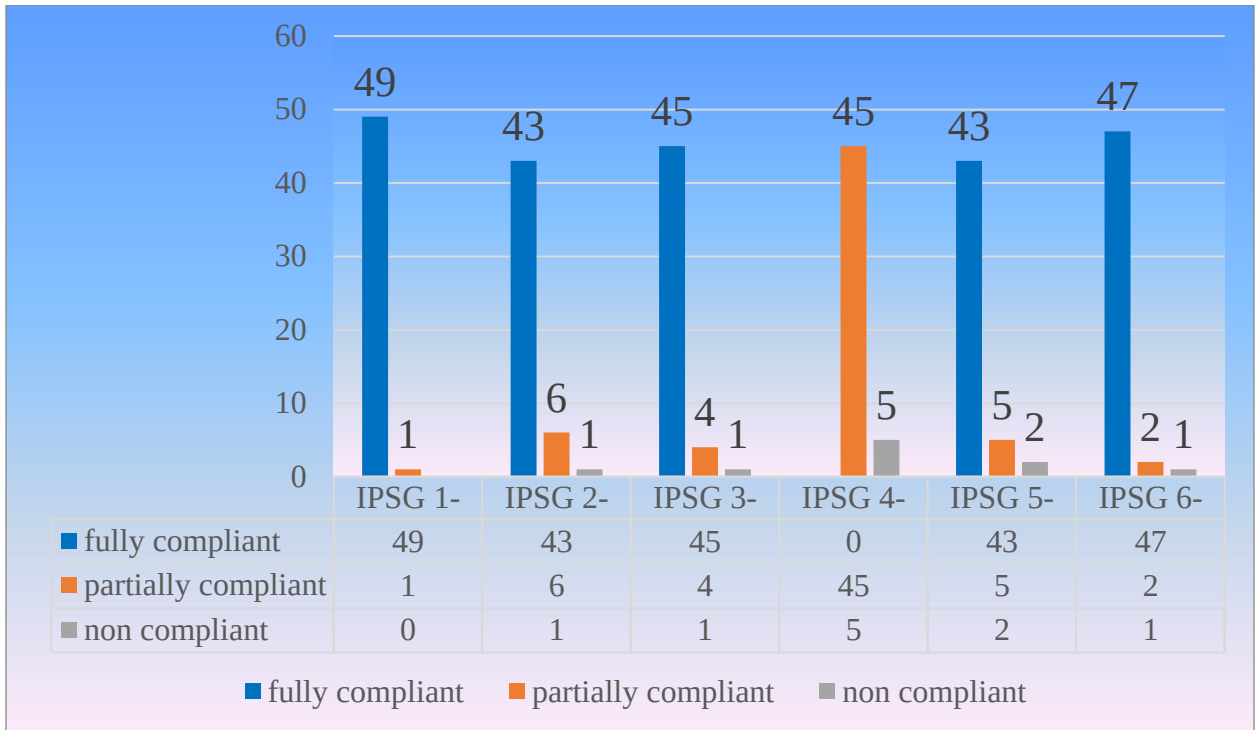
COMPLIANCE OF NURSES IN RADIOLOGY DEPARTMENT(in Numbers)



COMPLIANCE OF DOCTORS IN RADIOLOGY DEPARTMENT (in Numbers)

4WARDS:

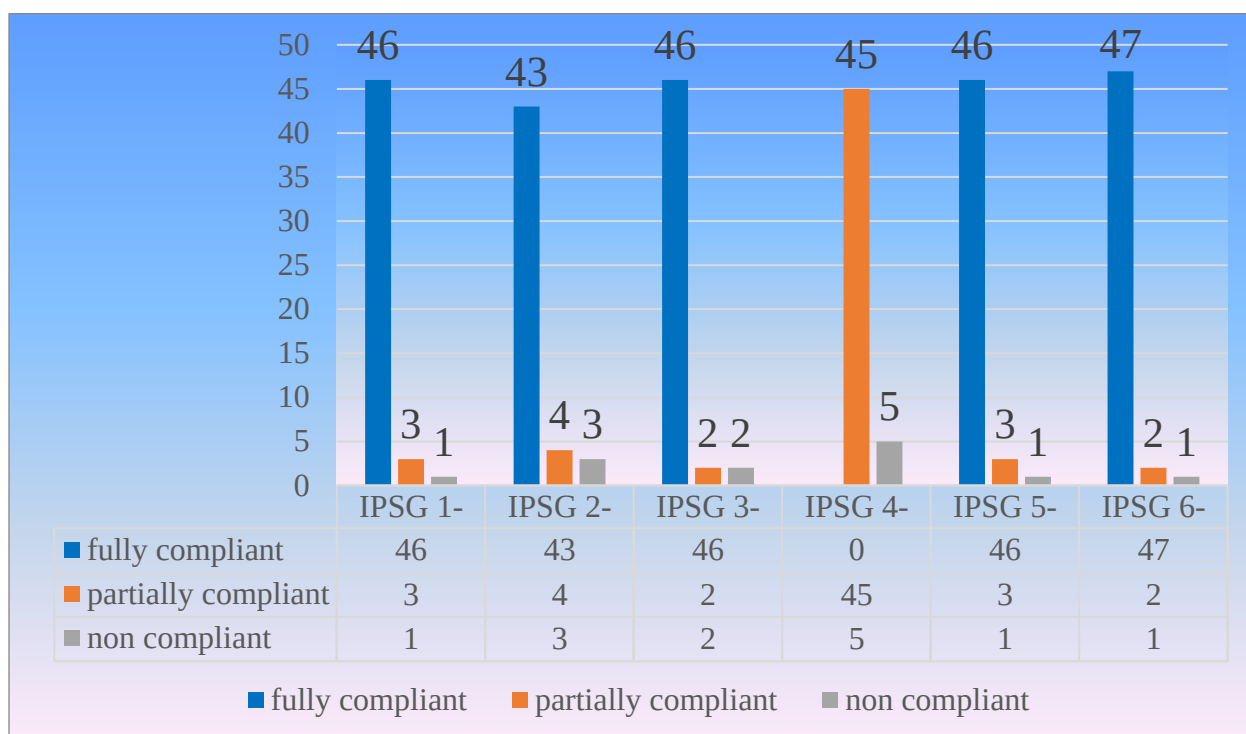
	Nurse (N-50) (percentage)	Doctors (N-50) (percentage)
IPSG 1-Identify patients correctly	98	96
IPSG 2-Improve effective communication	86	84
IPSG 3-Improve the safety of high alert medications	90	82
IPSG 4- Ensure correct site, correct procedure, correct patient surgery	NA	92
IPSG 5-Reduce the risk of health care associated infections	86	84
IPSG 6-Reduce the risk of patient harm resulting from falls	94	92



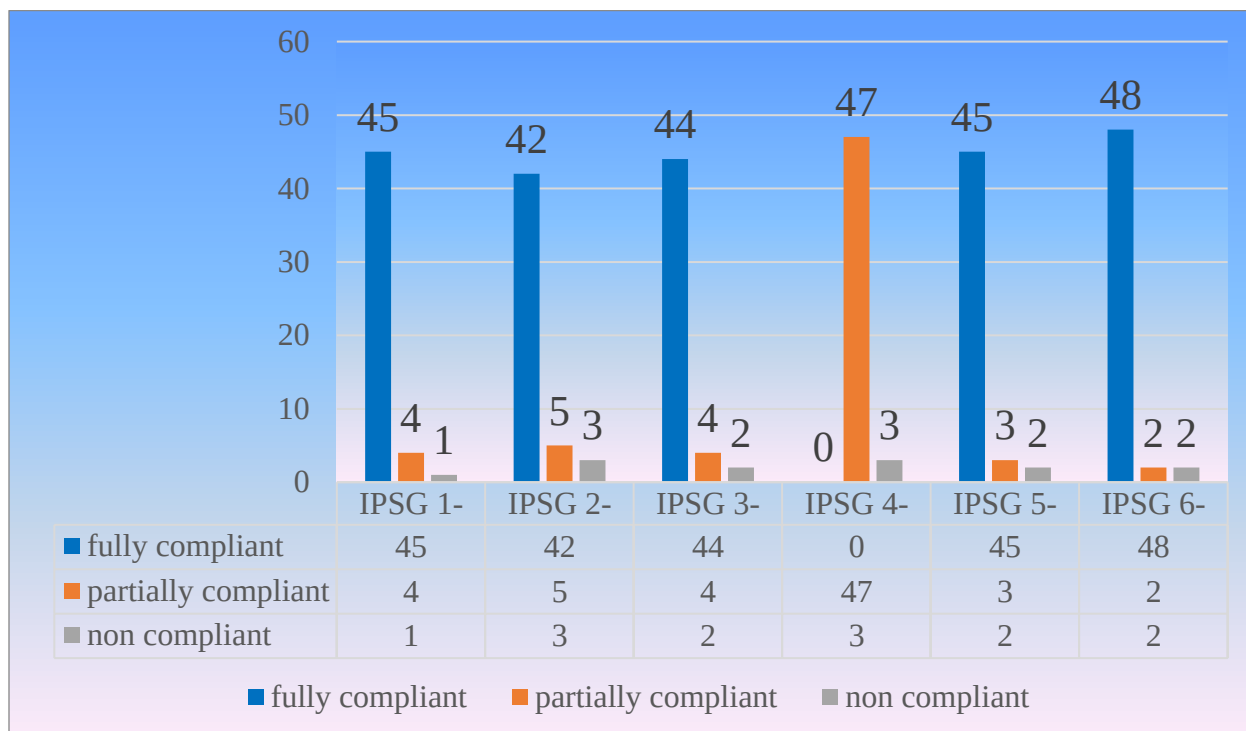
COMPLIANCE OF DOCTORS IN WARDS(in Numbers)

5LABOR ROOM:

	Nurse (N-50) (percentage)	Doctors (N-50) (percentage)
IPSG 1-Identify patients correctly	92	90
IPSG 2-Improve effective communication	86	84
IPSG 3-Improve the safety of high alert medications	92	88
IPSG 4- Ensure correct site, correct procedure, correct patient surgery	NA	NA
IPSG 5-Reduce the risk of health care associated infections	92	90
IPSG 6-Reduce the risk of patient harm resulting from falls	94	96



COMPLIANCE OF NURSES IN LABOUR ROOM(in Numbers)



COMPLIANCE OF DOCTORS IN LABOUR ROOM (in Numbers)

CHAPTER 4- GAP ANALYSIS ,
RECOMMENDATIONS AND
CONCLUSION

GAP ANALYSIS

DEPARTMENTS	ICU	LABOUR ROOM	EMERGENCY	WARDS	RADIOLOGY
	IPSG 2 -Counter signatures of consultant was not documented on verbal/ telephonic order. - Intra Hospital Transfer Form was not evident in patient medical record. -Doctors Handover documentation was not evident in Critical Care Areas. (i.e 45 out of 50 in numbers)	IPSG 3 - lack of effective communication between the doctors and nurses (i.e 43 in nurses and 42 in doctors out of 50)	IPSG 5 - carelessness regarding hand washing among the nurses while dealing with the patients (i.e 40 out of 50 in numbers)	IPSG 2: - In Doctors Handover reason for delay in Surgery was not documented (i.e 43 out of 50 in numbers)	IPSG 5 -Hand washing methods are not properly followed by doctors (i.e 42 out of 50 in numbers)

RECOMMENDATIONS:

- Training of the staff (doctors and nurses) regarding all the International Patient Safety Goals should be done periodically in between 2 months
- Hand washing methods (includes 8 steps) and moments (5 moments) should be properly followed by the doctors and nurses.
- Read back policy should be strictly followed for effective communication
- Regular internal Audits need to be conducted to assess the level of improvements at every step

CONCLUSION:

An approach to managing quality of an organization and in a hospital context is through the implementation of accreditation, which involves the assessment of work and organizational practices against predefined standards, conducted by multidisciplinary clinical and support service teams. International Patient Safety Goals should be done periodically in the hospital for the quality improvement. It can be done with the regular audits by the inter disciplinary teams.

CHAPTER 5- REFERENCES AND **ANNEXURE**

REFERENCES

- Joint Commission International Accreditation Standards for Hospital, Fifth Edition, September 2013 2.
- Central Board for Accreditation of Healthcare Institutions (CBAHI) Standards for hospitals, Second Edition, 2011
- Brennan TA, Leape LL, Laird NM, Hebert L, Localio AR, Lawthers AG, et al. Incidence of adverse events and negligence in hospitalized patients. Results of the Harvard Medical Practice Study I. New England Journal of Medicine 1991; 324: 370-376 7.
- Institute for Healthcare Improvement. 5 Million Lives Campaign. 2006. [Accessed 8th April 2008].
- Institute for Healthcare Improvement. 5 Million Lives Campaign. 2006. [Accessed 8th April 2008].
- Joint Commission International Accreditation, 2010

ANNEXURE

IPSG	Checkpoint	General Observation	Policy
IPSG 1	General Observation	Check for ALL IN PATIENTS (in the area auditing) to wear a white ID (Identification Band) for safety	Patient Identification
		Check Contents of White ID Band	
IPSG 1	General Observation	- Max UHID No.	Patient Identification
IPSG 1	General Observation	- IP No.	Patient Identification
IPSG 1	General Observation	- Patients First Name	Patient Identification
IPSG 1	General Observation	- Patients Last Name	Patient Identification
IPSG 1	General Observation	- Age/ Sex	Patient Identification
IPSG 1	General Observation	Check for Red Bracelet - To be worn by patients with known allergies	Patient Identification
IPSG 1	General Observation	Check for Allergy Name to be written in CAPITAL LETTERS in the Red ID band.	Patient Identification
IPSG 1	General Observation	Check for Red and white band to be on the same wrist of the patient	Patient Identification
IPSG 1	General Observation	- Observe whether FO staff is verifying the registration of the patient by asking them to state their full name & date of birth/ address	Patient Identification
IPSG 1	General Observation	- Observe whether the dr in the OPD is verbally confirming the patient's full name and date of birth/ address and matching with the invoice before starting examination.	Patient Identification
IPSG 1	General Observation	- Check correct pt identification before proceeding with blood transfusion	Patient Identification
IPSG 1	General Observation	- Check correct pt identification during medication administration	Patient Identification

IPSG 1	General Observation	- Check for correct sample labeling in ward	Patient Identification
IPSG 1	General Observation	- Check correct diet given to correct patient	Patient Identification
IPSG 1	General Observation	- Check patient identification practices during sample collection in sample collection room	Patient Identification
IPSG 1	General Observation	- Check for correct patient identification practices during imaging - USG, MRI, CT, X Ray	Patient Identification
IPSG 1	General Observation	- Check that nurse is applying two ID bands to the new born baby on two different limbs <i>immediately after birth.</i> Check for minimum information present in neonatal ID band as below:	Patient Identification
IPSG 1	General Observation	- Mothers name	Patient Identification
IPSG 1	General Observation	- UHID no. of Mother	Patient Identification
IPSG 1	General Observation	- Gender	Patient Identification
IPSG 1	General Observation	- Weight	Patient Identification
IPSG 1	General Observation	- Date of birth	Patient Identification
IPSG 1	General Observation	- Time of Birth	Patient Identification
		Check for the card to be attached to the baby's warmer/cot displaying the following information:	
IPSG 1	General Observation	- Mothers name	Patient Identification
IPSG 1	General Observation	- UHID no. of Mother	Patient Identification
IPSG 1	General Observation	- Gender	Patient Identification
IPSG 1	General Observation	- Weight	Patient Identification
IPSG 1	General Observation	- Date of birth	Patient Identification
IPSG 1	General Observation	- Time of Birth	Patient Identification

IPSG 1	General Observation	In case of twins check that they are named as Twin 1 & Twin 2	Patient Identification
		Check for the content of twins ID band as follows:	
IPSG 1	General Observation	- Mothers name	Patient Identification
IPSG 1	General Observation	- UHID no. of Mother	Patient Identification
IPSG 1	General Observation	- Gender	Patient Identification
IPSG 1	General Observation	- Weight	Patient Identification
IPSG 1	General Observation	- Date of birth	Patient Identification
IPSG 1	General Observation	- Time of Birth	Patient Identification
IPSG 1	General Observation	Check that an additional ID band is applied to the mothers wrist incorporating details of her baby along with the white ID band already present.	Patient Identification
		Check that the additional ID band of mother has following information:	
IPSG 1	General Observation	- Mothers name	Patient Identification
IPSG 1	General Observation	- UHID no. of Mother	Patient Identification
IPSG 1	General Observation	- Gender	Patient Identification
IPSG 1	General Observation	- Weight	Patient Identification
IPSG 1	General Observation	- Date of birth	Patient Identification
IPSG 1	General Observation	- Time of Birth	Patient Identification
IPSG	Checkpoint	General Observation	Policy
IPSG 2	General Observation	Check for a patient record documenting verbal/ telephonic order with countersignature	Verbal Order Policy
IPSG 2	General Observation	Check for critical test result list to be displayed in lab/ Radiology department	Reporting of Critical Tests Results
IPSG 2	General Observation	Check for register and its components outlining details of	Reporting of Critical Tests Results

		tests reported - Who has reported the test - To whom have the tests been reported to	
IPSG 2	General Observation	Check in records if it is being reported as to the TAT defined	Reporting of Critical Tests Results
IPSG 2	General Observation	- Check in CPRS hubs that "Patient Transfer Note" is being filled when patient is being transferred from one area of care to another within the hospital (Ward-ward/ Ward to OT/ Ward to ICU etc) and for Non CPRS hubs the use of Manual forms	Handover Communication
		Check for Nursing handover documentation in:	
IPSG 2	General Observation	- Floors	Handover Communication
IPSG 2	General Observation	- Critical Care Areas	Handover Communication
IPSG 2	General Observation	- Emergency Unit	Handover Communication
		Check for Doctor handover documentation in:	
IPSG 2	General Observation	- Floors	Handover Communication
IPSG 2	General Observation	- Critical Care Areas	Handover Communication
IPSG 2	General Observation	- Emergency Unit	Handover Communication
IPSG 2	General Observation	Check for completely filled "Nursing Pre Op checklist" when patients are going for surgery and cardiac- cath	Handover Communication
IPSG	Checkpoint	General Observation	Policy
IPSG 3	General Observation	Check for storage of HAM in locked cupboards	High Alert Medications
IPSG 3	General Observation	Check for high alert medications warning sticker on storage boxes	High Alert Medications
IPSG 3	General Observation	Check that insulin stored in refrigerator is present in boxes with orange colored labels.	High Alert Medications
IPSG 3	General Observation	Check for HAM list display	High Alert Medications
IPSG 3	General Observation	Check for the presence of LASA drug list in Patient care areas	LASA

		(Wards/ OT's/ ICU's/ Pharmacy etc	
IPSG 3	General Observation	Check for storage of Sound alike drugs in containers with blue colored containers	LASA
IPSG 3	General Observation	Check for storage of Look alike drugs in containers with pink colored containers	LASA
IPSG 3	General Observation	Check for the intact seal of the crash cart	Crash Cart
IPSG 3	General Observation	Check for storage of narcotics in double lock and key	Narcotics
IPSG 3	General Observation	Check for the two keys of the narcotic cupboard to be with two different people	Narcotics
IPSG 3	General Observation	Check the narcotic drug prescription form for completeness and state med council no mentioned of the dr	Narcotics
IPSG 3	General Observation	Check for register with documentation of narcotics stating the amount of drug disposed with relevant signatures of witnesses	Narcotics
IPSG 3	General Observation	Check for the storage of conc electrolytes (in locked cupboards)	Storage of Conc electrolytes
IPSG 3	General Observation	Check for display of list	Storage of Conc electrolytes
		Check for labeling in concentrated electrolytes done in:	
IPSG 3	General Observation	- storage containers	Storage of Conc electrolytes
IPSG 3	General Observation	- individual ampoules	Storage of Conc electrolytes
IPSG 3	General Observation	- IV bags	Storage of Conc electrolytes
IPSG 3	General Observation	- syringe attached to the syringe pumps	Storage of Conc electrolytes
		Check in a prescription of IV infusion the below mentioned:	
IPSG 3	General Observation	- prescribed in generic name	Intravenous Infusions of Medications
IPSG 3	General Observation	- strength	Intravenous Infusions of Medications
IPSG 3	General Observation	- route of administration	Intravenous Infusions of Medications

IPSG 3	General Observation	Check in documentation whether Ramsay Sedation Score is being maintained for all patients on narcotic infusions	Intravenous Infusions of Medications
		Check for a prescription of epidural/ nerve infusion	
IPSG 3	General Observation	- prescribed in generic name	Infusions of Local Anesthetics - Epidural and Nerve infusions
IPSG 3	General Observation	- strength	Infusions of Local Anesthetics - Epidural and Nerve infusions
IPSG 3	General Observation	- route of administration	Infusions of Local Anesthetics - Epidural and Nerve infusions
IPSG	Checkpoint	General Observation	Policy
IPSG 4	General Observation	Check for patients undergoing any operative/ invasive procedure to have the site marked if indicated	Surgical Safety
		Check the "mark" to be	
IPSG 4	General Observation	- distinctly visible	Surgical Safety
IPSG 4	General Observation	- at the correct site	Surgical Safety
IPSG 4	General Observation	- marked ideally prior the patient is transferred in the OT area	Surgical Safety
IPSG 4	General Observation	Check in Medical records - Marking to be done by operating surgeon or any of his clinician team members who will be present in the operating theatre at the time of the patient's procedure	Surgical Safety
IPSG 4	General Observation	Check that informed consent form has been filled for the procedure	Surgical Safety
IPSG 4	General Observation	Check whether Preoperative checklist is filled completely and signed	Surgical Safety
IPSG 4	General Observation	Check whether Surgical safety checklist is filled completely and signed in OT	Surgical Safety
IPSG	Checkpoint	General Observation	Policy

IPSG 5	General Observation	Check the display of Hand Hygiene Poster(s) to be present at all requisite facilities	Hand Hygiene Policy
IPSG 5	General Observation	Check whether hand washing basins are present in the requisite facilities or not	Hand Hygiene Policy
IPSG 5	General Observation	Check whether alcohol hand rub is present next to every patient bed.	Hand Hygiene Policy
IPSG 5	General Observation	Check that all material (soaps, alcohol rub etc) are present in requisite amounts at required places.	Hand Hygiene Policy
IPSG	Checkpoint	General Observation	Policy
IPSG 6	General Observation	Check in records if "Morse Fall risk assessment scale" has been conducted for in patients	Fall Prevention Policy
		Check in Patient Washrooms:	
IPSG 6	General Observation	- Floor to be dry	Fall Prevention Policy
IPSG 6	General Observation	- Presence of grab bar	Fall Prevention Policy
IPSG 6	General Observation	Check for presence of Side rails in patient beds	Fall Prevention Policy
IPSG 6	General Observation	Check in records if "Pediatric Fall risk (Little Schmidy) assessment scale" has been conducted for all pediatric in patients	Fall Prevention Policy

QUESTIONAIRE FOR NURSING

IPSG	Nurses	Checkpoint	Policy	Answer
IPSG 1	Nurse	How many identifiers do you use to identify patients and what are they?	Patient Identification	All patients are to be identified using at least two identifiers- name of the patient (First and Last Name of the Patient spelt in full – Initials are NOT PERMITTED) and Max UHID number
IPSG 1	Nurse	When all will you identify patients	Patient Identification	All patients' shall be identified - Before providing treatments - Before performing procedures - Before any diagnostic procedures - Before transferring patients from/to other department
IPSG 1	Nurse	Where is the white ID band placed on the patient	Patient Identification	• The ID band should be worn on the dominant arm that is the side used for writing • Placement of ID bands – Priority: - o Right Hand - o Left Hand - o Right Leg - o Left Leg
IPSG 1	Nurse	Where do you place the ID band on a patient with missing limb(s)	Patient Identification	If a limb is missing then bands must be securely attached to the patients clothing using strapping, on an area of the body which is clearly visible
IPSG 1	Nurse	When is red ID band placed on the patient	Patient Identification	To be worn by patients who have an allergy
IPSG 1	Nurse	How is the name of Allergy written on the red ID band	Patient Identification	Name of allergy written clearly in CAPITAL LETTERS
IPSG 1	Nurse	What are the color coded ID bands used for identification of neonates	Patient Identification	Blue coloured ID band are used for male and pink for female infant.
IPSG 1	Nurse	Where are the bands applied on babies	Patient Identification	Two ID bands should be applied to two separate baby limbs by the assigned nurse immediately after the birth

IPSG 1	Nurse	What should you do if you find an ID band damaged	Patient Identification	If the patient wristband is removed, faded damaged or unreadable, a replacement wristband will be applied immediately, by the assigned nurse caring for the patient
IPSG 1	Nurse	What do you do if the patient is CONFUSED/ UNCONSCIOUS/ COMATOSED or has LANGUAGE PROBLEMS	Patient Identification	If the patient is unable to tell their name or in case of comatose patients , refer to the ID band and, if possible verify the information by asking family member, attendant or another member of the clinical staff who knows the patient. Ask the patient's relative to identify the patient by name and/or date of birth
IPSG 1	Nurse	where will you place ID band in a deceased patient	Patient Identification	All deceased patients MUST be correctly identified with 2 identification bands - one attached to the wrist and one attached to the ankle.
IPSG	Nurses	Checkpoint	Policy	Answer
IPSG 2	Nurse	In which situations is verbal orders allowed	Verbal Order Policy	Verbal orders are to be limited to the barest minimum and should be allowed to be used in situations only where any delay in writing the order or test result could result in patient harm or have a possible negative outcome. The hospital does not allow Verbal orders except in following situations: - o Life threatening situations - o Serious nature of patients conditions such that if medication is not administered it may lead to permanent harm or even death of the patient - o Anti-diabetic drug orders - o Reporting of critical test results

IPSG 2	Nurse	What is "Read Back Policy" in verbal orders? Explain the steps	Verbal Order Policy	• In "Read Back" the receiver (recipient) documents the complete order and then reads back the message as he/she has heard, written and interpreted it. • The sender or the individual giving the order confirms that such recording and interpretation of the order is correct.
IPSG 2	Nurse	In what time period are verbal/ telephonic orders to be signed and by whom?	Verbal Order Policy	All verbal/ telephonic orders are to be counter signed by the doctor who has given the order as soon as possible and not later than 24 hours.
IPSG 2	Nurse	Who all are authorized to receive verbal orders	Verbal Order Policy	Only doctors & nurses are authorized to accept verbal orders in emergency situations. Primarily it is the responsibility of the doctors (junior doctors, floor residents) to take the verbal order. If the doctor is busy then the nurse should take the order
IPSG	Nurses	Checkpoint	Policy	Answer
IPSG 3	Nurse	What are High Alert Medications	High Alert Medications	Medications which have higher potential for Medication Error or high risk of abuse or heightened risk of causing significant patient harm, are called High Alert Medications.
IPSG 3	Nurse	What is "double check"	High Alert Medications	A procedure wherein two persons separately and independently check each component of prescription, dispensing and verify the dose and frequency of medication before administering to patient.
IPSG 3	Nurse	What are lookalike drugs	LASA	Are defined as that category of drugs that "appear" the same. That is their physical appearances match.
IPSG 3	Nurse	What are sound alike drugs	LASA	Are defined as that category of drugs which "sound" the same. These drugs are very similar in their pronunciations

IPSG 3	Nurse	What color labels for storage is used for Look Alike	LASA	Pink Colored Labels for Look Alike
IPSG 3	Nurse	What color labels for storage is used for Sound Alike	LASA	Blue Colored Labels for Sound Alike
IPSG 3	Nurse	What is the purpose of keeping a crash cart	Crash Cart	To ensure that emergency medications and equipments are available all the time
IPSG 3	Nurse	What all is checked in a crash cart	Crash Cart	Oxygen cylinder levels, charged defibrillator, operational laryngoscope, integrity of the lock and documenting compliance on crash cart checklist
IPSG 3	Nurse	What frequency of check is used	Crash Cart	The integrity of the seal of the crash cart is checked every shift and recorded by nursing staff.
IPSG 3	Nurse	What will you do if the seal is not intact	Crash Cart	If the seal is not intact, nursing will inform the pharmacy.
IPSG 3	Nurse	What is the frequency and method of checking defibrillator in the crash cart	Crash Cart	Defibrillator checks will be performed every shift by the nursing staff with the defibrillator plugged in and unplugged.
IPSG 3	Nurse	What are narcotics and why are they put in a separate category	Narcotics	Narcotic Drugs are the group of drugs, whose general availability is restricted and regulated by various legal norms, because of their potential for abuse or addiction.
IPSG 3	Nurse	What are the narcotic drugs used in the organization	Narcotics	• Injection Fentanyl • Fentanyl patch • Injection Morphine • Tablet Morphine
IPSG 3	Nurse	how are narcotics stored	Narcotics	Narcotic medications should be stored inside secured cabinet with double locking facility.
IPSG 3	Nurse	How are left over/ residual narcotics disposed	Narcotics	Dispose the leftover narcotic by dissolving the residual drug in 500 to 1000 ml water or place under running water in presence of the witness.

IPSG 3	Nurse	How do you discard the broken/ empty ampoules of the narcotics	Narcotics	The empty broken ampoules are to be sent to pharmacy at the time of requisition by the nursing department which should be disposed as per prevailing Bio-Medical Waste Disposal Rules
IPSG 3	Nurse	What is near expiry of drugs	Narcotics	Drug approaching expiry period within 3 months
IPSG 3	Nurse	How are narcotics approaching near expiry or "in the near expiry period" stored and what is done with them	Narcotics	Narcotics approaching or "in the" Near expiry (expiry within 3 months) should be stored in a separate box inside double locked Narcotic container both in pharmacy and ward. They should be labeled as "Near Expiry" and used with caution till their last expiry date
IPSG 3	Nurse	Give examples on conc elects	Storage of Conc electrolytes	• Inj Potassium Chloride 2 meq/ml (20meq/10ml) • Inj Potassium Phosphate 15ml (Per ml 93mg of Phosphorus & 170mg of potassium) • Inj Magnesium Sulphate 25% (500mg)-2ml & 50%(1gram) - 2ml • Inj Sodium Chloride Hypertonic 3% - 250ml • Inj Calcium Chloride 10ML (10%) • Inj Calcium Gluconate 10ML (10%)
IPSG 3	Nurse	Does NaCl fall in this catg?. If yes then what strength	Storage of Conc electrolytes	Sodium Chloride Hypertonic 3% - 250ml
IPSG 3	Nurse	how will kcl solutions be prepared	IV Pott Chloride	Where potassium chloride solutions are prepared from potassium chloride ampoules, the solution must be inverted a few times to ensure that the solute (potassium chloride) is thoroughly mixed throughout the solution.
IPSG	Nurses	Checkpoint	Policy	Answer
IPSG 4	Nurse	What is "Time out"	Surgical Safety	A pause, just prior to performing a surgical or other procedure, during which any unanswered questions or confusion about patient, procedure, or site are resolved by the entire surgical or procedural team.

IPSG 4	Nurse	What are the essential elements of "Time out"	Surgical Safety	• Correct Patient • Correct side and site(Marked) • Agreement to the procedure(Consent) • Correct patient position for procedure • Availability of implants and/or special equipment • Documents and reports availability
IPSG 4	Nurse	How do you confirm that you have received the correct patient in the OT	Surgical Safety	The patients' wrist band shall be checked by the nurse before accepting the patient in the OT and patient full name & UHID No is checked and confirmed with patient and in the medical record
IPSG 4	Nurse	Who all should be involved in the time out procedure	Surgical Safety	• The surgeon or his/her representative (e.g. registrar) • The anaesthetist or his/her representative (e.g. registrar) • The scrub nurse and/or his/her representative
IPSG 4	Nurse	What happens if all members are not participating in the time out procedure	Surgical Safety	All members actively participate during timeout. If one or more of these three individuals is not participating in the Time Out process then any other of the three has the right to call a halt to the operation proceeding until such time as all three are present and paying attention to the Time out process
IPSG 4	Nurse	When can time out be skipped/ not performed	Surgical Safety	Exceptions: In emergencies, life or limb threatening situations
IPSG 4	Nurse	What is done for "Time out" if two or more procedures are being performed on the same patient	Surgical Safety	When the same patient has two or more procedures and if the person performing the procedure changes, individual timeout needs to be performed before starting each procedure and it shall be properly documented in the patient's medical record
IPSG	Nurses	Checkpoint	Policy	Answer

IPSG 5	Nurse	What are the 5 moments of hand hygiene.	Hand Hygiene Policy	The “Your five moments for hand hygiene” are: 1. Before touching a patient 2. Before clean/aseptic procedure 3. After body fluid exposure risk 4. After touching a patient 5. After touching a patient surrounding
IPSG 5	Nurse	Demonstrate the steps of Hand wash with soap and water. (11 steps)	Hand Hygiene Policy	
IPSG 5	Nurse	Demonstrate the steps of Hand hygiene with alcohol based formulations. (8 steps)	Hand Hygiene Policy	
IPSG	Nurses	Checkpoint	Policy	Answer
		Which scale of fall risk assessment is used for the below mentioned areas:		
IPSG 6	Nurse	- IPD Areas	Fall Prevention Policy	Morse (Excluding OPD fall risk as that is not applicable Pan Max)
IPSG 6	Nurse	- Pediatric Scale	Fall Prevention Policy	Little Schmidy
IPSG 6	Nurse	Which are the medications that can contribute to patient fall (any 2 to3)	Fall Prevention Policy	Opiates, hypnotics/sedatives, anti-hypertensives, diuretics, anticonvulsants, antidepressants, and antipsychotics.
IPSG 6	Nurse	Which patients are prone to fall risk (give any 2 to 3 examples)	Fall Prevention Policy	(i) Patient < 12 years and > 65years of age. (ii) Frail and poorly nourished patients. (iii) Visually and physically handicapped patients (iv) Unconscious/ semi-conscious patient. (v) Patient under sedation. (vi) Patient on chemotherapy. (vii) Irritated/ violent patient.

				(viii) Psychotic patient. (ix) Head Injury. (x) Epilepsy. (xi) Eclampsia. (xii) Stroke, paresis/ paralysis of lower limbs. (xiii) Intra Cranial Space Occupying Lesions
IPSG 6	Nurse	When all do you perform fall risk	Fall Prevention Policy	On admission and post that every shift
IPSG 6	Nurse	What is the identification mark used for Patients identified with fall risk	Fall Prevention Policy	In Saket - Violet Coloured Wrist bands are placed on the patient's wrist and purple colored sticker on the door label Please ask for other units what they and document
IPSG 6	Nurse	What happens when a patient sustains a fall	Fall Prevention Policy	A patient who has experienced a fall shall have an immediate physical assessment, Primary Consultant notification, and the event documented on an incident report: including root cause analysis of the same. The reassessment for such patients is done in every shift
IPSG 6	Nurse	What are the steps to be taken to prevent patient falls (give any 2 to 3 examples)	Fall Prevention Policy	- Ensure patient's necessities are within reach. - Check bed is at correct height - Ensure proper lighting in the room - Clean up floor spills immediately - Assess patient's risk - Educate the patient to use bed alarms to alert staff whenever they require assistance. - Make sure side rails are raised to avoid falls and use safety belts during all transfers
		Pediatric Fall Risk Assessment		
IPSG 6	Nurse	- Which age group is it applicable to	Fall Prevention Policy	0 to 18 years

IPSG 6	Nurse	- When all should it be done	Fall Prevention Policy	1. Daily in morning shift 2. When the patient's condition changes 3. When transferred to a new department/unit 4. Following a fall incident
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QUESTIONNAIRE FOR DOCTORS

IPSG	Doctors	Checkpoint	Policy	Answer
IPSG 1	Doctors	When is red ID band placed on the patient	Patient Identification	To be worn by patients who have an allergy
IPSG 1	Doctors	How many identifiers do you use to identify patients and what are they?	Patient Identification	The hospital shall make process to identify all patients using at least two identifiers- name of the patient (First and Last Name of the Patient spelt in full – Initials are NOT PERMITTED) and Max UHID number
IPSG 1	Doctors	When all will you identify patients	Patient Identification	All patients' shall be identified - Before providing treatments - Before performing procedures - Before any diagnostic procedures - Before transferring patients from/to other department
IPSG 1	Doctors	What do you do if the patient is CONFUSED/ UNCONSCIOUS/ COMATOSED or has LANGUAGE PROBLEMS	Patient Identification	If the patient is unable to tell their name or in case of comatose patients , refer to the ID band and, if possible verify the information by asking family member, attendant or another member of the clinical staff who knows the patient. Ask the patient's relative to identify the patient by name and/or date of birth
IPSG	Doctors	Checkpoint	Policy	Answer
IPSG 2	Doctors	In which situations is verbal orders allowed	Verbal Order Policy	Verbal orders are to be limited to the barest minimum and should be allowed to be used in situations only where any delay in writing the order or test result could result in patient harm or have a possible negative outcome. The hospital does not allow Verbal orders except in following situations: - o Life threatening situations - o Serious nature of patients conditions such that if medication is not administered it may lead to permanent harm or even death of the patient - o Anti-diabetic drug orders - o Reporting of critical test results
IPSG 2	Doctors	What is "Read Back Policy" in verbal orders? Explain the steps	Verbal Order Policy	• In "Read Back" the receiver (recipient) documents the complete order and then reads back the message as he/she has heard, written and interpreted it. • The sender or the individual giving the

				order confirms that such recording and interpretation of the order is correct.
IPSG 2	Doctors	In what time period are verbal/ telephonic orders to be signed and by whom?	Verbal Order Policy	All verbal/ telephonic orders are to be counter signed by the doctor who has given the order as soon as possible and not later than 24 hours.
IPSG 2	Doctors	Who all are authorized to receive verbal orders	Verbal Order Policy	Only doctors & nurses are authorized to accept verbal orders in emergency situations. Primarily it is the responsibility of the doctors (junior doctors, floor residents) to take the verbal order. If the doctor is busy then the nurse should take the order
IPSG 2	Doctors	What are you supposed to do on receiving/ diagnosing a critical test value	Reporting of Critical Tests Results	Immediately inform the same to the Admitting Physician
IPSG 2	Doctors	Who and how do you go about informing on receiving a critical result of a patient.	Reporting of Critical Tests Results	To the Admitting Physician of the patient. In case the admitting physician is not contactable, the same shall be conveyed to the on call duty doctor/ consultant of the concerned speciality. In addition lab has facility for sending an auto SMS for the defined critical test results to the concerned admitting consultant.
IPSG 2	Doctors	What is the TAT for informing	Reporting of Critical Tests Results	Saket - 15 mins. Ask for other units. Should not be more than 30 mins
IPSG	Doctors	Checkpoint	Policy	Answer
IPSG 3	Doctors	What are High Alert Medications	High Alert Medications	Medications which have higher potential for Medication Error or high risk of abuse or heightened risk of causing significant patient harm, are called High Alert Medications.
IPSG 3	Doctors	What is the full form of LASA	LASA	Look Alike & Sound Alike Medications
IPSG 3	Doctors	What are lookalike drugs	LASA	Are defined as that category of drugs that “appear” the same. That is their physical appearances match.
IPSG 3	Doctors	What are sound alike drugs	LASA	Are defined as that category of drugs which “sound” the same. These drugs are very similar in their pronunciations

IPSG 3	Doctors	What are narcotics and why are they put in a separate category	Narcotics	Narcotic Drugs are the group of drugs, whose general availability is restricted and regulated by various legal norms, because of their potential for abuse or addiction.
IPSG 3	Doctors	What are the narcotic drugs used in the organization	Narcotics	• Injection Fentanyl • Fentanyl patch • Injection Morphine • Tablet Morphine
IPSG 3	Doctors	How are narcotics prescribed	Narcotics	Clinician should fill up the “Narcotic Drug Prescription cum In-dent Form” with his signature, name, date and State/ Delhi Medical Council Registration Number.
IPSG 3	Doctors	How are left over/ residual narcotics disposed	Narcotics	The empty broken ampoule are to be sent to pharmacy at the time of requisition which should be disposed as per prevailing Bio-Medical Waste Disposal Rules
IPSG 3	Doctors	Give examples on conc elects	Storage of Conc electrolytes	• Inj Potassium Chloride 2 meq/ml (20meq/10ml) • Inj Potassium Phosphate 15ml (Per ml 93mg of Phosphorus & 170mg of potassium) • Inj Magnesium Sulphate 25% (500mg) - 2ml & 50%(1gram) - 2ml • Inj Sodium Chloride Hypertonic 3% - 250ml • Inj Calcium Chloride 10ML (10%) • Inj Calcium Gluconate 10ML (10%)
IPSG 3	Doctors	Does NaCl fall in this catg?. If yes then what strength	Storage of Conc electrolytes	Sodium Chloride Hypertonic 3% - 250ml
IPSG	Doctors	Checkpoint	Policy	Answer
IPSG 4	Surgeon	What is "Time out"	Surgical Safety	A pause, just prior to performing a surgical or other procedure, during which any unanswered questions or confusion about patient, procedure, or site are resolved by the entire surgical or procedural team.
IPSG 4	Surgeon	What are the essential elements of "Time out"	Surgical Safety	• Correct Patient • Correct side and site(Marked) • Agreement to the procedure(Consent) • Correct patient position for procedure • Availability of implants and/or special equipment • Documents and reports availability

IPSG 4	Surgeon	When and where is the site marked?	Surgical Safety	The surgical site should, ideally, be marked in the ward or day care area prior to patient transfer to the operating theatre. It can also be done in pre-operative area before patient is wheeled in the Operation room. No patient should go beyond the pre-operative area without site marking. (Wherever applicable)
IPSG 4	Surgeon	Is the patient involved in the process of site marking	Surgical Safety	The process of preoperative marking of the intended site should be done with the patient involved, awake and aware, if possible
IPSG 4	Surgeon	Who all should be involved in the time out procedure	Surgical Safety	• The surgeon or his/her representative (e.g. registrar) • The anaesthetist or his/her representative (e.g. registrar) • The scrub nurse and/or his/her representative
IPSG 4	Surgeon	What happens if all members are not participating in the time out procedure	Surgical Safety	All members actively participate during timeout. If one or more of these three individuals is not participating in the Time Out process then any other of the three has the right to call a halt the operation proceeding until such time as all three are present and paying attention to the Time out process
IPSG 4	Surgeon	When can time out be skipped/ not performed	Surgical Safety	Exceptions: In emergencies, life or limb threatening situations
IPSG 4	Surgeon	What is done for "Time out" if two or more procedures are being performed on the same patient	Surgical Safety	When the same patient has two or more procedures and if the person performing the procedure changes, individual timeout needs to be performed before starting each procedure and it shall be properly documented in the patient's medical record
IPSG 4	Surgeon	Exclusion for site marking	Surgical Safety	Premature infants (for whom the mark may cause a permanent tattoo)
IPSG	Doctors	Checkpoint	Policy	Answer
IPSG 5	Doctors	What are the 5 moments of hand hygiene.	Hand Hygiene Policy	The "Your five moments for hand hygiene" are: 1. Before touching a patient 2. Before clean/aseptic procedure 3. After body fluid exposure risk 4. After touching a patient 5. After touching a patient surrounding

IPSG 5	Doctors	Demonstrate the steps of Hand wash with soap and water. (11 steps)	Hand Hygiene Policy	
IPSG 5	Doctors	Demonstrate the steps of Hand hygiene with alcohol based formulations. (8 steps)	Hand Hygiene Policy	
IPSG	Doctors	Checkpoint	Policy	Answer
IPSG 6	Doctors	Which are the medications that can contribute to patient fall (give any 2 to 3 examples)	Fall Prevention Policy	Opiates, hypnotics/sedatives, anti-hypertensive's, diuretics, anticonvulsants, antidepressants, and antipsychotics