

**IMPLEMENTATION OF WHO INTERNATIONAL PATIENT
SAFETY SOLUTIONS IN TERTIARY CARE HOSPITAL 525
BEDDED**

**Internship Training
at
Jaypee Hospital, Nodia**

**By
Aparna Yadav**

**Under the guidance of
Dr. Neetu Purohit**

**MBA Hospital & Health Management
2013–15**


**Institute of Health Management Research
Jaipur
2015**

Internship Training

At

JAYPEE HOSPITAL, Noida

Implementation of WHO International Patient Safety Solutions in Tertiary care
Hospital

By

Dr Aparna Yadav

Under the guidance of

Dr Neetu Purohit

Post Graduate Diploma in Hospital and Health Management

Year 2013-2015



Institute of Health Management Research

Jaipur

TO WHOMSOEVER MAY CONCERN

This is to certify that Dr. Aparna Yadav student of MBA Hospital and Health Management from IIHMR University, Jaipur has undergone internship training at Jaypee Hospital, Noida from 02/02/2015 to 12/05/2015.

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
IIHMR, Jaipur



Dr. Neetu Purohit
Associate Professor
IIHMR, Jaipur

The certificate is awarded to

Dr. Aparna Yadav

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

Hospital Operations

and has successfully completed her Project on

Implementation of WHO International Patient Safety Solutions in Tertiary Care Hospital
525 Bedded

12/5/2015

Jaypee Hospital, Noida

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

We wish her all the best for future endeavors


Human Resources





INSTITUTE OF HEALTH MANAGEMENT RESEARCH, JAIPUR

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled Implementation of WHO International Patient Safety Solutions in Tertiary Care Hospital 525 Bedded and submitted by Dr. Aparna Yadav Enrollment No 2013-15/1421 under the supervision of Dr. Aparna Yadav for award of MBA Hospital and Health Management of the university carried out during the period from 2013 to 2015 embodies my original work and has not formed the basis for the award of any degree, diploma association, fellowship, titles in this or any other Institute or other similar institution of higher learning.

A handwritten signature in blue ink, appearing to read "Aparna", with a stylized flourish underneath.

Signature

Implementation of WHO International Patient Safety
Solutions in Tertiary care Hospital

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I would like to take the opportunity to thank Mr Manish Tiwedi Chief Operating Officer (COO) for giving me the chance to do my internship at Jaypee Hospital, Noida

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I also convey my deep and sincere thanks to Dr. Ashok Kaushik, (Dean, Academic and Student Affairs) for being helpful, and receptive.

LIST OF ABBREVIATIONS

IPSS	-	International Patient Safety Solutions
WHO	-	World Health Organization
IPD	-	In patient department

Chapter 1

INTRODUCTION

Patient safety is a global public health problem affecting healthcare industry around the world. The initiative of developing strict patient safety culture to assure patients while they require tender care have come to prominence slowly and steadily and has become one of the prime concerns in defining quality improvement and care indicator in healthcare organizations.

All patients have a right to effective, safe care at all time. Increasing evidences from various hospitals show unacceptable number of patients being harmed mentally as well as physically in some or the other way during hospital stay worldwide. Therefore more knowledge and analytical approach is needed to define and measure the risks and underlying causes of various forms of harm..

Today, the Solutions for improving patient safety offer a constructive approach, in which safer care is determined by how well caregivers work together as a team, how effectively they communicate with one another and deliver the care processes.

Now a day's patients and their families are becoming increasingly skilled in accessing information to make personal health care decisions about treatments and their choice of providers, and demanding safer care similarly, health care practitioners are also becoming more proficient at incorporating evidence based knowledge into their clinical decision making process.

In 2005, the World Health Organization (WHO) launched the world alliance for patient safety and identified six action areas. One of these action areas is the development of "Solutions for Patient Safety". During 2005, the Joint Commission and Joint Commission International were officially designated as a WHO Collaborating Centre for Patient Safety Solutions.

These International Patient Safety Solutions include:

- Ensuring legibility of prescriptions or using preprinted orders or electronic prescriptions;
- Providing opportunities for practitioners to ask questions during handover of patients and involving the patients and their families in this process;

- Comparing the “home” list of all the drugs a patient is taking with the admission, transfer, or discharge order when writing medication orders and ensuring that the list is transferred to the next provider of care at transition points;
- Prohibiting the reuse of needles at healthcare facilities and ensuring safe needle disposal practices; and
- Making alcohol based hand rubs available at all points of care and putting reminders of hand hygiene techniques in the workplace.

Patient safety problems, medication errors and adverse events affecting patient health in any form can occur from variety of reasons at different health care levels. These solutions are directed at the various specific level to prevent human errors occurring to the patients.

CHAPTER2

LITERATURE REVIEW

Unintended harm to patients undergoing treatment is not a new phenomenon. The earliest record of this problem dates from the 17th century BC. The response in those days was clearly and solely punitive (for example, cutting off a surgeon's hand)(4)

Recognizing that health care errors affect one in every 10 patients around the world, the WHO's World Alliance for Patient Safety and the Collaborating Centre have packaged nine effective solutions to reduce such errors. Implementing these solutions is a way to improve patient safety (1)

"Patient Safety Solution" is defined as: Any system design or intervention that has demonstrated the ability to prevent or mitigate patient harm stemming from the processes of health care.

In April 2007, the inaugural set of Solutions was approved by the International Steering Committee for publication and dissemination, for use by WHO Member States as of May 2007. The Solutions were posted on the websites of both WHO and the Collaborating Centre. (4)

The following are brief descriptions of topics for 9 International Patient Safety Solutions:

- I. **Look-Alike, Sound-Alike Medication:**Confusing drug names is one of the most common causes of medication errors and is a worldwide concern. With tens of thousands of drugs currently on the market, the potential for error created by confusing brand or generic drug names and packaging is significant

Table1- List of Look Alike, Sound Alike Medication Drugs

Drug Name	Confused with
AcetaZOLAMIDE	acetoHEXAMIDE
Chlorpromazine	chlorproPAMIDE
buPROPion	busPIRone
CycloSERINE	Cyclosporine
chlorproMAZINE	chlorproPAMIDE

- II. **Patient Identification.** The widespread and continuing failures to correctly identify patients often leads to medication, transfusion and testing errors; wrong person procedures; and the discharge of infants to the wrong families.
For example- Use of ID bands for Adult patients on which a standardized pattern and specific info could be written.
- III. **Communication during Patient Hand-Over.** Gaps in hand-over (or hand-off) communication between patient care units, and between and among care teams, can cause serious breakdowns in the continuity of care, inappropriate treatment, and potential harm for the patient.
- IV. **Performance of Correct Procedure at Correct Body Site.** Considered totally preventable, cases of wrong procedure or wrong site surgery are largely the result of miscommunication and unavailable, or incorrect, information. A major contributing factor to these types of errors is the lack of a standardized preoperative process.
- V. **Control of Concentrated Electrolyte Solutions.** While all drugs, biologics, vaccines and contrast media have a defined risk profile, concentrated electrolyte solutions that are used for injection are especially dangerous.
- VI. **Assuring Medication Accuracy at Transitions in Care.** Medication errors occur most commonly at transitions. Medication reconciliation is a process designed to prevent medication errors at patient transition points. (i.e. comparison of the patient's medication list with the medications being ordered to identify omissions, duplications, inconsistencies between the patient's medications and clinical conditions, dosing errors, and potential interactions)
- VII. **Avoiding Catheter and Tubing Mis-Connections.** The design of tubing, catheters, and syringes currently in use is such that it is possible to inadvertently cause patient harm through connecting the wrong syringes and tubing and then delivering medication or fluids through an unintended wrong route.
- VIII. **Single Use of Injection Devices.** One of the biggest global concerns is the spread of Human Immunodeficiency Virus (HIV), the Hepatitis B Virus (HBV), and the Hepatitis C Virus (HCV) because of the reuse of injection needles.

IX. **Improved Hand Hygiene to Prevent Health Care-Associated Infections.** It is estimated that at any point in time more than 1.4 million people worldwide are suffering from infections acquired in hospitals. Effective hand hygiene is the primary preventive measure for avoiding this problem.(5)

The nine solutions are based on interventions and actions that have solved patient safety problems in one part of the world are made widely available in a form that is accessible and understandable to all.

In the past 12 months, the WHO Collaborating Centre on Patient Safety (Solutions) has brought together more than 50 recognized leaders and experts in patient safety from around the world to identify and adapt the nine solutions to different needs.

RATIONALE

The Healthcare Industry has become one of the most rapidly developing and expanding sectors in the past decade with a 7 % GDP growth. Not only are changes being seen in the health seeking behaviour of the patients but also the providers are doing their level best to provide an efficient and effective Healthcare delivery system that is at par with The International Standards.

Jaypee hospital operations management was mainly concerned about following 4 patient safety solutions amongst 9 WHO solutions as these were the problematic areas and due to which patient safety was at higher risk in the ward level of hospital.

This study was conceptualized for the following four areas:

1. **Patient Identification:** The FDA's own research concluded that correct patient identification will prevent 500,000 adverse drug events and blood transfusion errors over 20 years. Missing and incorrect patient identification are a major contributing factor to many adverse events.(3)
2. **Communication during Patient Hand-Over:** Research world over shows that poor clinical handover is a significant contributing factor to many adverse patient events. It is estimated that 80% of serious medical errors involve miscommunication during the handovers between healthcare professionals. A review of 3000 sentinel events demonstrated that 14 a communication breakdown occurred 65-70% of the time (Adamski, 2007).
3. **Hand Hygiene to Prevent Health Care-Associated Infections:** Hand hygiene reduces the incidence of healthcare associated infections. Each year nearly 2 million patients get an infection in hospitals, and about 90,000 of these patients die as a result of their infection.(6)
4. **Assuring Medication Accuracy at Transitions in Care:** Medication errors most frequently occur during prescribing and administering actions. (1)

AIMS AND OBJECTIVES

The aim of this study is to identify gaps and devise required interventions for implementation of patient safety solutions recommended by WHO, to reduce errors of patient safety from the perspective of health care providers.

GENERAL OBJECTIVE

To identify the gaps in implementation of World Health Organization International Patient Safety Solutions in 525 bedded tertiary care hospital and devise & implement necessary training interventions

SPECIFIC OBJECTIVES

1. To identify the gaps in implementation of International Patient Safety Solutions
2. To devise training interventions of International Patient Safety Solutions to all stakeholders
3. To monitor the change post training interventions
4. To evaluate the outcome of trainings and suggest the recommendations

CHAPTER 3

RESEARCH METHODOLOGY

Study design: Cross sectional Descriptive study

Study location: In Patient Wards - Jaypee hospital, Noida

Sample population:

- Clinical
- Para - Clinical
- Support staff of In Patient Ward of Jaypee Hospital, Noida

Sample and Sample Design:

Convenience sampling for the staff and Doctors

Sample size 90,

(Ward Nurses =75 & Resident medical officers=15)

It was based on the IPD wards (5th and 6th floor) being allotted for training purposes.

Data collection

1. Primary data:

Data was collected from the sample group taken for study (Ward Nurses =75 & Regional medical officers=15)by using the checklist and questionnaires based on WHO IPSS

- Direct observation
- Discussions with hospital IPD staff

2. Secondary data: Reports, forms and registers of various departments and other relevant records

For implementation of above mentioned four patient safety solutions in Jaypee hospital, the training period of 90 days were divided into followingseries of events

- Data collection for Pre training knowledge assessment=30 days
- Training intervention done=45 days
- Data collection for post training efficacy calculation= 10 days

Pre training knowledge assessment was carried out for four IPSS to identify gaps in the compliance of knowledge whereas post training assessment was done after every training program to check the efficacy of the same.

A total of 8 questionnaire (pre training knowledge assessment ,checklist and post training knowledge assessment)were developed on the above mentioned 4IPSS :

1. Patient Identification Pre Training Assessment
2. Patient Identification Post Training Assessment
3. Checklist for Doctors Communication during Patient Hand Over
4. Checklist for Nurses Communication during Hand Over
5. Hand Hygiene to Prevent Health Care-Associated Infections Pre Training Assessment
6. Hand Hygiene to Prevent Health Care-Associated Infections Post Training Assessment
7. Assuring Medication Accuracy at Transitions in CarePre Training Assessment
8. Assuring Medication Accuracy at Transitions in Care Post Training Assessment

Table-2 Details of tools used for gap analysis

S. No	Study	Maximum Marks	Passing Marks
1	Patient Identification	10	5

2	Hand Hygiene	10	5
3	Communication during doctors hand over	10	5
4	Communication during nurses hand over	10	5
5	Medication accuracy during transitions	10	5

Training need analysis was designed for following IPSS

1. Improved Hand Hygiene to Prevent Health Care-Associated Infections
2. Assuring Medication Accuracy at Transitions in Care
3. Patient Identification
4. Communication During Patient Hand- Overs

Steps for developing a training program for IPSS

1. Depending upon the objectives it was decided which mode of learning is most suitable for reaching the objectives {e.g. checklist tracker list, questionnaires(Open or Closed ended)}

2. A programme outline based on the above Construct
3. The assessment of learners to be included is to be Considered
4. Knowledge tests such as multiple-choice questions suitable to demonstrate knowledge, but practical examples are required to demonstrate skill. Here, the learner could analyse data to show that these solutions have been acquired.
5. Evaluate the training programme. Getting feedback from learners on what they found most useful and soliciting their suggestions for improvement will help determine what worked well and what should be refined for the next TIME.

CHAPTER 4

RESULTS

The health care professionals might not be aware of certain lacunae which create a gap for the smooth workflow of the organisation and service delivery. These gaps were evident during the Pre training analysis and majority of them

were covered in the training programs, while there were some which required some exercise as depicted by the Post Training Analysis.

1) **Patient identification**

1.1) Pre training nurses analysis

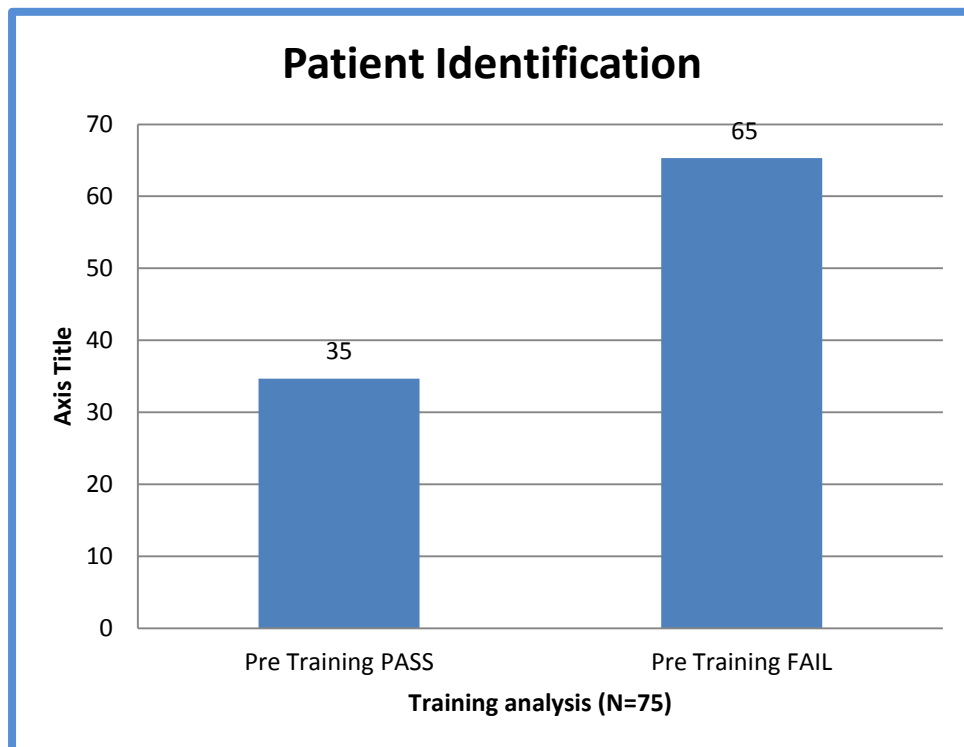


Figure 1

1.2) Post training Analysis

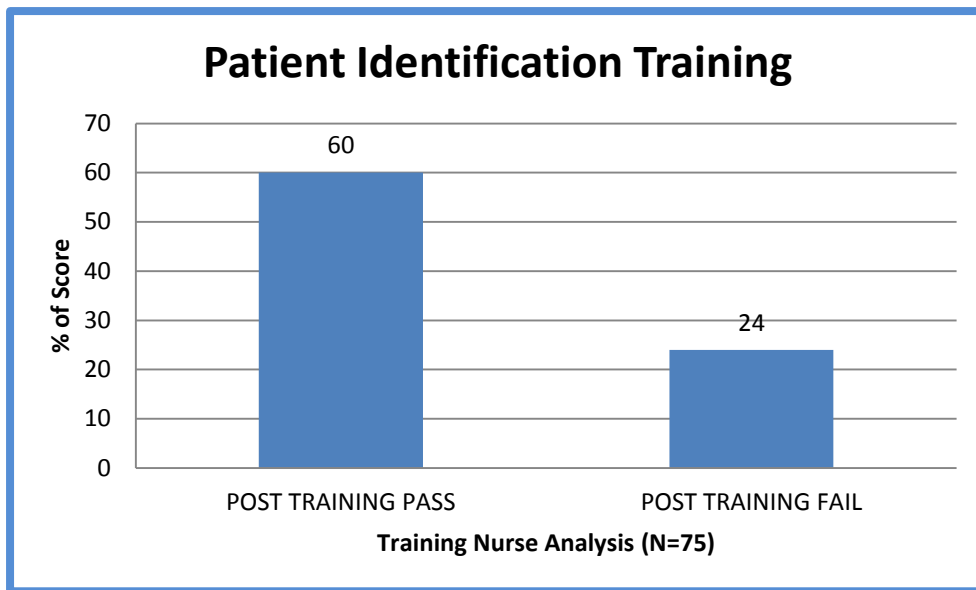


Figure 2

In the initial part of the assessment when Patient identification gaps were assessed before any formal training, it was found to be 65.33% (n=75) which was significantly reduced to 28% after training programs were conducted for them. The efficacy of formal training was found to be 25.33%. No Training Programs to correctly identify the patient was practiced causing gaps in patient identification. Hospital operations management staff shall encourage the ward nurses to use of at least 2 identifiers to verify a patient identity upon admission or transfer or prior to the care administration.

Use of blue ID bands for patient identification shall be made compulsory

2) HAND HYGIENE

2.1)Pre training nurses analysis

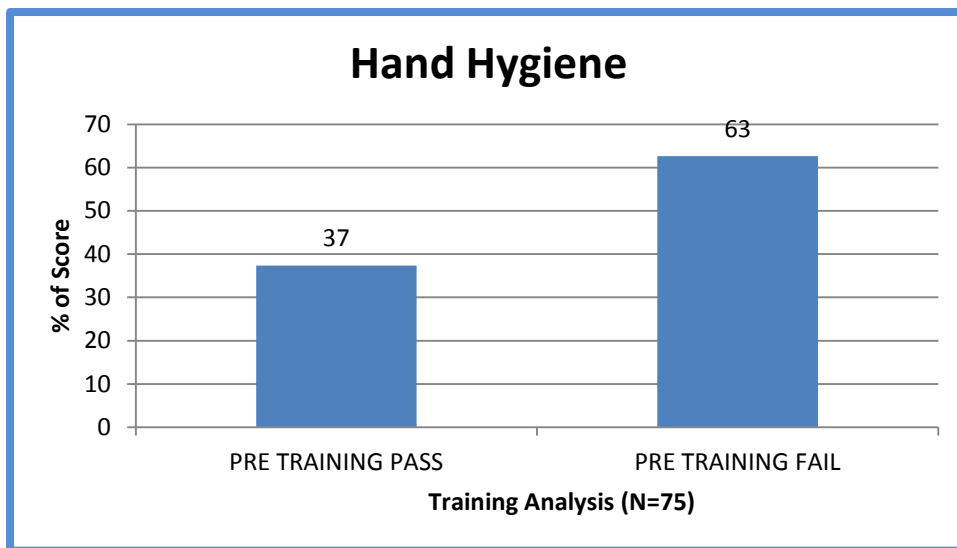


Figure 3

2.2.) Post training nurses analysis

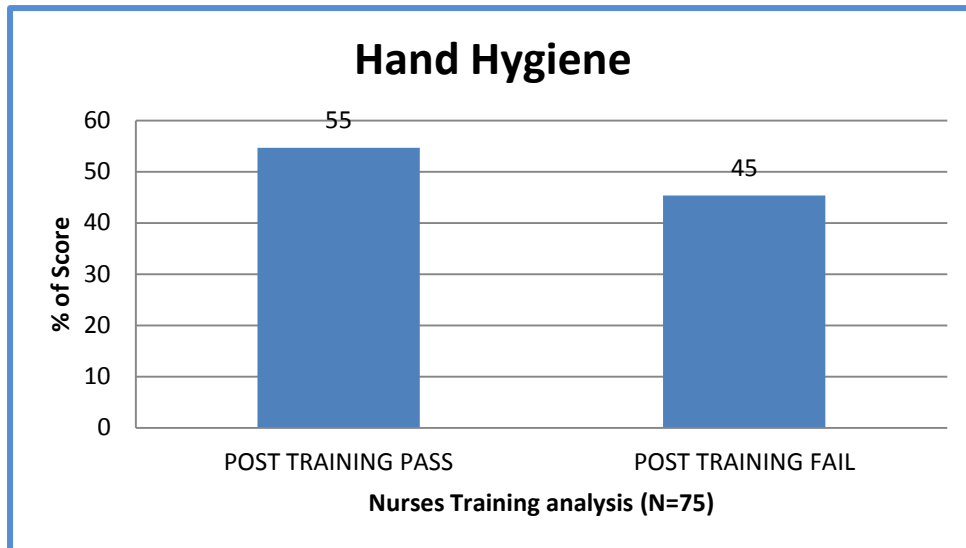


Figure4

Unawareness for hand hygiene to prevent hospital acquired infections was found to be 62.67% (N=75) which after hand hygiene awareness session was reduced to 45.33%. One of the common reasons was non display of hand hygiene posters near every wash basin of IPD. The efficacy of repeated hand hygiene trainings given was 17.33%. Arrangements of safe continuous water supply at all taps and the necessary facilities to perform hand hygiene was made available in IPD level

3)Communication during Patient Hand Over

3.1)Doctors Communication DuringPatient Hand Over

Pre training doctor's analysis

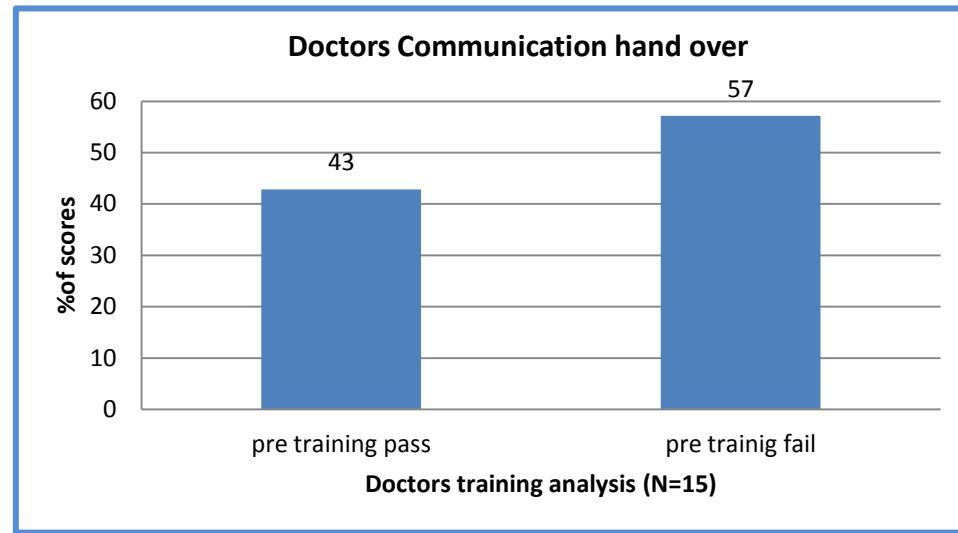


Figure 5

Post training doctors analysis

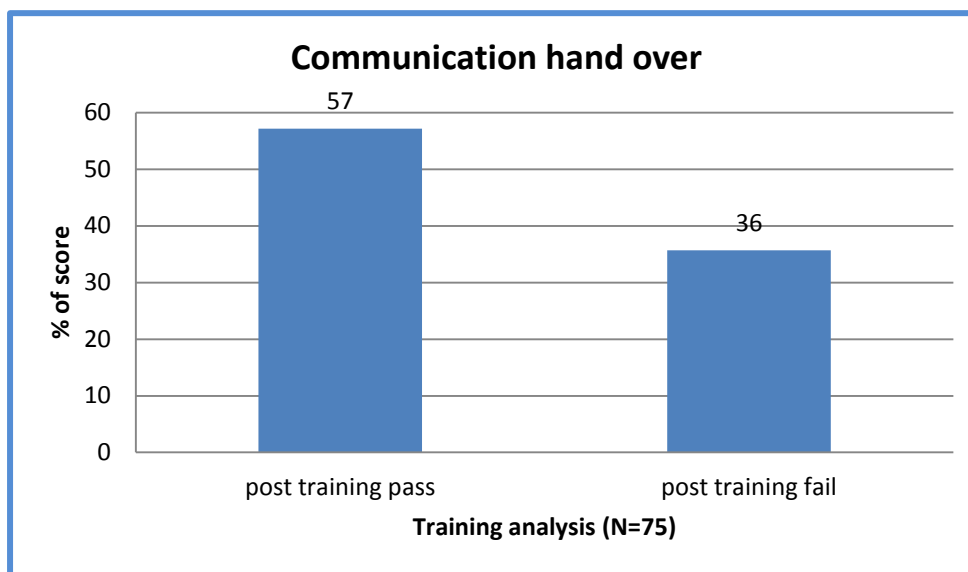


Figure 6

After analyzing checklists filled by respondents, only 42.86% of doctors were communicating thorough patient handing taking over during resumption or relieving of duties before training sessions whereas an improvement of 14.29 % was observed post training. No similar previous training programs for Resident medical officers were carried out earlier in the IPD's. Use of SBAR (Situation, Background, Assessment and Recommendations) technique shall be made mandatory in ward levels. Repeat –back and read back steps is included in the handover process provision of information regarding patient status, medications, treatment plans and any significant changes after training intervention was done.

3.2) Nurses Communication during Patient Hand Over

Pre training nurses analysis

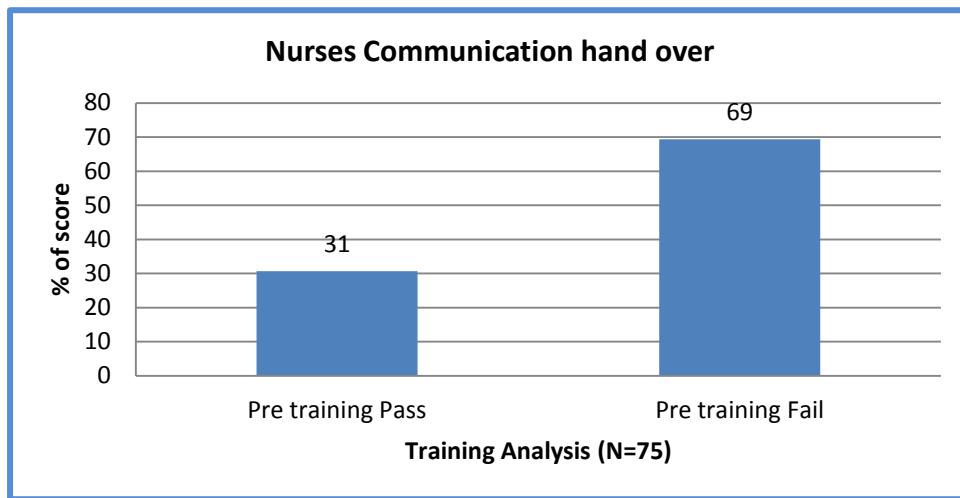


Figure 7

Post training nurses analysis

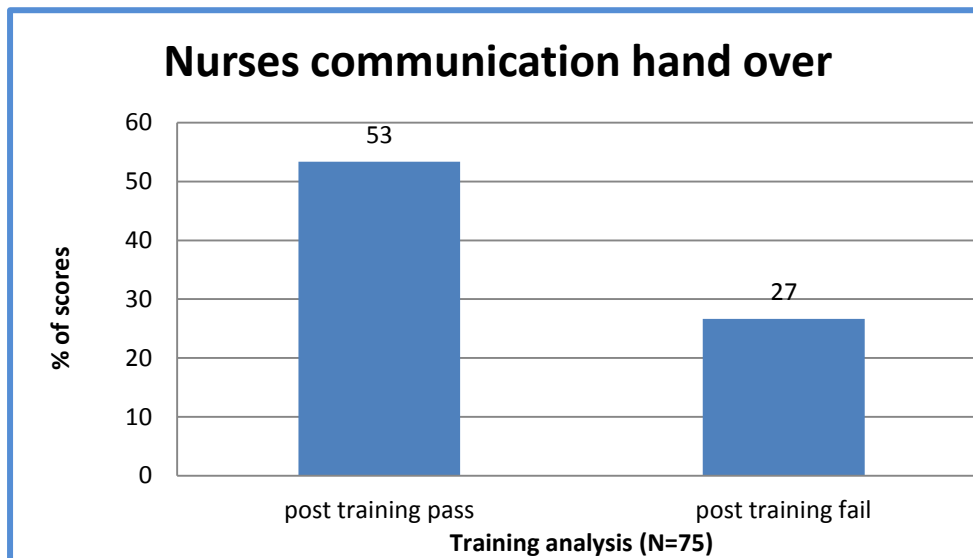


Figure 8

Only 30.33 % of nurses were following proper communication during patient hand over before such refresher training was given to them whereas after training nurses knowledge raised to 53.33 %. No previous refresher training program was imparted to them earlier.

4) Assuring Medication Accuracy at Transition in Care

4.1) Pre training doctor's analysis

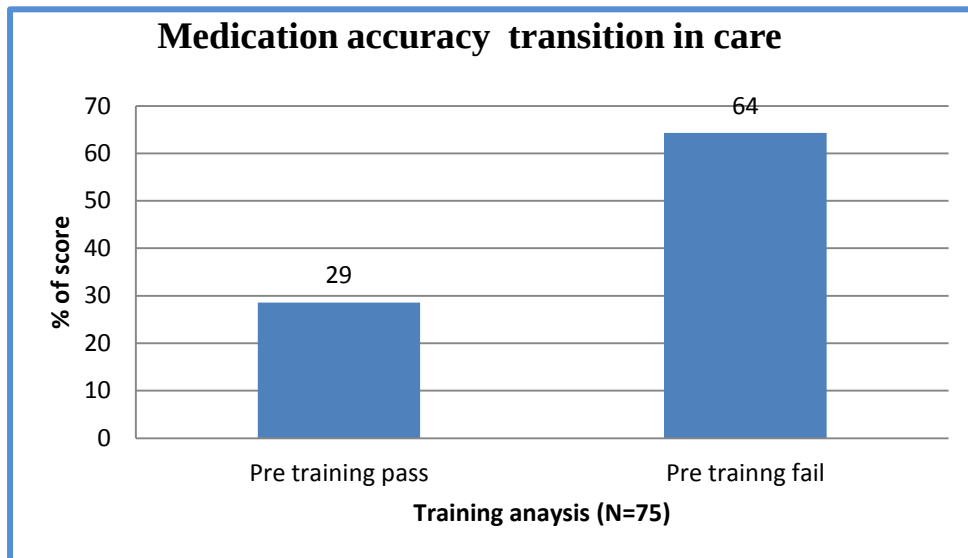


Figure 9

4.2) post training doctors analysis

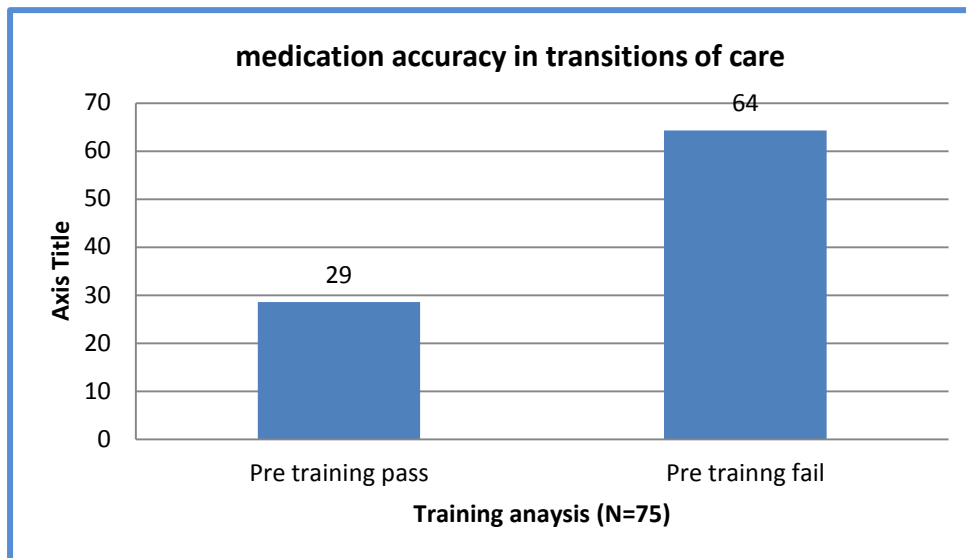


Figure 10

RMO (Resident medical officer's) knowledge about medication error during each transition (admission, transfer and discharge) in patient care was 72% before any formal training which rose to 84% afterwards. No previous education sessions were conducted for them in past. The reconciliation of medications (i.e. comparison of the patient's medication list with the medications being ordered to identify omissions, duplications, inconsistencies between the patient's medications and clinical conditions, dosing errors, and potential interactions) within specified time frames.

CHAPTER 5

CONCLUSIONS

Patient safety has recently been recognised as core value of patient care by WHO in 2005.

The study aimed to identify gaps and devise required interventions for implementation of patient safety solutions recommended by WHO

Healthcare industry is presently developing at excellent pace to meet health demands of populace, and as quality of life indices are rising, so are the expectations. Even a minor health care error stands out evident in front of patients.

After reviewing all the Nine International Patient Safety Solutions, in Jaypee hospital the most common problematic areas for patient safety were found to be Patient Identification, Communication during patient hand over, and hand hygiene to prevent Health Care Associated Infections and Accuracy in Medication Transitions of Care on which required interventions in the form of training was given to the staff in the Inpatient department areas.

The improvement in scores of post training assessment shows that unintentional harm or errors can be reduced down by giving regular trainings on regular hand wash with soap and water, use of ID band in every patients, following read back and repeat back policy while doing patient hand over and conducting medication reconciliation programs in the educational curricula, orientation, and continuing professional development for health-care professionals.

Further suggestive action for developing good patient safety culture in hospital is in under process to achieve the target of zero patient error.

CHAPTER 6

RECOMMENDATIONS

For proper patient safety in hospital

- ❖ Formulation of patient safety guidelines in departmental manual-detailed SOPs for the same so that it can be evaluated and edited as per the requirements of top management
- ❖ Where available, explore technologies such as electronic medical records, electronic prescribing systems to streamline information access and exchange for Patient Safety
- ❖ Consider implementation of automated systems (e.g. electronic order entry, bar coding, radiofrequency identification, biometrics) to decrease the potential for identification errors.
- ❖ The missing bilingual (Hindi & English) hand hygiene signage's/posters need to be displayed near all the taps in IPD
- ❖ Induction program for the staff to be introduced for patient safety
- ❖ Training monitoring records to be maintained on regular basis

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APPENDICES

Questionnaire

I am a 2nd year Student from IIHMR, Jaipur doing my internship at Jaypee hospitals, Noida. I am running a project on the Patient safety goals. The following questionnaire is seeking the views for the academic purpose. Please spare a few minutes to fill in the questionnaire and the information provided will be kept confidential.

PRE - TRAINING QUESTIONNAIRE

PATIENT IDENTIFICATION

Please tick the correct choice accordingly

1. Which of the following is used as a patient identifier in the In-patient Wards?
 - a) UHID
 - b) Photo ID
 - c) Driving license
 - d) None of the above

2. which are the 2 patient identifiers in Inpatient Ward?
 - a)
 - b)

3. Which of the following identifiers are present on the ID band?
 - a) MRN
 - b) Name
 - c) DOB
 - d) None of the above

- 4 What is the color of Adult-Inpatient ID band?
 - a) Black
 - b) Green
 - c) Orange
 - d) Blue

5. The patient UHID no. is
- a) His/her location in hospital
 - b) His/her DOB
 - c) A UHID that hospital assigns
6. Is patient UHID transferable /non transferable?
- a) Yes
 - b) No
 - c) May be
7. If there are two patients with same name, how will be the patient identified?
- a) UHID
 - b) Bed no.
 - c) Blood group of patient
 - d) Mother's name
8. Arrange the following in order of fixing the pt. ID band
- a) Lt. Upper limb
 - b) Rt. Upper limb
 - c) Lt Lower limb
 - d) Rt. Lower limb
9. Staff shall ensure patient ID band before:
- a) Transfusion of blood & blood products
 - b) Blood Sampling
 - c) X-ray and imaging procedures
 - d) all of the above
10. Patient ID Band shall be ensured before Administration of medications
- Yes/No

POST TRAINING QUESTIONNAIRE

Patient Identification

- 1) What is the color code of pediatric patient ID band
 - a) Blue
 - b) Orange,
 - c) Pink
 - d) Red

- 2) What is the color code of Allergy band in patient IP band
 - a) Blue
 - b) Orange,
 - c) Pink
 - d) Red

- 3) Photo ID can be considered as patient identification source in IP ward
Yes/No

- 4) Is DOB written in Patient UHID band
Yes/No

- 5) Blood group of patient is important patient identification source in IP ward
Yes/No

- 6) patient ID band is important before taking any blood samples of the patient
Yes/No

- 7) If ID band is illegible, missing or contains incorrect information, who is responsible person to put a new UHID Band:
 - a) Doctors
 - b) Nurses
 - c) Floor Coordinators
 - d) All Of the Above

8) Removal of ID band is documented in which file:

- a) Discharge Checklist Register
- b) Discharge Activity LIST Register
- c) Team Lead Hand Over Register
- d) None Of The Above

9) ID band is removed by

- a) Staff nurse
- b) Team lead of nurses
- c) Doctors
- d) Patient self

10) Sources of Patient identification includes:

- a. Patient
- b) Relative
- c) Guardian
- d) Stranger

PRE - TRAINING QUESSIONARE

HAND HYGIENE QUEISSONAIRE

1	Have you received any formal training on hand hygiene	Yes/No
2	Are hand hygiene steps followed before touching each patient	Yes/No
3	Are hand hygiene steps mandatory before /after touching bed railings of patient	Yes/No
4	Are hand hygiene steps mandatory before /after touching bed railings of patient	Yes/No
5	Are hand hygiene steps necessary after touching patient files	Yes/No
6	Do you follow hand hygiene steps after inserting IV lines to patient	Yes/No
7	How many steps of Hand washing are there as per World Health Organization	
8	What is the minimal time line needed for alcohol hand rub to kill the germs on your hand	
9	Are hand hygiene steps necessary before/ after touching patient dress	Yes/No
10	Are hand hygiene steps followed before giving IV medications to the patient	Yes/No

POST TRAINING QUESTIONNAIRE

HAND HYGIENE QUEISSONAIRE

1	Are hand hygiene steps followed before giving IV medications to the patient	Yes/No
2	Are hand hygiene steps followed before touching each patient	Yes/No
3	Are hand hygiene steps necessary to follow after patient body fluids exposure	Yes/No
4	Are hand hygiene steps followed before wearing gloves	Yes/No
5	Are hand hygiene steps necessary after touching patient files	Yes/No
6	Do you follow hand hygiene steps after inserting IV lines to patient	Yes/No
7	How many steps of Hand washing are there as per World Health Organization	
8	What is the minimal time line needed for alcohol hand rub to kill the germs on your hand	
9	Are hand How many steps of Hand washing are there as per World Health Organization hygiene steps necessary before/ after touching patient dress	Yes/No
10	Are hand hygiene steps mandatory before /after touching bed railings of patient	Yes/No

NURSES COMMUNICATION DURING HAND OVER

1	Is the assigned nurse staff being introduced to patient in every shift	Yes/No
2	Whether patient profile status explained during hand over (Name, age, sex, location, diagnosis, sign & symptoms at the time of admission) to next shift nurse	Yes/No
3	Is Vulnerability status of patient identified by the next shift assigned nurse	Yes/No
5	Patient medications (drug) route, frequency and timings written and explained to assigned staff	Yes/No
6	Any pending critical lab reports & investigations explained to assigned nurse	Yes/No
7	Whether patient current status, vital signs and Pain score written in nurses progress notes daily	Yes/No
8	Patients surroundings (cleanliness, bedside locker) checked and monitored during hand over	Yes/No
9	Is Patient decubitus /pressure ulcer status explained during hand over time	Yes/No
10	Any special planned procedure/surgery explained to assigned staff in each shift	Yes/No
11	Details of infection status and allergies documented during hand over	Yes/No
12	Details of all tubings and lines (ET tube, peripheral iv line, CVC line, feeding lines, drain, catheters) attached to patient explained in hand over time	Yes/No
13	Patients type of diet, parenteral nutrition/TPN explained during hand over	Yes/No
14	Patients assets (any valuables, suction machine, bipap, steam inhaler) noted by each assigned staff	Yes/No

DOCTORS COMMUNICATION DURING HAND OVER

1	Whether patient profile status narrated during hand over (Name, age, sex, location, diagnosis, sign & symptoms at the time of admission)	Yes/No
2	Whether patient current status (vital signs, GC scale, Pain scale, Braden scale) written daily in physician notes	Yes/No
3	Whether patient safety concerns documented in physicians notes daily (vulnerability status, allergies, critical lab reports and infection status)	Yes/No
5	Patient medications (drug) route, frequency and timings administered as per drug chart daily	Yes/No
6	Patients tubes and lines(ET tube, peripheral iv line, CVC line, feeding lines, drain, catheters) attached to patient checked and monitored daily	Yes/No
7	Any pending lab reports & investigations(including outside reports) checked during hand over time	Yes/No
8	Any pending referrals narrated during hand over time	Yes/No
9	Is Patient decubitus /pressure ulcer status documented daily	Yes/No
10	Any special planned procedure/surgery explained	Yes/No
11	Important orders to be followed explained	Yes/No
12	Patients type of diet, parenteral nutrition/TPN explained during hand over	Yes/No

PRE - TRAINING QUESSIONARE
MEDICATION ERROR QUESSIONARE

- 1) Any preventable event that may cause or lead to inappropriate medication use or patient harm ,while the medication is in the control of health care professional, patient or consumer is k./s

Medication error

Dispensing error

Administration error

Prescription error

- 2) How many categories of medication error are there in a hospital

a) 5

b) 6

c) 8

d) 9

- 3) Which of the following are Administration error

a) Wrong time

b) Wrong patient

c) Wrong dose

d) All of the above

- 4) Which o f the following are medication error

a) Prescription error

b) Indenting error

c) Dispensing error

d) All of the above

- 5) which are the 2 identifiers before administration of any medication

a.

b.

- 6) Incident reporting form filling up time is
- a) 1hr
 - b) 2hr
 - c) 3hr
 - d) 5hr
- 7) Incident reporting form to be submitted in which dept of hospital
- a) Quality
 - b) Operations
 - c) Human resource
 - d) Clinical services
- 8) Incident reporting form to be submitted with in how many days
- a) With in 24hr
 - b) With in 48 hr
 - c) With in 72 hr
 - d) Within 90 hr
- 9) Which type of error category is: circumstances or events that have capacity to cause error
- a) Category C
 - b) Category G
 - c) Category D
 - d) Category I
- 10) An error should be reported to whom immediately:
- a) Concerned Consultant
 - b) Nursing Supervisor
 - c) Floor Manager
 - d) Nursing In Charge

POST TRAINING QUESTIONNAIRE
MEDICATION ERROR QUESTIONNAIRE

- 1) Wrong dose is which type of medication error
 - a) Administration error
 - b) Dispensing error
 - c) Identing error
 - d) Prescription error

- 2) Incident form shall be filled up with sign of whom
 - a) Doctors
 - b) Nurses
 - c) Both
 - d) Floor Manager

- 3) Medication error which results in either permanent harm or transfer to ICU or death is:
 - a) Major medication error
 - b) Minor medication error
 - c) None
 - d) Both

- 4) Category A medication error is defined as
 - a) Events that have capacity to cause error
 - b) Error occurred but did not reach the patient
 - c) Both of the above
 - d) None of the above

- 5) Error that may contributed to permanent [patient harm is which category of Medication error
 - a) Category G
 - b) Category b
 - c) Category E
 - d) Category F

- 6) Correct prescription can be
 - a) One which is written in capital letters

- b) One which is written in small letters
 - c) Mix of capital & small letters
 - d) All of the above
- 7) Patient & family should be instructed to keep a list of which of the following
- a) All medications
 - b) Dietary supplements
 - c) Both of the above
 - d) None of the above
- 8) Do patient & family need to inform about known allergies and particular drug reactions
- a) yes
 - b) no
- 9) Administration error is which of the following
- a) Allergy information missing
 - b) Verbal order
 - c) Improper storage
 - d) All of the above
- 10) Cut strip medication should not be received in IPD
- a) True
 - b) False