INTERNSHIP TRAINING

AT

BLK-MAX SUPER SPECIALTY HOSPITAL

BY

NAME: DR PRITY KUMARI

ENROLL NO: PG/20/109

UNDER THE GUIDANCE OF

DR RUPSA BANERJEE

PGDM (Hospital & Health Management)

2020-22

International Institute of Health Management ResearchNew Delhi

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(COMPLETION OF DISSERTATION FROM RESPECTIVE ORGANIZATION)

The certificate is awarded to

Dr. Prity Kumari

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

Quality

And has successfully completed his/her Project on

Compliance to International Patient Safety Goals (IPSG)

At

Blk Max Super Specialty Hospital

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

We wish him/her all the best for future endeavors.

Training & Development

Dr. Vivek Gupta(Quality Head)

Zonal Head-Human Resources

Chandan Kumar

TO WHOMSOEVER IT MAY CONCERN

This is to certify that Dr. Prity Kumari, student of PGDM (Hospital & Health Management) from International Institute of Health Management Research, New Delhi has undergone internship training at Blk-Max Super Specialty Hospital from 08.04.22 to 07.07.22.

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

The Internship is in fulfillment of the course

requirements.I wish him all success in all his/her future

endeavors.

Rupsa Banerjee

Dr. Sumesh Kumar
Associate Dean, Academic and Student Affairs
IIHMR, New Delhi

Mentor- Dr. Rupsa Banerjee
IIHMR, New Delhi

CERTIFICATE OF APPROVAL

The following dissertation titled **"COMPLIANCE TO INTERNATIONAL PATIENT SAFETY GOALS(IPSG) "** at **"BLK-MAX SUPER SPECIALTY HOSPITAL"** is hereby approved as a certified study in management carried out and presented in a manner satisfactorily to warrant its acceptance as a prerequisite for the award of **PGDM (Hospital & Health Management)** for which it has been submitted. It is understood thatby this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation.

Name	Signature
Dr. Dhananjay.	
Dr. B.S Singh.	
Dr. Rupsa	

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled “Compliance to International Patient Safety Goals (IPSG)

In a Super Specialty Tertiary Care Hospital” and submitted by Dr. Prity Kumari

Enrollment No. PG/20/109
Under the supervision of Dr. Rupsa Banerjee.

For award of PGDM (Hospital & Health Management) of the Institute carried out duringthe period from 08.04.22 To 07.07.22

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 similarinstitution of higher learning.

Signature

FEEDBACK FORM

Name of the Student: Dr. Prity Kumari

Name of the Organization in Which Dissertation Has Been Completed:

Blk-Max Super Specialty Hospital

Area of Dissertation: Quality

Attendance: 96%

Objectives achieved: Audit of IPSG goals, Medical Record Audit, Data Analysis,

Deliverables: Audit of IPSG goals, Medical Record Audit, Data Analysis

Strengths: Hardworking, Ambitious, Punctual, Proactive

Suggestions for Improvement:

Suggestions for Institute (course curriculum, industry interaction, placement, alumni):

Organization mentor **Date: 07/07/22**

Dr. Vivek Gupta

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At last, I would thank Doctors, Nurses and other medical staff for their cooperation, supportive and learning attitude. The administrative staff of the hospital been very helpful to me and I would like to express my deep gratitude to all.

SECTION A

INTERNSHIP REPORT

AT BLK-MAX SUPER SPECIALTY HOSPITAL

INTRODUCTION

A hospital is a residential setting that provides both short- and long-term medical care, as well as observational, diagnostic, therapeutic, and rehabilitative services for those who are ill or injured, as well as for expectant women. It might or might not offer ambulatory patients outpatient services.

The hospital is a crucial component of a social and medical institution whose goal is to offer comprehensive healthcare to the populace, including both curative and preventive care, and whose outpatient services reach out to the family in its home environment. The hospital serves as a hub for bio-social research as well as the training of healthcare professionals.

HOSPITALs FUNCTION

a) Restorative or Curative
b) Disease prevention and Health promotion
c) Monitoring station
d) Education and Research
e) Expert assistance
f) Early pandemic detection
g) A component of the primary healthcare (PHC) programme.

The hospital features a large number of departments (both clinical and non-clinical), each of which is manned by a different group of healthcare experts with some cross-over.

THE MOST COMPLEX HUMAN ORGANIZATION EVER CONSIDERED IS A HOSPITAL

Due to the complexity of the organization, managers must not only provide direction but also oversee how the business is run and coordinate the efforts of its staff. They influence the company by making crucial decisions that ensure patients receive the best, most timely, and most effective care while also meeting the organization's performance goals.

The entire management of a hospital is the responsibility of the hospital administrator.

THE PURPOSE AND DUTIES OF HOSPITAL ADMINISTRATORS

Their main responsibility is to plan, organize, and deliver healthcare services.

They acquire new technologies and aid in enhancing the effectiveness and quality of services.

They make strategic decisions, participate in public debates, weigh financial concerns with the expenses of providing healthcare, keep an eye on governmental rules, supervise clinical

TRAINING OBJECTIVE

- To comprehend the correct general process and operating tenets of the Quality department.
- Should understand precisely how the hospital's quality department operates and be aware of each department's specific responsibilities.
- To comprehend how managerial tools and strategies are used in the organization.
- To apply theoretical information to real-world situations.
- To keep an eye on the orderly and synchronized flow of labor as it occurs.
- To understand the NABH rules clearly

BLK-MAX
Super Speciality Hospital

ORGANIZATION PROFILE

A major player in the area of tertiary super specialized healthcare, BLK-Max Super Specialty Hospital is a part of one of India's largest healthcare networks and provides a variety of services. The hospital can accommodate 650 patients and featuresA dedicated OPD block for each specialty, 125 critical care beds, and 17 modular operating rooms.

BLK-Max has constantly been listed as one of Delhi NCR's Top 10 Multi Super Specialty Hospitals.

The hospital has, among other things, the most up-to-date medical diagnostic and treatment equipment. Robotic Surgery System; India's First Computer Navigation for Joint Replacement; South Asia's First Signa Artist MRI; Revolution Frontier CT; Three-dimensional reconstruction in a flat panel combo cath lab; TomoTherapy (Next-generation intensity-modulated radiation therapy for the treatment of cancer)

The most recent version of PET-CT, Spectroscopy using two heads, a gamma camera with configurable angles, and ultrasound with 3D and 4D imaging. A holistic, comprehensive, and up-to-date treatment plan can be supported by BLK-Advanced Max's Centers of Excellence, cutting-edge facilities, and patient-centered services.

A desire to help people...

We at BLK-Max are committed to providing the best possible healthcare. Whether it's the best doctors, cutting-edge treatment, cutting-edge facilities, or smiling nursing staff. Nothing is too huge or too small to ignore when you are enthusiastic about restoring the lives that have been entrusted to us**.**

LEGACY:

A charitable hospital was founded in Lahore in 1930 by renowned obstetrician and gynaecologist Dr. B L Kapur. He relocated to post-partition India in 1947 and established a maternity hospital in Ludhiana. Dr. B L Kapur started the effort to build a 200-bed hospital in Delhi in 1956 at the invitation of the then-prime minister. On January 2, 1959, Pt. Jawaharlal Nehru, the Prime Minister, officially opened the hospital.

The hospital was growing and on its way to becoming Delhi's top multispecialty institute by 1984, when it celebrated its Silver Jubilee. In addition to mother and child care, services offered included general surgery, ophthalmology, ENT, dentistry, pulmonology, intensive care, and orthopedics.

A component that was crucial to the hospital was the community's health was a significant factor for the facility. To raise the level of community health in the area, enthusiastic doctors sponsored camps and public health lectures.

Dr. B L Kapur was so passionate and committed to realizing his ambition that he frequently contributed from his own salary, forgoing even the most fundamental needs.

In 1942, the Lahore Hospital Society was incorporated. Some of the most notable physicians and benefactors of the time were among the founding members of the Lahore Hospital Society, and they made significant contributions to the construction and administration of the hospital.

After being renovated, BLK-Max Super Specialty Hospital was reopened as a Multi Super Specialty facility with 650 beds, 125 of which were set aside for critical care, and 17 modular operating rooms. This facility provides patients with seamlessly integrated healthcare services and is the youngest in India to have received the prestigious NABH and NABL accreditations.

VISION

- To establish a patient-centric, tertiary healthcare organization that combines cutting-edge technology with a human touch to provide non-intrusive, high-quality care.

MISSION

- To deliver quality care with professional excellence.
- Provide care with honesty and morality.
- Through research and education, expand the boundaries of care
- Follow national and international standards for healthcare.
- Give everyone in society access to high-quality healthcare.

QUALITY & ACCREDATION

Joint Commission International

NABH

ilac - MRA

BLK-Max has been accredited by Joint Commission International (JCI) & National Accreditation Board for Hospitals & Healthcare Providers (NABH), National Accreditation Board for Testing and Calibration Laboratories (NABL).

SERVICES PROVIDED BY THE HOSPITAL

SPECIALITIES

- ✓ Anesthesiology
- ✓ Arthroscopy & Sports Medicine Centre
- ✓ Surgical Gastroenterology, Advance Laparoscopic & Bariatric Surgery
- ✓ Dental & Maxillofacial Surgery
- ✓ Dermatology
- ✓ Emergency & Acute Care Medicine
- ✓ Centre For Diabetes, Thyroid, Obesity & Endocrinology
- ✓ ENT & Cochlear Implant
- ✓ General & Minimal Access Surgery

- ✓ Centre for Women Health
- ✓ HepatoPancreato Biliary Surgery
- ✓ Internal Medicine
- ✓ Interventional Radiology
- ✓ IVF & Infertility Treatment
- ✓ Liver Transplantation
- ✓ Nuclear Medicine
- ✓ Nutrition & Health
- ✓ Ophthalmology
- ✓ Pain Management
- ✓ Laboratory Services
- ✓ Physiotherapy & Rehabilitation
- ✓ Psychiatry
- ✓ Radiology & Imaging
- ✓ Rheumatology
- ✓ Podiatry (Foot Care) & Wound Care

CENTRES OF EXCELLENCE

- ✓ Cancer Centre
- ✓ Centre For Bone Marrow Transplant
- ✓ Heart Centre
- ✓ Centre For Neurosciences
- ✓ Institute For Digestive & Liver Diseases
- ✓ Centre For Renal Sciences & Kidney Transplant
- ✓ Institute For Bone, Joint Replacement, Orthopedics Spine & Sports Medicine
- ✓ Centre For Chest & Respiratory Diseases
- ✓ Centre For Plastic & Cosmetic Surgery
- ✓ Centre For Child Health
- ✓ Centre for Critical Care

STATE OF ART EQUIPMENTS

- ✓ TomoTherapy System
- ✓ Robotic Surgery System
- ✓ Computer Navigation System
- ✓ Endoscopy Suites
- ✓ MRI
- ✓ CT Scan
- ✓ Nuclear Medicine

VARIOUS DEPARTMENTS IN THE HOSPITAL

FLOORS	DEPARTMENTS
BASEMENT	• Physiotherapy • Radiation oncology • In patient billing • Medical Record Department • LT room • Parking
GROUND FLOOR	• Reception • Admission & discharge • OPD Pharmacy • Emergency • Transfusion medicine • Pre Anesthesia Checkup clinic • Interventional Radiology • Waiting lounge • **OPD 1** : ENT & Cochlear implant, internal medicine, pediatric & pediatric surgery, general& minimal access surgery, orthopedics, rheumatology, Podiatry, psychiatry & psychology, dermatology • **OPD 2 :**gynecology& obstetrics • Diagnostic :Mammography , Radiology, Nuclear medicine, sample collection • Financial counseling • Cafeteria
1st Floor	• International patient lounge • Laboratory services • Dental science • OPD 3: cardiology & cardiac surgery, vascular surgery, non-invasive cardiology , nephrology & kidney transplant, urology, endocrinology, diabetes & thyroid, respiratory medicine, executive health check up, ophthalmology, Ayurveda medicine, • OPD 5 :Gastroenterology, hepatology, GI surgery, HPV surgery & liver transplant • OPD 6 : dialysis • OPD 7 : medical & surgical oncology, BMT& Hemato oncology, radiation oncology

	• OPD 8 :neurology & neuro surgery, neuro electrophysiology
2nd FLOOR	• OT • Cath lab • MICU • SICU • CTVS ICU • ICCU • OT-ICU • NSICU • KT-ICU • Pre & post-operative area
3RD FLOOR	• In patient rooms • Surgical onco HDU • Neuro HDU • Bronchoscopy • ECP • Sleep lab • Dialysis unit 2
4th FLOOR	• In patient room / MBU • PICU • NICU & HDU • Birthing suits • Labour OT, Nursery
5TH FLOOR	• In patient rooms • Chemotherapy & day care
6th floor	• In patient rooms • GL-ICU & GL-HDU • Bone marrow transplant unit
7TH FLOOR	• In patient rooms • OT • Plastic & cosmetic surgery • Bone marrow transplant unit • Administration area

NON CLINICAL DEPARTMENTS

Quality Department	**Front office Department**
HR Department	**IT Department**
Purchase Department	**Marketing Department**
Engineering Department	**Security Department**
Operations and Planning Department	**Outpatient Department**
Accounts	**Admission and Billing**
House Keeping Department and Biomedical waste Management Department	**Food and beverages**

CODES:

CODES	SCOPE	EXTENSION NO.
BLUE		CARDIAC ARREST
3023		
GREY		INTERNAL DISASTER
3055		
YELLOW		EXTERNAL DISATER
3055		
GREEN		TRAUMA
3055		
BLACK		DEATH
3055		
RED		FIRE
3055		
PINK		CHILD ABDUCTION
3055		

DEPARTMENTS VISITED/WORKED

S.NO.	DEPARTMENT	ACTIVITY ASSIGNED	KEY LEARNING
1	Department of Quality	Internal auditing	• Ways and procedure of internal audit. • Flaws and areas of improvement of emergency department are found as per compliance for NABH 5th edition.
2	Emergency	Observational activity	• Information on the department's purpose, basic functioning, and process flow. • Initial assessment parameters
3	Ambulance	Observational activity	• Information about the type of ambulance – BLS , ACLS • Equipment's and medicine present in ambulance
4	Front office and billing	Observational activity	• Information on the department's purpose, basic functioning, and process flow. • Complete process of admission , billing and discharge.
5	OPD	Observational activity	• Information on the department's purpose, basic functioning, and process flow.
6	IPD	Observational activity	• Information on the department's purpose, basic functioning, and process flow. • Information on the functioning of nursing station, nurse-to-patient ratios, and patient care coordination, such as addressing patient issues.
7	Radiology and laboratory	Observational Activity	• Information on the department's purpose, scope of services, basic functioning, and process flow.
8	CSSD	Observational Activity	• Information on the department's purpose, basic functioning, and

			process flow.
9	Oxygen Plant	Observational Activity	• Information on the department's purpose, basic functioning, and process flow.
10	LT- Room	Observational Activity	• Information on the department's purpose, basic functioning, and process flow.. •
11	Lift	Observational Activity	• Information on the department's purpose, basic functioning.
12	AC	Observational Activity	• Information on the department's purpose, basic functioning, and process flow.
13	Water	Observational Activity	• Information on the department's purpose, basic functioning, and process flow. • WTP
14	Linen and Laundary	Observational Activity	• Information on the department's purpose, basic functioning. • Process of receiving filthy and worn linen and delivering clean and sterile linen.
15	Medical Record Department	Observational Activity	• Information on the department's purpose, basic functioning, and process flow. • Maintenance of IPD files of discharged patient , ICD – 10 coding of particular disease

QUALITY DEPARTMENT

QUALITY: "the extent to which health care services are congruent with current professional knowledge and increase the possibility of desired health outcomes for people and populations."

- **Quality Department Objectives**
- Through internal or external training, participation in academic events like CMEs, seminars, and conferences, as well as the availability of journals and books in the hospital library, hospital staff members' expertise is continuously updated. Analyze the performance difference by performing a situational analysis.
- Conduct a situational analysis to:
  - Analyze the gap performance
  - Evaluate the efficient use of resources
  - Look for areas where you can improve
- Conduct a training workshops on:
- - Auditing Process
  - Capability to communicate
  - System for reporting incident
  - Safety of patients
- Give a summary of clinical effectiveness, patient safety, and quality.
- Let you know about chances to focus on quality, patient safety, and clinical effectiveness
- Inform you of opportunities to engage in Quality, Patient Safety & Clinical Effectiveness work
- Describe the process used to enhance patient outcomes and publicly available data.
- The organization must: - prove compliance with all applicable accreditation and regulatory requirements to ensure a network of qualified practitioners and pro
- Analyze the performance difference by performing a situational analysis.

KEY ACTIVITIES UNDERTAKEN OTHER THAN DISSERTATION

1. Consent audit in all the departments.
2. **Medical Record Audit** of all the patients in IPD department as per NABH on daily basis according to the focused audit checklist which consist of the audit of the following:
   i. Patient details
   ii. Initial assessment
   iii. Patient & Family Education
   iv. Patient & Family Communication
   v. Progress notes
   vi. Non-drug
   vii. Consent
   viii. Anesthesia Records
   ix. Operations note
3. **Audit of Critical values** from all labs of the hospital on daily basis. Finding the compliance rate of critical values and action taken by the doctors against critical values of the patients.
4. **Audit of Mortality death score** in all the ICUs of the hospital on daily basis. Different scoring for mortality tracking followed in different ICUs as follows:
   i. MICU- APACHE II
   ii. SICU- POSSUM
   iii. NSICU- APACHE II
   iv. CCU- SOFA
   v. CTVS- EUROSCORE II
   vi. NICU-SNAPPE II
   vii. PICU-PIMS III

SECTION B

COMPLIANCE TO INTERNATIONAL PATIENT SAFETY GOALS (IPSG) IN A SUPER SPECIALTY TERTIARY CARE HOSPITAL

TABLE OF CONTENTS

1. LIST OF ABBREVIATIONS

JCI- Joint Commission International

IPSG- International Patient Safety Goals

WHO- World Health Organization

IOM- Institute of Medicine

JCAHO- Joint Commission on Accreditation of Healthcare Organizations

JCR- Joint Commission Resources

APR- Accreditation Participation Requirements

ACC- Access to care and continuity of Care

PFR- Patient and Family Rights

AOP- Assessment of Patients

COP- Care of Patients

ASC- Anesthesia and Surgical Care

MMU- Medication Management and Use

PFE- Patient and Family Education

QPS- Quality Improvement and Patient Safety

PCI- Prevention and Control of Infections

GLD- Governance, Leadership, and Direction

FMS- Facility Management and Safety

SQE- Staff Qualifications and Education

MOI- Management of Information

MPE- Medical Professional Education

HRP- Human Subjects Research Programs

ME- Measurable elements

ID- Identification

C- Compliance

NC- Non Compliance

PC- Partial Compliance

OPD- Out Patient Department

CATH LAB- Catheterization lab

ICU- Intensive Care Unit

OT- Operation Theatre

SOS- Si Opus Sit

CCU- Cardiac Care Unit

SOP- Standard Operating Procedures

LASA- Look Alike & Sound Alike

US- United States

CDC- Centre for Disease Control

HAI- Healthcare Associated Infections

CSSD- Central Sterile Supply Department

HEPA- High Efficiency Particulate Air

PPE- Personal Protective Equipment

ADL- Activity of Daily Living

GDA- General Duty Assistant

BMT- Bone marrow transplant

2. LIST OF TABLES AND GRAPHS

3. INTRODUCTION

All healthcare organizations have patient safety as their first priority. The prevention of patient injury is referred to as patient safety (IOM). It involves minimizing dangerous behaviors within the healthcare system and implementing best practices that have been proved to produce the best results for patients. (1)

"Freedom from unintentional injury" is how the Institute of Medicine (IOM) defined safety. (2)

Patient safety is a significant concern for worldwide public health. Countries have begun to realize more and more recently how important it is to increase patient safety. A World Health Assembly resolution on patient safety was adopted in 2002 by WHO Member states. According to estimates, one in ten people receiving hospital care in wealthy nations suffer injury.

Compared to developed nations, the likelihood of patient injury in hospitals is higher in developing countries. 1.4 million People globally experience infections that they contracted in hospitals at any given moment. Some impoverished nations have up to a 20-fold higher risk of healthcare-associated infections than developed nations. (3)

Since quality management systems aid in enhancing Patient protection and reducing the chance of unfavorable outcomes and medical mistakes in healthcare companies, patient safety and quality cannot be distinguished from one another. (4)

The National Quality Forum and the Joint Commission work together to manage the enormous attention and effort focused on enhancing patient safety and quality. Joint Commission International (JCI) is the only Collaborating Centre for Patient Safety recognized by the World Health Organization. (5)

Joint Commission International is a non-profit accreditation body with a U.S. base that develops standards and procedures to foster an organizational culture of ethics, safety, and quality. Its Gold Seal of Approval, which it considers to be the pinnacle of patient safety and quality, is given to organizations that consistently strive to improve patient care processes and results.(9)

Mission of JCI:

To offer health care certification and associated services that encourage performance improvement in healthcare organizations in order to continuously improve the safety and quality of care provided to the general population.(9)

International specialists created JCI's accreditation programme, which establishes standardized, reachable standards for health care organizations' structures, methods, and results. International Patient Safety Goals, which identify trouble spots in healthcare and outline evidence- and consensus-based solutions to these issues, are also part of the accreditation standards.(9)

The first and most important criterion of JCI is the International Patient Safety Goal (IPSG). The IPSG contains six aims, which are further broken down into ten criteria and thirty quantifiable components. (2)

4. RATIONALE

The tested procedure that an organization needs to maintain a safe environment for your patients, workers, and visitors is Joint Commission International (JCI) accreditation and certification. The improved reputation among stakeholders and the local and global communities is the most significant advantage of JCI accreditation. The International Patient Safety Goals (IPSG), which are the first and foremost prerequisite for JCI accreditation, must be checked for conformity by tertiary care hospitals as they get ready for the accreditation. The International Patient Safety Goals and JCI Accreditation criteria are intended to assist organizations in enhancing patient safety. (1)

5. REVIEW OF LITERATURE

INTERNATIONAL PATIENT SAFETY GOALS (IPSG)

The JCI accreditation standards' International Patient Safety Goals are intended to assist organizations in enhancing patient safety.(3)

GOALS: 6

STANDARDS: 13

MEASURABLE ELEMENTS: 39

IPSG GOALS:

IPSG 1: Identify Patients Correctly

IPSG 2: Improve Effective Communication

IPSG 3: Improve the safety of High-Alert Medications

IPSG 4: Ensure Patients Safe Surgery

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

IPSG 6: Reduce the Risk of Patient Harm resulting from falls

GOAL 1: IDENTIFY PATIENTS CORRECTLY

Wrong-patients Almost every step of diagnosis and treatment involves mistakes. Throughout the hospital, patients are free to switch beds, rooms, or places; they may be sedated, disoriented, or not completely awake; they may have sensory impairments; they may forget who they are; or they may be vulnerable to various circumstances that could result in mistakes in correct identification. This objective has two parts: accurately determining the person for whom the service or treatment is meant; and matching the service or treatment to that person. Each patient must be identified in at least two different methods, according to the hospital's identification policy, such as by name, identification number, birthdate, bar-coded wristband, or another method. Rooms for the sick, in number (3)

Standard:

The hospital creates and uses a procedure to increase the precision of patient identifications.(3)

Measurable Elements:

i. At least two patient IDs, not including the patient's room number or location within the hospital, must be used to identify the patient and to label the patient's care and treatment plan's components..(3)

ii. Prior to conducting diagnostic tests, administering treatments, and carrying out other operations, patients are recognized. (3)

iii. In unusual situations, such as with a unnamed newborn or a patient who is unconscious, the hospital makes sure that patients are identified correctly.(3)

GOAL 2: IMPROVE EFFECTIVE COMMUNICATION

Effective communication decreases errors and increases patient safety because it is timely, precise, thorough, unambiguous, and understood by the recipient. You can communicate verbally, orally, or in writing. Poor communication can have a serious impact on patient care situations such as verbal and telephone patient care orders, verbal and telephone handoff interactions, and verbal and telephone delivery of important test results. (2)

Hand-off communication refers to the dissemination of patient-specific information from one caregiver to another, from one team of caregivers to another, or from caregivers to the patient and family in order to preserve the continuity and security of the patient's care. The repeat-back and read-back procedures need to be incorporated into the handover procedure in order to give the patient safe treatment. (2)

Standard IPSG.2

The hospital creates and implements a procedure to enhance caregiver communication via telephone and/or spoken means..(3)

Measurable Elements of IPSG.2

i. Orders given verbally in full are recorded, read back by the recipient, and confirmed by the person giving the order.(3)

ii. Orders placed over the phone are fully recorded, read back by the receiver, and verified by the person placing the order. (2).

iii. Complete test results are recorded, read back by the recipient, and verified by the person providing the result (2).

Standard IPSG.2.1

A protocol for reporting important diagnostic test findings is created and put into place by the hospital. (2)

Measurable Elements of IPSG.2.1

i. Defines critical outcomes as levels for diagnostic tests that may be urgent or emergent life-threatening. (2)

ii. Create a formal reporting procedure that will be applied throughout the hospital and specify how important diagnostic test results should be reported to or shared with healthcare professionals. (2)

iii determines what information is recorded in the patient's medical file. (2)

Standard IPSG.2.2

The hospital creates and uses a handover communication mechanism. (2)

Measurable Elements of IPSG.2.2

I. During the transfer of patient care, health care professionals deliver standardized critical content. (2).

ii. A consistent and thorough handover process is supported by the use of standardized forms, tools, or processes. (2)

iii. Data from unfavorable incidents brought on by handover communications are monitored, solutions to improve handovers are identified, and improvements are put into place. (2)

GOAL 3: IMPROVE THE SAFETY OF HIGH ALERT MEDICATIONS

Appropriate management is essential to maintaining patient safety when drugs are a part of the patient's treatment plan. Any medicine, even ones that don't require a prescription to buy, might harm you if used incorrectly. However, when high-alert drugs are administered incorrectly, harm is likely to be more severe, which can increase patient suffering and possibly increase the expense of caring for these individuals. Insulin, opioids, chemotherapeutic drugs, antithrombotic drugs, anticoagulants, thrombolytics, neuromuscular blockers, and epidural or intrathecal drugs are some of the most commonly mentioned examples of high-alert pharmaceuticals. (2)

Look-alike/sound-alike names are those for medications that, when written or pronounced, resemble or sound similar to those of other medications. Medicine containers or primary packaging that resembles that of another drug is referred to as "looking-alike" packaging. Drug names that are potentially hazardous, such as dopamine and dobutamine, may result from medications that are subject to LASA confusion or packaging that is similar. Worldwide, name confusion is a frequent reason for pharmaceutical mistakes. (2)

Standard IPSG.3

To increase the security of high-alert drugs, the hospital creates and implements a process. (2)

Measurable Elements:

I identify its list of high-alert drugs in writing. (2)

ii. Creates and puts into practice a process for lowering the risk and harm associated with high-alert medicine. (2)

iii. Annually evaluates and, if necessary, updates its list of drugs for high alert. (3)

Standard IPSG.3.1

The hospital creates and implements a procedure to increase the security of pharmaceuticals that look-alike or sound-alike. (2)

Measurable Elements:

i. lists in writing all of the drugs that sound and look alike. (2)

ii. Creates and implements a hospital-wide procedure for handling drugs that look-alike or sound-alike each other. (2)

iii. Periodically examines and updates its list of drugs with similar names and effects. (2)

Standard IPSG.3.2

The hospital creates and puts into action a procedure to oversee the secure application of concentrated electrolytes. (2)

Measurable Elements:

i. Concentrated electrolytes are only available to skilled and trained persons, and they are prominently marked with the proper warnings and kept apart from other prescriptions. (2)

ii. Only keeps concentrated electrolyte vials outside of the pharmacy when the circumstances are as stated in the aim. (2)

iii. For the treatment of hypokalemia, hyponatremia, and hypophosphatemia, standard procedures are followed for adult, paediatric, and/or neonatal electrolyte replacement therapy. (2)

GOAL 4: ENSURE SAFE SURGERY(3)

The improper site, inappropriate method, and wrong-patient surgery continue to be a source of serious patient damage as well as bad and sentinel events for hospitals. Such occurrences can be caused by poor or insufficient communication among team members doing invasive or surgical procedures, the absence of a method for marking the location of the procedure and of patient participation in the marking process. Other frequent contributing variables include a culture that discourages open communication among team members, problems with legible handwriting, the

use of acronyms, and improper patient assessment. The essential elements of the Universal Protocol are; (2)

• The operation's preoperative verification phase;

• The marking of the surgical site; and

• The timeout held just before the procedure begins. (2)

Standard IPSG.4

The hospital creates and puts into action a procedure for designating the surgical or invasive treatment location and preoperative verification. (2)

Measurable Elements:

I. The hospital uses a checklist or another mechanism to record that informed consent is appropriate for the procedure, the patient, procedure, and site are accurate, and that all required paperwork, blood products, medical equipment, and implantable medical devices are on hand, accurate, and functional before the surgical or invasive procedure.(2)

ii For the purpose of identifying the surgical or invasive location, the hospital employs a universally recognized and unmistakable symbol. (2)

iii. The person doing the surgery marks the surgical or invasive location, and includes the patient in the marking procedure.

Standard IPSG.4.1

The hospital creates and implements a strategy for the time-out conducted shortly prior to the start of any surgical or invasive operation, as well as the sign-out that occurs following it. (2)

Measurable Elements:

i. Before beginning the procedure, the entire team actively participates in a time-out process that involves steps in the intended location of the surgical or invasive procedure. The time and date when the time-out was completed are recorded.(2)
ii. A sign-out procedure is carried out before the patient departs the location where the surgical/invasive treatment was done, and it must at least contain steps d) through g) in the intent. (2)
iii. The hospital follows standardized methods to ensure safe surgery whenever surgical or invasive operations are carried out, including medical and dental procedures performed outside of the operating room. (2)

GOAL 5: REDUCE THE RISK OF HEALTH CARE-ASSOCIATED INFECTIONS

Most health care settings struggle with infection prevention and control, and patients and healthcare professionals are very concerned about the rising numbers of infections that are related to healthcare. Proper hand hygiene is essential to the eradication of these and other illnesses. The World Health Organization (WHO), the US Centers for Disease Control and Prevention (US CDC), and numerous other national and international organisations all provide hand hygiene recommendations that are universally accepted. The proper hand-washing and hand-disinfection techniques are taught to staff members, and hand-hygiene rules are posted in the relevant places. In situations where hand-washing and hand-disinfecting processes are necessary, soap, disinfectants, and towels or other means of drying are available. (2)

Standard IPSG.5

The hospital adopts and employs evidence-based hand hygiene measures to reduce the risk of infections associated with medical care. (2)

Measurable Elements:

i. Current evidence-based hand hygiene recommendations have been embraced by the hospital. (2)
ii. Establishes a hand-washing programme for the entire hospital. (2)
iii. Hand-washing and hand-disinfection techniques are utilized throughout the hospital in accordance with hand-hygiene guidelines. (2)

Standard IPSG.5.1

Hospital executives evaluate care procedures that need to be improved and embrace and implement evidence-based interventions in order to improve patient outcomes and reduce the risk of hospital-associated infections. (2)

Measurable Elements:

i. Determine the most important areas for infection prevention in hospitals. (2)
ii. Choose and put into practise evidence-based therapies (such bundles) for all pertinent patients. (2)
iii. Health care professionals assess evidence-based strategies (such bundles) used to lower the risk of HAIs for compliance and improvements in clinical outcomes. (2)

GOAL 6: REDUCE THE RISK OF PATIENT HARM RESULTING FROM FALLS

Falls are a common cause of injury in hospitals, affecting both inpatients and outpatients. The patient, the circumstance, and/or the environment all influence the risk of falls. Patients may be at risk for falling, using drugs, drinking alcohol, having balance or gait issues, having visual impairments, having changed mental status, and other things. Patients who had previously been

deemed to have a low risk of falling may now suddenly have a high risk. Surgery, anaesthesia, rapid changes in the patient's state, and medication adjustments are only a few of the causes. Throughout their hospital stay, many patients need to be reevaluated. (2)

Patients who are thought to be at high risk for falls are identified using fall risk criteria. These standards, together with any interventions used, are noted in the patient's medical file since they support the patient's classification as a fall risk. It is the hospital's duty to determine which patients in its patient population may be at a high risk for falling. (2)

Standard IPSG.6

The hospital creates and puts into practice a procedure to lessen the possibility of patient damage from falls for the inpatient population. (2)

Measurable Elements:

i. Establishes a methodology for determining the fall risk of every inpatient and applies tools and techniques of evaluation that are suitable for the patients being treated. (2)

ii. Establishes a procedure for reevaluating inpatients who, as a result of a change in their health, may now be at risk of falling or who, based on the documented evaluation, already are. (2)

iii. For those identified inpatients, situations, and locations within the hospital considered to be at risk, measures and/or interventions to reduce fall risk are undertaken. There are records of patient interventions. (2)

Standard IPSG.6.1

For the outpatient population, the hospital designs and implements a method to lower the risk of patient damage brought on by falls. (2)

Measurable Elements:

i. use screening instruments or techniques that are suitable for the individuals being served and implements a strategy for identifying outpatients who may be at risk for falls due to their disease, diagnosis, circumstance, or location. (2)

ii. The screening process and interventions are documented. Measures and/or treatments are implemented to lower fall risk for outpatients who are recognized as being at risk after the screening procedure identifies them as being at risk. (2)

iii. Measures and/or interventions to lower the risk of falls are put into place in areas and settings in the outpatient department(s) that are thought to be at risk. (2)

6. OBJECTIVE

To assess the level of compliance of International Patient Safety Goals (IPSG) as per Joint Commission International Accreditation Standard (JCIA) in a tertiary care hospital.

SPECIFIC OBJECTIVE

i. To study compliance to correct patient identification.

ii. To assess compliance to effective communication within hospital.

iii. To study compliance to safety of high alert medications.

iv. To study compliance to ensure patients safe surgery.

v. To study compliance towards reducing risk of Health care associated infections.

vi. To assess compliance of patients and other vulnerable patients towards prevention of falls.

7. METHODOLOGY

Study area:

Super Specialty Tertiary Care Hospital

Study design:

Descriptive and Cross-sectional study

Study period:

3 months

Sample size: 2287 Patients

Sample size calculation is done as per the Slovin's formula $n=N/(1+Ne^2)$, where n= number of samples, N= Screening population(Average monthly footfall/average IP(inpatient) days) and e=error tolerance (margin of error 0.05), source-NABH 5th Edition.

Sample size for the following IPSGs:

- IPSG 1- $30000/(1+30000x0.05^2) = 395$ (N= average monthly footfall)
- IPSG 2- $13000/(1+ 13000x\ 0.05^2)= 388$ N= average IP(Inpatients) days
- IPSG 3- $13000/(1+ 13000x\ 0.05^2) = 388$ (N= average IP days)
- IPSG 4- $2000/(1+ 2000x\ 0.05^2)= 333$ N= average procedures (OT and outside OT)
- IPSG 5- $13000/(1+ 13000x\ 0.05^2)= 388$ (N= average IP days)
- IPSG 6- $30000/1+ 30000x0.05^2)= 395$ (N= average monthly footfall)

Study tool:

IPSG audit tools checklist from hospital (Combination of 6 checklists)

Scoring pattern for checklist:

- Compliance to the requirements(C) – 10
- Partial compliance to requirements (PC) – 5
- Non-compliance to requirements (NC) – 0

No standard can have more than one zero

The average for a standard must exceed 5

The overall average score must exceed 7

Sampling technique:

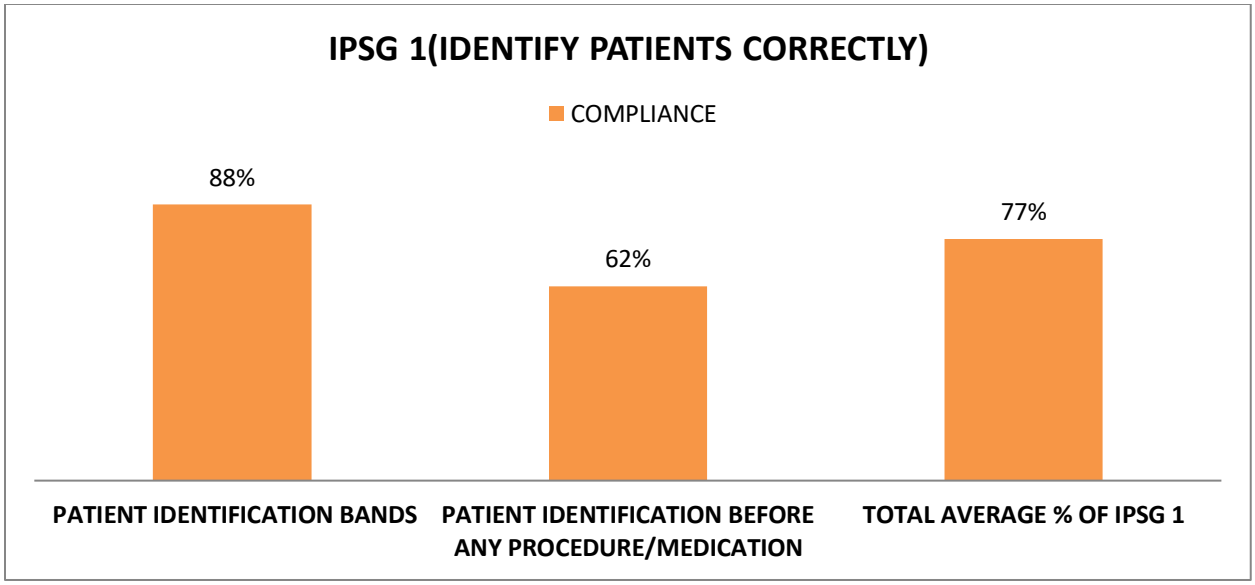
Simple random sampling technique was used

8. RESULTS

IPSG 1: IDENTIFY PATIENTS CORRECTLY

IPSG 1 (IDENTIFY PATIENTS CORRECTLY)						
	DEPARTMENT	SAMPLE SIZE	COMPLIANCE	NON COMPLIANCE	COMPLIANCE % (C)	NON COMPLIANCE %
PATIENT IDENTIFICATION BAND	EMERGENCY	9	9	0	100%	0%
	ENDOSCOPY	6	6	0	100%	0%
	DIALYSIS	9	0	9	0%	100%
	ICU's	61	61	0	100%	0%
	3rd Floor(Gen. surgery,Gen. Medicine,Surgical & Neuro HDU)	44	44	0	100%	0%
	4th Floor(MBU,PICU,NICU, Gyne & Obs)	19	19	0	100%	0%
	5th Floor(Oncology,Nephrology)	32	32	0	100%	0%
	6th Floor(Gastro & liver ICU & HDU,BMT)	17	17	0	100%	0%
PATIENT IDENTIFICATION BEFORE ANY PROCEDURE/MEDICATION	ICU's	63	46	17	73%	27%
	3rd Floor(Gen. surgery,Gen. Medicine,Surgical & Neuro HDU)	37	20	17	54%	46%
	4th Floor(MBU,PICU,NICU, Gyne & Obs)	23	11	12	65%	35%
	5th Floor(Oncology,Nephrology)	31	16	15	52%	48%
	6th Floor(Gastro & liver ICU & HDU,BMT)	34	17	17	50%	50%
	7th Floor(Plastic & cosmetic surgery)	10	8	2	80%	20%
OVERALL AVERAGE OF IPSG 1		**395**	**306**	**89**	**77%**	**23%**

2.1: checklist for compliance to IPSG 1



2.2: Graph for compliance to IPSG 1

Following are the parameters with which they were audited for compliance with goal:

- Are color coded ID bands used for patient identification?
- Are the patients always identified before a course of action (before administering medications, before distributing diet-specific food, before performing a treatment, etc.)?

In areas including the Emergency, Dialysis, Endoscopy, and IPD wards, patient observations were conducted. According to the data gathered, 77 percent of IPSG 1 was found to be compliance, with 23 percent not.

By dividing the overall compliance score by the total sample size and multiplying the result by 100, the total average percentage of IPSG 1 is determined.

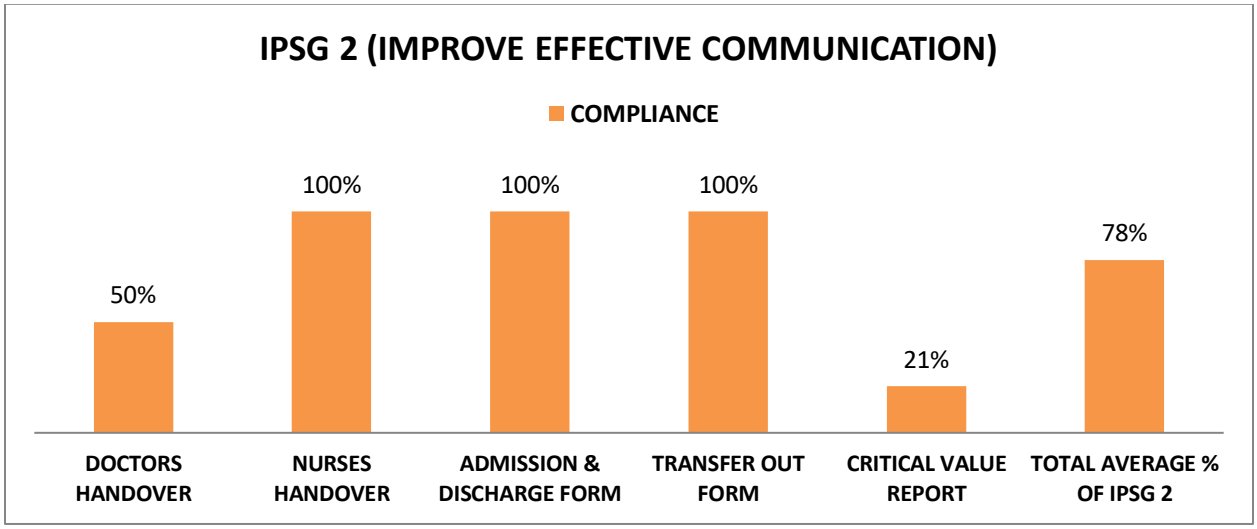
That is,

(306/395)*100= 77.4%

IPSG 2: IMPROVE EFFECTIVE COMMUNICATION

IPSG 2 (IMPROVE EFFECTIVE COMMUNICATION)					
	SAMPLE SIZE	COMPLIANCE	NON COMPLIANCE	COMPLIANCE %	NON COMPLIANCE %
DOCTORS HANDOVER	24	12	12	50%	50%
NURSES HANDOVER	91	91	0	100%	0%
ADMISSION & DISCHARGE FORM	91	91	0	100%	0%
TRANSFER OUT FORM	91	91	0	100%	0%
CRITICAL VALUE REPORT	91	19	72	21%	79%
TOTAL	**388**	**304**	**84**	**78%**	**22%**

2.3: Checklist for compliance to IPSG 2



2.4: Graph for compliance to IPSG 2

Following are the parameters with which they were audited for compliance with goal:

- Is the physician's handover register consistently updated?
- Are nurses in addition to the head nurse responsible for filling up and maintaining the nurse's handover register?
- Does the patient's file have the admissions and discharge criteria form attached, completed, and signed?
- Does the receiving and giving over employees complete and sign the transfer out form?
- Reporting of important findings from timely, well-documented diagnostic testing

The information was gathered by reviewing the patient's file and then using a hospital audit checklist. According to the data gathered, 78 percent of IPSG 2 was compliance , with 22 percent not.

By dividing the overall compliance score by the total sample size and multiplying the result by 100, the total average percentage of IPSG 1 is determined.

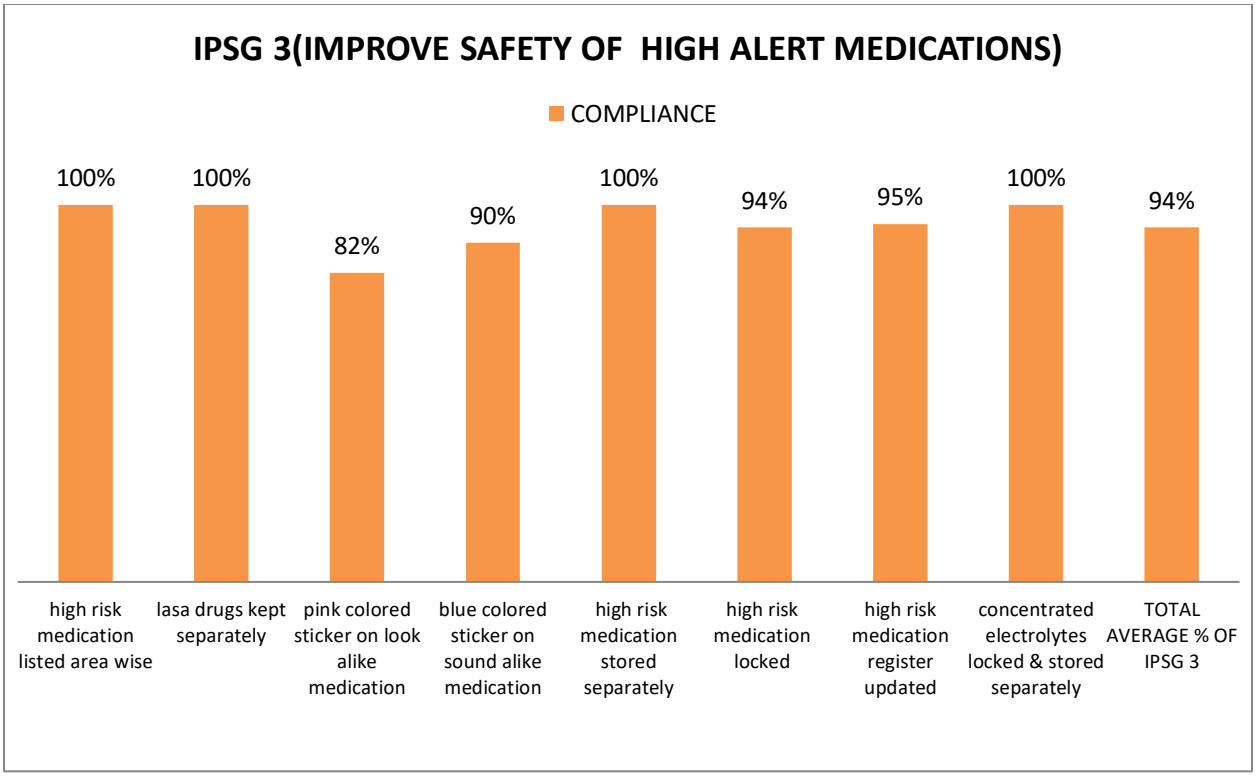
That is,

(304/388)*100= 78%

IPSG 3: IMPROVE THE SAFETY OF HIGH ALERT MEDICATIONS

IPSG 3 (IMPROVE THE SAFETY OF HIGH ALERT MEDICATION)					
ACTIVITY/OBSERVATION	**SAMPLE SIZE**	**COMPLIANCE**	**NON COMPLIANCE**	**COMPLAINCE %**	**NON-COMPLAINCE %**
HIGH RISK MEDICATION LISTED AREA WISE	26	26	0	100%	0%
LASA DRUGS KEPT SEPARATELY	26	26	0	100%	0%
PINK COLORED STICKER ON LOOK ALIKE MEDICATION	62	51	11	82%	18%
BLUE COLORED STICKER ON SOUND ALIKE MEDICATION	62	56	6	90%	10%
HIGH RISK MEDICATION STORED SEPARATELY	26	26	0	100%	0%
HIGH RISK MEDICATION LOCKED	62	58	4	94%	6%
HIGH RISK MEDICATION REGISTER UPDATED	62	59	3	95%	5%
CONCENTRATED ELECTROLYTES STORED IN OT, ICU & EMERGENCY	62	62	0	100%	0%
TOTAL	**388**	**364**	**24**	**94%**	**6%**

2.5: Checklist for compliance to IPSG 3



2.6: Graph for compliance to IPSG 3

The criteria that were used to check for goal compliance are as follows:

- Is the High risk medication listed area wise?
- Are the LASA drugs stored separately?
- Pink color sticker labeled on look-alike medication?
- Blue color sticker labeled on sound-alike medication?
- Are the High risk medications stored separately?
- High risk medications are kept locked?
- Is the High risk medication register updated on daily basis?
- Concentrated electrolytes are stored separately and locked?

Data for IPSG 3 was gathered by observation and a review of high alert medication records. 94 percent of the data obtained indicated compliance with IPSG 3; the remaining 6 percent indicated non-compliance.

Total average percentage of IPSG 3 is calculated by dividing the total compliance score by the total number of sample size and multiplies the fraction by 100.

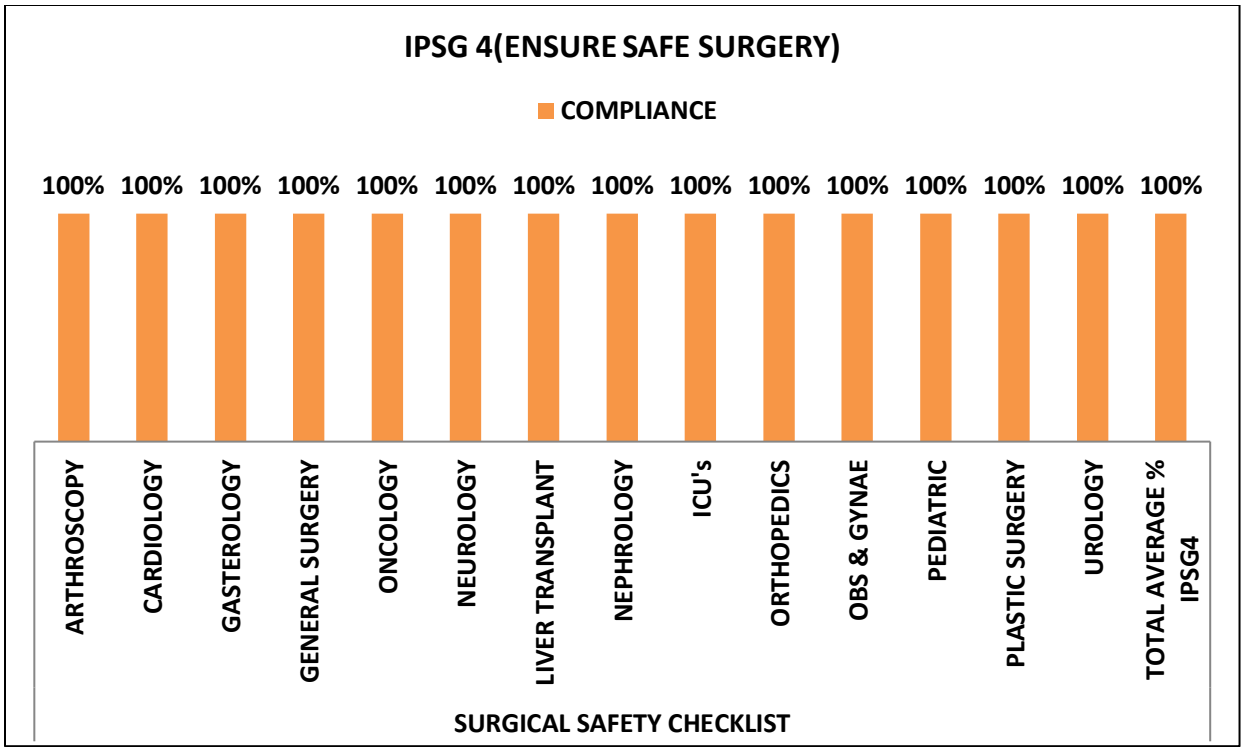
That is,

(364/388)*100= 93.8%

IPSG 4 (ENSURE SAFE SURGERY)

IPSG 4- ENSURE SAFE SURGERY						
	DEPARTMENT	SAMPLE SIZE	COMPLIANCE	NON COMPLIANCE	COMPLIANCE %	NON COMPLIANCE %
SURGICAL SAFETY CHECKLIST	ARTHROSCOPY	16	16	0	100%	0%
	CARDIOLOGY	16	16	0	100%	0%
	GASTEROLOGY	12	12		100%	0%
	GENERAL SURGERY	6	6	0	100%	0%
	ONCOLOGY	18	18	0	100%	0%
	NEUROLOGY	120	120	0	100%	0%
	LIVER TRANSPLANT	2	2	0	100%	0%
	NEPHROLOGY	1	1	0	100%	0%
	ICU's	27	27	0	100%	0%
	ORTHOPEDICS	71	71	0	100%	0%
	OBS & GYNAE	22	22	0	100%	0%
	PEDIATRIC	5	5	0	100%	0%
	PLASTIC SURGERY	2	2	0	100%	0%
	UROLOGY	15	15	0	100%	0%
	TOTAL	**333**	**333**	**0**	**100%**	**0%**

2.7: Checklist for compliance to IPSG 4



2.8: Graph for compliance to IPSG 4

Examining patient records served as the method for collecting IPSG 4 data (of those patients whose surgery was done). According to the data gathered, IPSG 4 was fully complied with.

Total average percentage of IPSG 4 is calculated by dividing the total compliance score by the total number of sample size and multiplies the fraction by 100.

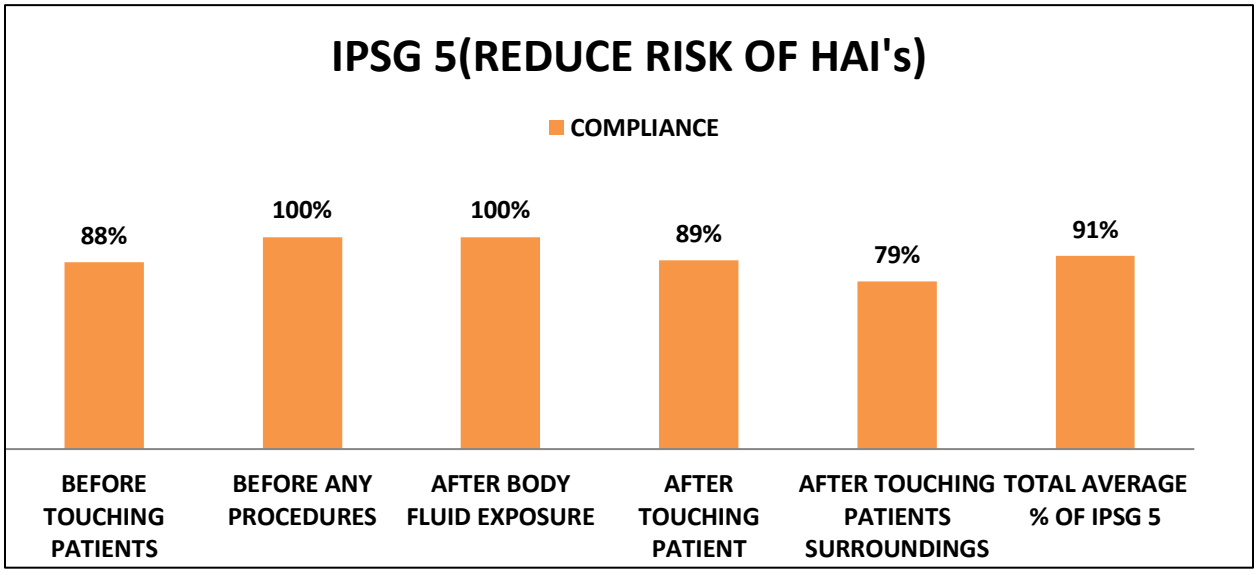
That is,

(333/333)*100= 100%

IPSG 5: REDUCING THE RISK OF HEALTH CARE ASSOCIATED INFECTIONS

IPSG 5(REDUCE THE RISK OF HEALTH CARE ASSOCIATED INFECTIONS)					
	SAMPLE SIZE	COMPLIANCE	NON COMPLIANCE	COMPLIANCE %	NON COMPLIANCE %
BEFORE TOUCHING PATIENTS	78	69	9	88%	12%
BEFORE ANY PROCEDURES	77	77	0	100%	0%
AFTER BODY FLUID EXPOSURE	77	77	0	100%	0%
AFTER TOUCHING PATIENT	79	70	9	89%	11%
AFTER TOUCHING PATIENTS SURROUNDINGS	77	61	16	79%	21%
TOTAL	**388**	**354**	**34**	**91%**	**9%**

2.9: Checklist for compliance to IPSG 5



2.1.0: Graph for compliance to IPSG 5

Direct observation in the hospital served as the basis for the data gathering. 91 percent of the data collected indicated compliance with IPSG 5; the remaining 9 percent indicated non-compliance.

Total average percentage of IPSG 5 is calculated by dividing the total compliance score by the total number of sample size and multiplies the fraction by 100.

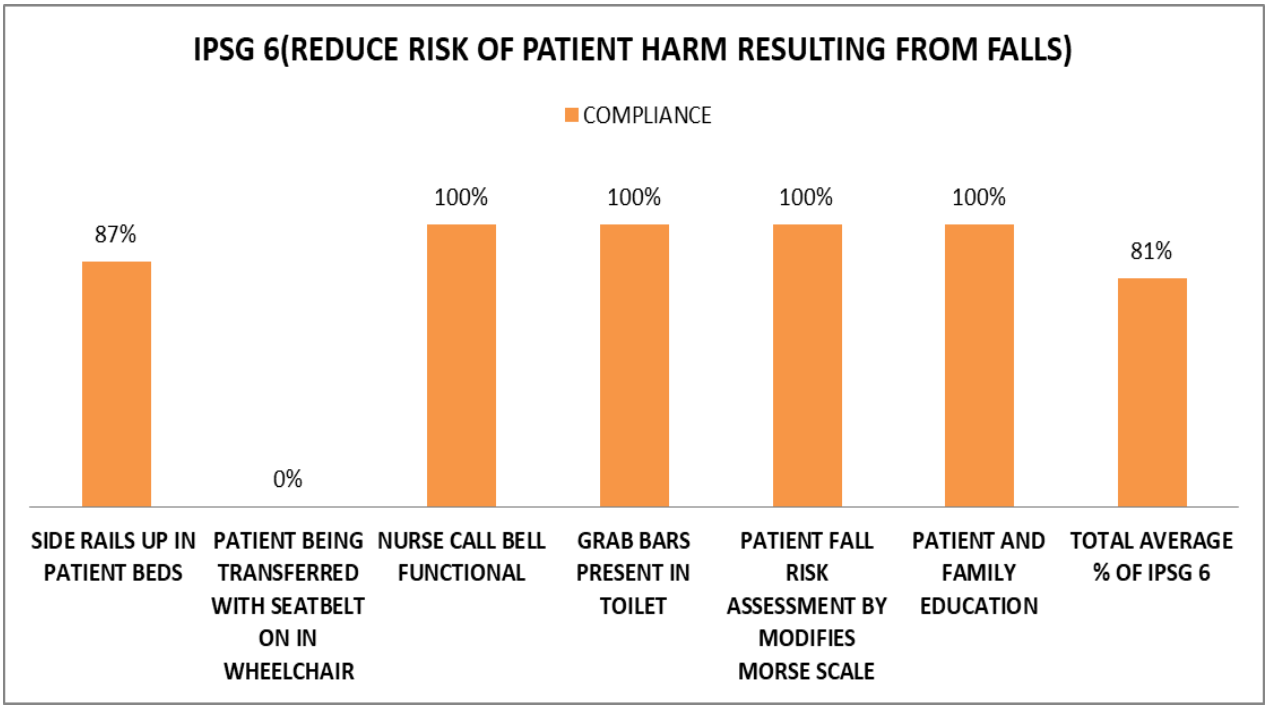
That is,

(354/388)*100= 91%

IPSG 6: REDUCE THE RISK OF PATIENT HARM RESULTING FROM FALLS

IPSG 6-REDUCE THE RISK OF PATIENT HARM RESULTING FROM FALLS					
	SAMPLE SIZE	COMPLIANCE	NON COMPLIANCE	COMPLIANCE %	NON COMPLIANCE %
SIDE RAILS UP IN PATIENT BEDS	69	60	9	87%	13%
PATIENT BEING TRANSFERRED WITH SEATBELT ON IN WHEELCHAIR	66	0	66	0%	100%
NURSE CALL BELL FUNCTIONAL	65	65	0	100%	0%
GRAB BARS PRESENT IN TOILET	65	65	0	100%	0%
PATIENT FALL RISK ASSESSMENT BY MODIFIES MORSE SCALE	65	65	0	100%	0%
PATIENT AND FAMILY EDUCATION	65	65	0	100%	0%
TOTAL	**395**	**320**	**75**	**81%**	**19%**

2.1.1: Checklist for compliance to IPSG 6



2.1.2: Graph for compliance to IPSG 6

Direct observation and a review of the patient's file were used to get the data. According to the data collection, 81 percent of IPSG 6 was compliance by 19 percent of non-compliance.

Total average percentage of IPSG 6 is calculated by dividing the total compliance score by the total number of sample size and multiplies the fraction by 100.

That is,

(320/395)*100= 81%

9. DISCUSSION

IPSG 1

In areas including the Emergency, Dialysis, Endoscopy, and IPD wards, patient observations were conducted. According to the data collected, 77 percent of facilities complied with IPSG 1, with 23 percent failing to do so due to the use of bed numbers as identifiers prior to a course of action (such as administering medications, serving diet-specific food, performing procedures, etc.) and failing to use color-coded ID bands with basic patient information, respectively.

IPSG 2

Based on the data gathered, the compliance to IPSG 2 was 78 percent, with 22 percent non-compliance due to doctors in departments like general surgery, cardiology, obstetrics & gynecology, neurology, orthopedics, surgical oncology, nephrology, urology, ENT, BMT, gastro & liver HDU not filling out the doctor handover register to the tune of 50 percent. In 22% of critical value report situations, the action done was not documented, and the time it was taken was not mentioned.

IPSG 3

According to the data gathered, 94 percent of IPSG 3 was found to be compliance. Out of which 100% compliance was observed where concentrated electrolytes were locked and stored separately and where high risk medications and LASA pharmaceuticals were listed by area and stored separately. On look-alike medications, there were no pink color-coded sticker, sound-alike medications lacked blue color-coded stickers and the high risk medication record was not updated in 6% of cases.

IPSG 4

According to the data gathered, IPSG 4 was fully complied with.

The sign-in, sign-out, and time-out process using a Surgical Safety Checklist was the criteria used to audit for IPSG 4. The documenting of the Surgical Safety Checklist, which comprises Sign in (before induction of anesthesia), time out (before skin incision), and Sign out, is the sole component of this aim that was examined for compliance (Before patients leave operating room).

IPSG 5

According to the data collected, 91 percent of IPSG 5 was adhered to. The nine percent non-compliance was brought about by failing to follow the five-moment hand hygiene routine and the required hand hygiene measures.

IPSG 6

Based on the data collection, the compliance to IPSG 6 was 81% while the lowest compliance of 19% is seen where wheelchair patients being transferred without seat belt on and side rails of patient's bed were not up.

To be considered in good compliance, the aggregate average score must be higher than 70%. As a result, it was determined that all of the IPSG goals were being met.

LIMITATIONS OF THE STUDY

- Because there was no access to the operating rooms, the findings for target 4 were solely reliant on the Surgical Safety Checklist, which includes an oral confirmation by the surgical team that the fundamental stages had been followed. The surgical safety checklist has three sections: Sign in, Time out, and Sign out.
- Limited time span of the study.

RECOMMENDATION

- For each employee's ongoing improvement in terms of the quality parameters, there are regular training and update sessions.
- Staff members need to be made aware of the fall danger created by wheelchair strap belt violations.
- The respected staff should be taught appropriately and documentation audits should be conducted on a regular basis.
- Staff members need to be made aware of hospital acquired infections and the value of five moments of hand hygiene.

10. CONCLUSION

Although the compliance revealed by the statistics might be considered to be good, hospitals must constantly work to make improvements. The cause of staff members' non-compliance with the goals was identified to be either a lack of expertise or an excessive workload that makes implementation difficult, or occasionally a mix of the two. Doctors and other medical professionals have noted that their lack of compliance is a result of insufficient training sessions, whereas nurses often attended training sessions but did not recognize or put them into practice. In addition, it was discovered that certain Employees lacked the foundational knowledge and motivation to learn and practice the same things that interventional actions must be performed for.

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