NARCHI BULLETIN

LHMC, Issue 3, September 2023

Prioritizing patient safety and satisfaction in Obstetrics and Gynaecology practice

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NARCHI DELHI

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LHMC, Issue 3, September 2023

Contents

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Dr Pikee Saxena, Dr Vidhi Chaudhry and Dr Aishwarya Kapur on behalf of National Association for Reproductive & Child Health of India, Delhi Branch.

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Lady Hardinge Medical College & Associated Hospitals, New Delhi -110001

From The President's Pen

Dear NARCHI Members

Greetings!

We are in the second year of our term. Team NARCHI Delhi, with the support of its members, has been actively promoting the importance and need for providing quality care to our mothers and newborns. Quality care is one that is safe, effective, timely, evidence based, efficient, equitable and client centric. It is the right of every mother and newborn. The care experience of mothers and their family in facilities determines their future health seeking behavior. The resource crunch has often been implicated for poor quality care but is vital to understand that there are many other gaps in the processes of providing care which are in our hands and do not require additional resources. These relate to clinical practices that are not evidence based like irrational use of antibiotics, patient safety in terms of errors in medication, handovers, adverse events, and lack of providing respectful maternity care. Team NARCHI has been conducting workshops on respectful maternity care across Delhi in various districts in collaboration with the Directorate of Family Welfare Government of NCT of Delhi. These have been well received and appreciated. This bulletin is a step further to promote the concept of quality care. It is dedicated to prioritizing patient safety and satisfaction in Obstetrics and Gynecology practice. The topics have been selected meticulously by the Editorial team led by Dr Pikee Saxena. I am very thankful to the Quality champions of NARCHI for contributing articles to this bulletin. Do spare your valuable time to read and relate to the topics and reflect on the practices requiring improvement at your facility.

NARCHICON 2023 the Annual conference of NARCHI Delhi is planned for November 25th and 26th with a post conference workshop on 27th November. The theme of the conference is Sharing Knowledge Refining Skills. The post conference workshop is a Video workshop basically aimed for honing up the skills of practicing gynecologists, obstetricians, and residents with an opportunity to discuss their doubts one to one. On behalf of Team NARCHI Delhi, I cordially invite you all to this conference. I promise you value for your time.

In the last I also take this opportunity to invite NARCHI Delhi members to volunteer to participate in PMSMA which is conducted on 9th of every month at public facilities for high-risk pregnancies between 9 am to 1 pm. You need to invest only 2 hours every month for conducting ANC for high-risk pregnancies and contribute towards reduction in maternal mortality and morbidity. Feel free to share your names with me or Dr Sharda Patra or Dr Swati Agrawal. We will connect you with an ANC point near your home or workplace as per your convenience.

Best wishes

Dr Manju Puri

President
NARCHI (Delhi)

From The Secretary's Desk

Dr Sharda Patra
Secretary

Dr Swati Aggarwal
Joint Secretary

Dr Kanika Chopra
Joint Secretary

"Continuous improvement is better than delayed perfection."
-Mark Twain

Greeting from the secretariat of NARCHI-Delhi Branch!

The season of festivities is around the corner and so is the most awaited 29th annual conference of NARCHI-Delhi (NARCHICON 2023) which is planned for November 25th and 26th with a post conference workshop on 27th November. The theme of the conference is Sharing Knowledge Refining Skills. It will be a skill based conference where the emphasis will be on strengthening the clinical and surgical skills of the delegates through video lectures and interactive case based panel discussions. We are sure that the scientific proceedings of this academic extravaganza will enrich the audience and will be especially useful in the day to day clinical practice. We request you all to kindly block your dates for this event.

The theme of this issue of NARCHI bulletin is "Prioritizing patient safety and satisfaction in Obstetrics & Gynaecology practice." World Patient Safety Day 2023 is celebrated every year on 17 September to spread awareness around the world about patient safety. Quality of care is crucial for patient safety. The topics of the current issue have been meticulously selected and are sure to provide food for thought to inculcate the concept of Point of care Quality Improvement (POCQI) among the readers. Let us all practice the philosophy of continuous improvement and get a little bit better every single day.

Once again, on behalf of the entire organizing team of NARCHICON 2023, we invite you to the iconic campus of Lady Hardinge Medical College from 25th to 27th November 2023, for an unforgettable academic as well as social experience. Please visit the website www.narchicon2023.com for availing early bird discounts on registration and submit your abstracts for paper and poster presentations.

Au revoir!

From The Editorial Board

Dr Pikee Saxena
Editor

Dr Vidhi Chaudhary
Co-Editor

Dr Aishwarya Kapur
Co-Editor

Editorial Team

Dear Esteemed Readers,

Our mission with this current bulletin has been clear: to advocate for and promote the highest standards of patient safety and satisfaction in obstetrics and gynaecology practice. We are deeply committed to facilitating a platform for knowledge sharing, best practices, and innovative strategies that benefit both healthcare providers and the women they serve.

Over the years, we have been privileged to collaborate with some of the foremost experts in the field, whose research and insights have shed light on critical issues and emerging trends. Your feedback, questions, and contributions have added layers of depth to our content, enriching the discourse surrounding patient safety and satisfaction in obstetrics and gynaecology.

Patient safety in Obstetrics and gynaecology touch the very heart of human life. They encompass the profound experiences of childbirth, reproductive health, and the intimate moments of patient-doctor interactions. This bulletin is carefully curated to incorporate various articles focussing on prioritising patient safety by learned faculty and researchers in this field.

We believe that by equipping healthcare professionals with the most up-to-date knowledge and insights, we can collectively work towards creating safer, more satisfying experiences for patients in obstetrics and gynaecology practice.

We invite you to continue your active involvement in our bulletin. Your ideas, suggestions, and personal experiences are invaluable. The field of obstetrics and gynaecology is dynamic, and we are committed to evolving alongside it, guided by the principles of patient-centered care and safety.

This bulletin will give insights on how to improve healthcare experiences for women, ensuring that they receive the highest standard of care and support during their journey to motherhood and beyond.

With warm regards,

The Editorial Team "Prioritizing Patient Safety and Satisfaction in Obstetrics and Gynaecology Practice"

Editorial team

To Err is human: Ensuring a safer health care system

Manju Puri
Director Professor, Department of Obstetrics & Gynecology, Lady Hardinge Medical College, New Delhi

Introduction

Globally, medical errors or unsafe care in hospitals is a serious public health problem and a leading cause of death. These are widespread and pose a serious threat to patient safety. Of all patients receiving care in hospitals, on average approximately one in 10 patients in high income countries and 1 in 4 patients in low- and middle-income countries are subjected to an adverse event. Overall, unsafe, and poor-quality care accounts for 60% of deaths in low and middle-income countries from conditions amenable to health care. According to a Harvard study, 5.2 million medical errors occur in India annually. This is just the tip of the iceberg as medical errors often are not reported and are kept undercover due to fear of punishment, disciplinary action, and loss of job. It is a challenge to increase the reporting of medical errors to understand the causes and find solutions to prevent their recurrence. The way forward to improve patient safety is to recognize and report untoward events, learn from them, and work towards preventing them.

These errors not only affect the patients and their families adversely but also have a profound negative impact on the healthcare providers in the form of guilt, anger, inadequacy, tarnishing of their reputation, depression, suicide, quitting or loss of the job and stress of inquiries and litigations.

The patient and their families are the first victim of the trauma related to medical errors, the healthcare providers involved in the care process the second victim and the whistle blower or the others who speak up for patient safety and the risk managers are the third victim of any adverse event. It is important to understand that blaming, shaming and punishing does not address the cause or prevent its recurrence. Most errors are due to system failure rather than individuals. Systemic failure of protocols and suboptimal internal checks and balances often lead to errors in the practice of medicine. The involved individuals are mere players in and are often the victims of the same system. These events should be used as an opportunity to improve the health care delivery system by constructive changes and improved education. It is important to remove the culture of blame while retaining accountability.

Types of Medical Errors

There is no clear definition of medical error**.** Medical error has been defined as an unintended act either of omission or commission or one that does not achieve its intended outcome. It is one that is preventable with the current state of medical knowledge. Errors of omission occur due to actions not taken like not scrubbing properly prior to surgery, not pulling up the rails of a bed for a patient with eclampsia to prevent a fall. Errors of commission are a result of wrong action taken like prescribing or administering a wrong medication, operating on the wrong patient or wrong site, wrong labelling of specimen etc.

Medical error can result from an error of execution, an error of planning, or a deviation from the process of care that may or may not cause harm to the patient. The nomenclature of errors is growing to use the term event that is adverse event or near miss event rather than error and preventable errors or events so that the scale of potential for improvement can be highlighted.

Common medical errors include errors related to surgical procedures, general diagnosis, diagnosis of serious problems like cardiac problems, pulmonary embolism, neurological conditions and cancers, medication, device and equipment, iatrogenic infections, falls, information technology, communication, written orders or prescription, patient hand offs and acute interventions.

Reasons for medical errors

Communication related errors:

Errors related to communication can be in verbal orders, written orders, and patient hand offs. Verbal communication errors are mostly related to disruptive behavior, environmental noise issues, cultural differences, hierarchal issues, language barriers, personality differences, multiple conversations occurring simultaneously, lack of team work etc. Written errors are related to poor handwriting, use of non-standard abbreviations, failure to label specimens or samples correctly. Errors related to handoffs include passing wrong or incomplete information by the outgoing teams to incoming team or failure of the incoming team to follow up the pending issues.

Surgical errors:

Most of the surgical errors occur before or after the surgery. This is due to multiple factors like lack of adequate training and education of surgeon, lack of standard operating procedures, communication gap between the surgeon and anesthetist and ancillary staff and between surgeon and the patient. Rush to complete surgical procedures and inadequate postoperative monitoring and response.

General diagnostic errors:

Inaccurate diagnosis by clinicians, radiologists, and pathologists may occur. The most common diagnostic errors that occur in primary care settings include failure to order appropriate tests, faulty interpretation, failure to follow-up, and failure to refer. Delay in treatment after the diagnosis is a common error and results in increased costs for treatment. These errors are most common with diagnosis of cardiac disease, pulmonary thromboembolism, and cancers.

Medication errors:

These errors are caused by faulty dispensing, wrong dose, incorrect storage, use of expired medicines, overriding safety guards for using medications.

Device and equipment errors:

Flaws in the design, mishandling, user-error, and malfunction are common causes of medical errors. User errors are often due to differences in function between devices from different manufacturers, inadequate training and testing, lack of standardization, poor design and poor maintenance.

Iatrogenic infections:

Healthcare-related infections are considered a failure of the system. Nosocomial infections are a common problem in hospitalized patients. Preventing them requires adherence to infection control protocols. The common causes include failure to practice basic hand hygiene and poor technique in placing indwelling urinary catheters, and intravenous or arterial lines.

Falls:

Falls are a common problem and can be due to intrinsic or extrinsic factors. Intrinsic factors include vision, gait, and health history and are not typically modifiable. Extrinsic factors include environmental hazards and medications. These may be modifiable and preventable.

Common preventable extrinsic factors for fall include hypovolemia due to blood or fluid loss, side effects of medications, post-anesthesia effects such as diminished lower-body sensation, hypoglycemia, altered mental status, etc.

Computer order entry errors:

Computerized order entry helps clinicians, pharmacists, and nurses distributing medications to reduce adverse drug events. Errors are known to occur when orders are entered manually when the health care provider is distracted or is in a hurry.

Errors during acute lifesaving interventions:

In conditions like collapse or arrest, intubation, or other acute, life-threatening events, there is a high-risk situation for medical error. Due to the rapidity of decision making and the instant need for life-saving drugs and procedures, there is a significant risk of error.

Making Healthcare system safer for patients and providers:

Most errors are due to system failure rather than individuals. WHO has come up with a Global Patient Safety Action Plan 2021–2030 that strives to eliminate avoidable harm in health care with the vision of "a world in which no one is harmed in health care, and every patient receives safe and respectful care, every time, everywhere". The goal is to achieve the maximum possible reduction in avoidable harm due to unsafe health care globally.

It has seven guiding principles engage patients and families as partners in safe care, achieve results through collaborative working, analyze and share data to generate learning, translate evidence into actionable and measurable improvement, base policies, and action on the nature of the care setting, use both scientific expertise and patient experience to improve safety and instill a safety culture in the design and delivery of health care.

There are seven strategic objectives (SOs) of the Global Patient Safety Action Plan 2021–2030 that are as follows.

SO1: Make zero avoidable harm to patients a state of mind and a rule of engagement in the planning and delivery of health care everywhere.

SO2: Build high-reliability health systems and health organizations that protect patients daily from harm.

SO3: Assure the safety of every clinical process.

SO4: Engage and empower patients and families to help and support the journey to safer health care.

SO5: Inspire, educate, skill and protect every health worker to contribute to the design and delivery of safe care systems.

SO6: Ensure a constant flow of information and

knowledge to drive mitigation of risk, a reduction in levels of avoidable harm and improvements in the safety of care.

SO7: Develop and sustain multisectoral and multinational synergy, partnership, and solidarity to improve patient safety and quality of care.

These objectives can be achieved through various measures like improvement in communication, training, standard protocols, infection control, technology, safety culture, workforce wellbeing, medication safety, patient engagement, patient advocacy, continuous improvement, regulations, and research.

Communication:

Enhanced communication among healthcare teams can prevent errors. Encourage open dialogue and effective handovers. Use of communication tools like check back, SBAR (Situation, background, assessment, and recommendation) and I PASS (Illness severity, Patient summary, Action lists, Situational awareness, and contingency planning, and Synthesis by the receiver) improve communication.

Training:

Comprehensive training of healthcare professionals with emphasis on safety protocols and error prevention. Adopting the practice of using checklists of things that must be done like surgical checklists and safe childbirth checklists are effective tools to minimize errors. SOPs for preoperative preparation and postoperative care must be strictly followed. Team training using high or low fidelity simulation and development of standardized carts for acute response teams (reduce device and medication errors)

Standard operating procedures and protocols:

This is an effective method for preventing errors as it removes the element of subjectivity and makes processes and treatment clear and objective. There is uniformity in the care provided by different healthcare providers. This also helps with audits and quality improvement.

Infection prevention:

Strict enforcement of infection prevention and control practices must be ensured to prevent healthcare associated infections. This can effectively reduce adverse events related to these.

Technology:

Use of technology in the form of electronic health records can minimize errors related to writing, handoffs etc. Use of advanced technology like use of infusion pumps etc. can reduce medication errors.

Safety culture:

This is important to foster a culture of safety to encourage the healthcare providers to report errors without the fear of being shamed, blamed, and penalized. This is important to do a root cause analysis and institute interventions to prevent recurrence of preventable errors.

Workforce wellbeing:

Addressing healthcare providers burnout and mental health is important to improve their efficiency and prevention of errors due to overwork. They must be adequately rested physically and supported mentally when involved in any error.

Medication safety:

Use of barcode scanning and medication reconciliation processes to prevent medication errors are useful interventions.

Patient engagement:

Involving the patients in their care decisions and providing them full information on the treatment, risks, complications, and alternatives is an effective intervention. Patients must be encouraged to ask questions. Patient feedback is yet another powerful source for identifying gaps in care to prevent errors.

Patient advocacy:

Patient advocacy groups must be supported and encouraged to raise awareness and influence changes in policy regarding the safety of patients.

Continuous improvement:

Regular monitoring and assessment of safety practices and collection of data on identified key performance indicators can help identify areas that need attention. Rapid quality improvement cycles can be initiated by quality teams to plug the gaps. Patient satisfaction scores and monthly review of trends of key indicators are useful for sustenance.

Regulations:

The regulations as regards patient and healthcare provider safety must be dynamic with regular updating and effective enforcement.

Research:

Government and corporates must invest in research to identify emerging safety risks and find innovative solutions.

Conclusion

Human error is inevitable. We cannot eliminate it however we can increase its visibility and design safer

systems to reduce its frequency and related adverse consequences. A multi-tier approach including making health system conducive for health care providers to report errors so that their effects can be intercepted, have standard operating procedures for response that needs to be triggered with each reported medical error, make errors less frequent by following principles that take human limitations into account and share data nationally and internationally like any other innovation or research for the benefit of others.

A courteous and respectful workplace with good interpersonal relationships and teamwork provides a safe work environment both to the providers and the patients. Regular trainings and retraining using high or low fidelity simulation, use of checklists, switch from a culture of blame and shame to focus on understanding and implementing changes in processes and policy to improve the system, training in quality improvement methodology and appropriate use of technology can go a long way in making healthcare facilities safe.

Suggested Reading

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Minimising Medication Errors for Patient Safety

Pikee Saxena[1], Raksha Soni[2]

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[2]Consultant gynaecologist at Maharaja Agrasen sat Narain Gupta hospital, Bahadurgarh

Medication errors are a serious public health problem and a leading cause of injury and death globally[1]. These errors affect all medical specialities and patient populations. As per 2019 World Health Organization (WHO) Patient Safety Factsheet, adverse events due to unsafe patient care are among the top ten causes of death and disability worldwide[2].

Epidemiology

Estimating the prevalence of medication errors is difficult due to the varying definitions and classification systems employed. Each year, in the United States alone, 7,000 to 9,000 people die as a result of a medication error[3]. In a study conducted by Rothschild JM et al medication errors accounted for 28% of medical errors in general wards and 78% in ICU[4].

In India, medication errors are mainly due to irrational use of medications. In a recent study, the incidence of adverse drug events was found to be as high as 82/1,000 prescriptions in Delhi, with national figures reported up to 5.2 million medical errors annually[5].

Definitions

1. Medication error:

The United States National Coordinating Council for Medication Error Reporting and Prevention defines **a medication error** as: "any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient or consumer[6]."

2. Adverse drug events (ADE):

An adverse drug event is an injury (increased morbidity and mortality) from a medication or missed or inappropriately dosed medication[3].Adverse drug events can be further classified based on preventability of the event[7].

- A preventable ADE is an injury caused by a medication that is caused by an error in the medication use, for example anaphylactic reaction to an antibiotic to which patient was known to be allergic.
- A non preventable ADE also called adverse drug reaction is an injury caused by medication and is not the result of error. Example: patient develops diarrhea when given amoxicillin for an infection.
- A potential ADE or near miss is a medication error that has the potential to cause harm but does not, either because it is intercepted or as a matter of luck.

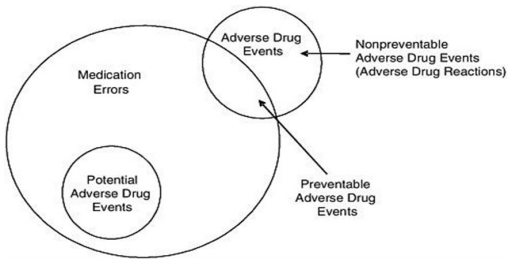


Fig.1: Relationship between medication errors and adverse drug events[8].

Types of Medication Error

Medication error can be classified in many ways. Some classifications are discussed below-

1. Based on the stage at which error occurs - from manufacturing, prescribing, dispensing, and administering of medicine to monitoring of patient.[9]

Table 1

Medicine-reconciliation stage	Prescribing Stage	Verification or dispensing Stage	Administration Stage	Monitoring Stage
Medicine – reconciliation error on administration or discharge.	• Dose error • Route error • Frequency error • Strength error • Formulation error • Substitution error • Premedication not ordered • Course length or duration • Policy not followed • Failure to recognize drug-drug interaction • Inappropriate drug • Generic –name or brand name error • Medication prescribed: patient had documented allergy • Unnecessary drug • Avoidable delay of treatment • Failure to recognize contraindication	Substitution error Avoidable delay of treatment	Preparation error Administration error Avoidable delay of treatment	Monitoring error Inadequate follow-up

2. Based on extent and outcome of errors[10].

Table 2

CATEGORIES	DESCRIPTION
A	No ME occurred but had the capacity for one to occur
B	ME but did not reach the receiving end, the patient
C	ME that reached the patient but unlikely to cause any harm, omission errors
D	ME that reached patient which needed extra monitoring
E	ME that cause temporary/reversible harm
F	ME that caused harm which needed hospitalization
G	ME that results in permanent harm
H	ME that required life-saving interventions
I	MEs that results in death

Causes of Medication Error

1. Human related factors:

Table 3

DOCTOR/ SPECIALIST	NURSE	PHARMACIST
• Lack of knowledge • Poor handwriting • Use of abbreviations for drugs and dose units • Overworked • Casual attitude Avoiding known allergen or drug contraindication • Stress/Illness • Distractions (mobiles, crowd etc)	• Lack of knowledge of dose calculation, drug interactions & tubing connections • Guess work to overcome physician's illegible handwriting. • Taking verbal orders from physician • Poor documentation of patient's medication • Poor labelling of oral drugs , iv drugs or iv sets in use • Poor drug management or storage • Poor adherence to prescription or protocols • Overworked • Distractions	• Lack of pharmaceutical knowledge to judge drug –drug interaction, drug contraindications, and drug safe dosage etc • Giving improper directions to patients • Guess work to overcome physician's illegible writing. • Improper storage of drugs • Giving high risk medication without proper prescription • Distractions

2. System related factors:

Table 4

• Lack of staff, poor management or leadership • Lack of funds or resources • Time pressure • Lack of protocols and supervision • Unclear error reporting processes • Inefficient software or staff for keeping record of medication & patients.	• Poor lighting , temperature control & ventilation • Poor crowd management in OPDs and Wards • Lack of training and education programs • Lack of communication between health professionals

3. Look-alike or sound-alike (LA/SA) drugs

When different medications have names that look or sound alike, and/or have similar packaging, they may be confused, leading to medication errors called look-alike, sound-alike (LASA) errors .LASA errors can occur at any point on the treatment pathway during prescribing, dispensing or administration of medicines leading to overdosing or under-dosing. Prevalence of LASA errors range from 0.00003 to 0.0022% of all prescriptions, 7% of near misses, and between 6.2 and 14.7% of all medication error events.[11]

The increasing potential for LASA error is recognized by NABH and requires each accredited organization to identify a list of look-alike or sound alike drugs.

Table 5A: Sound-Alike Drugs

Avanza (Mirtazapine)	Avandia (Rosiglitazone)
Diamox (Acetazolamide)	Zimox (Amoxycillin)
Glynase (Glyburide)	Zinase (Serratiopeptidase)
Incidal (cetrizine)	Inderal (Propanolol)

Table 5B: Look-Alike Drugs

Domstal (Domperidone)	Alprax (Alprazolam)
Zyloric (Allopurinol)	Buscopan (Hyoscine)
Lasix (Fursemide)	Avil (Pheniramine)
Veltam (Tamsulosin)	Pantium (Pantoprazole)

Figure 2A: Look-alike ampoules of verapamil HCl and Naloxone HCl injection

Figure 2B: Look-alike ampoules of ephedrine sulphate and adrenaline injection

4. Abbreviations:

Abbreviations are used commonly in prescriptions but they can cause serious injury or death of a patient if interpreted wrongly. For examples see table 7.

5. High Risk Medications

High-alert (or high-hazard) medications are medications that are most likely to cause significant harm to the patient, even when used as intended (Table 6). These drugs fall into as many as 19 categories and improved management of all of them is important. The types of harm most frequently associated with these drugs include hypotension, bleeding, hypoglycemia, delirium, lethargy, over-sedation or even death .[12]

Table 6

• Epinephrine • Vasopressin • Neuromuscular blockers • Opiates, benzodiazepines • Anaesthetic agents like ketamine, fentanyl	• Insulin • Anticoagulants • IV Adrenaline, IV digoxin • IV magnesium sulphate • Potassium phosphate etc

6. At Risk Population

Certain patient population is at higher risk of suffering due to medication error as compared to others-

- Child <16 years or old age >65 years
- Physically challenged
- Patients receiving urgent, life saving care
- Patients undergoing high-risk surgeries
- Patients on multiple medications
- Patients with multiple medication allergies
- Anyone being discharged from the hospital

Prevention of Medication Errors:

1.Electronic Health Records (EHRS)

- Computerized physician order entry (CPOE) avoids spelling error, helps in medication dosing, provides access to patient's laboratory data and provides safety checks like drug-drug interactions, drug allergy list of patient etc.

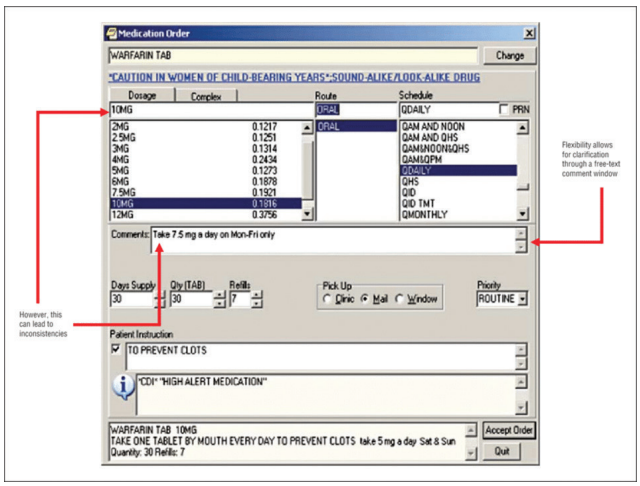


Figure 3: Computerized provider order entry interface showing structured entry and free-text window[13]

- Barcode technology with an electronic medication administration record (eMAR) allows matching of medication orders with drug products, verification of drugs at dispensing and administering stages and checks 5 rights of medication administration: who/what/when/dose/route.
- Use of information technology enables electronic exchange of key clinical information (such as medication lists, medication allergies, and test results) with other providers and pharmacist.
- Electronic OPD prescriptions overcome illegible handwriting and spelling errors as well as ensure prescription completeness and availability of patient's active medications to avoid drug-drug interaction and drug duplication.

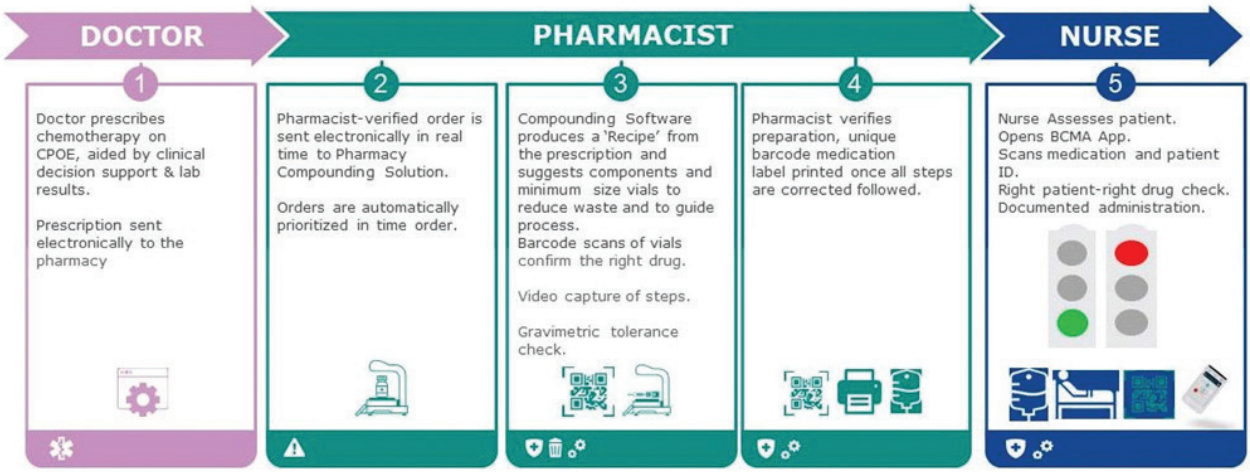


Figure 4: Bedside BCMA (Barcode Medication Administration) scanning by nursing staff to support right patient-right medication verification at the bedside.[14]

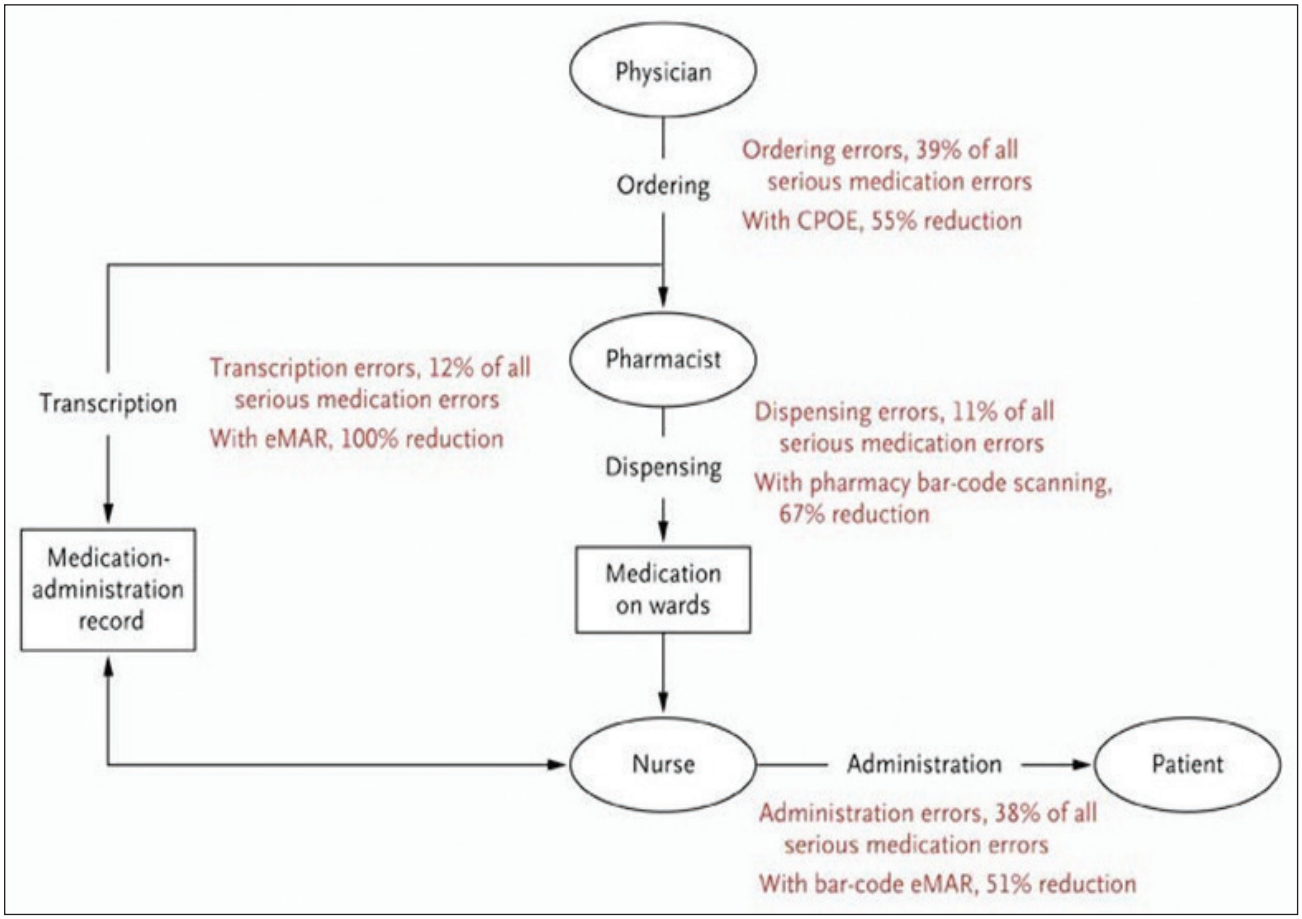


Figure 5: Effect of Health Information Technology at Key Stages in the Process of Medication Use.[15]

2. For hand written OPD prescription/ IPD Medication order:

- Use capital letters for drug names
- Precisely mention drug route , frequency and total treatment duration
- Drug dose should be calculated carefully as per age, weight and if needed LFT/KFT etc.
- The FDA recommends that clinicians review the Institute for Safe Medical Practices' List of Error-Prone Abbreviations, Symbols and Dose Designations as shown in the following tables with few examples

:16

Table 7A: Dangerous abbreviations

Abbreviation	Misinterpretation	Intended Meaning	Correction
µg	Mistaken as "mg"	Microgram	Use "mcg"
cc	Mistaken as "u" (units)	Cubic centimeters	Use "mL"
IU**	Mistaken as IV (intravenous) or 10 (ten)	International unit	Use "units"
HS	Mistaken as bedtime	Half-strength	Use "half-strength" or "bedtime"
hs	Mistaken as half-strength	At bedtime, hours of sleep	Use "half-strength" or "bedtime"
SSRI	Mistaken as selective-serotonin reuptake inhibitor	Sliding scale regular insulin	Spell out "sliding scale (insulin)"

Table 7B: Error-Prone Dose Designations

Dose Designations and Other Information	Intended Meaning	Misinterpretation	Correction
Trailing zero after decimal point (e.g., 1.0 mg)**	1 mg	Mistaken as 10 mg if the decimal point is not seen	Do not use trailing zeros for doses expressed in whole numbers
"Naked" decimal point (e.g., .5 mg)**	0.5 mg	Mistaken as 5 mg if the decimal point is not seen	Use zero before a decimal point when the dose is less than a whole unit
Drug name and dose run together (especially problematic for drug names that end in "l" such as Inderal40 mg; Tegretol300 mg)	Inderal 40 mg, Tegretol 300 mg	Mistaken as Inderal 140 mg, Mistaken as Tegretol 1300 mg	Place adequate space between the drug name, dose, and unit of measure
Large doses without properly placed commas (e.g., 100000 units; 1000000 units)	100,000 units; 1,000,000 units	100000 has been mistaken as 10,000 or 1,000,000; 1000000 has been mistaken as 100,000	Use commas for dosing units at or above 1,000, or use words such as 100 "thousand" or 1 "million" to improve readability

Table 7C: Error-Prone Drug Name Abbreviations

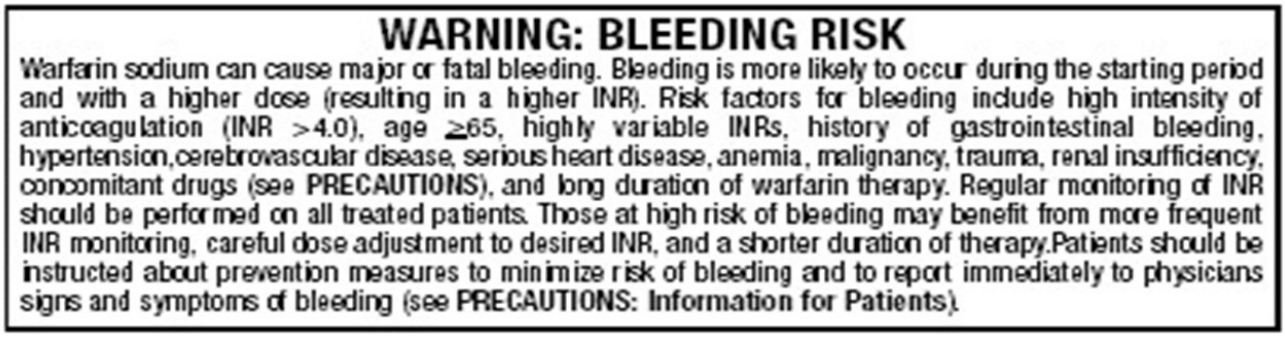
Drug Name Abbreviations	Intended Meaning	Misinterpretation	Correction
To avoid confusion, do not abbreviate drug names when communicating medical information. Examples of drug name abbreviations involved in medication errors include:			
MgSO4	magnesium sulfate	Mistaken as morphine sulfate	Use complete drug name
MS, MSO4	morphine sulfate	Mistaken as magnesium sulfate	Use complete drug name

Table 7D: Error-Prone Stemmed Drug names

Stemmed Drug Names	Intended Meaning	Misinterpretation	Correction
"Nitro" drip	nitroglycerin infusion	Mistaken as sodium nitroprusside infusion	Use complete drug name

Table 7E: Error-Prone Symbols

Symbols	Intended Meaning	Misinterpretation	Correction
> and <	More than and less than	Mistaken as opposite of intended; mistakenly use incorrect symbol; "< 10" mistaken as "40"	Use "more than" or "less than"
@	At	Mistaken as "2"	Use "at"
&	And	Mistaken as "2"	Use "and"



WARNING: BLEEDING RISK

Warfarin sodium can cause major or fatal bleeding. Bleeding is more likely to occur during the starting period and with a higher dose (resulting in a higher INR). Risk factors for bleeding include high intensity of anticoagulation (INR >4.0), age ≥65, highly variable INRs, history of gastrointestinal bleeding, hypertension, cerebrovascular disease, serious heart disease, anemia, malignancy, trauma, renal insufficiency, concomitant drugs (see PRECAUTIONS), and long duration of warfarin therapy. Regular monitoring of INR should be performed on all treated patients. Those at high risk of bleeding may benefit from more frequent INR monitoring, careful dose adjustment to desired INR, and a shorter duration of therapy. Patients should be instructed about prevention measures to minimize risk of bleeding and to report immediately to physicians signs and symptoms of bleeding (see PRECAUTIONS: Information for Patients).

Figure 6: Example of black box warning

3. High-Alert Medications and Black Box Warnings

The FDA's Black Box Warning System consists of a heavy black line surrounding the warning— to alert healthcare providers and patients about safety concerns associated with use of high alert medication like heparin, warfarin, insulin, antidepressants etc. Mandatory Periodic education of nursing staff about high alert medications, their maintenance, storage and benefit of double or triple check of drug label and black box warning while giving these medications.

4. Safety checks for medication administration

- Double /Triple checks before and during drug administration includes patient's details, expiry date of drug, drug dose, drug labels, patients drug allergy history and patient's active drug list.
- Prepare drug in well lighted room and read instructions on drug packaging for preparation.
- Use of smart pump for IV administration of drugs with narrow safety margins like magnesium sulphate and those which require frequent dose adjustment like oxytocin thereby reducing risk of over or under dosing.
- Documentation as soon as drug given.
- Proper labelling of oral /IV drugs in desks to avoid look - alike drug error.
- Store drugs in proper conditions, remove dangerous drugs from floor stock and discard expired drugs.
- Not accepting verbal orders from physician to avoid sound-alike drug error.

5. Positive work atmosphere:

- By abolishing blaming and punishment culture.
- Joint education programs to help providers and support staff learn their respective roles and develop interpersonal relationships.
- Proper communication and working atmosphere.
- Proper management of crowd in OPD and IPD to avoid unnecessary confusion and noise.
- Work should be properly distributed and shifts should be planned for all the staff to avoid undue pressure.

6. Identify and notify every medication error:

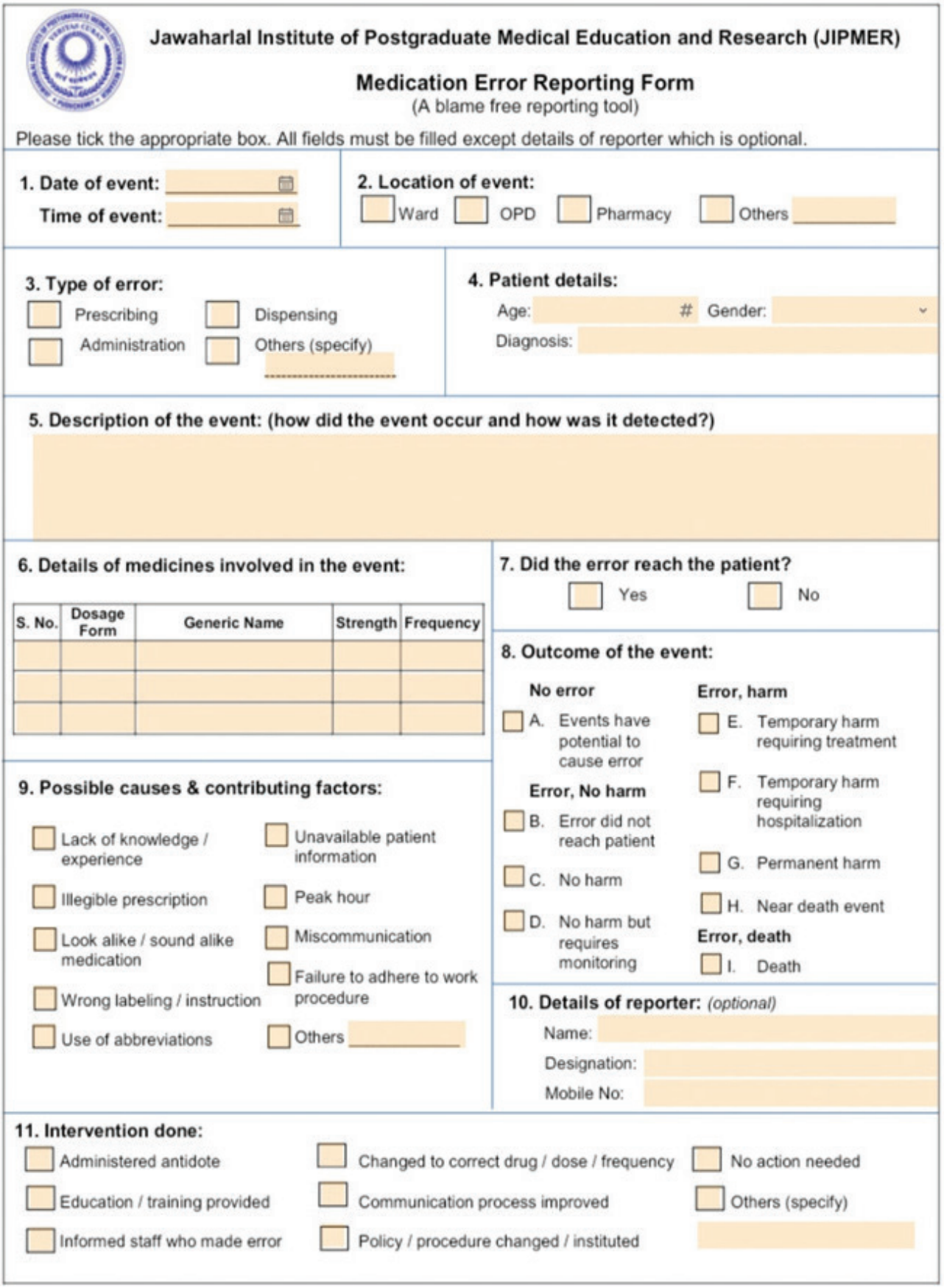
Fear of punishment makes healthcare professionals reluctant to report errors. Governmental, legal and medical institutions must work together to remove culture of blame while retaining accountability. Healthcare professionals should identify and notify every medication error as this will help to evaluate the cause and prevent similar events in future. Figure 7 is an example of medication error reporting form.

7. Encouraging active participation of patient and relatives in treatment plan by giving clear instructions about drugs dose , timing ,duration of treatment and follow up while discharging as well as in OPDs. Educating them about possible side effects of drugs.

Keypoints:

- Medication error is a serious public health hazard.
- Recognition of medication error and its source is important.
- Reporting of medication error decreases likelihood of similar events in future.
- Electronic health records in hospitals will significantly reduce medication errors.
- Periodic training of staff , healthy work culture, eliminating time pressure, well planned work shifts ,properly managed drug stores, clear defined protocols etc all help to reduce medication error.

It is human to make error but it is also human to react and create solution



Jawaharlal Institute of Postgraduate Medical Education and Research (JIPMER)

Medication Error Reporting Form

(A blame free reporting tool)

Please tick the appropriate box. All fields must be filled except details of reporter which is optional.

1. Date of event: _____

Time of event: _____

2. Location of event:

☐ Ward ☐ OPD ☐ Pharmacy ☐ Others _____

3. Type of error:

☐ Prescribing ☐ Dispensing

☐ Administration ☐ Others (specify) _____

4. Patient details:

Age: # Gender:

Diagnosis:

5. Description of the event: (how did the event occur and how was it detected?)

6. Details of medicines involved in the event:

S. No.	Dosage Form	Generic Name	Strength	Frequency

7. Did the error reach the patient?

☐ Yes ☐ No

8. Outcome of the event:

No error

☐ A. Events have potential to cause error

Error, No harm

☐ B. Error did not reach patient

☐ C. No harm

☐ D. No harm but requires monitoring

Error, harm

☐ E. Temporary harm requiring treatment

☐ F. Temporary harm requiring hospitalization

☐ G. Permanent harm

☐ H. Near death event

Error, death

☐ I. Death

9. Possible causes & contributing factors:

☐ Lack of knowledge / experience

☐ Illegible prescription

☐ Look alike / sound alike medication

☐ Wrong labeling / instruction

☐ Use of abbreviations

☐ Unavailable patient information

☐ Peak hour

☐ Miscommunication

☐ Failure to adhere to work procedure

☐ Others _____

10. Details of reporter: *(optional)*

Name:

Designation:

Mobile No:

11. Intervention done:

☐ Administered antidote

☐ Education / training provided

☐ Informed staff who made error

☐ Changed to correct drug / dose / frequency

☐ Communication process improved

☐ Policy / procedure changed / instituted

☐ No action needed

☐ Others (specify)

Figure 7: Medication error reporting form

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Ensuring patient safety-Effective handover

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The clinical handover is highly important part in a patient care and is a basic skill that should be taught to our medical students and junior clinicians. It is defined as "The exchange of information between health care workers about a patient health details to another health care worker who will either accompany or transfer the control or be responsible for, the patient". It is one of the most crucial in a patient management.[1]

A proper handover process ensures that important patient information is accurately and comprehensively communicated between healthcare providers during shift changes or transfers of care.[2] The key strategies to promote effective handovers and enhance patient safety include:

- Standardized Handover Protocols: Establishing standardized protocols or checklists for handovers helps ensure that essential information is consistently shared. These protocols should outline the critical points to be communicated, e.g. patient diagnoses, treatment plans, pending test results, allergies, and any recent changes in the patient's condition.[3]
- Clear Communication: Encourage clear and concise communication during handovers. Providers should use standardized language, avoid jargon, and focus on relevant information. Encourage active listening and allow opportunities for clarification or questions[3,4]
- Structured Handover Format: Adopt a structured format for handovers to ensure that all necessary information is covered. For example, using the Situation, Background, Assessment, and Recommendation (SBAR) framework can provide a systematic approach to handovers.[5]
- Use of Technology: recent technology may be used to enhance handover processes. Electronic health records (EHRs) and computerized provider order entry (CPOE) systems can facilitate accurate and efficient information transfer. Digital platforms can also provide access to real-time updates and alerts for pending tasks or critical results.[6]
- Face-to-Face Handovers: Whenever possible, face-to-face handovers enable direct communication and immediate clarification. This allows for a more comprehensive exchange of information and the opportunity to address any concerns or questions.[7]
- Multidisciplinary Involvement: Ensure that handovers involve all relevant healthcare team members, including nurses, physicians, pharmacists, and other care providers. Each discipline should have an opportunity to contribute and provide updates or insights.[8]
- Education and Training: Provide ongoing education and training for healthcare providers on effective handover practices. This should include communication skills, standardized protocols, and the importance of accurate and timely information exchange.[9]
- Continuous Quality Improvement: Establish mechanisms for feedback and evaluation of handovers. Encourage an open culture where providers can report near misses, errors, or communication breakdowns to identify areas for improvement and implement necessary changes.[3]
- Teamwork and Collaboration: Foster a collaborative and supportive team environment that values effective communication and encourages shared responsibility for patient safety. Encourage team members to actively participate in handovers and voice any concerns or observations.[8]
- Documentation and Audit: Ensure that handover information is appropriately documented in patient records. Regularly audit handover processes to identify areas of improvement and ensure compliance with established protocols.[10]

By implementing these strategies, healthcare organizations can promote effective handovers, reduce the risk of errors or omissions, and ultimately enhance patient safety.

The clinical handover model works best when all involved in patient care are using the same language and **ISBAR** provides a popular model. It can be used for the transfer of relevant, basic information between clinicians and the information details transfer from doctor to doctor; nurse to nurse; doctor to nurse; allied health care worker to doctor; nurse to allied health care worker.

Tips for preparing for ISBAR

There are important elements to consider in the clinical handover process. Handover must include transfer of accountability for patient care, and the confidentiality of patient information must be maintained. **Key tips for preparing for ISBAR are listed in Fig. 2.[11,12] The benefits and challenges of using ISBAR are listed in Fig. 3.[12]** Challenges can include the complexity of patient cases, and ensuring the person receiving the handover has understood correctly. To help overcome challenges, face to face handover is recommended wherever possible, allowing for interaction and clarification of information.[12] Flow of patient information is vital to patient safety, and a balance. between efficiency and comprehensiveness is required.[13] In planning and organising clinical handovers, it is essential to consider:

1. Who should be involved?
2. When should it take place?
3. Where should it take place?
4. How should it occur?
5. What information should be handed over?

Examples of the use of ISBAR in a role play

I - I am Shruti post graduate 2nd year posted in labour room

S - I would like you to come and see Mrs Rama in labour room bed number 5 – Her bag of membranes just ruptured and the colour of liquor is green.

B- Mrs Rama a low risk Primigravida with term pregnancy cephalic presentation was admitted this morning in early labor and reactive admission test

A- At present her BP is 120/70 mm of Hg pulse rate is 84 per minutes she is having regular uterine contractions at three minutes interval lasting for forty seconds, the fetal heart sounds are between 136 to148 on monitor with good beat to beat variations her P/V findings are cervix fully effaced os six cms dilated vertex well applied at -1station pelvis appears adequate for fetus liquor is light green

R- Will you be able to attend her on urgent basis and what would you like me to do in the meantime?

For the effective Handover

- Communicate objectively, appropriately and concisely with other health professionals;
- Understand and use medical/nursing terminology;
- Interpret charts and other documents;
- Write up patient observations;
- Understand clinical procedures.

There are five tips to polish handover technique:

- Be organized. Try to follow an organized sequence when handing over: patient details, presenting complaint, significant history, treatment and plan of care.
- Stay focused. Stay relevant.
- Communicate clearly. Be concise and speak clearly.
- Be patient-centred.
- Allow time.

The four aspects of bedside handover

1. Staff and patient allocation;
2. Updating the handover sheet;
3. Informing patients;
4. Family and Other Visitors

ISBAR
The ISBAR framework onsists of five elements focused on communication, which include:

Introduction
Who you are, your role, where you are and why you are communicating?

Situation
What is happening at the moment?

Background
What are the issues that led up this situation?

Assessment
What do you believe the problem is?

Recommendation
What should be done to correct this situation?

Fig. 1. ISBAR framework

Key tips for preparing for ISBAR

- Preparation is vital, with the reason of the referral being made absolutely clear.
- Having written, prepared questions will assist
- It is important to gather all patient information before handover e.g. charts, ECG, CXR.
- Take notes and record any instructions
- ISBAR works best when both parties are using the same framework.

Fig. 2 Key tips for preparing for ISBAR

Benefits of ISBAR	Challenges of ISBAR

• Handover occurring with complete information, reducing missed information and duplication of information • Reduced length of handover • Focused, brief - but clear - approach to communication in the clinical setting • Provides confidence to both parties, with clear recommendations in a professional manner • Focuses on the problem, not those involved in the communication interaction • Also useful in written documentation	Summarising complex cases can be difficult for junior staff The person making the referral may be asked to repeat information and may not get the help expected The person receiving the referral may interrupt and make assumptions about the capability of person making the referral All required documentation must be updated and completed (eg. discharge summary, referrals)

Fig. 3. Benefits and challenges of using ISBAR

Logistic factors	Sufficient & relevant information	Following handover
• Cross-over of shifts • Dedicated time for handover • Clear leadership identified • Adequate technological support	• Clinically unstable patients clearly identified to senior clinicians • Junior staff briefed adequately, with concerns highlighted • Incomplete tasks identified and explained to the incoming team	• Prioritisation of tasks • Plans for care carried out • Timely review of unstable patients

Fig. 4. Key elements in helping to ensure continuity of patient information and care during and following clinical handover

Conclusion

The clinical handover is the effective transfer of professional responsibility and accountability for some or all aspects of care for a patient/s to another person or professional group on a temporary or permanent basis. Adopting ISBAR protocol is safe simple and systematic and practical for patient care.

There are four aspects to the preparation for bedside handover: 1) Staff and patient allocation; 2) Updating the handover sheet; 3) Informing patients; and 4) Family and Other Visitors.

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Adverse Event Reporting and the 'Just Culture': a primer for providing quality care

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All health care professionals and organizations are striving to improve the quality and safety in women's health care of which adverse event reporting and management is key component. Adverse events due to human and system errors are an inherent part of complex health care work environment and increased attention is being given to not only the effects of medical adverse events on the patients, families and the care givers, but also building systematic ways to manage them.

By encouraging open communication of error in a non-punitive environment, *just culture*[1] holds both institutions and providers accountable for actions and establishes a uniform and fair approach to improving patient care. Accepting that adverse events do occur and establishing a learning, no-blame environment is the main prerequisite for an effective response to them is being increasingly accepted by organizations. This article outlines some principles of adverse event reporting and learning systems in healthcare and Obstetrician–gynecologists are encouraged to practise these in the hospitals and other settings where they work.

Adverse Events [AE]

AEs are defined as treatment outcomes that are below the currently expected medical standard and result in temporary or permanent harm to patients [2]. The incidence of AEs in hospitalized patients ranges from 3 to 17% and up to 50% of these are classifed as preventable [PAE] [2].

Healthcare organizations cannot fully prevent adverse events, but they do have the obligation to investigate and to learn from these events. The methodology is usually based on root-cause-analysis, which describes the event in detail and the analysis about which underlying factors played a causative role by asking, in every step, why this happened. Factors that contribute to adverse events may be categorized as technical, human, organization or patient related.

A systematic approach to adverse event management is a critical part of any safety program and involve following steps-

- Identification, reporting and classifying adverse events
- Event investigation and Analysis
- Suggested Action plan or Solutions- which may be
  - o Organisational
  - o Technical
  - o Individual Caregiver related
  - o Patients related

Event identification and Reporting -

There should be a clear institutional policy about how incidents are defined and recognized and whether reporting voluntary or mandatory. Generally reporting is mandatory for statutory requirements, patient safety-related deaths, severe harm whereas less serious incidents are reported voluntarily. Reporting is to be done according to external agencies [government or professional bodies] as per laws or regulations maternal death review or internally to the hospital authorities perinatal review. It is impotant to have clear concept of how adverse event differ from known complications.

The reporting is usually done in predefined timelines and format a paper reporting form, telephonic hotline, electronic form with or without addition of later documentation. The responsible attending staff specialist and the head nurse are responsible for reporting.

Generally, these formats usually capture the information in three main domains:

- Description (what happened)- include patient characteristics, incident characteristics and location;
- Explanation (why it happened)- include perceived causes of the event, contributing factors and mitigating factors
- Remedial measures (the actions that were taken as a result)- include review of processes, redesign, educational measures and organizational changes.

The WHO Minimal and Advanced Information Model[3] for Patient Safety Incident Reporting and Learning Systems helps to identify the data to be collected for adverse event reporting in both structured information and free text narrative elements and useful in all settings. [Annexure 1]. The format

used for adverse event reporting in Department of Obstetrics and Gynecology of Maulana Azad Medical College, Delhi is shown in [Annexure 2].

Classification

The adverse events can be classified in categories per need of institution.

The patient safety incidents vary in severity of effects and may not always result in adverse event. Classification based on concept of spectrum according severity to is helpful and is as follows-

1. Near miss: an incident that did not reach the patient (for example, a unit of blood being connected to the wrong patient's intravenous line, but the error was detected before the transfusion started);
2. No harm incident: one in which an event reached a patient, but no discernable harm resulted (for example, if the unit of blood was transfused, but was not incompatible);
3. Harmful incident or adverse event: It is an incident that results in harm to a patient (for example, the wrong unit of blood was transfused, and the patient died from a haemolytic reaction). And these are further classified as -preventable or nonpreventable
4. Never Event-These are the defined adverse events which should never occur or have zero tolerance.

The adverse events in patient safety are more commonly classifed for statistical and comparison purposes. The broad classification suggested-

- Maternal,
- Fetal
- Interventional-Medication or Surgical errors
- Communication errors-between staff, with patient
- Organizational

The incidents should be classified as per institutional protocol to gain systemic insights from aggregated incident data which can then also provide a basis for policy decision-making.

Event Investigation and Analysis.

Healthcare organizations cannot fully prevent adverse events, but they do have the obligation to investigate and to learn from these events. The methodology is usually based on root-cause-analysis which is a systematic iterative process whereby the factors that contribute to an incident are identified by reconstructing the sequence of events and repeatedly asking why, until the underlying root causes have been elucidated.[3]

Event investigation and analysis needs to be timely, efficient, comprehensive and should include a systems review analysis. It is generally done in two steps-

Primary review - It is usually done by Response team of 2–5 people, within the first 72 hours of an event, who interview the staff and patient involved, review all records and support the patient, family, and caregivers at the time of the event.

Root cause analysis - It is performed by the investigation team which includes the primary response team, an administrative leader, and support system who determines the appropriateness of standard of care and "root causes" which may be categorized as technical, human, organizational or patient related. Generally within 4-6 weeks of the event, they prepare a report which describes the event in detail and the analysis about which underlying factors played a causative role by asking, why it happened, what normally happens and assign a solution to each cause and a person responsible for implementing solutions .

The team also conducts follow up 6 weeks later to ensure compliance with the solutions, and closes the investigation.

The limitations of root cause analysis include: time required , does not support immediate actions, facts and details about the event may be lost due to delay and limited involvement of the caregivers.

The sole objective of the Event Investigation and Analysis of an adverse event is to learn what happened and improvement mechanisms prevent future adverse events focused on systems-based solutions and not to apportion blame or liability. A systems approach includes an analysis of how the system failed rather than focusing on individual blame.

Action plan or solutions

Human errors are abundant and inevitably repeated when system processes are not corrected.

Actions suggested may be directed to the identified contributory factors–

- Organizational - clinical governance
- Technical-substandard medical care, communication & equipments
- Human or individual
- Patient related

The organizational /clinical governance

Hospital management need to take action on individual events and can also periodically analyse the data independently to find and design the solutions that will prevent future harm .

After individual event analysis and review, feedback is provided to staff . The solutions should focus on the most critical contributing factors of the event, and likelihood of recurrence determined during the root cause analysis.

Aggregated data regularly produce systemic insights. By focusing on system processes and factors that facilitated the event, adjustments can be made to minimize human error, resulting in minimizing the risk of repeat adverse event . The challenge is to formulate effective improvement suggestions, for example, using the SMART criteria[10] (Specific, Measurable, Acceptable, Realistic, in a Time frame) and to assign a responsibility. Continuous organizational learning allows for identification of contributing factors that led to errors, and once contributing factors and unrelated hazards are identified create and implement sustainable and effective solutions which can help the organization improve and prevent similar events in the future

Technical

The investigation teams, should inform the clinical staff about the incident, explain what went wrong, and circulate a description to others to share the learning. Such information-sharing actions should form part of the plan, to systemic measures that will reliably and significantly reduce the risk to patients. The technical experts can formulate actions more training, new guidelines, better communication, standard operating procedures, alerts and focus on how to adopt locally the patient safety practices necessary to prevent harm. It is important to monitor their impact. The fact remains that despite all efforts, cases of wrong-site surgery, look/ sound-alike medicines causing harm and laboratory results not acted upon still continue to occur. Good communication and coordination with responsibility and accountability is key to learning and improvement.

Individual Caregiver

Many health care systems reinforce a focus on individual behaviors designed to prevent mistakes and fail to recognize the impact of faulty systems that lead people to make mistakes. This approaches that focus on punishing individuals instead of changing systems discourage people to report the events. The individual Caregivers should be supported through the event and investigation. At the same time those involved must also hold themselves accountable by recognizing when they are engaging in at-risk behavior and how their behavior might cause unjustifiable harm to patients.

The individual behaviours can be grouped[4] into-

- Human error - inadvertent action, lapse or mistake; inadvertently doing other than what should have been done.
- At-risk behavior – action that increases risk where risk is not recognized or is mistakenly believed to be justified. This type of behavior tends to occur over time in systems where the rate of adverse outcomes is very low.
- Reckless behavior – actions which consciously disregard a substantial and unjustifiable risk, This type of behavior puts patients at significant risk and shows a conscious disregard of unreasonable risk.

The general principle when dealing with these situations is summarized as "console the human error; coach the at risk behavior; and punish the reckless behavior"[4] while ensuring full caregiver support, during the patient safety reporting and learning process.

Patient Support-

All patients whose care has involved an adverse event should receive a full information of what went wrong, why it happened and the action being taken to prevent a recurrence. This strengthens patient physician relationship and promotes trust. [5]

Patients and families who have suffered harm due to adverse event should be provided further treatment for the original condition and consequences of the harm as well as ongoing psychological support free of charge and by a new clinical team if they want. A fair compensation can be considered as per institutional policy.

They should be involved , if they wish to be, in working with the organization in process to make change.

It is important to note that although an investigation team interacts with the patient and/or family, this track of investigation is separated from processes for filing complaints or a legal case. These demands should be professionally and empathetically dealt with, but the investigation part as described above is solely focused on learning from the event, without, denying its severity. Protecting the organization to

ensure that the event analysis is not discoverable during a potential lawsuit is important and this protection should be included in the organization's policy on Event Investigation and Analysis.

Just Culture

'Just culture' is a term coined by safety experts. The acknowledgement that even experienced professionals make mistakes can lead to an reporting system where everyone is encouraged to speak up without fear of punishment. Allowing immediate, anonymous, confidential input from frontline staff and providers supports the creation of just culture. This can result in shared learning from errors and an eventual culture shift that prevents errors from occurring again.

David Marx's Just Culture model refers to a system of "shared accountability" where the accountability of the system and individual are balanced to create an environment that is non-punitive and non-threatening and promotes open reporting of adverse events.

Key component of just culture

- Commitment of organization to shared accountability
- Learning from mistakes vs. blaming individuals
- Managing behavioral choices (human error, at-risk behavior, reckless behavior)
- Designing safety into all clinical systems and processes

A Just Culture supports disclosure and encourages viewing every event as an opportunity to learn how to improve system performance relative to patient safety. This philosophy that, a culture of blame can inhibit adverse event reporting and thus individual and system-wide performance improvement in patient safety, is increasingly being adopted by health care institutions.

Other sources of information of adverse events

The various sources of information, other than adverse event reports, that might provide information indicating that an event has occurred, include:

- Patients: Complaints, HCAHPS scores, letters, claims, consumer reports.
- Providers: Event reporting system, morbidity and mortality forums, HSOPS surveys.
- Internal environment: Electronic health record surveillance, peer reviews, event reviews, employee surveys.
- External environment: FDA device/drug reports, regulatory bodies.

Every obstetric unit should register their severe adverse events from all sources and develop a protocol on how to evaluate and learn from them. A timely, comprehensive, and supportive event reporting system can positively impact an organization's culture of safety.

Summary

- Despite our best intentions to improve health, human and system errors are an inherent part of working in a complex environment like health care and adverse event reporting should be a component of a overall patient safety system.
- Each unit should have a guideline on defining and what to do after an adverse event.
- After events are reported, a system for classifying events, a structured event investigation and analysis using root cause analysis with system approach and accountability is necessary.
- Identification of innovative solutions to prevent adverse events and related risky behaviors or system processes is critical.
- The Event Investigation and Analysis is completed by informing the involved caregivers and the patient/family of the results.
- Full and transparent disclosure to the patient and/or family improves trust and has the potential of reducing long-term liability costs.
- Continuous organizational learning as a result of identification of contributing factors and their solutions helps prevent similar events from happening in the future.
- The review improves the adverse impact of an event for individuals and their strong commitment, willingness to prevent born again.
- A "just culture" where the accountability of the system and individual are balanced to create a non-punitive environment, improves patient safety by encouraging employees to proactively participate in workplace safety efforts.

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Annexure 1

WHO[Minimal Information Model (MIM) for Patient Safety Incidents
http://www.who.int/patientsafety/implementation/information_model/en/]

A.Structured part

1. PATIENT INFORMATION –Age, Sex
2. INCIDENT TIME
3. INCIDENT LOCATION
4. CAUSES
5. CONTRIBUTING FACTORS
6. MITIGATING FACTORS
7. INCIDENT TYPE
8. INCIDENT OUTCOME
9. RESULTING ACTIONS REPORTER'S ROLE

B. Free text part-

Annexure 2

Maulana Azad Medical College and LokNayak Hospital Delhi
Department of Obstetrics and Gynecology

Adverse Event Analysis (Unit IV)

Serial No. _____/Year _____ Date_____

Name_____CR No. _____Phone no_____

DOA_____ DOD_____

Trigger Event:

Maternal- Near Miss/ Avoidable Complication/Readmission within 1 wk/ Return to theatre/ other ____

_____

Neonatal- Intrapartum stillbirth/IUD in booked patient /Avoidable complication/ Other _____

_____

Organizational-wrong gender labeling/theft /others

Brief Summary of Diagnosis:

_____

_____

_____

_____

Situational Analysis:

What Happened-_____

Why :

Work load_____

Staffing_____

Training/skill_____

Non-availability of essential services_____

Other_____

Root Cause Analysis: _____

_____

_____

Action Plan: _____

_____

Brief case summary with sequence of events-

Respectful Maternal Care-Non-negotiable practice

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Overview

1. Introduction
2. Defining RMC
3. Beginning of RMC
4. Evidences of Disrespect and Abuse (D and A)
5. Barriers and factors contributing to D and A
6. Consequences
7. Interventions and Promoting RMC
8. Conclusion

1. Introduction

Indian government has implemented various programs to reduce maternal and infant mortalities and morbidities by promoting institutional delivery for poor pregnant women and ensuring cost-effective skilled health care professionals.[1] And over the last two decades, India has witnessed a steady increase in the rates of institutional births. Interventions like Janani Shishu Suraksha Yojana, have helped in improving institutional births to 88.6% (NFHS-5) in the country.[2] Recent evidence however, suggests that the quality of care for institutional births needs a lot to be desired.[3] There is evidence suggesting that the principles of compassionate and respectful care during childbirth are violated in maternity facilities.[4]

2. Defining Respectful Maternity Care (RMC)

RMC is humane and dignified treatment of childbearing women throughout her pregnancy,birth and period following childbirth. It is the care provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth

3. Beginning of RMC

The discussion of human rights began in earnest with the declaration of human rights in 1948. In 1990 there was the declaration on the Elimination of Violence against Women. From 1990s onwards, there was simultaneous gathering of evidence on violation of women's right in childbirth by Human Rights Commission. In a landmark report about disrespect and abuse (D and A) faced by birthing women in Health Facilities, evidence was gathered from desktop review of the published and Gray literature in addition to individual interviews with nine expert informants and structured group discussion on the topic of D and A in facility-based childbirth. This led to the development of the RMC Charter based on International Human Rights Declarations and Conventions (Table 1), which constitute the universal rights of childbearing women contained in the RMC Charter of 2011 which was updated in 2019.[5]

Table 1. Tackling Disrespect and Abuse: Seven Rights of Childbearing women, 2011

S. No	Categories of disrespectful care	Corresponding Right
1	Physical abuse	Freedom from harm and ill treatment
2	Non-consented care	Right to information, informed consent and refusal, respect for choices and preferences ,including the right to companionship of choice wherever possible
3	Non-confidential care	Confidentiality, privacy
4	Non-dignified care	Dignity and respect
5	Discrimination	Equality freedom from discrimination and equitable care
6	Abandonment or withholding of care	Right to Timely healthcare and to highest attainable level of health
7	Detention in Facilities	Liberty, autonomy, self-determination, and freedom from coercion

Table 2: Universal Rights of Women and Newborn, 2019

1	• Right to freedom from harm and ill treatment.
2	• Right to information and informed consent.
3	• Right to a companion of their choice and preference during maternity care.
4	• Right to privacy and confidentiality.
5	• Right to be treated with dignity and respect.

6	• Right to equality , freedom from discrimination and equitable care
7	• Right to healthcare and highest attainable level of health.
8	Right to liberty, autonomy, self-determination, freedom from arbitary detention, and refusal to informal payments
9	• Right of every child to be with their parents or guardians.
10	• Right to an identity and nationality from birth.
11	• Right to adequate nutrition and clear water.
12	• Right of women and newborn for timely and effectively grievance redressal.

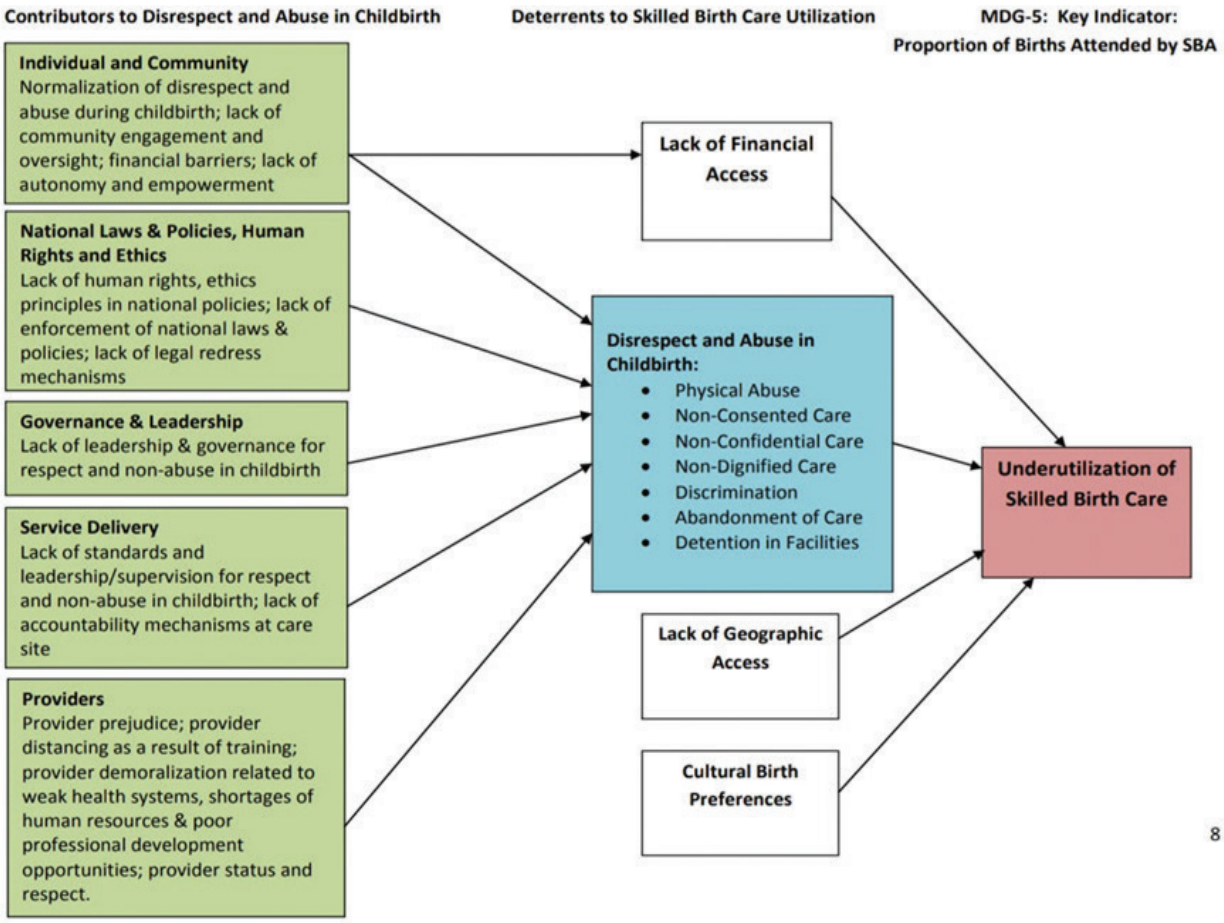
4. Evidences of Disrespect and Abuse (D and A)

In one systematic review of obstetric violence, it has been reported that in India women experience at least one instance of mistreatment during childbirth.[5] In another systematic review, the pooled prevalence of disrespect and abuse during labour was 71.31% in India. Disrespectful treatment threaten women's rights to dignified life and health and deters them from seeking evidence-based institutional care.[6] Many studies highlight the mistreatment of childbearing women during labor, just before and after childbirth by health care providers.[6]

Disrespectful experiences are seen both in low income(LMIC) as well as high income countries(HMIC). In LMICs there is women's dissatisfaction with health facilities due to barriers such as cleanliness, equipment quality or availability, provider competence, or behaviour and in HMIC , bullying, coercion, and non-consented procedures are noticed. There is evidence that indicates that disrespect and abuse especially amongst the care seekers from underprivileged and lower socio-economic status women population is a significant barrier to accessing intrapartum care services.[7-9]

5. Barriers and factors contributing to D and A

The factors which contribute to D and A have been summarised in Figure 1[5] :Figure 1: Drivers of D and A



6. Consequences of D and A

Disrespect and abuse of women during facility-based maternity care has multiplicative effects. First, it can lead to a human rights violation; second, it can prevent women from utilizing maternal health services in health facilities; third, it may also erode satisfaction and trust in the health system and lead to poor pregnancy outcomes[10-12] On the other hand, respectful maternity care can contribute to the timely provision of care, improved patient–provider communication, and increased adherence to treatments and maternal health service utilization, all of which can improve maternal and neonatal effects.[13-15]

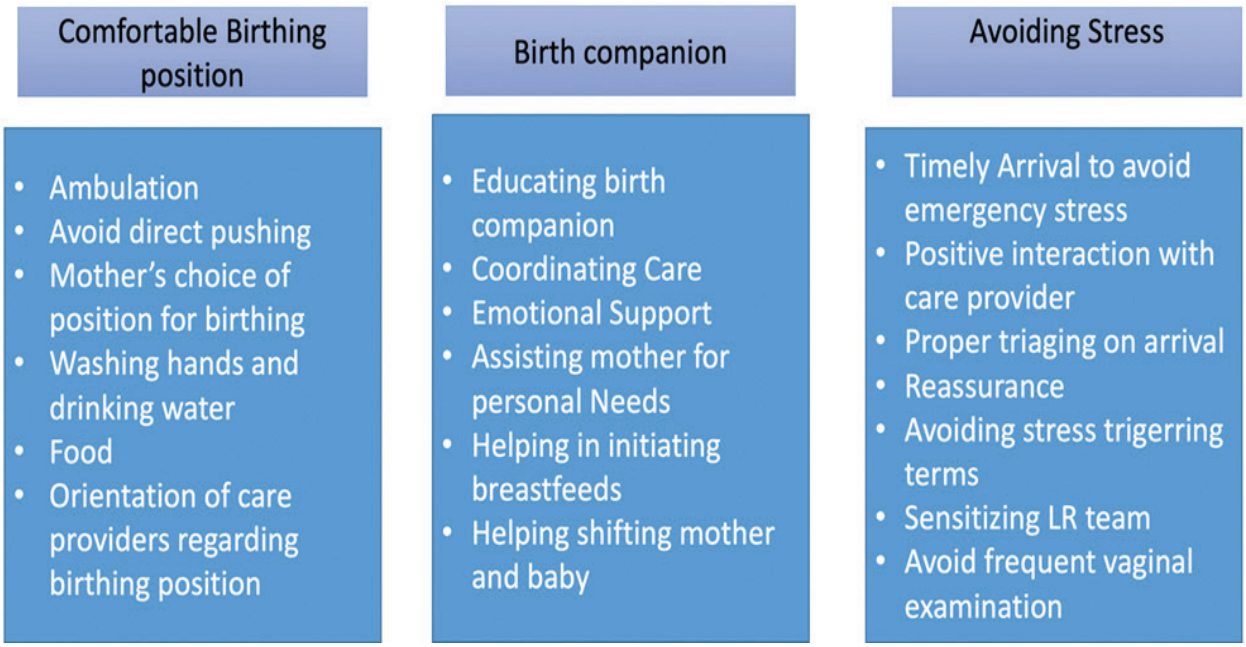
7. Interventions promoting RMC

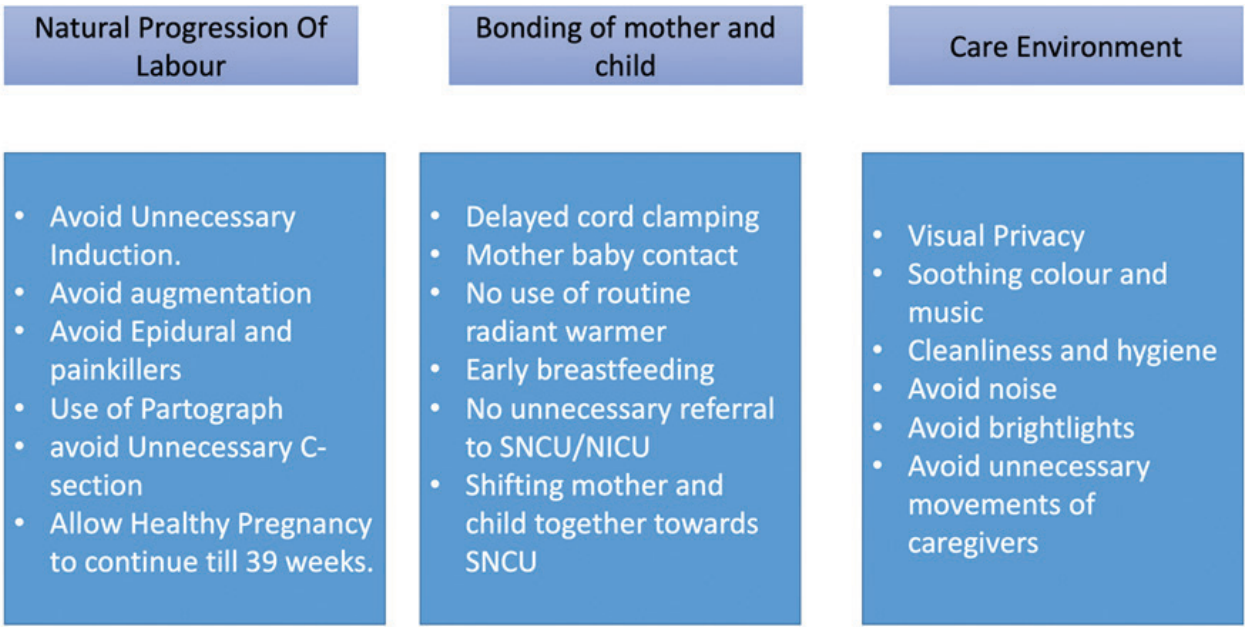
Interventions involving both women and healthcare providers need to be context-specific and women-centred maternity services need to be designed focussing on the key areas. Policies need to be made after careful analysis of the barriers to RMC from both women's and HCW's perspectives so that sustainable policy is in place to provide high-quality maternal health care . Interventions should focus on social class, age, disability, religion, attitudes, beliefs, norms, and infrastructure challenges which contribute to RMC. In India, as the government has promoted institutional births, the focus needs to be providing quality-based care. Many of these provider related factors come under modifiable factors like poor interpersonal communication skills that can be improvised by behaviour change interventions for health workers .Health workers may change their disrespectful behaviour toward women if they are introduced with stress reduction strategies, and capacity-building programs,

7.1 Society recommendations and existing policies

Various organisations have provided framework for implementation of RMC including WHO (2012), NHM, India under the laqshya guidelines (2017), WHO recommendations on Intrapartum care for positive Childbirth experience, 2018, the International Childbirth Initiative, 2019 and the FIGO Medical Ethical Guidelines. These policy statements lay down guidelines for implementation of practices within the facilities.

The key stakeholders in implementation are (Figure 2): Under the Laqshya program the components of RMC have been defined under various categories (Figure 3):





The international childbirth initiative provides clear steps for implementing evidence-based maternity care worldwide, acknowledging the interaction between the Mother-Baby dyad, Family and Environment as well as their interactions with health providers and health systems. The ICI also supports the implementation of the 12 steps and self-initiated quality improvement mechanisms that can be used to monitor the process, effect and engagement in safe and respectful maternity services.

7.2 Interventions for RMC

Various studies have attempted to understand the effect of targeted interventions towards establishing the practice of RMC in various healthcare settings. Some of the interventions which have shown to have a positive impact are[16-23]:

- Training HCPs on communication skills, support during childbirth, providing information and empathy
- Open Birth Days (OBD), a birth preparedness and antenatal care education program for women while they are in third trimester pregnancy
- Establishing quality improvement team and participation in Improvement Collaborative workshops to work towards the improvement of person-centred maternity care through a plan-do-study-act (PDSA)
- RMC and monitoring and evaluation training for HCPs and managers, setting up waiting room, availing resources for ensuring privacy (curtains), essential, drugs written guideline and protocol, recognizing best performing staff and continuous supportive supervision by quality improvement team
- Childbirth companion promotion- a multidimensional educational intervention delivered as interactive workshop for HCPs, banners and posters at labor ward, brochures and video program promoting birth companion
- Posters in labor ward used as on job aids incorporating universal rights of childbearing women developed by White Ribbon Alliances and infographics prepared by WHO
- Integrated simulation-based training for health care providers including midwives, medical doctors, anesthetists, and nurses
- Simultaneous intervention at multiple levels including Community level, facility level and policy interventions

8. Conclusion

A high standard of respectful care during childbirth, is the need of the hour and health systems must be organized and managed in a manner that protects human rights of women and respect their sexual and reproductive health. Globally many governments, professional societies, researchers, international organizations, civil society groups and communities worldwide in spite of having recognised the problem and taken actions, there is no clear defined policies that have been adopted, and if adopted then

the policies are not specific, or have not yet been translated into meaningful action.

Health sectors need to have a structure where process of provision of care and experiences are interlinked. Experience of care includes effective communication with woman and her family, respectful and dignified care and woman has freedom to chose her emotional support at time of delivery[24]

To conclude, respectful maternity care is the right of all pregnant women and is the predictor of health seeking behavior of our future generations. RMC is today a non- negotiable part of Health care. Till date, one of the very important yet overlooked aspect of maternity care is respect, dignity and emotional support using effective communication and serious women centered steps need to be taken. It should be in the DNA of all health systems and can be provided without any additional resources. Policy makers need to concentrate on the deficiencies in knowledge regarding respectful maternity care and rights among both women and healthcare providers seeking and providing maternity care respectively. The role of community advocacy groups, professional association and government in promoting awareness is vital to proactively promote the rights of child-bearing women as outlined in the Respectful Maternity Care Charter. Improving the institutional policies, resources, and capacity building of health care professionals about women's rights during childbirth would help strengthen the quality of care to ensure evidence-based care and positive birth experiences to women.

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Enhancing Patient Safety through Effective Incident Reporting and Response in Obstetrics and Gynaecology (OBG) Practice

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Abstract

Patient safety is paramount in healthcare, particularly in Obstetrics and Gynaecology (OBG) practices. This comprehensive article explores the critical aspects of incident reporting and response, with an emphasis on sentinel events, within the context of OBG practice. We delve into NABH standards, incident types, reporting criteria, response strategies, Corrective and Preventive Actions (CAPA), analysis tools, and the vital role of the Safety Committee. The article underscores the crucial role of patient safety in OBG and concludes with a comprehensive framework for incident reporting and an overview of incident management in this specialized field.

Introduction

In the realm of healthcare, few areas are as emotionally charged and critical as Obstetrics and Gynaecology (OBG) practices. The welfare of both mothers and her newborn is at stake, making patient safety the highest priority. To guide OBG professionals in their mission to provide safe and high-quality care, the National Accreditation Board for Hospitals and Healthcare Providers (NABH) 5th edition standards, specifically Chapter 6 on Patient Safety and Quality Improvement (PSQ), offer invaluable guidance.

This comprehensive article aims to provide an in-depth exploration of incident reporting and response within the context of OBG practice. We will examine the core elements of incident management systems, focusing on identification, reporting, review, and action. Moreover, we will shed light on sentinel events—critical incidents that demand immediate attention and analysis—and emphasize the critical role of the Safety Committee in ensuring patient safety.

Understanding Incidents

An incident in the context of healthcare, is an event or circumstance that deviates from the expected standard of care and has the potential to harm a patient or disrupt normal operations. These incidents can vary in nature, severity, and impact.

NABH 5th edition standards emphasize the significance of Incident management system under PSQ.7. An incident management system comprises of the following key components:

1. Identification: This phase involves recognizing incidents within the organization.
2. Reporting: Once identified, incidents should be promptly reported through a standardized incident report form.
3. Review: Reported incidents are subject to a thorough review process.
4. Action on Incidents: After review, appropriate actions are taken to address the incidents.

This incident management system should be designed to facilitate factual reporting and foster a culture of learning. It should adhere to the principle of "just culture," ensuring fairness in dealing with incidents.

The organization should place great importance on the reporting mechanism, aiming for simplicity (minimal steps), clarity (precise guidelines on what to report, how to report, and to whom), confidentiality, and a strong focus on process improvement. It is essential to note that incidents are captured without initially considering their severity or whether harm was caused.

These critical incidents warrant special attention due to their gravity and impact These incidents span a wide spectrum, ranging from medication errors and falls to surgical complications, communication breakdowns, and near-miss situations.

Types of Incidents

Incidents in healthcare can be categorized into three primary types:

1. **Adverse Events:** These incidents result in harm to the patient, ranging from minor complications to severe harm, including patient deaths.
2. **Near-Miss Events:** Near-miss incidents are events that, while avoided, highlight potential errors or harm and are vital for identifying system vulnerabilities.
3. **Sentinel Events:** Sentinel events are a subset of adverse events with severe consequences, often involving patient death or serious harm, demanding immediate investigation and response.

Sentinel Events

Sentinel events, as defined by NABH, refer to relatively infrequent, unexpected incidents related to system or process deficiencies that lead to one of the following outcomes:

1. **Death:** Sentinel events include incidents resulting in the death of a recipient of healthcare services.
2. **Major and Enduring Loss of Function:** This category encompasses incidents that result in major and enduring loss of sensory, motor, physiological, or psychological function for a recipient of healthcare services. Importantly, this impairment must not have been present at the time services were sought or initiated and should last for a minimum period of two weeks. Additionally, the impairment should not be related to an underlying condition.

Event Type Description of Sentinel Events

Sentinel Event Categories	Specific Events
1. **Surgical Events**	Surgery performed on the wrong body part
	Surgery performed on the wrong patient
	Wrong surgical procedure performed on the wrong patient
	Retained instrument or object in patient discovered after surgery/procedure
	Patient death during or immediately after surgical procedure
	Anaesthesia related event
2. Device Or Product Events	**Patient death or severe disability associated with** the use of contaminated drugs, devices, or any other product supplied by the hospital
	The use and function of a device in a manner other than the device's intended use
	The Failure or breakdown of a device or medical equipment
	Intravascular air embolism
3. **Patient Protection Events**	Discharge of an infant to the wrong person
	Patient death or severe disability associated with elopement from the hospital
	Patient suicide, attempted suicide, or deliberate self-harm resulting in serious disability
	Any incident in which a line designated for oxygen or other came to be delivered to a patient and contains the wrong gas or is contaminated by toxic substances
	Nosocomial infection or disease causing serious disability
4. **Environmental Events**	Patient death or serious disability while being cared for in the hospital associated with:
	• A burn incurred from any source
	• A slip, trip, or fall
	• An electric shock
	• Use of restraint or bedrail
5. **Care Management Event**	Patient death or serious disability associated with a haemolytic reaction due to the administration of ABO-incompatible blood or blood products
	Maternal death or serious disability associated with labour or delivery in a low-risk pregnancy
	Medication error leading to the serious disability of a patient due to incorrect administration of drugs, e.g.:
	• Omission error
	• Dosage error
	• Dose preparation error
	• Wrong time error
	• Wrong rate of administration error
	• Wrong administrative technique error
	• Wrong patient error
	Patient death or serious disability associated with an avoidable delay in treatment or response to abnormal test results
6. **Criminal Events**	Any instance of care ordered by or provided by an individual impersonating a clinical member of the staff
	Abduction of a patient
	Sexual assault on a patient within or on the grounds of the hospital
	Death or significant injury of a patient or staff member resulting from a physical assault or other crime that occurs within or on the grounds of the hospital

These sentinel events in OBG underscore the critical importance of robust incident reporting and response mechanisms in ensuring the safety and well-being of both mothers and infants. Immediate investigation, analysis, and action are essential to prevent the recurrence of such incidents and continually improve the quality of maternal and neonatal care.

Reporting of Incidents

Incident reporting is a cornerstone of patient safety and quality improvement in healthcare. Accurate and comprehensive reporting of incidents is crucial for identifying areas for improvement and preventing future occurrences.

Healthcare professionals encountering incidents should adhere to specific parameters for reporting:

1. **Identification of Incident:** Healthcare staff should be trained to recognize and differentiate incidents, including adverse events, near misses, and sentinel events. Clear criteria should be established to determine what qualifies as an incident.
2. **Timeliness:** Incidents should be reported promptly after their occurrence or discovery, ensuring that no critical details are forgotten or overlooked.
3. **Location and Context:** Reporting should include information about where the incident occurred, the department or unit involved, and the context in which it happened.
4. **Individuals Involved:** The reporting should identify all individuals involved in the incident, including healthcare providers, patients, and witnesses. This information is crucial for understanding the incident's chain of events.
5. **Detailed Description:** A thorough description of the incident is essential. This should include a step-by-step account of what happened, any contributing factors, and the sequence of events leading to the incident.
6. **Date and Time:** Precise information about the date and time of the incident is necessary for tracking and analyzing patterns.
7. **Documentation and Evidence:** Whenever possible, include supporting documentation such as medical records, test results, or photographs. This helps in the accurate assessment of the incident.
8. **Severity Assessment:** Healthcare providers should evaluate the incident's severity using established criteria, which can include harm to the patient, potential for harm, and the impact on the organization.
9. **Root Cause Analysis (RCA) Indicators:** If available, identify any indicators that may suggest a need for a more in-depth RCA. These indicators can help prioritize incidents for further analysis.
10. **Confidentiality and Anonymity:** Encourage a culture of reporting by ensuring that the reporting process is confidential and that reporters can choose to remain anonymous if they wish.

Challenges in Incident Reporting

While incident reporting is essential for patient safety and quality improvement, several challenges can hinder the process. These challenges include:

1. **Fear of Blame:** Healthcare professionals may be hesitant to report incidents due to fear of being blamed or facing disciplinary action. It's crucial to establish a culture of safety that encourages reporting without punitive consequences for honest mistakes.
2. **Underreporting:** Many incidents go unreported, leading to a significant gap in understanding safety risks. Efforts should be made to identify and address underreporting through education and cultural changes.
3. **Lack of Standardization:** Inconsistent reporting formats and processes can make it challenging to collect and analyze data effectively. Standardized reporting formats and procedures should be established to streamline the process.
4. **Incomplete Reporting:** Sometimes, incident reports lack essential details, making it difficult to conduct thorough investigations and implement effective CAPA measures. Training and feedback mechanisms can address this issue.
5. **Documentation Challenges:** Accurate and comprehensive documentation is vital for incident reporting. Inadequate documentation can hinder investigations and hinder the ability to identify root causes.
6. **Cultural Barriers:** An organizational culture that does not prioritize safety and reporting can inhibit incident reporting. Addressing cultural barriers is essential to fostering a reporting culture.

Response to Incidents

Effectively responding to incidents is as crucial as reporting them. **The immediate response to a safety incident should prioritize addressing the urgent care and support needs of those involved. This should not wait for the completion of the analysis.**

The Role of the Safety Committee

In healthcare organizations, the Safety Committee plays a pivotal role in ensuring that incident reporting and response processes are effective. **The Safety Committee's responsibilities include:**

1. **Overseeing Incident Reporting:** The Safety Committee is responsible for ensuring that incident reporting mechanisms are in place, well-communicated, and accessible to all staff members.
2. **Analysis and RCA:** The committee is involved in the review and analysis of incidents, especially sentinel events. They oversee the root cause analysis (RCA) process and ensure that it is thorough and objective.
3. **CAPA Implementation:** The Safety Committee monitors the implementation of Corrective and Preventive Actions (CAPA) resulting from incident analysis. They track progress and verify that actions are taken in a timely manner.
4. **Training and Education:** The committee is responsible for providing education and training to healthcare staff regarding incident reporting, RCA, and CAPA processes.
5. **Communication and Feedback:** They facilitate communication between various departments and stakeholders regarding incidents, their analysis, and actions taken. The Safety Committee also ensures that feedback loops are in place for continuous improvement.

Corrective and Preventive Actions (CAPA)

CAPA is a fundamental aspect of incident management. It involves taking actions based on the findings of incident analysis to prevent the recurrence of similar incidents. The objective is to continually improve the quality of patient care services. Key steps in the CAPA process include:

Root Cause Analysis (RCA): Root cause analysis is a systematic process for identifying the underlying causes of incidents. It seeks to uncover not only what happened but why it happened.

Tools for RCA: Commonly used tools for RCA include the **"5 Whys" technique, fault tree analysis, fishbone diagrams (Ishikawa diagrams), and Pareto analysis.**

Input from Stakeholders: Inputs for CAPA can be sought from the units, disciplines, and departments concerned. Patients and other stakeholders can also provide valuable insights during this phase.

Timely Initiatives: In the case of sentinel events, corrective actions should be initiated within 24 working hours of occurrence or reporting. The analysis of sentinel events should be completed within seven working days.

Documentation: All actions taken as part of the CAPA process should be documented. The findings and recommendations from the analysis should be communicated to all personnel concerned.

Policy and Procedure Updates: Any changes in policies or procedures resulting from incident analysis should be reflected in the organization's documented standards and practices.

Analysis Tools

Effective incident analysis relies on appropriate tools and methodologies. Some commonly used tools include:

Fishbone Diagram (Ishikawa Diagram): This visual tool helps identify potential causes of an incident by categorizing them into branches representing different aspects of the process.

Pareto Analysis: The Pareto principle, often referred to as the 80/20 rule, suggests that a significant proportion of issues result from a small number of causes. Pareto analysis helps prioritize efforts by focusing on the most critical factors.

Root Cause Analysis (RCA): As mentioned earlier, RCA is a systematic approach to identifying the root causes of incidents. It involves asking "why" multiple times to uncover underlying issues.

Fault Tree Analysis: This technique is used to model the various events and conditions that can lead to a specific incident. It helps visualize the relationships between causes and effects.

Failure Mode and Effects Analysis (FMEA): FMEA is a structured approach to assessing the potential failure modes of a system or process and their consequences. It assigns risk priorities to each potential failure mode.

Incident Reporting Format Framework

A standardized incident reporting format is essential to ensure that all necessary information is captured consistently. Here's a framework for an incident reporting format:

1. **Incident Details:**
   - Date and time of the incident
   - Location and department
   - Type of incident (adverse event, near-miss, sentinel event)
   - Description of the incident

2. **Persons Involved:**
   - Names and roles of healthcare professionals
   - Patient information (if applicable)
   - Witnesses (if any)
3. **Severity Assessment:**
   - Harm caused to the patient (if applicable)
   - Potential for harm
   - Impact on the organization
4. **Incident Analysis:**
   - Root cause analysis findings
   - Contributing factors
   - Identified system deficiencies
5. **Corrective and Preventive Actions (CAPA):**
   - Actions taken to address the incident
   - Timelines for implementation
   - Responsible parties
6. **Documentation and Evidence:**
   - Attach supporting documents, such as medical records, images, or test results
7. **Confidentiality and Reporting Party Information:**
   - Option for anonymous reporting
   - Contact information of the reporting party (if disclosed)
8. **Review and Approval:**
   - Signatures and comments of reviewing personnel
   - Approval for CAPA initiatives
   - Incorporating Risks into Risk Management

The organization should incorporate risks identified during incident analysis into the risk management system. If the analysis reveals previously unidentified risks, these should also be subjected to risk management processes.

Communication with Stakeholders

In case of a near miss, adverse event, or sentinel event, the organization should have a process for informing various stakeholders. This includes patients and their families when applicable. Communication should include relevant concerns and information about the initiated corrective and preventive actions.

Conclusion

Patient safety is the cornerstone of healthcare, and this commitment is especially crucial in Obstetrics and Gynaecology (OBG) practices. By adhering to NABH standards, diligently reporting incidents, implementing robust response and Corrective and Preventive Actions (CAPA) mechanisms, and adopting standardized incident reporting formats, OBG professionals can continue their commitment to providing the highest standard of care to women and new-borns. The comprehensive incident management approach outlined in this article serves as a roadmap for improving patient safety, enhancing the quality of care, and ensuring the well-being of OBG patients and their infants. Through the collective efforts of healthcare professionals, organizations, and the Safety Committee, we can achieve safer and more effective OBG practices, ultimately benefiting patients and their families.

Suggested Reading

- National Accreditation Board for Hospitals and Healthcare Providers (NABH) 5th Edition Standards: Read more.
- Institute for Healthcare Improvement (IHI) Root Cause Analysis Toolkit: Access here.
- Joint Commission International - Preventing Infant Abductions: Learn more.
- Vincent, C., Taylor-Adams, S., & Chapman, E. J. (2000). How to investigate and analyze clinical incidents: Clinical Risk Unit and Association of Litigation and Risk Management protocol. BMJ Quality & Safety, 9(3), 160-168.
- World Health Organization (WHO) Patient Safety: Incident Reporting Systems: Explore here.
- Reason, J. (1997). Managing the Risks of Organizational Accidents: View the book.
- National Patient Safety Foundation Root Cause Analysis (RCA) 2: Improving Root Cause Analyses and Actions to Prevent Harm: Access here.

Informed Consent and Shared Decision Making

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Informed consent emerged from the ethical principle of "Respect for Persons". Individuals should be treated as capable of taking decisions for themselves ("autonomy") and those with diminished autonomy should be protected. Before the 20th century, guidelines required physician's need to adhere to acceptable medical standards. Issue of patient's agreement to the research was never discussed. The first evidence of informed consent was found in The Tuskegee Syphilis Study in 1932-72 which formulated the Belmont report. In 1932, the Public Health Service, working with the Tuskegee Institute, began a study to record the natural history of syphilis in hopes of justifying treatment programs for blacks. It was called the "Tuskegee Study of Untreated Syphilis in the Negro male."In truth, they did not receive the proper treatment needed to cure their illness. In exchange for taking part in the study, the men received free medical exams, free meals, and burial insurance. The study initially involved 600 black men – 399 with syphilis, 201 who did not have the disease. The study was conducted without the benefit of patients' informed consent. The men were never given adequate treatment for their disease. Even when penicillin became the drug of choice for syphilis in 1947, researchers did not offer it to the subjects.In Nazi Prisoner Research during World War II came out the Nuremberg Code of 1947.

The expression informed consent has simply been transposed in Italian and roughly translated in an ambiguous fashion into "consenso informato" when, on the contrary, it should be referred to as "informazione per ilconsenso" "information for consensus" not only to respect the concept but, surely, for a more correct deciphering and a more precise interpretation related to the numerous concepts it presupposes and implies. Information and consent may be compared to the two sides of the same coin. The World Medical Association (WMA) has developed the Declaration of Helsinki as a statement of ethical principles for medical research involving human subjects, including research on identifiable human material and data. The Declaration is intended to be read as a whole and each of its constituent paragraphs should not be applied without consideration of all other relevant paragraphs. It is not a legally binding instrument under the international law, but instead draws its authority from the degree to which it has been codified in, or influenced, national or regional legislation and regulations. Its role was described by a Brazilian forum in 2000 in these words "Even though the Declaration of Helsinki is the responsibility of the World Medical Association, the document should be considered the property of all humanity".

Informed Consent

Voluntary acceptance after full understanding, by a competent patient, of a plan of medical care after physician adequately discloses the plan, its risks and benefits, and alternative approaches.

Informed consent is a key concept in the provision of health care which has ethical, legal and practical dimensions. From an ethical perspective, informed consent forms an essential component of the moral right of individuals to autonomy over their own bodies and is based on the principle of free agency. From a legal perspective, informed consent is defined in terms of an agreement or process by which the rights of individuals to agree or to refuse treatment are upheld. In practical terms, informed consent refers to the process by which a health care provider informs a consumer of their treatment options, and associated risks and benefits, and supports them to make a decision about their care.

Basic ethical principle

1. Autonomy (respect for person /participant) -Each individual should be given the respect, time, and opportunity necessary to make his or her own decisions.
2. Beneficence -The obligation of physician to act for the benefit of the patient and, remove conditions that will cause harm, help persons with disabilities, and rescue persons in danger.
3. Non-maleficence -do no harm
4. Justice -interpreted as fair, equitable, and appropriate treatment of persons

***Seven criteria define informed consent*:** (1) competence to understand and to decide, (2) voluntary decision making, (3) disclosure of material information, (4) recommendation of a plan, (5) comprehension of terms (3) and (4), (6) decision in favour of a plan, and (7) authorization of the plan. A person gives informed consent only if all of these criteria are met. If all of the criteria are met except that the person rejects the plan, that person makes an informed refusal.

An Informed consent should be REAL and VALID.

The information disclosed should include:

- The condition/disorder/disease that the patient is having/suffering from
- Necessity for further testing
- Natural course of the condition and possible complications
- Consequences of non-treatment
- Treatment options available
- Potential risks and benefits of treatment options
- Duration and approximate cost of treatment
- Expected outcome
- Follow-up required

Documentation of informed consent

i. Write legibly and logically

ii. Vernacular language

iii. File /Records

iv. Common but not devastating risks

v. Extra considerations specific to this patient

vi. Signed and attested.

vii. Date and Time

viii. Refusal of Medical Treatment

Implied Consent-It is a legal term that refers to the idea that a patient does not have to specifically consent to treatment or care by a healthcare provider. It is when a patient, without any explicit request for consent, implicitly agrees to participate in a medical procedure.

Shared Decision Making

Shared decision making is a key component of patient-centred health care. Shared decision making (SDM) offers a structured process to incorporate evidence as well as patient values and preferences into screening decisions. There are two core elements to SDM: risk communication and values clarification. The choice must be congruent with what matters to the patient—his or her values and preferences are to be incorporated into the decision.

Preferences are inclinations toward or away from an option. Values are the underlying feelings that help determine preferences. They represent concepts relevant to the decision that matter to patients or their family members and include attributes relevant to a decision.

Steps of SDM

A. Identify a clear decision point.

B. Provide information about the clinical problem and options at the decision point.

C. Elicit the patient perspective

D. Guide the patient toward a final decision

E. Assess how comfortable the patient is with his or her decision.

F. The clinician can assess patient comfort with the decision by asking four brief questions, using the SURE screening test:

The SURE test: *A response of yes scores 1 and a response of no scores 0; a score of < 4 is a positive result for the patient to be at risk of clinically significant decisional conflict.*[1]

SURE ACRONYM	TEST
Sure of myself	Do you feel SURE about the best choice for you?
Understand information	Do you know the benefits and risks of each option?
Risk-benefit ratio	Are you clear about which benefits and risks matter most to you?
Encouragement	Do you have enough support and advice to make a choice?

Obtaining consent is not only an ethical obligation, but also a legal compulsion. A good informed consent and shared decision making does not only avoid legal litigations on the part of the medical professionals, it also increases the bond and reciprocal respect between doctor and patient and thus enhances the efficacy and benefits of the entire healthcare system.

Suggested Reading

1. Légaré F, Kearing S, Clay K, Gagnon S, D'Amours D, Rousseau M, et al. Are you SURE? Assessing patient decisional conflict with a 4-item screening test. Can Fam Physician. 2010;56:e308–14.

Antimicrobial Stewardship in Obstetrics and Gynaecology

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Infections have threatened human health since ancient times. Antibiotics have a critical role in improving and promoting health of women. However unscrupulous use of antibiotics has led to antimicrobial resistance (AMR), which has emerged as a blooming public health crisis. It is imperative to handle AMR at war footing as the available antibiotics are becoming ineffective and there are no new antibiotics in the pipeline.

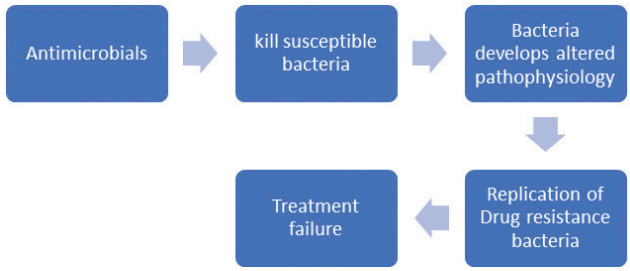
Antimicrobial stewardship is a coherent set of actions which promote the responsible use of antimicrobials. AMS is an integral component of health system and should be established in every health care facility. Today AMS is one of three "pillars" of an integrated approach to health systems strengthening. The other two are infection prevention & control (IPC) and medicine & patient safety. AMS is promoting the selection of the optimal choice, dose, duration and route of the antibiotic which in turn lead to improved patient outcomes. As the ultimate goal of an AMS programme is sustainable behaviour change in physicians' antibiotic prescribing practices, every facility should start quality initiatives on how to plan, perform and assess AMS interventions including feedback on antibiotic use over time.

Core elements for AMS programmes in health-care facility include

1. Leadership commitment
2. Accountability & responsibilities
3. AMS actions
4. Education & training
5. Monitoring & surveillance
6. Reporting & feedback

Antibiotic abuse happens due to common fallacies such as a belief that broad spectrum antibiotics are "safer" and failure to distinguish between bacterial infections nonbacterial infections and non-infectious syndromes. In addition, antibiotics for durations longer than necessary, redundant cover (like double gram negative or double anaerobic cover) or treatment of colonizers or contaminants also constitute inappropriate antibiotic use.

Inappropriate use of antibiotics leads to development of altered mechanism in pathophysiology of microbes as a survival technique. This leads to selective replication of drug resistant bacteria.



AMR has compromised our ability to treat infections. It is demotivating not only for the patients but also for healthcare providers.

Not all conditions in obstetrics, gynaecology require antimicrobials. Common gynaecological conditions which need treatment with antibiotics are pelvic inflammatory disease, bacterial vaginosis, vaginal candidiasis and vaginal trichomoniasis. Serious conditions like surgical site infections (SSI), puerperal sepsis and septic abortion.

Recommendations for antibiotic prophylaxis in surgical procedures

Antibiotics are increasingly being administered to women for whom the drugs are of unproven benefit. Antibiotic for prophylaxis should be chosen on basis of effectiveness against most common pathogen to be encountered rather than against every possible pathogen. There is no evidence to support prolonged use of antibiotics postoperatively in clean or clean-contaminated surgeries for prevention of post-operative infections.

Prophylactic antibiotics should be administered 15 to 60 minutes prior to skin incision. No additional doses are recommended. (I-A) If an open abdominal procedure is lengthy (e.g., > 3 hours), or if the estimated blood loss is > 1500 mL, an additional dose of the prophylactic antibiotic may be given 3 to 4 hours after the initial dose. (III-C). In patients with morbid obesity (BMI > 35 kg/m2) doubling the antibiotic dose may be considered (III-B) (WHO 2021, ACOG 2018).

There is strong evidence that antibiotics given prior to skin incision reduce the risk of post operative endometritis and surgical site infection by approximately 50%. Antibiotic prophylaxis in surgical

procedures is not to sterilize tissues but to reduce colonization by microorganisms introduced during surgery to a level which the patient's immune system can overcome.

First or second-generation cephalosporin's (cefazolin 1 or 2 g single dose intravenously) have emerged as the drugs of choice for the vast majority of operative procedures because of their broad antimicrobial spectrum, better tolerance and low incidence of allergy. They are cheap and effective against commonly encountered organisms. There is evidence that azithromycin may be an alternative or adjunct to first-generation cephalosporins. Clindamycin can be started if patient is allergic to cephalosporins.

Procedure	Antibiotic	Dosage	Level of evidence
Emergency/ Elective Caesarean Section	Cefazolin IV 15–60 min prior to skin incision	1–2 g IV	1A
Operative vaginal delivery	Amoxicillin Clavulanic acid	1g IV 200mg	
Operative vaginal delivery	None recommended		II-1C
Repair of third or fourth degree laceration	Cefotetan Cefoxitin	1 g IV 1 g IV	1-B I-B

Source *- WHO Recommendations on prophylactic antibiotics for patients undergoing caesarean section 2021*

Routine antibiotic prophylaxis is strongly recommended by WHO in 2021 for women undergoing operative vaginal birth. A single dose of intravenous amoxicillin (1 g) and clavulanic acid (200 mg) administered as soon as possible after birth and no more than 6 hours after birth in high income countries. In resource-limited settings providers should consider the use of an appropriate class of antibiotics with similar spectrum of activity, based on local antimicrobial resistance patterns, safety profile (including allergies), the clinician's experience with that class of antibiotics, availability and cost. This recommendation supersedes the previous WHO recommendation on routine antibiotic prophylaxis for women undergoing operative vaginal birth as published in the 2015 guideline WHO recommendations for prevention and treatment of maternal peripartum infections.

Antibiotics are required only in third/fourth degree perineal tear as there are chances of fistula formation. Not recommended in uncomplicated vaginal delivery or episiotomy (WHO 2021, ACOG 2018)

For manual removal of placenta, patchy evidence is available (III-L). No evidence is available for use of antibiotics for postpartum dilatation and curettage.

It is important to restrict antimicrobial use in perinatal period as pregnant women and fetus both are in a vulnerable state. Antibiotic use in pregnancy may disturb pregnant women's microbiota which is very important for normal fetal development. Consequences of overuse of antibiotics in pregnancy is abnormal intestinal microbiome composition in the infant leading to increased risk of childhood atopy, asthma, allergy and rise in childhood obesity. Even a single course of antibiotic can change the bacterial flora with unwanted effects.

All women undergoing an abdominal or vaginal **hysterectomy** should receive antibiotic prophylaxis. All women undergoing laparoscopic hysterectomy or laparoscopically assisted vaginal hysterectomy should also receive prophylactic antibiotics. All women undergoing surgery for pelvic organ prolapse and/or stress urinary incontinence should receive a single dose of first-generation cephalosporin.

Procedure	Antibiotic	Dosage	Level of evidence
Abdominal hysterectomy	First- or second-generation cephalosporin	Single dose, IV	I-A
Vaginal hysterectomy	First- or second-generation cephalosporin	Single dose, IV	I-A
Laparoscopic hysterectomy	First- or second-generation cephalosporin	Single dose, IV	III-B
Pelvic organ prolapse and/or stress urinary incontinence surgery	First-generation cephalosporin	Single dose, IV	III-B

Source - *SOGC clinical practice guideline 2012*

The antibiotic of choice for hysterectomy should be a single dose of a first-generation cephalosporin. If patients are allergic to cephalosporin, then clindamycin, erythromycin, or metronidazole should be used (I-A). Give oral metronidazole 400 mg BD x 7 days, starting at least 4 days before surgery to prevent post-operative vaginal cuff infection if there is evidence of bacterial vaginosis.

In addition to antibiotic prophylaxis it is very essential to have a robust infection prevention and control mechanism in place. Hand hygiene to be strictly followed and sterility of surgical fields should be ensured in OT. Regular surveillance of quality

parameters should be done. Postoperative wound care should to be done as prophylaxis does not prevent infection caused by postoperative contamination.

Procedure	Antibiotic	Dosage	Level of evidence
Laparoscopy (uterus and/ or vagina not entered)	None recommended		I-E
Hysteroscopy	None recommended		II-2D

Source - *SOGC clinical practice guideline 2012*

Antibiotic prophylaxis is not recommended for **laparoscopic** procedures that involve no direct access from the abdominal cavity to the uterine cavity or vagina whether diagnostic, operative or tubal sterilization. Antibiotic prophylaxis is not recommended for **hysteroscopic** surgery diagnostic, operative or endometrial ablation.

All women undergoing an induced (therapeutic) surgical **abortion** should receive prophylactic antibiotics to reduce the risk of post-abortal infection (I-A). Prophylactic antibiotics are not suggested to reduce infectious morbidity following surgery for a missed or incomplete abortion (I-E)

Procedure	Antibiotic	Dosage	Level of evidence
Therapeutic abortion	doxycycline	100 mg po pre-procedure and 200 mg po post-procedure	I-A
Missed/incomplete abortion	None recommended		I-E
IUCD insertion	None recommended		I-E
Endometrial biopsy	None recommended		III-L
Hysterosalpingogram	Doxycycline	100 mg BD for 5 days	II-3B

Source - *SOGC clinical practice guideline 2012*

Antibiotic prophylaxis is not recommended for insertion of an intrauterine device (I-E) However, health care professionals could consider screening for sexually transmitted infections in high-risk populations. (III-C)

There is insufficient evidence to support the use of antibiotic prophylaxis for an endometrial biopsy. (III-L) Women with dilated tubes found at the time of hysterosalpingography are at highest risk and prophylactic antibiotics (e.g., doxycycline) should be given. (II-3B)

For **Cervical encirclage** ampicillin 2 gm IV single dose is recommended to reduce the risk of infection due to exposed membranes in the vagina.

For **preterm labour** the use of antibiotic prophylaxis in the absence of membrane rupture is not supported by any evidence. Antibiotics in PPROM is given for group B streptococcal chemoprophylaxis and to prolong gestation. Choice of antibiotics depends whether PPROM is with or without chorioamnionitis.

All pregnant women should be screened in 1st trimester for **UTI** and it should be treated as per sensitivity result for 7 days. Even asymptomatic bacteriuria needs treatment as chances of pyelonephritis(25%) and recurrence(30%) are higher in pregnancy. Till the culture reports are awaited patients can be started on nitrofurantoin or amoxicillin or cephalosporins. Nitrofurantoin should be used with caution as its use near delivery can cause hemolytic anemia of newborn and also has been associated with cardiac birth defects when taken in the first trimester.

Puerperal sepsis / sepsis induced abortion / chorioamnionitis: Inj. Piperacillin tazobactam 4.5 gm IV 6 hourly x 7-14 days.If patients have received antibiotics elsewhere or have septic shock or are intubated, consider optimum and appropriate antibiotics like imipenem and vancomycin, or teicoplanin to cover MRSA.

Genital tract infections - Syndromic Case Management (SCM) is the cornerstone of STI/RTI management, being a comprehensive approach for STI/RTI control endorsed by the World Health Organization (WHO). Treatment has been standardized through the use of pre-packaged colour coded STI/RTI drug kits. Green coloured KIT 2 is for vaginal discharge and contains 1 tablet of 2g tab secnidazole and 1 tab of tab fluconazole (150mg). Gray colour Kit 1 is used cervical discharge and for both partners. It contains 1 tab of tab azithromycin 1g , 1 tab of tab fluconazole. Yellow coloured KIT 6 is for PID and contains 1 tab cefixime 400mg, 28 tablet of doxycycline 100mg, 28 tablet of metronidazole to be taken BD for 14 days.

For viral infections no antibiotics to be given

Antibiotic use should be targeted with precision and narrow spectrum effective antibiotic should be developed as a policy. Guidelines for antibiotic choice may be adapted based on hospital formulary and antibiogram. A stop date should be planned and recorded in advance to ensure antibiotic is not given beyond the recommended duration.

Antimicrobial stewardship should result in a reduction of cost and related harm of administering antibiotics when not required and a reduction of infection and related morbidities when antibiotics have demonstrated a proven benefit.

Collateral damage caused by the indiscriminate use of antibiotics has led to depletion of antimicrobial armamentarium. Time is running out but we still have a window of opportunity to turn the tide on AMR and ensure continued effective treatment of bacterial infections for future generations.

Let us act now!!!

Suggested Reading

1. Antimicrobial Stewardship Programmes in Healthcare Facilities in Low and Middle-income countries, A WHO Practical Toolkit, 2019
2. WHO recommendations for prevention and treatment of maternal peripartum infections 2015
3. Antibiotic Prophylaxis in Gynaecologic Procedures SOGC clinical practice guideline No. 275, JOGC April 2012.
4. Treatment Guidelines for Antimicrobial Use in Common Syndromes, ICMR, New Delhi India, 2022
5. WHO recommendation on routine antibiotic prophylaxis for women undergoing operative vaginal birth. Geneva: World Health Organization; 2021. Licence: CC BY-NC-SA 3.0 IGO.
6. ACOG Guidance: Antibiotic Prophylaxis during Labor and Delivery 2018
7. FOGSI FOCUS Surgical Skills in Obstetrics and Gynaecology, 2018, Jaideep Malhotra, Pratima Mitta, Shalini Rajaram
8. STI/RTI syndromic case management, NACO, National Aids Control Organization.
9. National guidelines for infection prevention and control in healthcare facilities, Ministry of Health and Family Welfare Government of India, January 2020.

Establishing birth companionship in labour ward of a tertiary care center: A Quality improvement initiative towards safe and respectful childbirth

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Background

There is enough scientific evidence to support that continuous support to the birthing mothers by a companion of their choice improves their birthing experience and birth outcomes.[1] A birth companion ensures the mother's safety in the labour ward by providing continuous physical as well as moral support. Opting for a birth companion is the basic right of a mother and a core element of Respectful Maternity Care (RMC).[2] The Ministry of Health and Family Welfare launched the Labour Room Quality Improvement Initiative (LaQshya) in March 2018 to improve the quality of care provided to mothers in the labor wards[3] with birth companionship as one of the interventions. Due to space constraint and heavy patient load in public health facilities, the healthcare providers believed that it was impossible to implement this evidence-based practice.

Problem Description

Our hospital is a tertiary-level health facility with approximately 10,000 mothers birthing annually. The labour ward has more than 60% high-risk mothers and the residents, nursing officers, and support staff are often overwhelmed with the workload trying to do their best for the birthing mothers in the prevailing circumstances. Despite the directive from the Government of India to allow a birth companion with each mother in the labor wards, the practice is not followed universally. Hence, there was felt need to address this problem using quality improvement (QI) methodology.

Aim

To establish the practice of allowing birth companions with all the eligible mothers admitted in the labor ward of our hospital for birthing from 0% to 70% within 8 weeks .

Material and Method

Context: A team was made including the consultant in charge of the labour ward, and representatives from residents, nursing officers, security staff, and support staff. The baseline data was collected from all three shifts over 24 hours, and the birth companion rate was confirmed to be 0%.

Outcome Indicator

The outcome indicator was the percentage of eligible women accompanied by birth companions during labour. It was calculated as the total number of mothers having a vaginal birth accompanied by a companion divided by the total number of eligible mothers who had a vaginal birth during the same time. The nursing officer at the admission desk of the labour room marked the entry of the companion in each shift in the labour room register. The designated nursing officer, who was a part of the team calculated the entries daily and further compiled them on a weekly basis. Later, once the target was achieved data was compiled on a monthly basis.

Interventions

The team did an in-depth analysis of the barriers to allowing a birth companion using a process flow chart (Figure 1a) and fishbone analysis (Figure 2) and held discussions with their colleagues to collate all the thoughts and ideas.

The members realized that there was a lack of awareness amongst healthcare providers regarding the concept of the birth companionship model and its benefits. The other reasons highlighted were overcrowding, non-availability of an eligible companion, the unwillingness of a companion to stay back, lack of counselling of birth companions, and the reluctance of the healthcare providers to allow birth companions for the fear of interference in treatment and overcrowding. The team members proposed various change ideas which were implemented as various plan-do-study-act (PDSA) cycles. The details of the PDSA cycles are mentioned in Table 1.

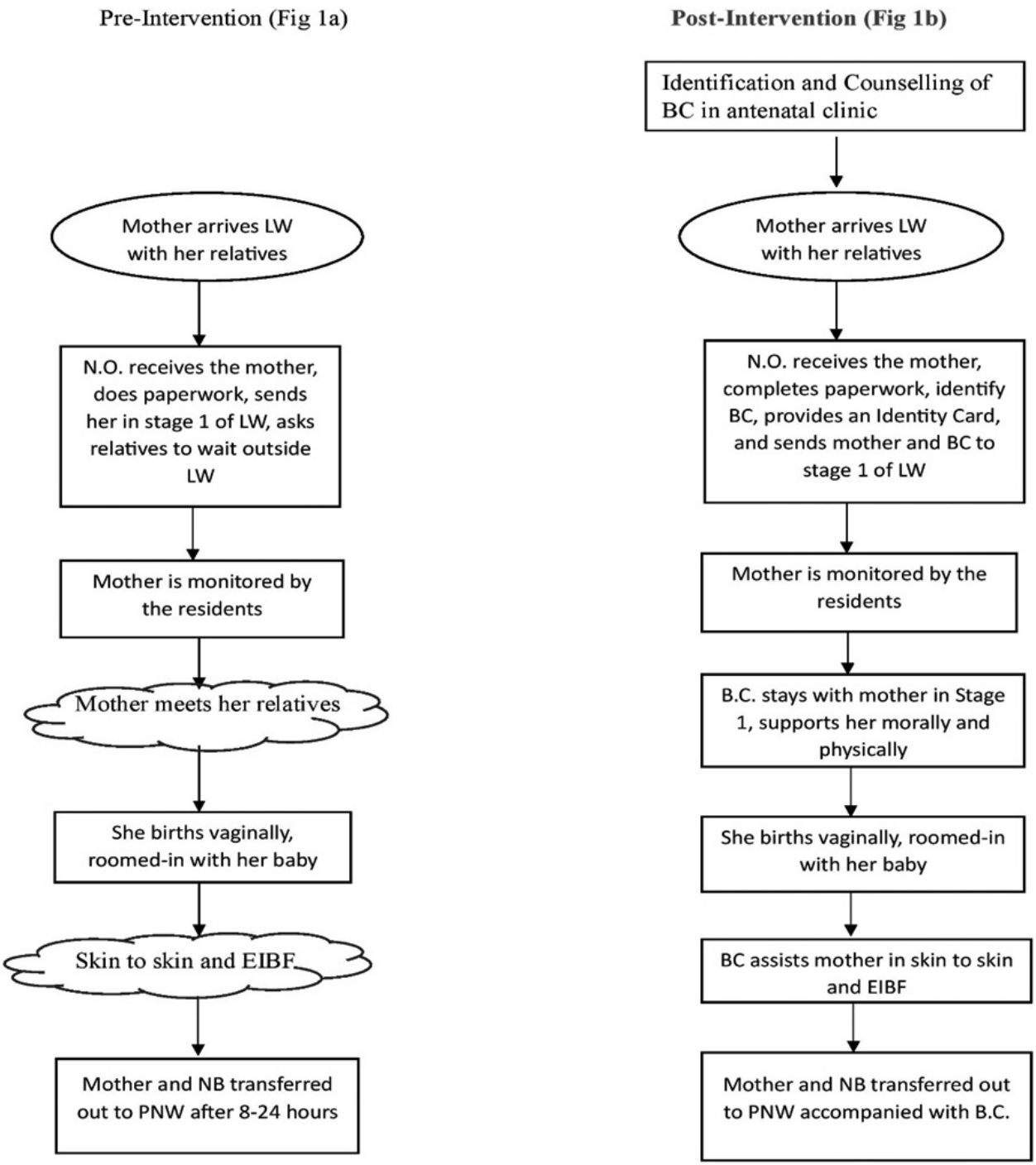

Fig 1a: Process flow of mothers received in labour in labour ward before intervention

Fig 1b: Process flow of mothers received in labour in labour ward after establishment of birth companion practice
(Abbreviations: BC:Birth companion, LW: Labour ward, N.O.: Nursing officer, EIBF: Early initiation of breast feeding, PNW: Postnatal ward)

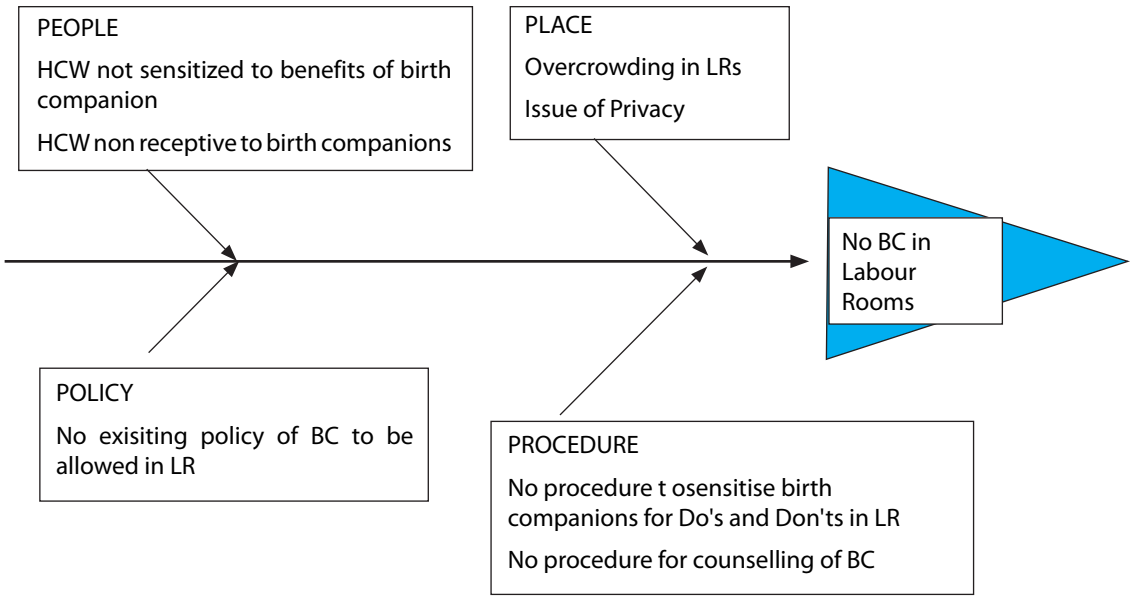

Fig 2. Fish bone analysis for reasons of no birth companions with mothers in labor ward (HCW-Health care workers, LR-Labor room, BC-Birth companion)

Table 1: Documentation of PDSA cycles: (Abbreviations: PDSA-Plan-do-study-act, SOP-Standard Operating Procedures, GOI-Government of India, ANM-Auxiliary Nurse Midwife, BC-Birth companion

Intervention Start date. End date	PLAN	DO	STUDY	ACT
PDSA 1 (week1)	1. Development of departmental policy to allow BC. 2. Dissemination of the idea amongst all the faculty members, residents, and labour ward staff.	1. SOPs prepared by a team of senior faculty members as per GoI guidelines. 2. Disseminated the idea in an interactive workshop. 3. Displayed the SOPs as posters in the labour ward.	Birth companion rate 20%. Many mothers did not have an eligible companion due to a lack of prior information.	Adapted Lesson learnt Need for identification and counselling of BC in the antenatal period regarding the do's and don'ts inside the labour ward.
PDSA 2 (week 2)	Identification and counselling of the BC in the antenatal clinic.	1. BC counselling room identified in the antenatal area. 2. Information displayed on the boards in the antenatal waiting area. 3. Two counsellors, one ANM and one nursing officer posted in BC counselling room to identify and counsel the mothers and BC regarding the do's and don'ts in local (Hindi) language. 4. They were provided with information pamphlets.	The BC rate was 35%. However, the BC was frequently changing in labour ward.	Adapted. Lesson learnt The BC's to be provided with identity cards.

PDSA 3 (week 3 and 4)	Provision of identity card to the preidentified BC	The name of BC was mentioned on the Antenatal card of mother in ANC The nursing officer at the admission desk was instructed to provide identity cards to the preidentified BC at the time of entry.	The BC rate was 45% by the end of the third week. It increased to 88% by the fourth week. A mismatch between the percentage of BC reported and the actual presence of the BC in the labour room was observed as the BC accompanied the mother inside but did not stay in with mothers.	Adopted Lesson learnt There was need to revise the criteria for the BC and record only those who stayed with the mothers for most of the time in labour room.
PDSA 4 (Week 5)	Revision for criteria for counting the presence of BC with the mothers. .	The nursing officer at the admission desk was instructed to record only those BC's who stayed with the mothers for most of the time in labour ward.	BC rate was 56% by the end of the fifth week . It was observed that BC found it inconvenient to stay back in labour ward for lack of any sitting facility next to mother.	Adopted Lesson learnt There was need to make provision for sitting arrangement for BC
PDSA 5 (week 6 and 7)	Provide for a sitting arrangement for BC in labour ward	A nursing officer was assigned the task of ensuring provision of bedside stools inside the labour ward for the BC to sit.	BC rates went up to 72% A fall to 48 % was noted in the subsequent week. due to change in team of residents who did not allow BCs as the labour ward was overcrowded	Adopted Lesson learnt Need for sensitization of the incoming teams The BCs to be allowed in staggered manner whenever Labour ward was overcrowded
PDSA 6 (week 8)	Staggered entry of BCs	The circulating nursing officer was instructed to allow a staggered entry of BCs whenever labour ward was overcrowded	The BC rate increased to 75%	Adopted.

Analysis

The data information was tabulated in accordance with the Standards for Quality Improvement Reporting Excellence Guidelines.[4] Weekly team meetings were held to analyze the data. The first six (weekly) data points were used to calculate the baseline median. Each data point was calculated based on the percentage of eligible mothers who were accompanied by birth companions each week. A run chart was used to plot the data points. (figure 3)

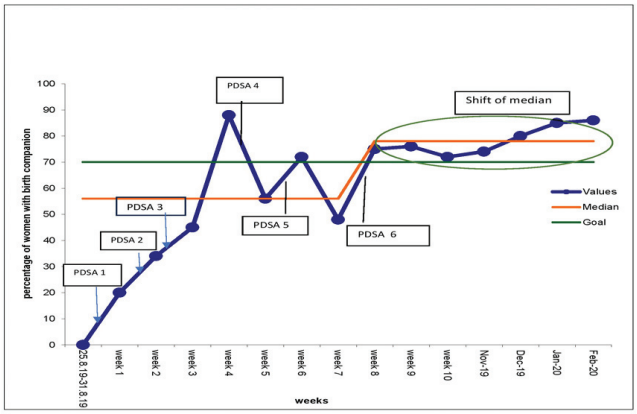

Fig 3: Run chart showing birth companion percentage and shift of median after 8th week of intervention.

Results

After the first PDSA cycle, the percentage of mothers who birthed with birth companion increased to 20% from a baseline of 0% as shown in Table no.1. But there was a felt need for sensitization and preparation of the family members of the mothers to this new practice in the antenatal period. After initiating the process of identification and counselling of birth companions of mothers near their expected date of delivery in antenatal clinics, the outcome measure gradually improved to reach 88% by the end of the fourth week. This unexpected increase triggered us to review the process of data collection and it was discovered that companions were counted at the entry with mothers but they did not actually stay inside due to the lack of any sitting facility in the labour ward. This led to the idea of the introduction of identity cards for the companions to ensure a single companion for every woman. The target was achieved by the seventh week .

Sustenance

The percentage of mothers with birth companions has been maintained between 74-86% since then. The QI team planned monthly labour room induction classes to reinforce respectful maternity care as well as provision of birth companions. The class was taken by a designated faculty member in the presence of the head of the department to have the maximum impact. Faculty members were assigned the responsibility to ensure compliance by random checks by asking the mothers if they were offered a birth companion and checking the entry in the register to bridge any gap left by the nursing officers and residents, Regular reminders were sent on WhatsApp group and data was initially shared weekly and later monthly. The senior nursing officer posted in the labour ward was given the responsibility to display the monthly census in the labour wards. The data was also included in the monthly departmental statistics of the key performance indicators of LaQshya.

Discussion

A review article by Tamar et al.[5] identified barriers such as health care provider's perception, space constraints, privacy issues, and cultural preferences of the birth companion. We also faced similar barriers. Allowing a birth companion is challenging in heavy-load public facilities but not impossible. Space constraints, privacy issues, and cultural preferences must be circumvented by novel ideas and the cooperation of the team. A pilot study conducted in government health systems in a low-income country revealed significantly higher satisfaction in mothers and health care workers in intervention sites allowing birth companions.[6] A cross-sectional study in a public health facility reinforced that women with birth companions perceived better respectful maternal care.[7]

Despite all proven benefits, it is still not implemented in India in the majority of healthcare centres especially public health facilities due to high patient load and restricted space, and scarce manpower. But Quality tools can be applied to implement the practice even in government set-ups as has been experienced by Chawla et al who were successful in establishing the birth companionship model after the COVID pandemic too.[8] Few other studies document the successful implementation of the birth companion model using quality tools with different interventions.[9]

The presence of birth companions helped improve many essential practices like hydration and ambulation of mothers in labour, encouraging mothers to frequently evacuate their bladder, provide skin-to-skin contact and early initiation of breastfeeding in newborns. The health care providers found their presence useful except when the labour ward was crowded.

Conclusions

In this study, we eventually achieved our goal to establish the practice of allowing birth companions during labour at our hospital from 0% to 70%. Multiple change ideas were conceived and tested. After initial resistance, a motivated team could implement this useful evidence-based practice with patience and perseverance. Any good practice once implemented can be revived with much ease even if it is disrupted or discontinued.

Suggested Reading

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4. Goodman D, Ogrinc G, Davies L, et al. Explanation and elaboration of the Squire (standards for quality improvement reporting excellence) guidelines, V.2.0: examples of Squire elements in the healthcare improvement literature. BMJ Qual Saf 2016;25:e7.
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6. Chaote P, Mwakatundu N, Dominico S, Mputa A, Mbanza A, Metta M, Lobis S, Dynes M, Mbuyita S, McNab S, Schmidt K, Serbanescu F. Birth companionship in a government health system: a pilot study in Kigoma, Tanzania. BMC Pregnancy Childbirth. 2021 Apr 16;21(1):304. doi: 10.1186/s12884-021-03746-0. PMID: 33863306; PMCID: PMC8052747.
7. Sheferaw ED, Bazant E, Gibson H, et al.. Respectful maternity care in Ethiopian public health facilities. *Reprod Health* 2017;14:60. 10.1186/s12978-017-0323-4 [PMC free article] [PubMed] [CrossRef] [Google Scholar]
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9. Bharti J, Kumari A, Zangmo R, et al. Establishing the practice of birth companion in labour ward of a tertiary care centre in India—a quality improvement initiative. BMJ Open Quality 2021;10:e001409. doi:10.1136/ bmjoq-2021-001409

Quiz

1. When is World Patient Safety Day observed?
2. As a measure of patient safety, WHO had launched GLASS programme in 2015. What does GLASS stand for?
3. Spaulding's classification is a system of classifying the potential infection transmission risk of _____and recommends appropriate methods of decontamination for the same. Fill in the blank.
4. WHO recommends that all blood donations should be screened for infections prior to use. Mention four infections for which screening is universally mandatory.
5. Radiation damage to tissue and/or organs depends on the dose of radiation received and the absorbed dose. What is the unit used for expression of the radiation dose in consideration?
6. Audio-visual recording of informed consent is permitted in which scenario in Indian Law?
7. There had been no formal organized programme for patient safety in India until recently. Mention the name of the programme launched by MoHFW for the patient safety in India and in which year was it launched?

Answers

1. 17th September
2. Global Antimicrobial Resistance and Use Surveillance System (GLASS)
3. Reusable medical equipment/devices
4. HIV, hepatitis B, hepatitis C, and syphilis
5. Gray (Gy)
6. Clinical trials
7. National Patient Safety Implementation Framework, 2015

Gear up for the academic extravaganza!!

NARCHICON 2023

25th – 27th November, 2023

Organized by NARCHI-Delhi Branch, Lady Hardinge Medical College, New Delhi

HIGHLIGHTS

Workshops:

Pre-conference video workshop on enhancing skills in Obstetrics & Gynaecology
Post conference satellite workshops on postnatal care

Talks and Panels:

Dispelling the myths and fears in Vaginal birth: Panel discussion.

Reviving the art of vaginal surgery: Suture less vaginal hysterectomy, vaginal removal of big uteri & adnexa, High uterosacral plication

Surgical competence-Raising the bar: Extraperitoneal C-section, V-NOTES hysterectomy.

ART & Surrogacy bill decoded: Panel discussion.

Bridging gaps - Cross talks between Obstetrician, Neonatologist, Radiologist & Anaesthetist

Uterus sparing surgeries for pelvic organ prolapse.

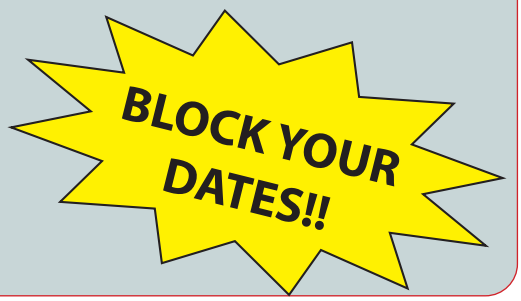
Trouble shooting in Caesarean Section: Morbidly obese mother, preterm, 2nd stage CS.

Adnexal masses-What a gynaecologist must know? A Panel discussion

Orations: Abnormal cervical screening way forward, Reg flags to reduce maternal morbidity: A reflection

Competition: Obstetric Drills

Quiz on Skills & Drills in Obstetrics & Gynaecology



29th Annual Conference of
National Association for Reproductive & Child Health of India (NARCHI) - Delhi Branch

NARCHICON 2023

Theme:- **"Sharing Knowledge, Refining Skills"**

CONFERENCE

Date:- **25th - 26th November 2023**

Venue:- **Swarn Jayanti Auditorium, Lady Hardinge Medical College, New Delhi**

WORKSHOP

Date:- **27th November 2023**

Venue:- **Mini Auditorium, 5th Floor, New Academic Block, Lady Hardinge College, New Delhi**

INVITATION LETTER

It gives us immense pleasure to announce the 29th Annual Conference of National Association for Reproductive & Child Health of India (NARCHI)-Delhi Branch, "NARCHICON 2023". We invite you all to be a part of this academic extravaganza which is scheduled to be held from 25th to 27th November 2023 at the iconic campus of Lady Hardinge Medical College, New Delhi. The event will be spread over 3 days with the conference on 25th & 26th November and the post conference workshop on 27th November 2023.

The theme of this year's conference is "Sharing Knowledge, Refining Skills". This event promises to be like no other academic event as the main focus will be on enhancing the quality of our day to day medical practice. The conference will witness stimulating video lectures, panel discussions and orations which are sure to keep you engaged. The post conference video workshop is bound to leave you mesmerised by the practical demonstrations, evidence-based knowledge and practical tips shared by the experts in the field. It will also be a great platform for you to present your research work and interesting cases as well as engage in interactive discussions with peers. The postgraduate Quiz on Skills & Drills in Obstetrics and Gynaecology will provide a befitting climax to the conference proceedings and is not to be missed.

Our team has worked hard to bring this academic event together and we will look forward to your presence in large numbers to make this event a colossal success.

Team NARCHICON 2023

Organizing Chairperson

Dr. Manju Puri

Co-Organizing Chairperson

Dr. Reena

Organizing Secretary

Dr. Sharda Patra

Organizing Secretary

Dr. Swati Agrawal

Treasurer

Dr. Shilpi Nain

REGISTRATION FEE

Registration	Early Bird (Till 15th October)	Till 15th November	Spot (After 15th November)
Only Workshop (Members)	₹ 1800	₹ 2400	₹ 3000
Only Workshop (Non-Members)	₹ 2400	₹ 3000	₹ 3600
Only Workshop (PG Students)	₹ 1200	₹ 1800	₹ 2400
Only Conference (Members)	₹ 3000	₹ 3600	₹ 4800
Only Conference (Non-Members)	₹ 3600	₹ 4200	₹ 5400
Only Conference (PG Students)	₹ 2400	₹ 3000	₹ 4200
Conference + Workshop Combo (Members)	₹ 4200	₹ 5200	₹ 7100
Conference + Workshop Combo (Non-Members)	₹ 5400	₹ 6500	₹ 8300
Conference + Membership Combo (Non-Members)	₹ 6000	₹ 6500	₹ 7700
Conference + Workshop + Membership Combo (Non-Members)	₹ 7700	₹ 8300	₹ 9500
Conference + Membership Combo (PG Students)	₹ 5000	₹ 5500	₹ 6700
Conference + Workshop + Membership Combo (PG Students)	₹ 6700	₹ 7300	₹ 8500

- Including 18 % GST.
- PG students must produce certificate from HOD to avail discount.
- Members must have their name in the membership list for registration.
- Cancellation (T&C): 50% cancellation charges will be applicable till 01st Nov. 2023 afterward 100% Cancellation charges will be applicable.
  Register now: https://narchicon2023.com/registration.html

CONFERENCE PROGRAMME

25th - 26th November 2023

Reviving the art of vaginal surgery

- Sutureless vaginal hysterectomy
- Vaginal removal of a big uterus
- High uterosacral ligation
- Managing adnexal masses vaginally

Surgical Competence-Raising the bar

- Extra peritoneal caesarean section
- Caesarean myomectomy
- vNOTES hysterectomy

Cross talks on Important Obstetrical Conditions

- Obstetrician - Neonatologist
- Obstetrician - Radiologist
- Obstetrician - Anaesthetist

Fertility sparing surgeries for pelvic organ prolapse

- Manchester repair
- Laparoscopic Sacro hysteropexy
- Sacrospinous hysteropexy
- Shirodkar's sling

Trouble shooting in Caesarean Section

- Morbidly obese mother
- Second stage caesarean section
- Previous caesarean section (Parietal adhesion, bladder adhesions, scar dehiscence)
- Placenta Praevia

Orations

- Smt Lilavati Oration: Multiple pregnancies- Antenatal fetal monitoring
- Dr. S.K.Das Oration: Abnormal cervical screening result -way forward

Panel discussion

- ART bill
- Adnexal masses- What gynaecologist must know?
- Dispelling the myths and fears of vaginal birth

Competition - Obstetric Drills

Dr. Sheila Mehra Quiz on Skills & Drills in Obstetric & Gynaecology (Final round)

POST CONFERENCE
Video Workshop

27th November 2023

Management of PPH

- External and Internal uterine compression
- Stepwise devascularisation of uterus
- Internal Iliac artery ligation
- Obstetric Hysterectomy

Diagnostic Procedures – The right way

- Endometrial Biopsy
- HSG/SSG
- Diagnostic Hysteroscopy
- Diagnostic Laparoscopy
- Ultrasound for follicular monitoring
- Basic Obstetric Ultrasound in Third Trimester

Endoscopic Management of Ectopic Pregnancy

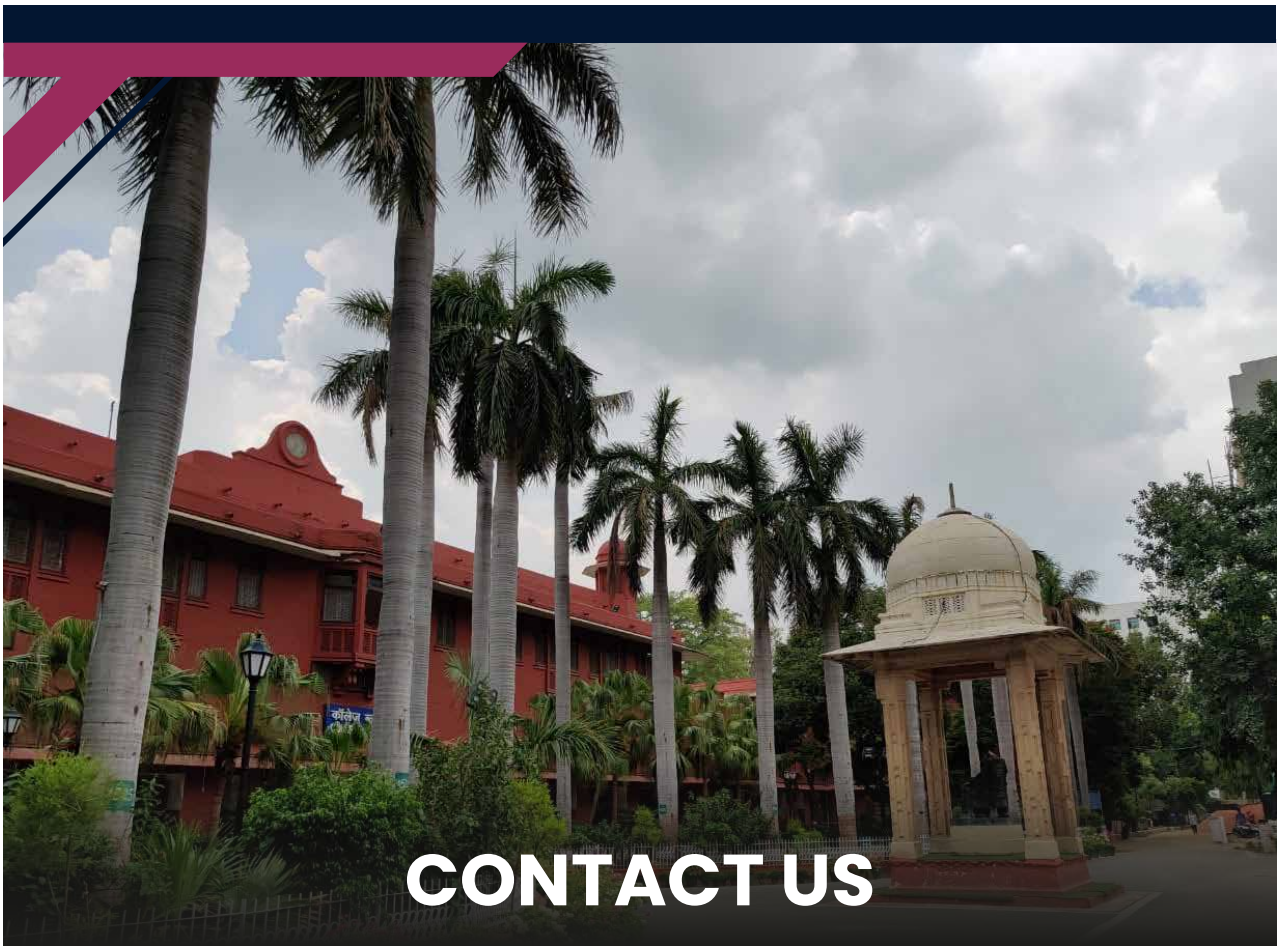
- Tubal ectopic
- Cervical ectopic
- CS scar ectopic
- Cornual ectopic

Mixed Bag

- PPIUCD
- MVA
- Implant insertion and removal
- Hysteroscopic tubal cannulation
- Tubal recanalization

Gynaecological surgeries

- Abdominal Myomectomy
- Surgical staging for adnexal mass
- Cervical cerclage-Abdominal
- Cervical cerclage- Vaginal
- Ovarian cystectomy
- Bartholin cyst marsupialization/excision



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NARCHI Events March 2023 to August 2023

1st March

Rural health committee AOGD along with FOGSI and NARCHI Delhi held anemia sensitization camp at Jag Pravesh Chandra Hospital. 30 patients, 24 nurses and doctors were screened for anemia by digital hemoglobinometer.

1st March

Training and orientation program for Anemia Mukt Bharat was done in Burari Hopital for nursing orderly and housekeeping staff. It was attended by 50-60 staff.

2nd March

Rural health committee AOGD along with Narchi Delhi and FOGSI, held anemia detection camp at Parmila Bai Chavan School for deaf. Total 75 people were screened for anemia using digital hempglobinometer including school children, female staff and mothers. Iron tablets were also distributed. Heath talks were given by Dr Deepa Gupta and Dr Radha Jain on nutrition, menstrual hygiene and cervical cancer prevention.

4th March

A workshop on Respectful Maternity Care was organised in Lady hardinge medical college by the department of obstetrics and gynaecology in association with QI committee AOGD and NARCHI, Delhi. The workshop was attended by 30 participants including post-graduates, senior residents and consultants.

RESPECTFUL MATERNITY CARE- WORKSHOP
ORGANISED BY
DEPARTMENT OF OBSTETRICS & GYNAECOLOGY
&
QI COMMITTEE AOGD
In Association with
NARCHI, Delhi Branch
Venue: ME Hall, Lady Hardinge Medical College
Date: 4th March 2023 (10:00 am to 1:00 pm)

Chairperson: Dr Reena Yadav
Co Chairpersons: Dr Manju Puri
Dr Aparna Sharma
Convener: Dr Meenakshi Singh
Co Convener:Dr Kanika Chopra

Time	Session	Speaker
10:00-10:10AM	Welcome address	Dr Reena Yadav
10:10-10:25AM	Objectives of the Workshop Concept and need for RMC	Dr Manju Puri
10:25-10:40AM	Voices of women Poll	SNO Kala
10:40-11:00AM	Birth Needs activity	Group Facilitation
11:00-11:10AM	Team building and Communication (Communication Matching Questions)	Dr Kanika Chopra
11:10-11:30AM	Paper Chain Activity	Group Facilitation
11:30-12:00PM	Introduction to simulation	Dr Aparna Sharma
12:00-12:30PM	Simulation Demo	Group Facilitation
12:30-12:45PM	Barriers to RMC	SNO Kala
12:45PM-1:00PM	Way forward	Dr Aparna Sharma
High Tea		

10th March

Rural health committee AOGD in association with NARCHI, Delhi and FOGSI organised anemia awareness camp at Guru Gobind Singh hospital on 10.3.23 for women security staff and women health care workers. 53 women were tested for hemoglobin. Anemia awareness talks were delivered.

15th March

Anemia sensitization and awareness camp was held in Lady Hardinge Medical College under the aegis of NARCHI, Delhi, FOGSI and Rural heath Committee, AOGD. The camp was held in two sessions- morning and afternoon. In the morning session, 55 BSC Nursing students attended the program and in the afternoon 50 ASHA's attended. All the students and ASHA's hemoglobin was tested and all were given nutritional counselling. Those anemics were advised necessary investigations and prescribed iron tablets.

28th March

An anemia sensitization program was held for ANM's under the guidance of Dr Manju Puri at Lady Hardinge Medical College under the guidance of aegis of NARCHI, Delhi. 25 ANM'S were sensitized to work towards "Anemia Mukt Dilli".

1st April

An awareness program on prevention of cervical and breast carcinoma was organised for the HCW and staff of LHMC by Department of Obstetrics and Gynaecology and NARCHI, Delhi branch at SJ Auditorium, LHMC. 368 HCW including doctors, nursing officers, nursing students, security guards, MTS workers were sensitised regarding routine Pap smear testing, HPV vaccine, self-breast examination, warning signs and symptoms of cervical and breast cancer through talks by the faculty and role play by MBBS students.

15th April

A workshop on RMC was conducted for doctors and nurses at Burari Hospital, Delhi under Dr Leena Bhatnagar. Around 50 health care professionals were trained from BH, DCB and BJRM hospitals.

15th April

A health camp was organised at Ambience School by FOGsd, NARCHI Delhi in association with inner wheel and Rotary by Dr Anita Sabharwal. The camp was attended by 400 women and girls of school and adjoining residential areas. Attendees were made aware about menstrual hygiene, cervical and breast cancer, anemia and bone health. 40 PAP's testing, 130 bone mineral density testing, 100 breast clinical check-ups, 25 mammography and 80 hemoglobin testing were done.

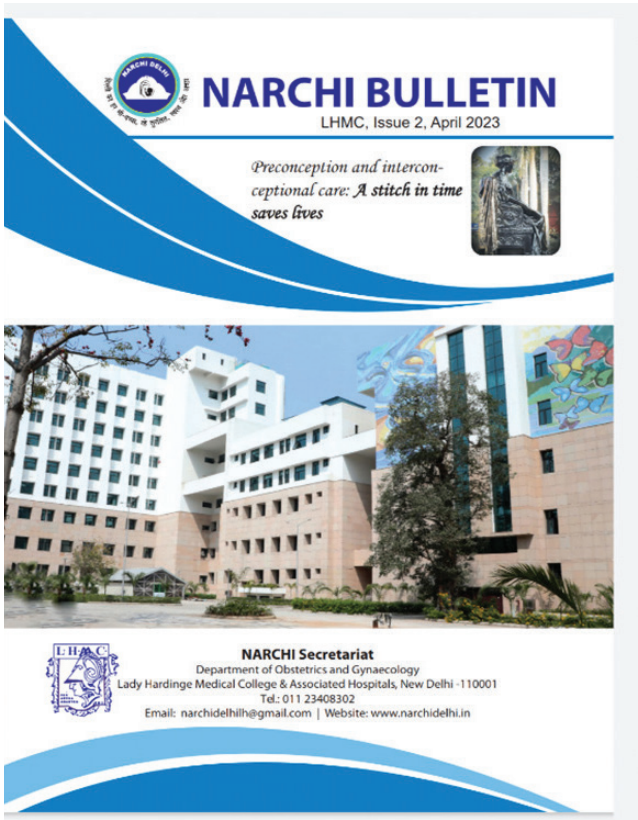
22nd April

Institute of critical care medicine and Institute of Obstetrics and Gynaecology, Sir Ganga Ram Hospital, Delhi in association with NARCHI, Delhi organised a conference on "Obstetrical emergencies and critical care conference" at SGRH. The conference was attended by 110 delegates and faculty members belonging to obstetrics, anaesthesia and critical care medicine. There were lectures by eminent speakers on topics relevant to obstetrics critical care followed by hands on workshop on ABG analysis, BLS training, mega codes and oxygen therapy.

29th April

RMC Workshop was successfully conducted at VMMC and Safdarjung Hospital under the aegis of QI committee AOGD, NARCHI DELHI and DFW Govt of Delhi and more than 60 participants attended and benefitted from it. There were participants from DH, SDH, Medical Colleges, AYUSH, District Program Officers, ESI Hospital, CGHS, MCD, NDMC, Cantonment Board. Dr Manju Puri, Dr Aparna, Dr Shakun, Dr Kanika, Dr Rajesh and Dr Sumitra were the Master Trainers for this RMC Workshop.

NARCHI Bulletin was released in May 2023, on "Optimising pregnancy outcomes: pre-conceptional and inter-conceptional care". The bulletin holds important highlights like to optimize maternal health before conception for a favourable feto-maternal outcome and reduces the link to future NCD in different medical disorders like obesity, heart disease, hypertensive disorders, epilepsy, haemoglobinopathies and care after diabetes in pregnancy, point of care testing in obstetrical haemorrhage along with an interesting quiz. First information for Annual NARCHI conference was included with important highlights.



19th May

Anaemia sensitization programme followed by a focused group discussion with ASHA was conducted at Deep Chand Bandhu Hospital, North-West district on 19th May 2023. 50 Asha's and 50 other HCP s attended. Their Hb was tested, 50% were found to be anaemic and they were counselled for IFA supplementation. It was coordinated by Dr Sumita from BJRM and Dr Jassal from DCBH.

19th May

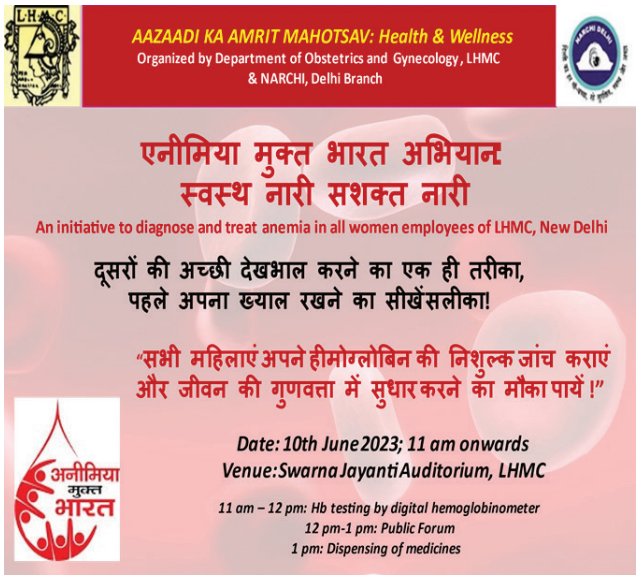
Ninth work shop on Respectful maternity care was conducted in North district Delhi, SRHC hospital for a mixed group of 50 doctors, nurses and support staff. The residents did a role play. The programme was well received.

8th June

NARCHI Delhi conducted the 10th Workshop on Respectful Maternity care jointly with directorate of Directorate Family Welfare, Delhi and AOGD in East District of Delhi. It was attended by more than 50 health care professionals including doctors, nurses and ANM's.

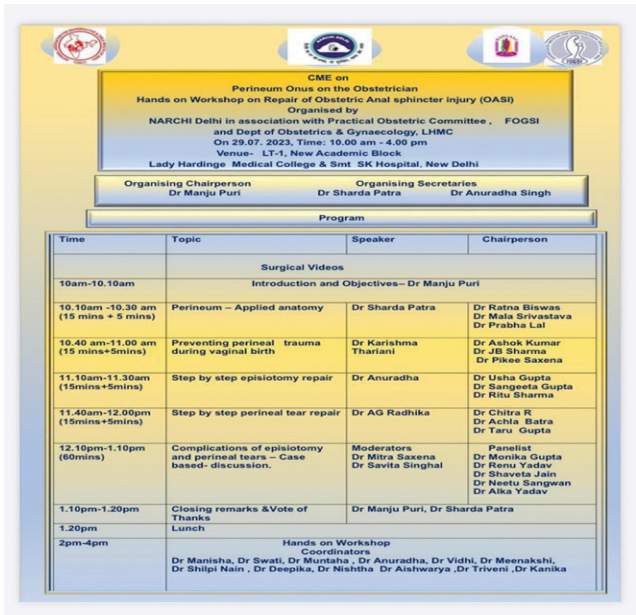
10th June

NARCHI Delhi Branch along with the department of Obstetrics and Gynaecology, Lady Hardinge Medical College, New Delhi organised a public forum and amenia detection cum treatment camp for women employees and students of LHMC. More than 300 women employees and students got their hemoglobin tested and many were found to be anemic. Iron, vitamin C, vitamin B12 and B complex tablets along with anemia information pamphlets were distributed to the participants.



29th July

NARCHI Delhi in association with Practical Obstetric Committee, FOGSI and Department of Obstetrics & Gynecology LHMC Delhi, conducted a CME on Perinuem – Onus on the Obstetrician and Hands on work shop Repair of Obstetrics Anal Sphincter Injury on 29th July, 2023 in Lady Hardinge Medical College. The CME focused on anatomy of the perineum, ways of preventing perineal trauma during vaginal birth followed by step by step repair of episiotomy and perineal tear repair. All were video sessions and in the end there was a panel discussion covering the complications of episiotomy and perineal tears. It was attended by 130 delegates including faculty, postgraduates, interns from Delhi and NCR, Chandigarh, Lucknow, Kanpur, Indore, and Moradabad.


CME on
Perineum Onus on the Obstetrician
Hands on Workshop on Repair of Obstetric Anal sphincter injury (OASI)
Organised by
NARCHI Delhi in association with Practical Obstetric Committee , FOGSI
and Dept of Obstetrics & Gynaecology, LHMC
On 29.07. 2023, Time: 10.00 am - 4.00 pm
Venue- LT-1, New Academic Block
Lady Hardinge Medical College & Smt SK Hospital, New Delhi

Organising Chairperson: Dr Manju Puri
Organising Secretaries: Dr Sharda Patra, Dr Anuradha Singh

Program

Time	Topic	Speaker	Chairperson
	Surgical Videos		
10am-10.10am	Introduction and Objectives– Dr Manju Puri		
10.10am -10.30 am (15 mins + 5 mins)	Perineum – Applied anatomy	Dr Sharda Patra	Dr Ratna Biswas Dr Mala Srivastava Dr Prabha Lal
10.40 am-11.00 am (15 mins+5mins)	Preventing perineal trauma during vaginal birth	Dr Karishma Thariani	Dr Ashok Kumar Dr JB Sharma Dr Pikee Saxena
11.10am-11.30am (15mins+5mins)	Step by step episiotomy repair	Dr Anuradha	Dr Usha Gupta Dr Sangeeta Gupta Dr Ritu Sharma
11.40am-12.00pm (15mins+5mins)	Step by step perineal tear repair	Dr AG Radhika	Dr Chitra R Dr Achla Batra Dr Taru Gupta
12.10pm-1.10pm (60mins)	Complications of episiotomy and perineal tears – Case based- discussion.	Moderators Dr Mitra Saxena Dr Savita Singhal	Panelist Dr Monika Gupta Dr Renu Yadav Dr Shaveta Jain Dr Neetu Sangwan Dr Alka Yadav
1.10pm-1.20pm	Closing remarks &Vote of Thanks	Dr Manju Puri, Dr Sharda Patra	
1.20pm	Lunch		
2pm-4pm	Hands on Workshop Coordinators Dr Manisha, Dr Swati, Dr Muntaha , Dr Anuradha, Dr Vidhi, Dr Meenakshi, Dr Shilpi Nain , Dr Deepika, Dr Nishtha Dr Aishwarya ,Dr Triveni ,Dr Kanika		

2nd August

Dissemination meeting for the activity-Antenatal Care Practices Among Frontline Health Care Providers was organized on 2.8.23 at Swarna Jayanti Auditorium, LHMC, New Delhi by Dr Manju Puri. The participants were technical experts involved in the activity, Delhi state Coordinators and Obs and Gynae Specialists of different hospitals of Delhi. There were a total of 68 participants including Dr Jyoti Sachdeva (State Program Officer, Family planning and Maternal Health, GNCT of Delhi), Dr Vandana Bagga (Director, Directorate of Family Welfare, Delhi, GNCT of Delhi) and Dr Monica Rana (Advisor South District, Ex Director, Directorate of Family Welfare, GNCT of Delhi). There were members of executive Committee of NARCHI from Delhi and four online participants.

26th August

RMC workshop was organised at Mata Gujri Hospital, organised by IDHS, West District in collaboration with QI committee AOGD and NARCHI, Delhi and Directorate of family welfare, GNCTD and MCD on 26th August. It was attended by 33 participants including medical officers, nursing officers and nursing orderly from DDU, SVBP, GGSGH, ESI Basaidarapur, Mata Gujri Hospital, and maternity homes of Jwalapuri, Vishnun Garden and Madipur.