



# Khyber Pakhtunkhwa Health Care Commission



1<sup>st</sup> Edition, Revision 1

## MINIMUM SERVICE DELIVERY STANDARDS **REFERENCE MANUAL**



**Hospitals**  
(50 and above beds)

KP HCC-01RM-Ed1





1<sup>st</sup> Edition, Revision 1

**Minimum Service Delivery  
Standards**

**REFERENCE  
MANUAL**

**In-patient Health Care Establishment  
Hospital with 50 and above Beds**



## Message from Chairman



Aristotle stated, “Quality is not an act, it is a habit.” In order to ensure that quality in the health care sector becomes a habit, the government established the Khyber Pakhtunkhwa Health Care Commission (KP HCC) through the Khyber Pakhtunkhwa Health Care Commission Act, 2015. The KP HCC is a statutory body of the Government of Khyber Pakhtunkhwa to regulate both public and private Health Care Establishments (HCEs) in the province.

Prior to 2015 the private health institutions including hospitals, nursing homes, maternity homes, medical & dental clinics, blood banks, clinical laboratory, x-ray clinics and operation theaters etc. were registered under the Medical and Health Institutions and Regulation of Health Care Services ordinance 2002 (Amendment Act, 2010), which was subsequently repealed through the Act of 2015.

The legal mandate of KP HCC is to regulate the health care services on sound and technical footings in the public and private sectors, make provisions for safe and high quality health care services to the people of Khyber Pakhtunkhwa, and to provide mechanism for banning quackery in all its forms and manifestations.

The Government of Khyber Pakhtunkhwa through the Health Care Commission is committed to improve and maintain the quality of health care. The KP HCC is already registering the various types of Health Care Establishments. The other mechanism to ensure optimum level of safety and quality is the framework of clinical governance. To achieve this end the KP HCC initiated the process of licensing of Health Care Establishments.

The former Board of the KP HCC strived very hard and visited the sister organizations in the other provinces for experience sharing. In order to save energies and resources, the Board adopted the Minimum Service Delivery Standards (MSDS) of the Punjab Healthcare Commission (PHC). I, on behalf of the Board and Khyber Pakhtunkhwa Health Care Commission, am very grateful for support provided by PHC in this regards.

The journey of ensuring quality is not easy and assistance of various stakeholders is required. I would specifically mention the all-out support of the Government of Khyber Pakhtunkhwa and especially the Minister for Health and Secretary to the Government of Khyber Pakhtunkhwa, Health Department. Without their support, initiation of licensing of the HCEs to ensure quality was not possible.

I would take this opportunity to reach out to all the health care establishments to get themselves registered with KP HCC and implement the Minimum Service delivery Standards in their respective establishments to achieve the required quality of health care and get a license to function. Providing health care without getting license from KP HCC is illegal and may lead to legal consequences, including, but not limited to, closure of the facility.

**Dr. Ikram Ghani**  
**Chairman**  
**Board of Khyber Pakhtunkhwa Health care Commission**



## Foreword

Quality costs but poor quality costs higher. This is true for all walks of life; however, in the health sector its importance cannot be overemphasized. It ensures safety of patients as well health care providers. Patient safety is not new in the medical field but is relatively newer concept for general public. Regulation of health care services is now a priority at the national and provincial government level. In order to ensure quality of care and safety in health care system of Khyber Pakhtunkhwa, the provincial government established the Khyber Pakhtunkhwa Healthcare Commission (KP HCC) through the promulgation of Khyber Pakhtunkhwa Health Care Commission Act, 2015. KP HCC is a statutory body, constituted to regulate Health Care Establishments (HCEs), both in public and private sectors in the province, to improve quality of health care, and ensure safety of patients and health care providers.

To ensure quality the HCEs are regulated through assessment against set standards. The Punjab Healthcare Commission (PHC) developed the Minimum Service delivery Standards (MSDS) through extensive consultations with the stakeholders. PHC developed MSDS for hospitals, providing in-patient care. Moreover, MSDS were also developed for different kinds of HCEs providing out-patient services, including Basic Health Units in the public sector, and the clinics of general practitioners, dental clinics, clinical laboratories, radiological diagnostic centers, as well as homeopathic clinics and Tibb clinics.

The former Board of Khyber Pakhtunkhwa Healthcare Commission took the right decision and approved adoption of the MSDS of Punjab in its 34th meeting on 6th January 2022. The KP HCC duly acknowledges this gesture of support by the Punjab Healthcare Commission.

Subsequent to adoption, appropriate amendments were required to adapt the MSDS to the local context and legal provisions of Khyber Pakhtunkhwa. This was a challenging assignment and despite shortage of staff, KP HCC made the required amendments, utilizing its internal resources. I would like to thank the former Board of KP HCC for its wholehearted effort towards improving the quality of healthcare through adoption of PHC MSDS. My thanks are also due to the whole KP HCC team for working tirelessly and completing the process of adaptation in a very short time. The role of senior management was commendable. Moreover, I am highly grateful to Mr. Adil Waqas, Mr. Zeeshan Khan, Mr. Muhammad Latif Khan, Mr. Malik Waqar Ahmad, Mr. Zia Mohyuddin and Mr. Muhammad Farhan Khan of KP HCC for thoroughly reviewing all the manuals of MSDS, identifying the sections to be changed, and finding appropriate replacements for making the required amendments for adaptation.

The MSDS Reference Manual for hospitals having 50 and above beds, comprises 35 standards and 168 indicators. It also provides the survey and scoring methodology, in addition to the guidelines to facilitate implementation and assessment of compliance.

Every journey begins with the first step and I firmly believe that this first step followed by implementation of the MSDS will lead to improved quality of healthcare in Khyber Pakhtunkhwa.

**Dr. Nadeem Akhtar**  
**Chief Executive Officer**

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## List of Acronyms & Abbreviations

A&E	Accident and Emergency
AAC	Access, Assessment, and Continuity of Care
ABG	Arterial Blood Gas (test)
ACR	Annual Confidential Report
ACLS	Advanced Cardiac Life Support
ADL	Activities of Daily Living
ADR	Adverse Drug Reaction
AGPR	Accountant General of Pakistan Revenues
AIN	Asset Identification Number
ANC	Ante-Natal Care
APPM	Accounting Policies and Procedures Manual
ASA	American Society of Anaesthesiologists
AST	Aspartate Amino Transferase
ATLS	Advanced Trauma Life Support
AWP	Annual Work Plan
BCF	Bromo Chloride Fluoromethane
BHU	Basic Health Unit
BoM	Board of Management
BTS	Blood Transfusion Service
BLS	Basic Life Support
C&W	Communication and Works Department
CABG	Coronary-Artery Bypass Grafting
CCBs	Citizen Community Boards
CDC	Centers for Disease Control and Prevention (US government)
CEmOC	Comprehensive Emergency Obstetric Care
CFAO	Chief Finance and Accounts Officer
CFO	Chief Financial Officer
CIs	Confidence Intervals
CMC	Complaint Management Committee
CMO	Causality Medical Officer

CME	Continued Medical Education
CNIC	Computerized National Identity Card
CoA	Chart of Accounts
COMS	Clinical Outcomes Measurement System
CPOE	Computerized Prescriber Order Entry
CQI	Continuous Quality Improvement
CRP	C-Reactive Protein
CSOs	Civil Society Organization
CSSD	Central Sterilization Services Department
CT	Computerized Tomography
DDO	Drawing and Disbursing Officer
DGHS	Directorate General of Health Services
DHIS	District Health Information System
DHMT	District Health Management Team
DHQH	District Headquarter Hospital
DoB	Date of Birth
DRA	Drug Regulatory Authority
DVT	Deep Venous (Vein) Thrombosis
ECG	Electro Cardiography
ED	Emergency Department
EDL	Essential Drug List
EMO	Emergency Medical Officer
EMR	Electronic Medical Record
EMS	Emergency Medical Services
ENC	Essential Newborn Care/ Emergency Neonatal Care
EmOC	Emergency Obstetric Care
EmONC	Emergency Obstetric and Neonatal Care
EQA	External Quality Assessment
FAR	Fixed Asset Register
FFP	Fresh Frozen Plasma
FGI	Facility Guideline Institute

FHT	Family Health Team
FMS	Facility Management and Safety
FP	Family Planning
GAAP	Generally Accepted Accounting Principles
GATHER	Greet, Ask, Tell, Help, Explain, Return
HAOP	Hospital Annual Operational Plan
HCE	Healthcare Establishment
HCP	Healthcare Provider
HEPA	High Efficiency Particulate Air
HIC	Hospital Infection Control
HID	Health Institute Database
HMIS	Health Management Information System
HOD	Head of Department
HRD	Human Resource Development
HRM	Human Resource Management
HTC	Hospital Transfusion Committee
HVAC	Heating, Ventilation, And Air Conditioning (System)
IBC	International Building Code
IC	Infection Control
ICC	Infection Control Committee
ICD	International Classification of Diseases
ICN	Infection Control Nurse
ICO	Infection Control Officer
ICP	Infection Control Practitioner
ICT	Information and Communication Technology
ICT	Infection Control Team
ICU	Intensive Care Unit
IEC	Information, Education and Communication
IFRS	International Financial Reporting Standards
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IMPAC	Integrated Management of Pregnancy and Childbirth

IMS	Information Management Systems
IPD	Inpatient Department
IPM	Integrated Pest Management
ISMP	Institution for Safe Medication Practices
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JD	Job Description
KCl	Potassium Chloride
KPBTA	Khyber Pakhtunkhwa Blood Transfusion Authority
KP HCC	Khyber Pakhtunkhwa Health Care Commission
KPIs	Key Performance Indicators
KPPRA	Khyber Pakhtunkhwa Public Procurement Regulatory Authority
LAMA	Left/Leaving Against Medical Advice
LASA	Look-Alike, Sound-Alike
LDH	Lactate Dehydrogenase
LHV	Lady Health Visitor
LHW	Lady Health Worker
LSC	Liquid Scintillation Counting
MAR	Medication Administration Record
MCH	Maternal and Child Health
MD	Medical Director
MDR	Multiple Drug Resistance
MIS	Management Information System
MLC	Medico-Legal Cases
MLR	Medico-Legal Report
MOM	Management of Medication
MRI	Magnetic Resonance Imaging
MRSA	Methicillin Resistant Staph Aureus
MS	Medical Superintendent
MSDS	Minimum Service Delivery Standards
N.B.	Nota Bene (Note well)
NFPA	National Fire Protection Agency

NGO	Non-Government Organization
NICU	Neonatal Intensive Care Unit
NMNCHP	National Maternal Newborn and Child Health Promotion
OEM	Original Equipment Manufacturer
OPD	Outpatient Department
OR	Operating Room
OSHA	Occupational Safety and Health Administration
OT	Operation Theater
OTA	Operation Theatre Assistant
OTMC	Operation Theatre Management Committee
PACS	Picture Archiving and Communication System
PACU	Post Anaesthesia Care Unit
PALS	Paediatrics Advanced Life Support
PAR	Post Anaesthesia Recovery
PEPP	Payment Error Prevention Program
PGD	Patient Group Direction
PIP	Patient Identification Procedure
PMDC	Pakistan Medical & Dental Council
PNC	Pakistan Nursing Council
PNC	Post-Natal Care
PNRA	Pakistan Nuclear Regulatory Authority
PO	Purchase Order
POD	Patients Own Drugs
PPE	Personal Protective Equipment
PRE	Patient Rights and Education
QA	Quality Assurance
QC	Quality Control
QI	Quality Improvement
RBS	Random Blood Sugar
RHC	Rural Health Centre
RIS	Radiology Information System

ROM	Responsibilities of Management
RTAT	Radiology Turn Around Time
RTI	Reproductive Tract Infection
SAM	Self-Administration of Medicine
SMPs	Standard Medical Protocols
SOPs	Standard Operating Procedure
SPSS	Statistical Package of Social Sciences
SSI	Surgical Site Infection
SSIS	Surgical Site Infection Surveillance
STI	Sexually Transmitted Infections
SVD	Spontaneous Vaginal Delivery
SWOT	Strengths, Weaknesses, Opportunities, Threats
TAC	Technical Advisory Committee
THQH	Tehsil Headquarter Hospital
TNCC	Trauma Nursing Care Course
V/Q	Ventilation/Perfusion
WHO	World Health Organization
WM	Waste Management
WMO	Woman Medical Officer
WMT	Waste Management Team
ZBB	Zero-Based Budgeting

# 1. Introduction

The Government of Khyber Pakhtunkhwa promulgated the Khyber Pakhtunkhwa Health care Commission Act, 2015, to establish the Khyber Pakhtunkhwa Health Care Commission (KP HCC) as a regulatory body with the prime objective to improve the quality of healthcare services and ban quackery in Khyber Pakhtunkhwa in all its forms and manifestations. The KP HCC is legally mandated<sup>1</sup> to regulate all Health Care Establishments (HCEs) in the public and private sectors through registration and licensing. It is the responsibility of the HCEs throughout the province to get registered with KP HCC. Moreover, the KP HCC is ensuring to improve and maintain quality of healthcare through the implementation of Minimum Service Delivery Standards (MSDS). The HCEs are required to follow these standards in order to get license. No Health care Establishment can function legally without being registered and licensed by the Khyber Pakhtunkhwa Care Commission.

The KP HCC has adopted MSDS developed by the Punjab Healthcare Commission (PHC) for the three recognized systems of treatment; Allopathy, Homeopathy, and Tibb. These Minimum Service Delivery Standards include hospitals, Basic Health Units, General Practitioners/Specialist Clinics, Dental Clinics, Clinical Laboratories and Collection Points, Radiological/Imaging Diagnostic Centers, Homeopathic Clinics, and Tibb Clinics. Hospitals have been divided into the following categories, having different standards and indicators.

*Table 1: Categorization of Hospitals*

Category 1	Bed Strength
Hospitals	50 and more beds
	31-49 beds
	01-30 beds

## 1.1 Service Delivery Standards

Setting service delivery standards and indicators is an established practice for continually improving the provision of quality services in the health sector. Joint Commission International (JCI) in the USA is one such organisation that sets standards to improve the quality of health services. Likewise, the Quality Care Commission in the UK ensures clinical governance with the help of a system of setting standard and facilitating compliance. The Indian Public Health Standards' were introduced in 2005 and since then the Quality Council of India expanded their scope with the launching of 'Standards for the Health and Wellness Industry in 2008. The Australian Council on Healthcare Standards was initiated in 1974 that has facilitated the development of the New Zealand and Singapore Councils. Accreditation Canada (formerly the Canadian Council on Health Services Accreditation) became independent from the Joint Commission for Accreditation of Hospitals (JCAH) in 1953. The Quality Holistic Accreditation (QHA) Trent Accreditation Scheme is based in the UK and Europe and has serviced hospitals in Asia.

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<sup>1</sup> Khyber Pakhtunkhwa Health Care Commission Act, 2015

Internationally accredited hospitals can be found in Pakistan, India, Bangladesh, Kazakhstan, China and Iran.

Standardization of healthcare services by implementing Minimum Service Delivery Standards is however, a newer concept in Pakistan, and Khyber Pakhtunkhwa province has taken the initiative by establishing the Khyber Pakhtunkhwa Health Care Commission.

The primary objective of developing MSDS is to set a benchmark for health care establishments to become eligible for the grant of a license by the KP HCC. These standards are primarily designed to regulate the premises in terms of the various functional areas to improve quality of healthcare services. The issuance of a certificate of registration allowing the health practitioners according to their mandate, however, remains the responsibility of their respective council/commission in accordance with their statutory provisions.

## 1.2 Reference Manual for Hospitals with 50 & Above Beds

In order to meet its legal obligations towards all recognized systems of healthcare, the Commission has developed the Minimum Service Delivery Standards and Indicators for implementation at hospitals having 50 and above beds. The document comprises 35 standards with 168 associated indicators grouped in 10 universally accepted Functional Areas for such services along with Reference Material and Assessment Scoring Matrix. Keeping in view the ground realities, these standards have been kept **dynamic** and subject to evidence based improvement. All aspects of implementation, assessment and scoring have been included in this single document to better facilitate the implementers at HCEs as well as the surveyors involved in inspections.

A **Colour Coding** scheme has been introduced to facilitate the Hospital/HCE staff responsible to implement and assess implementation status at their own level before formal assessment by the KP HCC. The RED indicators are required to be fully implemented and have been ascribed 100% weightage, while YELLOW requires partial compliance at least to the extent of 80%. This is acceptable level to qualify for a license from KP HCC. Following scoring scale shall be used for Self-Assessment by the HCE staff as well as by the KP HCC Assessors:

Lowest		Shades of Levels of Implementation							Highest	
0	1	2	3	4	5	6	7	8	9	10

The compliance level for hospitals having 50 & above beds is 100% for some indicators, while others require partial compliance of 80%. 123 indicators require full compliance and have been ascribed 100% weightage while 45 are acceptable even at partial compliance at least to the extent of 80% (ascribed 80% weightage).

Assessment Scoring Matrix is given at the end of each standard and related set of indicators. The HCE staff is advised to have self-assessment to ensure complete implementation, before the KP HCC assessors carry out formal assessment and score the HCE for licensing on the basis of criteria described above. Summary Scoring Matrix is given at **Annexure A**.

**PART 2**  
**STANDARDS, INDICATORS**  
**AND**  
**ASSESSMENT SCORING**  
**MATRIX**

## 2. STANDARDS, INDICATORS AND ASSESSMENT SCORING MATRIX

### 2.1 Responsibilities of Management (ROM)

#### 05 Standards & 17 Indicators

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These standards provide the structure to help leaders effectively work together to enhance organizational performance. To meet their obligations effectively, leaders/managers must collaborate, which means working together in a spirit of collegiality to achieve a common end. Good relationships thrive when leaders work together to develop the mission, vision, and goals of the organization, encourage honest and open communication, and address conflicts of interest.

Many hospitals have three leadership tiers, the governing body, senior managers and clinical staff, who work together to deliver safe and high quality care. The leadership standards address topics such as creating a culture that fosters safety as a priority; planning and providing services that meet patient needs; ensuring availability of the physical, financial and human resources necessary to provide care and engaging in performance improvement. The standards make clear that management of these functions is the direct responsibility of all leaders and that a well-functioning relationship amongst the leadership tiers enhances the quality of care provided to the patients.

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## Standard 1. ROM-1: Hospital is identifiable as an entity and easily accessible.

### Indicators (1-2):

**Ind 1. The hospital is identifiable with name, discipline and KP HCC registration / licence number on sign board(s).**

#### Survey Process:

The essence of the indicator is to ascertain that any one approaching the hospital is able to locate it with the help of sign board(s)<sup>2</sup> having clearly written Name, Discipline(s) / Specialty of the Hospital and the Registration/Licence number<sup>3</sup> issued by KP HCC, as the case may be. Surveyor is required to assess this indicator while approaching the Hospital from a distance of about 30-40 Meters.<sup>4</sup>

#### Scoring:

- If there is a sign board(s) with clearly written Name of the Hospital, its Discipline(s) / Specialty and the KP HCC Registration/License number visible from a distance as above, then score as **fully met** or if there is a main sign board/s with clearly written Name of the Hospital, the Discipline(s) / Specialties available in the hospital and the KP HCC Registration/License number displayed on a board inside,<sup>5</sup> then also score as **fully met**.
- If there is no sign board or there are non-conformities to above, then score as **not met**.

### GUIDELINES

#### Identification of the HCE

Identification of the HCE is of paramount importance. It is an essential requirement that every HCE can be clearly identified by its name, discipline and status of registration / license from KP HCC. It shall create a positive impact of the HCE in terms of its being a legitimate Healthcare Service Provider while excluding those who are not qualified/authorized to practice.

HCEs are required to install appropriate boards taking into consideration safety measures and fulfilling legal/codal Municipal requirements including:

1. Size of the board in relation to the HCE building.
2. Location and fitting strength of the board in view of the wind.
3. Clear visibility from the approach road.

<sup>2</sup> Registration/license number can be on the main sign board or on separate smaller board or plate as considered feasible and the detailed list of specialties on a board is prominently displayed inside the hospital.

<sup>3</sup> All HCEs are required to get registered with KP HCC vide Section 12 of KPH CC ACT 2015.

<sup>4</sup> Minimum 3x4 ft. size of the board is recommended.

<sup>5</sup> Relaxation in terms of displaying KP HCC Registration/License number on the main sign board is for initial ONE year.

## Ind 2. Location of the hospital is easily accessible to the people.

### Survey Process:

Surveyors are to see that the location of the Hospital is easily accessible to a common patient. Main entrance is free from encroachment as far as possible<sup>6</sup> and preferably has separate IN and OUT gates<sup>7</sup> to facilitate smooth access to the Ambulances/Transport/Fire Fighting Vehicles (Link FMS Ind. 15, 23-26). The entrance of the HCE also provides an easy access to the old and disabled people with a RAMP to facilitate stretcher and wheelchair movement.

### Scoring:

- If the location of the HCE is accessible as described above, then score as **fully met.**
- If the location of the HCE is not easily accessible to a common patient/in emergency and there are no efforts on record by the management to improve the situation, then score as **not met.**

## GUIDELINES

### Location and Accessibility

There is a tendency of encroachment on the in/out gates of the HCEs by the shops, Taxis/Rickshaws and other vendors which hinders the traffic flow and passage of the patients. This scenario needs intervention by the management of the HCE who should coordinate with concerned authorities for remedial actions. The management of HCE is required to facilitate access to the disabled and old aged patients through ramps for the movement of stretcher, wheel chair etc. The ramps should not be steep or slippery.

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<sup>6</sup> A hospital should preferably not be located in a commercial building where other activities are also on going. The Hospital Administration will be responsible to coordinate in writing with the relevant authorities (traffic/TMA etc.) to keep the approach road/gate cleared but no existing HCE will be closed down on this account. The record of existing HCEs shall demonstrate efforts/plans for improvement of accessibility to achieve the standard.

<sup>7</sup> All new constructions/conversions will be responsible to cater for this requirement.

## Assessment Scoring Matrix

**Standard 1. ROM 1: Hospital is accessible and easily identifiable as an entity.**

Indicator 1-2		Max Score	Weightage (Percentage)	Score Obtained
Ind 1.	The hospital is identifiable with name, discipline and KP HCC registration / licence number on sign board(s).	10	<b>100</b>	
Ind 2.	Location of the hospital is easily accessible to the people.	10	<b>100</b>	
<b>Total</b>		20	-	

## Standard 2. ROM-2: The staff on duty is identifiable.

### Indicators (3-4):

**Ind 3. Door plate(s) at clinics/offices clearly display name, qualification(s), and designation(s) of the staff on duty**

#### Survey Process:

Observe the placement of the door-plate(s), qualifications / designation(s) and conformity of the text on the plates with law / Act / ethical guidelines of the respective councils. It generally means, the registered name, authorized qualification/s and specialty in full or with permissible abbreviations as the case may be are written.

#### Scoring:

- If all the door-plates are according to the above, then score as **fully met.**
- If less than 100% of the door-plates exist/display full information as above, then score as **not met.**

### GUIDELINES

#### Staff Identity

Identification of the staff on duty at HCEs is essential because;

1. Patients/relatives have a right to know as to who is providing care to the patient.
2. For seeking follow up of treatment.
3. To provide feedback regarding quality of care.

**Ind 4. The staff on duty uses the provided identity badge.<sup>8</sup>**

#### Survey Process:

The essence of the indicator is to ascertain that every employee of the hospital<sup>9</sup> who is on duty can be identified by means of the Identity badge which is either hanged around the neck with a ribbon or is clipped on to the front pocket of the shirt/coat. The badge has clearly written name/designation, specialty/discipline, where applicable, date of joining, with specimen signatures duly authenticated (signed & stamped) by the issuing authority.<sup>10</sup>

#### Scoring:

- If the staff is using an identification badge which clearly identifies the Hospital Staff as above,

<sup>8</sup> Means a full identity card with photo and signatures to be issued by the hospital/HCE.

<sup>9</sup> With the exception of female staff like nurses/ lady doctors etc. who may not like their names/photos to be displayed, a modified system having appointment and some number may be devised.

<sup>10</sup> Medical Superintendent or Administrator.

then score as **fully met.**

- If the authorized identification badge is not in use or there are non-conformities to above, then score as **not met.**

## GUIDELINES

### **Issuing Authority for Identity Badges**

The identity badge(s) should provide correct and standardized information regarding particulars of the person to whom the card is issued to avoid impersonation.

The Medical Superintendent/Administrator of the HCE is responsible to finalize the specimen and to sign the identity badge.

## Assessment Scoring Matrix

**Standard 2. ROM 2: The Staff on duty is identifiable.**

Indicator 3-4		Max Score	Weightage (Percentage)	Score Obtained
<b>Ind 3.</b>	<b>Door plate(s) at clinics/offices clearly display name, qualification(s), and designation(s) of the staff on duty.</b>	10	<b>100</b>	
<b>Ind 4.</b>	<b>The Staff on duty uses the provided Identity Badge</b>	10	<b>100</b>	
<b>Total</b>		20	-	

## Standard 3. ROM-3: A suitably qualified / experienced individual manages the hospital

### Indicator (5):

**Ind 5. The individual who heads the hospital has requisite qualifications and experience.**

#### Survey Process:

Review the roles and responsibilities of the individual who is managing the hospital and assess if he/she has appropriate qualification and experience as described below, to manage the portrayed services.

The head of the hospital should preferably be a Medical Graduate, and preferably with hospital management experience. However, in case where the hospital administrator/manager is not a medical graduate, he/she should have a management qualification to manage the support services only while all technical matters related to patient care will be managed/supervised by the person(s) having medical qualification and experience

#### Scoring:

- If the head of hospital has the required qualification and experience as given above, then score as **fully met**.
- If the head of hospital does not have the required qualification and experience as given above, then score as **not met**.

### GUIDELINES

#### Qualification and Experience of Hospital Administrators

Medical Superintendent/Medical Director/Administrator/In-charge of these HCEs should preferably be a Medical Graduate, and preferably with hospital management experience. However, in case where the hospital administrator/manager is not a medical graduate, he/she should have a management qualification to manage the support services only while all technical matters related to patient care will be managed/supervised by the person(s) having medical qualification and experience. Following Job Description (JD) may be taken as a sample to prepare JDs for Medical Superintendent/Administrators of the same level Hospitals to suit the local needs.

#### **1. Job Summary**

Medical Superintendent is the overall administrator in charge of hospital functioning. He/she exercises administrative and financial powers allocated to him/her under delegation of administrative and financial Powers / Rules. He achieves his goals by planning, budgeting, organizing, staffing, directing, coordinating, delegating, monitoring, controlling and regulating various functions. Ensures best possible medical services within the available resources. Evolves strategies to improve financial resources of the hospital and optimizes patient satisfaction.

## **2. Duties / Responsibilities**

### **i. Administrative / Management**

- a. Overall responsible for delivery of preventive, curative, rehabilitative and promotive health care.
  - a. Ensures medical cover in emergency arising due to floods, heavy rains, epidemics or disaster situation like major accidents or earthquakes.
  - b. Preparation and implementation of Annual Operational Plan (AOP).
  - c. Sanctions leave of the officers/officials as per delegation / rules.
  - d. Constitutes a Planning Committee to make and execute Facility Health Plan to improve health care system and its delivery.
  - e. Ensures regular maintenance / prompt repair of all the equipment of the hospital for keeping it in working order at all times.
  - f. Responsible for redressing the grievances of the public by taking quick & appropriate decisions.
  - g. Delegates powers to his subordinate administrative staff for smooth functioning of the hospital.
  - h. Prepares Disaster Plan and ensures its implementation through regular drills and revisions.
  - i. Responsible for developing and smooth functioning of the Hospital Management Information Systems (HMIS) through proper and timely collection of statistics from all source points.
  - j. Reviews the hospital services quarterly to know about lapses and takes measures to improve upon.
  - k. Holds regular meetings with clinical staff in order to keep in touch with their problems if any, and to have an appraisal of the services provided by them.
  - l. Assigns duties to his subordinate administrative staff.
  - m. Signs all the Local Purchase medicines of admitted and outdoor patients.
  - n. Leads the Waste Disposal Committee to take care of the disposal of human tissues, other wastes etc., according to SOPs.
  - o. Leads the Infection Control Committee to ensure actions according to SOPs.
  - p. Adapts broader Policies/Protocols/SOPs to meet local requirements/ conditions to make those specific to the facility and ensures that every employee is conversant with these.
  - q. Recruitment, promotion and transfer of staff within the hospital as authorized by the Government.
  - r. Submits the disciplinary cases to the appropriate higher authorities.
  - s. Conducts round of the hospital at least once a day in order to meet the patients to ensure their satisfaction, find out their problems, to randomly check the patient charts to see written clinical notes of doctors & compliance of nurses, provision of medical facilities / treatment accordingly and ensure general cleanliness of hospital.
  - t. Checks that expense book / Empty Vial drugs register is being maintained by the Charge Nurse/relevant staff.
  - u. Conducts at least one surprise round of hospital departments and support services in a week in order to ensure that they are doing their jobs as prescribed and are helping/ supporting the clinical services to be delivered in conformance to Minimum Service

Delivery Standards.

- v. Identifies the deficiencies in performance of the staff during visits and suggest corrective measures in consultation with relevant staff.
- w. Reviews the HMIS reports and ensures their timely submission.
- x. Issues job descriptions to each employee under their signatures and maintains that record.
- y. Initiates the Performance Evaluation Reports of staff of the hospital.
- z. Countersigns the Performance Evaluation Reports of the staff initiated by the officers under his direct control.
- aa. Ensures that hospital protocols and procedures are amended from time to time as per requirement / Government instructions.
- bb. Acts as member of Hospital Management Committee (HMC) and participates in its meetings.
- cc. Ensures the implementation of decision of HMC.
- dd. Performs any other professional duty assigned by the relevant higher authority.

**ii. Financial**

- a. Acts as Drawing and Disbursing Officer for the hospital.
- b. Ensures timely submission of annual budget proposal for the hospital.
- c. Ensures utilization of the budget in accordance with the Financial Rules.
- d. Ensures that all types of receipts are timely deposited and record is accordingly maintained.
- e. Makes sure that contractors of canteen, parking stands and telephone booths etc. deposit the requisite amount of contract timely with the cashier.

**iii. Logistics**

- a. Participates as a member of procurement committee for procurement of the supplies and medicines.
- b. Monitors the allocation and distribution of supplies and medicines within the hospital.
- c. Responsible for keeping all the ambulances in running condition and getting timely repair of any out of order ambulance.
- d. Signs on the duty slips of ambulances.
- e. Countersigns on the log books of ambulances.

**iv. Trainings**

- a. Ensures appropriate training of concerned personnel for enabling them to perform duties effectively as laid down in the objectives of the health care deliverance.
- b. Receives trainings as and when organized by the higher authorities.

## Assessment Scoring Matrix

Standard 3. ROM 3: A suitably qualified / experienced individual manages the Hospital.

Indicator 5		Max Score	Weightage (Percentage)	Score Obtained
Ind 5.	The individual who heads the hospital has requisite qualifications and experience.	10	100	
Total		10	-	

## Standard 4. ROM-4: The responsibilities of the management are defined.

### Indicators (6-14):

**Ind 6. Those responsible for management establish the Hospital's Organogram and appoint staff accordingly.<sup>11</sup>**

#### Survey Process:

Review i. The chart that displays the hospital's organizational structure; ii. The Job Descriptions (JDs); and iii. The Credentials of the key Hospital Staff in that whether they fulfill the requirement of the Job Description. For example, review the roles and responsibilities of the individual who is heading the hospital and assess if the incumbent has appropriate qualification and experience to manage the portrayed services and connected requirements e.g. appointing qualified and experienced staff on every appointment under him / her and overall management. Similarly, the heads of the departments / sections, specialists and nurses / paramedics etc. are to have qualifications / experience commensurate to their respective roles.

#### Scoring:

- If all the staff appointments are as described above and match the organizational chart (organogram), then score as **fully met**.
- If staff appointments are not as described above, or the organogram does not exist, then score as **not met**.

### GUIDELINES

#### Organogram

An Organizational Chart (often called Organization Chart, or Organogram) is a diagram that shows the structure of an organization and the relationships of its departments and positions. An organizational chart gives a clear line of authority and responsibility in terms of immediate supervisors for various positions.

It is defined as "formal and informal framework of policies and rules, within which an organization arranges its lines of authority and responsibilities and allocates rights and duties. An organizational structure determines the manner and extent to which roles, responsibilities and power are delegated, controlled, and coordinated, and how information flows between various levels of management" The higher management is responsible to develop the Organizational Charts in consultation with Departmental Heads and appoint staff against various positions accordingly.

A good organizational chart of a HCE clearly depicts the following:

1. Functions/services
2. Relationships

<sup>11</sup> This indicator is applicable to every section of the hospital/HCE, hence scoring of this will be on overall assessment.

3. Responsibilities
4. Authorities
5. Communications
6. Span of control

HCEs should have a policy for regularly reviewing (annually) and updating the organogram in terms of changes in positions. The organogram is to be displayed at all relevant places and be available with the pertinent staff. A Sample Organogram is depicted on the following page.

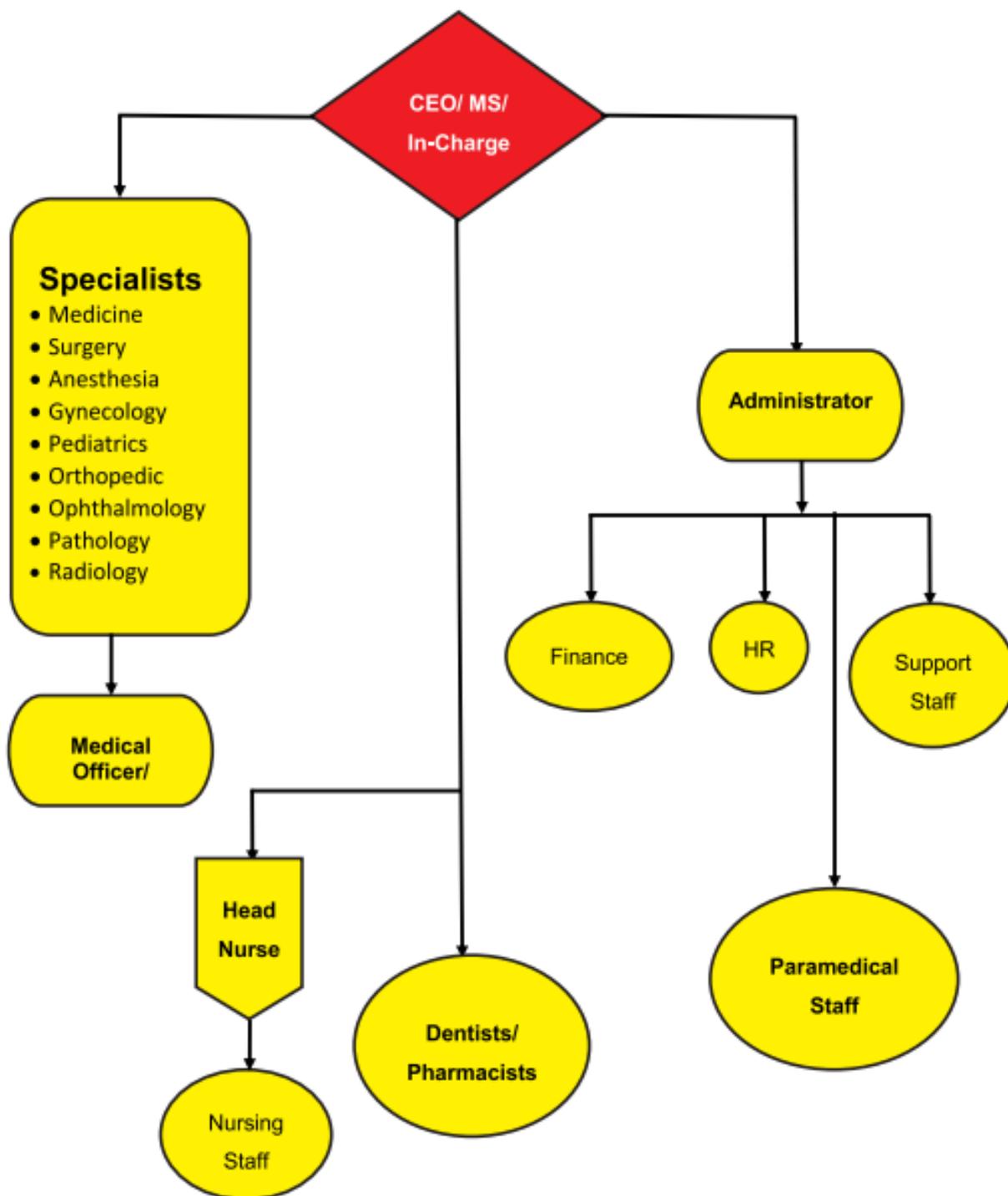
The Indicative Organogram of these HCEs (given at figure 1 below) can be modified as per requirements considering sanctioned/available staff positions.

### **Staff Appointment**

The senior management e.g. Management Committee, a Board or the owner of the HCE as the case may be are responsible for appointment of the staff as depicted in the organogram to ensure proper functioning of the system and to achieve the assigned goals. In doing so they ensure that the appointed staff has the qualification/s and experience to match the job requirements.

Figure 1: Indicative Organogram

## Indicative Organogram



## Ind 7. The hospital management lays down the hospital's mission statement.

### Survey Process:

Review the hospital's mission statement and see if policies support the statement. See if the mission is published for the staff and interview the staff to ascertain if they are aware of and support achievement of the mission.

### Scoring:

- If there is a mission statement and staff members are aware of the mission, then score as **fully met.**
- If there is no mission statement, or if the staff is not aware of it, then score as **not met.**

## GUIDELINES

### Responsibility of Laying Down the Mission

A mission statement presents the aims of the organization and summarizes the long term expected output whereas the vision statement outlines the hopes and dreams for the future medical practices. Responsibility of laying down the mission of the Hospital rests with the Senior Management i.e. The Board of Directors and/or Owners, with the help of the Executives i.e. the MS and the HoDs, along with and other relevant Stakeholders. Mere availability of a Mission Statement in the documents or publishing on the web is not sufficient. The mission statement is to be displayed at prominent places like the office of the hospital in-charge, OPD, waiting areas, emergency and conference room etc. It is also desirable that the hospital performance reports also contain the mission statements.

The involvement of the senior management in the development of the mission can be confirmed by seeing the relevant signed documents i.e. Minutes of Meetings or such development records, or a final mission statement.

The responsibility to provide the appropriate resources to achieve the mission including infrastructure, equipment, qualified & trained HR, finance and support services etc. lies with the senior management.

Samples of mission statements are given below:

#### ***MISSION—Sample 1***

At \_\_\_\_\_ Hospital we recognize the value of every person and are guided by our commitment to excellence. We demonstrate this by: providing exemplary physical and psychological care for each of our patients and their families; balancing the continued commitment to the care of the poor and those most in need; building a work environment where each person is valued, respected and has an opportunity for personal and professional growth.

#### ***MISSION—Sample 2***

\_\_\_\_\_ Hospital is a \_\_\_\_\_ bedded Multi-Specialty Public Sector Tertiary Care Hospital. Its Mission is to provide Healthcare Services of a highly specialized nature, contribute to the Prevention and Cure of Disease and Promote Medical Research and Education Programs, including

Undergraduate, Postgraduate Education and Training.

**MISSION—Sample 3**

At \_\_\_\_\_ Hospital, we are committed to provide Healthcare of the Highest Quality in a Compassionate, Friendly, and Professional Environment.

**MISSION—Sample 4**

Hospital strives to provide Quality Treatments, Health Education, Rehabilitative and Preventive Services at par with International Standards.

**Ind 8. The hospital management develops the long- and short-term work plans.**

**Survey Process:**

Review the long- and short-term plans. Verify that the plans are in accordance with the hospital's mission and the resources support implementation of the plans. Check to see that staff members are aware of the plans and know where they can access a copy.

**Scoring:**

- If there are both long- and short-term plans and they are in accordance with the hospital's mission and adequately supported by the senior management in terms of resources, then score as **fully met**.
- If there is a long-term plan but no short-term plan to define how the strategy will be implemented, then score as **partially met**.
- If there is no long-term plan, then score as **not met**.

**GUIDELINES**

**Long-and Short-Term Work Plans<sup>12</sup>**

Planning is the process by which leaders of an organization determine what it intends to be in the future and how it will get there. They develop a vision for the organization's future and determine the necessary priorities, procedures, and operations (strategies) to achieve this vision. Included in this vision are measurable goals which are realistic and attainable, but also challenging; emphasis is on long-term goals and strategies, rather than short-term (such as annual) objectives.

While closely related to long-term planning, strategic planning is generally considered to place a greater emphasis on strategies on how the organization will achieve its vision, while long term planning places greater emphasis on determining the vision. Strategic planning helps assure that an organization remains relevant and responsive to the needs of its community, and contributes to organizational stability and growth. It provides a basis for monitoring progress, and for assessing results and impact.

<sup>12</sup> Strategic Planning: A Ten Step Guide. Retrieved from [http://siteresources.worldbank.org/INTAFRREGTOPTEIA/Resources/mosaica\\_10\\_steps.pdf](http://siteresources.worldbank.org/INTAFRREGTOPTEIA/Resources/mosaica_10_steps.pdf)

## 1. The Purpose

Work Planning is intended to accomplish three important tasks:

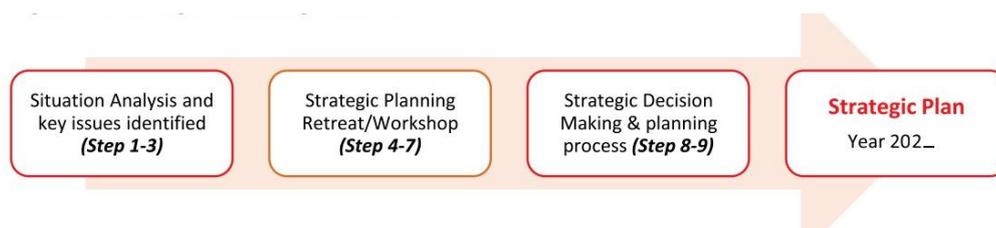
- i. To clarify the goals/outcomes that an HCE wishes to achieve.
- ii. To select the broad Plans which will enable the HCE to achieve those outcomes.
- iii. To identify ways to measure progress in achieving the goals/outcomes.

## 2. The Process

There are many different models and action steps for strategic planning. One approach is summarized below. It assumes a cooperative effort between the Management and staff, proposing a *Strategic Planning Committee* (constituted by the hospital in-charge), comprising of management members and staff, taking the responsibility. Some of the work can be done in the committee, while planning sessions or a retreat/workshop will be required; both early and late in the planning process. Following figure provides the sample strategic planning process.

*Frequently, Steps i-iii occur before a strategic planning retreat, Steps iv-vi during the retreat, and Steps vii-viii after the retreat, as shown in Figure 2 below:*

**Figure 2: Strategic Planning Process**



Typical steps along with some suggested approaches for carrying out each step are described below:

### i. Agree on a strategic planning process.

This may be done at a meeting between management, key staff, and some external stakeholders like district health management and community leader(s). The meeting agenda may be:

- a. Understanding of what strategic planning is and how it is done.
- b. Discuss its potential value to the HCE, in terms of providing a common vision and focus, with agreed-upon goals and strategies.
- c. Consider procedures or steps which can be used to establish and implement a strategic plan.
- d. Constitution of a strategic planning committee comprising of committed key staff to the process with willingness to devote time to the planning effort.
- e. Agree upon a process and establish responsibilities for various steps in the process, including organizing a planning retreat/or a series of planning meetings.

### ii. Carry out Situation Analysis

In order to plan for the future, an HCE must know where it currently stands and what factors

might influence its future. The HCE therefore, must consider its current strengths and weaknesses and to examine its environment for potential opportunities and problems at an early stage. Some planners call this a situation analysis or environmental scan. The approach might include: Understanding of what strategic planning is and how it is done.

- a. Critical Issues Review: an analysis of the issues most important to the future of the organization.
- b. SWOT (Strengths, Weaknesses, Opportunities, Threats): an analysis and evaluation of internal conditions and external factors that affect the organization.
- c. Force Field Analysis: an analysis of the forces propelling an organization forward and those holding it back.

### **iii. The external component of the Situation Analysis**

This should include a review of the target or service community and the broader environment in which the organization operates, to identify the opportunities and threats facing the organization. This might include taking account of the following: Critical Issues Review: an analysis of the issues most important to the future of the organization.

- a. Changing demographics, political trends, economic trends, the implications of new or changing laws and regulations, technological trends and consider their impact on your organization and the population it serves.
- b. Immediate target community or service area to determine its status and needs, and specifically those of current and potential clients and beneficiaries of the hospital's services.
- c. Opportunities and challenges related to resources and funding sources.
- d. Actual and potential collaborators, including organizations which may serve the same area or target population.
- e. This process may involve a community needs assessment with interviews, focus groups and surveys, or a small number of informal discussions with clients and other community residents, public officials, funder representatives, and other appropriate individuals.

### **iv. The internal component of the Situation Analysis**

This includes an assessment of the organization's strengths and weaknesses. This may include a number of components or approaches.

- a. Assess current organizational performance in terms of financial and human resources (inputs), operating methods or strategies (processes), and results or outcomes (service utilization/outputs). Also, understand how stakeholders, including the community, view the organization using brief questionnaires and/or interviews conducted by a third party, to assure frank and honest responses. This information will further analyze the reasons - in terms of inputs and processes - for perceived weaknesses in outcomes.
- b. Identify critical success factors for the organization to understand what factors are necessary to the future and continued success of the organization. These may be factors like relationship with target community, resources, governance structure, and staff skills and style.
- c. An HCE may obtain this information through a staff retreat or a series of meetings with

staff in various components and at various levels within the organization. The committee responsible for the strategic plan should work with staff to plan the situation analysis/environmental scan, help to conduct external interviews with community leaders and assure that the management receives a full report on the results of the environmental scan process.

- d. The result of the environmental scan should be an analysis of organizational strengths and weaknesses and external opportunities and threats. This may be verbal or written, and requires careful review and discussion by the strategic planning committee. Strategic planning retreat will begin with a presentation of results of the environmental scan.

**v. Identify key issues, questions, and choices to be addressed as part of the strategic planning effort.**

It means specifying "strategic issues" or questions that the organization should address, and setting priorities in terms of time or importance. If there is little disagreement about issues and priorities, it may move immediately to the organizational vision and then goals. If there is no agreement on general directions and organizational goals, it may be important to explore issue priorities and identify critical choices. This might be done in several ways, for example:

- a. Management and staff might be asked to identify strategic issues from the environmental scan, with individuals identifying a specified number of such issues and indicating why each is strategic, including the benefits of addressing it and the negative consequences of not addressing it. This might involve a wide range of program or other issues e.g., the need for initiating new programs to address a particular community need. For example, education/awareness or housing etc., which would result in expansion of the organization's target area from particular neighborhoods to the entire city, or would involve a decision as to whether the HCE should consider collaboration with another organization/department.
- b. The planning group might work to identify strategic issues emerging from the environmental scan, and then prioritize them in terms of importance, timing, and feasibility. The result should be a set of strategic issues that will be addressed as part of the strategic planning process, preferably during the retreat, and a second set that will not be addressed or will receive limited attention at the retreat, but will be considered by the management or appropriate staff.

Whatever the method used, the discussion on issues should generate some level of agreement or choices to be considered and decisions to be made as part of the strategic planning process.

*Once **Steps i-v** have been completed, you are ready to develop a strategic planning retreat agenda and schedule a one- to two-day retreat or a series of shorter meetings.*

**vi. Define or review the organization's values, community vision, and mission.**

Be sure there is a consensus on why the HCE exists, what goals or outcomes the hospital seeks to achieve, what it stands for, whom it serves, things it must do or not do based on

its bylaws, and then these should be clearly defined.

Consider beginning of strategic planning by agreeing on the following:

- a. **Organizational core values or operating principles.** Those principles that guide the organization; these values are shared by management and staff, strongly held, and not easily changed.
- b. **Community Vision.** Vision for the community; it might be viewed as an image of what the community being served would be like if values were shared and practiced by everyone. [Note that this is a vision for the community, not a personal vision of what the organization will look like in three to five years or more].
- c. **Mission.** The stated purpose for organization's existence; it might be viewed as the organization's public statement of the contribution it promises to make to help accomplish the community vision.

Agreeing on values, vision, and mission is usually best accomplished as a part of a planning retreat or at a special meeting; the process will usually take several hours, and should include the Board and at least senior staff. Often, the draft values and mission statement will describe the vision as part of the strategic planning session, and then the Strategic Planning committee or task force will review and refine the specific language, and bring the refined language to the Board for approval.

#### **vii. Develop a shared vision for the organization.**

In some strategic planning efforts, a vision for the organization is developed after a vision for the community has been discussed - with the assumption that a shared organizational vision may be dependent upon a shared vision of what society should become. Whenever this is done, it is important to agree on where the organization wants to be in three to five years (It is often helpful to focus on where the HCE is required to be at the end of the period covered by the strategic plan).

For many Board and staff members/senior management/owner, it makes sense to first develop a vision of where the HCE is required to be in a specified number of years, and then define strategies/ways that will help it get there. The vision might describe the HCE broadly, in terms of its mix of services, reputation or status inside and outside its primary target community, key accomplishments, and relationships with stakeholders; specific descriptions might be included in relation to service/target area, its scope, funding, governance, staffing, relationships with other entities, visibility, etc. This form of "visioning" can be done by selected team members who should complete a formal worksheet indicating where they see the HCE in broader and specific terms. For example:

- a. **Broad categories.** Describe the HCE in five years, in terms of categories such as services, resources, status, relationships, institutional development, and governance; or
- b. **Specific characteristics.** Describe the HCE in five years, in terms of target area, target populations, budget, percentage of funding from public and private sources, staff size and composition, staff/component structure, program areas, offices/locations, relationship with the private sector and relationship with major local public agencies. Individuals would then share the information in small groups, reach some form of shared responses, then present these to the larger group. The group must then reach consensus on a shared vision.

**viii. Develop a series of goals or organizational status statements, which describe the organization in a specified number of years.**

It is usually a short step from the vision to goals - the statements describing the vision are essentially goal statements. It is extremely valuable to transform the vision into a series of key goals for the organization, preferably in the form of status statements describing the organization. For example, goals might cover a variety of categories, stated as follows:

- a. **Program/Services:** "The hospital will operate an alternative maternity unit with public funding that will serve 20 clients"; "The hospital will provide comprehensive EmONC services to clients."
- a. **Resources:** "The hospital will have a budget of Rs. 50 million and a staff of 250."
- b. **Status:** "The hospital will be the largest and most respected healthcare facility in the district."
- c. **Relationships:** "The hospital will be represented on major alliance in healthcare and teaching areas."
- d. **Institutional Development:** "The hospital will expand its building, which will also provide space for rent to other community-based organizations working in health sector"; "The hospital will have a fully computerized financial management, Electronic Medical Record (EMR) and Management Information System (MIS), with all staff connected through a network."
- e. **Governance:** "The hospital management will take an active role in resource development, taking responsibility for one major special event each year"; "The hospital will establish three active working committees - Programs/Services, Finance, and Resource Development - which will meet and report monthly."

**ix. Agree upon key strategies to reach the goals and address key issues identified through the environmental scan.**

The major emphasis should be on strategies related to specific goals. The process requires looking at where the organization is now and where its vision and goals indicate it to be, and identifying tactics/interventions to get there. The management needs to provide its view to guide this effort, while the planning group or staff can do much of the detailed analysis. Approaches might include the following:

- a. Once the key issues to be addressed and the goals have been specified, the planning group looks back at the SWOT results of the environmental scan, and identifies changes in current strategies/plans which may be required to reach the goals and address the issues. These would be presented to the Board and key staff for discussion and decisions.
- b. The planning group might review the planning process to date, develop and present to the management and key staff a series of alternative approaches or scenarios, for example; should there be increased decentralization or more centralization. Based on the decisions made using these scenarios, strategies / plans will be determined. Whatever the specific approach used, specific criteria for evaluating and choosing among strategies should be agreed upon. They may include such criteria as suggested below:

- **Value** - Will the strategy/Plan contribute to meeting agreed-upon goals?
- **Appropriateness** - Is the strategy/plan consistent with the HCE's mission, values, and operating principles?
- **Feasibility** - Is the strategy practical, given personnel and financial resources and capacity?
- **Acceptability** - Is the strategy acceptable to the Board, key staff, and other stakeholders?
- **Cost-benefit** - Is the strategy likely to lead to sufficient benefits to justify the costs in terms of time and other resources?
- **Timing** - Can and should the hospital implement this strategy at this time, given external factors and requirements?

Based on these or other agreed-upon criteria, strategies/plans can be evaluated and selected, or prioritized.

In agreeing upon strategies, the planning group should always consider the need to clearly define responsibilities for their implementation. For example, if a strategic plan goal is to make primary health care available to the target group, regardless of the ability to pay; then a key strategy might be to establish an alliance with local agencies/organizations to work towards establishment/support of a community health center. Implementing this strategy must be assigned to someone or some unit within the hospital.

*Steps vi-ix will be completed during a strategic planning retreat/workshop. The Strategic Planning committee or a designated staff member will need to take notes from the retreat/workshop, the results of the environmental scan, and other relevant materials and begin drafting a strategic plan. Once this draft has been prepared, the next step can begin.*

**x. Develop an action plan that addresses goals and specifies objectives and work plans on an annual basis.**

Once a strategic plan/broader plan has been developed, a specific work plan to begin implementation must be ensured. Based on strategies and annual objectives, an action plan must be developed. Annual program objectives should be time-based and measurable. The annual plan may be a part of the strategic plan or may be an annual addendum to it. Objectives and work plans would also serve annual budget estimates and funding sources. Developing objectives and annual work plans requires both management and staff input, with staff often taking major responsibility for program-related goals and objectives, once the management has defined organizational goals.

The management must approve the action plan, while staff can do much of the development of the written plan. This is an area of staff expertise, since implementation of programs and other strategies based on policies set by the management is a staff function.

**xi. Finalize a written plan that summarizes the results and decisions of the strategic planning process.**

There is no set format, but be sure to include the outputs of each major step. Be sure progress towards goals and objectives and use of strategies is monitored regularly, with

strategies revised and annual objectives developed yearly, based on the progress made, obstacles encountered and the changing environment.

**SWOT Analysis**

The first part of any SWOT analysis is to collect a set of key facts about the organization and its environment. This will include facts about the organization's scope, financial resources, facilities, employees, inventories, management, environmental setting (e.g. technology, political, social, and economic trends), history and reputation. It is customary for the analysis to take account of internal resources and capabilities (strengths and weakness) and factors external to the organization (opportunities and threats).

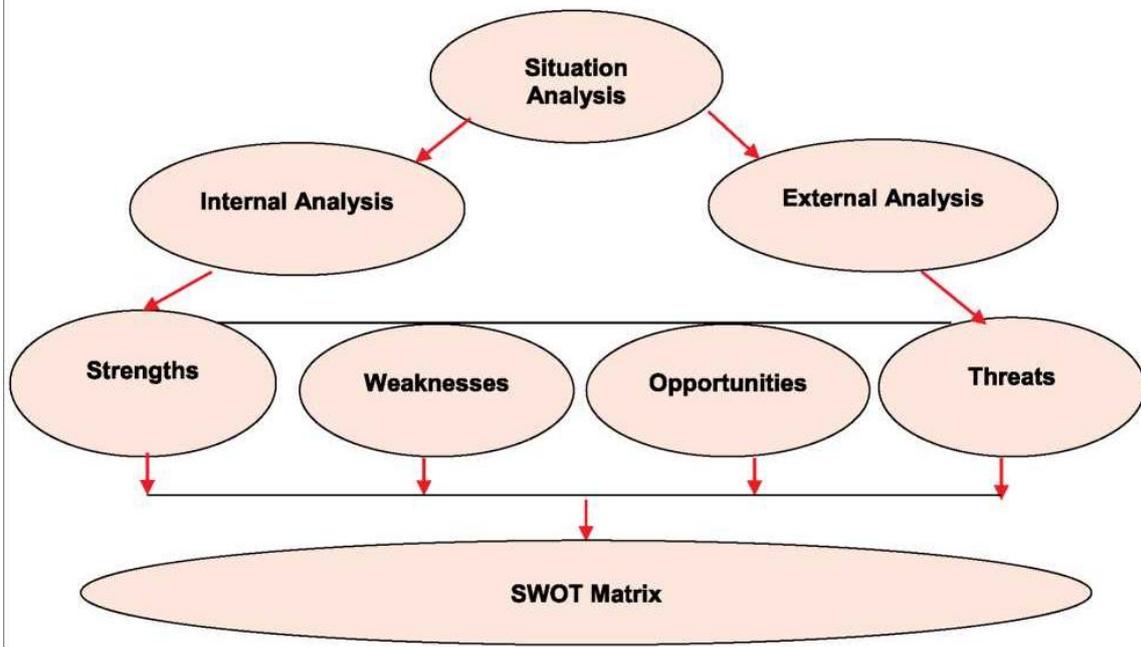
**SWOT Analysis Framework:**

Following table provides a sample framework for analysis:

*Table 2: SWOT Analysis Sample*

<p><b>Strengths</b></p> <ul style="list-style-type: none"> <li>• What are your advantages?</li> <li>• What do you do well?</li> <li>• What do other people see as your strengths?</li> </ul>	<p><b>Weaknesses</b></p> <ul style="list-style-type: none"> <li>• What could you improve?</li> <li>• What do you do badly?</li> <li>• What should you avoid?</li> </ul>
<p><b>Opportunities</b></p> <ul style="list-style-type: none"> <li>• Where are the good opportunities facing you?</li> <li>• What are the interesting trends you are aware of?</li> <li>• Opportunities can come from: Changes in technology and markets, changes in policy. Changes in social patterns, population profiles, lifestyle changes, etc.</li> </ul>	<p><b>Threats</b></p> <ul style="list-style-type: none"> <li>• What obstacles do you face?</li> <li>• What is your competitor doing?</li> <li>• Are the requirements for your service changing?</li> <li>• Is changing technology threatening?</li> <li>• Do you have funding problems?</li> </ul>

**Figure 3: SWOT Matrix**



**Sample Planning Format**

**1. Introduction**

- i. Need for a Long-Term Plan
- ii. How the Plan was Developed

**2. The Situation Analysis/Environmental Scan**

- i. Organizational History and Structure
- ii. The External Environment
  - a. Provincial/National Situation and Trends
  - b. Local Situation and Trends
  - c. Summary of Opportunities and Threats
- iii. The Organization
  - a. Scope of Activities
  - b. Program Operations
  - c. Governance
  - d. Management
  - e. Summary of Strengths and Weaknesses

**3. Organizational Values, Vision and Mission**

- i. Values or Operating Principles
- ii. Community Needs
- iii. Organizational Mission

**4. Goals, Planned Accomplishments and Future Plans**

- i. Organizational Vision and Planned Accomplishments: The Organization in X Years.
- ii. Goals and Priorities
- iii. Strategies / Plans

**5. Monitoring and Review**

- i. Monitoring Progress
- ii. Plans for Reviewing and Refining the Plan

**6. Annual Plan/Short Term Plans (may be prepared separately)**

- i. Programs/Services
- ii. Governance
- iii. Management/Institutional Development
- iv. Monitoring and Evaluation

**Attachments**

- 1. Environmental Scan Data
- 2. Other Supporting Information

*Table 3: Action Planning Lay Out Sample*

Area	Strategy /Plan	Intervention	Timeframe (months)									Responsibility	Cost
			2	3	4	5	6	7	8	9			
Services													
Quality													
Human Resource													

*Table 4: Hospital's Strategic/Long-term Planning Process Sample*

Assessment Activities	Timeline	Responsible Person	Activity Description
Primary Care Demand			Estimated annual primary care
Utilization of services			Estimated annual utilization of services
Revenue Analysis			Estimated annual revenue by hospital expenditure heads
Community Survey			<ul style="list-style-type: none"> <li>• Survey of catchment population addressing satisfaction and concerns with clinic and health care clinicians</li> <li>• Develop survey questionnaire</li> <li>• Acquire survey mailing list</li> <li>• Analyze and review survey results</li> </ul>
Key Informant Interviews			Perceptions of 25-30 local residents regarding health care issues including clinic facilities, services, quality, governance and medical providers.
Employee Satisfaction			Survey completed by hospital employees along with interviews of key department heads to solicit their

Survey and Focus Group Interviews			perceptions of what is working/what is not; what changes they feel would be beneficial to the organization; etc.
Review of Assessment Findings			<ul style="list-style-type: none"> <li>• Presentation of assessment findings;</li> <li>• Discussion of data usage to improve the healthcare delivery system</li> </ul>
Mission Statement Development and Vision Creation			A mission statement distinguishes, making clear what is unique about what you do. It tells, from the client's perspective, what you offer. A vision is a powerful mental image of what the future could hold. It is a framework for what you want to create, which guides decisions and commitments for action.
Strategic Planning workshop			Facilitated discussion to develop an action plan of goals and strategies based on assessment findings, mission and vision.

**Ind 9. Those responsible to approve the hospital's budget, allocate resources required to implement the work plans.**

**Survey Process:**

Determine by review that the hospital has adequate resources required to implement the work plans in line with the Hospital's mission.<sup>13</sup>

**Scoring:**

- If the budget supports the implementation of the work plans, then score as **fully met**.  
OR if those responsible for management certify that there have been no budgetary issues in the implementation of work plans, score as **fully met**.
- If the budget does not support the work plans, then score as **not met**.

**GUIDELINES**

**Budget Allocation**

Budget formulation and allocation of resources is a responsibility of the senior management. It requires forecasting and finalization of the draft budget. Budgeting refers to the setting of the expenditure with respect to the organization's core function. Budgeting is the setting and allocation of the capital which is then used to achieve the set targets of the HCE. The budget needs to be focused and prepared to cover all the financial requirements so that the financial targets of the HCE are viable with the overall financial plan. It needs to include the capital cost and recurrent expenditures. The capital cost and recurrent expenditures have proportionate allocation so that any future investments does not affect the scheduled existing expenses of the HCE. Budgeting needs to be done in a meaningful way so that it covers all the financial targets of the HCE.

<sup>13</sup> Ideally there should be a participatory / consultative process of developing the budget of the hospital on need basis with a "bottom-up approach."

**Ind 10. Those responsible for management monitor and measure the performance of the hospital against the work plans.**

**Survey Process:**

There should be objective measures/indicators that allow monitoring of progress toward meeting the hospital's goals/targets indicated in the work plan. Review any documentation such as meetings of the governing body, management committee or the senior administration of the hospital to review the performance of the hospital on the basis of a checklist.

**Scoring:**

- If there is documentation of monitoring of the progress toward the hospitals operational goals/targets indicated in the work plans, then score as **fully met.**
- If there is no documentation, then score as **not met.**

**GUIDELINES**

**Internal Monitoring and Evaluation**

The HCE will be required to monitor the implementation of its plan and to report on progress towards achievement of defined objectives in line with the planned activities. As part of its monitoring responsibility, the HCE should prepare regular reports to identify the progress in terms of implementation.

**Some of the questions which may be answered during the monitoring process are as follows:**

1. Original HCE activity plan and schedule
  - i. Have the planned activities been implemented at the intended time and by the designated person/s or not and if not, why?
  - ii. Should activities that have not been implemented be rescheduled?
2. HCE's general objectives  
Are the activities implemented achieving the desired result?
3. Original activity plan/schedule and general objectives of the HCE  
Should any of the activities given in the HCE's planned schedules and general objectives be adjusted, rescheduled or cancelled on the basis of experience to date?

The HCE should prepare an annual report, which compares progress on planned objectives, constraints experienced during the year and recommendations on the way forward.

Following table provide monitoring parameter format:

*Table 5: Performance Monitoring Format*

Target/Goal	Timeline	Responsibility	Achievement	Gaps	Further Plan
Description	Dates	Names	Description	Description	Description

**Ind 11. The hospital management addresses the hospital’s social and community responsibilities.**

**Survey Process:**

Look for documents that demonstrate that the hospital is aware and has shown sensitivity towards its community's healthcare needs. Also look for any voluntary "out-reach" activities catering for community's health needs such as medical camping, awareness campaigns and providing aid to people hit by calamities etc.

**Scoring:**

- If there is evidence that the Hospital is sensitive to the social responsibilities mentioned as above, then score as **fully met**.
- If there is NO evidence that the Hospital is sensitive to the social responsibilities mentioned as above, then score as **not met**.

**GUIDELINES**

**Social and Community Responsibilities**

The HCE should be sensitive to the needs of the community it serves and should demonstrate awareness about prevalent health related problems in its catchment area. The demonstration may be in the form of some record that confirms voluntary "out-reach" activities catering for community's health needs such as providing out door health care by medical camping, awareness campaigns and providing aid to people hit by calamities etc.

Private Sector HCEs are also expected to provide lifesaving care to those who fall prey to accidents/emergencies while in the close proximity of Private HCE, as transportation of a serious patient to a Public Sector HCE for want of free treatment may be at the cost of patient's life. The expected social responsibility of an HCE would be limited to providing basic life support (BLS), documenting the life saving measures taken, and referring the patient to the appropriate facility.

HCEs are expected to use the potential of CSOs/NGOs, as they are always willing to contribute in such activities.

1. The organization should have SOPs for handling a sudden rush of victims of Natural Calamities and Disaster Situations like:
  - i. Earthquakes
  - ii. Floods
  - iii. Hurricanes
  - iv. Plane Crashes
  - v. Train Accidents
  - vi. Civil Unrest Outside The Organization's Premises
  - vii. Terrorist Attacks
  - viii. Bomb Blasts
  - ix. Major Fires
  - x. Enemy Actions/War, etc.
2. The SOPs to ensure adequacy of medical supplies, equipment, materials, trained and identified personnel, transportation means, communication aids and Mock Drill Methodology.
3. The HCE should have a documented Disaster Management Plan which incorporates essential element of alert code, information and communication, written orders for each of the staff, availability and earmarking of the resources, establishment of a command nucleus, training and mock drills. The following points should be incorporated in the plan;
  - i. The A&E Department should follow the triage policy.
  - ii. Provision is made for availability of medical supplies, equipment and materials during such emergencies.
  - iii. Resource availability should be according to threat perception e.g. quantity of resources, like in medical stores etc., to be cross-checked with expected workload. First Aid Boxes prepared and labelled with relevant Emergency like "Flood" or "Fire" and kept as standby would reduce the response time. However, this would require periodical checks to replenish the consumed stock and to avoid the expiry of medicines etc.
  - iv. Staff is trained in the hospital's disaster management plan.
  - v. The training shall include various elements of the disaster plan.
  - vi. The plan is tested through Mock Drills at least twice a year or more frequently as per requirement.
  - vii. Mock Drills shall test all the components of the plan and not just awareness using simulated patients (not real).

At the conclusion of every Mock Drill, the variations are identified and the reason for the same is analyzed, debriefing of the drill conducted and where appropriate, necessary corrective and/or preventive actions are taken.

## Ind 12. Those responsible for governance appoint the senior leaders in the organization.

### Survey Process:

Look for the existence of management board/team or committee constituted of senior professionals who are in decisive role. Clear ToRs of management committee/board are defined.

### Scoring:

- If the hospital has a management board including senior professionals and defined ToRs, then score as **fully met**.
- If the hospital does not have any management board including senior professionals and defined ToRs, then score is **not met**.

## GUIDELINES

### Board of Management/Directors

For appropriate and efficient utilization of resources and to become a quality service provider for the catchment population, the HCE will need inputs from diverse stakeholders.

The HCE, in the first instance could be overseen by a Board of Management (BoM)/Board of Directors or Management Committee, as the case may be, comprising of experts (official/non-official) from various streams of professions and social set ups. The BoM/Management Committee shall have the following broad TORs:

1. A non-official member shall, unless otherwise directed by the Government, hold office for a period of three years and shall be eligible for re-appointment.
2. The MS shall also act as Secretary of the Management Committee.
3. All decisions of the BoM/Management Committee shall be taken by a majority of votes; provided that, in case of equality of votes, the Chairman of the Board/Committee shall have a second or casting vote.
4. No Act or proceeding of the BoM/Management Committee shall be invalid merely on the ground of existence of any vacancy or defect in the constitution thereof.
5. It shall be lawful for the BoM/Management Committee to start functioning as soon as it is notified.
6. The BoM/Management Committee shall appoint senior leaders in the HCE.

## Ind 13. Those responsible for governance support research activities or hospital data analysis for quality improvement.

### Survey Process:

Review the Continuous Quality Improvement (CQI) programme for research or hospital data analysis component and verify that legal and ethical requirements are fulfilled in accordance with the national/international guidelines. Similarly, hospital data is analyzed and used for CQI.

### Scoring:

- If research or hospital data analysis is conducted and its results are utilized in CQI programme, then score as **fully met**.

- If all research or hospital data analysis is not conducted and/or its results are not utilized in CQI programme, then score as **not met**.

## GUIDELINES

### **Research/Hospital Data Analysis and Quality Improvement**

Research in healthcare is a process of gathering information, gaining knowledge about a condition, disease or a medicine etc. for the purpose of initiating, modifying or terminating a particular treatment/management of a disease for continually raising the standards of healthcare.

All research including the protocols must be formally approved by the senior management of the HCE. Research/hospital data analysis reports are submitted to the governing body that documents the results of the CQI programme. Ideally, the governing body should ask for more information or direct actions when required.

It also needs to be verified that those responsible are providing guidance, resources and budget, fulfilling all legal and ethical requirements. It is important that HCEs undertake research/hospital data analysis which is relevant to improvement in healthcare services ensuring conformity to the approved National/International Guidelines.

**Ind 14. The organization complies with the laid down and applicable legislations and regulations.**

### **Survey Process:**

Observe the placement of color coded waste bins, signage for infection control, fire safety and other building codes. Randomly interview the staff to ascertain if they are aware of and support implementation of applicable laws/rules/regulations.

### **Scoring:**

- If there are clear indicators mentioned above and staff is aware of applicable laws, then score as **fully met**.
- If there are no indicators mentioned above and staff is not aware of applicable laws, then score as **not met**.

## GUIDELINES

### **Compliance to Legislation and Regulations**

HCEs are required to abide by the relevant laws of the State/Province to ensure safety and comfort of patients and the care providers like waste management, infection control and building codes etc.

It is the responsibility of the senior management to be familiar with these laws/rules/regulations and ensure the same by other relevant staff for implementation. List of some relevant laws is at **annexure B**.

## Assessment Scoring Matrix

**Standard 4. ROM 4: The responsibilities of the management are defined.**

Indicator 6-14		Max Score	Weightage (Percentage)	Score Obtained
Ind 6.	Those responsible for management establish the Hospital's Organogram and appoint staff accordingly.	10	100	
Ind 7.	The Hospital management lays down the Hospital's mission statement.	10	100	
Ind 8.	The Hospital management develops the long- and short-term work plans.	10	80	
Ind 9.	Those responsible to approve the Hospital's budget, allocate resources required to implement the work plans.	10	100	
Ind 10.	Those responsible for management monitor and measure the performance of the Hospital against the work plans.	10	100	
Ind 11.	The Hospital management addresses the Hospital's social and community responsibilities.	10	100	
Ind 12.	Those responsible for governance appoint the senior leaders in the organization.	10	100	
Ind 13.	Those responsible for governance support research activities and quality improvement plans	10	100	
Ind 14.	The organization complies with the laid down and applicable legislations and regulations	10	100	
<b>Total</b>		90	-	

## Standard 5. ROM-5: Hospital premises support the scope of work /services.

### Indicators (15-17):

**Ind 15. The hospital space is in accordance with the minimum requirement.**

#### Survey Process:

Observe that the clinical and non-clinical areas have space sufficient to cater for the minimum requirements and to allow performing the functions related to patient care and support services. The space allows comfortable sitting and movement for patients / staff between various areas.

#### Scoring:

- If the hospital has well demarcated portions to cater for the portrayed clinical and related support services and patients are comfortably placed, then score as **fully met.**
- If the hospital **does not** have well demarcated portions to cater for the portrayed services and the premises is congested / overcrowded, then score as **not met.**

### GUIDELINES

#### Hospital Space Parameters

Considering 500 sq ft per bed in case of a General Hospital for calculating total hospital area and separate calculations for special services when bed strength alone is not the decisive factor should be considered for a Category I HCEs to be established in future.

Comfortable sitting may include a comfortable posture and not touching each other. Comfortable movement may include not hitting / touching each other when crossing each other. Minimum 10 patients may be considered to be there in the waiting area at a time.

Following space approved by the Government for different level HCEs in the public sector<sup>14</sup> may be used for guidance:

*Table 6: Health Department Categorization of HCEs*

Category of HCEs	Number of Beds	Area (Kanals)
Category A	350	70
Category B	210	60
Category C	110	40-50
Category D	40	20-30
Rural Health Centre	20	10-12
Basic Health Centre	-	5-6

<sup>14</sup> Essential Package of Health Services, Health Department, Government of Khyber Pakhtunkhwa

## Ind 16. Hospital has adequate facilities and civic amenities for the comfort of the patients and attendants.

### Survey Process:

During survey observe the presence of the following in the Hospital:

1. Sitting arrangement in OPD, waiting areas & bedside attendants.
2. Alternate arrangements of electricity, at least emergency lights for all patient areas and electric generator for OT, Emergency, Labor Room, ICUs/ CCUs etc.
3. Waste Container /Receptacle(s).<sup>15</sup>
4. Proper ventilation.
5. Mosquito and Fly proofing (Wire Gauze).
6. Clean drinking water.
7. Toilets with adequate washing and bathing facilities.
8. Air conditioning where required.
9. Playing areas preferably for admitted children.

### Scoring:

- If the Hospital has facilities from 1 to 9, then score as **fully met**.
- If any one of the facilities stated at 1 to 9 is not existing, then score as **not met**.

## GUIDELINES

### Adequacy of the facilities

Hospitals/HCEs are a public place where sick and wounded come for seeking medical care. As such the patients and relatives have to spend varying lengths of times at the HCE during which they are required to remain comfortable for which basic amenity provision becomes essential. The provision of amenities and facilities varies at various HCEs according to their charging rates. However, every HCE is required to provide certain basic requirements like proper reception and sitting arrangements in OPD, waiting areas & bedside. Similarly, alternate arrangements of electricity, at least emergency lights for all patient areas and electric generator for OT, Emergency, Labor Room and ICUs/ CCUs etc., waste Container /Receptacle/s<sup>16</sup>, proper ventilation, mosquito and Fly proofing (Wire Gauze), Clean drinking water, toilets with adequate washing and bathing facilities and air conditioning where ever required.

## Ind 17. Hospital has adequate arrangements for the privacy of patients during consultation / examination / procedures etc.

### Survey Process:

Observe if arrangements for patient's privacy during consultation/examination and performing

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<sup>15</sup> As per the Hospital Waste Management Rules (amended from time to time) framed under the Environment Protection Act.

<sup>16</sup> As per Khyber Pakhtunkhwa Waste Management Rules, 2018.

procedures are respected.<sup>17</sup> It is unethical / undesirable to even take history when other unrelated persons are sitting close by and overhearing. The history taking and examination should not be visible to any unrelated person by any means.

**Scoring:**

- If the arrangements for patient's privacy during consultation / examination / performing procedures are adequate, then score as **fully met.**
- If privacy arrangements are not available, then score as **not met.**

GUIDELINES
<p><b><u>Privacy of the Patient</u></b></p> <p>The script from the Hippocratic Oath signifies the entire concept of the privacy of the patient as follows:</p> <p><i>"..... I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know....."</i></p> <p>Privacy of the patients during conduct of examination for assessment is a key component of the clinical methodology taught to medical students. Respecting privacy and confidentiality of the patient/s is an integral part of the Code of Ethics of PM&amp;DC reproduced below:</p> <p><b>"Section 17. Examination, consultation or procedures on a female patient:</b></p> <p>(1) A female patient shall be given consultation either by a female medical or dental practitioner or shall be examined in the presence of a female attendant by a male doctor. Under no circumstances a male attendant, assistant or husband or relative etc. shall be allowed during a gynecological and obstetrical consultation, examination or during normal delivery being conducted by a female medical practitioner. However, in exceptional circumstances a patient may file a request with the medical practitioner to allow her husband to witness a normal delivery and the medical practitioner may consider the request and shall ensure that sanctity of the female patient is preserved during procedures and consultation and there is no unnecessary exposure.</p> <p><b>Permission of patient before examination:</b></p> <p>A doctor shall normally take permission from a patient before making a physical examination. In case of minors, the child's guardian shall be present or give permission for the examination. For any intimate examination the patient, irrespective of age, patient is entitled to ask for an attendant to be present. Such requests shall be acceded to whenever possible.</p> <p><b>Confidentiality:</b></p> <p>The physician has a right to and shall withhold disclosure of information received in a confidential context, whether this is from a patient or as a result of being involved in the management of the patient, or review of a paper, except in the following specific circumstances where he may carefully</p>

<sup>17</sup> Female patient and minors are not examined alone. In such an event another female should be requested to remain present. (Details to be seen in Reference Manual - during or for examination patient consent is obtained; conversation during history taking not audible and interview/examination place not visible to others not concerned.)

and selectively disclose information where health, safety and life of other individual may be involved, namely:

1. The medical or dental practitioner cannot seek to gain from information received in a confidential context (such as a paper sent for review) until that information is publicly available;
2. There is no legal compulsion on a doctor to provide information concerning a criminal abortion, venereal disease, attempted suicide, or concealed birth regarding his patients to any other individual or organization. When in doubt concerning matters, which have a legal implication, the medical or dental practitioner may consult his/her legal adviser;
3. The professional medical record of a patient shall not be handed over to any person without the consent of the patient or his/her legal representative. No one has a right to demand information from the doctor about his patient, save when the notification is required under a statutory or legal obligation and when in doubt, the medical or dental practitioner or a dentist may consult a legal advisor;
4. confidences concerning individual or domestic life entrusted by patients to a medical or dental practitioner and defects in the disposition or character of patients observed during medical attendance shall never be revealed unless their revelation is required by law;
5. a medical or dental practitioner who gains access to medical records or other information without consent shall be guilty of invasion of privacy; and
6. the medical or dental practitioner who grants access of an information of a patient to a third person except. Councilor law enforcing agencies, without consent shall be guilty of breach of confidentiality, but where a medical or dental practitioner is of the opinion to determine it his duty to society requiring him to employ knowledge about a patient obtained through confidence as a medical or dental practitioner, to protect a healthy person against a communicable disease to which he is about to be exposed, the Medical or dental practitioner shall give out information to concerned quarters.

**Taking of photograph or videos for teaching purpose:**

Taking of patients' photographs and videos shall be done in such a manner that a third party cannot identify the patient concerned. If the patient is identifiable, he or she shall be informed about the security, storage and eventual destruction of the record."

## Assessment Scoring Matrix

**Standard 5. ROM 5: Hospital premises support the scope of work / services.**

Indicator 15-17		Max Score	Weightage (Percentage)	Score Obtained
<b>Ind 15.</b>	<b>The hospital space is in accordance with the minimum requirement.</b>	10	<b>100</b>	
<b>Ind 16.</b>	<b>Hospital has adequate facilities and civic amenities for the comfort of the patients and attendants.</b>	10	<b>100</b>	
<b>Ind 17.</b>	<b>Hospital has adequate arrangements for the privacy of patients during consultation / examination / procedures etc.</b>	10	<b>100</b>	
<b>Total</b>		30	-	

## 2.2 Facility Management and Safety (FMS)

### 03 Standards & 12 Indicators

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A hospital not only serves the medical needs of the society but even generates revenues that are utilized in meeting expenses and further expansions. With every passing day, the need to have excellent hospitals is on the rise. The focal point is that in a hospital there is no second chance as we are talking of human lives, so it is desirable that laboratories and theaters are in prime working condition and precision of all equipment is at the highest level. It is imperative to let professionals handle and maintain these facilities in accordance with the relevant standards because reliability, professionalism and the sustainable reputation of the hospital relies on these services and facilities.

Healthcare facility management is constantly required to maintain a clean and healthy environment. Maintenance plays a major role in keeping the hospital running in an orderly fashion. Healthcare facilities can use software to figure out how much is being spent on generators and expensive surgical equipment, parts of the building or type of maintenance problem, to enhance their efficiency and drag-and-drop labor calendars to efficiently manage overtime costs. Service requests need to be responded to quickly and efficiently and preventive maintenance schedules need to be set up in order to provide a clean, healthy environment, without interruption.

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## **Standard 6. FMS-1: The hospital/HCE is aware of and complies with the relevant regulations, rules, laws and bylaws, facility inspection requirements under the relevant building and associated codes applicable to hospitals.**

### **Indicators (18-21):**

**Ind 18. The management is conversant with the relevant laws and regulations.**

#### **Survey Process:**

Check to see that management is conversant with and have copies of the relevant laws and regulations including fire safety requirements, lifts/elevators (where applicable), building codes/specifications, handling of contaminated & nuclear waste, clean water supply, sanitation, ventilation, safe food and procurement of safe pharmaceuticals etc. The management need to have effective contingency plans in the event of primary systems failure.

#### **Scoring:**

- If there is clear evidence that the management is conversant with the above regulations, rules, laws and codes/specifications etc. then score as **fully met.**
- If there is no evidence of applied knowledge of above legal and regulatory requirements, then score as **not met.**

### **GUIDELINES**

#### **Applicability of Laws and Regulations to HCE**

The basic design of a HCE is ideally required to support its functions e.g.

1. Emergency services
2. Outpatient-related functions
3. Indoor facilities
4. Diagnostic and treatment activities
5. Research, training and teaching.
6. Pharmacy services
7. Administration/hospital management
8. Support and supply services
9. Residential accommodation for essential staff
10. Mortuary
11. Catering services
12. Civic services
13. Parking areas
14. Horticulture

The legal aspect is one of the most significant considerations in planning and designing a project. Architects, engineers, planners, economists and those in allied professions must have working knowledge of the applicable laws, rules and regulations and relevant codes before they can practice their profession.

In the Public Sector, Communication and Works Department (C&W) is the main governmental body that is responsible for planning and designing hospital buildings. The department has an architect section headed by the Chief Architect, with the responsibility to design hospital projects. In the private sector hospital buildings are designed by the architectural firms in accordance with the local government/TMA Codes.

In either case, designing and planning of the hospital should be done in accordance with the relevant laws/regulations and codes including the following:

### **1. Zoning Regulations**

With the land-use map, this regulation (Guidelines for Development and Operations) ensures that the site selected is located in the area appropriate for the intended use. A planner/designer who designs a site plan must consider the following aspects of the project while remaining within zoning restrictions of the law pertaining to the locality:

- i. Access and accessibility.
- ii. Catchment area to be served.
- iii. Volumetric dimensional limits of the building in terms of site coverage.
- iv. Building height.
- v. Distance of other facilities and utilities required.
- vi. Easements and rights of way, if any.
- vii. Sources of materials and of local skilled and unskilled labour.

Although such regulations constrain design, they also establish the criteria that help to evolve a design which is consistent with the overall plan for the community, without disturbing the local ethos and environment while ensuring safety.

### **2. Building Code**

The building code is provided to achieve the maximum safety and to establish standard requirements for the construction of buildings that can withstand powerful earthquakes and other calamities. It contains provisions for:

- i. Classification and general requirements for hospital by use or occupancy.
- ii. Types of construction.
- iii. Light and ventilation.
- iv. Labour safety and welfare during construction.
- v. Sanitation.
- vi. Electrical and mechanical regulations.
- vii. Design, keeping in view of history of incidence of earthquakes, cyclones and other disasters/calamities.
- viii. Protection from ionizing radiation from X-ray equipment.
- ix. Permits and inspection requirements.
- x. Any other code prescribed by State.

### **3. Fire code**

The fire code should be provided by the Rescue Department; however, the following provisions of the fire code must be adhered to in order to minimize injury, death, and loss to the staff, patients and families and also to curtail damage to hospital infrastructure:

- i. General precautions against fire.
- ii. Principles of fire safety in buildings/structures.
- iii. Fire protection appliances.
- iv. Maintenance of fire exits.
- v. Purpose specific design of high-risk building, such as theatres and auditorium etc.
- vi. Suppression control in hazardous areas.
- vii. Specifying smoking areas as per provisions of relevant Law/Rules.
- viii. Management and use of combustible materials.

### **4. Movement of Patients, Attendants and Visitors**

- i. Patients should be requested not to leave their ward or floor although walking within the ward area is encouraged when appropriate.
- ii. Children admitted to the hospital should have an attendant, preferably a female.
- iii. Ladies in the delivery suite may have their spouse or a female attendant.
- iv. Patients in private rooms should also be allowed an attendant.
- v. For all other inpatients, the ward nurse shall decide on the necessity of an attendant on the basis of the patient's clinical condition.
- vi. Where permitted, only one attendant shall be allowed per patient.
- vii. Attendants in female wards should be female.
- viii. Attendants shall be issued an entry pass to enter and remain in the hospital outside visiting hours.
- ix. Authorized attendants in the Pediatric Intensive Care and High Dependency Units shall be provided with free sleeping accommodation.
- x. All visitors should enter and leave the hospital only through the main entrance. For their own protection, children below 12 years are not allowed to visit patients. Visitors are restricted in the Coronary Care Unit, Intensive Care Units and Special Care Baby Unit.

### **5. Other codes**

Other relevant bylaws, regulations and codes include **sanitation codes, environmental protection laws** and **water codes**. These vary in form and content according to the requirements and need of the hospital. By complying with these, the planner and designer should ensure that:

- i. Design is consistent with the national/international standards for Public Health and Safety.
- ii. The permits and licenses necessary for establishing the hospital, related to above mentioned codes, are obtained.

The following International Standards should also be considered while designing the hospital:

- i. Facility Guideline Institute (FGI) Guidelines for Design and Construction of Hospitals and Health Care Facilities
- ii. International Building Code (IBC)
- iii. National Fire Protection agency (NFPA)
- iv. The American with Disabilities Act (ADA)
- v. Occupational Safety and Health Administration (OSHA)

## 6. Inspection of Hospital Design

Hospital administration can hire some professional private construction company for inspection of the building design in addition to the indigenous systems of inspection. During inspection, application of National/International building codes, where necessary, must be checked in addition to the following parameters:

- i. The land or site upon which hospital is being constructed.
- ii. Design or structure of the hospital.
- iii. Use of standardized raw material and its consumption.
- iv. Methods of construction or workmanship.
- v. Sanitation codes, environmental protection laws and water codes.
- vi. Minimum standards for the width/size of the doors, aisles, passageways, stairways, or other means of exit.
- vii. Structural strength or the stability of the building to withstand any damages by fire, earthquake, wind, flood, or by any other cause.

**Ind 19. The management regularly updates any amendments in the prevailing laws of the land.**

### Survey Process:

Directly observe evidence of routinely updated, laws and regulations.

### Scoring:

- If there is evidence of a process to identify, acknowledge, update and incorporate changes in laws and regulations, then score as **fully met.**
- If there is no evidence of an update process, then score as **not met.**

## GUIDELINES

### Compliance to Legislation and Regulations

HCEs are required to abide by the relevant laws of the State/Province to ensure safety and comfort of patients and the care providers like waste management, infection control and building codes etc. It is the responsibility of the senior management to be familiar with these laws/rules/regulations, any amendment thereto and ensure the same by other relevant staff for implementation.

**Ind 20. The management ensures implementation of these requirements.**

### Survey Process:

Check to see if the concerned staff is aware of the compliance requirements and the documentation supports implementation and that this is confirmed with observable examples.

### Scoring:

- If the concerned staff is aware of the compliance requirements of prevailing laws and regulations and there is evidence of compliance, then score as **fully met.**

- If there is substantial compliance, then score as **partially met.**
- If the concerned staff is not aware of the compliance requirements of prevailing laws and regulations and / or there is no compliance, then score as **not met.**

## GUIDELINES

### **Risk Management**

Every organization depending on its size is required to assign one or more individual/s to provide leadership and oversight for planning and implementation of the requirements of the risk management program. All aspects of the risk management program including inter alia the following features, must be managed effectively in a consistent and continuous manner:

1. Planning all aspects of the program.
2. Implementing the program.
3. Educating the staff.
4. Testing and monitoring the program.
5. Periodical review and revision.
6. Annual reports to the governing body/Board on the effectiveness of the program.
7. Providing consistent and continuous management support.

This is particularly important during construction or renovation of a facility. For that purpose, qualified engineering services should be mandatory for every HCE.

## Ind 21. There is a mechanism to regularly update licences / registrations / certifications.

### **Survey Process:**

Directly observe and note the validity and currency of the range of compliance documents.

### **Scoring:**

- If there is a full range of current compliance documents, then score as **fully met.**
- If there is a full range of compliance documents however some are not current then score as **partially met.**
- If there is incomplete range of compliance documents, then score as **not met.**

## GUIDELINES

### **Renewal of Licenses and Certifications**

This Indicator applies to the renewals of licenses/certifications for Radiology Equipment, Lifts, Diesel Generating sets, etc. The organization should maintain a Log Book/Tracker Sheet for this purpose. A designated official/staff member should be made responsible to enlist the licenses/registrations/ certifications required under the laws and regulations applicable to the HCE. This official in turn could identify the appropriate personnel in the organization who can be made responsible to implement the respective laws and regulations ensuring the timely renewal of the pertinent licenses/certificates.

## Assessment Scoring Matrix

**Standard 6. FMS 1: The hospital/HCE is aware of and complies with the relevant rules and regulations, laws and bylaws and facility inspection requirements under the relevant building and associated codes applicable to hospitals.**

Indicator 18-21		Max Score	Weightage (Percentage)	Score Obtained
Ind 18.	The management is conversant with the relevant laws and regulations.	10	100	
Ind 19.	The management regularly updates any amendments in the prevailing laws of the land.	10	100	
Ind 20.	The management ensures implementation of these requirements.	10	80	
Ind 21.	There is a mechanism to regularly update licenses / registrations / certifications.	10	80	
<b>Total</b>		40	-	

## Standard 7. FMS-2: The hospital/HCE has a program for clinical and support service equipment management

### Indicators (22-25):

**Ind 22. The hospital/HCE plans for equipment in accordance with its services and long / short term plans.**

#### Survey Process:

Review any written plan that includes at least: i. Requisition, ii. Testing, iii. Planned preventive maintenance and iv. An inventory of ALL medical equipment in the hospital that includes evidence of a formal disposal (write-off) process. While visiting patient care areas, identify five pieces of medical equipment and ask for documentation that the equipment is listed on the hospital's inventory.

Confirm that there is an adequate budget to support implementation of the full plan including in house as well as outsourced maintenance plan<sup>18</sup>.

#### Scoring:

- If there is a plan (and evidence that it is resourced and being implemented), then score as **fully met**.
- If there is a plan but it does not include the requirement for testing prior to use, or there are inadequate skills and resources for implementation, then score as **partially met**.
- If there is no medical equipment plan or if it does not include the preventive maintenance plan or if there is no inventory of medical equipment, then score as **not met**.

### GUIDELINES

#### **Procurement Planning**

While planning for selection and procurement of the type, number and specifications of various equipment to be installed in the HCE, the organization must keep into consideration the;

1. Scope of services to be provided.
2. Catchment population to be served.
3. Burden of disease in the pertinent location.
4. Future expansion/up graduation requirements.

The plans and SOPs regarding equipment selection and procurement should be periodically reviewed and revised.

**Ind 23. Equipment is selected by a collaborative process.**

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<sup>18</sup> In case of in-house maintenance, staff training and availability of service manuals, required tools, parts and consumables to deliver the required preventive maintenance and servicing regime needs to be ensured. For the maintenance which is beyond the scope of in-house maintenance staff, outsourced arrangements need to be ensured.

### Survey Process:

Review the process for assessing needs and prioritizing the requests for new or replacement medical equipment. There should be evidence that the appropriate department / section heads and 'end-users' participate in determining the best options and procurement priorities.<sup>19</sup>

### Scoring:

- If there is process for prioritizing requests for new or replacement medical equipment and there is input from the appropriate department/ section heads, then score as **fully met**.
- If there is a process, but no “meaningful” (surveyor judgment) input from the appropriate department heads, then score as **partially met**.
- If there is no process, or if the decision is left to a single individual, then score as **not met**.

## GUIDELINES

### Collaborative Procurement

Collaborative process in the context of selection of equipment implies that the end-users, facility management/administration, Finance and Biomedical Engineering Departments as the case may be are involved in decision making. Each HCE, depending on its size and requirement shall notify a Technical Committee comprising of relevant experts to standardize, regularly review and update the specifications of the equipment/supplies and to provide technical assistance to the hospital management/Procurement Committee and vet the specifications of the bids/tenders. The HCE shall also notify a Procurement Committee comprising of relevant staff/officials which shall process procurement cases in accordance with the relevant procurement rules on the basis of demand placed to it by the users. The Committee shall also co-opt/consult other relevant experts for finalizing procurement proposals keeping in view the future needs. The public sector hospitals must ensure that provisions of the rules framed by the Khyber Pakhtunkhwa Procurement Regulatory Authority (KPPRA) under its statutes, are followed.

## Ind 24. Qualified and trained personnel operate and maintain<sup>20</sup> the equipment.

### Survey Process:

To determine if appropriate personnel operate and maintain the equipment correctly, look for documented training and any data (in the medical equipment department) that identifies "user error".<sup>21</sup> Also review the job description of personnel deputed to operate and /or for maintenance

### Scoring:

- If staff are adequately qualified and experienced and trained for all equipment within the scope

<sup>19</sup> There should preferably be a dedicated/notified committee with membership from the clinical and management departments etc. for prioritizing and selection of equipment.

<sup>20</sup> Servicing and planned preventive maintenance can be outsourced to appropriately qualified technicians if required or a combination of in - house and outsourced maintenance and servicing would be fine.

<sup>21</sup> Equipment failures due to incorrect use is common in hospitals.

of their ability and other equipment is serviced by contracted experts, then score as **fully met**.

- If there is evidence of a system of planned preventive maintenance but concerns with the ability of the staff and service contractors then score as partially met.
- If the staff or contracted experts have inadequate expertise, then score as **not met**.

## GUIDELINES

### **Qualified and Trained Operators**

Every HCE shall ensure that all the equipment installed in the facility are operated by appropriately qualified, trained and skilled staff. The HCE should ensure that arrangements for proper calibration and maintenance of equipment are in place. Ideally, the HCE shall establish a Biomedical Engineering Department under the supervision of a qualified Biomedical Engineer/Instrument Technician. This department shall provide calibration, repair and backup support to the end users. Private hospitals may make contract arrangement with some outside firm or may establish their own department.

**Ind 25. Equipment is periodically inspected, serviced and calibrated to ensure its proper functioning. There is a documented operational and maintenance (preventive breakdown and replacement) plan.**

### **Survey Process:**

There should be a written schedule that is based at least on manufacturer's recommendations. The inspection, calibration (if needed), and maintenance must be documented<sup>26</sup>. The surveyors should review this documentation.

### **Scoring:**

- If ALL the requirements for this standard are documented, then score as **fully met**.
- Since this is a significant patient safety issue, if any of the requirements are not documented, then score as **not met**.

## GUIDELINES

### **Preventive Maintenance Plan**

The HCE shall ensure that the staff operating the equipment is trained in handling the equipment as per the manufacturer instruction manual. There shall be a documented<sup>22</sup> preventive maintenance plan for all equipment and machinery including DG sets etc. using log book/tracker. The organization shall develop a schedule of weekly/monthly/annual inspection and calibration of equipment which shall involve measurement in accordance with Original Equipment Manufacturer (OEM) guidelines. These services can be provided through an in-house arrangement or alternatively through outsourcing. The organization shall ensure that calibration and conformance testing of the

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<sup>22</sup> In accordance with the Log Book, History Sheet and Preventive Maintenance schedule etc. as detailed in the Reference Manual. The end user /concerned specialist to certify that; i. The equipment is in working order, ii. It is being periodically serviced.

equipment has been done prior to commissioning. The HCEs shall ensure that the record regarding purchase and maintenance of equipment and machinery is properly documented and maintained. The facilities shall ensure that no equipment is non-functional/out of use merely for want of minor repairs, preventive maintenance, lack of essential spares and electrical faults etc. Important factors resulting into gross equipment wastage may also include the following:

1. Mishandling of equipment.
2. Untrained and unskilled manpower.
3. Purchase of highly sophisticated equipment without competent personnel to handle it.
4. Purchase of excess equipment without a justifiable demand.

This calls for an efficient system for equipment management in the form of carrying out the Equipment Audit. In other words, there is a need for periodic evaluation of the quality of performance of the equipment in a hospital. Some of the advantages of equipment audit include:

1. It helps in standardization of the equipment.
2. Concurrently evaluates performance and utility.
3. Provides a satisfactory mechanism to assist phasing out/condemnation.
4. The equipment audit reports provide an objective method for procurement of equipment in future.
5. To identify inadequacies and recommend remedial measures.
6. Cost per reportable result and cost effectiveness can be evaluated.

#### **Defining Equipment Audit**

1. "A retrospective evaluation of quality of performance of equipment in a hospital by an *Equipment Audit Committee* based on documented records of the equipment at the time of purchase and its subsequent maintenance."

*OR*

2. "Equipment audit is the periodic evaluation of the quality of performance of the hospital equipment."

#### **Equipment Audit Committee**

The Equipment Audit Committee may comprise of:

1. Health facility in-charge
2. User HoD or representative
3. Head of hospital maintenance workshop
4. The matron or representative

The Equipment Audit Committee shall meet once in three months and select its chairperson and secretary from among the members in the first equipment performance audit. Maintenance of the history sheet and its subsequent write-up is sine-qua-non for performance of the equipment audit by the committee. A Format of the History Sheet and Log Book is given on the following page.

Table 7: Equipment History Sheet

<b>HISTORY SHEET</b>	
<b>S. No.</b>	<b>Description</b>
1.	Name of Equipment
2.	Date of Purchase
3.	Cost of Equipment
4.	Name and Address of Supplier
5.	Date of Manufacture
6.	Date of Installation
7.	Department where installed
8.	Environmental Control*
9.	Spare parts inventory
10.	Technical Manual/Circuit Diagrams/Literature
11.	After Sale Service arrangement
12.	Warranty period
13.	Life of Equipment
14.	Depreciation per year
15.	Charges of Tests**
16.	Use Coefficient***
17.	Down-time/up time
18.	Cost of maintenance
19.	Date of Condemnation
20.	Date of Replacement
21.	Other Relevant Remarks

\*Proper environment control in terms of temperature, lighting, and ventilation should be ensured and recorded, wherever applicable.

\*\* charges of tests must be specified, wherever applicable.

\*\*\*Should be applied to assess the utilization of equipment.

Table 8: Equipment Log Book

<b>LOG BOOK</b>							
<b>S/No.</b>	<b>DESCRIPTION</b>						
	<b>Name of Equipment</b>	<b>Warranty Period</b>	<b>Validity Period of maintenance contract</b>	<b>Date of breakdown</b>	<b>Date of repair</b>	<b>Cost incurred</b>	<b>Details of Preventive Maintenance</b>
1.							
2.							
3.							

The various parameters to be considered in equipment audit procedure are as follows:

### **Procurement**

The following need consideration:

1. Need assessment - Was the equipment required? What was the use coefficient of the equipment?
2. Were the technical specifications worked out and provided by user department?
3. Were the same specified in the tender notification?
4. Was the receipt of equipment as per the specifications of the supply order?
5. Was availability of spares ensured, after services contract specified and training arranged?

History sheet and log book may be gainfully utilized for this. It is essential that periodic scientific evaluation of the quality of performance of the equipment is carried out. The process of equipment audit will also prove to be an indispensable tool in formulating standards/specifications of medical equipment and in establishment of bench marking for medical equipment.

Maintenance or 'planned preventive maintenance' is regular and repetitive work done to keep equipment in good working order and to optimize its efficiency and accuracy. This activity involves regular, routine cleaning, lubricating, testing, calibrating and adjusting, checking for wear and tear and eventually replacing components to avoid breakdown. Productive preventive maintenance refers to the proper selection of equipment to be included in planned preventive maintenance. Decisions must be made on what to include and to reduce costs (consideration is cost-effectiveness).

An important aspect of planned preventive maintenance is the participation and commitment of the user (Planned Preventive Maintenance). Preventive maintenance should start with users, and the bulk of the work should be their responsibility. The task must be performed daily, with joint activities involving the user and a technician engineer at the end of the week. Highly technical repairs, which are the engineer's responsibility, may be scheduled every six months or on a need basis.

### **Setting Up a Planned Preventive Maintenance System**

In order to establish an effective, efficient planned preventive maintenance system, a Registry Filing System is needed. The Manufacturer's Manual for preventive maintenance of the equipment can be supplemented by computer packages in setting up such a system; if a computer is not available, a manual file can be set up. The planned preventive maintenance administrative system requires the following:

#### **1. Equipment Inventory**

All relevant information about the equipment must be entered, including its location, records of repair and maintenance, and the manufacturer.

A reference number is given and written on a printed paper label, which is attached to each item. This number is recorded in a ledger of equipment with full identifying details.

All equipment in the hospital that is in the care of the hospital service workshop should be recorded on registers or cards, as shown in the format ahead.

Table 9: Sample Equipment Service History Form

Sample Equipment Service History Form									
Name of facility							EQUIPMENT FUNCTION		
Location									
Department									
Name of equipment:				Approved by:		Date installed			
Manufacturer						Manuals			
Distributer.				Power: V A no. of wires.		Freq. of P.M			
Model No.				Type of enclosure:		Remarks			
Serial No.				Type of Plugs:					
Date	C/P	WO. No.	LEAKAGE		WORK DONE	Work By	Total labour hours	Parts Cost	Remarks
			GRD	O.GRD					

C = Curative repair., P = Preventive repair., V=Volts., A=Ampere., WO.=Work Order., No.= Number., GRD=Grid., O.GRD=Off Grid., Leakage = Leakage Current

**2. Establishing a 'Maintenance Schedule'**

After determining what is to be done, the frequency of the task must be decided. A heavily used item must be cleaned and checked more frequently than one, which is used less often; however, minimum frequency must be set. The frequency suggested in the manufacturer's manual can be used as a guide, but the actual usage should determine the maintenance procedure required. The schedules presented here are meant to serve only as guidelines; modifications may be introduced to conform to the manufacturers' specifications. An outline record card will be included with each schedule for recording measurements. The engineer should also note on the record card any item that needs to be replaced, if work is to be carried out later, and whether or not the same engineer is to carry out the work.

## Assessment Scoring Matrix

**Standard 7. FMS 2: The hospital/HCE has a program for clinical and support service equipment management.**

Indicator 22-25		Max Score	Weightage (Percentage)	Score Obtained
Ind 22.	The hospital/HCE plans for equipment in accordance with its services and long / short term plans	10	80	
Ind 23.	Equipment is selected by a collaborative process.	10	80	
Ind 24.	Qualified and trained personnel operate and maintain <sup>23</sup> the equipment.	10	80	
Ind 25.	Equipment is periodically inspected, serviced and calibrated to ensure its proper functioning. There is a documented operational and maintenance (preventive breakdown and replacement) plan.	10	100	
<b>Total</b>		40	-	

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<sup>23</sup> Servicing and planned preventive maintenance can be outsourced to appropriately qualified technicians if required - or a combination of in - house and outsourced maintenance and servicing would be fine.

## Standard 8. FMS-3: The hospital/HCE has plans for fire and non-fire emergencies within the facilities.

### Indicators (26-29):

**Ind 26. The hospital has plans and provisions for i. Early detection, ii. Containment and iii. Abatement of fire and non-fire emergencies.**

#### Survey Process:

Review the plan to ensure that it addresses all 3 requirements. Then, by observation, review of documentation and interview, determine if all the requirements have been implemented.

#### Scoring:

- If the plan includes all 3 requirements and there is evidence that all are implemented, then score as **fully met**.
- Since this is such an important patient safety issue, if any of the requirements are not included in the plan, or if any are not clearly implemented, then score as **not met**.

### GUIDELINES

#### Emergency Plans

The Organization shall:

1. Have a fire plan covering fire arising out of burning of inflammable items, explosion, electric short circuiting or acts of negligence or due to incompetence of the staff on duty.
2. Deploy adequate and qualified personnel for implementation of the plan.
3. Acquire adequate firefighting equipment and ensure that records are kept up to date.
4. Have adequate training program.
5. Have schedules for, and conduct, Mock Fire Drills.
6. Maintain Mock Drill Records.
7. Explicitly display Exit Plans.
8. Have an Alarm and dedicated emergency illumination system, which come into effect in case of fire.

#### Necessary Items and Equipment

1. Fire-proof blanket.
2. Safety shower.
3. Buckets with sand.
4. Portable fire extinguishers are essentially of two types; CO<sub>2</sub> and Bromochloridefluoromethane (BCF) (halon, halogenated hydrocarbons) and can be used without causing damage to electrical equipment. The extinguishing power of halon is about 6 times that of CO<sub>2</sub>. Water has the disadvantage that it conducts electricity whereas powder extinguishers (containing salts) cause damage to instruments.

### **Actions**

1. When fire is detected, stay calm, try to oversee the situation and watch out for danger. Then the following actions should be taken in this order:
  - i. Close windows and doors.
  - ii. Give fire alarm (shouting, telephone, fire alarm).
  - iii. Rescue people (and animals if present).
  - iv. Switch off electricity and/or gas supply.
  - v. Fight fire, if possible with at least two persons.
2. Persons with burning clothing should be wrapped in a blanket on the floor, sprayed with water or be pulled under a safety shower. A CO2 fire extinguisher can also be used, but do not spray on the face.
3. When using fire extinguishers, it is important that the fire is fought at the seat of the fire i.e. at the bottom of the flames, not in the middle of the flames.

If gas cylinders are present there is the danger of explosion by overheating. If they cannot be removed, take cover and try to cool them with a fire-hose. When the situation looks hopeless, evacuate the building. Let everybody assemble outside and check that no one is missing. To practice this, a Regular Mock Fire Drill (once a year), should be held

## **Ind 27. The hospital has a documented safe exit (evacuation) plan in case of fire and non-fire emergencies.**

### **Survey Process:**

Review the "evacuation" plan and the documented evidence that the plan has been tested. It is not necessary that the hospital has actually evacuated patients, but at least has conducted a "simulation" exercise to verify that the plan would work in an actual emergency. Since it is unlikely that the entire hospital must be evacuated, "simulation" drills can be conducted for a single area or department. However, the plan should clearly define a "whole hospital" evacuation (as in an earthquake) plan, including defined alternate sites for the patients and how to transport them. This should be included in the induction orientation program for new staff. The plan should be readily available and visible.

### **Scoring:**

- If there is a written facility evacuation plan, staff is aware of and trained in its use and it has been tested, then score as **fully met.**
- If there is a written evacuation plan but it has not yet been tested, then score as **partially met.**
- If there is no plan, then score as **not met.**

## **GUIDELINES**

### **Emergency Exit Plans**

All workplaces should have adequate exits and unobstructed escape routes in case of fire. The number of exits required for all employees to exit safely depends on several factors, including whether the facility uses substances that are at a high risk for combustion, the layout of the building

and the type of construction materials used. Fire Exit Signs must also be posted.

All hospitals must have at least two exits, so if one is blocked during a fire, the other may be used. These exits must be clearly marked and obstructions must be kept away from exits at all times.

The organization shall take care of non-fire emergency situations by identifying those and deciding appropriate course of action. These may include:

1. Earthquake
2. Civil disorders effecting the HCE
3. Terrorist attacks
4. Invasion of swarms of insects and pests
5. Invasion of stray animals
6. Hysteric fits of patients and/or relatives
7. Anti-social behavior by patients/relatives
8. Temperamental disorders of staff causing deterioration in patient care
9. Spillage of hazardous (acids, mercury, etc.), infected materials (used gloves, syringes, tubing, sharps, etc.) and medical wastes (blood, pus, amniotic fluid, vomits, etc.)
10. Building or structural collapse
11. Fall or slips or collision of personnel in the corridors
12. Fall of patient from the bed/stretchers
13. Bursting of pipelines
14. Sudden flooding of areas like basements due to clogging in pipelines or heavy rains.
15. Sudden breakdown of supply of electricity, gas, vacuum, etc.
16. Bursting of boilers and/or autoclaves

The HCE shall prepare and act according to the specific instructions of the Health Department regarding allocation of beds, calling staff on emergency duty and ensuring uninterrupted supplies etc. in case of war related emergencies.

The HCE shall establish liaison with civil and police authorities, and **Rescue 1122** and the **Fire Brigade** as required by law for enlisting their help and support in case of an emergency.

### **Emergency Exit System**

1. The floors of beams of egress shall be illuminated at all points including angles and intersections of corridors and passageways, landings of stairs and exit doors with bulbs of not less than one thousandth (0.001) lumens per square centimeter.
2. Lighting source is of reasonably assessed reliability, such as public utility electric service.
3. Emergency lighting facilities maintain the specified degree of illumination in the event of failure of the normal lighting for a period of at least one hour.
4. Illuminated "EXIT" signs - distinctive in colour, reliable source - five thousandth lumens (0.005) per square centimeters.
5. Size of signs - plainly legible letters not less than fifteen centimeters high with the principal strokes of letters not less than nineteen millimeters wide.
6. Provide luminous directional exit signs located one foot or below floor level.
7. There should be separate ingress and egress routes.
8. Corridors, hallways and aisles must be 2.4 meters in width.
9. Use of ramps as access to second and higher floors.
10. Stairways with safe and adequately secured railings.
11. Stairway must be at least 112 cm. wide and made of concrete.

12. Any opening in any wall shall be protected by fire doors or fixed wire glass windows. It must have protection for vertical openings also.
13. Any door in a stairway, ramp, elevator shaft, stairway enclosure or light and ventilation shaft or chute, shall be self-closing, and shall normally be kept closed

## Ind 28. Simulation exercise is held at least once in a year.

### Survey Process:

See **Ind 26**. Look for documentation that "simulation" drills have been done at least once in the past year. As for fire drills, the "simulation" drills should have involved different areas and different shifts. The drills should be fully reported noting the staff involved, major observations and any subsequent changes to the system.

### Scoring:

- If there is documented evidence that simulation drills have been held at least once in the past year and that they involved different areas or shifts, then score as **fully met**.
- If no drill has been conducted, then score as **not met**.

## GUIDELINES

### Simulation exercises/Mock Drills

Following actions should be taken to comply with the standards;

#### **1. Simulation exercises / Mock drills are conducted on all shifts in all buildings**

Simulation exercises are conducted in all locations on each shift. For the Hospital, drills on top and network floors are conducted so that the area of fire origination is evaluated along with the floor above and below. All drills are reviewed for the purpose of identifying deficiencies and for improvement. Unless specifically arranged, all mock drills are unannounced.

#### **2. At least 50% of the required drills are unannounced.**

Management maintains a schedule of drills which is designed to cover all areas of the facility. The Fire Safety Manager reviews the schedule and makes adjustments based upon drill performance and real events.

#### **3. All Simulation exercises / mock drills are critiqued to identify deficiencies and opportunities for improvement.**

Health and Safety fire safety staff coordinates fire drills, which includes critiques. Fire wardens observe staff reaction and participation. After the drill, the lead fire warden conducts a debriefing with the nurse in-charge and/or the fire warden, advising of any problems or areas for improvements. A report of the drill is maintained identifying what went well and opportunities for improvements and tracks their progress.

#### **4. The effectiveness of fire response training according to the fire plan is evaluated at least annually.**

The Health and Safety committee completes an annual evaluation of the Environment of Care. A score is utilized to rate compliance to the main elements of the Standards.

**5. During fire drills, staff knowledge is evaluated including the following:**

- i. When and how to sound fire alarms (where such alarms are available).
- ii. When and how to transmit for offsite fire responders.
- iii. Containment of smoke and fire.
- iv. Transfer of patients to areas of refuge.
- v. Fire extinguishment.
- vi. Specific fire response duties.
- vii. Preparation for building evacuation.

*Table 10: Sample Format of a Fire Drill Report*

<p><b>Fire Alarm/Fire Drill Report</b></p> <p>To be completed after every alarm or drill by designated fire safety officer</p> <p>Date: _____ Time: _____</p> <p>Location of Alarm/Fire sign: _____</p> <p>Name of person pulling alarm: _____</p> <p>1) Rounds of hospital made by:</p> <p>1<sup>st</sup> Floor: _____ 2<sup>nd</sup> Floor: _____</p> <p>Doors Closed: _____</p> <p>Hallways Cleared: _____</p> <p>Visitors/Parents – Instructed Appropriately: _____</p> <p>Staff knows how and when to turn off O<sub>2</sub>: _____</p> <p>Fire Extinguishers on Location: _____</p> <p>Staff was aware of location of fire and prepared to evacuate through appropriate Exits:</p> <p>_____</p> <p>_____</p> <p>Staff from departments other than Nursing at appropriate posts:</p> <p>_____</p> <p>_____</p> <p>Staff Co-operation:</p> <p>_____</p> <p>2) Reason for Alarm (if not a planned drill): _____</p> <p>3) Communication to Switchboard: _____</p> <p>4) Additional Comments: _____</p> <p>5) Problems Identified/Recommendations: _____</p> <p>Signed: _____ Position: _____</p>
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## Ind 29. Staff members are trained for their role in case of such emergencies.

### Survey Process:

Look for documentation of the training which should include at least key personnel from every area. They should be able to demonstrate awareness of their own role and the role of others.

### Scoring:

- If there is documented evidence of training of key personnel in every area, then score as **fully met.**
- If only a few (approximately 5) key personnel (surveyor judgment) have not yet been trained, then score as **partially met.**
- If there has been no training or if more than 5-10 key personnel have not been trained, then score as **not met.**

## GUIDELINES

### Training in Emergency Situation Handling

The training shall include various classes of fire, information and demonstration on how to use a fire extinguisher and the procedure to be followed in case of fire and non-fire emergencies.

1. **All Hospital Staff especially the following is required to attend a Training Course on the theory of fire and the practical use of fire extinguishers:**
  - i. Chefs
  - ii. Staff of the A&E Department
  - iii. Designated Maintenance Staff
  - iv. Designated Technical Staff
  - v. Senior Residents
  - vi. Other staff identified according to Risk Assessments
2. **Specific roles and responsibilities of staff, and volunteers at a fire's point of origin.** Fire Wardens are trained to respond to the enunciator panel in their area to determine location of alarm. The Fire Warden assigns additional specific duties in and away from the fire point of origin as needed.
3. **Specific roles and responsibilities of staff, and volunteers away from a fire's point of origin.** When chimes sound, indicating the alarm source is on another floor, staff is trained to be on standby for further instructions. In departments away from the fire origin, staff should prepare the area in case an evacuation is necessary. At a minimum, the following is done: keep patients and visitors calm and informed, close doors in department to limit spread of smoke from a fire, and clear corridors of equipment to ensure clear evacuation route. In offsite facilities, staff, patients, and visitors exit to the exterior of the building, no matter where the fire is located.
4. **Specific roles and responsibilities of staff and volunteers in preparing for building evacuation.** In the event of a total building evacuation, it is the responsibility of each area Director/Manager/Supervisor to insure that all staff and patients are accounted for. Nursing staff is trained and responsible to first evacuate patients from the immediate fire area. This normally includes the room that is on fire, rooms on either side or the room directly across the hall, closing all other patient room doors for temporary protection. They will then proceed with

full compartment evacuation to the closest adjacent smoke compartment. They will then complete the evacuation of the involved smoke compartment. Further vertical evacuation occurs when and if the Fire Warden determines the area or building is untenable and needs to be evacuated. This will occur with the assistance of Fire Department manpower as well as a manpower pool formed by hospital employees for the specific incident.

## Assessment Scoring Matrix

**Standard 8. FMS 3: The hospital/HCE has plans for fire and non-fire emergencies within the facilities.**

Indicator 26-29		Max Score	Weightage (Percentage)	Score Obtained
Ind 26.	The hospital has plans and provisions for i. Early detection, ii. Containment and iii. Abatement of fire and non-fire emergencies.	10	<b>100</b>	
Ind 27.	The hospital has a documented safe exit (evacuation) plan in case of fire and non-fire emergencies.	10	<b>80</b>	
Ind 28.	Simulation exercise is held at least once in a year.	10	<b>100</b>	
Ind 29.	Staff members are trained for their role in case of such emergencies.	10	<b>80</b>	
<b>Total</b>		40	-	

## 2.3 Human Resource Management (HRM)

### 04 Standards & 10 Indicators

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The goal of the Human Resource standards is to ensure that the hospital determines qualifications and competency for staff positions that match the organization's mission and patient care needs. Hospitals must provide the right number of qualified staff to meet patient care requirements. To meet this goal, the standards require the hospitals to plan for staffing; orientation, educating, and training the staff. The hospital also needs to have a system for assessing, maintaining and improving staff capability and promote self-development and learning. There should be well organized HR department in each hospital and its function is not merely the hiring and firing of the staff, but in fact the development of human resource and considering it an asset for the hospital.

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## Standard 9. HRM-1: The employees<sup>24</sup> joining the hospital are oriented to the environment, respective sections and their individual jobs.

### Indicators (30-32):

**Ind 30. Each regular / part time employee, student and voluntary worker is appropriately oriented to the hospital's mission and goals as well as relevant department /unit / service / program policies and procedures.**

#### Survey Process:

The orientation should be in three parts: i. Mission and Goals ii. Orientation to the hospital (such subjects as overall scope of services, fire and general safety, infection control & CQI/QA) and iii. Orientation to the assigned department. The content of each level of orientation should be written to ensure that whoever provides the orientation always covers the same topics.

#### Scoring:

- If there are written orientation "guides" / programs covering all three areas and documented participation, then score as **fully met**.
- If there are the three orientation programs but no written definition of what is to be covered, then score as **partially met**.
- If there is no orientation program, then score as **not met**.

### GUIDELINES

#### General Orientation

Once the selection process is completed, the new employee must be oriented in order to become productive contributor. Orientation not only improves the ability of the employee to perform their job but also helps to satisfy their personal desire and feeling that they are part of the organization's social fabric. Supervisors, in coordination with the Human Resource (HR) Department, complete the orientation by introducing new employee to the co-workers. Every HCE/Department should recognize that its success depends upon the capacities of its staff and shall design a comprehensive induction orientation program as an integral component of capacity building for all employees. The hospital's induction and orientation processes will provide the information, guidance and support required for staff to undertake their organizational responsibilities and to develop and succeed in their new role. This will be achieved by familiarizing new staff with the hospital's significant policies, systems, procedures, governance structure and the work location, and encouraging commitment to the vision, mission and values of the hospital.

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<sup>24</sup> Employees include all full time/regular or part time/visiting consultants/employees or staff members as the case may be.

The 'Balanced Score Card' (Corporate Finance, Treasury and Risk Management) approach is a good start towards implementing performance management systems in any organization. This must be explained to the employees at the induction, in order to align their daily activities with the overall organizational goals (the mission). The new employee should be briefed about past achievements, in terms of services provided, future objectives, plans and targets so as to create a positive image about and for the organization. General responsibilities towards the institution and as to what the staff will be required to do, should be explained to the employee.

### **1. Policy**

The aim of the policy is to specify a program to introduce new joiners to the organization, work colleagues, its culture and environment. All new employees will go through an induction orientation program designed by the HR Department, which should include the following:

- i. The vision, mission, values, objectives and policies of the HCE.
- ii. Overview of the organizational structure, systems and key processes.
- iii. Brief on key processes of the relevant department.
- iv. Description of the HCE's specialty/s and target population.

### **2. Procedure**

At the time of joining the HCE, the employee will submit photocopies of his/her past credentials to the designated HR representative who will complete the necessary documentation and will get signatures of the employee where necessary. Documentations include the following:

- i. Appointment letter.
- ii. Joining Report (**annexure C**).
- iii. Statement of ethics (**annexure D**).
- iv. Confidentiality Agreement (**annexure E**).
- v. Reference Forms for at least two Referees will be filled by the employee. Referees must not be blood relations (**annexure F**).
- vi. Employee will fill a Health Questionnaire Form (**annexure G**).

After completion of documentation, the designated HR Person will brief the employee about the HCE's vision, mission, values, objectives, policies and will issue the **Employee Handbook** to him/her in order to study all the policies in detail. The employee will also be introduced to all the colleagues through a physical tour of the HCE.

Ideally, an **Employee Handbook** should contain:

- i. Mission statement, values and goals of the institution.
- ii. Standards of Conduct to follow (towards a client, for communication, teamwork, maintaining sense of accountability, appearance etc.).
- iii. Expectations from employees and their responsibilities, such as to keep personal business to a minimum, reporting procedures and personnel, disciplinary action to be taken in various situations.
- iv. Policies and procedures to follow in the respective departments and in emergency situations.
- v. Efficient and safe use of equipment with regards to health and safety standards.
- vi. Information regarding Employee Benefits schemes and special recognition / appreciation criteria etc.

After orientation, the HR Representative will issue an **Orientation Checklist (annexure H)** to the employee, where the employee will fill the checklist and will give his/her feedback about the orientation. The orientation checklist will be filed into the employee file and feedback will also be

used for further improvements in orientation program (if required).

## Ind 31. Each regular/part time employee is made aware of their Job Description.

### Survey Process:

Essence of the indicator is to stress upon the importance of the existence and knowledge about the Job Descriptions (JDs) for effectively performing the assigned duties. Each individual employee is provided detailed Job Descriptions and is made fully aware of requirements given therein. The record bears the signatures of the relevant employees certifying that it has been read and fully understood.

### Scoring:

- If the JDs are available and signed by all employees,<sup>25</sup> then score as **fully met**.
- If the JDs are available but not signed by any one employee, then score as **not met**.

## GUIDELINES

### Job Specific Orientation

This could be made part of the hospital's general orientation as in **Indicator No. 30** but it is better that it be done as part of a separate detailed departmental orientation. All employees like to know what is expected of them and how they will be evaluated. Job descriptions can also be a great value to employers. Creating a job description often results in a thought process that helps determine how critical the job is, how this particular job relates to others and identify the characteristics needed by a new employee filling the role. A Job Description (JD) is a detailed narration of actions that an employee must take to achieve the objective. It typically provides the necessary skills, training and education needed by an employee. It spells out duties and responsibilities of the job. It serves as a basis for interviewing the candidates, orienting a new employee and finally in the evaluation of job performance. Using job descriptions is part of good management and always produces better results.

### **Components of a Job Description**

1. **Job Code.** It is a specific number assigned to the document e.g. 001, 004.
2. **Position Name.** It is the exactly the Title which the employee will use and typically conveys the main function of the job/position.
3. **Physical location and surroundings.** This description provides information about the place where a particular HCE is located and what are its surroundings and communication links.
4. **Reporting.** Name the authority to whom the employee has to report.
5. **A Summary statement.** These few sentences include the scope of duties.
6. **Functions of the position.** Usually this section is the most lengthy. It details what the job actually entails and can be quite specific. It should detail any supervisory functions in addition to being

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<sup>25</sup> Employees include all full time/regular or part time/visiting consultants/employees or staff members as the case may be.

as specific as possible describing tasks the employee will face every day. This is also the best place to indicate whether the person will deal with customers, the public or only internal employees. You can also use this section to place priorities on the activities.

7. **Attributes needed for the position.** If the position involves the use of machinery (or computers), spell out what type of machines or software the employee will use. Also detail any technical or educational requirements that may be critical or desired. This is also the place to provide some insights into the type of work environment you are attempting to maintain. Is it pure business, or must the person be able to contribute to an overall spirit of the organization?
8. **Reporting.** Provide details on the reporting and organizational structure. This will help the employee better understand how their activities fit into the total organization.
9. **Compensation.** Including a grade/range instead of a specific figure will give you more flexibility, but most people will feel they should be at the top of the range. It is usually better to have a specific amount, especially when the job description is being given to the employee.
10. **Evaluation criteria.** The more specific you can get the better. Writing this section will probably enable you to define what is most important for the organization as well as the employee. Try to make sure the evaluation criteria of the position will promote the type of activities to enhance the success of the business. Also provide details on when evaluations will take place.
11. **Acknowledgement.** This includes the signatures of the authorized person of the HCE who usually is Manager HR/HOD/MS/CEO and the employee to confirm that he/she has read and is aware of the JD.

Job descriptions of Physician is given below as a sample. JDs of all other categories of hospital staff can be seen in the Job Description Manual<sup>26</sup>. These JDs can be modified and utilized to suit the local requirements of the private sector hospitals and others.

### Sample Job Description

<b>Physician</b>	
<b>Job Code</b>	
<b>Job Title</b>	Physician
<b>Qualification &amp; Experience</b>	M.B.B.S. and FCPS (if person possessing FCPS is not available then MCPS or other equivalent qualification recognized by PMDC)
<b>BPS</b>	18
<b>Recruitment</b>	Initial / Transfer
<b>Position Type</b>	Full Time
<b>Dress Code</b>	
<b>Jurisdiction</b>	Hospital (50 & above beds)
<b>Reports to</b>	MS

### Job Summary

In-charge of the Medical Unit for deliverance of optimal standard of medical care. Scope of work includes Medical OPD, admission of patients needing indoor medical care, care of admitted patients

<sup>26</sup> Job Descriptions Manual "Reference Manual for implementing secondary health care standards in Khyber Pakhtunkhwa Management volume No.1 page 123."

and planned procedures on specific days.

### **Duties / Responsibilities**

#### **1. Curative/Clinical**

- i. Overall in charge of the Medical OPD and admitted patients.
- ii. Conducts Medical OPD regularly on notified days and time.
- iii. Reviews referrals by MOs/other Specialists and from the lower facilities to establish diagnosis and proper management.
- iv. Plans and performs procedures e.g. endoscopies on specified days & time as per hospital policy.
- v. Performs emergency procedures on patients admitted through A & E Department as & when required.
- vi. Writes Post Procedural Notes and instructions for each case.
- vii. Takes one planned round of the wards daily along with doctors and staff nurse to review/follow-up the old cases and examines in detail the newly admitted. Round is repeated if required.
- viii. Ensures that treatment prescribed is being administered to the patients.
- ix. Ensures availability of medicines / functioning of equipment to handle emergencies at all times in the Unit. Attends the patients with medical problems admitted in other wards as and when requested.
- x. Ensures smooth functioning of the Medical ICU if entrusted the responsibility.
- xi. Exercises authority for discharge of patients from the ward/emergency.
- xii. Explains the patients about the use and effects of prescribed drugs.
- xiii. Refers the patients to other specialists within the hospital and/or to higher level facilities if needed.

#### **2. Preventive / Promotive**

- i. Ensures compliance of SOPs particularly on Infection Control and Waste Management in the OPD, Medical Wards.
- ii. Ensures that instruments/equipment being used in examinations and procedures are properly sterilized.
- iii. Ensures that all staff participating in the procedures is physically well protected by wearing of proper dress i.e. Gowns, Masks, Caps, Gloves and shoes.
- iv. Provides educational information about common diseases and ways to promote physical health.

#### **3. Rehabilitative**

- i. Provides psychological, social and nutritional rehabilitative measures to patients if required.
- ii. Recommends physiotherapy to needy patients.
- iii. Teaching / Supervision
- iv. Trains Medical, Nursing and Paramedical Staff as per Departmental/ Specialty requirements/ Protocols and work instructions.

#### **4. General**

- i. Remains on call after working hours.
- ii. Checks the cleanliness and up keep of the unit.
- iii. Ensures that responsible staff regularly upkeep & maintains electro-medical equipment of

the unit to ensure their functionality at all the time.

- iv. Ensures that responsible staff is regular in supply/replenishment of medicines & stores.
- v. Provides technical assistance to the management for purchase of new equipments / instruments needed from time-to-time for the unit.
- vi. Ensures the preparation and implementation of the duty roster for his unit.
- vii. Checks that the subordinate staff performs their duties as per JD's, SOP's & SMP's.
- viii. Writes Objective Performance Evaluation Reports of subordinate staff.
- ix. Performs outreach duties to lower facilities as required.
- x. Performs any other professional duty assigned by higher authorities.

(I have read and accept the job description)

#### 5. Signature of the incumbent:

Using job descriptions helps an HCE to better understand the experience and skill base needed to improve the service delivery. They help in the hiring, evaluation and termination of employees when required. All too often, there is a misunderstanding of what a position entails and a well-prepared job description can help both sides share a common understanding.

**Ind 32. Each regular / part time employee is made aware of his/her responsibilities, rights, patient's rights and patient's responsibilities.**

#### Survey Process:

This standard would require that written job description (JDs)<sup>27</sup> of each staff member points to his / her responsibilities towards patients and others as well as his / her rights. Staff member's rights are detailed in the human resource / employee manual or other such documentation. The rights and responsibilities of the patients are available as Patient Charters and HCE's Charters. There should exist an evidence that the employee has been oriented/made aware of these.

#### Scoring:

- If evidence of orientation of each staff member as above exists, then score as **fully met**.
- If only direct caregivers have been educated, then score as **partially met**.
- If evidence of orientation of any of the staff member as above does not exist, then score as **not met**.

## GUIDELINES

### **Staff Rights and Responsibilities**

This standard would require that each staff member have a written Job Description (JD) that defines his or her responsibilities. Every staff member should have a copy of his/her JD to understand their duties and responsibilities.

#### **1. Responsibilities**

The HR Department must have well-defined JDs for each category of staff, which will also be an important component of the respective personal file duly signed by the employee.

<sup>27</sup> Job Descriptions as in Ind. 31 to include responsibilities particularly towards patients.

## **2. Rights**

The rights of the staff member should be detailed in the employee manual maintained by the HR Department which should also be shared with the employee/s.

## **3. Patients' Rights**

The rights and responsibilities of the patients are available as Patient Charters (Section 2.9: Patient rights and Education).

The following points regarding the rights and responsibilities of employees are to be considered;

1. Staff members may have cultural, religious or personal conflicts concerning their involvement with specific components in the care or treatment of patients. The HCE shall provide a mechanism for employees to submit their requests for review of work assignments by their HoD. However, the continuum of patient care services shall be ensured at all levels.
2. Staff members will make their requests known to their HoD, manager or supervisor in writing. Examples of procedures, which may conflict with some staff members' beliefs include, blood administration, therapeutic abortion, circumcision and sterilization procedures etc.
3. The HoD, manager or supervisor shall make every effort to accommodate the request and maintain the duties referenced in the employees' JD.
4. The HoD, manager or supervisor shall reassign duties, if reasonable and possible, to accommodate the request and meet the needs of the patient.
5. Response to all requests for reassignment of duties, whether approved or denied will be provided in writing to the employee.
6. A record of all requests and actions taken shall be maintained in the employee's departmental file.
7. If the request of the staff member cannot be granted, the employee may appeal to the next higher authority to review the request. The decision of the Human Resources Department shall be final to the extent of respective request.

Similarly, the staff is to be apprised about the Rights and Responsibilities of the patients and the HCEs.

## Assessment Scoring Matrix

**Standard 9. HRM 1: The Employees joining the Hospital/HCE are oriented to the environment, respective sections and their individual jobs.**

Indicator 30-32		Max Score	Weightage (Percentage)	Score Obtained
<b>Ind 30.</b>	Each regular / part time employee, student and voluntary worker is appropriately oriented to the hospital's mission and goals as well as relevant department / unit / service / program policies and procedures.	10	<b>80</b>	
<b>Ind 31.</b>	Each regular / part time employee is made aware of their Job Description.	10	<b>100</b>	
<b>Ind 32.</b>	Each regular / part time employee is made aware of his/her responsibilities, rights, patient's rights and patient's responsibilities.	10	<b>80</b>	
<b>Total</b>		30	-	

## Standard 10. HRM-2: An appraisal system for evaluating the performance of the employees exists as an integral part of the human resource management process.

### Indicators (33-36):

**Ind 33. A well-documented performance appraisal system exists in the hospital.**

#### Survey Process:

There is a documented Performance Appraisal System conforming to the employee's working parameters / Job Descriptions and the appraisals of their performance is based on these parameters/JDs.

#### Scoring:

- If there is a documented Performance Appraisal System for the employees and their performance is evaluated accordingly, then score as **fully met**.
- If there is a documented appraisal but it only includes administrative issues and not actual performance evaluation, then score as **partially met**.
- If there is no documented Performance Appraisal System or it is deficient, then score as **not met**.

## GUIDELINES

### Performance Appraisal

A performance appraisal, employee appraisal, performance review, or career development discussion is a method by which the job performance of an employee is evaluated (generally in terms of quality, quantity, cost, and time) typically by the corresponding manager or supervisor.<sup>28</sup>

A performance appraisal is a part of guiding and managing career development and is a process of obtaining, analyzing, and recording information about the relative worth of an employee to the organization. It is an analysis of an employee's recent successes and failures, personal strengths and weaknesses, and suitability for promotion or further training. It is also the judgment of an employee's performance in a job based on considerations other than productivity alone.

The comprehensive appraisal system shall evaluate actual performance against given targets and not just administrative factors. Appraisal shall document and include appraisal of the employees' actual performance and an agreed plan for staff development to address any performance issues. In the public sector, performance of employees is evaluated through an Annual Confidential Report (ACR) written by the supervisor (reporting officer)/second reporting officer. ACR generally covers evaluation of the respective employee against the JD assigned to the position and covering strength and areas of improvement. In the private sector, the employee is asked to give written

<sup>28</sup> [http://en.wikipedia.org/wiki/Performance\\_appraisal](http://en.wikipedia.org/wiki/Performance_appraisal) - cite note - 1.

KPIs relevant to the assignment to be evaluated at time of performance appraisal. The employee and concerned manager should have a copy of KPIs for the performance evaluation.

**Ind 34. The employees are made aware of the system of performance appraisal at the time of induction.**

**Survey Process:**

The employees are briefed about the performance appraisal system practiced in the HCE as an integral part of the initial orientation. The staff knows that Patient Satisfaction Surveys (PSS)<sup>29</sup> have a bearing on their evaluation. There is a documented evidence (such as the employee's signature on the JD having above details) which confirms that the employee understands the evaluation / appraisal system.

**Scoring:**

- If there is a system to make the employees understand how their performance will be evaluated then score as **fully met.**
- If there is no system or the deficiency is more than 20%, then score as **not met.**

**GUIDELINES**

**Orientation of Performance Appraisal**

As an integral part of the initial orientation, the employee should be briefed about the performance appraisal system in practice in the HCE/organization. There should be documented evidence (such as the employee's signature on the JD) that confirms that the employee understands about the evaluation.

**Ind 35. The appraisal system is used as a tool for further development.**

**Survey Process:**

There is documented evidence that the employee's appraisal is used as a tool for further development (such as more experience, more training, a different job assignment etc.). This may not be required for every employee and will be applicable only if the appraisal indicated the need.

**Scoring:**

- When appropriate the appraisal indicates the need for further development and this is documented, then score as **fully met.**
- If the appraisal indicates the need for further development, but there is no documentation of this, then score as **not met.**

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<sup>29</sup> Patient Satisfaction Surveys and exit interviews should be planned and conducted by the HCE's Administration and their results linked with the Performance Evaluation of the concerned Employee.

## GUIDELINES

### Career Development

There should be documented evidence (when appropriate to the employee's appraisal) that the appraisal system is used as a tool for further development (such as more experience, more training, and a different job assignment). This may not be required for every appraisal - only if the appraisal indicated the need.

A performance appraisal is a part of guiding and managing career development. It is the process of obtaining, analyzing, and recording information about the relative worth of an employee to the organization.

### **Ind 36. Performance appraisal is carried out at pre-defined intervals and is documented.**

#### **Survey Process:**

The hospital has defined the frequency of performance appraisals. Customarily this is within the first 3-4 months for a new employee (Probationers) and at least annually for ALL other employees. The surveyors should evaluate two things: i. Has the hospital defined how often the appraisal should occur; and ii. What percent of employees have had their appraisal on time? It is common that a hospital has a schedule for periodic appraisals, but inconsistently follows it. Select a representative sample of HR files and determine if there was a documented periodic appraisal and if it was done "on time".

#### **Scoring:**

- If the frequency of employees' appraisal is defined and there is evidence that more than 90 percent employees have received timely appraisals, then score as **fully met.**
- If the hospital has defined the frequency of employee appraisal, but the documentation shows that only between 75 and 90 percent of employees had their appraisal on time, then scores **partially met.**
- If either the hospital does not have a schedule for periodic employee appraisal or if less than 75 percent of the employees received their appraisal "on time" then score as **not met.**

## GUIDELINES

### Frequency of Performance Appraisals

The hospital should have defined the frequency of performance appraisals. Customarily this is within first 3-4 months (probation period) for new employees and at least annually for ALL other employees.

## Assessment Scoring Matrix

**Standard 10. HRM 2: An appraisal system for evaluating the performance of an employee exists as an integral part of the human resource management process.**

Indicator 33-36		Max Score	Weightage (Percentage)	Score Obtained
Ind 33.	A well-documented performance appraisal system exists in the Hospital.	10	<b>80</b>	
Ind 34.	The employees are made aware of the system of performance appraisal at the time of induction.	10	<b>100</b>	
Ind 35.	The appraisal system is used as a tool for further development.	10	<b>100</b>	
Ind 36.	Performance appraisal is carried out at pre-defined intervals and is documented.	10	<b>80</b>	
<b>Total</b>		40	-	

## Standard 11. HRM-3: There is a documented personnel record for each staff member.

### Indicator (37):

**Ind 37. The personal files are maintained and contain information regarding the employee's qualification/education, in-service training, disciplinary background, evaluation results and health status.**

#### Survey Process:

Randomly select representative sample of employees (either from a list of all employees, or by name of personnel identified during visits to hospital areas). Then determine if all have a HR/personal file containing information regarding the employee's qualification / education, in-service training, disciplinary background, evaluation results and health status.

#### Scoring:

- If all reviewed files have all of the above-mentioned information, then score as **fully met**.
- If the files are not complete or any file does not contain all the required information, then score as **not met**.

### GUIDELINES

#### Personal Files

The purpose of maintaining personal files is to keep an updated record of employees. The personal files of employees should be maintained because:

1. It makes good business sense to have accurate information handy and organized when you want to use it for official purpose.
2. Immediate supervisors will eventually encounter the need to produce documentation about employee performance and work history
3. Some employee records are required by federal or provincial government/other agencies and must be kept in the personal files. Organizing the record of employees in a proper manner makes access easy.

The personal file of each employee is very confidential and access to the file is only allowed after the approval from a competent authority. Access to information about employees should be strictly limited to those people in the HCE who need to use it for official purposes. Since unauthorized access to personal files can result into severe repercussions, any breach in this connection should make the responsible person liable to severe penalties. It should be ensured that personal files (hard and soft copies) are stored in a secure physical location and are not left unattended even during working hours. When asked by the people outside the organization to provide "verification" of certain employment information about the employee(s) of the HCE, it should be ensured that only the information which has been authorized by the employee(s) is released. Employment verifications are usually required to support such things as mortgage applications, credit

applications etc. Employee authorization should be in writing and specify the information they wish you to reveal. Tell your employee the policy is designed for his/her protection.

### **Contents of Personal Files**

The HR Departments in the good organizations customarily maintain the following documents in the personal file of each employee in a standard manner;

1. Curriculum Vitae
2. Offer letter
3. Contract copy and JD
4. Joining report
5. Photograph (two, blue background, passport size)
6. CNIC copy
7. Copies of documents pertaining to all academic and professional qualifications
8. Copies of trainings/certifications
9. Salary slip/certificate (previous employer)
10. Experience certificate
11. Official email account issuance form
12. Reference form/background check
13. Medical/personal information form
14. Information for employee/business card
15. Leave forms (if any)
16. Notice (if any)
17. Performance Evaluation Form
18. In-service trainings
19. Salary Increment/Promotion
20. Resignation/termination letter (whichever is received in the HRD)
21. Exit interview form (whenever employee leaves office)

Review the Personal Files and check the following are maintained:

1. Qualifications of the staff member.
2. Record of in-service education/training.
3. Job description as applicable.
4. Work history / disciplinary background.
5. Results of evaluations.
6. Personal files contain record of health status of employee.

## Assessment Scoring Matrix

**Standard 11. HRM 3: There is a documented personnel record for each staff member.**

Indicator 37		Max Score	Weightage (Percentage)	Score Obtained
Ind 37.	The personal files are maintained and contain information regarding the employee's qualification/education, in-service training, disciplinary background, evaluation results and health status.	10	<b>100</b>	
<b>Total</b>		10	-	

**Standard 12. HRM-4: There is a process for collecting, verifying and evaluating the credentials (education, registration, training and experience) of medical professionals including doctors, nurses, pharmacists and others permitted to provide patient care without supervision.**

**Indicators (38-39):**

**Ind 38. Only medical professionals permitted by law, regulation and the hospital are to provide patient care without supervision.**

**Survey Process:**

Look for documentation of the way the hospital validates that its medical staff has the appropriate and required documents which demonstrate that they are legally permitted to care for patients. The hospital has a process to validate the accuracy of these documents (there are multiple examples internationally of fraudulent "credentials"). The hospital verifies the documents with the primary source - such as the university or the training organization. Professionals are currently registered with their respective councils etc.

While scoring, give attention to the following, that:

1. Those permitted by laws, regulations, are identified and listed by the organization to provide patient care without supervision.
2. Required credentials (education, licensure, registration, among others) as determined by regulation and organization policy for each medical staff member are copied by the organization and maintained in the personnel file or in a separate credential file for each medical staff member.
3. All credentials (education, licensure, registration, among others) are verified with the source that issued the credential before the individual begins providing services to or for patients.
4. All credentials on file (education, licensure, registration, among others) are current and updated as required.
5. At initial appointment, a firm determination is made about the current qualification of the individual to provide patient care services.
6. At initial appointment, an undertaking is obtained that the employee will update any change in the current status of the qualification/certification that permits patient care services immediately on occurrence.

**Scoring:**

- If there is a clearly defined process to validate the "credentials" of all staff members, then score as **fully met**.
- Since this is an important legal and patient safety issue, if there is no recognized process to validate the "credentials", then score as **not met**

## GUIDELINES

### Verification of Licensure/Certification

There should be a process to validate the accuracy of these documents (there are multiple examples of fraudulent "credentials" internationally). The hospital should have verified the documents with the primary source such as the college/university/authority or the training organization, as the case may be, as follows;

1. Current licensure/certification or registration is verified with the primary source at the time of hiring and at renewal prior to expiration.
2. Primary source verification will be obtained through a secure electronic communication. If a licensing board/agency/authority cannot provide this type of verification, a letter in that respect must be obtained from it.
3. In the event that an employee is hired against a position that requires license, certification or registration, and the same has been revoked, suspended or rendered invalid, the HCE may terminate the concerned employee on these grounds.
4. Practitioners should have current/valid registration with the respective professional council or body e.g. PMDC for doctors, Pharmacy Council for pharmacists, PNC for nurses and Khyber Pakhtunkhwa Medical Faculty for paramedics.
5. It is the employee's responsibility to provide proof of license, certification and/or registration, and to notify their manager and HR immediately of any change in the status of the license, certification, and/or registration.

**Ind 39. The 1. Education, 2. Registration, 3. Training and 4. Experience of the identified health professionals is documented and updated periodically.**

### **Survey Process:**

Personal file of each staff member containing information regarding education, registration, training and experience is maintained and updated regularly.

### **Scoring:**

- If updated personal file of staff is maintained, then score as **fully met**.
- If personal file of staff is maintained but not updated, then score as **not met**.

## GUIDELINES

### Periodical Updating of Credentials

1. The HR Department should update the file at least once in a year or more frequently if required.
2. Employee should intimate the HR Department about any change in the credentials immediately/soon after its occurrence.

The HR Department shall maintain/place copies of credentials of all employees of the HCE in their respective personal files which shall include at least;

1. Educational Degrees/Diplomas, both Undergraduate and Postgraduate.
2. Registration with Registering/Licensing Body.
3. Pre-Service and In-Service Trainings.
4. Related Experience; Local or Foreign.

## Assessment Scoring Matrix

**Standard 12. HRM 4: There is a process for collecting, verifying and evaluating the credentials (education, registration, training and experience) of medical professionals including physicians, nurses, pharmacists and others permitted to provide patient care without supervision.**

Indicator 38-39		Max Score	Weightage (Percentage)	Score Obtained
Ind 38.	Only medical professionals permitted by law, regulation and the hospital are to provide patient care without supervision.	10	<b>100</b>	
Ind 39.	The 1. Education, 2.Registration, 3.Training and 4. Experience of the identified health professionals is documented and updated periodically.	10	<b>100</b>	
<b>Total</b>		20	-	

## 2.4 Information Management Systems (IMS)

### 02 Standards & 12 Indicators

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The Standards pertaining to the Information Management System (IMS) highlight the fact that patient care is highly dependent upon accurate and correct information. The standards also signify that the work of physicians and staff across the hospital must be facilitated by timely information to provide coordinated and integrated care. In addition, it is important to protect the privacy of the data collected by limiting unauthorized access.

Medical records serve many functions but their primary purpose is to support patient care. There is currently a major drive to computerize medical records, but without improvement in the quality of paper records the full benefits of computerization are unlikely to be realized. The onus for improving records lies with individual health professionals as well as the management. Structuring the record can bring direct benefits to patients by improving patient care, treatment outcomes and health system performance.

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## Standard 13. IMS-1: The hospital has a complete and accurate medical record for every patient.

### Indicators (40-45):

#### Ind 40. Every medical record has a unique identifier.<sup>30</sup>

#### Survey Process:

The essence of the indicator is that each medical record (indoor as well as outdoor) has a unique identifier. There may be more than one record for a patient and there is possibility of placing the laboratory/radiological results / other documents of the patient into the wrong patient's medical file. This is to be averted by allocating a unique identifier for each patient's record. Surveyor needs to identify that each medical record (indoor as well as outdoor) has a unique identifier.

#### Scoring:

- If there is a clear mechanism to positively identify each patient's medical record, then score as **fully met**, or if there is the possibility that an individual patient has more than one record, but there is a system to identify this and consolidate the various records, then also score as **fully met**.
- If there is evidence that there is more than one record for a patient but no mechanism to consolidate these records, then score as **not met**.

### GUIDELINES

#### Unique Patient Identifiers

All documents of a patient must be consistently labelled with at least 1 unique identifier so that it can be verified that documents correspond to particular patients. Computer Generated Unique ID Number is the easiest and correct Identification Method to be adopted as early as possible. The patient's medical record always becomes a focal point whenever there is a question regarding the care and treatment rendered. It is important that the medical record be kept accurately and timely. A Sample Template for Patient Medical Record is given at **annexure I**. The medical record serves three primary purposes: 1) to ensure quality patient care; 2) to provide documentary evidence of the patient's course of illness and treatment; and 3) to facilitate review.

One often thinks of the medical record as a means of protecting the hospital or providing a defense in a medical malpractice action. However, the purpose of the medical record is not to protect or to provide a defense only. The purpose of the medical record, as it pertains to risk management, is to preserve the truth. In reality, a complete and accurate medical record will protect the legal interests of the patient, the hospital, and the responsible practitioner. The medical record will provide a justifiable defense, if one exists, or will indict the responsible party if there is no justifiable defense. Accurate identification of a patient is the backbone of an effective and efficient medical record system. Correct identification is needed to positively identify the patient and ensure that each patient has one medical record number and one medical record with no more duplicates. In order

<sup>30</sup> An alpha/numeric system that gives each patient their own code number

to identify patients, we need a **UNIQUE PATIENT CHARACTERISTIC**. The type and number of unique patient characteristics used will change from one setting to other, and are defined as: **Something about a patient that does not change.**

Some useful unique patient characteristics are:

1. Client/Patient full name.
2. Gender.
3. DoB.
4. National Identification Number (CNIC number).
5. Mother's first name.
6. Father's first name.
7. Social security number.
8. Health insurance number.
9. In the case of a new-born infant a physical/anatomical characteristic, e.g. fingerprint or footprint.

The following are NOT considered unique characteristics:

1. Where a person lives is NOT a unique patient characteristic because it can change.
2. A person's age is NOT a unique patient characteristic because it DOES change.
3. Although it should not change, it is important that a patient's birthplace is NOT used, as it is often identified by most people as being the place where they "come from" as opposed to the place where they were actually born. Similarly, many people are born at the same place/city/hospital/town etc.

**Ind 41. The staff authorized to make entries in the medical record is reflected in the hospital's policy<sup>31</sup> and is identifiable.**

**Survey Process:**

Review any policy and then during review of medical records for any of the previous reasons for review, confirm that only authorized individuals have made entries into the medical record and those who have made entries can be identified.

**Scoring:**

- If all entries are by identifiable authorized persons, then score as **fully met**.
- If there are any entries by unauthorized persons, then score as **not met**, or if the persons making entries are not identifiable, then also score as **not met**.

**GUIDELINES**

**SOPs for Identification of Medical Record Entries**

1. The Organization maintains a list of authorized persons along with the details of documents which they can sign. The list also contains their specimen signatures, initials and the stamps

<sup>31</sup> Written policy on IMS is essential.

they use. Any professional who, in the execution of his or her professional duties, signs official documents relating to patient care, such as prescriptions, certificates (excluding death certificates), patient records, hospital or other reports, shall do so by signing such a document and clearly writing his/her name, appointment and the date in block letters, stamping the same. A sample of such a list is given below;

Table 11: Sample Authorized Personnel List

No.	Particulars & Appointment	Authorization	Initials	Signatures	Stamp
1.	Prof. Dr. (HOD Surgery)				
2.	Dr. (Registrar)				
3.	Dr. (PG Trainee)				

- The organization must provide the individual signatories a list of what they can sign and what not.

## Ind 42. Every medical record entry is dated, timed and signed.

### Survey Process:

This is a difficult standard to meet since the "timing" of ALL entries especially in the OPD record may be difficult to achieve. Focus attention on timing of medication orders, examination/progress notes and any entries in emergency and ICU's. This can be evaluated during the review of the previously selected records.

### Scoring:

- If all entries are dated, timed and signed then score as **fully met**.
- If some entries are not timed and signed (ALL must be at least dated), then score as **partially met**.
- If there is inconsistent dating (more than 5 examples) or if there are more than 5 examples of entries that should have been timed and signed but were not, then score as **not met**.

## GUIDELINES

### SOPs for Medical Record Documentation

This indicator demands that every time an entry is made in the medical records, it is timed and dated along with the particulars of the person making the entry.

Recording of Date and Time starts from the time a patient enters the hospital and seeks care. The first such record is the Register at the Reception and the 'Parchi' issued for consulting a doctor. Then it is the turn of the attending doctor at OPD/Emergency who examines the patient, prescribes medicine/s or refers the patient if required, while putting the date and time along with his/her signatures on the slip. The pharmacist also signs and puts the date and time after issuing the medicines. Similarly, in the indoor record, every entry is signed stamped, dated and timed by doctors, nurses and supervisors.

Accurate date and time recording is of paramount importance whenever there is a need to produce the documentation as a proof of certain action having been taken on time. It is a valuable source of data for coding, health research, a source of evidence and rationale for funding and resource management. Hospital authorities shall make strategies to ensure implementation of this requirement.

**Ind 43. The record provides an up-to-date and chronological account of patient care.**

**Survey Process:**

Review the record to determine if the record adequately documents the care and treatment pathway for all patients. Check the systems of records storage to ensure they are in good order and stored for a period in compliance with the statutes. Detail of weeding of old record is given at **annexure J**.

**Scoring:**

- This should default to a score of **fully met** unless the survey team identifies significant deficiencies in the medical records.

**GUIDELINES**

**Up-to-date Chronological Record**

Information **documented during or immediately** after care is provided or about an event which has occurred, is considered to be more reliable and a more accurate record of care than information recorded later, based on memory.

Chronological entries present a clear picture of the sequence of care provided / of events over time and facilitates better communication amongst care providers. Late entries should be appropriately recorded as soon as possible, but these should be endorsed by the in-charge.

**Minimum Requirements for Patients' Medical Records.<sup>32</sup>**

Upon completion, medical records for inpatients and outpatients shall contain, at a minimum, the documents as specified below. Records for patients at the hospital for other specialized services, such as emergency services or surgical services, shall contain such additional documentation as required for those services.

**1. Outpatient Record**

Medical reports for outpatients shall contain at least the following:

- i. A unique identifying number and a patient identification form.
- i. Name, address, date of birth, sex, and person to be notified in an emergency.
- ii. Diagnosis of the patient's condition.
- iii. The name of the physician ordering treatment or procedures.
- iv. Patient allergies.

<sup>32</sup> Authority O.C.G.A. Sec. 31-7-2.1. History. Original Rule entitled "Medical Records" adopted. F. Nov. 22, 2002; eff. Dec. 12, 2002.

- v. Physician's orders or orders from another practitioner authorized by law to give medical or treatment orders as applicable.
- vi. Documentation that the patient has been offered the opportunity to consent to procedures for which consent is required by law/regulations.
- vii. Reports from any diagnostic testing.
- viii. Sufficient information to justify any treatment or procedure provided, report of outcome of the treatment or procedure, progress notes and the disposition of the patient after treatment.

## **2. Inpatient Record**

Medical records for inpatients shall contain at least the following:

- i. A unique identifying number and a patient identification form.
- ii. Name, address, DoB, sex, and person to be notified in an emergency.
- iii. The date and time of the patient's admission.
- iv. The admitting diagnosis and clinical symptoms.
- v. The name of the attending physician.
- vi. Any patient allergies.
- vii. Documentation regarding advanced directives.
- viii. The report from the history and physical examination.
- ix. The report of the nursing assessment performed after admission.
- x. Laboratory, radiological, electrocardiogram, and other diagnostic assessment data or reports as indicated.
- xi. Reports from any consultations.
- xii. The patient's plan of care.
- xiii. Physician's orders or orders from another practitioner authorized by law to give medical or treatment orders.
- xiv. Progress notes from staff members involved in the patient's care, which describe the patient's response to medications, treatment, procedures, anaesthesia, and surgeries.
- xv. Data, or summary data where appropriate, from routine or special monitoring.
- xvi. Medication, anaesthesia, surgical, and treatment records.
- xvii. Documentation that the patient has been offered the opportunity to consent to procedures for which consent is required.
- xviii. Date and time of discharge.
- xix. Description of condition, final diagnosis, and disposition on discharge or transfer.
- xx. Discharge summary with a summary of the hospitalization and results of treatment.
- xxi. If applicable, the report of autopsy results.

**Ind 44. The medical record contains information regarding reasons for admission, diagnosis, plan of care, informed consent,<sup>33</sup> care provided<sup>34</sup> and details if shifted<sup>35</sup>/discharged<sup>36</sup> displaying continuity of care, copy of death certificate<sup>37</sup> and copy of clinical autopsy report<sup>38</sup> when done in chronological order.**

#### **Survey Process:**

Review representatives' sample of records (they can be the same record as for previous Indicators) to determine if the reason for i. Admission, ii. The provisional diagnosis iii. The plan of care iv. Informed Consent v. The care provided and vi. Copy of Discharge/Referral Slip,<sup>39</sup> is documented. This is then scored on the cumulative findings for ALL the records reviewed.

#### **Scoring:**

- If all the required elements mentioned above are documented in all the records, then score as **fully met.**
- If any of the required elements is missing in any record, then score as **not met.**

## **GUIDELINES**

### **Scope of Medical Records**

The medical record contains information regarding reasons for admission, diagnosis and plan of care. Accurate medical record documentation should comply with the following minimum parameters.

1. The medical record should be complete and legible.
2. The documentation of each patient contact should include: the reason for the visit, relevant history, physical examination findings, diagnostic test results, clinical impression/diagnosis, and plan for care, date and legible identity of the service provider.
3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred. Past and present diagnoses should be accessible to the treating and/or consulting physician.
4. Appropriate health risk factors should be identified. The patient's progress, response to and changes in treatment and revision in diagnosis should be documented.
5. The hospital has a complete and accurate medical record for every individual assessed or

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<sup>33</sup> Informed Consent where required is obtained, countersigned and added.

<sup>34</sup> Operative and other (diagnostic/curative) procedures performed are incorporated in the record.

<sup>35</sup> Ask for the medical record of 3 or more patients who were transferred to another hospital. The date of shifting, the reason for the shifting and the name of the receiving hospital is recorded.

<sup>36</sup> A copy of the discharge note/slip duly signed by appropriately qualified/authorized staff is added.

<sup>37</sup> A copy of the death certificate indicating the cause, date and time of death.

<sup>38</sup> Ask for medical records of autopsy, verify that the final report is available in the medical record.

<sup>39</sup> Including shifting to other departments of the hospital or other hospitals.

treated. Every medical record entry is timed, dated and initialed and its author identified when required.

### **Contents of the Medical Record**

1. The content of the medical record, which includes written and electronic documents, must be sufficiently detailed, legible and organized to enable:
  - i. The practitioner responsible for the patient to identify the patient, provide continuing care, determine the patient's condition at a specific time, review the diagnosis & therapeutic procedures performed and the patient's response to treatment.
  - ii. Consultant's opinion after a patient examination and review of the medical record.
  - iii. Another practitioner to assume patient care at any time.
  - iv. Retrieval of information required for utilization review, quality review and transfer recommendations, etc.
2. The medical record contains the following clinical information:
  - i. The reason(s) for admission for care, treatment and services.
  - ii. The patient's initial diagnosis, diagnostic impression(s) or conditions(s).
  - iii. Findings of assessments and reassessments.
  - iv. Any allergies to food or latex.
  - v. Any allergies to medication.
  - vi. Conclusions drawn from the patient's medical history and physical examination.
  - vii. Diagnoses/conditions established during the patient's course of treatment and services.
  - viii. Any consultation reports.
  - ix. Any observations relevant to care, treatment and services.
  - x. The patient's response to care, treatment and services.
  - xi. Any emergency care, treatment and services provided to the patient before arrival.
  - xii. Progress notes.
  - xiii. All orders.
  - xiv. Medications ordered or prescribed.
  - xv. Medications administered, including the strength, dose, frequency and route.
  - xvi. Any access site for medication, administration devices used and rate of administration.
  - xvii. Any adverse drug reactions.
  - xviii. Readmission notes.
  - xix. Shifting record from one department to another department.
  - xx. Treatment goals, plan of care, and revisions to the plan of care.
  - xxi. Results of diagnostic and therapeutic tests and procedures.
  - xxii. Medications dispensed or prescribed on discharge.
  - xxiii. Discharge diagnosis.
  - xxiv. Discharge plan and discharge planning evaluation.
  - xxv. Follow-up plans.
  - xxvi. Referral letters.
3. The medical record contains the following information as needed to provide care, treatment and services:
  - i. Any advance directives (Before admission of patient).
  - ii. Informed consent, when required by hospital policy.
  - iii. Any records of communication with the patient, such as telephone calls or email.

- iv. Any patient-generated information.
- 4. The medical record of a patient who receives urgent or immediate care, treatment and services contain all of the following:
  - i. The time and means of arrival.
  - ii. Indication that the patient left against medical advice, when applicable.
  - iii. Conclusions reached at the termination of care, treatment and services, including the patient's final disposition, condition and instructions given for follow-up care, treatment and services.
  - iv. A copy of information made available to the practitioner or medical organization providing follow-up care, treatment or services.
- 5. A summary list is initiated for the patient on third visit containing the following information:
  - i. Any significant medical diagnoses and conditions.
  - ii. Any significant operative and invasive procedures.
  - iii. Any adverse or allergic drug reaction.
  - iv. Any current medications, over-the-counter medications and herbal preparations.
  - v. The patient's summary list is updated whenever there is a change in diagnoses, medications or allergies to medications and whenever a significant procedure is performed.

#### **Operative and Procedure Notes**

An operative or other high-risk procedure report is written or dictated upon completion of the operative or other high-risk procedure before the patient is transferred to the next level of care or immediately after transferring the patient. The progress note and dictated operative report should be part of the patient's medical record and must include the following:

1. Name(s) of the independent practitioner(s) & assistant/s who performed the procedure.
2. Name of the procedure performed.
3. Description of the procedure.
4. Findings of the procedure.
5. Whatever is done in a procedure.
6. Estimated blood loss.
7. Any specimens removed.
8. The postoperative diagnosis.
9. Complications during and after surgery, if any.

**The surgeon must authenticate the completed operative report as soon as possible after surgery/procedure.**

#### **SOPs for Transfer of Patients**

Following the decision to refer a patient to another hospital, there should be a written communication containing the reasons of referral with date, time, name of the receiving hospital and a copy of the same should be retained in the medical record of the patient. If the patient has been transferred at his/her own request, a note to that effect is added in the patient's record. In such cases the name of the receiving hospital would be of the one where the patient desires to go to. However, if the patient has been transferred by the HCE under care with medical staff, it shall have acknowledgement from the receiving hospital.

**Any element of care/treatment carried out during patient transfer must be documented.**

#### **Discharge Summary Record**

A discharge summary is a summary of the patient's stay in the hospital written by the attending doctor. The summary should contain following minimum details:

1. Patient identification.
2. Reason for admission.
3. Examinations and findings.
4. Treatment while in hospital.
5. Proposed follow up.
6. Medications.
7. Diet and instructions to maintain health status.

A discharge summary may be written on a pre-printed form or on plain paper and typed or word processed in the Medical Record Department/room. Alternatively, the attending doctor writes a discharge summary in duplicate when the patient is discharged. The original is kept in the medical record and the copy given to the patient. On discharge/death of the patient the medical record, including ALL forms relating to the admission plus any previous records, should be sent to the Medical Record Department/room as soon as possible or within 72 hours. The medical record should remain in the Medical Record Department/room.

Medical record staff responsible for the discharge procedure should be trained to ensure that the medical records are completed promptly and correctly.

Discharge lists should be kept in order of date in the Medical Record Department. The list should contain the patient's name, age, treating doctor, ward, and service, i.e., medical, surgical, obstetric, orthopedic, etc., and whether the patient is alive or dead. Discharge lists are usually used to prepare the hospital inpatient statistics.

By using the discharge list, the staff responsible for the discharge procedure in the Medical Record Department can check to see if they have all the medical records of discharged/dead patients from the previous. Once a patient has been discharged, the medical record should be returned promptly to the Medical Record Department and acknowledgement to this effect should be received. Failure to do so may result in a missing medical record. Once the patient is no longer in the ward, their medical record can easily be misplaced. Any qualified and trained individual can compile the discharge summary such as the patient's physician or a house medical officer.

### **Death Certificate Record**

In case of death, details of circumstances leading to the death of patients like primary and secondary cause of death should be mentioned. The death certificate must be signed and stamped by registrar and dead body handed over to blood relations like father, mother, spouse etc. On the death of the patient, the medical record including ALL forms relating to the admission plus any previous records should be sent to the Medical Record Department as soon as possible or within 72 hours. All deaths occurring in hospital, either inpatient or outpatient must be documented in the Medical Record Department.

### **Autopsy Report Record**

Clinical autopsies serve two major purposes. They are performed to gain more insight into pathological processes and determine what factors contributed to a patient's death. Autopsies are also performed to ensure the standard of care at hospitals. Autopsies can yield insight into how patient deaths can be prevented in the future.

## Ind 45. Authorized care providers have access to current and past medical records.

### Survey Process:

HCE policy identifies and authorizes those care providers who can access the patient's record to ensure confidentiality of patient information. Request the names of representative sample of 5 patients who were previously discharged and request for their records for review.

### Scoring:

- If ALL the requested records are available (brought to the surveyor), then score as **fully met.**
- If only 4 of the 5 are available, then score as **partially met.**
- If only 3 are available, then score as **not met.**

## GUIDELINES

### Access to Medical Record

The medical record serves as the central repository for planning patient care and documenting communication amongst the patient and HCP and professionals contributing to the patient's care. In addition to facilitating high quality patient care, an appropriately documented medical record serves as a legal document to verify the services provided. The medical record may be used to validate the site of the service, the medical necessity and appropriateness of the diagnostic and/or therapeutic services provided, and also to validate that the services have been reported accurately. HCE policy identifies and authorizes those care providers who can access the patient's record to ensure confidentiality of patient information.

## Assessment Scoring Matrix

**Standard 13. IMS 1: The Hospital / HCE has a complete and accurate medical record for every patient.**

Indicator 40-45		Max Score	Weightage (Percentage)	Score Obtained
Ind 40.	Every medical record has a unique identifier.	10	100	
Ind 41.	The staff authorized to make entries in the medical record is reflected in the Hospital's policy and is identifiable.	10	100	
Ind 42.	Every medical record entry is dated, timed and signed.	10	80	
Ind 43.	The record provides an up-to-date and chronological account of patient care.	10	100	
Ind 44.	The medical record contains information regarding reasons for admission, diagnosis, plan of care, Informed Consent, care provided and details if shifted /discharged displaying continuity of care, copy of death certificate and copy of clinical autopsy report when done in chronological order.	10	100	
Ind 45.	Authorized care providers have access to current and past medical records.	10	80	
<b>Total</b>		60	-	

## Standard 14. IMS-2: The hospital regularly carries out review of medical records.

### Indicators (46-51):

#### Ind 46. The medical records are reviewed regularly/periodically.

##### Survey Process:

There is a policy or other documentation that the hospital has a process for review of medical record and it should:

1. Define the frequency of review.
2. Calculate the representative sample based on statistical principles.
3. Identify/specify the professionals to conduct the review from those who are authorized to make entries in the medical record and NOT only by those from statistical staff/ or the medical record personnel.

##### Scoring:

- If the hospital has a medical record review process and a schedule complying the above, then score as **fully met**.
- If the hospital has a medical record review process, but it complies upto 80% of each of the above directions, then score as **partially met**.
- If the hospital does not have a medical record review process, or it has less than 80% compliance of any one of the above three requirements, then score as **not met**.

### GUIDELINES

#### Periodical Review for M&E of Medical Record

Each hospital determines the content and format of the patient clinical record and has a process to assess the content and completeness of records. That process is a part of the hospital's performance improvement activities and is carried out regularly. Patient clinical record review is based on a sample representing the practitioners providing care and the types of care provided. The review process is conducted by the medical staff, nursing staff, and other relevant clinical professionals who are authorized to make entries in the patient record. The review focuses on the timeliness, completeness, legibility, and so forth of the record and clinical information. Clinical record content required by any existing law or regulation is included in the review process.

The hospital's clinical record review process includes records of patients currently receiving care as well as records of the patients who have been discharged or died in the HCE.

#### Ind 47. The review focuses on the timeliness, legibility and completeness of both active (current) and discharged patients records.

##### Survey Process:

Analyze documentation of the review to verify that it includes timeliness, legibility and completeness

of both active/current and discharged patients medical records.

**Scoring:**

- If the documentation of the review demonstrates evidence of review of timeliness, legibility and completeness of the medical records of both active/current and discharged patients, then score as **fully met**.
- If the review process does not include all of timeliness, legibility and completeness of both active/current and discharged patients' medical records, then score as **not met**.

**GUIDELINES**

**Scope of Review of Medical Records**

All entries must be legible, signed and dated. Signature includes the first initial, last name and title. Initials may be used only if signatures are specifically identified elsewhere in the medical record (e.g. signature page). Stamped signatures are acceptable, but must be authenticated. Methods used to authenticate signatures in electronic medical records will vary, and must be individually evaluated by reviewers. Date includes the day/month/year. Only standard abbreviations are used. Entries are in reasonable consecutive order by date. Handwritten documentation, signatures and initials are entered in ink that can be readily copied. Handwritten documentation does not contain skipped lines or empty spaces where information can be added later on. Entries are not backdated or inserted into spaces above previous entries. Omissions are charted as a new entry. Late entries are explained in the medical record, signed and dated.<sup>40</sup>

**Note; Legibility means the record entry is readable by a person other than the writer.**

Although assessment of legibility may be subjective to a degree, the criterion for readability is simple: a notation can either be clearly and easily read or not. HCPs who work together regularly may become accustomed to each other's handwriting. Even though a record may be readable between healthcare coworkers, the same concessions may not apply in legal actions. Records must be objectively reviewed for legibility. If a record fails to be readable at any level, hospital policy and medical staff bylaws should guide resultant actions. Offenders should be formally notified, corrective action taken, and improvements monitored. It is important for the HCE management to ensure the legibility of records. Illegibility patterns in patient records should be seriously considered during re-credentialing activities for credentialed and professional staffs. Although legibility is addressed primarily as a physician issue, a number of allied health professionals have record documentation authority as well. Among them are nurses, therapists, and technicians. Legibility should be objectively measured in performance improvement activities and addressed in performance reviews as appropriate for all responsible health professionals.

**Extent of Review Process**

This indicator demands that in the review process all the documentation pertaining to patients who are currently in the hospital and of those who are discharged is included. Review of documents of those patients who are admitted should be done strictly based on the SOPs, clearly dividing the documentation during three stages i.e., i. On admission, ii. During Stay, iii. On discharge. Typically,

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<sup>40</sup> Glondys, B. (May 2003). "Ensuring Legibility of Patient Records (AHIMA Practice Brief)." Journal of AHIMA 74, no.5: 64A-D.

the review at admission and discharge should be done by the MS and AMS and the HoD must review the record for all aspects of care during stay to ensure that quality care is delivered. However, the management should devise other means to have a counter check randomly, which should be recorded too. Regular review of records of patients should be done by a committee

### **Ind 48. The review identifies, and documents any deficiencies in the record.**

#### **Survey Process:**

Review the minutes or other documents that demonstrate the findings of the review, including deficiencies found. It is highly unlikely that the hospital's review has not identified any problems with medical record documentation.

#### **Scoring:**

- If the documentation includes identification of any deficiencies, then score as **fully met**.
- If not, then score as **not met**.

## **GUIDELINES**

### **Identification and Documentation of Deficiencies in Records**

It is important to understand the requirement of this indicator that it is demanding the actions which the review team/reviews are required to do and document. Therefore, reviewers must be aware of at least the following types of errors which they are required to check and document. Indicator 44 and 45 are required to be read and evaluated together. The person who makes the documentation error corrects the error. A single line is drawn through the error, with "error" written above or near the lined-through incorrect entry. The corrected information is written as a separate entry and includes date of the entry, signature (or initials), and title. There are no unexplained cross-outs, erased entries or use of correction fluid. Both the original entry and corrected entry are clearly preserved. If the person realized a documentation error, it should be corrected by that person there and then with the same pen and ink as described above but if it is a delayed realization or checked by another then it should be corrected in RED ink. Reviewers must determine method(s) used for correction of documentation errors in computerized records on a case to case basis.<sup>41</sup>

**Note: No information or entry may be removed from a health record.**

### **Ind 49. Appropriate corrective and preventive measures undertaken are documented.**

#### **Survey Process:**

Review the minutes to confirm the response to deficiencies.

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<sup>41</sup> Medical Record Review Guidelines California Department of Health Services. Medi-Cal Managed Care Division.

### Scoring:

- If the minutes document corrective action when indicated, then score as **fully met.**
- If not, then score as **not met.**

## GUIDELINES

### Documentation of Corrective and Preventive Measures

Indicator 49 and 50 are required to be read and evaluated together.

1. Errors inevitably occur in any medical record. They may be minor errors in transcription, inadvertently omitted test results, physicians' orders, other information omitted or deliberate falsifications.
2. First, deliberate falsifications must be avoided at all costs. This will most likely lead to allegations of a cover up which will at best, create a prima facie case of negligence.
3. Effort should be made to avoid other types of errors. However, in the event an error occurs, they can be corrected legally by the following procedure:
  - i. The person who made the incorrect entry should change it and initial the correction.
  - ii. The person making the change should cross out the incorrect entry with a single line, enter the correct information, and enter the date and time of the correction.
  - iii. If the correction requires more than the available space, a supplement should be prepared and a reference to the supplement should be made in the available space by the erroneous entry.
  - iv. The original entry should not be obliterated or erased and following should be ensured;
    - a. Never use pencil to write entries.
    - b. Never use "white-out".
    - c. Do not alter past-dated notes, chart notes/progress notes (e.g., by writing alongside or adding to prior entries).
    - d. Error corrections that are not done according to procedure will result in inadequate source documentation.
4. Guidance for when to state a reason for changes in documentation is as follows:
  - i. If it is something a reviewer can "see" or is obvious, such as a transcription error, then it needs no explanation. For example, if the site corrected a lab value that was transcribed incorrectly, then an explanation for the correction is not necessary as long as it can be verified with the original lab report.
  - ii. If it is not clear, like a diagnosis or symptom that was deleted after initial entry, then there should be a rationale for the change.

**Ind 50. The review uses a representative sample based on statistical principles.**

### Survey Process:

Review minutes and other documents that validate certain statistical principles used for sampling.

**Scoring:**

- If sampling policy for review of medical record exists, then score as **fully met.**
- If sampling policy for review of medical record does not exist, then score as **not met.**

**GUIDELINES****Sampling Policy for Record Review<sup>42</sup>**

1. Medical records shall be randomly selected using methodology decided upon by the reviewer/s.
2. Sample size determination is a mathematical process to decide how many subjects are needed in order to make a reasonably sound judgment about a hypothesis.
3. How the sample size is calculated depends on the statistical tests used in the analyses. Generally, results are reported with Confidence Intervals (CIs) around the summary measure. Therefore, the sample size should be based on the desired CI width (usually 95%).
4. The formulas for sample size calculations are found in most health research statistics books and automated methods of computing them can be found at a number of Web sites. There are no published recommendations for what proportion of the abstracted data should be randomly checked for accuracy of abstraction. Generally 10% data can be used for review of the record in a small hospital, while 5% data is to be used for large hospitals.

**Ind 51. The review is conducted by identified care providers and health professionals.**

**Survey Process:**

There is documented policy for review of medical record that identify professionals for the review process.

**Scoring:**

- If professionals are identified for review process, then score as **fully met.**
- If professionals are not identified for review process, then score as **not met.**

**GUIDELINES****Policy on Authorization to Review Medical Record**

Access to information is based on needs and defined by job title and functions, including students in an academic setting. An effective review process defines following parameters;

1. Who has an access to information.
2. The information to which an individual has access.
3. The user's obligation to keep information confidential.
4. The process followed when confidentiality and security are violated.
5. One aspect of maintaining the security of patient information is to determine who is authorized to obtain a patient's clinical record for review. The organization develops a policy to authorize such individuals (e.g., doctors, nurses, statisticians etc.) and makes SOPs for the review process.

<sup>42</sup> Academic Emergency Medicine Vol. 11(2). (February, 2004), Retrieved from [www.aemj.org](http://www.aemj.org)

## Assessment Scoring Matrix

**Standard 14. IMS 2: The Hospital/HCE regularly carries out review of medical records.**

Indicator 46-51		Max Score	Weightage (Percentage)	Score Obtained
Ind 46.	The medical records are reviewed regularly/periodically.	10	<b>80</b>	
Ind 47.	The review focuses on the timeliness, legibility and completeness of both active (current) and discharged patients records.	10	<b>100</b>	
Ind 48.	The review identifies, and documents any deficiencies in the record.	10	<b>100</b>	
Ind 49.	Appropriate corrective and preventive measures undertaken are documented.	10	<b>100</b>	
Ind 50.	The review uses a representative sample based on statistical principles	10	<b>100</b>	
Ind 51.	The review is conducted by identified care providers and health professionals	10	<b>100</b>	
<b>Total</b>		60	-	

## 2.5 Continuous Quality Improvement (CQI)

### 03 Standards & 14 Indicators

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Continuous Quality Improvement (CQI) has been used in the manufacturing world more extensively than in the healthcare field. However, the underlying foundation of medicine is in fact quite closely tied to the principles of CQI. This includes the observation of a phenomenon, isolating variables and changing the process, observing the results and taking action. If the results are beneficial, continue with the change and look for the next area to improve. If the results are adverse, discard them and try something else. Continue to observe the results until a pattern of foreseeable positive results emerges from performing certain actions.

CQI is easy for healthcare professionals to learn since it is based on this basic scientific model of discovery. As healthcare professionals learn the concepts and strategies behind CQI, they will infuse their scientific background and experience into the program. Innovative measures and positive results follow quickly. These results include higher quality of service delivered, satisfied patients and customers, and lower costs. Quality Control (QC) has been proven time and again to cut costs dramatically.

These standards focus on a systematic approach of using data to measure, assess and improve current performance. This continuous process focuses on outcomes of care, and must include reducing actual and potential risks to patient safety. To achieve this goal, the standards emphasize processes, systems and individual behaviors that reduce the likelihood of unanticipated adverse events. Physicians should be involved in all stages of improvement. They can help design patient care processes, identify the data necessary to measure performance, help analyze this data, and suggest and implement the process improvements.

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## Standard 15. CQI-1: There is a structured quality improvement and continuous monitoring programme in the hospital.

### Indicators (52-56):

**Ind 52. A comprehensive programme covering ALL the major elements related to quality improvement and risk management is developed, implemented and maintained by a notified committee.**

#### Survey Process:

There is a written CQI plan including at least: i. A committee comprising members from relevant sections with terms of reference, ii. The responsibilities and authorities of the committee. iii. The CQI methodology to be used, iv. Reporting structure of CQI results, v. Recording the minutes of the committee meetings.

#### Scoring:

- If there is a written plan and it includes at least the 5 above requirements, then score as **fully met**.
- If there is a plan but it lacks defining the responsibilities and authorities of the committee, then score as **partially met**.
- If there is no plan or it includes 3 or fewer of the above requirements, then score as **not met**.

## GUIDELINES

### Quality Improvement Plan

Provision of Quality services entails timely, safe, effective, equitable, recovery-oriented and recipient-centered approach in their delivery. Quality Improvement Plan serves as the foundation of the commitment of the hospital to continuously improve the quality of the treatment and services provided to the Patients. The concerned Hospital is committed to continuous improvement of the quality of care delivered to its clients which is evidenced by the outcomes of the care.

The Essentials of CQI Plan are as follows:

1. A CQI Committee comprising members from relevant sections including the following:
  - i. In charge/MS of the HCE/Hospital.
  - ii. Representative from the Hospital Board of Directors.
  - iii. Heads of Clinical Departments as appropriate for the facility.
  - iv. Managers/Directors, Ancillary Services.
  - v. Nursing Managers/Senior Nurse.
  - vi. QI Manager.
  - vii. Head of Pharmacy Department.
  - viii. Infection Control Nurse.

- ix. Any co-opted member.
- 2. The CQI Committee is assigned the TORs including interalia the following.<sup>43</sup>
  - i. Prioritizing issues referred to the QI Committee for review.
  - ii. Assuring that the review functions outlined in the plan are completed.
  - iii. Assuring that the data gathered through QI activities is analyzed, recommendations for resolving problem are made and followed.
  - iv. Identifying other sources of Patient Safety Goals such as the KP HCC's MSDS, for incorporating into the hospitals overall quality improvement efforts.
  - v. Reporting the HCE Management findings, recommendations and trends, quarterly annually or on as and when required basis, to the Board of Management/Directors.
  - vi. Identifying Continued Professional Development needs and assuring that continued education for quality improvement takes place.
  - vii. Appointing sub committees or teams to work on specific issues, as necessary.
  - viii. Assuring availability of necessary resources.
  - ix. Undertake coordinating activities with the KP HCC as and when required.

**3. The CQI Methodology:**

Continuous Quality Improvement refers to following an approach which entails examining work processes to make them better, effective, efficient and responsive using the following Methodology:

- i. Patients and caregivers are at the center of improvement efforts.
- ii. Focus on work processes.
- iii. Involvement of interdisciplinary teams to identify issues and make improvements.
- iv. Use of data and information to guide changes.
- 4. Structured arrangements for reporting CQI results.  
All executing staff reports the action taken on a prescribed format to the respective in - charge and the CQI Committee members report to the Chairperson of the Committee who in turn reports to the in charge of the HCE.
- 5. Recording the minutes of the committee meetings.  
Following format is provided as guidance for recording the minutes of the CQI Committee Meetings:

*Table 12: Minutes of Meeting Template*

Venue: Conference Room of HCE				
Subject: Minutes of CQI meeting No.— held on , 2020				
Agenda Item	Description	Discussion	Decision	Other remarks
1.				
2.				
3.				

<sup>43</sup> Model Quality Improvement Program CAH Hospital Network.

**Ind 53. There is a designated individual for coordinating and implementing the quality improvement programme.**

**Survey Process:**

The "Quality Improvement Coordinator" is either a doctor or a nurse or any other professional. There should be a job description for this individual that defines the requisite qualifications and the duties. This may be either a full time or a part time position (depending on the size of the hospital and its scope of services). The person has adequate knowledge and authority to undertake the role and hospital staff members are aware of the person and the role he/ she has to play.

**Scoring:**

- If there is a designated quality improvement coordinator and a job description for the individual, then score as **fully met**.
- If there is a designated coordinator but no job description, then score as **partially met**.
- If there is no designated coordinator, then score as **not met**.

**GUIDELINES**

**QI Program Coordinator**

1. The Director/Manager QI is a professional who works collaboratively with the CEO/MS, committee members and departments to coordinate and facilitate the activities of the CQI program throughout the organization.
2. He/she is responsible for identifying quality indicators, collecting and analyzing data, developing and implementing changes to improve service delivery, and monitoring to assure that improvement is made and sustained.
3. The ultimate goal is to improve the quality of care that is routinely provided to the patients in the HCE.

**Ind 54. The designated programme is communicated and coordinated amongst all the employees of the HCE through a proper training mechanism.**

**Survey Process:**

There should be documented evidence that ALL the appropriate staff including a minimum of i. All the senior leaders, ii. All department heads, and iii. All members of the CQI committee have participated in a formal process to ensure they fully understand the program. Interview staff and ask regarding orientation on the CQI program.

**Scoring:**

- If there is documented evidence of training of ALL the personnel listed above, then score as **fully met**.
- If only 1-2 department heads have not been trained, then score as **partially met**.
- If there has been no training, or it has not included at least the senior leadership, the committee members and "most" of the department heads, then score as **not met**.

## GUIDELINES

### Communication of QI Program

All staff is assigned the responsibility and authority to participate in the Hospital's QI Plan. To fully accomplish this, all staff shall be provided education regarding the QI Plan during their initial orientation and on an annual basis thereafter.

This education shall include a description of the QI Plan and how they fit into the plan, based on their particular job responsibilities. It shall also include education regarding the QI methodology utilized by the HCEs.

**Ind 55. The quality improvement programme is a continuous process and updated at least once in a year.**

### **Survey Process:**

Review the documented evidence that the program has been reviewed at least once in the past year or at the frequency defined in the hospital's policy or on as and when required basis.<sup>44</sup>

### **Scoring:**

- If there is documented evidence that the programme was reviewed at least once in the past year, or more frequently if required by hospital policy, then score as **fully met.**
- If there has been no review or if the review is more than one year ago, then score as **not met.**

## GUIDELINES

### Annual Review of QI Program

The QI Plan shall be evaluated on an annual basis for effectiveness in achieving the goal of assuring that the most appropriate quality of care has been provided to patients. A summary of activities, improvements made, care delivery processes modified, projects in progress, and recommendations for changes to this QI Plan, shall be compiled and forwarded to the Board for action.

**Ind 56. The quality improvement programme is documented.**

### **Survey Process:**

There is documented quality improvement programme including quality improvement plan, quality improvement principles and continuous quality improvement activities.

### **Scoring:**

- If CQI plan with listed activities is available, then score as **fully met.**
- If CQI plan with listed activities is not available, then score as **not met.**

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<sup>44</sup> For example on transfer of incumbent/s or change in scope of services.

## GUIDELINES

### Quality Improvement Plan

Quality services are services that are provided in a timely, safe, effective, equitable, and recovery-oriented and recipient-centered approach.

The following QI Plan serves as the foundation of the commitment of this hospital to continuously improve the quality of the treatment and services it provides. The concerned Hospital is committed to the ongoing improvement of the quality of care its clients receive, as evidenced by the outcomes of that care. The organization continuously strives to ensure that:

1. The treatment provided incorporates evidence based effective practices.
2. The treatment and services are appropriate to each client's needs, and are available when needed.
3. Risk to clients, providers and others is minimized, and errors in the delivery of services are prevented.
4. Clients' individual needs and expectations are respected; clients or those whom they designate, have the opportunity to participate in taking decisions regarding their treatment and services are provided with sensitivity and care.
5. Procedures, treatments and services are provided in a timely and efficient manner, with appropriate coordination and continuity across all phases of care and all providers of care.

### Quality Improvement Principles

QI is a systematic approach to assessing services and improving them on a priority basis. The HCE's approach to Continuous Quality Improvement (CQI) is based on the principles that follow.

1. **Client Focus:** High quality organizations focus on their internal and external clients and on meeting or exceeding needs and expectations.
2. **Recovery-oriented:** Services are characterized by a commitment to promoting and preserving wellness and to expanding choice. This approach promotes maximum flexibility and choice to meet individually defined goals and to permit client-centered services.
3. **Employee Empowerment:** Effective programs for QI involve people at all levels of the organization.
4. **Leadership Involvement:** Strong leadership and direction/support for quality improvement activities by the governing body/Hospital Committee and CEO/MS are key to performance improvement. This involvement of organizational leadership assures that quality improvement initiatives are consistent with the provider's mission and/or strategic plan.
5. **Data Informed Practice:** Successful QI processes create feedback loops, using data to inform practice and measure results. Evidence-based decisions are likely to be correct decisions.
6. **Statistical Tools:** For continuous improvement of care, tools and methods are needed that foster knowledge and understanding. CQI organizations use a defined set of analytic tools such as flow charts, cause and effect diagrams, Pareto charts, histograms, and control charts to turn data into information.
7. **Prevention Overcorrection:** CQI entities seek to design good processes to achieve excellent outcomes rather than designing processes after the event.
8. **Continuous Improvement:** Processes must be continually reviewed and improved. Small incremental changes do make an impact and providers can always find an opportunity to make things better.

**Continuous Quality Improvement Activities**

CQI activities emerge from a systematic and organized framework for improvement. This framework, adopted by the hospital leadership, is understood, accepted and utilized across the organization, as a result of continuous education and involvement of staff at all levels. QI involves two primary activities:

1. Measuring and assessing the performance of hospital services through collection and analysis of data.
2. Conducting quality improvement initiatives and taking action where indicated, including the:
  - i. Design of new services
  - ii. Improvement of existing services

The QI Plan described previously may be documented as per the following format;

*Table 13: Sample Format for QI Plan*

Name of Hospital _____
Date of the Current Plan _____
<b>Introduction: Mission, Vision, Scope of Service</b> (Describe briefly the hospital program that will be covered by this Plan, including the HCE’s mission and vision, the types of services provided, its relative
_____
_____
_____
_____
_____

## Assessment Scoring Matrix

**Standard 15. CQI 1: There is a structured quality improvement and continuous monitoring programme in the Hospital/HCE.**

Indicator 52-56		Max Score	Weightage (Percentage)	Score Obtained
Ind 52.	A comprehensive programme covering all the major elements related to quality improvement and risk management is developed, implemented and maintained by a notified committee.	10	80	
Ind 53.	There is a designated individual for coordinating and implementing the quality improvement programme.	10	80	
Ind 54.	The designated programme is communicated and coordinated amongst all the employees of the HCE through a proper training mechanism.	10	80	
Ind 55.	The quality improvement programme is a continuous process and updated at least once in a year.	10	100	
Ind 56.	The quality improvement programme is documented	10	100	
<b>Total</b>		50	-	

## Standard 16. CQI-2: The hospital identifies key indicators to monitor the clinical structures, processes and outcomes which are used as tools for continual improvement.

### Indicators (57-63):

#### Ind 57. Monitoring includes appropriate patient assessment.

##### Survey Process:

Review the documentation in the committee minutes. When surveying the hospital ask to see examples of the impact of CQI programme. Examples should be observable at i. Admission, ii. Regularly through the course of the treatment and iii. Based on the condition of the patient and Recorded in the medical record. In the initial stages healthcare establishments can set their own benchmarks, which need to be documented. These will eventually be compared across similar institutions and shared with the intent of achieving the right benchmarks across the province.

##### Scoring:

- If there is documented evidence that this has been monitored and examples can be seen as a result of the CQI program, then score as **fully met**.
- If not, then score as **not met**.

### GUIDELINES

#### Monitoring of Patient Assessment

The hospital shall develop appropriate key performance indicators suitable to it including but not limited to the following;

1. Time for initial assessment of indoor and emergency patients.
2. Percentage of cases (in-patients) wherein care plan with desired outcomes is documented and counter-signed by the clinician.
3. Percentage of cases (in-patients) wherein screening for nutritional needs has been done.
4. Percentage of cases (in-patients) wherein the nursing care plan is documented.

#### Ind 58. Monitoring includes safety and quality control programmes of the diagnostic services.

##### Survey Process:

Review the documentation in the committee minutes and check the diagnostic services to observe the following: i. Documented Standard Operating Procedures (SOPs), ii. Documented occupational health and safety protocols iii. Documented training of staff in SOPs and Occupational Health and Safety (OH&S), iv. Reference testing / calibration to ensure validity, v. External audit of facilities, procedures and protocols.

**Scoring:**

- If there is documented evidence that these factors are present and related activities are being monitored and reflected in the minutes of the CQI program, then score as **fully met.**
- If not, then score as **not met.**

**GUIDELINES****Monitoring of Diagnostic Services**

The hospital shall develop appropriate key performance indicators suitable for all diagnostic services including but not limited to the following:

1. Number of reporting errors/1000 investigations.
2. Percentage of re-dos.
3. Percentage of reports co-relating with clinical diagnosis.
4. Percentage of adherence to safety precautions by employees working in diagnostics.

Interpretation(s): Reporting errors need to be captured. It is better if the organization captures these errors as errors picked up before dispatching the reports and errors picked after the dispatch of reports. This includes transcription errors also.

Re-dos include tests which needed to be repeated in view of poor sample or improper positioning and in case of radiology also includes film wastage.

To capture co-relation, it becomes mandatory that all investigation forms have a provisional diagnosis/relevant clinical details written on them. The organization could decide which tests will be monitored. However, in case of laboratory errors shall be captured for all histo-pathological tests and in case of radiology they shall be captured for CT and MRI. The form can have the differential diagnosis also written on them.

To capture adherence to safety precautions, the organization needs to do a random check of all employees per month (working in these areas and including all categories of staff) and capture data.

**Ind 59. Monitoring includes all invasive procedures.****Survey Process:**

Review the documentation in the CQI committee minutes. Check to see if indicators such as the reporting of all adverse occurrences<sup>45</sup> is included such as return to operating room within 24 hours and re-admissions within 24 hours if related to invasive procedures.

**Scoring:**

- If there is documented evidence that this has been monitored, then score as **fully met.**
- If not, then score as **not met.**

**GUIDELINES****Monitoring of Invasive Procedures**

The hospital shall develop appropriate key performance indicators for all invasive procedures

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<sup>45</sup> An unplanned event with a negative consequence for the patient

suitable to it including but not limited to the following: Number of reporting errors/1000 investigations.

1. Percentage of unplanned invasive procedures.
2. Percentage of rescheduling of invasive procedures.
3. Percentage of cases where the organization procedures, to prevent adverse events like wrong patient and wrong procedure, have been adhered to.
4. Percentage of cases who received appropriate prophylactic antibiotics within the specified time frame.

**Interpretations:** Unplanned procedure shall be captured only during the same admission. Re-scheduling of patients include cancellation and postponement (beyond four hours) of the procedure because of poor communication, inadequate preparation or inefficiency within the system.

Prophylactic antibiotics should be administered ideally within 30-60 minutes but certainly within two hours of the time of incision.

## Ind 60. Monitoring includes adverse drug events.

### Survey Process:

Review the documentation in the CQI Committee minutes and check to see if there are references to adverse drug reactions (ADRs) and events such as allergic reactions, wrong dose, wrong drug, wrong patient, contraindications and similar issues and see how these events have been managed.

### Scoring:

- If there is documented evidence that this has been monitored, then score as **fully met**.
- If not, then score as **not met**.

## GUIDELINES

### Monitoring of Adverse Drug Events

The hospital shall develop appropriate key performance indicators for monitoring adverse drug reactions including inter alia the following: Percentage of unplanned invasive procedures.

1. Percentage of medication errors (Prescribing, dispensing, administration).
2. Incidence of adverse drug reactions.
3. Percentage of admissions with adverse drug reaction/s (ADR).
4. Percentage of medication charts with error prone abbreviations.
5. Percentage of patients receiving high risk medications developing adverse drug event.

**Interpretations:** The organization shall document a list of approved abbreviations for medication charts. This shall be based on best national and international practices. For example, "ISMP list of Error-Prone abbreviations, Symbols, and Dose Designations."

ADR monitoring and reporting programs encourage ADR surveillance, facilitate ADR documentation, promote the reporting of ADRs, provide a mechanism for monitoring the safety of drug use in high-risk patient populations, and stimulate the education of health professionals regarding potential ADRs. A comprehensive, ongoing ADR program should include mechanisms for monitoring, detecting, evaluating, documenting, and reporting ADRs as well as intervening and

providing educational feedback to prescribers, other healthcare professionals, and patients. Additionally, ADR programs should focus on identifying problems leading to ADRs, planning for positive changes, and measuring the results of these changes. Positive outcomes resulting from an ADR program should be emphasized to support program growth and development.

A comprehensive ADR-monitoring and reporting program should be an integral part of an organization's overall drug use system.

An ADR-monitoring and reporting program should include the following features;

1. The program should establish:
  - i. An on-going and concurrent (during drug therapy) surveillance system based on the reporting of suspected ADRs by pharmacists, physicians, nurses, or patients.
  - ii. A prospective (before drug therapy) surveillance system for high-risk drugs or patients with a high risk for ADRs.
  - iii. A concurrent surveillance system for monitoring alerting orders. Alerting orders include the use of "tracer" drugs that are used to treat common ADRs (e.g., orders for immediate doses of antihistamines, epinephrine, and corticosteroids), abrupt discontinuation or decreases in dosage of a drug or stat orders for laboratory assessment of therapeutic drug levels.
2. Prescribers, caregivers, and patients should be notified regarding suspected ADRs.
3. Information regarding suspected ADRs should be reported to the pharmacy for complete data collection and analysis, including the patient's name, the patient's medical and medication history, a description of the suspected ADR, the temporal sequence of the event, any remedial treatment required, and outcomes.
4. High-risk patients should be identified and monitored. High-risk patients include but are not limited to pediatric patients, geriatric patients, patients with organ failure (e.g., hepatic or renal failure), and patients receiving multiple drugs.
5. Drugs likely to cause ADRs ("high-risk" drugs) should be identified, and their use should be monitored. Examples of drugs that may be considered as high risk include aminoglycosides, amphotericin, antineoplastics, corticosteroids, digoxin, heparin, lidocaine, phenytoin, theophylline, thrombolytic agents, and warfarin.
6. The cause(s) of each suspected ADR should be evaluated on the basis of the patient's medical and medication history, the circumstances of the adverse event, alternative etiologies, and a literature review.
7. A method for assigning the probability of a reported or suspected ADR (e.g., confirmed or definite, likely, possible, and unlikely) should be developed to categorize each ADR. Algorithms may be useful in establishing the causes of suspected ADRs. Subjective questions and the professional judgment of a pharmacist can be used as additional tools to determine the probability of an ADR. Questions might include the following:
  - i. Was there a temporal relationship between the onset of drug therapy and the adverse reaction?
  - ii. Was there a de-challenge; i.e., did the signs and symptoms of the adverse reaction subside when the drug was withdrawn?
  - iii. Can signs and symptoms of the adverse reaction be explained by the patient's disease state?
  - iv. Were there any laboratory tests that provide evidence for the reaction being an ADR?
  - v. What was the patient's previous general experience with the drug?
  - vi. Did symptoms return when the agent was re administered?

- a. A method for ranking ADRs by severity should be established.
- b. A description of each suspected ADR and the outcomes from the event should be documented in the patient's medical record.
- c. Serious or unexpected ADRs should be reported to the Drug Regulatory Authority (DRA) or the drug's manufacturer (or both).
- d. All ADR reports should be reviewed and evaluated by a designated multidisciplinary committee (e.g., a pharmacy and therapeutics committee).
- e. ADR-report information should be disseminated to health care professional staff members for educational purposes. Good topics for medical staff education include preventing ADRs and appropriate and effective care for patients who experience ADRs. Educational programs can be conducted as morning "report" discussions, newsletters, algorithms for treatment, and multidisciplinary reviews of drug-use evaluations. Patient confidentiality should be preserved.
- f. In settings where it is possible, a pharmacy-coordinated ADR team or committee, consisting of a physician, nurse, QI leader, an administrator, and a pharmacist is recommended. The team should be charged with adopting a definition for the organization, promoting awareness of the consequences of ADRs, establishing mechanisms for identifying and reporting ADRs, reviewing ADR patterns or trends, and developing preventive and corrective interventions.
- g. Continuous monitoring of patient outcomes and patterns of ADRs is imperative. Findings from an ADR monitoring and reporting program should be incorporated into the organization's on-going quality improvement activities. The process should include the following:
  - Feedback to all appropriate health care staff.
  - Continuous monitoring for trends, clusters, or significant individual ADRs.
  - Educational efforts for prevention of ADRs.
  - Evaluation of prescribing patterns, patient monitoring practices, patient outcomes, and the ADR program's effect on overall and individual patient outcomes.

An overall goal of the ADR process should be the achievement of positive patient outcomes.<sup>46</sup>

## Ind 61. Monitoring includes use of anaesthesia.

### Survey Process:

Review the documentation in the committee minutes and observe for reporting of adverse occurrence and adequate follow up from anesthetic services.

### Scoring:

- If there is documented evidence that this has been monitored and adequate follow up has occurred, then score as **fully met**.
- If not, then score as **not met**.

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<sup>46</sup> Society of Health-System Pharmacists. (1995). AHSP guidelines on adverse drug reaction monitoring and reporting. American Journal of Health-System Pharmacy. 52:417-9.

## GUIDELINES

### **Monitoring Use of Anaesthesia**

The hospital shall develop appropriate key performance indicators suitable to it including but not limited to the following:

1. Percentage of modification of anaesthesia plan
2. Percentage of unplanned ventilation following anaesthesia
3. Percentage of adverse anaesthesia events
4. Anaesthesia-related mortality rate.

**Interpretations:** Anaesthesia plan is prepared at the time of pre-anaesthesia assessment. The same shall be reviewed during the immediate pre-operative re-evaluation. Modifications done in the plan based on this assessment shall be captured.

Adverse anaesthesia events include events, which happen during the procedure like hypoxia, arrhythmias, cardiac arrest, etc.

## Ind 62. Monitoring includes use of blood and blood products.

### **Survey Process:**

Review the documentation in the committee minutes and observe for reporting adverse occurrence and adequate follow up from the blood services.

### **Scoring:**

- If there is documented evidence that this has been monitored and adequate follow-up has occurred, then score as **fully met.**
- If not, then score as **not met.**

## GUIDELINES

### **Monitoring Use of Blood and Blood Products**

The hospital shall develop appropriate Key Performance Indicators (KPIs) suitable to it including the following mandatory parameters:

1. Percentage of transfusion reactions.
2. Percentage of wastage of blood and blood products.
3. Percentage of blood component usage.
4. Turnaround time for issue of blood and blood components.

**Interpretations:** Wastage includes blood products found unfit for use.

Every blood transfusion service should develop an effective quality system to ensure the implementation of these strategies. The quality system should cover all aspects of its activities and ensure traceability, from the recruitment and selection of blood donors to the transfusion of blood and blood products to patients. It should also reflect the structure, needs and capabilities of the BTS, as well as the needs of the hospitals and patients that it serves.

Key elements of quality systems include:

1. Organizational management
2. Standards
3. Documentation

4. Training
5. Assessment.

Selective elements are discussed as below:

### **Organizational Management**

Commitment and support from the management at all levels is central to an effective quality system, including;

1. Clearly defined organizational structure that defines accountability, authority and responsibility.
2. Designation of a quality manager, with the necessary skills and expertise, in each blood centre and hospital blood bank.
3. Formation of a quality section or identified work area in the hospital blood bank from which quality activities can be coordinated.
4. Development of a culture of quality through a management focus on building quality into all activities.
5. Motivation of staff to ensure their commitment and support for the quality system.
6. Identification of specific processes and procedures and their critical control points.

### **Documentation**

An effective and accurate documentation system, that ensures traceability of all BTS activities, is the foundation of good quality management. Important activities include;

1. Development of a quality manual: a document describing the quality system, including the organization's quality policy, standards and procedures.
2. Production and use of appropriate, comprehensive documents for all activities, including standard operating procedures, forms, labels and any other documents required.
3. Generation and maintenance of complete and accurate records.
4. Development of a system to manage the issue, use and retrieval of documents.

### **Assessment**

Ensuring quality is a continual process; ongoing assessment of the effectiveness of the quality system is essential and can be achieved through;

1. Validation of all processes, procedures, equipment and reagents.
2. Ongoing collection and analysis of data generated from key activities and their use in QI.
3. Establishment of haemovigilance through a system of monitoring, reporting and investigation of adverse incidents related to all blood transfusion activities.
4. Regular review of all activities to assess the overall effectiveness of the quality system and ensure CQI.
5. Programme of regular internal and external audits of the quality system.
6. Reporting and analysis of errors with effective corrective and preventive action.
7. Active participation in appropriate external quality assessment schemes to improve laboratory performance.<sup>47</sup>

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<sup>47</sup> WHO. Essential Health Technologies. Retrieved from [www.who.int/bct](http://www.who.int/bct)

## Ind 63. Monitoring includes availability and content of medical records.

### Survey Process:

Review the documentation in the committee minutes to observe references to the quality of medical records. Records should be standardized across the hospital with specific entries for each specialty service as required and entries for each shift, all procedures, vital signs and the status of the patient. Integrated notes are preferred.<sup>48</sup>

### Scoring:

- If there is documented evidence that this has been monitored, then score as **fully met**.
- If not, then score as **not met**.

## GUIDELINES

### **Monitoring Availability and Contents of Documentation**

The hospital shall develop appropriate KPIs suitable to it including interalia the following:

1. Percentage of medical records not having discharge summary.
2. Percentage of medical records not having codification as per International Classification of Diseases (ICD).
3. Percentage of medical records having incomplete and/or improper consent.
4. Percentage of missing records.

**Interpretations:** Missing records include records within the retention time only. The content, completion, timeliness and accuracy of medical record (documentation) have a direct impact on the evaluation of the quality of assessment, planning and delivery of quality services. Documentation has a universal effect on organizational operations, evaluation of care and services, reimbursement, and survey compliance. The quality and type of care and services delivered to the patient are determined in part through documentation. On-going planning and assessment rely heavily on the quality and accuracy of the documentation in the chart.

Proactive concurrent monitoring of the completion, timeliness and accuracy of the medical record documentation is critical. Both the need for good documentation and risk factors hindering quality, support the importance of an on-going, scheduled audits and monitoring for every patient's medical record. Some of the alerts and Quality Assurance (QA) monitors may be included in the clinical and administrative software used. The quality monitoring process will focus on the combination of using manual and computerized clinical and billing data as well as standards/requirements.

Establishing the qualitative and quantitative monitoring process is expected to be tailored to the HCE, their needs, the services they provide, workflow issues, survey findings and overall management of the facility.

#### **1. Internal Qualitative vs. Quantitative Audits and Monitoring**

There are various types of audits/monitoring systems - qualitative, quantitative and self-monitoring including manual and automated methods. Qualitative audits look at the quality of documentation assessing adherence to clinical practice guidelines, evaluating consistency in charting, and adherence to regulations, standards and interpretations. This type of audit is

<sup>48</sup> Integrated notes involve all care providers writing in the progress notes in a chronological order so that doctors' nurses and paramedics all write in the same section of the notes.

usually completed by a staff member or consultant who has professional training, education or experience. Qualitative audits adhere to the SOPs on qualitative patient care protocols, both internal and those prescribed by the regulatory agencies. Qualitative protocols include increased knowledge and skills of the reviewer to evaluate documentation that focuses on the clinical practice and standards. The results or findings from the qualitative monitoring provide the data for QA reviews of the quality of care, in relationship to the standards, clinical practices and the regulatory requirements.

The HCE staff can be trained and internal systems can be established for self-monitoring to complete quantitative audits which focus on whether a document is complete (all sections of a form), authenticated, or timely. This type of audit is more objective than a qualitative audit. Increased self-reliance and self-monitoring is within reach of the clinical staff documenting, using the following methods:

- i. Self-auditing; before you put the pen down, look for those clinical interventions, observations or assessment that would demonstrate the quality of care you just provided or planning for the future.
- ii. Look at the automated edits or warning/alerts for inconsistencies of documentation based on the software criteria.
- iii. Set an expectation to periodically run reports to identify areas of deficiencies or information to evaluate the documentation, examples, un -noted orders report, alerts for individuals - to check against the charting planned or just completed.
- iv. Establish 'shift to shift' or 'person to person' monitoring of documentation with a "sign-off" either manual/or electronic to indicate self-monitoring. Some examples are medication and treatment, ADL monitoring etc.

On an on-going basis, facilities should have quantitative and qualitative monitoring in place to assure complete and timely records. Admission, current and discharged, record monitoring assures that analysis is completed throughout the patient stay. The goal to continuous monitoring throughout a patient stay is to identify problems or omissions when correction is possible. Analyzing the record on discharge makes it virtually impossible to legally and ethically address or correct documentation problems when it can still impact the patient during their stay while maintaining the integrity of the medical record. For example, if an assessment is not completed on admission nothing can be done on discharge, but if it is found during an admission audit, the assessment can still be completed in order for the facility to provide appropriate care and services for the patient. Signatures for manual systems shall meet the requirements for a full signature, initials that are referenced by the clinician's full name, including title.

## **2. External Qualitative and Quantitative Audits**

Audits of health record information may be performed for the licensing and certification process, for legal reviews from licensing boards and for billing reviews.

## **3. Assessing the Quality of Documentation**

When completing a qualitative audit, the reviewer should have the ability to assess the following issues, identify strengths and weaknesses, and provide suggestions to correct future documentation discrepancies:

- i. Consistency in documentation between progress notes, assessments, care plans, etc.
- ii. Duplication or redundancy in documentation.
- iii. Contradiction in documentation without a clear reason for the differences. This may occur between two disciplines or within one discipline such as nursing where multiple staff

- members document on a similar issue.
- iv. Documentation that is missing key elements for the proper assessment or planning of a problem.
  - v. Documentation reflects application of appropriate practice guidelines, standards, regulations, reimbursement rules, and clinical protocols across all disciplines.
  - vi. Understanding of the reason for all types of documentation in a long-term care record and the underlying guidelines, standards, regulations, or clinical practice protocols.

A health information consultant should have the ability to provide a qualitative and quantitative analysis of the documentation content of the medical record, identify potential workflow issues and provide feedback and suggestions for resolution.

#### **4. Routine Audits/Monitoring (Criteria and Timeframes)**

Every long-term care facility should have systems in place for monitoring completion of their documentation on an on-going basis. At a minimum, records should be reviewed on admission and hospital return, concurrently on a monthly/quarterly basis, and upon discharge/death. Not all audit findings will be correctable. For findings that cannot be corrected, the information should be gathered for training/retraining, system evaluation and improvement. The QA process should incorporate the findings into their overall quality management program.<sup>49</sup>

#### **Maintaining a Unit Record**

A unit record and unit numbering system is recommended for long term care facilities. With a unit record, the patient is assigned a medical record number on the first admission to the HCEs. This number is retained for each subsequent admission/readmission, and is used for both paper and electronic portions of the record. Though there may be multiple volumes, folders and formats, the patient's entire medical record is filed as a unit under one number.

In long term care, the record(s) from previous admissions should be brought forward and filed in the same area as the current admission. Bringing previous records forward provides the most comprehensive picture of the resident's medical history and therapy. The previous records should be readily accessible to staff for use in the assessment and care planning process.

When a resident is readmitted, all records from previous admissions should be pulled forward and maintained in the overflow files. Records from previous admissions should be separated from other discharged/closed records to prevent the inadvertent destruction of the record(s) prior to the required medical records retention period (Refer to Government/Statutory requirements). The medical records from previous stays remain in their original file folder and are retained, chronologically, with other records for residents currently in the facility. The records from one discharge to another are not combined into one folder.

If the previous records cannot be brought forward and kept in the same area as the current record, the facility must have a process in place to ensure that previous records are not inadvertently destroyed prior to the required retention period for the record.

#### **Defining What is Part of the Medical Record**

The medical record in a long-term care facility reflects the multi-disciplinary approach to assessment, care planning and care delivery. The medical record includes, but is not limited to, the following types of information: patient identification, admission/readmission documentation,

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<sup>49</sup> American Health Information Management Association (AHIMA), 2012

advance directives and consents, history and physical exams and other related hospital records, assessments, care plan, physicians orders, physician and professional consult progress notes, nursing documentation/progress notes, medication and treatment records, reports from lab, X-rays and other diagnostic tests, rehabilitation and restorative therapy records, social service documentation, nutrition services documentation, and other miscellaneous records including correspondence and administrative documents.

HCEs policy should specifically be outlined in the format of a chart order, the exact documents and records that will be considered part of the medical record.

### **Maintenance of the Medical Record**

It is critical that both the active record and the overflow records are maintained in a systematically organized fashion. This means that all records have an established chart order or order of filing that is followed. All records (records on the nursing station, overflow records, and discharge records) should be readily accessible, maintained in an organized chart order, filed in an easily retrievable manner, and maintained in folders or chart holders sufficient in size for the volume of the record. The chart holders and folders should be kept neat, clean and orderly. Products are available for cleaning/disinfecting the chart holders (binders). Cleaning is recommended periodically during the stay and upon discharge.

### **Identification (Name and Number) on pages of the Medical Record**

From a legal perspective, each page or individual documents in the medical record should contain the patient identification information. At a minimum, both the patient name and medical record number should be on each form. If labels/label paper is used, the patient identification information must be included on the label. The patient name and number should be placed on both sides of a two-sided form/page because records are frequently copied. Identification information appearing on both sides of a form helps to ensure that the copy is not lost or misplaced. If the back of the form is blank, no identification information is required on the blank side. There should not be documentation on the back of a one-sided form. If, for any reason, documentation is placed on the back of a one-sided form, a label or identifying information must be added and any blank space on the form lined or X'd out to prevent further documentation that may be out of sequence.

Patient identification information can be noted on forms by methods such as writing on the page in permanent ink, stamping by an addressograph, or affixing a printed or manually completed label. Regardless of the method used, identification information should not obscure any content on the form. Patient specific documents printed from a computer system to be filed in the medical record, such as physician orders, care plans, etc., should include patient identification information on each page.

## Assessment Scoring Matrix

**Standard 16. CQI 2: The Hospital/HCE identifies key indicators to monitor the clinical structures, processes and outcomes which are used as tools for continual improvement.**

Indicator 57-63		Max Score	Weightage (Percentage)	Score Obtained
Ind 57.	Monitoring includes appropriate patient assessment.	10	<b>100</b>	
Ind 58.	Monitoring includes safety and quality control programmes of the diagnostic services.	10	<b>100</b>	
Ind 59.	Monitoring includes ALL invasive procedures.	10	<b>100</b>	
Ind 60.	Monitoring includes adverse drug events.	10	<b>100</b>	
Ind 61.	Monitoring includes use of anaesthesia.	10	<b>100</b>	
Ind 62.	Monitoring includes use of blood and blood products.	10	<b>100</b>	
Ind 63.	Monitoring includes availability and content of medical records.	10	<b>100</b>	
<b>Total</b>		70	-	

## Standard 17. CQI-3: Sentinel events are intensively analyzed.

### Indicators (64-65):

#### Ind 64. The hospital has defined sentinel events.

##### Survey Process:

Review the written definition of a sentinel event and the list which should include at least: i. All unexpected deaths including infants, mothers and suicide, ii. Serious adverse patient events that caused, or could have caused, harm to the patient including return to the operating room within 24 hours, readmission within 24 hours, wrong-patient, wrong-site, wrong-procedure, medication error, iii. Patient violence against staff, iv. Violence against patients, 5. Infant abduction, and vi. Switching over of babies. Although not specifically required, it is good practice to also include "near misses".

##### Scoring:

- If there is a list and significant evidence of a rigorous documented process of monitoring, reviewing, responding to and mitigating sentinel events, then score as **fully met**.
- If there is no list, or the monitoring and mitigating processes are not adequately comprehensive, then score as **not met**.

### GUIDELINES

#### Sentinel Events

A sentinel event is defined as "An unexpected occurrence involving death or serious Physical or Psychological Injury, or the Risk thereof". Serious Injury specifically includes loss of limb or function. The phrase, 'or risk thereof' includes any process variation for which a recurrence carries a significant chance of a serious adverse outcome."

Such events are called "SENTINEL" because they signal the need for immediate investigation and response.

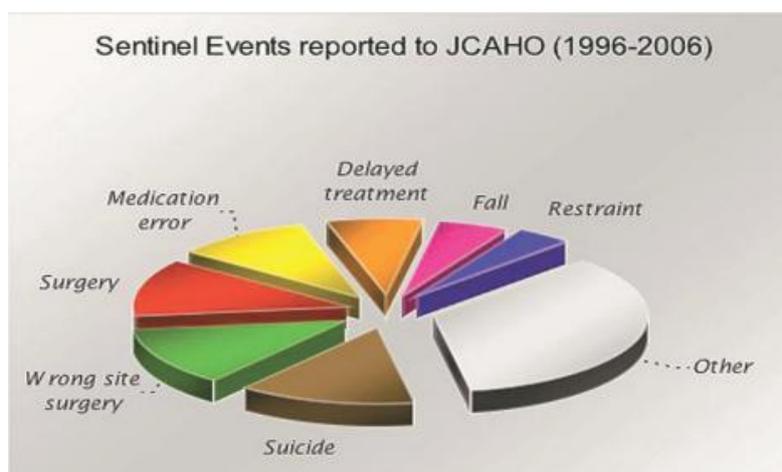
The real tragedy is that most of these medical mistakes are preventable. They are most often caused by systems that break down and don't support the highly qualified and dedicated hospital caregivers the way they should.

While significant and attracting attention, medication errors aren't the only types of medical errors that hospitals need to pay attention to.

Sentinel events also include the following, even if the outcome was not death or major permanent loss of function:

1. Newborn abduction, or discharge to the wrong family.
2. Unexpected death of a full-term fetus.
3. Surgery on the wrong individual or wrong body part.
4. Surgical instrument or object left in a patient after surgery or another procedure.
5. Rape in a continuous care setting.
6. Suicide in a continuous care setting, or within 72 hours of discharge.
7. Hemolytic transfusion reaction due to blood group incompatibilities.
8. Radiation therapy to the wrong body region or 25% above the planned dose.

**Figure 4: Sample of Sentinel Events**



**Ind 65. Sentinel events are intensively analysed when they occur.**

**Survey Process:**

Ask for any documentation of intense analysis of any sentinel event that has occurred in the past 12 months. (It is highly *unlikely* that none have occurred. If none were reported, the surveyors should explore the reporting process). Determine the corrective actions taken as a result of the analysis such as a change in policy and operating procedures and training for staff. Look to see if the system analyses the root cause and associated factors that contributed to the event.

**Scoring:**

- If there was a reported sentinel event and it was intensively analyzed, including corrective action to prevent or reduce the likelihood of reoccurrence, then score as **fully met** OR if no sentinel event was reported, but if one occurred it would be reported and analyzed, then also score as **fully met**.
- If there was a sentinel event, but there was either no analysis or the analysis was "superficial" such as limited to assigning blame to an individual, then score as **not met**.

**GUIDELINES**

**Analysis of Sentinel Events**

HCEs are expected to identify and respond appropriately to all sentinel events occurring in the hospital or associated with services that the hospital provides, or provides for. Appropriate response includes conducting a timely, thorough, and credible root cause analysis; developing an action plan designed to implement improvements to reduce risk, implementing the improvements, and monitoring the effectiveness of those improvements. Root Cause Analysis and Action Plan are described as follows:

**Root Cause Analysis**

Root cause analysis is a process for identifying the factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses

primarily on systems and processes, not on individual performance. The analysis progresses from special causes in clinical processes to common causes in organizational processes and systems and identifies potential improvements in these processes or systems that would tend to decrease the likelihood of such events in the future or determines, after analysis that no such improvement opportunities exist.

**Action Plan**

The product of the root cause analysis is an action plan that identifies the strategies that the hospital intends to implement in order to reduce the risk of similar events occurring in the future. The plan should address responsibility for implementation, oversight, pilot testing as appropriate, time lines, and strategies for measuring the effectiveness of the actions.<sup>50</sup>

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<sup>50</sup> Centre for Addiction and Mental Health (CAMH), Refreshed Core, January 2011.

## Assessment Scoring Matrix

Standard 17. CQI 3: Sentinel events are intensively analyzed.

Indicator 64-65		Max Score	Weightage (Percentage)	Score Obtained
Ind 64.	The Hospital has defined sentinel events.	10	100	
Ind 65.	Sentinel events are intensively analyzed when they occur.	10	100	
Total		20	-	

## 2.6 Access, Assessment, and Continuity of Care (AAC)

### 04 Standards & 17 Indicators

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A healthcare organization should consider the care it provides as part of an integrated system of services, healthcare practitioners and professionals, and levels of care, which make up a continuum of care. The goal is to correctly match the patient's healthcare needs with the services available, to coordinate the services provided to the patient in the organization, and then to plan for reception, registration, management, disposal and follow-up. The result is improved patient care outcomes and more efficient use of available resources.

The laboratory services are required to respond to the clinical needs of the hospital/clinicians. The reports issued by the laboratory must be legible, accurate and promptly available to the authorized persons. Reference values/normal ranges must be readily available to clinicians, preferably on the test report itself.

Similarly, the radiological/imaging services are the key diagnostic tools for many diseases and are also important in monitoring treatment outcome/prognosis. Radiologists have been involved in technological developments and are responsible for the evaluation of strengths and weaknesses of different investigations. They have developed the knowledge of the appropriate integrated imaging algorithms to maximize clinical effectiveness. The standards described here deal with the implementation of these developments in the clinical setting and for ensuring the best use of technological resources.

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## Standard 18. AAC-1: Services are provided as portrayed.

### Indicator (66):

**Ind 66. Only the services being provided at the hospital are displayed.**

#### Survey Process:

This will require knowledge of the scope of services provided at the hospital and observation of the displayed services both for on and off site. It means that there is a board clearly displaying (Menu of services)<sup>51</sup> what the patient should only expect from a hospital.

#### Scoring:

- If the displayed services match the services being actually delivered, then score as **fully met**.
- If there is superfluous / misleading information or no information about the scope of services is displayed, then score as **not met**.

### GUIDELINES

#### Menu of Services

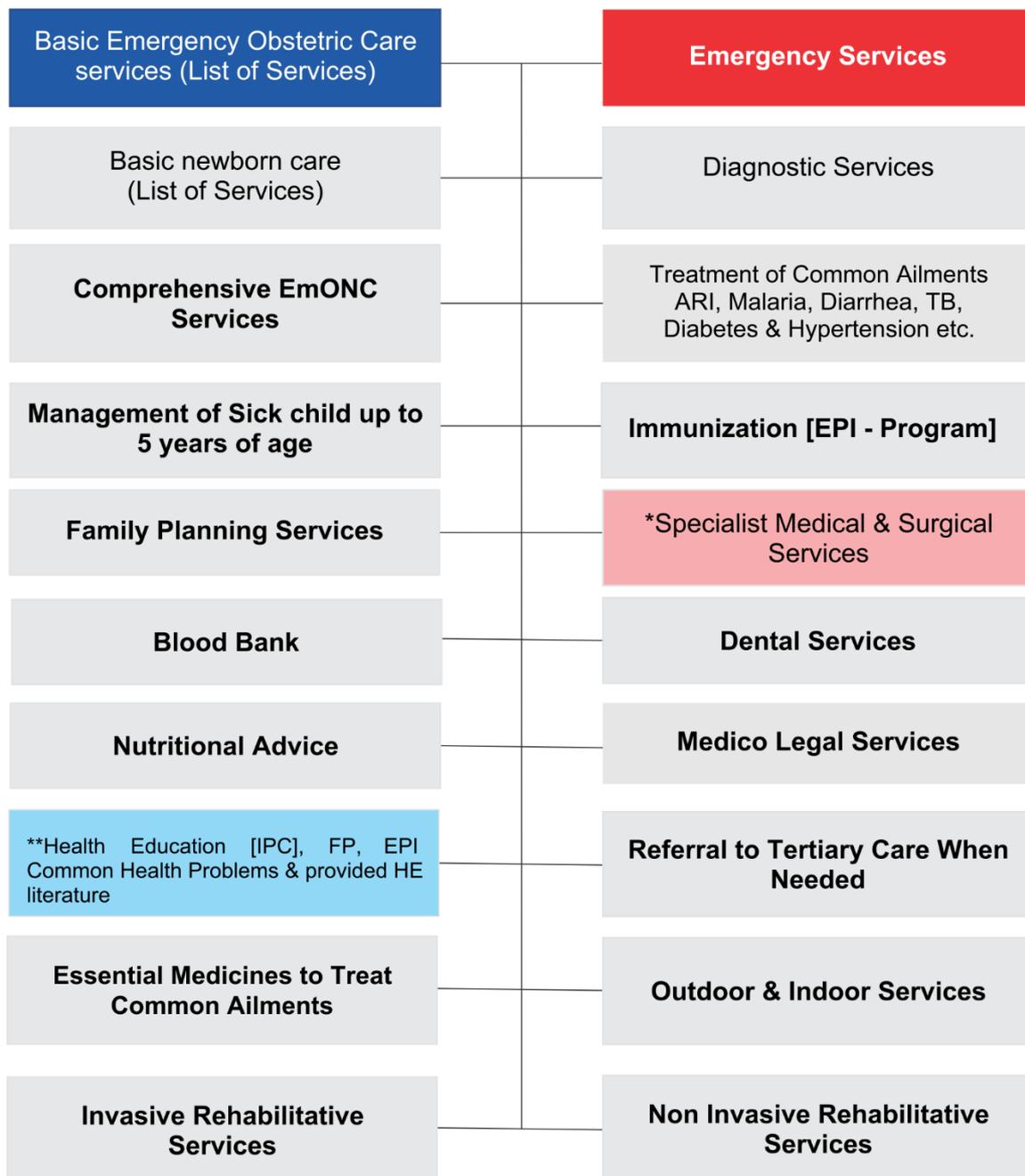
It is of immense importance for patients to be aware of the services available at a particular HCE. Therefore, correctness of information being displayed is vital<sup>52</sup>. The services being provided may be titled as "menu of services" and are to be displayed considering the following;

1. Purpose of Menu is to display information about available Services in the Facility.
2. It is to be clearly & boldly written on a large board proportionate to the facility & fixed at the entry points, (Main Gate), Key Turning Points & Receptions/Waiting Areas.
3. Only Services available are to be shown in this Menu.
4. A suggested sample is provided after scoring of this indicator

<sup>51</sup> An example/format provided in the Manual.

<sup>52</sup> Malafide intention can be considered if a service provision is displayed from the beginning and continues to do so but the service has never been created. Whereas a service created and displayed then discontinued but the display remained can well be taken as an oversight.

**Figure 5: Menu of Services**



*\*Specialist Services Anesthesia, Medicine, Gynecology, Radiology, Pathology, Eye, ENT, Pediatrics, Urology, Orthopedics, Physiotherapy, Cardiology, Neurosurgery, Psychiatry, Chest Diseases, Dermatology, Pediatrics surgery.*

**\*\* Appropriate Health Education Messages will be imparted by all Care Providers**

## Assessment Scoring Matrix

Standard 18. AAC 1: Services are provided as portrayed.

Indicator 66		Max Score	Weightage (Percentage)	Score Obtained
Ind 66.	Only the services being provided at the hospital are displayed.	10	100	
Total		10	-	

## Standard 19. AAC-2: The HCE has a well-established Patient Management System.

### Indicators (67-68):

#### Ind 67. There is a well-established Registration and Disposal Process.

#### Survey Process:

Observe as well as check from the record that there is a well-established Reception, Registration and Disposal<sup>53</sup> Process with written SOPs to cater for the needs of the patients. Patients access the reception comfortably and get registered as per SOPs. The reception staff is polite and guides the patients to the facility/professionals where they are to be examined / assessed for further management or explain such other requirement.

#### Scoring:

- If the registration and disposal process based on written SOPs is being practiced, then score as **fully met.**
- If there are non-conformances to the above then, score as **not met.**

### GUIDELINES

#### **Registration and Disposal**

A well-functioning Registration and Disposal Process is an important indicator of established Patient Management System. If the patients are received, registered and appropriately guided for further actions as the case may be, it confirms the satisfaction of the patients and other care providers. Following SOPs can be adopted and used as guidelines by appropriate modification in respect of a particular HCE to suit the local needs.

#### **Reception / Registration**

1. Sufficient number of Receptionist / Computer Operators to perform duty in shifts is to be ensured according to type of facility/workload.
2. Information to patients is provided both verbally & on telephone in a pleasant manner.
3. Patient is sent / taken to the EMO / relevant section/department as the case may be.
4. Particulars of patients are entered in the register / on a computer and a form or slip is provided after data entry.
5. Minimum time is to be taken up to this stage.

#### **Guidance of Patients/Visitors**

1. Sign boards showing Services available in a particular setup (Menu of Services) are to be clearly displayed at the Key Points (Gates), Key Turning Points, Reception, A & E & OPD areas so that users know what services are available in a particular facility.

<sup>53</sup> At this stage, disposal means direction/guidance to patients regarding further actions in connection with their medical needs and its management i.e. OPD or Laboratory or medical store/dispensary etc.

2. Sign Boards with Directional Arrows indicating the location of service areas/specific departments are to be placed and maintained.
3. Services available at a particular service area should also be displayed within that area.
4. Leaflets providing Information about the services in simple language are to be prepared, kept in stock and distributed / kept available at key points to create awareness amongst the patients/visitors about the available Services in the Facility.
5. Services which are not available are not to be displayed.
6. Use of Close Circuit TV & Public Address System may be considered for Information and Education of Clientele on Health matters.

## Ind 68. There is a well-established Patient Assessment Process.

### Survey Process:

Observe and check the records if patients are assessed by the Doctor by documenting the related signs, symptoms and relevant diagnostic evaluations, where applicable with the objective of providing quality care at outdoor/indoor or for referral within the facility or outside the facility, adhering to the prescribed Code of Ethics.<sup>54</sup> Check documentary evidence by reviewing the representative sample of record of patients.

### Scoring:

- If all checked records of the patients show documentation of patient's assessments according to the above, then score as **fully met**.
- If the record shows deficiency on the above, then score as **not met**.

## GUIDELINES

### Patient Assessment and Management Methodology

The standard way of patient assessment and management is to follow the Clinical Methods viz Observation, History of Present illness, History of Past illnesses for picking up any relevant point, Social Habits, recording/noting the symptoms, examining and eliciting the signs for reaching at a Provisional Diagnosis/Differential Diagnoses and then deciding about the laboratory tests/investigations to be done and line of management to be advised (Disposal). At this stage, patient shall have a Prescription if medication is required along with advised tests and clear advice in writing to be followed after going home or admission or referral to another facility as the case may be. Doctors must follow the Standardized Medical Protocols when managing any particular disease, at the same time using their own clinical acumen in treating and saving the patients' lives.

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<sup>54</sup> Available at the PM&DC website and also copied in the Reference Manual.

## Assessment Scoring Matrix

**Standard 19. AAC. 2: The HCE has a well-established Patient Management System.**

Indicator 67-68		Max Score	Weightage (Percentage)	Score Obtained
Ind 67.	There is a well-established Registration and Disposal Process.	10	<b>100</b>	
Ind 68.	There is a well-established Patient Assessment Process.	10	<b>100</b>	
<b>Total</b>		20	-	

## Standard 20. AAC-3: Laboratory services are provided as per the requirements of patients.

### Indicators (69-74):

**Ind 69. Scope of the laboratory services is according to the clinical services provided by the HCE.**

#### Survey Process:

This will require an understanding of the full scope of clinical services provided at the healthcare establishment and observation of the diagnostic facilities provided both on and off site. Check the outsourced laboratory arrangements and validate.<sup>55</sup> A list of tests is provided at **annexure K**.

#### Scoring:

- If the healthcare establishment's laboratory and any qualified outsourced facility<sup>56</sup> support the scope of services, then score as **fully met**.
- If the laboratory diagnostic procedures or an outsourced laboratory do not support the scope of services provided by the hospital<sup>57</sup> then score as **not met**.

### GUIDELINES

#### Scope of Laboratory Services

1. The hospital shall have a well-organized, adequately supervised laboratory with adequate space, facilities and optimum temperature for equipment to perform services commensurate with the hospital's needs for its patients.
2. Basic clinical laboratory services necessary for routine examinations shall be available regardless of the size, scope and nature of the hospital. Provision shall be made to carry out adequate clinical laboratory examinations including Chemistry, Microbiology, Hematology, Serology, and Clinical Microscopy.
3. Laboratory facilities and services shall be available for emergency tests at all times.
4. Some services may be provided through arrangements (Contracts/TORs) with other Licensed Hospitals and Laboratories/Diagnostic Centres in the Public/Private Sector which have the appropriate facilities.
5. The Health Care Establishment (HCE) should ensure the availability of laboratory services commensurate to the healthcare services provided by it during hospital working hours, either by in house or outsource arrangement, however the emergency tests directly affecting the patient's emergent care should be available in house for example RBS, ABG, Cardiac Enzymes etc.

<sup>55</sup> Patients should be informed about laboratory tests that are outsourced.

<sup>56</sup> Independently accredited by KP HCC or a recognized body.

<sup>57</sup> A future date to be determined for all laboratories which will be required to be separately licensed.

**Ind 70. Adequately qualified and trained personnel perform and/or supervise the investigations.**

**Survey Process:**

Each laboratory personnel has a job description to accomplish the assigned job. Review the human resource files for laboratory technical and supervisory staff to determine if their credentials (qualifications, experience and training) match the requirements of the respective position and the job description including handling the equipment being used. A system of Continuous Professional Development<sup>58</sup> should be active.

Scope of services of laboratory and requirements of the head is given below:

Category	Scope of Services/Type of Tests	Qualification of the Lab Director/Technical Head for Supervision
A	Immunology, PCR Histopathology, Genetic testing, Advanced Hematology, Enzyme / Hormone studies, Tissue typing, etc.	<ol style="list-style-type: none"> <li>1. Registered Medical Practitioner with recognized post-graduation (FCPS, MRCPPath, PhD or equivalent) in any branch of pathology as technical head</li> <li>2. Subject specialist pathologist or scientist as section heads</li> <li>3. Full time director/technical head</li> <li>4. Per shift section heads as per workload</li> </ol>
B	Microbiology (C/S, etc.), Chemical pathology ELISA/ Immunoassay	<ol style="list-style-type: none"> <li>1. Registered Medical Practitioner with recognized medium (M-Phil or equivalent) degree in any branch of pathology as technical head</li> <li>2. Technologist or scientist or pathologist as section heads as per work load</li> </ol>
C	Routine clinical lab tests	<ol style="list-style-type: none"> <li>1. Registered Medical Practitioner with recognized diploma/equivalent PG qualification in pathology</li> </ol>

**Scoring:**

- If qualifications of the head and other staff is according to the category of the laboratory, then score as **fully met**.
- If only one technician does not have the qualifications required by the job description, then score as partially met, provided that there is evidence of enhanced supervision or training of this individual.
- If the head and/or two or more technicians do not have the required qualifications, then score as **not met**.

**GUIDELINES**

**Staff Authorized to Perform or Supervise**

The HCE identifies the laboratory staff members performing tests, including those who are approved to perform point of care screening tests at the bedside, and those who direct or supervise

<sup>58</sup> A recognized program administered by a professional college/council or equivalent

staff performing tests. Supervisory and technical staff should have appropriate and adequate qualifications (Histopathology, Microbiology, Immunology, Haematology and Chemical Pathology etc.), training, experience, skills and are oriented to their work. The technical staff is given work assignments consistent with their qualification, training and experience. In addition, the HCE shall ensure that there is a sufficient number of staff to perform tests promptly and to provide necessary laboratory services during all hours of operation and for emergencies. Staff with proper qualifications, appropriate training and experience shall interpret tests and write reports.

Clinical laboratory services are under the direction of an individual who is qualified by virtue of documented training, expertise, and experience. This individual assumes professional responsibility for the laboratory facility and the services provided in the laboratory, as well as tests performed outside the laboratory such as the testing performed at bedside (point of care testing). The oversight of services outside of the laboratory includes ensuring consistent organization wide policies and practices, such as training, supply management etc., but not daily supervision of those activities.

Daily supervision remains the responsibility of the leaders of the department or unit in which the testing is conducted.

1. A Laboratory Manager/Director with the following qualifications may be positioned at a hospital according to the category:
  - i. A medical graduate qualified in any discipline of pathology. He/she may be a PhD, FCPS, MRCPATH, M.Phil or some equivalent degree, OR
  - ii. A person with diploma in clinical pathology (DCP)
  - iii. The Manager/Director is responsible for testing, Quality Assurance, personnel training, equipment and inventory.
2. Other required staff are given below:
  - i. Technicians and Technologists, with a Diploma in Lab Technology/BSC/MSC who are responsible for conducting testing.
  - ii. Support Staff
    - a. Phlebotomists: They should be given in-house training on the Sample Collection Manual
    - b. Typist/Administrative staff
    - c. Cleaning staff

**Ind 71. Policies and procedures guide the: i. Collection, ii. Identification, iii. Handling, iv. Safe transportation, v. Processing and vi. Disposal of specimens.**

#### **Survey Process:**

Review the laboratory policy and procedure manual to validate that it covers ALL the 6 requirements. It is always important to verify that the policy or procedure is not just written, but is actually implemented and followed. Ask operational staff about the 6 policy requirements to establish if they are aware of the policies and procedures and have received appropriate orientation and training. Then, by observation check, how a patient whose blood is being drawn was positively identified and how the specimen was labelled.

### Scoring:

- If there are policies and procedures for all the 6 requirements, and evidence that the manual is present at the work place, that documented training has been delivered and that the policies and procedures are followed, then score as **fully met**.
- Since this is significant for patient safety (misidentified patient and mislabeled specimens are a common source of laboratory errors), if the policies and procedures for all 6 requirements are not implemented, then score as **not met**.

## GUIDELINES

### SOPs for Handling of Specimens

#### **Sample Collection:**

Specimen collection is the first phase of interaction between the patient and the laboratory. Appropriate counseling should be done before specimen collection, and consent taken whenever needed. Attention should be paid to the patient's sensibilities during the entire process. Any error in specimen collection can lead to erroneous results. It is therefore considered an important step of good clinical laboratory practice and is referred to as "pre-analytic control".

A phlebotomist/laboratory technician will be responsible for collecting the sample.

1. Specimen collection can be done at the patient's bedside, in the laboratory or in the field.
2. Trained manpower should be employed for specimen collection.
3. A Laboratory should have a "Primary Specimen Collection Manual," containing information on patient preparation before specimen collection (if any), and the exact methodology of specimen collection, labelling, handling, transportation and storage of the specimens. In addition, the laboratory should provide adequate and appropriate information/instructions to patients wherever necessary. All pre-analytical factors that may influence the test results should be identified. This manual should be available for reference and should be used for the training of staff engaged in specimen collection.

#### **Guidelines for obtaining/collecting specimens:**

1. Collect the material from the site in which the etiologic agent will most likely be found.
2. Collect the specimen at the optimum time (e.g., early morning sputum for acid-fast bacillus)
3. Obtain cultures prior to administration of antibiotics whenever possible.
4. Collect adequate volume of material. Inadequate amounts of specimen may yield false negative results.
5. Collect the specimen in a manner that minimizes or eliminates contamination from indigenous flora as much as possible, to ensure that the sample will be representative of the infected site.
6. Use appropriate collection devices, transport media and sterile, leak proof containers.
7. Use sterile equipment and aseptic technique to collect the specimen, to prevent introduction of microorganisms during invasive procedures.
8. Clearly label the specimen including specific information regarding the site of collection (e.g., blood obtained via blue lumen of right subclavia central catheter) and complete the ordering process.
9. Identify the specimen source and/or specific site correctly so that proper processing methods and culture media will be selected by the laboratory personnel.

10. If the specimen is collected through intact skin, cleanse the skin first with 70% alcohol followed by an iodine solution (e.g. povidone-iodine) or chlorxidine/alcohol combination. If iodine is used, remove excess iodine after the specimen has been collected.
11. Provide clear instructions to patients if they are collecting their own specimen (e.g., clean catch urine, or stool) in order to obtain the best quality specimen and allay their fears.
12. Deliver the specimen promptly to the laboratory. Delay in transport may compromise the specimen.
13. As with all patient contact episodes, consistent attention must be given to hand hygiene and use of appropriate personal protective equipment (PPE).
14. Use appropriate safety devices to minimize risk of accidental needle stick, cut or puncture. It is advisable to make sure the user is knowledgeable about how the safety device works prior to its use.

Every laboratory should make a LAB Safety Manual according to the following guidelines:

### **Laboratory Safety Procedures**

#### **1. GENERAL**

- i. Work carefully and cautiously in the laboratory, using common sense and good judgment at all times.
- ii. EATING, DRINKING AND SMOKING IS PROHIBITED in the laboratory and in the laboratory space of a combined lecture/laboratory room.
- iii. Long hair must be tied back during laboratory sessions.
- iv. Open toed shoes are prohibited.
- v. No sleeveless tops are permitted. Thighs and midriiffs must be covered with protective clothing while working in the laboratory. Lab coats must be worn when directed by the instructor.
- vi. Identify the location of all exits from the laboratory and from the building.
- vii. Be familiar with the location and proper use of fire extinguishers, fire blankets, first aid kits, spill response kits and eye wash stations in each laboratory.
- viii. Note the location of the red phones (if available) that provide direct access to the Office of Management. In the event of an emergency, pick up the red receiver and state the location and the nature of the emergency. Identify the location of the nearest desk phones.
- ix. Report all injuries, spills, breakage of glass or other items, unsafe conditions, and accidents of any kind, no matter how minor, to the instructor immediately.
- x. Keep sinks free of paper or any debris that could interfere with drainage.
- xi. Lab tables must be clear of all items that are not necessary for the lab exercise.
- xii. Wash hands and the lab tables with the appropriate cleaning agents before and after every laboratory session.

#### **2. OPEN FLAMES - FIRE HAZARD**

- i. Identify and be familiar with the use of dry chemical fire extinguishers that are located in the hallways and laboratory rooms.
- ii. Flames are only to be used under the supervision of the instructor.

### **3. SHARP OBJECTS AND BROKEN GLASS**

- i. Pointed dissection probes, scalpels, razor blades, scissors, and microtome knives must be used with great care, and placed in a safe position when not in use.
- ii. Containers designated for the disposal of sharps (scalpel blades, razor blades, needles, dissection pins, etc.) and containers designated for broken glass are present in each laboratory. Never dispose of any sharp object in the regular trash containers.
- iii. Report all cuts, no matter how minor, to the senior.
- iv. All labs and the preparation room house a first aid kit containing antiseptics, bandages, Band-Aids and gloves to care for minor cuts.
- v. Do not touch broken glass with bare hands. Put on gloves and use a broom and dustpan to clean up glass. Dispose of ALL broken glass in the specific container marked for glass. Do not place broken glass in the regular trash.
- vi. When cuffing with a scalpel or other sharp instrument, forceps may be used to help hold the specimen. Never use fingers to hold a part of the specimen while cuffing.
- vii. Scalpels and other sharp instruments are only to be used to make cuts in the specimen, never as a probe or a pointer.

### **4. NOXIOUS CHEMICALS**

- i. Material Safety Data Sheets should be available in a yellow binder mounted on the door of the laboratory. In case of a spill, an accident or a safety question, staff can find chemical safety information in the Data Sheets.
- ii. The lab should be equipped with a portable safety exhaust hood for the handling of noxious fumes.
- iii. Chemical spill clean-up kits should be available in every lab.

### **5. INSTRUMENTS AND EQUIPMENT**

Care must be used when handling any equipment in the laboratory. The staff is responsible for being familiar with and following correct safety practices for all instruments and equipment used in the laboratory.

#### **i. MICROSCOPE HANDLING**

- a. Microscopes must be carried upright, with one hand supporting the arm of the microscope and the other hand supporting the base. Nothing else should be carried at the same time.
- b. Microscopes must be positioned safely on the table, NOT near the edge.
- c. After plugging the microscope into the electrical outlet, the cord should be draped carefully up onto the table and never allowed to dangle dangerously to the floor.
- d. The coarse adjustment must NEVER be used to focus a specimen when the 40x or oil immersion lens is in place.
- e. When finished with the microscope, the cord should be carefully wrapped/secured before returning it to the cabinet.
- f. The microscope must be placed upright and in the appropriate numbered slot in the cabinet.
- g. All prepared microscope glass slides are to be returned to their appropriate slide trays; wet mount preparations are to be disposed of properly.
- h. Malfunctioning microscopes should be reported to the instructor.

**ii. HOT PLATES AND WATER BATHS**

- a. The instructor will regulate the temperature of hot plates and water baths with a thermometer.
- b. This equipment must be placed in a safe place.
- c. Use insulated gloves or tongs to move beakers or test tubes in and out of the water baths.
- d. Use care when working near hot plates and water baths, as they may still be hot even after being turned off.

**iii. PRESERVED SPECIMENS**

- a. Gloves (latex and non-latex) are provided to handle preserved specimens.
- b. When larger specimens are being dissected, the part of the specimen that is not being dissected should be kept enclosed in the plastic bag.
- c. When dissecting smaller specimens, seal the bag after removing the specimen, so as to confine the preservative in the specimen bag.
- d. Notify the instructor if there is a spill of preservative.
- e. Body parts or scraps of the specimen are NOT to be disposed of in the sink.
- f. Dispose of dissecting pins or other sharp objects in the red sharps containers, NOT in the regular trash.
- g. Specimens are to be clearly labelled and stored in designated containers or cabinets when not in use.
- h. Follow the directions of the instructor concerning the proper disposal of preserved specimens after they are finished being used.

**iv. BODY FLUIDS**

Special precautions are to be followed in all laboratories using any body fluids, such as blood, saliva, and urine because of the potential to transmit disease-causing organisms.

- a. Follow all instructions carefully.
- b. Use gloves and goggles in all laboratory experiments that involve the use of body fluids.
- c. All contaminated material, such as slides, cover slips, toothpicks, lancets, alcohol swabs etc., must be placed in a biohazard bag for proper disposal and should never be reused.
- d. No samples of body fluids are to be brought into the laboratory from outside sources.

**v. HISTOLOGY & CYTOLOGY LABORATORY SAFETY PROCEDURES**

The following laboratory safety guidelines for Histology and Cytology are in addition to the laboratory safety procedures to be followed for all sorts of laboratories:

- a. Students are only permitted to work on the preparation of histology slides (including infiltration and embedding, sectioning, and staining) during the scheduled class time and under the guidance of the instructor.
- b. Staff should wear protective gloves when handling fixatives, embedding solutions, and staining solutions.
- c. Only water is to be poured down the sinks; all chemical solutions should be collected in labelled waste containers.
- d. Xylene must be used under the hood.
- e. Any spills should be reported immediately to the instructor or laboratory technician.

- f. Staff must use forceps to transfer slides from one coplin jar to the next.
- g. All lids on the coplin jars must be secured except when transferring slides from one jar to the next.
- h. All sharp instruments (e.g., razor blades and microtome blades) must be handled with extreme care and disposed of in designated sharps containers.
- i. Before removing a paraffin block from the microtome, the microtome wheel must be locked in position and the microtome blade must be removed from the blade holder.
- j. All scraps of paraffin must be swept from the floor and the microtome table, using a dustpan and brush.
- k. Microtomes must be covered when not in use.
- l. The specimen should be secured properly so that there is no leakage, spillage or contamination. A Biohazard symbol should be used on the containers during transportation. Appropriate specimen transportation kits (such as use of dry ice, etc.) should be used wherever required. The specimen should be sent to the laboratory along with the requisition form.

**Figure 6: Labelling of Sample**



### **Identification and Labelling:**

A properly labelled sample is essential so that the results of the test match the patient. The key elements in labelling are:

1. Patient's surname, first and middle.
2. Patient's ID number.

**NOTE: Both of the above MUST match the same on the requisition form.**

3. Date, time and initials of the sample collector must be on the label of EACH tube.
4. Automated systems may include labels with bar codes.

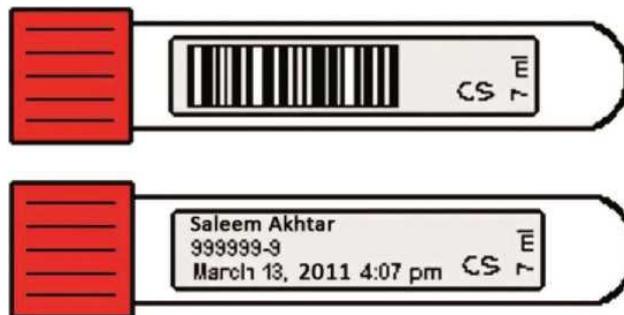
The date and signature/initials of the collector must be recorded after the specimen has been collected and after verifying that the patient's name and ID on the label agrees with that on the test requisition. This is the single most important factor in preventing errors in a patient's specimen identification. ***Use of a request form wrapped around the container is not acceptable as a specimen label.*** Specimens will not be accepted if the information on the specimen label does not match the information on the accompanying requisition.

**Figure 7: Labelling Sample Tube**



Examples of labelled collection tubes are shown below:

**Figure 8: Labelling Sample Tubes**



### **Handling**

There is clearly a difference between the hazards posed by packages sent to a specialist or reference laboratory and those to a routine diagnostic laboratory. The former are likely to contain cultures or concentrates of infectious agents whereas the bulk of the latter is not particularly infectious. It is advisable that cultures and such specialized materials are unpacked in the laboratory by professional staff. There is concern over the use of clerical staff for receiving and documenting specimens. It is not unusual to see food and drink being consumed by clerical staff near the specimens. The disturbingly large numbers of untrained staff who acquire infections in the laboratory undoubtedly include clerical and reception staff. Therefore, it is essential that clerical staff handling specimens should be given some form of training in the safe handling of specimens. Any specimen in a plastic bag which carries a "Danger of Infection" label should not be removed from that bag. The accession number can be put on the outside of that bag. Leaking or broken specimens should not be touched. Provision should be made for a member of the professional staff to deal with such samples. These specimens should not be allowed to be moved to other parts of the room.

**Figure 9: Protective Measures**



Note: Handle all samples as if infectious.

## Safe Transportation

**Figure 10: Safe Transportation of Samples**



### 1. Transport within hospitals and to referral labs.

All employees are required to take reasonable care of their own health and safety as well as that of all other persons who may be affected by their acts or omissions at work. Responsibility for the safe collection and packaging of clinical samples shall rest entirely upon the sender, it is therefore imperative that all areas where clinical materials are generated remain conversant

with up to date safety codes of practice.

## **2. All laboratory specimens are potentially hazardous.**

It is important that care is taken when collecting and handling clinical samples to ensure that the risk of infection to staff is kept to an absolute minimum. These rules must be observed at all times and never allowed to lapse at busy periods or because of a failure to maintain adequate supplies of bags or containers. Members of staff employed within the laboratory must not be put at risk because of ignorance, negligence or bad technique.

**Note: Never leave samples unattended in a public area.**

## **3. Transport of Samples using Courier Services**

- i. Samples must always be carried in closed boxes, which are clearly marked as Biological Substance.
- ii. Samples must be individually bagged, placed in a secondary bag containing absorbent material, sealed and carefully placed in the transport container.
- iii. Two storage boxes will be provided for each surgery or clinic, one for holding blood specimens and one for non-blood specimens.
- iv. On collection by the couriers, the samples will be transferred by the couriers into two separate transport boxes, one for blood, and one for non-blood, lined with a clear plastic bag containing absorbent material and which can be secured with a cable tie when full.
  - a. Where a patient's pathology request requires both blood and non-blood samples, these should be placed in the non-blood containers.
  - b. Blood and tissue slides should be regarded as sharps and placed in an appropriate plastic slide transport box before packaging.
  - c. Handle specimen containers gently at all times.
  - d. Samples must never be carried unprotected in the open hand or given to other members of staff in this way.
  - e. Samples must not be left unattended when not secured in the van.
- v. The patient's confidentiality must be preserved at all times.
- vi. In the event of a vehicle breakdown or a road traffic accident, do not allow persons other than courier or laboratory staff to handle specimens.
  - a. Any spillage must be reported immediately to a designated senior member of the department concerned.
  - b. Decontamination materials shall be carried in each vehicle to enable small spillages to be contained. In the event of major contamination, the Pathology Support Services must be contacted before any material is touched.
- vii. The response by the Pathology laboratory staff will depend upon the size and extent of the spillage and upon the level of contamination.
- viii. All decontamination shall be in accordance with the Pathology Safety Policy which should be available as SOPs. Always wash hands thoroughly before rest breaks and at the end of a work period.

## **Sample Processing**

1. Collect the required amount of specimen. While small amounts of blood are now used for many automated tests, there are minimum requirements. Optimum collection volumes allow for the test to be repeated and verified, if necessary.

2. Minimum volumes are to be used for patients where unnecessary blood loss may affect the patient's status.
3. When difficulties are encountered with blood volumes, consult the laboratory. Avoid haemolysis, which can elevate certain analytes (e.g., LDH, K, AST).
4. Follow specific specimen processing instructions. The laboratory should develop its SOPs in this regard.
5. A Quality Control manual should be developed by each laboratory.
6. Instrument and method of testing for each test should be defined.
7. Periodic calibration of equipment as per laboratory/manufacturer guidelines should be conducted and records should be documented.
8. Never decant or aliquot the specimen from one type of container to another.
9. Unusual specimens (lipemic, icteric, hemolyzed) may require a repeat specimen.
10. When using tubes with anticoagulants, especially for coagulation tests, a sufficient fill volume is required to ensure the appropriate specimen dilution.
11. Use the proper container and mix all specimens containing anticoagulant or preservative by gentle inversion 8 to 10 times.
12. Reference ranges and critical values should be defined for each test.

***Figure 11: A View of Laboratory***



### **Sample Disposal**

Make an inventory of toxic compounds in the laboratory and prepare a protocol for their collection and disposal.

Waste sample remains should never be disposed of by washing down a drain. Use proper receptacles for this purpose. Nevertheless, sinks and gullies should be fitted with removable SILT TRAPS which should be emptied regularly. In certain cases, heavily polluted samples may have to be treated as toxic chemical waste.

**Figure 12: Hazardous Materials Warning Sign**



General guidelines for hazardous materials disposal are given on the following page.

## **1. INFECTIOUS WASTE**

### **i. General**

- a. Infectious waste must be disposed of in a carefully controlled manner in accordance with National Guidelines on Hospital Management.
- b. Infectious waste has been defined to include biological waste, cultures and stocks, pathological waste, and sharps.
- c. Infectious waste must either be incinerated or treated prior to disposal.
- d. The term infectious waste is synonymous with biohazard; it does NOT include chemical agents, such as carcinogens, which affect living organisms through chemical means.

### **ii. Definitions**

#### **a. Biological Waste**

- Includes blood and blood products, excretions, exudates, secretions, suction and other body fluids that cannot be directly discarded into the municipal sewer system.
- EXCLUDES articles contaminated with fully absorbed or dried blood.
- Biological waste must either be incinerated or sterilized with steam in a dedicated autoclave.
- After treatment, biological waste may be treated as normal refuse.

#### **b. Cultures and Stocks**

- Includes etiologic agents and associated biologicals, including specimen cultures and dishes and devices used to transfer, inoculate and mix cultures.
- Includes wastes from the production of biologicals, serums, and discarded live or attenuated vaccines.
- Cultures and stocks must be treated in the same way as biological waste.

#### **c. Pathological Waste**

- Includes biopsy materials, all human tissues and anatomical parts from surgery and other procedures.
- Includes carcasses and bedding from animals exposed to pathogens in research, but does NOT include teeth or preservative agents such as formaldehyde.
- Pathological waste must be incinerated.

**d. Sharps**

- Includes needles, scalpel blades, lancets and syringes that have been removed from their original sterile containers.
- Sharps must be incinerated.
- The definition DOES NOT EXEMPT needles or syringes used for non-infectious materials, such as transferring chemical solutions.

**iii. Disposal**

- a. Waste which is to be incinerated must be collected and taken to an infectious waste incinerator.
- b. Waste which may be disposed in the ordinary trash should be clearly marked "NON-INFECTIOUS" or "STERILE" and put inside outer packaging which is NOT red or orange in color.
- c. Autoclaves used for infectious waste treatment must be designated and tested.
- d. Autoclave users must develop written operating procedures to keep records with detailed parameters for treatment, methods for monitoring, methods for indicating adequate sterilization conditions during each treatment, and monthly tests of sterilization conditions using a specified biological indicator.

**iv. Storage**

- a. Infectious waste should be segregated from other wastes by putting it in separate containers at the point of generation.
- b. Locate containers to minimize access by unauthorized persons and clearly identify as containing infectious waste.
- c. Except for sharps, store infectious waste in red plastic bags OR containers made of other materials impervious to moisture and strong enough to prevent tearing under normal use conditions.
- d. Pathological, biological and culture/stock wastes should be treated or disposed within 7 days of generation, or within 30 days if refrigerated or frozen.
- e. If a generator (laboratory or department) produces less than 50 pounds of waste in a calendar month, the 7 day storage limitation does not apply.
- f. Sharps should be contained in leak proof, rigid, puncture resistant RED containers which have tight lids or are taped closed.
- g. There is no limit on the length of storage for sharps.

**2. CHEMICAL WASTE GENERAL**

- i. Prior to disposal of any chemical waste, a designated person must perform an official hazardous waste determination to see if the waste is hazardous.
- ii. A short list of non-hazardous chemicals can be notified; all others should be considered hazardous until the determination has been made.
- iii. Hazardous waste is incinerated, at off-site locations, whenever possible. Departments are encouraged to employ waste reduction procedures to limit costs. Use these guidelines to prepare and request disposal of hazardous chemical waste.

Hazardous chemical waste refers to any material substance that is;

- a. CORROSIVE (pH<2 or pH>12)

- b. REACTIVE (oxidizers, water reactive)
- c. FLAMMABLE (flash point <140 F)
- d. TOXIC

#### **Containers**

1. All waste must be in appropriate NON-LEAKING containers with lids that are non-leaking, tight fitting and are not cracked, broken, or chemically damaged.
2. The container size should match the amount of waste.
3. Containers must be compatible with the waste contained.
4. Liquid containers must be less than 5 gallons and weigh less than 45 pounds.
5. Paper or cardboard primary containers should be put into sealed plastic bags.
6. Except for common solvents which can be bulked together, waste disposal charges are related to container volume rather than solely a weight basis; a partially full container may cost the same as a full one.

#### **Labels**

1. All unused chemicals in original non-leaking containers with the manufacturer's label will be accepted as it is.
2. All other waste requires a hazardous waste label. The labels must be completed and attached to each waste container, except for very small containers.
3. Labels should be affixed in a manner that does not cover existing labels or markings.
4. Solvent labels should preferably be put onto string tags attached to containers.
5. Complete the LOWER part of the label with your name, building, room number, department, and identification of contents. Include total weight or volume and percent ranges for all constituents.

#### **Packing**

1. Generators should find cardboard boxes and make them available to the designated staff at the time of waste removal.
2. DO NOT pack waste in boxes, since waste containers will be examined by visual inspection.
3. Sanitary staff will pack waste in boxes according to compatibility.
4. Boxes should be sealable when necessary, and sturdy enough to transport the material.
5. Boxes exceeding 45 pounds or 18 inches on a side cannot be safely handled by one person, and will not be picked up.

### **3. EMERGENCIES**

- i. **HAZARDOUS MATERIAL SPILLS** are an inevitable part of most work environments. To effectively combat spills, it is necessary to prepare for them beforehand. Whenever employees work with a substance, they should be aware of its characteristics, and should have formulated plans of what to do in case of a spill, including what steps to take, who to call for assistance, what PPE is necessary, and what material is appropriate to contend with a spill, and where to find appropriate spill-response equipment. Departments are encouraged to have spill response kits at strategic locations.
- ii. **GENERAL GUIDELINES** The first step in dealing with any chemical spill is to assess the magnitude of spilled material and the associated level of hazard. No one should attempt to

deal with a spill until properly equipped with adequate PPE and spill treatment materials. Risk assessment is successful only if personnel are familiar with the hazardous properties of the material they are handling and have developed methods to follow in the event of a spill.

- iii. **PROCEDURES** If the risk assessment suggests you can safely and properly clean up the spill:
- a. **Get personal protective equipment.** Do not attempt spill response until you have put on PPE appropriate for the situation. Available equipment may include respiratory protection, goggles, gloves, impervious shoes/boots, and body protection. All equipment will not be necessary for every situation, but should be available. If you are unsure about your ability to control a spill, get assistance. Any spill for which respiratory protection is needed must not be conducted without backup personnel equipped in the same manner.
  - b. **Get spill control equipment** from your department's spill kit. Spill control materials are sold in two general forms: loose materials (vermiculite, cat litter) and spill control pillows, which are produced in various shapes and contain different types of absorbents. Spill control pillows are preferred because they are much easier to pick up when finished. Also available are materials designed for specific types of chemical spills such as acids or solvents. In general, spilled liquids present more danger than solids, and quick response is therefore critical. For flammable liquids, special attention should be paid to potential ignition sources in the vicinity.
  - c. Absorb the spill. If there is danger the spill may spread, dike the perimeter with absorbent, then absorb. "Floor chemistry" should not be attempted. If you desire to perform simple neutralization/treatment schemes, first absorb and contain the material.
  - d. Collect the contaminated absorbent and put into a sturdy leak proof container. Close the container if there are volatile substances which may continue to pose a threat.
  - e. Dispose of the contaminated absorbent in the same manner you would dispose of the substance that was spilled. If the spilled chemical is hazardous, do not put the clean-up residue in the dumpster. If hazardous, contact professionals to dispose.

#### 4. EMPTY CONTAINERS AND GLASS

##### i. Empty Containers

- a. Containers that have held hazardous substances are empty by definition when one of two following conditions is met. For one group of materials, a container is empty when all contents have been removed by techniques ordinarily used for that type of material (e.g., pouring for liquids), and the container has less than 3% of the original contents. For another group, a container is only empty when it has been triple rinsed with a solvent capable of removing the remaining contents. Contact the manufacturer for specific discussions of which group a material falls into.
- b. In all cases, remove as much of the contents as possible before disposal (including recycling). For liquids, this would be turning the container upside down and letting it drain until no more drops will come out. For low viscosity liquids such as aqueous solutions, let drip no less than 60 seconds.

## ii. Hazardous Chemicals

- a. A designated person must perform an official hazardous waste determination for disposal of all chemicals.
- b. Collect solids in disposable, non-leaking containers, labelled with contents, clearly marked as non-hazardous, and prepared for disposal.
- c. Solutions containing only non-hazardous, water miscible liquid materials, with pH between 6 and 9.5, can be disposed through the sewer system.
- d. Remember: "hazardous" includes flammable liquids even if water soluble.

The items listed below are considered NON-hazardous:

- Acetates: Ca, K, Na, K, Mg, NH<sub>4</sub>
- Naturally occurring amino acids and salts
- Citric acid and salts of Na, K, Mg, NH<sub>4</sub>, Ca
- Bicarbonates: Na, K
- Borates: Na, K, Mg, Ca
- Bromides: Na, K, NH<sub>4</sub>
- Carbonates: Na, K, Mg, Ca, NH<sub>4</sub>
- Chlorides: Na, K, Mg, Ca, NH<sub>4</sub>
- Formates: Na, K, Mg, Ca, NH<sub>4</sub>
- Lactic acid and salts of Na, K, Mg, NH<sub>4</sub>, Ca
- Sugars and sugar alcohols
- Starch
- Iodides: Na, K, Ca
- Oxides: B, Mg, Ca, Al, Si, Fe, Zn
- Phosphates: Na, K, Mg, Ca, NH<sub>4</sub>
- Silicates: Na, K, Mg, Ca
- Sulfates: Na, K, Mg, Ca, NH<sub>4</sub>

**Caution:** Chemicals and chemical products should not be given or sold to the general public or offered as surplus property. Commercial chemical products may be offered as surplus property if reasonable cautions are followed.

## iii. Treatment

- a. Elementary neutralization can be performed on wastes which are hazardous only because they are corrosive (acids, bases).
- b. A neutralized solution should have a final pH value between 6 and 9. Corrosive waste should not be discharged through the sewer system.
- c. Treatment of other materials to lessen the hazard or amount of waste can be included as part of the SOPs in laboratories.
- d. Such procedures should be written and made a part of specific experimental protocol.

## 5. RADIOACTIVE WASTE DISPOSAL

### i. General Procedures

- a. Only containers available from authorized departments shall be used.
- b. Each radioactive waste container must have a record of materials in the container which is kept up-to-date.

- c. Mark each container with a "Caution-Radioactive Material" label.
- d. Package the waste according to the instructions given for each waste type below.
- e. Segregate waste according to half-life:
  - less than 91 days = short-lived
  - greater than 90 days = long-lived
- f. When the container is full, complete a Radioactive Waste Disposal tag. Instructions are on the back of the tag.
- g. Attach the tag to the outer surface of the container.

**ii. Solids**

- a. Segregate by half-life.
- b. Place dry waste in drums, marked "Dry Radioactive Waste Only."
- c. Place all solid radioactive waste (filter papers, gloves, bottle caps, empty scintillation vials, etc.) into the innermost plastic liner.
- d. When full, tape the plastic liner shut; do not overfill.
- e. Do not put unabsorbed liquid in dry waste drums.
- f. Do not put contaminated equipment or radioactive powders in dry waste drums.
- g. Contain sharps in a separate rigid red plastic container to prevent puncture injuries.

**iii. Liquids**

**a. Aqueous wastes**

- Segregate aqueous waste by half-life.
- Must be placed in carboys with secure screw tops.
- Must have a "Caution - Radioactive Material" label attached.
- Keep containers closed during storage.
- Supply secondary containment able to contain the liquid in case of breakage.
- Segregate LSC fluid, aqueous, and other liquids.

**b. Scintillation vials with counting fluid**

- Must be placed in a container supplied by the duly authorized firm.
- Mark container "Scintillation Vials Only".
- Carefully place UNOPENED vials into the inner plastic liner. When full, tape the plastic liner shut; do not overfill.
- Dispose of bulk liquid scintillation counting fluid by emptying into properly labelled liquid waste jugs and treating as liquid waste.
- Segregate scintillation fluid from other liquid wastes.
- Empty scintillation vials may be washed and reused, or may be disposed as dry waste if they contain NO residual scintillation fluid.

**iv. Mixed Waste**

Mixed waste is any waste material, other than LSC fluid, that contains radioisotopes and possesses other hazardous properties; i.e. the waste is:

- a. Flammable or explosive
- b. Toxic
- c. Corrosive (pH greater than 12.5 or less than 2)
- d. Reactive

- e. Persistent (halogenated hydrocarbons and polycyclic aromatic hydrocarbons with more than three and less than seven rings)
- f. Carcinogenic
- g. Mixed waste must be characterized for isotope as well as hazardous components and concentrations (% by weight or volume)
- h. Common examples of mixed waste include:
  - Radio-labelled carcinogens
  - Solvents containing radioisotopes
  - Contaminated lead
- i. There is a disposal option for liquid scintillation cocktail containing radioisotopes

**v. Waste Storage**

The storage of hazardous materials must be in compliance with National Guidelines on Hospital Management. Your methods of handling waste are subject to unannounced inspections by regulatory inspectors.

- a. All containers need to have a label at all times indicating the contents. For waste materials, this could be a simple label such as "WASTE SOLVENT" or "USED ACETONE".
- b. Put the label on the container BEFORE ADDING WASTE.
- c. All containers need a lid at all times when not actively adding or removing waste. Evaporation in a hood is not a legal disposal method. Funnels do not count as lids.
- d. Secondary containment is advised for liquid containers.
- e. Storage limits and locations are the same for waste as for new materials. For example, storage of flammable liquids in excess of 10 gallons requires a flammable liquid storage cabinet. Glass bottles may not be stored on the floor because they can easily be broken by accidental kicking.

**Figure 13: Safe Packing for Disposal**



- f. Storage of Specimens and Blood in the Wards, Labs and in other Departments  
It is the responsibility of the laboratory staff that:
  - Specimens should be stored in wards or labs, for a limited time period, and arrangements should be made for processing or disposal as early as feasible.
  - Proper storage facility should be provided in the wards and labs (storage cabinets, freezers etc.).

- Ensure the appropriate labelling of the specimen container and the pathology request form if the patient is known or suspected of having a disease considered as "high risk".
- Ensure that the specimen is packaged and stored in a suitable and safe manner.
- Routine Histology specimens must be placed directly into formalin and can be stored at room temperature until transported to the Histology Laboratory.
- Frozen Section specimens must be sent dry, directly to the Histology Laboratory.
- FNA slides for Cytology Referral should be stored at room temperature until transported to the Histology Laboratory.

Some of the carriage boxes are as given below:

**Figure 14: Slides Storage for Safe Carriage**



**Figure 15: Film Storage for Safe Carriage**



## Ind 72. Laboratory results are available within a defined time frame.

### Survey Process:

Review the written definition of time frames for test results to be available. Then, see if the laboratory has data to show that the times are being met. While on an inpatient unit, review 3-5 medical records and look for the time of the physician order for the test, and compare with when the result was available.

### Scoring:

- If there are defined times for results to be available and these timelines are met, then score as **fully met.**
- If there are defined time frames, but they are met in up to 80 percent cases, then score as **partially met.**
- If there are no defined time frames or they are met less than 80 percent of the time, then score as **not met.**

## GUIDELINES

### Timely Reporting of Laboratory Results

1. The organization defines the time period for reporting laboratory test results. Results are reported within a time frame based on patient needs, services offered, and clinical staff needs. Emergency tests and after-hours and weekend testing needs are included. Results from urgent tests, such as those from the Emergency Department, Operating Theatres, and Intensive Care Units, are given special attention in the planning and monitoring process. In addition, when laboratory services are by contract with an outside organization, the reports must also be timely as set forth by organizational policy or the contract.
2. Turnaround time is defined as the period of time from receipt of the specimen in the laboratory to release of the result. Results of routine tests drawn are generally available, the following day. In some cases, owing to the complexity of the test or when the test is not performed on a daily basis, a longer turnaround time may be indicated.
3. The head of the laboratory must establish a liaison with the clinical administration requesting for a test to ensure that specimens are delivered promptly to the laboratory and that there is no delay between dispatches of the reports from the laboratory until they reach their destination. Any delays that have occurred must be investigated and steps must be taken to solve the problems and avoid the problems in future. The HCE/Laboratory shall ensure availability of adequate staff, material and equipment to make the laboratory results available within a defined time line

**Ind 73. Critical results are reported immediately to the concerned personnel.**

### **Survey Process:**

The laboratory should have defined critical values for ALL relevant tests and should have documentation (such as a log book) that the critical results were reported as soon as available. This is a significant patient safety issue.

### **Scoring:**

- If there are defined critical values and there is documentation that they are reported as soon as available, then score as **fully met.**
- If the critical values are not defined or if there is no consistent and defined process to report them as soon as available, then score as **not met.**

## GUIDELINES

### SOPs for Reporting Critical Laboratory Results

1. Critical test results are defined as any values/interpretations for which delays in reporting can result in serious adverse outcomes for patient care. These values should be defined by the laboratory director, in consultation with the concerned clinicians. The scope includes laboratory, cardiology, radiology, and other diagnostic tests in the inpatient, emergency, and

ambulatory settings.<sup>59</sup>

2. All critical reports are verbally informed to the concerned consultant immediately by the pathologist. The laboratory should have procedures for immediate notification of a physician, or other clinical personnel responsible for patient care, when results of certain tests fall within established "alert" or "critical" ranges.
3. As soon as the technical validity of the results has been established by a senior technician/technologist, the requesting doctor must be contacted without delay. If the identity of the requesting doctor is not obvious from the request form, his/her identity must be ascertained from the ward. If this fails, urgent results can be phoned to the ward or clinic sister or the most senior nurse on duty.
4. When results are transmitted verbally, in all cases the request form must be signed to indicate when and to whom and by whom the results are communicated. This must always be followed by a written report.
5. Such results will be telephoned to any patient-care unit lacking a computer terminal. A written record of test results telephoned to patient care areas must be made by the physician, nurse or other individual who receives the report.
6. The process developed by the organization for managing the critical results of diagnostic tests must include a definition of critical tests and critical values for each type of test, by whom and to whom the critical test results are reported, the established time frames for reporting and follow-up and an established method for monitoring compliance.
7. Advanced technologies and innovations may be used for prompt reporting/communication of results to the requesting clinicians.

**Note: Blood Group results must never be given by telephone**

**Ind 74. Laboratory tests not available in the HCE are outsourced to laboratories, based on their quality assurance system.**

#### **Survey Process:**

Determine which referral/outsourced laboratory or laboratories the hospital uses and then look for documentation that the laboratory or laboratories have demonstrated quality {for example accreditation by the Pakistan National Accreditation Council (PNAC) or any other evidence of quality assurance}. If the hospital has used a referral laboratory for some time and is comfortable that the results are accurate and timely, this experience can also be sufficient. The arrangements including quality Indicators and turnaround times should be specified in the formal contractual arrangement.

#### **Scoring:**

- If there is documented evidence that the referral laboratory or laboratories deliver quality indicators (even if only by the hospital's experience in the first year), then score as **fully met**.
- If there is no or limited evidence that the referral laboratory demonstrates quality, then score as **not met**.

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<sup>59</sup> Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Standards.

## GUIDELINES

### **Outsourcing Specialized Tests**

Specialized tests not performed in the hospital are referred to external laboratories. The laboratory director shall select the reference laboratory. Specimens for referral laboratories are dispatched from the Pathology Department. When results are received from the referral laboratory, the original report is always forwarded to the requesting clinician. A list of the referral laboratories currently being used should be displayed. Laboratory management, with the advice of users where appropriate, shall establish a procedure(s) for the referral of specimens to other laboratories and to consultants who are to provide second opinions, which includes:

1. Evaluating and selecting referral laboratories and consultants in terms of competence to perform the requested examinations and ensuring that there are no conflicts of interest.
2. Maintaining a record of all referral laboratories.
3. Maintaining a record of all specimens referred.
4. Recording of dispatch dates.
5. Maintaining a record of reports.
6. Monitoring the return of reports from the referral laboratory or referral consultant.
7. Defining the responsibilities for the interpretation and reporting of referred examinations.
8. Periodically reviewing the arrangements with referral laboratories to ensure that requirements including terms of EQA performance and turnaround times continue to be met.

***Note: Referral laboratories should, where possible, be accredited by some accreditation body or meet the requirements of the sender's quality management system***

9. Memorandum of Understanding (MOU) For Outsourcing Diagnostic Services (Between ABC Hospital & XYZ Lab) is given at **annexure L**.

## Assessment Scoring Matrix

**Standard 20. AAC 3: Laboratory services are provided as per the requirements of patients.**

Indicator 69-74		Max Score	Weightage (Percentage)	Score Obtained
Ind 69.	Scope of the laboratory services is according to the clinical services	10	<b>100</b>	
Ind 70.	Adequately qualified and trained personnel perform and/or supervise the investigations.	10	<b>80</b>	
Ind 71.	Policies and procedures guide the: i. Collection, ii. Identification, iii. Handling, iv. Safe transportation, v. Processing and vi. Disposal of specimens.	10	<b>100</b>	
Ind 72.	Laboratory results are available within a defined time frame.	10	<b>80</b>	
Ind 73.	Critical results are reported immediately to the concerned personnel.	10	<b>100</b>	
Ind 74.	Laboratory tests not outsourced to laboratories, based on their quality assurance system.	10	<b>100</b>	
<b>Total</b>		60	-	

## Standard 21. AAC-4: Imaging services are provided as per the clinical requirements of the patients.

### Indicators (75-82):

#### Ind 75. Imaging services comply with legal and other Regulatory Requirements.<sup>60</sup>

#### Survey Process:

There should be documentation in the Radiology Department of its compliance with all legal and regulatory requirements, especially clearance from Pakistan Nuclear Regulatory Authority (PNRA), use of dosimeters, lead sheets, lead aprons, signage, and display.

Key staff should be aware of the regulatory requirements.

#### Scoring:

- If supporting documents regarding legal and regulatory requirements are present in the department, especially PNRA certificate, and staff is aware of the content and is clearly applying the requirements, then score as **fully met**.
- If the legal and regulatory requirements are present and understood but not fully applied then score as **partially met**.
- If the documents regarding regulatory requirements are not present and most of staff members are unaware of their compliance obligations, then score as **not met**.

### GUIDELINES

#### Compliance with Statutes

A request for a Radiological Examination/Diagnostic Imaging will be regarded as a request from a Clinician or Health Professional to the Radiology Department for an opinion based upon a radiological examination, to assist in the management of a clinical problem.

1. Diagnostic Imaging or radiological procedures will only be performed upon a written request signed by a Registered Medical or Dental Practitioner.
2. Signed referrals (request form or letter) must precede or accompany the patient. Signed faxes are also accepted. Only doctors are permitted to sign, not nurses or other paramedical staff. There should be an appropriate use of the PMDC ID i.e. the Registration Number.
3. All requests must carry sufficient information to identify the patient. This normally consists of the first name, middle name if any, and family name, date of birth and address.
4. All requests must carry sufficient clinical information to enable the requested examination to be justified. The referral forms should contain adequate information to justify the procedure requested. The radiologist is responsible for justifying the procedure.
  - i. All requests shall clearly state the examination requested.
  - ii. All requests must include the contact details of the Referring Clinician, including the address

<sup>60</sup> Building Code of Pakistan and management of ionising radiation.

and telephone number.

- iii. All requests for X-ray examinations (between the diaphragm and the knees) for all fertile females must state the date of the first day of the patient's menstrual period.
- iv. The organization shall have a system for providing radiology and diagnostic imaging services required by its patient population, clinical services offered and Health Care Provider (HCP) needs.
- v. Radiology and diagnostic imaging services, including those required for emergencies, may be provided within the HCE, by agreement with another organization, or both. Radiology and diagnostic imaging services are available after normal working hours for emergencies.
- vi. Outside sources are convenient for the patient to access, and reports are received in a timely way that supports continuity of care. The HCE selects outside sources based on the recommendation of the director or other individual responsible for radiology and diagnostic imaging services. Radiology and diagnostic imaging services, in house as well as outside sources, must meet applicable laws and regulations (enforcement of PNRA regulations and other statutory requirement) and have an acceptable record of accurate and timely services. Patients are informed when an outside source of services is owned by the referring physician.
- vii. Every HCE should have SOPs for outsourcing (from the request to the assessment of service provider and turnaround time of the report).
- viii. All the statutory requirements e.g. clearance from Pakistan Nuclear Regulatory Authority (PNRA), use of dosimeters, lead sheets, lead aprons, signage, display as per relevant regulations are to be met with.

## Ind 76. Scope of the imaging services is in accordance with the clinical services provided by the hospital.

### Survey Process:

This requires an understanding of the full scope of services provided at the Hospital and observation of the diagnostic facilities provided both on and off site. A full complement of imaging services should also be provided to cater for emergency situations that may arise from the services delivered by the hospital. Where invasive imaging services are provided there must be adequate support service in the event of an emergency. This involves resuscitation, and in some cases, emergency surgery when cardiac or other invasive procedures are involved.

### Scoring:

- If there is access to a full range of imaging services in accordance with the scope of hospital services, then score as **fully met**.
- If there is insufficient scope and number of imaging services to support the services within the hospital, then score as **not met**.

## GUIDELINES

### Scope of Imaging Services

The Radiological/Diagnostic Imaging Services shall aim at providing safe, efficient, and quality

services as required for good patient care. Specific radiological and diagnostic imaging services provided shall depend upon the size and scope of the facility (to be enlisted by the HCE). Staff strength shall be commensurate with the number of beds, patient load and investigations performed.

A full complement of imaging services (to be enlisted by the HCE) should also be provided to cater to the emergency situations arising from the services delivered by the HCE. Adequate support service must be available at places where invasive imaging services are provided, to meet with an event of emergency. This involves resuscitation and in some cases emergency surgery/CABG when cardiac procedures e.g., angioplasty etc. are involved

**Ind 77. Adequately qualified and trained personnel perform, supervise and interpret the investigations.**

**Survey Process:**

Each member of Radiology Department has a job description to accomplish the assigned job. Review the human resource files for radiology department technical and supervisory staff to determine if their credentials (qualifications, experience and training) match the requirements of the respective position and the job description including handling the equipment being used. A system of Continuous Professional Development<sup>61</sup> should be active.

Requirements for the head of the various types of radiological centres are given below:

Category	Type of Facility	Qualification of Technical Head
A	Radiotherapy/Nuclear Medicine	MBBS plus the following qualification in order of preference: a. FCPS/FRCR (Radiotherapy) or equivalent recognized by the PM&DC; or b. Diplomate American Board (Radiotherapy) recognized by the PM&DC; or c. DMRT/MCPS (Radiotherapy) recognized by the PM&DC with 03 years of practical experience in Radiotherapy after postgraduation
B	Radiology (Interventional Diagnostic, Computerized Tomography (CT), Fluoroscopy and Mammography), Magnetic Resonance Imaging (MRI) and Ultrasonography (USG)	MBBS plus the following qualification in order of preference: a. FCPS/FRCR or equivalent recognized by the PM&DC; or b. Diplomate American Board (Radiology) recognized by the PM&DC; or c. DMRD/MCPS (Radiology) recognized by the PM&DC with 03 years practical experience in Radiology after postgraduation
C	Conventional Diagnostic Radiology (X-ray)	MBBS plus DMRD/MCPS (Radiology) recognized by the PM&DC

<sup>61</sup> A recognized program administered by a professional college/council or equivalent

### Scoring:

- If qualifications of the head and other staff is according to the category of the radiological centre, then score as **fully met**.
- If only one technician does not have the experience required by the job description, then score as **partially met**. Provided that there is evidence of enhanced supervision or training of this individual.
- If the head and/or two or more technician do not have the required qualifications, then score as **not met**.

## GUIDELINES

### **Authorization to Perform, Supervise and Interpret**

Radiology and diagnostic imaging services, provided at any location in the organization, are under the direction of an individual who is qualified by documented training, expertise and experience, consistent with applicable laws and regulations. This individual assumes professional responsibility for the radiology and diagnostic imaging facility and the services provided. When this individual provides clinical consultation or medical opinion, he/she is a qualified/authorized radiologist.

The radiology and diagnostic imaging director's responsibilities include;

1. Developing, implementing, and maintaining policies and procedures.
2. Administrative oversight.
3. Maintaining any necessary quality control program.
4. Recommending outside sources of radiology and diagnostic imaging services.
5. Monitoring and reviewing all radiology and diagnostic imaging services.

The organization identifies which radiology and diagnostic imaging staff members perform diagnostic and imaging studies, those who are approved to perform point of care tests at the bedside, those who are qualified to interpret the results or verify and report results, as well as those who direct or supervise the processes. Supervisory staff and technical staff have appropriate and adequate training, experience, and skills and are oriented to their work. Technical staff members are given work assignments consistent with their training and experience. In addition, there is a sufficient number of staff to perform, interpret and report studies promptly and provide necessary staffing during all hours of operation and for emergencies.

### **Human Resource for Diagnostic Radiological and Imaging Services:**

1. The radiologist in charge of the diagnostic imaging services may be available full -time or part-time depending on the size and complexity of the department.
2. The authority and accountabilities (e.g. Error report, Audit report) of the person in charge are clearly delineated.
3. The diagnostic imaging services shall be staffed with a qualified radiologist, qualified radiographers, nursing, clerical and administrative staff.
4. Sufficient numbers of qualified personnel and support staff are employed to enable the services to meet the documented purposes.
5. A qualified radiologist and radiographer shall be on duty or be available on-call after normal working hours.

6. There is evidence of a staff development plan, which provides the knowledge and skills required for staff to maintain competency in their current positions as the demands on the positions evolve. There is evidence of competency assessment.
7. There is a structured orientation programme where new staff is briefed on their services and relevant aspects of the facility to prepare them for their roles and responsibilities.
8. There are continuing education activities for staff to pursue professional interests and to prepare for current and future changes in practice. There is evidence that staff education and development needs have been appraised and identified.
9. Staff receive written evaluations of their performance at the completion of the probationary period and annually thereafter, or as defined by the facility.
10. Proper instructions are provided and safety precautions are implemented for the protection of patients and staff who are exposed to the hazardous equipment.
11. In a teaching hospital, the diagnostic imaging services, subject to requirements of safety and comfort, provide for the relevant educational needs of under-graduates and post-graduates.
12. In facilities which have teaching and research responsibilities, the staff of the diagnostic imaging services gives their cooperation or participate in the teaching and research programmes related to the field of diagnostic imaging<sup>62</sup>.
13. A radiologist performing a therapeutic interventional procedure is considered a treating physician. A radiologist performing a diagnostic interventional or diagnostic procedure is not considered a treating physician.

A physician should supervise diagnostic tests. Supervision may be of following type:

**General Supervision:** This means the procedure is performed under the physician's overall direction and control, but the physician's presence during the performance of the procedure is not required. Under general supervision, training of the non-physician personnel who actually performs the diagnostic procedure, and maintenance of necessary equipment and supplies are the continuing responsibility of the physician.

**Direct Supervision:** This means a physician must be in attendance in the room during the performance of the procedure and be available to furnish immediate assistance and direction throughout the performance of the procedure.

Interpretation of results is an important component of the service provided by the Radiology and Diagnostic Imaging Department. The frequency of such comments may vary between specialties;

1. The management of the Laboratory/Radiology Department shall ensure that advice on examinations and the interpretation of results is available to meet the needs and requirements of users.
2. Interpretive comments on reports shall be clear, succinct and unambiguous.
3. Clinical advice and interpretive comments shall only be provided by authorized personnel with appropriate training.
4. There shall be systematic communication between Laboratory/Radiology and clinical staff to promote effective utilization of services and to consult on scientific and logistic matters. Where appropriate, a record of such meetings shall be kept.

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<sup>62</sup> Malaysian Society for Quality in Health. (2008). Hospital Accreditation Standards 3rd Edition.

## Ind 78. Policies and procedures guide identification and safe transportation of patients to imaging services.

### Survey Process:

Review the policies and procedures. Specifically look for how the patient is positively identified and it is ensured that the correct imaging procedure is done. Look for evidence that specific medical attendant or equipment is available and provided if needed to accompany the patient during transportation to the imaging department and that there is a clear process to ensure this happens. Specifically look for evidence (by observation and interview of staff) that the patient is positively identified and safely transported.

### Scoring:

- If there are documented and implemented policies and procedures for patient identification and safe transport, then score as **fully met**.
- If either there are no policies or there is no evidence that they have been implemented and are being followed, then score as **not met**.

## GUIDELINES

### Identification and Safe Transportation of Patients

#### 1. Identification

Identification of a patient is done by asking the patient/relatives and comparing the particulars on a Request Form which is on a standard format and contains:

- i. Client's/Patient's name
- ii. Identification number
- iii. Computerized National identity card (CNIC) number
- iv. Address
- v. Date of birth (if not available, then age)
- vi. Examination requested
- vii. Previous examinations
- viii. Clinical diagnosis/indications/relevant history
- ix. Information relating to the gestational status in women of childbearing age
- x. Identity of the requesting physician
- xi. History of allergy, in red ink
- xii. The Radiologist is responsible for the justification of any radiological investigation
- xiii. He/she will also have to communicate with the primary referring physician and obtain optimum clinical information to perform the investigation.
- xiv. For medico legal cases (MLC), a mark of identification of the client/patient and name of the police official bringing the client/patient.
- xv. Fee to be charged/not to be charged.

#### 2. Safe Transportation

- i. Some radiology tasks demand the usage of some push or pull force that radiographers must exert when moving patients from one area to another. Exertion of an excessive force may

increase the risk of injury to the back, legs, shoulders or any other part. Fragile bodies of older patients/already injured are more prone to further trauma or harm.

- ii. For the safety of the human resource, use mechanical power assisted devices whenever heavy patients or large equipment are required to be moved for longer distances. Ensure that a sufficient number of employees are available to move heavy patients. Employee/s should not exert excessive force at any point during the transportation/shifting.
- iii. For example, radiographers should be trained to use correct body mechanics when moving patients during procedures, including inter alia the following;
  - a. Push instead of pull. Lean slightly into the load to let your body weight assist with force exertion.
  - b. Push at about chest height.
  - c. Push smoothly and slowly to start.
  - d. Do not bend or twist while exerting force.
  - e. Keep wrists straight.
  - f. Keep elbows close to the body.

#### **Transferring Patients to and from the Examination Table**

1. Radiographers may need considerable support and assistance to move patients to or from examination tables.
2. Use mechanical powered transfer devices such as lifts or hoists to move patients, especially non-ambulatory, from wheelchairs, beds, or stretchers.
3. When appropriate, use multi-use devices such as chairs that can open up into beds. These allow patients to move from a sitting position to a prone position, without transfer.
4. Additional employees should assist in moving and transferring equipment or patients if:
  - i. A mechanical powered device is not available.
  - ii. Awkward postures are forced to be used.
  - iii. Excessive push force or lifting or supporting a heavy weight is required.<sup>63</sup>

### **Ind 79. Imaging results are available within a defined time frame.**

#### **Survey Process:**

While visiting the Radiology Department, review their written definition of time frames both for the availability of the procedures and the availability of the reports. Then, see if the department has data to show that the times are being met. For further validation, review representative sample of medical records while on an in-patient unit. Look for the time of the physician order for the procedure, and compare with when the result was available.

#### **Scoring:**

- If there are defined times for the procedures to be available and the results to be reported and these times are met, then score as **fully met.**
- If there are defined time frames, but they are met in up to 80 percent of the cases, then score as **partially met.**

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<sup>63</sup> United States Department of Labor, Hospital e-Tool, Transporting Patients and Equipment.

- If there are no defined time frames and/or they are met in less than 80 percent of the cases, then score as **not met**.

## GUIDELINES

### **Timely Reporting of Radiology Results**

The organization defines the time period for reporting diagnostic radiology and diagnostic imaging study results. Results are reported within a time frame based on patient needs, services offered, and the clinical staff's needs. Emergency tests, after-hours and weekend testing needs are included. Results from urgent radiology and diagnostic imaging studies, such as those from the Emergency Department, Operating Theatres, and Intensive Care Units, are given special attention in the planning and monitoring process. Radiology and diagnostic imaging studies performed by outside contractors of services are reported according to organizational policy or contract requirement. Radiology Turnaround Time (RTAT) means the time from the examinations until the reports are completed;

1. It would be feasible to have all the inpatient reports within 24 hours and all the outpatient report within 48 hours.
2. The referring physician should formally communicate with the radiologist for all emergency procedures (RTAT should be one hour).
3. All verbal communications have to be followed by written documentation. Use of PACS/EMR/ICT should be encouraged.
4. Reports can be amended only by adding addendums (timed and signed).

The implementation of a Radiology Information System (RIS) and a Picture Archiving and Communication System (PACS), and the integration of these systems with the Electronic Medical Record (EMR), may improve the use of diagnostic imaging in clinical practice. This Information and Communication Technology (ICT) can reduce the radiologist's reporting time, and make the reports and images instantly available to clinicians' hospital-wide. Before the ICT introduction, radiologists used to read images on film and clinicians had to walk to the Radiology Department to look at these images. Reports were printed and distributed on paper. For emergency ultrasound cases, handwritten summaries accompanied the patients returning to the wards. After the ICT introduction, images are immediately (within five minutes) available hospital-wide to clinicians with legal access to the patient's record. All radiology reports are entered directly into the EMR as soon as they are finished (also within five minutes). The reports are issued in two versions: a preliminary version after one radiologist's examination of the images, and a final version once a specialist in radiology had verified the conclusion.<sup>64</sup>

**Ind 80. Critical results are intimated immediately to the concerned personnel.**

### **Survey Process:**

Unlike the laboratory, critical findings on images depend to a great extent on the clinical judgment of the radiologist. However, the department should at least have some general guidelines and a way to

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<sup>64</sup> BMC Health Services Research. (2010). Retrieved from <http://www.biomedcentral.com/>

document that the findings were reported as soon as possible. This is a significant patient safety issue.

**Scoring:**

- If there are documented guidelines to manage critical findings and there is evidence that they are reported as soon as available/noted, then score as **fully met**.
- If there is no understanding of what constitutes a critical imaging finding, or if there is no consistent and defined process to report those as soon as available/noted, then score as **not met**.

**GUIDELINES**

**SOPs for Reporting Critical Laboratory Results**

Critical results MUST be communicated in a timely manner, within one hour. Communication of these results to the physician has to be ensured using any one or a combination of forms of communication e.g. Telephone/fax/email - PACS/EMR/ICT.

1. Appropriate people for communication:
  - i. MUST be a trained HCP responsible for the patient.
  - ii. The patient/next of kin if the HCP is not accessible.
2. Not acceptable for communication:
  - i. A nurse or physician or an employee of the unit with no responsibility for the patient.
3. When communication is verbal it MUST be documented, including:
  - i. Person communicating and person to whom the communication is made.
  - ii. Time and date of communication.

**List of Radiology Critical Results**

1. General: Retained sponge or other clinically significant foreign body, new/unexpected and clinically significant mass/tumour or arterial dissection/occlusion.
2. Acute Abdomen: Life-threatening obstruction; previously undiagnosed abscess, acute thrombotic or embolic event, including DVT; unexpected or previously undiagnosed free air or active leakage; previously undiagnosed, clinically significant haemorrhage or vascular disruption, ectopic pregnancy and intestinal ischemia.
3. Acute Head: Unexpected and clinically significant intracranial haemorrhage, new midline shift, aneurysm, abscess and meningoencephalitis; clinically significant herniation; new/unexpected cerebral infarction.
4. Acute Neck: Acute airway compromise, new, clinically significant, unexpected abscess, discitis and unexplained haemorrhage.
5. Acute Spine: New, unexpected, clinically significant discitis, abscess, cord compression or transection and acute cord haemorrhage or infarct.
6. Acute Chest: New, unexpected, clinically significant collapse of lung, pneumothorax and pulmonary artery embolus.
7. Acute Skeletal: Impending pathologic fracture and new, unexpected, clinically significant fracture.

8. Nuclear Medicine: Newly diagnosed absent perfusion in a postoperative kidney, brain death (transplant team waiting for results) and new high probability ventilation/perfusion (V/Q) lung scan.<sup>65</sup>

## Ind 81. Quality Assurance activities are evident in the Imaging Department.

### Survey Process:

There should be documented evidence that a Quality Assurance (QA) System is implemented in the department. This should include observation of activities such as a register of repeat images due to image quality related reasons and recording of adverse occurrences.

### Scoring:

- If a QA System is in place along with evidence that the staff is aware of it and the associated activities, then score as **fully met**.
- If either a QA System is not in place or the staff is not aware of it and the associated activities, then score as **not met**.

## GUIDELINES

### Quality Assurance (QA) Program

1. A QA Program is designed by the management to assure the quality of a product or service. Such a program can have wide-ranging aspects including client feedback, employee empowerment and Quality Control (QC).
2. QC involves specific actions designed to keep measurable aspects of the process involved in manufacturing a product or providing a service within specified limits. These actions typically involve measurement of a process variable, checking the measured value against a limit and performing corrective action if the limit is exceeded.
3. All medical facilities using X-ray equipment, from a simple intraoral dental unit to an image intensified special procedures system, will benefit from adopting a QA program. An established program will monitor the imaging process from start to finish and reveal potential problems that may otherwise go unrecognized. QA in medical imaging is a rapidly evolving concept and each facility is encouraged to continually pursue ways to improve and expand its program.
4. It is essential that one person at a given facility, the QA Coordinator, be in charge of maintaining the QA program and be allotted the time, equipment and space necessary to carry out required duties.
5. The QC program is based on planning and purchasing the proper equipment, then establishing a high standard of quality and maintaining it. The information provided should enable the Coordinator to set up and monitor the entire program. If a facility protocol is not available for a specific type of equipment (e.g., digital imaging systems), the manufacturer's recommendations should be followed. Establishing an open line of communication with representatives from the PNRA and other technical experts, will make it much easier to set a standard.

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<sup>65</sup> UAB School of Medicine, Department of Radiology. Retrieved from <http://medicine.uab.edu/radiology/83495>.

6. The following equipment may be used for a QC program.
  - i. Sensitometer (21 Step)
  - ii. Densitometer
  - iii. Box of film (clinically used)
  - iv. Aluminum step wedge
  - v. Brass or copper mesh screens (1/8 inch or 3 mm spacing) large enough to cover largest cassette in use at facility
  - vi. Measuring tape
  - vii. Non-mercury thermometer
  - viii. Cleaning equipment for screens, cassettes and darkroom
  - ix. Fluoroscopic test tool

Once you have become proficient at performing the tests, the time spent will be minimal. Daily tests should take about 5 minutes to perform and should be done prior to the first patient image of the day. Monthly tests will add an additional 10 minutes to the daily tests. Quarterly tests will take about 45 minutes to perform. The semiannual test for darkroom fog should take no more than 5 minutes to perform and analyze. The annual tests will probably take 1 to 2 hours to perform.

### **Quality Control Manual**

A QC Manual should be created and reviewed at least annually. The manual should include the facility's objectives, QC instructions, QC results, and personnel responsibility. Daily/monthly/quarterly/annual audit should be performed and recorded. SOPs for QA should be clearly defined in the manual.

These can be the following:

1. Patient related (satisfaction/complaints/RTAT)
2. Service related (HR/Equipment/Work space etc.)
3. Confidentiality of patients and their reports

### **The following should also be included in a QC Manual:**

1. A list of the tests to be performed and the frequency for each test, including acceptable test limits, test procedures, maintenance and service records.
2. A list of equipment to be used for testing.
3. Policy and procedures for QC tests as well as for the facility.
4. Sample forms.

### **Questions asked during a review might include:**

1. Is image quality maintained at the desired level?
2. Is the X-ray technique chart up-to-date?
3. Is the screen-film combination used still the best suited for our facility?
4. Do all personnel meet the required or established qualifications?
5. Does any equipment need to be replaced?
6. Do any QC procedures need to be changed or updated?
7. Are personnel adequately performing assigned tasks?
8. Is patient and personnel radiation exposure as low as reasonably achievable?

9. Are all documents up-to-date and accurate?<sup>66</sup>

**QA is done with monitoring the following:**

1. Tracking Turnaround time and waiting times:
  - i. Methodology: Turnaround time is tracked by manually tracking the in and out time of the patient for each modality in the department.
  - ii. A suitable sample (7 days) will be taken for this study.
2. Grading of X-ray films is done by the radiologist:
  - i. Grading of X-ray films is done on the following criteria
    - a. Positioning - 1
    - b. Artifacts - 1
    - c. Exposure factors - 1
  - ii. Grading - scores
    - a. Total score of 3 for each Patient to be documented for X-rays.
    - b. In case the quality is graded 1, the X-ray is to be repeated on the radiologist's opinion and more care is to be taken during repeat X-ray.
    - c. Grading score should not be less than 90%.
    - d. If below 90%, the reason should be evaluated and discussed with the radiologist and rectified immediately.
3. Reject rates for films:

It should be less than 3% of the Monthly consumption.
4. Confidentiality of Reports: Confidentiality of patients and their test reports are ensured through the following:
  - i. In the course of performing work responsibility all information with regard to the patient, their family, their physician and/or the hospital is kept confidential.
  - ii. All staff of the department is cautioned not to discuss any such information with others.
  - iii. The radiologist is the only person authorized to inform reports to the doctors.
  - iv. Sound QC systems are essential for providing excellent radiology and diagnostic imaging services.

In summary there is a QC program for the radiology and diagnostic imaging services and it comprises of following:

1. Validating test methods.
2. Daily surveillance of imaging results.
3. Rapid correction when a deficiency is identified.
4. Testing reagents and solutions.
5. Documenting results and corrective actions.

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<sup>66</sup> Quality Control Recommendations for Diagnostic Radiography, Vol. 3. (July 2001). Radiographic or Fluoroscopic Machines. Published by Conference of Radiation Control Program Directors, Inc.

**Ind 82. Imaging tests not available in the hospital are outsourced on the basis of quality assurance system and compliance with applicable laws and regulations.**

**Survey Process:**

There should be documented evidence that the radiology services to which patients are referred have been approved by the Pakistan Nuclear Regulatory Authority (PNRA) and that the hospital has a history of receiving timely and accurate reports from the referral radiology service commensurate with the clinical needs of the patient.

**Scoring:**

- If the referral imaging services are approved by the PNRA and the hospital demonstrates sufficient experience to know that reports are timely and accurate, then score as **fully met**.
- This should only be scored as **not met** if a majority of the survey team agrees that there are significant problems with the referral radiology services regarding timely and accurate reporting.

**GUIDELINES**

**Outsourcing of Radiological Tests**

When the organization uses outside sources of radiology and diagnostic imaging services, it should regularly receive and review the QC results of that outside source through qualified individuals. When diagnostic imaging QC of outside sources is difficult to obtain, the manager develops an alternative approach for quality oversight. Mechanism/SOPs have to be developed e.g., who will approve/call/respond and what would the turnaround time of the service be.

Outside sources are convenient for the patient to access, and reports are received in a timely way that supports continuity of care. Outside sources of radiology and diagnostic imaging services should meet applicable laws and regulations (as specified by PNRA) and should have an acceptable record of accurate and timely services.

***Note: Referral Radiology and Diagnostic Imaging Services should where possible, be accredited by some accreditation body or meet the requirements of the sender's Quality Management system.***

Memorandum of Understanding (MOU) for Outsourcing Diagnostic Services (Between ABC Hospital & XYZ Radiological Diagnostic Center) is given at **annexure M**.

## Assessment Scoring Matrix

**Standard 21. AAC 4: Imaging services are provided as per the clinical requirements of the patients.**

Indicator 75-82		Max Score	Weightage (Percentage)	Score Obtained
Ind 75.	Imaging services comply with legal and other Regulatory Requirements.	10	80	
Ind 76.	Scope of the imaging services is in accordance with the clinical services provided by the hospital.	10	100	
Ind 77.	Adequately qualified and trained personnel perform, supervise and interpret the investigations.	10	80	
Ind 78.	Policies and procedures guide identification and safe transportation of patients to imaging services.	10	100	
Ind 79.	Imaging results are available within a defined time frame.	10	80	
Ind 80.	Critical results are intimated immediately to the concerned personnel.	10	100	
Ind 81.	Quality Assurance activities are evident in the Imaging Department.	10	100	
Ind 82.	Imaging tests not available in the Hospital are outsourced on the basis of quality assurance system and compliance with applicable laws and regulations.	10	100	
<b>Total</b>		80	-	

## 2.7 Care of Patients (COP)

### **06 Standards & 44 Indicators**

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The process of patient care includes planning of care, providing care, evaluating the patient's response to care, and planning follow-up care. Care may be provided in multiple locations, by multiple disciplines, and it may involve different processes. The following standards for the Care of Patients address essential principles and processes for the clinical care of patients who come to hospitals for their treatment, with excellent care being the overarching goal. These standards offer guidance on multidisciplinary patient care, especially in the fields of Emergency Services, Blood Transfusion, Obstetrics, Anaesthesia and Surgery. Comprehensive treatment shall take place in the respective clinical specialty areas with strict adherence to the Standards of Care.

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## Standard 22. COP-1: The services provided to patients meets the mandatory staff requirements.

Indicators (83-86):

**Ind 83. Every patient care department is headed by a qualified specialist as per PMDC criteria.**

### Survey Process:

Get a list of patient care and allied services provided by the hospital. In addition get a list of the head of the departments and their PMDC registration/licence. Ensure that all have valid PMDC recognized relevant specialty qualification.

If any service is provided without PMDC recognized relevant specialist, note down that department and attach it to the scoring manual for submission to the Commission. This indicator shall be considered as met only for the department having qualified specialist.

There is no requirement of the number of minimum specialties. A hospital can be multi or single specialty. Although not a requirement for Health care Commission, the PMDC has minimum requirements for services for teaching hospitals.

### Scoring:

- If all the patient care and allied services departments are headed by valid PMDC recognized relevant specialist, then score as **fully met**.
- If any of the patient care and allied services departments are not headed by valid PMDC recognized relevant specialist, then score as **not met**. Mention names such departments below:

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The hospital shall not be allowed to provide these services.

**Ind 84. Relevant specialist is available round-the-clock, at least on call, in every patient care department.**

### Survey Process:

Check the availability of round-the-clock relevant specialist, having valid PMDC registration/licence, at least on call, in all the patient care departments of the hospital.

If any service is provided without even the on call availability of round-the-clock PMDC recognized relevant specialist, note down that department and attach it to the scoring manual for submission to the Commission. This indicator shall be considered as met only for the department having at least on call round-the-clock availability of qualified specialist.

**Scoring:**

- If all the patient care departments have, at least on call, round-the-clock PMDC recognized (valid) relevant specialist, then score as **fully met.**
- If any of the patient departments does not have, at least on call, round-the-clock PMDC recognized (valid) relevant specialist, then score as **not met.** Mention names such departments below:

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The hospital shall not be allowed to provide these services.

**Ind 85. The required medical officers are available round-the-clock in every patient care department.**

**Survey Process:**

Check the availability of round-the-clock medical officers, having valid PMDC registration, in all the patient care departments of the hospital. Visit all the departments and review the relevant documents.

If any service is provided without the availability of round-the-clock PMDC recognized medical officers, note down that department and attach it to the scoring manual for submission to the Commission. This indicator shall be considered as met only for the department having round-the-clock availability of the required medical officers.

**Scoring:**

- If all the patient care departments have round-the-clock PMDC recognized (valid) medical officers, then score as **fully met.**
- If any of the patient departments does not have round-the-clock PMDC recognized (valid) relevant medical officers, then score as **not met.** Mention names such departments below:

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The hospital shall not be allowed to provide these services.

**Ind 86. The required nursing staff is available round-the-clock in every patient care department.**

**Survey Process:**

Check the availability of round-the-clock nursing staff, having valid PNC registration, in all the patient care departments of the hospital. Ensure availability of nursing-to-patient ration as given below:

General care wards - 1:10

Special care wards - 1:3

Visit all the departments and review the relevant documents. If any service is provided without the availability of round-the-clock PNC recognized nursing staff as given above, note down that department and attach it to the scoring manual for submission to the Commission. This indicator shall be considered as met only for the department having round-the-clock availability of the required nursing staff.

**Scoring:**

- If all the patient care departments have the required ratio of round-the-clock PNC recognized (valid) nursing staff, then score as **fully met.**
- If any of the patient departments does not have the required ratio of round-the-clock PNC recognized (valid) nursing staff, then score as **not met.** Mention names such departments below:

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The hospital shall not be allowed to provide these services.

## Assessment Scoring Matrix

**Standard 22. COP 1: Emergency services are guided by policies, procedures and applicable laws and regulations.**

Indicator 83-86		Max Score	Weightage (Percentage)	Score Obtained
Ind 83.	Every patient care department is headed by a qualified specialist as per PMDC criteria.	10	<b>100</b>	
Ind 84.	Relevant specialist is available round-the-clock, at least on call, in every patient care department.	10	<b>100</b>	
Ind 85.	The required medical officers are available round-the-clock in every patient care department.	10	<b>100</b>	
Ind 86.	The required nursing staff is available round-the-clock in every patient care department.	10	<b>100</b>	
<b>Total</b>		40	-	

## Standard 23. COP-2: Emergency services are guided by policies, procedures and applicable laws and regulations.

### Indicators (87-92):

#### Ind 87. Policies and procedures for emergency care are documented.

#### Survey Process:

Review the policies and procedures, which should cover the administration of the emergency area (prioritization/triage, waiting times, admission/registration, legal reporting requirements, discharge and patient referral). The HCE should have emergency policy and procedure manual and an evidence that staff members are aware of the manual. There should be evidence by observation and interview with staff that the policies and procedures have been implemented.

#### Scoring:

- If there are policies and procedures as described above, then score as **fully met**.
- If there are no written policies and procedures, or there is any deficiency, then score as **not met**.

### GUIDELINES

#### Policies and Procedures

Each HCE should have well thought out and documented policies and procedures for emergency care, in line with statutory requirements. These policies and procedures, developed in the light of applicable laws, shall guide and encourage patient safety as the overall principle for providing healthcare services to patients. These documents include SOPs/Protocols to provide either general emergency care or management of specific conditions, e.g. myocardial infarction, acute abdomen, poisoning etc. and shall address both adult and paediatric patients. The procedure shall incorporate at least identification, assessment and provision of care. The HCE policy should spell out and ensure availability of all the necessary equipment in working order, in line with the international standards, required in the Emergency Department (ED) to function round the clock (24/7) without interruption of its services. Hospitals should make policies i.e. SOPs/SMPs, on at least the following topics:

1. ED design
2. Staffing of emergency services
3. Patient assessment and care
4. Initial screening exam
5. Emergency medical services (EMS)
6. Continuing education
7. Disaster plan
8. Medications
9. Equipment and supplies
10. Power failure
11. Electrical safety
12. Fire plan

13. Security/traffic control
  14. Inter-hospital transfers
  15. Laboratory down time procedure
  16. Consent
  17. Confidentiality of patient information
  18. Triage
  19. Shock-trauma area
  20. Patient belongings and valuables
  21. Standing orders
  22. Integration of diagnostic radiology with ED
  23. Integration of operating room with ED
  24. Integration of special care units with ED
  25. Reporting of criminal injury
  26. Invasive procedures
  27. General anaesthesia
  28. Special procedures
  29. Patient transport for radiological procedures
  30. Admission
  31. Return of admitted patients to the ED
  32. Length of stay in the ED beyond 8 hours
  33. Injury prevention of unconscious, confused or irrational patients
  34. Social works services consultation
  35. Release of information to media
  36. Pesticide poisoning
  37. Patient discharge
  38. Infection control
  39. Blood borne pathogen exposure in patients presenting to the ED
  40. Visitors
  41. Medical records
  42. Elective sedation and analgesia
  43. Patients pronounced dead in the ED
  44. Poisonings
  45. Tetanus prophylaxis
  46. Rabies prophylaxis
  47. Major adult trauma
  48. Major pediatrics trauma
  49. Adult Medical Resuscitations
  50. Paediatric Medical Resuscitations
  51. Paediatric Medication Administration
  52. ED Control Register (ED log)
  53. QC
  54. Follow-Up program - Call Back
  55. Patient Follow-Up procedure
  56. Continuous Quality Improvement (CQI)
- The ED should be appropriately staffed and must have one to two CMOs/EMOs depending upon

the patient load of the HCE in each shift of 8-1/2 hours, with a half hour overlap of duties for handing/taking over of charge. Night duty of 12 hours i.e. from 8PM to 8AM, currently in vogue, hampers the quality of service and therefore a uniform duty of 8-1/2 hour must be enforced. It should be mandatory to have sufficient experience and/or a house job in Medicine/Allied and Surgery/Allied specialties for the appointment of CMO/EMO.

## Ind 88. Policies also address handling of medico-legal cases.

### Survey Process:

The surveyor should first determine the status of the hospital as public or private, because there are different guidelines from the government for them. At private hospital, only first aid shall be provided, followed by referral to a public hospital. The surveyor should ask for a written policy having definition of MLC, identification of nearby government referral facility in case of private hospital. Secondly, the knowledge of the relevant medical officer of Emergency Department should be assessed about the MLC Policy.

### Scoring:

- If MLC Policy is available and the relevant medical officer is knowledgeable about handling MLCs, then score as **fully met**.
- If there is no policy and/or the relevant medical officer is not knowledgeable about handling MLCs, then score as **not met**.

## GUIDELINES

### Medico Legal Case

A Medico Legal Case (MLC) is defined as “any case of injury or ailment where, the attending doctor after history taking and clinical examination, considers that investigations by law enforcement agencies are warranted to ascertain circumstances and fix responsibility regarding the said injury or ailment according to the law.”

Patients of medico legal cases can go to any public or private hospital to receive medical treatment.

### Policy on Handling of Medico Legal Cases by Private Hospitals

Where an injured person is brought to a hospital, he shall be provided medical aid and without delay, on priority basis, over all other medico-legal formalities.<sup>67</sup>

All private hospitals are required to give first aid to medico-legal cases and then transfer such cases to a public sector hospital where a medico-legal team will perform an examination; however, if the patient is in a life-threatening situation, the private hospital is permitted to admit the patient under its care. Following the admission of a patient under such life-threatening circumstances, private hospitals are required to contact the local police at which time a medico-legal officer from the public hospital will be dispatched to examine the patient.

Medico-legal report shall only be prepared by a medico-legal officer, so designated in public

<sup>67</sup> The Khyber Pakhtunkhwa Injured Persons and Emergency (Medical Aid) Act, 2014.

hospitals.

### **Instructions on Handling of Medico Legal Cases**

The policy shall be in line with legal requirements with reference to documentation and intimation to the police. Medico Legal Cases/ Medico Legal Reports (MLC/MLR) will be defined by the HCE in the light of the statutory rules. MLC/MLR must be handled by the medical officers of the Forensic Department where it is available, as in teaching hospitals; *vis-a-vis* where a Forensic Department is not available then CMOs must be given capacity building training. Female victims of MLC/MLR must be dealt by female doctors. If not available in the ED, then a female doctor from the Gynaecology Department must be appointed in the ED, with her name and telephone number noted. An approved Government Policy/Procedure is to be followed while handling and reporting Medico Legal Cases.

**Ind 89. Policies and procedures guide the prioritization of patients for initiation of appropriate care.**

### **Survey Process:**

Look for a formal prioritization / triage process, ideally based on a written algorithm. The most important issue is to validate that process is based on an evaluation of the patient's presenting complaint and / or clinical condition / need and NOT on time of arrival (first come, first served) or mode of arrival (ambulance versus walk-in). A walk-in patient may well have more emergent needs than the patient who arrived by ambulance.<sup>68</sup>

### **Scoring:**

- If there is: 1. A prioritization / triage process and 2. It is based on actual clinical evaluation<sup>69</sup> 3. By appropriately trained staff 4. Using appropriate facilities and 5. Staff members are aware and 6. Applying the process, then score as **fully met**.
- If there is noncompliance of prioritization/triage process or if it is only on a first come, first served basis, then score as **not met**.

## **GUIDELINES**

### **Triage and Treatment**

Triage and Treatment is a protocol based Clinical Care/Management system, aimed at early and appropriate care and discharge from the ED.

Triage is the process of determining the priority of treatments based on the severity of the condition of patient. This rations patient treatments efficiently when resources are insufficient for all to be treated immediately. Triage may result in determining the order and priority of emergency treatment, emergency transport or the transport destination for the patient.

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<sup>68</sup> Existing standards on emergency management and disaster response should be observed. In keeping with the National Disaster Management Agency and Government of Khyber Pakhtunkhwa hospital requirements for the management of disasters. -The Society of Emergency Physicians Pakistan (SEPP)

<sup>69</sup> Commensurate with the triage process of initial assessment.

Triage may also be used for patients arriving at the ED, or to telephone medical advice systems among others, and cater for medical emergencies, including the pre-hospital setting, disasters and emergency room treatment.

The outcome and grading of the victim is frequently the result of physiological and assessment findings. Some models, such as the START (Simple Triage and Rapid Treatment) model, are committed to memory, and may even be algorithm-based. As triage concepts become more sophisticated, triage guidance is also evolving into both software and hardware decision support products for use by caregivers in both hospitals and the field.

It is imperative to designate a dedicated staff with the responsibility of regular reevaluation and assessment of the patient and the initiation of appropriate clinical care. It shall be ensured that waiting patients know that they have someone looking after them. Currently, the patients experience significant delays with regard to timely access to a medical officer, symptom management, timely decision making and total treatment time. Improving the treatment time in managing the patient by a senior emergency staff with extended skills, at an earlier stage in the ED is an effective strategy in optimizing patient flow.

For the efficient management of patient workload, the following points need to be spelled out by the administration in consultation with Head of the ED:

1. Criteria for identification of "non-emergency cases" presenting to the ED and requiring little or no clinical care and not needing assessment by a consultant at the ED. The criteria should enlist inclusions and exclusions and specified timelines for management.
2. A policy/procedure to sort and manage non-emergency patients.
3. Assessment criteria should include evaluation of vital signs, age, mobility and absence of co-morbidities.

Patients are **TRIAGED** on the **Basis of the Urgency** with which they need medical attention. The Triage Nurse allocates a **Triage Category** to a patient based on the statement and/or the condition of the patient as evaluated by the EMO.<sup>70</sup>

1. Ensure that SOPs regarding Triage and Treatment is well defined and understood by all staff.
2. The SOPs should include management protocols for each category of patient viz. cardiac, road traffic accident and poisoning etc.
3. Ensure clearly defined Roles and Responsibilities.

A suggested triage pattern for patients, presenting to the ED is described in the following lines, however this is not a rigid document and prescribes only a general guideline for HCEs. The aim is to achieve a certain level of performance as a benchmark in terms of the time patients wait to be seen in EDs.

## **1. Triage Categories**

### **i. Immediate Resuscitation**

Patients who need treatment immediately or within two minutes are categorized as having a life-threatening condition. Most of them would have arrived in the ED by ambulance and would probably be suffering from a critical injury or cardiac arrest.

### **ii. Emergency**

Patients who need to be treated within 10 minutes are categorized as having an imminently

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<sup>70</sup> NSW Ministry of Health. (2013). Hospital Triage. Retrieved from [http://www.health.nsw.gov.au/hospitals/going to hospital/triage.asp](http://www.health.nsw.gov.au/hospitals/going%20to%20hospital/triage.asp)

life-threatening condition. This group of patients includes those suffering from a critical illness or are in very severe pain e.g. chest pain, difficulty in breathing and fractures etc.

**iii. Urgent**

This group of patients requires treatment within 30 minutes and is categorized as having a potentially life-threatening condition. These include patients suffering from severe illnesses, bleeding heavily from cuts/wounds, have major fractures, or are dehydrated.

**iv. Semi-Urgent**

People in this group are having a potentially serious condition with less severe symptoms or injuries, such as a foreign body in the eye, sprained ankle, migraine or earache etc. and need to be treated within one hour.

**v. Non-Urgent**

This category includes patients who have a less urgent condition and need to have treatment within two hours. This includes those having minor illnesses or symptoms which may have been present for more than a week such as rashes or minor aches and pains.

**2. Patient-Staff Contact/Introduction**

Staff should reach the patient as soon as he/she enters the ED with words of comfort to break the ice and make him/her feel confident and comfortable. Courtesy and help rendered by the ED staff helps in preventing unpleasant situations. Special care is solicited in the ED with respect to staff behavior and care, therefore certain queries need to be clarified upon the patient's arrival.

**i. Clarify to the patient whether he/she can eat or drink anything**

Sometimes the patient should not eat or drink while waiting to see a doctor because the patient may need to undergo a test or an operative procedure requiring the stomach to be empty.

**ii. Clarify the complaint of pain and assess the requirement of pain relief.**

Triage medical staff/nurse should clearly ask the patient about pain or any discomfort while waiting for the final disposal.

**iii. Medications**

Triage staff should elicit the history of medications from the patient.

**iv. Contact the next of kin as soon as possible.**

Triage staff should explain the condition of the patient to the relatives/friends accompanying the patient. In case the patient is brought to the ED by others, then the triage staff shall contact family, relatives or friends of the patient to let them know that the patient is in Emergency.

**v. Interpreter**

Triage staff should arrange an interpreter for the patient, if necessary.

**Ind 90. Staff members are familiar with the policies and trained on the procedures for care of emergency patients.**

**Survey Process:**

This is surveyed by observation and interview with HCE staff. Participation in Training and orientation

should be documented in terms of content as given in Ind. 83, 84, 85.

**Scoring:**

- If the documentation regarding training of staff on policies is available, staff is aware of relevant policies and practices the same, then score as **fully met.**
- If there is inconsistency/non-compliance in any of the above described requirements, then score as **not met.**

**GUIDELINES**

**Training in Policies and Procedures**

A specialist in emergency medicine is appointed to assume overall responsibility of the A&E services. The specialist shall regularly review the facilities, equipment and training of the staff for services. The CMO should remain in the A&E Department 24/7. A registered nurse who is trained and experienced in the practice of emergency nursing is available at all times to supervise nursing care in the A&E services.

An appropriate number of suitably qualified and experienced staff is in attendance. The hospital shall have a policy in place to mobilize additional personnel to attend to emergency situations.

The hospital maintains an up-to-date roster of specialty doctors who are readily available to render consultation service and necessary assistance.

All medical and nursing staff deployed to the A&E Department shall also receive training on the following courses:

1. Advanced Trauma Life Support (ATLS);
2. Advanced Cardiac Life Support (ACLS);
3. Trauma Nursing Care Course (TNCC);
4. Paediatrics Advanced Life Support (PALS);

**Ind 91. The patients receive care in consonance with the policies.**

**Survey Process:**

This will need to be surveyed by reviewing and interviewing the staff members. The policies should be readily available and understood by staff and embrace ALL the aspects of care being received by patients. There should be evidence of a process whereby the staff is trained regarding the policies and associated procedures.

**Scoring:**

- If there is sufficient evidence that policies are being followed by staff, then score as **fully met.**
- If there is evidence that one or more policies are not being followed, then score as **not met.**

**GUIDELINES**

**SOPs/SMPs for Accident and Emergency (A&E) Department**

The HCE shall evolve a solid and comprehensive policy for its ED, encompassing all the details regarding assessment and treatment protocols to be followed in the department. Cases/patients

requiring immediate attention e.g. victims of road traffic accidents, patients with cardiac complaints, poisoning cases etc., shall be handled according to set HCE policies and procedures. Link this indicator's requirement with that of **Indicator No. 83, 84 and 85** above.

## **Ind 92. Admission or discharge to home or transfer to another organization is documented.**

### **Survey Process:**

Review a sample of at least 10 medical records, files or other documentation (emergency services log book) of patients who were treated in the Emergency Department. Observe the records and determine the discharge process. Review the advice and information provided to the patient or other clinician or treatment facility and determine if it is adequate to ensure support, recovery, ongoing treatment and follow-up that is clinically required.

### **Scoring:**

- If this is 100 percent documented, then score as **fully met**.
- If only 1-2 cases fail to meet this requirement, then score as **partially met**.
- If 3 or more of the cases reviewed do not document this, then score as **not met**.

## **GUIDELINES**

### **Emergency Admission, Discharge and Transfer Policy**

All patients who present an **Emergency Medical Condition** must receive treatment to the extent that their emergency condition is medically "**stabilized**," irrespective of their ability to pay for such treatment, in case of a Private HCE.

**An Emergency Medical Condition** is defined as one that manifests itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbance, and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in the following:

1. Placing the health of the individual (or unborn child) in serious jeopardy.
2. Serious impairment of a bodily function.
3. Serious dysfunction of any bodily function or part.
4. Inadequate time to affect a safe transfer of a pregnant woman to another hospital before delivery or, that the transfer may pose a threat to the health or safety of the woman or unborn child.

**"Stabilization"** means "that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer or discharge of the patient from a facility".

However, once the emergency is over and a patient's condition is stabilized, the patient can be discharged and refused further treatment by private hospitals. If the individual seeks routine medical care or schedules a doctor's appointment for non-emergency medical problems, doctors have a general right to refuse treatment if they have no insurance or any other means of paying for the provided care.

In case of discharge to home, a **Discharge Summary** shall be given to the patient. The patient's treating doctor determines the readiness for discharge during regular reassessments. The same is discussed with the patient and his/her family.

The **Discharge Procedures** are documented to ensure coordination amongst various departments including Accounts so that the discharge papers are complete well within time. For MLC/MLR, the HCE shall ensure that the police are informed.

The HCE hands over the **discharge papers** to the patient/attendant in all cases and a copy is retained. In Leaving Against Medical Advice (LAMA) cases, the declaration of the patient/attendant is to be recorded and signed on a proper format.

The Discharge Summary shall be signed by the treating doctor or a member of his/her team and should contain the following:

1. Patient's name
2. Unique identification number
3. Date of admission and discharge
4. Reasons for admission
5. Significant findings
6. Diagnosis
7. Patient's condition on discharge
8. Investigation results
9. Any procedure performed
10. Medication administered
11. Treatment given
12. Follow up advice and other instructions deemed necessary

(The instructions shall be in a manner that the patient can easily understand)

The HCE should have a documented policy for clients/patients LAMA and those being **Discharged on Request**. The treating doctor should explain the consequences of this action to the patient/attendant. This policy could address the reasons of being LAMA for any possible corrective and/or preventive action by the HCE.

In case of transfer to another facility, details regarding medical history of the patient, investigations/procedures performed, treatment provided, reasons for referral and the name of the HCE to be referred will be recorded in the prescribed referral form. In such cases, SOPs regarding patient transfer (Reproduced below) shall be strictly followed so as to ensure proper care during transportation and handing over of the patient to referred facility takes place.

#### **SOPs for Transfer of Patients:**

Following the decision to refer a patient to another hospital, there should be a written communication containing the reasons of referral with date, time, name of the receiving hospital and a copy of the same should be retained in the medical record of the patient.

If the patient has been transferred at his/her own request, a note to that effect is added in the patient's record. In such cases the name of the receiving hospital would be of the one where the patient desires to go to.

However, if the patient has been transferred by the HCE under care with medical staff, it shall have acknowledgement from the receiving hospital.

## Assessment Scoring Matrix

**Standard 23. COP 2: Emergency services are guided by policies, procedures and applicable laws and regulations.**

Indicator 87-92		Max Score	Weightage (Percentage)	Score Obtained
Ind 87.	Policies and procedures for emergency care are documented.	10	100	
Ind 88.	Policies also address handling of medico-legal cases.	10	100	
Ind 89.	Policies and procedures guide the prioritization of patients for initiation of appropriate care.	10	100	
Ind 90.	Staff members are familiar with the policies and trained on the procedures for care of emergency patients.	10	100	
Ind 91.	The patients receive care in consonance with the policies.	10	100	
Ind 92.	Admission or discharge to home or transfer to another organization is documented.	10	80	
<b>Total</b>		60	-	

## Standard 24. COP-3: Policies and procedures define rational use of blood and blood products.

### Indicators (93-97):

**Ind 93. Documented policies and procedures are used to guide rational use of blood and blood products.**

#### Survey Process:

Review the policies and procedures which should at least cover: i. donor screening, ii. processing of blood, iii. storage of blood, iv. administration of blood, v. use of blood products, vi. identification and analysis of real or suspected transfusion reactions and vii. Disposal of blood and related products. This is a significant patient safety issue.

#### Scoring:

- If there are policies and procedures and they include at least these 7 requirements (relevant to the scope of services available for the hospital's blood service), then score as **fully met**.
- Since blood services are such a critical patient safety issue, if any of the 7 requirements (relevant to the scope of service for the hospital's blood service) are not present, then score as **not met**.

### GUIDELINES

#### SOPs for Rational Use of Blood and Blood Products

The policies should include, at the least:

1. Donor screening
2. Processing and storage of blood
3. Administration of blood
4. Identification and analysis of real or suspected transfusion reactions

All patients requiring transfusion should have access to safe blood/blood products including whole blood, labile blood components and plasma-derived medicinal products appropriate to their clinical needs, provided in time and safely administered. However, over prescription of blood products should be avoided.

WHO recommends safe and rational use of blood to minimize unnecessary and unsafe transfusions and to improve patient outcomes and safety, thus reducing the risk of adverse events including errors, transfusion reactions and transmission of infections.

The policies should include:

1. Prevention, early diagnosis and effective treatment of conditions that could result in the need for transfusion (through health promotion, disease control and screening for early detection).
2. Optimal patient management and rational use of blood/blood products for the treatment of conditions that could not be managed by alternative treatment modalities, including use of pharmaceuticals, good surgical and anaesthetic techniques.
3. Safe clinical transfusion processes.

#### 4. Using blood transfusion only as a life saving measure.

The decision to transfuse blood should be on the basis of estimation of the risk of developing complications of inadequate tissue-oxygenation. Therefore, the decision to transfuse must be based on BOTH the haematologic and the clinical status of the patient. Red blood cell transfusions should not be initiated in response to a hemoglobin determination alone, or to an increase in heart rate and/or respiratory rate, as these may be normal compensatory mechanisms for anemia. Red cell transfusion is rarely indicated when haemoglobin levels are greater than 10 g/dL, and is usually indicated when haemoglobin concentrations are less than 5 g/dL. However, even severely anemic patients who have Hb less than 5 g/dL but are clinically stable, may not require transfusion.

In case of emergencies requiring blood transfusions, efforts should be made to stabilize patients through prompt and appropriate supportive care, including intravenous fluid replacement with crystalloid or colloid solutions and oxygen inhalation without waiting for the blood to become available.

The patient should be clinically re-evaluated immediately prior to blood transfusion to ensure that the transfusion is still required. The patient may have stabilized with supportive measures and may no longer need transfusion. The patient should not be transfused merely because of availability of compatible blood.

Effective transfusion requires a minimum of 2 units of blood for an adult or 20ml whole blood (10-15ml packed cells) per kilogram body weight for a child. Transfusion of one unit in an adult (or equivalent for a child) usually indicates that transfusion was not needed at all.

The post-transfusion haemoglobin level should be checked and compared with the pre-transfusion value to assess the benefit of the transfusion.

Blood transfusion is not a cure for anemia and is a measure to relieve the clinical signs of cardiac or respiratory distress. The underlying cause of anemia still needs to be investigated and treated<sup>71</sup>.

### 1. SOPs for Blood Transfusion

#### i. Blood Screening

WHO recommends protocols for screening all donated blood for five Blood Transmitted Infections namely Hepatitis B and C, HIV, Malaria and Syphilis, and this should be practiced.

#### ii. Processing of Donated Blood

Blood collected in an anticoagulant can be stored and transfused to a patient in an unmodified state. This is known as 'whole blood' transfusion. However, blood may be used more effectively if component therapy is practiced. One unit of donated blood may be divided into components, including red cell concentrates, fresh frozen plasma, cryoprecipitate and platelet concentrates, to meet the needs of more than one patient.

The following elements are essential for safe and effective blood component processing:

- a. Commitment and support by health authorities for sustainable, well-organized, coordinated blood transfusion services, with adequate resources and quality system for all areas.
- b. Centralization of blood processing and testing within major centers to permit economies of scale by maximizing utilization of personnel and equipment and

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<sup>71</sup> General Guidelines for Appropriate Transfusion Practice

enforcing uniform standards.

- c. Effective and timely testing of all donated blood to ensure maximum safety and availability of blood components.
- d. Promotion of appropriate blood component therapy.
- e. Using surplus plasma for the production of plasma-derived medicinal products through fractionation.

## **2. Storage and Collection of Blood from Blood Refrigerator<sup>72</sup>**

- i. Incorrect collection, labelling and storage of blood are the major source of errors leading to transfusion of wrong blood.
- ii. Blood is to be stored only in designated blood refrigerators or blood boxes, and never placed in a ward or domestic refrigerators.
- iii. The blood refrigerator must be secured to prevent unauthorized access and it must be alarmed to the Blood Bank in the event of a malfunction.
- iv. The whole blood units and the packed red cells shall be stored at a constant T° of +4°C (between +2 and +6°C). The duration for whole blood and red cell concentrates varies between 21, 35 and 42 days depending on the composition of the preservative solution.
- v. The Fresh Frozen Plasma (FFP) and the Cryoprecipitate shall be stored at -30°C during two years.
- vi. The platelet concentrates shall be stored between 20 and 24°C during 3 to 5 days, under a constant T° and agitation.
- vii. The mentioned T° must be respected all along the blood or blood products transport.
- viii. Only suitably trained nursing staff are authorized to collect blood and they should ensure that:
  - a. The patient is wearing the correct identity bracelet.
  - b. The patient is still consenting to the transfusion.
  - c. The patient has a patient cannula of the right size.
- ix. The following points apply until such time as electronic blood tracking is fully in place OR when electronic tracking is unavailable (system malfunction, fridge unavailability for instance).
  - a. The staff member collecting blood must bring documentation (drug chart and compatibility form) bearing full patient identification details -name, surname, DoB and hospital number, to the blood refrigerator.
  - b. The person collecting blood must check the patient identification details on the documentation against the unit/s being collected
- x. The blood bag must be matched with the patient's identity and the particulars mentioned on the compatibility card which should also include the blood groups of the patient and the donor.
- xi. Only one unit of blood should be removed at any one time.
- xii. Do not remove blood from the refrigerator if the alarm sounds; (inform the Blood Transfusion Laboratory immediately).
- xiii. The delivery of blood to a ward should be brought to the attention of a senior member of staff to avoid undue delay in starting the transfusion. A unit of blood should not be left

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<sup>72</sup> Blood Transfusion Policy and Procedure V.1.3 Plymouth Community Healthcare CIC

- out of the refrigerator or blood box for more than 30 minutes.
- xiv. Platelet concentrates should be kept at room temperature at all times and should not be placed in a blood refrigerator.
  - xv. FFP should be collected and transfused as soon as possible (or within four hours) after thawing by the Blood Transfusion Laboratory (if not used, return to the issuing Blood bank for disposal).
  - xvi. If there is no blood refrigerator available, blood can only be stored in a blood box with cool packs for a maximum of four hours.

**Figure 16: Storage and Collection of Blood**



### **3. Administration of Blood and Blood Products<sup>73</sup>**

- i. The final identity check must be done next to the patient, by matching the bag of blood or blood product with the patient's identity. It is mandatory for hospital staff to properly identify the patient as per hospital record and match it with the blood bag before starting transfusion. A double entry check system requiring checking and recording one event by two persons involved in transfusion is to be adopted for this purpose.

**Note: No Transfusion without confirming Identity first.**

- ii. ID details must be identical in the:
  - a. Patient's notes
  - b. Blood collection slip
  - c. Drug chart
  - d. ID wristband (Where applicable)
  - e. Compatibility form
  - f. Compatibility label
- ii. Also check that the:
  - a. Unit number matches the Blood bag
  - b. Expiry date matches the Compatibility label
  - c. Blood product matches Compatibility form
- iii. Also check the bag of blood for:
  - a. Integrity of the bag

<sup>73</sup> Blood Transfusion Policy and Procedure V.1.3 Plymouth Community Healthcare CIC

- b. Haemolysis or plasma interface
  - c. Large clots
  - d. Turbidity or discoloration
  - e. Special transfusion requirements being met
- iv. When these checks have been completed, the drug chart should be signed immediately, timed and dated.
  - v. The blood is now ready to be administered.
  - vi. All blood should be administered via an administration set containing a 200-micron filter.
  - vii. No other medication may be added to the blood or administered through the same cannula. The red cell administration set should be changed after two units, and must be changed if blood of a different group is to be transfused, i.e. homologous blood following the transfusion of emergency O Rh D negative blood.
  - viii. If the blood is not set up i.e. transfusion started, within 30 minutes of leaving the refrigerator, it must be considered unsafe. It should be labelled as "**Dangerous to Patient**" and returned to the blood bank for disposal and an Incident Report Form completed. The transfusion must be completed within four hours of blood leaving the refrigerator.
  - ix. If the transfusion cannot start within 30 minutes the unit should be returned to the blood refrigerator before the 30 minutes is exceeded. The unit of red cells must be signed back into the refrigerator on the refrigerator log form (located on top of the refrigerator), giving a clear indication of the date and time returned.
  - x. Transfusion of platelets should be commenced as soon as possible after it is received and in case of any delay in transfusion, platelets should be returned to blood bank. Platelet packs must **not** be refrigerated.
  - xi. If there are any discrepancies found in the checking procedure, the **blood should not be transfused**. The blood bank must be informed and the unit and the blood transfusion compatibility report form returned to the blood bank.
  - xii. Empty bags must be plugged and will be collected from the blood refrigerators by the blood bank staff.

### **Analysis of real or suspected transfusion reactions**

Undesirable reactions may occur as a result of the infusion of blood or blood components. Generally, these reactions tend to be mild and short lived, however, many of the serious adverse events following blood transfusion are unpredictable. All adverse events are significant and should be reported immediately to the Blood Bank and/or Consultant Haematologist/Physician for advice on immediate management and investigation. There are different classifications of transfusion reactions, however classification should be based on the time of onset (Immediate/Acute in which symptoms occur either during or within 24 hours of the transfusion or delayed which is beyond the first 24 hours) and whether the cause is Immune or Non-immune.

### **Essential Documentation**

When the transfusion of blood or blood components becomes necessary, a permanent record of the transfusion of all blood and blood components must be kept in the patient's medical notes in a manner that facilitates straight-forward and accurate review when required e.g. in the event that a transfusion-related adverse occurrence is being investigated, for the purposes of conducting quality improvement audits and blood utilization review, and to support the management of legal risk.

These records must include the following;

1. The medical officer's prescription/instruction for transfusion.
2. Indications for transfusion.
3. Comments on whether the desired effect of the transfusion was achieved.
4. The peel-off compatibility label from the blood component affixed to notes.
5. The date and time each unit was commenced and completed.
6. The identity of the persons responsible for the performing the pre-transfusion checks.
7. Nursing observations recorded during the transfusion - at the start of infusion, 15 minutes later, then hourly and at the complete on of transfusion.
8. Any undesirable effects and their management.
9. Record of 'Informed Consent' for transfusion.
10. The significant risks, benefits and alternatives to transfusion including the patient's right to refuse, should have been discussed.
11. Medication(s) to be administered before or after transfusion clearly and appropriately transcribed in the medicines' order form and medical records.
12. Request forms for transfusion should contain the following information:
  - i. Full Name of Patient, DoB, Age, Gender, Registration Number.
  - ii. Names of the Hospital, medical/surgical ward.
  - iii. Name of the requesting medical officer.
  - iv. Indication for transfusion and haemoglobin level (if available).
  - v. Date and time for intended transfusion.
  - vi. Type and quantity of required blood components.
  - vii. Indicate modifications (irradiated, washed cells etc.).<sup>74</sup>

*Table 14: Transfusion Reaction Report/Incident Report Format*

#### **TRANSFUSION REACTION REPORT**

##### **INSTRUCTIONS:**

1. Pursuant to (Specify R&R) Blood Banks must report haemolytic and/or delayed haemolytic and other known or suspected life-threatening transfusion reactions within 10 days of occurrence using this form; and must report and/or suspected fatal transfusion reactions by telephone call to \_\_\_\_\_ by the next working day after the day the event occurs, with written follow-up within 10 days of the occurrence using this form.
2. Forward the original copy of the report to the address listed above; retain a copy for your records.
3. If there are any questions, contact the Blood Bank Unit at \_\_\_\_\_
4. Briefly summarize the events leading to the reaction below. Attach copies of the transfusion reaction work-up performed.
5. Describe corrective action(s) taken to prevent adverse event from recurring.

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<sup>74</sup> Guidelines by National Blood Transfusion Service of the Ministry of Health Jamaica, 2011.

Name of Blood Bank		Telephone Number
Date of Transfusion	Time of Transfusion	Day, Date and Time of Reaction
Amount of Blood Transfused	Patient ABO Group	Donor ABO Group
Location of Patient at Time of Reaction		
Patient Name	Patient Age	Diagnosis
Type of Reaction <input type="checkbox"/> Fatal <input type="checkbox"/> Non-Fatal <input type="checkbox"/> Haemolytic <input type="checkbox"/> Anaphylactic <input type="checkbox"/> Delayed Haemolytic a. Amount of time after transfusion _____ b. Specify antibody, if applicable _____ <input type="checkbox"/> Bacterial (List Organism) _____		
Describe the events leading to the reaction and corrective action taken (if more space is needed attach additional sheets)		
Date Reported	Name of Blood Bank Director	Signature of Blood Bank Director

**Ind 94. The transfusion services are governed by the applicable laws and regulations.**

**Survey Process:**

The surveyors will need to be aware of the applicable laws and regulations on blood transfusion.<sup>75</sup> This

<sup>75</sup> See the Khyber Pakhtunkhwa Blood Transfusion Safety Authority Act, 2016 and its standards.

is surveyed by reviewing documentation (such as an external official inspection, copies of the legislation and compliance requirements), interviews, and observation. This includes an observable mechanism to ensure that only blood and blood products derived employing recognized Indicators is provided to patients. This is a significant patient safety issue.

**Scoring:**

- If the laws and regulations are present and being employed by all staff, then score as **fully met.**
- Considering the critical nature and risk with blood services, if there are any examples of non-compliance that compromise the safety of patients, then score as **not met.**

## GUIDELINES

### Compliance to Statutes

The Khyber Pakhtunkhwa Blood Transfusion of Safety Authority Act was promulgated in 2016 and the Khyber Pakhtunkhwa Government constituted the Khyber Pakhtunkhwa Blood Transfusion Authority (KPBT) under the Act. The Act says, the Authority shall “prescribe minimum standards and specifications for registration and licensing of the Blood Banks or Regional Blood Centre,” and “register and issue licences to Blood Banks or Regional Blood Centre in private sector on payment of such fee and in manner as may be prescribed.”

The KPBT shall ensure the implementation of the approved laws, to ensure high quality services and availability of adequate safe blood and blood products, through monitoring of the blood banks according to the mandate given to the Authority under the Law/Rules.

## Ind 95. Informed consent is obtained for donation and transfusion of blood and blood products.

**Survey Process:**

While reviewing, identify the medical records of those patients<sup>76</sup> who have received blood. Then review the medical records of these patients to determine if there is documented 'informed consent' and if the consent adequately informs the patient. If the hospital processes donors, also review a representative sample of patient's record to determine if the donor gave informed consent and this was appropriate for the individuals concerned. It is important to note that evidence of informed consent can be either a signed form or a note by the physician that the patient's verbal consent was obtained. Informed consent must be designed to ensure that people of all backgrounds truly understand the risks and options involved and the evidence provided must clearly support this. This includes information and education of the patient and their family, when present.

**Scoring:**

- If informed consent is obtained for 100 percent of cases, then score as **fully met.**<sup>77</sup>
- Since this is a significant medico-legal issue, if any case does not have a documented informed consent, then score as **not met.**

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<sup>76</sup> Surveyors should decide the representative sample size according to work load/size of the hospital.

<sup>77</sup> There are exceptions when the recipient is an emergency unconscious patient without family or guardians present at the time.

## GUIDELINES

### **Informed Consent for Donation and Transfusion**

It is important to note that evidence of informed consent can be either a signed form or a note by the physician that the patient's verbal consent was obtained in emergency which should be documented later.

Informed consent for transfusion includes two main processes:

1. The medical officer communicates with the patient or guardian in terms they clearly understand about the transfusion of blood or blood components, necessity in the particular circumstance, probable complications, possible medical consequence of refusal, and available alternatives.
2. The patient or guardian after expressing satisfaction with the information provided, asks pertinent questions with regards to the process, and agrees or not (in writing) to be transfused.

In life-threatening emergencies when uncross-matched blood may be necessary or in the absence of serologically compatible components, signed consent for their use must be obtained from the attending medical officer.

Informed consent will have to be incorporated in the donor history card accordingly. A Sample Format for Informed Consent is given below.

*Table 15: Sample Format of Informed Consent*

<b>CONSENT FORM FOR BLOOD OR BLOOD COMPONENT TRANSFUSION</b>	
Date: _____	
Patient's Name: _____	
Age: _____	
Identity Card No.: _____	
Sex: Male/Female* _____	
Address: _____	
Attending Medical Practitioner: Dr. _____	
Identity Card No./PMDC Reg. No.: _____	
I, the parent/guardian/spouse/next-of-kin of the above-named*, have been informed of the need for a blood transfusion for the patient. The attending medical practitioner has explained to me the risks and benefits involved in the transfusion as well as answered all my inquiries satisfactorily. I understand that despite testing and screening on the blood/blood components for HIV, hepatitis B, hepatitis C and syphilis, there are still risks of developing the disease. I also understand that unavoidable complications of transfusion may also occur.	
I fully understand the above and hereby agree to the blood/blood component transfusion.	
_____ Signature of the patient/ parent/guardian/spouse/next-of-kin* Thumb Impression	_____ Signature of Attending Medical Practitioner
Name of parent/guardian/spouse/next-of-kin** _____	
Identity Card No. of the above: _____	
I was present while the above matter was explained to the patient/parent/guardian/spouse/	

next-of-kin\* whose signature appears above. In my opinion, the person referred to has understood the contents of this form and agreed to the transfusion willingly.

\_\_\_\_\_  
Signature and thumb  
Impression of Witness

Name of Witness: \_\_\_\_\_

Identity Card No.: \_\_\_\_\_

\* Delete appropriately

\*\* If necessary

## Ind 96. Staff members are trained to implement the policies.

### Survey Process:

While visiting the blood bank, ask for the policy and procedure manual in the work area. Look for compliance with the documented policies and procedures and discuss with staff. Review the staff training records.

### Scoring:

- If the policies and procedures are present in the blood bank and staff has been trained to apply them, then score as **fully met**.
- If the policy and procedure manual is not available and there are critical gaps in either knowledge or practice, then score as **not met**.

## GUIDELINES

### Training for Implementation of Policies<sup>78</sup>

The hospital shall generally assume vicarious liability for the acts of its staff, including those on honorary contract. However, it is incumbent on staff to ensure that they:

1. Have undergone any suitable training identified as necessary under the terms of hospital policy or otherwise.
2. Have been fully authorized by their line manager and their Directorate to undertake the activity.
3. Fully comply with the terms of any relevant hospital policies and/or procedures at all times.
4. Only depart from any relevant hospital guidelines providing always that such departure is confined to the specific needs of individual circumstances. In healthcare delivery such departure shall only be undertaken where, in the judgment of the responsible clinician, it is fully appropriate and justifiable. Such a decision is to be fully recorded in the patient's notes.

<sup>78</sup> National Policy and Guidelines on Safe Blood Transfusion.

## Ind 97. Transfusion reactions are analysed for preventive and corrective actions.

### Survey Process:

Ask for documentation that reports transfusion reactions. Evaluate whether the documentation demonstrates adequate analysis and remedial actions. In the case where no reactions are reported as occurring,<sup>79</sup> the surveyors should evaluate whether there are adequate clearly written procedures for analysis and remedial action if a reaction does occur. Check that staff members are aware of the reporting process.

### Scoring:

- If there had been a transfusion reaction and it was fully analyzed and remedial action proposed or if there are written procedures to follow if one occurs, then score as **fully met**.
- If there had been a transfusion reaction and there is no documented evidence of how it was analyzed, or if there had been no transfusion reaction and the blood bank also does not have any written procedure for analysis, then score as **not met**.

## GUIDELINES

### Transfusion Reaction Analysis

Corrective and preventive actions<sup>80</sup> are part of the QA process. Recognized principles of quality management include a component for process improvement, comprising largely of corrective and preventive actions taken in response to identified problems. The importance of identifying and investigating problems has been clearly established in transfusion medicine. Such problems can be identified in the following ways: error, incident, and accident reports; adverse reaction reports; customer complaints; process indicator measurements; results of proficiency testing; and results of internal or external audits, inspections, or assessments. Responses to reported events can be remedial, in which the symptom is addressed, or corrective, in which the underlying cause is addressed with the intent to prevent recurrence. If identified problems or their root causes are trended to look for patterns or problems not yet occurring but are anticipated, the action taken is proactive and considered preventive.

#### 1. Corrective Action

Procedures for corrective action shall include an investigative process to determine the underlying cause or causes of the problem. Laboratory management shall record and monitor the results of any corrective action taken, in order to ensure that they have been effective in overcoming the identified problems.

#### 2. Preventive Action

The laboratory shall have procedures for preventive actions that allow for identifying needed improvements and potential sources of nonconformities, either technical or concerning the

<sup>79</sup> This would be highly unlikely.

<sup>80</sup> Moore, S.B, Motschman, T.L. (1999). Corrective and preventive action. Department of Laboratory Medicine and Pathology, Mayo Foundation, Rochester, MN 55905, USA and Quality in Biomedical Laboratories Second Edition Canada.

quality management system. If preventive action is required, action plans shall be developed, implemented, and monitored to reduce the likelihood of the occurrence of such nonconformities. The preventive action shall be recorded.

The transfusion service should complete and send out a preliminary report of the reaction as soon as possible after receiving the specimens. A full report shall be dispatched after completion of serological and/or bacteriological investigation, and will include advice for further transfusion therapy. The report must be inserted into the patient's file.

A Sample Form for Corrective and Preventive Action is given ahead.

*Table 16: Sample Form for Corrective and Preventive Action*

Institution Name	Document	Version	Number
TITLE	Managing Corrective and Preventive Action		
<b>1. Description</b>			
a) Corrective Action    b) Preventive Action			
Description of the problem:			
Problem Causes:			
Person In charge/Date:			
<b>2. Suggested Action</b>			
1 <sup>st</sup> action:			
Person In charge/Date:			
Effective    a) Yes    b) No    c) Go on to next action			
Person In charge/Date:			
2 <sup>nd</sup> action:			
Person In charge/Date:			
<b>3. Closing the file</b>			
Long-term effectiveness:    a) Yes    b) No			
Person In charge/Date: _____			
Comment: _____			
Closed by: _____ Date: _____			

## **Hospital Transfusion Committees: *Their Role in Haemovigilance***<sup>81</sup>

Hospital Transfusion Committees (HTCs) are multidisciplinary teams created to oversee and promote best transfusion practices within healthcare institutions. HTCs act through a peer-reviewed process aimed at improving safety, enhancing education, developing policies and monitoring appropriateness of blood component use. They are also responsible for disseminating local transfusion protocols according to published guidelines.

### **Structure and Membership**

HTCs are recognized worldwide as multidisciplinary, hospital-wide groups established with the purpose of integrating all institutional components involved in the blood transfusion process. Their members should include:

1. Representatives of the medical and surgical staff.
2. A transfusion medicine specialist, usually the director of the blood transfusion service.
3. Representatives of the nursing staff, of the clinical governance and/or quality staff, of pharmacy and of the Biomedical Engineering Department.
4. Representatives of blood donor associations.
5. Clerical staff.

### **Functions of HTCs**

1. Control of the utilization of blood and blood products.
2. Monitoring of transfusion requests.
3. Traceability of all transfusion activities.
4. Reporting of adverse effects.

The HTC should work through a continuous, ongoing, monitored peer-review process, aimed at quality assessment and performance improvement of blood transfusion activities within a specific institution. The HTC process can be described in a circular way, as follows:

#### **Hospital Transfusion Committee Process**

→ Problem (target area) identification → Documentation → Improvement through corrective actions (i.e. to establish adequate policies and procedures) → Regular monitoring of the effectiveness of actions → Implementation of preventive actions → New problem (target area) identification → .....

This dynamic process should be managed through a number of actions in those areas of blood transfusion which require continuous quality assessment and performance improvement. Many of these actions tend to overlap within the general frames of policy setting, practice monitoring and education and communication.

1. Key HTC activities mainly related to safety and hemovigilance (Risk Management)
  - i. Investigation, documentation and reporting of adverse events and incidents.
  - ii. Investigation of errors and sentinel events (such as acute hemolytic transfusion reactions).
  - iii. Audits concerning errors and near miss events.

<sup>81</sup> Ref: d'Onofrio G.(1), Bianchi M.(1), Cambieri A.(1), Fiore A.(1), Pupella S.(2), Grazzini G.(2)(1) Servizio di Emotrasfusione, Catholic University, Rome, Italy; (2) Italian National Blood Centre, National Institute of Health, Rome, ItalyLE07.Hospital transfusion committees: their role in haemovigilance. Doi 10.2450/2009.00129.

- iv. Implementation, documentation and monitoring of corrective actions.
  - v. Identification and intervention on problem-prone areas: i.e. patient identification, blood assignment and administration, blood component contamination, prevention of adverse events.
  - vi. Development, dissemination and review of transfusion policies on prevention.
  - vii. Review and corrections of existing procedures.
2. Key HTC activities mainly related to quality/appropriateness/effectiveness
- i. Integration with Medical and Surgical Departments and with clinical governance bodies.
  - ii. Analysis of quality indicators.
  - iii. Audits of the transfusion process.
  - iv. Development, dissemination and review of transfusion policies on appropriateness.
  - v. Monitoring of blood component use, wastage, discards.
  - vi. Reduction, when suitable, of unnecessary homologous blood use.
  - vii. Monitoring of the use of the correct blood component (i.e. irradiated and/or leucodepleted platelets or red cells in specific types of patients).
  - viii. Alternatives to blood transfusion (blood conservation, autologous transfusion).
3. Other HTC key activities and characteristics
- i. Open forum to promote proactive culture.
  - ii. Dissemination of information.
  - iii. Education, learning, especially toward specific targets (nurses, interns etc.).
  - iv. Feedback and monitoring compliance.
  - v. Promotion of blood donations and enhancing new donation methods.
  - vi. Evaluation and implementation of new transfusion technologies (such as blood component inactivation, blood contamination prevention, implementation of bedside check systems etc.).
  - vii. Keeping records and minutes, and follow-up of HTC meetings.
  - viii. Promotion of transfusion-related research.

### **Development of Institutional Policies and Procedures**

One of the main functions of HTCs is the development of shared policies within specific areas which need to be monitored. In particular, the HTCs should establish a criteria and guidelines for the definition and application of institutional practices in the area of blood transfusion, as well as identify and monitor indicators of the quality and compliance to recommendations and indicators of effectiveness of the HTC activities.

Specific aspects, for which policies and procedures are required, are currently related mainly to safety and appropriateness, such as:

1. Consent for transfusion.
2. Refusal to receive transfusions.
3. Ordering practice and documentation (modules, content of forms etc.).
4. STAT versus non -STAT blood component orders.
5. Surgical blood order schedules (such as MSBOS).
6. Pre-transfusion testing (decision between type and screen versus type and cross-match).
7. Medical indications for the transfusion of red cells, platelets, plasma and other blood

components.

8. Use of multi-component versus pooled or single unit platelet transfusions.
9. Patient identification issues, at the moment of specimen collection, labelling and blood component administration.
10. Decision between universal or targeted leucodepletion.
11. Review programmes for blood usage, wastage and discard.
12. Procedures for documentation of blood component administration.
13. Procedures for treatment and reporting of adverse reactions (both infectious and non-infectious).
14. Management of massive blood transfusions.
15. Integrated plans for the management of blood shortages.
16. Response to external disasters (institution policy).
17. Integration with Hospital Risk Management policy.

## Assessment Scoring Matrix

**Standard 24. COP 3: Policies and procedures define rational use of blood and blood products.**

Indicator 93-97		Max Score	Weightage (Percentage)	Score Obtained
Ind 93.	Documented policies and procedures are used to guide rational use of blood and blood products.	10	<b>100</b>	
Ind 94.	The transfusion services are governed by the applicable laws and regulations.	10	<b>100</b>	
Ind 95.	Informed consent is obtained for donation and transfusion of blood and blood products.	10	<b>100</b>	
Ind 96.	Staff members are trained to implement the policies.	10	<b>100</b>	
Ind 97.	Transfusion reactions are analyzed for preventive and corrective actions.	10	<b>100</b>	
<b>Total</b>		50	-	

## Standard 25. COP-4: Policies and procedures guide the care of high risk obstetrical patients.

### Indicators (98-105):

**Ind 98. The hospital defines and displays whether high-risk obstetric cases and their neonates can be cared for or not.**

#### Survey Process:

Since many patients will not know if they are high risk or not, it is important that the hospital informs its obstetrical patients about the definition of high risk and its capability/competence (Link with Ind. 90) to provide services for such cases and their neonates. The second important issue is that the hospital has informed those practitioners and health facilities that might refer such patients, about the hospital's capability to provide care to high-risk obstetric cases.

There must be documentation of this information (such as letters to referring doctors and facilities plus information available and provided to its own obstetric patients regarding facilities and availability of competent doctors/staff<sup>82</sup>).<sup>83</sup>

#### Scoring:

- If the hospital has informed its own obstetric patients and its referring practitioners and other health facilities of its capability to care for high-risk obstetric cases, then score as **fully met**.
- If the hospital has informed its own patients, but not the referring healthcare providers or facilities, then score as **partially met**.
- If the hospital has neither informed its own patients nor referring healthcare providers and the health facilities, then score as **not met**.

### GUIDELINES

#### High Risk Obstetrical Cases

A high-risk pregnancy is one in which some condition puts the mother, the developing foetus, or both, at a higher risk than normal for complications during or after the pregnancy and birth. At a HCE, high-risk pregnancies may present with any of the following conditions:

1. Haemorrhage
2. Prolonged or obstructed labour
3. Postpartum sepsis
4. Complications of abortion
5. Pre-Eclampsia or Eclampsia
6. Ectopic pregnancy

<sup>82</sup> Availability of 24 hours/day, 7 days/week coverage by the staff who are fully qualified in obstetrics and who have advanced training in high-risk obstetrics and documented experience. In addition, there should be evidence that members of the nursing staff who care for such patients have advanced qualifications and documented experience.

<sup>83</sup> Dissemination of information contrary to required availability of services is equally important.

7. Ruptured uterus
8. Foetal Distress/Newborn Distress (intrapartum)
9. Pregnancy with medical disorders
10. Malpresentation
11. Twin pregnancy
12. Pregnancy with scarred uterus

Women visiting the HCE with a high-risk pregnancy (not necessarily limited to above conditions only) will need closer monitoring than the average pregnant woman and availability of Comprehensive Emergency Obstetric Care (C-EmOC) Services 24/7 is mandatory to save the mother's life. Signal functions<sup>84</sup> used to identify C-EmOC Services include:

1. Administer parenteral antibiotics.
2. Administer uterotonic drugs (i.e. Parenteral Oxytocin).
3. Administer parenteral anticonvulsants for preeclampsia and Eclampsia (i.e. Magnesium sulfate).
4. Manually remove the placenta.
5. Remove retained products (e.g. Manual vacuum extraction, dilatation and curettage)
6. Perform assisted vaginal delivery (e.g. Vacuum extraction, forceps delivery)
7. Perform basic neonatal resuscitation (e.g. with bag and mask).
8. Perform surgery (e.g. Caesarean section [C-Section]).
9. Perform blood transfusion

**Note: As per WHO definition, Sr. No. 1-6 constitute Basic EmOC Services, Sr. No. 1-7 constitute Basic EmONC [Emergency Obstetric and Neonatal Care] Services and Sr. No. 1-9 constitute Comprehensive EmONC Services.**

Although the eight original obstetric signal functions do not form an exhaustive list, they were chosen because of the role they play in the treatment of the five major causes of maternal death. International standards of care will be used to determine in practice which drugs and types of equipment are used to perform the signal functions. These standards are dynamic and can change over long periods with technological progress. Most of the signal functions are likely to be performed only in an obstetric context, but parenteral antibiotics or anticonvulsants and blood transfusions can be administered in other contexts.

In an assessment of the HCE's capacity and performance for delivering EmOC, the signal functions should have been performed in an obstetric context. In an emergency, there must be a quick physiological response to antibiotics when needed. In addition, the key life-saving drugs for main complications can only be administered parenterally. Therefore, the EmOC specifies parenteral rather than oral administration.

Use of the partograph and active management of the third stage of labour (AMTSL) are both part of good obstetric practice and should be used for all women in labour to prevent prolonged, obstructed labour and its sequelae, such as obstetric fistula. Anaesthesia and plasma expanders are also implicit in the availability of obstetric surgery, e.g. C-Section.

The HCE should establish policies and procedures for handling emergencies, resuscitation and

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<sup>84</sup> WHO. (2003). Managing complications in pregnancy and childbirth: a guide for midwives and doctors. Retrieved from [http://www.who.int/making\\_pregnancy\\_safer/documents/9241545879/en/index.html](http://www.who.int/making_pregnancy_safer/documents/9241545879/en/index.html)

referral procedures. Written procedures and guidelines, consistent with the facility policies and functions, should be used for:

1. Antenatal care and booking/registration
2. Postnatal care
3. Perinatal care
4. Counselling for parenthood e.g. Family planning, genetic, referral and IEC material
5. Identifying high risk pregnancy
6. Admission to labor room/ward
7. Planning treatment and mode of delivery
8. Plan for managed pain during labor and delivery
9. Delivery monitoring process
10. Referral
11. Discharge, including discharge summary
12. Birth record and certificate
13. Labor register
14. Immunization for mother and baby
15. Infection control
16. Disposal of placentas

#### **Identifying high risk pregnancy**

1. Routine antenatal care of all pregnant patients includes identification and management of high-risk pregnancies.
2. The attending HCP must inform the patient about the high-risk nature of the pregnancy and counsel the patient on adopting appropriate measures of care.
  - i. In addition to routine examinations, special radiological or blood examinations should be conducted in high-risk pregnancies, if indicated.
  - ii. The patient and the caregiver must be appraised about the imminent risks and educated on how to minimize the risk, including when to seek emergency care.
  - iii. If the facilities (human and material resources) available in the hospital are considered insufficient, referral of the patient must be made at the earliest to the nearest competent health facility.

The delivery room is to be equipped with functioning, safe and well-maintained sterilized instruments specific for deliveries including, but not restricted to, the following:

1. Fetoscope
2. Ultrasound machine
3. Delivery table which can be turned to the Trendelenburg position
4. An anaesthesia machine with emergency oxygen supplies
5. Endotracheal tubes and laryngoscope
6. An incubator, with temperature adjustable for infants in need.
7. Separate oxygen supply to the incubator
8. Resuscitation equipment and drugs for newborns and adults
9. Intravenous crystalloid and plasma expanders
10. Weighing machine for the baby
11. A suction apparatus
12. Cardiotocography (CTG) machine

**Figure 17: Incubator**



**The HCE should ensure that:**

1. A separate room for seriously ill or intensive patients e.g. Eclampsia, is available.
2. The area for labour provides space for the woman and a female companion, alternative birthing methods, ambulation throughout labour, washing and toilet facilities for the comfort of the mother and companion.
3. Lighting is versatile enough to provide a restful environment and allow birthing procedures to be performed.
4. The post-natal ward provides sufficient room for the babies to room-in with mothers.
5. Privacy for mothers e.g. when breast-feeding.
6. There should be an established laboratory with all relevant tests available, a blood bank facility which ensures availability of all rare blood groups, FFP and platelets.
7. Intensive care set up should be available, with multidisciplinary team support for critical cases.
8. Disposal of placentas as well as other waste material should be ensured according to SOPs.
9. NICU facility should be available with support staff; if not, then proper referral procedure especially for premature and sick babies should exist.
10. A signed agreement and close professional links with a referral hospital (Providing Specialized Care) offering more comprehensive services, ensures provision of necessary emergency maternity services not available in the hospital.

**Ind 99. Persons caring for high-risk obstetric cases are competent and specialized care is available round the clock.**

**Survey Process:**

Surveyors should look for the availability of round the clock specialized care<sup>85</sup> (24 hours/day, 7

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<sup>85</sup> This is the absolute minimum to provide 24hrs, 7 days per week service based on 3 shifts per day and 270 productive workdays per employee per year.

days/week coverage) by the staff who are fully qualified in obstetrics and who have advanced training in high-risk obstetrics and documented experience. In addition, there should be evidence that members of the nursing staff who care for such patients have advanced qualifications and documented experience.

Qualification of HOD/Head of Clinical Unit include:

1. MBBS qualified physician with FCPS Obstetrics and Gynaecology/MRCOG/ American Board Certification in Obstetrics and Gynaecology or any other equivalent degree, or
2. MBBS qualified physician with MCPS and 2 years post-qualification experience, or
3. MBBS qualified physician with Diploma in Obstetrics and Gynaecology and 2 years post-qualification experience.

### Scoring:

- If the head of unit is specialist of Obstetrics and Gynaecology as per PMDC registration certificate and round the clock specialist care is available, then score as **fully met.**
- If the head of unit is not a specialist of Obstetrics and Gynaecology as per PMDC registration certificate and/or round the clock specialist care is available, then score as **not met.**

## GUIDELINES

### Professional Competence

Head of Department (HOD)/Head of Clinical Unit will be required to provide clinical care to patients and oversee clinical and administrative functioning of the Maternity Department. Responsibilities should be as recommended by PMDC/PMC, however a general description of his/her assignment is given below:

The HOD/Head of Clinical Unit will be responsible for the management of human and material resources and the implementation of existing hospital policies for provision of quality services to patients and their attendants.

1. Candidates considered eligible for the post of HOD/Head of Clinical Unit include:
  - i. MBBS qualified physician with FCPS Obstetrics and Gynaecology/MRCOG/ American Board Certification in Obstetrics and Gynaecology or any other equivalent degree, or
  - ii. MBBS qualified physician with MCPS and 2 years post-qualification experience, or
  - iii. MBBS qualified physician with Diploma in Obstetrics and Gynaecology and 2 years post-qualification experience.
2. Formal assignment to the position will include verification of:
  - i. Certification of the concerned candidate.
  - ii. Registration with PMDC.
  - iii. Formal complaints/malpractice cases registered with the previous employer or with PMDC concerning the candidate.
3. Following induction to the post, the HOD/Head of Clinical Unit must be provided with and explained the hospital policies regarding patient care, quality of care and HR management.
4. The job summary of the HOD/Head of Clinical Unit includes being responsible for a high standard of gynaecological work in the hospital.
5. The scope of work of the HOD/Head of Clinical Unit includes being in-charge of the Department of Gynaecology, and personally ensuring the smooth functioning of the department, through

staff and colleagues. This includes conducting Antenatal Clinics, Gynaecological OPD, admission of patients requiring surgical intervention, conduct planned, emergency surgeries (on specific/notified days or as per need), postoperative care of patients in the ward, follow up of surgeries in OPD as per need, teaching by lectures/tutorials in the ward and bedside coaching of medical and nursing staff.

6. Duties/Responsibilities of the HOD/Head of Clinical Unit include:

**i. Administrative**

- a. The HOD/Head of Clinical Unit is the Administrative and Technical in-charge of the Department of Gynaecology.
- b. She/he has to remain available during working hours for routine/emergency cases and teaching.
- c. She/he is second on-call after working hours.
- d. She/he ensures attendance of subordinate staff through the Registrar.
- e. She/he checks punctuality of the staff attached to her/his section.
- f. She/he checks cleanliness and up keep of the Gynaecological/Obstetric ward.
- g. She/he ensures regular upkeep and maintenance of departmental electro-medical equipment to ensure their functionality at all times.
- h. She/he ensures that responsible staff is regular in maintaining supply/replenishment of medicines and stores.
- i. She/he guides the Management for purchase of new equipment/instruments needed from time to time for OPD, Wards and OT.
- j. She/he checks and controls subordinate staff to ensure their performance as per Job Description (JDs), SOPs and SMPs.
- k. She/he allocates duties to other specialists/doctors from within the defined framework of particular JDs.

**ii. Preventive**

**a. Antenatal Care**

- She/he thoroughly examines pregnant women, whether referred or reporting directly, and advises on all aspects of pregnancy, Tetanus Toxoid immunization, any abnormality (if detected) and discusses arrangements for the conduct of delivery.
- She/he will conduct surprise visits to check validity of reports and on ground performance of MCH staff.
- She/he shall be involved in designing capacity building program for the staff at BHUs and RHCs, including periodic visits by the qualified staff to facilitate antenatal services in peripheral settings.

**b. Care during delivery**

She/he examines and identifies pregnant women with abnormalities (in particular) and conducts the delivery her/himself at the health facility. The number of deliveries performed at the health facility is an indicator of her/his performance.

**c. Postnatal Care**

- She/he arranges post-natal examination of all mothers, particularly those with intra-partum and/or postnatal complications, either her/himself or by out-reach MCH staff.
- She/he advises mothers on family planning and child spacing during these visits.

**d. Care of Infant**

She/he ensures resuscitation of the new born, care of the cord and examines for abnormalities (if any).

**e. Family Planning**

- She/he performs invasive Family Planning (FP) procedures at the health facility.
- She/he practices prevention of STIs and RTIs.
- She/he advises ladies/couples on how to safe guard themselves from STIs and RTIs.

**f. Major Micronutrient Deficiencies**

She/he persuades the use of and prescribes micronutrients.

**g. Health Promotion**

- During antenatal and postnatal sessions and while attending patients for treatment of diseases in general, the Gynaecologist will disseminate information on nutrition and other health issues, particularly related to MCH.
- She/he will participate in the establishment and conduct of Medical Camps pertaining to MCH and FP activities.
- She/he will ensure compliance of SOPs, especially Infection Control (IC) and Waste Management (WM) in the OPD, Wards, Operation Theatres, Pre and Postoperative Wards.
- She/he will ensure that instruments/equipment used in surgeries are properly sterilized.
- She/he will ensure that all staff participating in surgery/procedures are physically well protected by wearing assigned protective gear i.e. Gowns, Masks, Caps, Gloves and theatre shoes.

**h. Curative/Clinical**

- She/he will be in-charge of the functioning of Antenatal/ Gynaecological OPD, admitted patients of the Gynaecological/Obstetric Wards and Gynaecological/Obstetrical patients admitted in private rooms.
- She/he will conduct Antenatal/Gynaecological OPD with her his team regularly on specified/notified days and time as per hospital policy.
- She/he will attend all Gynaecological patients screened by the departmental doctors and referred by other departments/hospitals before they are admitted through OPD.
- She/he will plan and perform surgeries on specified days and time as per hospital policy.
- She/he will conduct complicated deliveries her/himself.
- She/he will perform emergency Gynaecological/Obstetrical Surgeries on patients admitted through the A&E Department, as and when required.
- She/he will write postoperative notes and postoperative instructions for each admitted patient.
- She/he will take **one planned round** of the wards **daily** along with all departmental doctors for the review/follow-up of old cases and examination (in detail) of newly admitted patients. The clinical round is to be repeated (with or without MO in-

charge of the ward), if so required due to patient condition.

- She/he will ensure that treatment prescribed is being administered to the patients.
- She/he will ensure availability of medicines/functioning equipment for emergencies at all times.
- She/he will attend to patients with Gynaecological problems admitted in other wards as and when required.

**h. Rehabilitative**

She/he will recommend physiotherapy and other rehabilitative measures to women in the post-natal period for early return to normal life.

**i. Referrals**

- She/he will provide consultation to patients referred by MOs/Specialists from Primary or Secondary Health Care facilities, or the same facility.
- She/he will refer clients to appropriate specialist/services within and outside the hospital.

**j. Teaching**

She/he will teach and train WMOs, LHVs, LHWs, Midwives, Nursing and Paramedical Staff as per departmental/specialty requirements/protocols and SOPs as per routine and under special arrangements.

**k. Research**

She/he will write a Research Article based on local experiences every year.

**l. Supervisory**

- She/he will supervise and control functioning of Registrar/Woman Medical Officers of the department.
- She/he will supervise Technical functioning of Paramedical staff of the department.

**m. Representation**

- She/he will inform the Medical Superintendent (MS) about matter/s which need her/his attention.
- She/he will report and returns statistics of the department to the MS.

**n. Medico-Legal**

She/he will follow established and approved SOPs on the subject.

**o. Quality Control/Conformance to Standards**

She/he will comply with standards of service delivery as provided in the MSDS SOPs especially on IC and WM and SMPs.

**p. Performance Evaluation**

- She/he will conduct an evaluation based on achievements against set targets.
- She/he will write Objective Performance Evaluation Reports of subordinate staff.
- She/he will perform any other professional duty which may be assigned by the MS from time to time.

**Continued Medical Education (CME) programme for Staff**

Continuous training of staff involved in the provision of healthcare services is essential to ensure familiarity with treatment protocols, uniformity of care, adoption of scientific advances in healthcare and provision of good quality of healthcare services.

1. Planning for the training of staff is the responsibility of the HOD/Head of Unit, who will develop

a training plan for all members of staff posted in the department. These training plans must be shared on a two-monthly basis with the MS.

2. Developed training plans must consider:
  - i. Required level of skills training for different cadres of staff.
  - ii. Which members of staff should undergo training.
  - iii. Type of training e.g. initial/refresher.
  - iv. Purpose of training e.g. skill development, introduction to an existing standard protocol, development of a new protocol, or procurement of new equipment.
3. All personnel attached with the Maternity Department and involved in the provision of healthcare services must undergo continuous trainings in Maternal, Neonatal and Child Health (MNCH). These trainings should include, but not be restricted, to
  - i. EmONC,
  - ii. Emergency Neonatal Care (ENC),
  - iii. Integrated Management of Neonatal and Childhood Illnesses (IMNCI),
  - iv. Integrated management of Pregnancy and Childbirth (IMPAC),
  - v. FP Surgical and Counselling
  - vi. Client Centeredness
  - vii. Basic Life Support (BLS)
  - viii. Advanced Cardiac Life Support (ACLS)
  - ix. General First Aid
  - x. Correct and appropriate use of biomedical equipment
4. Specialists (Gynaecologists, Paediatricians and Anaesthetists) and Auxiliary staff (including Technicians) posted to the Maternity and Surgical Departments should be assigned the task of conducting ongoing trainings of staff.
  - i. Workload of trainings should be divided equally among all Specialist and Auxiliary staff by conducting trainings on rotation basis.
  - ii. Standardized Training Manuals available with NMNCHP, WHO and the European Resuscitation Guidelines should be acquired and used to conduct these trainings.
5. Individual HCPs, including medical staff, midwives and nurses must be trained in each of the preceding training areas at least once in two years.
  - i. Newly assigned Staff to the Maternity Department should be provided these trainings at the time of induction into service.
  - ii. Attendance of nominated persons for the full duration of the course must be noted.
  - iii. Only that staff who has attended the entire course should be considered "fully- trained" and accordingly be certified by Trainers.
6. A record of trainings attended by each member of staff should be maintained in the Maternity Department by the Administration staff. A signed two-monthly record of conducted trainings along with planned training must be submitted by the HOD/Head of Clinical Unit to the MS Office for record keeping and future planning.

**In order to address high risk pregnancies, the HCE must ensure that:**

1. A roster indicates 24 hour arrangements for on-site availability of a suitably qualified and experienced doctor and an anaesthesiologist in case of an emergency.
2. A guideline on calling for medical assistance at any time during labour is used by nurses and midwives.

3. A trained mid-wife/nurse is present at every birth.
4. Anaesthetists with relevant qualifications/experience are available for epidural, C- Section, emergency breech, instrumental deliveries, emergency resuscitation and women with Eclampsia.
5. A paediatrician is involved in the team developing and reviewing policies and procedures.
6. Each woman accessing the Maternity Department is cared for by a suitably qualified, registered and experienced nurse, doctor or senior midwife who can be contacted for advice and help throughout her pregnancy.
7. A record of regular training in maternal and neonatal resuscitation is kept in the department for medical and nursing staff attending deliveries.
8. Written procedures are followed by staff to arrange for consulting physicians, surgeons, and paediatric physicians and surgeons, for women or babies with medical or surgical needs such as multiple, high risk deliveries, instrument deliveries or C-sections.

**Ind 100. The hospital caring for high risk obstetric cases has the facilities i.e., OT and Blood Bank.**

**Survey Process:**

The surveyor should ensure that the hospital providing care for high risk obstetric cases has a functional OT and Blood Bank.

**Scoring:**

- If the hospital has a functional OT and Blood Bank, then score as **fully met.**
- If the hospital has no functional OT and Blood Bank, then score as **not met.**

**Ind 101. High-risk obstetric patient's assessment also includes maternal nutrition.**

**Survey Process:**

This will be surveyed by review of a representative sample of medical records of high-risk obstetric patients.

**Scoring:**

- If all records document assessment of the patient's nutritional status (including corrective measures/advice if needed), then score as **fully met.**
- If only one medical record / prescription (max. 20%) does not document this but it is clinically obvious that the patient had good nutritional status, then score as **partially met.**
- If more than one record fails to document the patient's nutritional status, then score as **not met.**

**GUIDELINES**

**Maternal Nutritional Assessment**

"The objective of maternal nutritional assessment is to ensure that every expectant and nursing

mother maintains good health, learns the art of child care, has a normal delivery, and bears healthy children. Maternity care in the narrower sense consists of care of the pregnant woman, her safe delivery, her postnatal care and examination, the care of her newly -born infant, and the maintenance of lactation. In the wider sense, it begins much earlier in measures aimed to promote the health and well-being of the young people who are potential parents, and to help them to develop the right approach to family life and to the place of the family in the community. It should also include guidance in parent craft and in problems associated with infertility and family planning."

Research found that good evidence linking poor maternal nutrition to several leading causes of infant mortality, including birth defects, preterm birth, foetal growth restriction, and maternal complications of pregnancy (preeclampsia, anemia, infections/inflammation) exists. Maternal folate and vitamin B12 deficiencies have been associated with neural tube defects, while deficiencies in B vitamins, vitamin K, magnesium, copper, and zinc have also been linked to other birth defects. Low pre-pregnancy body mass index (BMI) and poor gestational weight gain are associated with greater risk for preterm birth and foetal growth restriction. While the contribution of specific nutrient deficiencies to preeclampsia remains unclear, maternal nutrition can potentially play an important role in the pathogenesis of preeclampsia by affecting endothelial function, exacerbating or ameliorating oxidative stress, modulating inflammatory response, and improving insulin action. In light of the importance of abnormal implantation and placentation in the pathogenesis of preeclampsia, periconceptual nutrition may be of paramount importance. Nutritional deficiencies of iron, folate, and vitamins A, B6, and B12 can cause anemia. Vitamin A and other micronutrient deficiencies have been implicated in maternal infections, and antioxidants can potentially play a major role in modulating inflammation and oxidative stress from maternal infections.

Adaptive measures prevent deterioration in the nutritional status in the pregnancy and lactation in spite of continued low habitual dietary intake. When the adaptive mechanism fails, the situations become associated with deterioration in maternal nutrition and reproductive performance. They are:

1. Reduction in the dietary intake below the habitual level.
2. Increase in the physical activity above the habitual level.
3. Combination of low dietary intake and increased physical activity.
4. Pregnancy in an adolescent girl.
5. Pregnancy in lactating women.
6. Pregnancy within two years of last delivery.

The evidence of effectiveness of any single macro/micronutrient supplement for preventing foetal growth restriction, preterm birth, birth defects, and maternal complications (preeclampsia, anemia, and infections) is far from conclusive, with the possible exceptions of peri-conceptual folic acid supplementation for prevention of neural tube defects and iron and folate supplementation for prevention of maternal anemia. Fish oil for prevention of recurrent preterm birth, balanced protein-energy supplementation for prevention of foetal growth restriction, and calcium supplementation for prevention of preeclampsia in high-risk women also appear promising.

This should be verified by reviewing of a sample of at least 5 medical records of high-risk obstetric patients for nutritional assessment and advice.

**Ind 102. The hospital caring for high risk obstetric cases has the facilities and technically competent staff to take care of neonates of such cases.**

**Survey Process:**

Technically competent staff with the following minimum should be present (in working condition) in order to provide intensive care to neonates of such cases: i. Emergency resuscitation drugs, ii. Ambu bag with iii. Appropriate neonatal size facemasks, iv. Laryngoscope with neonatal size blades, v. Neonatal size endo-tracheal tubes, vi. An oxygen and suction source, vii. A warmer work station, viii. Incubators, ix. Trays to allow cannulation of an umbilical artery, x. Exchange transfusion trays, xi. Infusion pumps to assure no volume overload of the neonate and xii. Neonatal resuscitation drugs.

**Scoring:**

- If all the above listed requirements are present and is in good working order, then score as **fully met.**
- If ALL the required equipment and supplies defined above are not present, but the hospital has safely defined alternatives, then score as **partially met.**
- If any critical requirements are not fulfilled, then score as **not met.**

**Ind 103. The hospital caring for high risk obstetric cases has nursery, and located close to post-natal ward.**

**Survey Process:**

The surveyor should look for a standard nursery as given below:

1. Nurseries should be located close to post-natal wards and be accessible only to nursery staff and parents of the new-born.
2. Temperature and humidity control of nurseries is essential. Heating should be provided by working radiant warmers or electric fans, maintaining ambient temperatures at 28-30°C and 50% humidity.
3. All windows should have functioning and tight-fitting screens during summer months and covered during winter months.
4. Care must be taken to prevent cross contamination from other areas of the hospital.
  - i. This can be achieved through ensuring double-door entry in the nursery.
  - ii. Provision of shoe covers after the first door or provision of a change of outside shoes for indoor shoes for patients and nursery staff.
  - iii. Hand washing facilities should be available and functional outside and inside the nursery. One basin per 6 children is recommended by the WHO.

**Scoring:**

- If the hospital has a nursery with all the required features given above, then score as **fully met.**
- If the hospital has no nursery with all the required features given above, then score as **not met.**

**Ind 104. All the staff providing care to high risk obstetric cases should be trained in Essential Newborn Care (ENC).**

**Survey Process:**

The surveyor should ask for formal training certificate of ENC of all the staff providing care to the high risk obstetric cases. In addition the surveyor should check skills of staff also.

**Scoring:**

- If all the staff is trained on ENC and have the requisite skills, then score as **fully met.**
- If all the staff is not trained on ENC or they do not have the requisite skills, then score as **not met.**

**GUIDELINES**

**Scope of Neonatal Care**

Majority of neonatal deaths are due to neonatal asphyxia. All HCPs delivering midwifery services must be trained in new born resuscitation. Five days in-service training on "Essential Newborn Care (ENC)" has been designed to develop the newborn resuscitation skills in these HCPs. The HCE must get their staff trained in such compulsory trainings and provide logistics to implement these skills. The HCE must make sure that:

SOPs/Protocols for proper identification of the newborn, including placing an ID tag while handing over baby to the relatives, is developed. SOPs for handing over of the baby should also be in place.

**Figure 18: New-born ID Tag**



1. Nurseries should be located close to post-natal wards and be accessible only to nursery staff and parents of the new-born.
2. Temperature and humidity control of nurseries is essential. Heating should be provided by working radiant warmers or electric fans, maintaining ambient temperatures at 28-30°C and 50% humidity.
3. All windows should have functioning and tight-fitting screens during summer months and covered during winter months.
4. Care must be taken to prevent cross contamination from other areas of the hospital.
  - i. This can be achieved through ensuring double-door entry in the nursery.
  - ii. Provision of shoe covers after the first door or provision of a change of outside shoes for indoor shoes for patients and nursery staff.
  - iii. Hand washing facilities should be available and functional outside and inside the nursery. One basin per 6 children is recommended by the WHO.

- a. Each basin should have facilities of running hot and cold water, soap, nail files and clean disposable towels.
- b. All staff and mothers are required to be trained in hand-washing techniques and should adhere to these practices when handling or examining new-born.
- c. Visual signs should be posted at nursery doors to remind personnel to wash hands before entering the nursery.
- d. A separate area should be available for seating of groups of mothers (3-5) for education sessions conducted by nursery staff. These sessions should include general health and hygiene of the new-born and the mother, techniques of breast feeding and post-partum contraception. Pamphlets, brochures or posters should be used for visual re-enforcement of health education messages.

The following minimum should be present, in working order:

1. Emergency resuscitation drugs.
2. Ambu bag.
3. Appropriate neonatal size facemasks.
4. Laryngoscope with neonatal size blades.
5. A selection of neonatal size endo-tracheal tubes.
6. An oxygen and suction source.
7. A warmer work stations.
8. Incubators.
9. Trays to allow cannulation of an umbilical artery.
10. Exchange transfusion trays.
11. Infusion pumps to assure no volume overload.

**Ind 105. No treatment is administered until the identity of the patient is guaranteed.**

#### Survey Process:

The surveyor should look for a system<sup>86</sup> of safe patient identification and confirm that the administration of ALL treatments and therapies are preceded by confirming the identity of the patient.

#### Scoring:

- If the identification of the patient is clearly observable and fail safe for all patients and staff confirm identity, then score as **fully met**.
- If there is no fail-safe system of identification, then score as **not met**.

## GUIDELINES

### Identity of the Patient

Administration of ALL treatments and therapies should be preceded by confirming the identity of the patient.

There are different manual and technology-based methods of confirming the identity of patient. In addition to already defined traditional methods in other sections of manual, there are few other

<sup>86</sup> For ALL patients the system employed must be permanently with the patient and fail-safe.

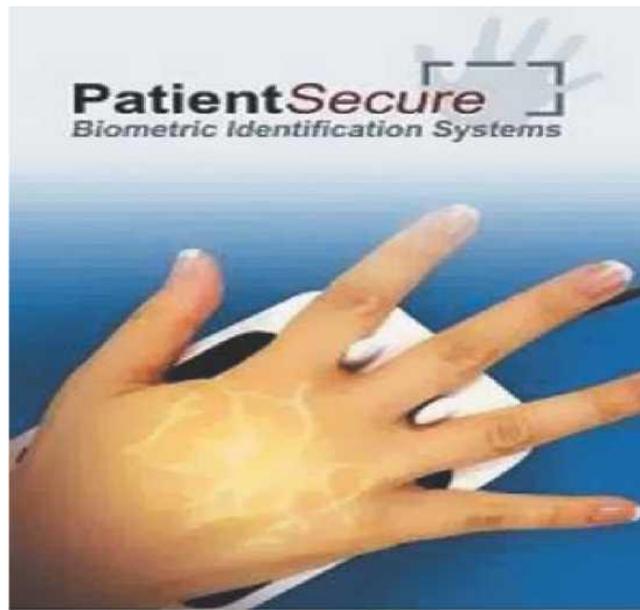
examples which are given as follows:

1. Bedside identity checking.
2. Automated identification methods such as use of barcodes in blood, patient samples and medication.
3. Ask the name of patient before receiving blood transfusions.
4. Double independent checking for high risk tasks.
5. Active radio frequency identification (RFID) tagging system to compile operating lists.
6. Each patient has an electronic record which includes a digital photograph taken by the admission ward staff. These photographs then appear on a screen in the Operating Theatre (OT). A reusable WiFi tag is allocated to each patient to monitor their progress throughout surgery.
7. Positioning technology allows a patient's location to be tracked within the hospital and their Electronic Patient Record (EPR) is available on all hand-held computers. The pre-operative checks made by the surgical team are added to the EPR and contribute to the 'mistake proofing'. Final manual checks are also logged, and only then can the operation proceed.
8. The hand-held computer can help avoid misidentification when tests are ordered or drugs administered. The patient's ID is included on all labels. If a biopsy or test is undertaken in a theatre, patient ID labels can be printed from the tag to prevent mislabeling.
9. Card based technologies (magnetic strip, IC chips) may be used i.e. using cards which incorporate a magnetic stripe digitally encoded with information.
10. Biometrics (for example, finger printing and iris scan) may also be made use of i.e. using automated methods of identifying or authenticating a living person based on physiological or behavioral characteristics.

**Figure 19: Methods of Identification**



**Figure 20: Methods of Identification**



*“Ensuring the Right Care is given to the Right Patient”*

## Assessment Scoring Matrix

**Standard 25. COP 4: Policies and procedures guide the care of high risk obstetrical patients.**

Indicator 98-105		Max Score	Weightage (Percentage)	Score Obtained
Ind 98.	The Hospital defines and displays whether high-risk obstetric cases and their neonates can be cared for or not.	10	80	
Ind 99.	Persons caring for high-risk obstetric cases are competent and specialized care is available round the clock	10	100	
Ind 100.	The hospital caring for high risk obstetric cases has the facilities i.e., OT and Blood Bank.	10	100	
Ind 101.	High-risk obstetric patient's assessment also includes maternal nutrition.	10	80	
Ind 102.	The hospital caring for high risk obstetric cases has the facilities and technically competent staff to take care of neonates of such cases.	10	80	
Ind 103.	The hospital caring for high risk obstetric cases has nursery, and located close to post-natal ward.	10	100	
Ind 104.	All the staff providing care to high risk obstetric cases should be trained in Essential Newborn Care (ENC).	10	100	
Ind 105.	No treatment is administered until the identity of the patient is guaranteed.	10	100	
<b>Total</b>		80	-	

## Standard 26. COP-5: Policies and procedures guide the administration of anaesthesia.

### Indicators (106-116):

**Ind 106. An anaesthesiologist is available along with qualified staff to take care of patients from evaluation till handing over patient to ward after surgery.**

#### Survey Process:

The surveyor should look for the availability of anaesthesiologist as per PMDC registration (medical graduate with post-graduation in anaesthesia), alongwith qualified staff (anaesthesia technologist/technician) to take care of the patients. Check for registration certificates to ensure that all the staff possess the required qualification.

#### Scoring:

- If anaesthesiologist along with qualified staff is available to take care of patients from pre-anaesthesia evaluation till handing over to ward after stabilisation, then score as **fully met**.
- If anaesthesiologist and/or qualified staff is not available to take care of patients from pre-anaesthesia evaluation till handing over to ward after stabilisation, then score as **not met**.

**Ind 107. There is a documented policy and procedure for the administration of anaesthesia.**

#### Survey Process:

The surveyor should look for at least the following policies: i. Pre-anesthesia evaluation leading to anesthesia plan, ii. Assignment of an anesthesia risk scoring (such as an ASA<sup>87</sup> scoring), iii. Documentation requirements during anesthesia, iv. Recording of any complications, v. Post - anesthesia monitoring requirements, and vi. Criteria for discharge from anesthesia care.

#### Scoring:

- If there are policies and procedures that are implemented that cover all the 6 requirements, then score as **fully met**.
- If either there are no policies and procedures, or if there is any non-compliance to any of the above requirements, then score as **not met**.

### GUIDELINES

#### Anaesthesia Policy

The HCE shall implement and document the following policies regarding indications, the type of anaesthesia and procedure for the same, as a **Check List**:

<sup>87</sup> Physical Status Classification and Scoring by the American Society of Anaesthesiologists.

1. Pre-anaesthesia evaluation/assessment followed by formulation of an Anesthetic Plan.
2. Assessment of an anaesthesia risk and its scoring (**annexure N**).
3. Documentation required during anaesthesia.
4. Recording of any complications.
5. Post-anaesthesia monitoring requirements.
6. Discharge from post anaesthesia/post-operative care (Recovery Room)

**Ind 108. All patients for anaesthesia have a pre-anaesthetic assessment and an anaesthetic plan formulated by a qualified individual.**

#### **Survey Process:**

Review a representative sample of records of patients<sup>88</sup> who underwent anaesthesia. Determine if there is a documented pre-anaesthesia assessment and an anesthetic plan. An anaesthetist should do the assessment unless the hospital has identified another specialty that is qualified to do the pre-anaesthesia assessment.

#### **Scoring:**

- If there is a pre-anaesthesia assessment and an anesthetic plan by an anaesthetist or qualified/authorized doctor with documented appropriate training for ALL patients, then score as **fully met**.
- Since this is an important patient safety issue, if any medical record does not include a documented pre-anaesthesia assessment and an anesthetic plan, then score as **not met**.

## **GUIDELINES**

### **Pre-Anaesthesia Assessment**

This shall be done before the patient is brought to the OT complex and shall be applicable for both routine and emergency cases. It is required that the assessment be done in a standardized format. The Pre-Anaesthetic Assessment may even be carried out prior to admission in case of elective surgeries.

All patients undergo Pre-Anaesthesia Assessment by the Anaesthetists (Anaesthesia Professional) a day before their scheduled day of operation in the Preoperative Anaesthetist Clinic/Bedside, if needed, and all the findings are recorded in the specific form. An anaesthesia plan for the patient is prepared on the basis of the Pre-anaesthesia assessment and the same is documented. The anaesthesia plan depicts the type of anaesthesia (local, general, epidural etc), monitoring and plan for post-operative analgesia etc.

### **Recommendations for Pre-Anaesthesia Assessment<sup>89</sup>**

#### **1. Introduction**

The pre-anaesthesia assessment is an integral part of safe anaesthesia practice. It serves to identify associated medical illness and anaesthetic risks, with the ultimate aim of reducing morbidity and mortality associated with anaesthesia and surgery.

<sup>88</sup> Surveyors should decide the representative sample size according to work load/size of the hospital.

<sup>89</sup> Recommendations on Pre-anaesthesia Assessment, Chapter of Anaesthetists, Academy of Medicine, Malaysia.

The objectives of the pre-anaesthesia assessment are manifold. At times, to achieve these objectives, the anaesthetist has to resort to resources such as medical consultation and treatment as well as laboratory and other investigations. In an era where cost containment is important, factors like cost-benefit and benefit-risk ratios will have to be taken into consideration. With the above considerations, this portion of the MSDS Reference Manual provides recommendations on pre-anaesthesia assessment to enhance patient safety. The objectives of the pre-anaesthesia assessment are to:

- i. Evaluate the patient's medical condition from medical history, physical examination, investigations and, when appropriate, past medical records.
- ii. Optimize the patient's medical condition for anaesthesia and surgery.
- iii. Determine and minimize risk factors for anaesthesia.
- iv. Plan anaesthetic technique and perioperative care.
- v. Develop a rapport with the patient to reduce anxiety and facilitate conduct of anaesthesia.
- vi. Inform and educate the patient about anaesthesia, perioperative care and pain management.
- vii. Obtain consent for anaesthesia.

## **2. General Principles**

- i. The pre-anaesthesia assessment should be performed by the anaesthetist who is to conduct the anaesthesia. If this is not possible, a satisfactory mechanism is required whereby the findings of the pre-anaesthesia assessment can be conveyed to the anaesthetist concerned.
- ii. The pre-anaesthesia assessment should be performed at an appropriate time before the scheduled surgery to allow adequate preparation of the patient. This also applies to day surgery patients.
- iii. Pre-operative admission is indicated in patients who require further medical evaluation or prior to major surgery. Admission should not be merely for pre-operative investigations which can be done as an out-patient.
- iv. The pre-anaesthesia assessment may be conducted as a personal interview in the ward, OT or pre-anaesthesia clinic using pre-set questionnaires assisted by trained nursing or paramedical staff under the supervision of an anaesthetist.
- v. Input from other medical specialties may be required in the pre-anaesthesia management of the patient. However, only the anaesthetist may determine a patient's fitness to undergo anaesthesia.
- vi. In the case of emergency surgery where early consultation is not always possible, the anaesthetist is still responsible for the pre-anaesthesia assessment. If surgery cannot be delayed in spite of increased anaesthetic risks, documentation to that effect should be made.

## **3. Detecting Disease and Assessing Severity**

- i. A patient's medical history provides vital information to identify disease that may affect perioperative outcomes. Medical history should include medical problems, current medication and allergies, previous anaesthesia and family history of anaesthesia complications. System review should focus on those pertinent to anaesthesia and surgery. Menstrual history may be important in women of child-bearing age. Useful information may

be obtained from the patient's family doctor or relatives.

- ii. Physical examination of the patient is an essential part of the pre-anaesthesia assessment. Although the cardiovascular and respiratory systems (including the airway) are important in the assessment of the patient, other systems i.e. the renal, hepatic and central nervous systems may also require detailed attention as guided by the history.
- iii. Laboratory and radiological investigations complement history and physical examination in detecting and assessing disease. These investigations should not be done as a routine but ordered as guided by the history and physical examination.
- iv. Multidisciplinary management, subspecialty referral and medical record retrieval may be helpful in the overall assessment of the patient.

#### **4. Risk Assessment**

- i. The patient's pre-operative condition is not the only determinant of perioperative outcome. Other factors such as complexity of surgery, urgency of surgery, surgical skill and factors related to anaesthesia also contribute to outcome.
- ii. In assessing risk factors and optimizing the patient for anaesthesia and surgery, the anaesthetist may need to consider the nature and urgency of the surgery, social and economic factors, or any financial constraints that prevail. It is imperative that the anaesthetist be knowledgeable and well-informed to make a balanced judgment with regard to the benefit-risk ratio of anaesthesia and surgery for the high-risk patient. In such cases, risks associated with anaesthesia should be discussed with the surgeon and conveyed to the patient and/or the next-of-kin. It should also be documented in the consent form or the patient's case notes.

#### **5. Pre-operative Medication**

Pre-operative medication may be prescribed to facilitate the anaesthetic management. The patient's current medication should be reviewed and continued when necessary.

#### **6. Consent**

The pre-anaesthesia assessment should include confirmation with the patient or the patient's guardian, in the case of children below 18 years or the intellectually challenged, of the nature of the anaesthetic procedure and his/her consent for anaesthesia.

#### **7. Documentation**

A written summary of the pre-anaesthesia assessment, orders or arrangements should be explicitly and legibly documented in the patient's anaesthetic record.

#### **Anaesthetic Plan**

1. The plan should mention the pre-medications, type of anaesthesia i.e. GA, regional or local, the drugs to be used for induction and the drug to be used for maintenance. It should also mention about other concomitant medications and IV fluids, special monitoring requirements with appropriate and anticipated post-anaesthesia care. However, the plan and the anaesthesia professionals should be responsive to the condition of the patient on the Operation Table and any changes made in the Anaesthesia Plan must be documented with justification.
2. The pre-anaesthesia assessment should identify any risks and determines the appropriate anaesthetic approach (for example, a patient with multiple back injuries or surgeries might not be a safe candidate for a spinal anaesthesia or a patient with chronic obstructive pulmonary

disease might not be a safe candidate for inhalation anaesthesia).

Table 17: Recommended Pre-Anaesthesia Investigations

RECOMMENDED PRE-ANAESTHESIA INVESTIGATIONS	
<b>Electrocardiogram</b> Age above 50 Cardiovascular disease Diabetes Mellitus Renal disease	<b>Chest X-ray</b> Age above 60 Significant respiratory disease Cardiovascular disease
<b>Full Blood Count</b> Age above 60 Clinical anemia Hematological disease Renal disease Chemotherapy Procedures with blood loss > 15%	<b>Renal Profile</b> Age above 60 Renal disease Liver disease Diabetes Mellitus Cardiovascular disease Procedures with blood loss > 15%
<b>Coagulation Profile</b> Hematological disease Liver disease Anticoagulation Intra-thoracic/Intra-cranial procedures	<b>Random Blood Sugar</b> Age above 60 Diabetes Mellitus Liver dysfunction
<b>Liver Function Tests</b> Hepatobiliary disease Alcohol abuse	

**Ind 109. Informed consent for administration of anaesthesia is obtained by a qualified member of the anaesthetic team.**

**Survey Process:**

By reviewing the same sample records<sup>90</sup> as in **Ind 100**, determine if all patients who underwent anesthesia have a documented informed consent.<sup>91</sup> This documentation can either be a signed consent form or written note by the responsible physician that contextually accommodates all patient levels of understanding.

**Scoring:**

- If all records contain documentation of informed consent, then score as **fully met**.
- Since this is a significant medico-legal issue, if any of the reviewed record does not contain documentation of informed consent, then score as **not met**.

<sup>90</sup> Surveyors should decide the representative sample size according to work load/size of the hospital.

<sup>91</sup> Informed consent must truly be appropriate for each patient and include reference to the associated risks involved

## GUIDELINES

### **Informed Consent**

The patient and/or their family are educated on the risks, benefits, and alternatives of anaesthesia by the anaesthetist. This shall be separate from the surgery consent. Prior to the administration of anaesthesia, the patient/relative is informed about the planned anaesthetic procedure, risk and benefits involved etc. An informed consent is obtained from the patient by the concerned anaesthetist. In case the patient is incapable or a minor etc., consent is obtained from the patients relatives as specified by the hospital.<sup>92</sup>

Consent should be obtained for all medical treatment. It is a basic tenet of our society that everyone has a right to determine what is done to his/her own body, and is entitled to know the implications of any treatment before it is administered and to seek clarification of any issues that may be of concern.

### **General Principles**

Consent for treatment provided by an anaesthetist is different from a statement as to the necessity for anaesthesia (which may form part of the consent for an operative procedure). The process of obtaining consent for medical treatment involves discussion in which both the patient and the doctor participate actively, and which is open, honest and effective.

#### **1. Elements of Consent**

- i. Consent must be given voluntarily and without coercion; refusal or withdrawal of consent must be a realistic option. The environment, and timing of the consent process, and presence of support people (if so desired by the patient), are important in this regard.
- ii. Consent may only be given by a person capable of doing so.
- iii. All persons are presumed to be competent to give consent, unless there are reasonable grounds for believing otherwise. A judgment that the patient is incapable of giving consent must be supported by appropriate evidence, such as that of:
  - a. Very young age
  - b. Lack of mental capacity
  - c. Unconsciousness
  - d. *Presence of sedative medication*
- iv. The criterion at which a young person is able to consent independently to medical treatment depends not only upon their age, but also the nature of the proposed treatment and local legislative requirements. To be able to give consent, the young person should be able to understand;
  - a. The nature, purpose and possible consequences of the treatment, as well as
  - b. The consequences of non-treatment. If in any doubt, consult appropriate management representatives or legal or other advisers.
- v. In the absence of a capacity to give consent, another person can give consent on behalf of the patient in certain legally defined circumstances, such as the parent or legal guardian of a child. In such circumstances, the person giving consent has a legal duty to always act in

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<sup>92</sup> Australian and New Zealand College of Anaesthetists. (2005). Guidelines on consent for anaesthesia or sedation.

the best interests of the person for whom the consent is being given.

- vi. If no person is able to give consent, then treatment can only proceed if it is in the patient's best interests, reasonable steps have been taken to ascertain the views of the patient, the doctor believes that it would have been chosen by the patient if he/she was competent to do so, or the doctor takes into account the views of other suitable persons who are interested in the welfare of the patient, and that further delay is likely to be detrimental to the patient. It may be necessary to arrange for a legal guardian to be appointed. In these cases, it is strongly recommended that appropriate legal or other advice be obtained.
- vii. If the situation is so urgent that immediate intervention is necessary to preserve life or prevent serious harm, it may not be possible or sensible to obtain full consent. In such cases, there must be provision of information and discussion of the treatment undertaken with the patient, or other suitable persons, as soon as possible.
- viii. In some circumstances, Statutory Bodies, such as a Guardianship Board or Legal Representative may give consent or authorize others to give consent.
- ix. It must be recognized that the patient can withdraw the given consent which must be respected (e.g. during multiple attempts at regional blockade).
- x. Consent must be informed.
- xi. The patient should be provided with the information that a reasonable patient in the position of that patient might wish to know, and to which the patient might attach significance. It is necessary to provide information about all material risks inherent in any proposed treatment.
- xii. Information about the proposed treatment should be provided, even if the patient requests no information. Where the patient clearly does not wish for further information, and states this wish, information should still be firmly offered and if still refused, that fact should be documented, and no further information forced on the patient.
- xiii. The discussion of risks and benefits should include those associated with the proposed treatment, alternative treatments, or no treatment at all.
- xiv. In considering risks to be discussed with the patient, ask:
  - a. Would a reasonable person, in the position of the patient, be likely to attach significance to the risk?
  - b. Are you aware, or should you be reasonably aware, that this particular patient would be likely to attach significance to that risk?
  - c. In other words, is it possible that the patient, if informed of that risk, would change his mind about having the procedure?

## **2. Risks**

- i. Discussion of risks should be based on the provider's assessment of the proposed treatment, the seriousness and nature of the patient's condition, the complexity of the proposed treatment, the questions asked by the patient, and the patient's attitude and apparent level of understanding.
- ii. Known risks should be explained when an adverse outcome is rare.
- iii. The uncertainty of adverse outcomes/events should be explained, as should the difficulty of relating the incidence of such events to the patient.
- iv. Where blood products may be required, discussion should take place concerning the advantages, disadvantages and alternatives to blood products.

- v. The risk of doing nothing should be discussed.
- vi. Opportunity must be given to discuss the nature and risks of the treatment, and the alternative treatment(s), and to have questions answered honestly and accurately.
- vii. Where appropriate, the financial implications of the proposed treatment should be discussed.
- viii. Information should be provided in a form the patient is likely to understand. This may include the option of presenting information in the printed form or via computer or other electronic means (e.g. by video). Printed and visual aids are useful. Prepared information sheets or "consent forms" can help understanding, but are not a substitute for the required discussion with the patient.

### 3. Documentation of Consent

The extent of documentation may vary but it is wise to record significant details of the consent as part of the patient's notes, including reference to the discussion of relevant material risks and the agreement by the patient to undergo the treatment.

In order to defend claims that "informed consent" information was not given or was inadequate, it is highly recommended that detailed notes of the discussion and all risks considered are kept by the provider.

### 4. Standard Consent Forms and Information Sheets

The use of standard "consent forms" and information sheets will not necessarily be sufficient to maintain "informed consent". Standard information forms are useful, but are no substitute for personal information to an individual patient. Under the requirements of "informed consent", the information to be given to a patient must be specific to the particular patient. It must take into account the particular circumstances, and requirements, of the patient.

Similarly, a simple form signed by a patient is not conclusive proof that valid consent has been obtained. It therefore, should be countersigned by designated persons.

Prepared consent forms and prepared information sheets certainly can have their place and can be used as an aid or educational tool, as well as a prompt or **Checklist** for the **discussion that must take place between doctor and patient**. They are also useful for the patient to take away after the discussion as a reminder of some of the issues that have been considered. However, they are not, **in themselves**, adequate to ensure that informed consent has been obtained.

### 5. Personnel

Disclosure of information and discussion must be performed by a person who understands and is able to discuss the risks and benefits of the proposed treatment and the alternative treatments, which includes no treatment.

A qualified interpreter (not a family member) should be used wherever necessary.

Disclosure of information and discussion is best performed by the anaesthetist who will be conducting the treatment.

Ideally, consent should be obtained by the anaesthetist who will be conducting the treatment. (The anaesthetist may be liable if inadequate consent is obtained by another person on the anaesthetist's behalf).

- i. When the procedural anaesthetist can only see the patient immediately prior to anaesthesia, a separate anaesthetist may interview the patient and provide information for

the elements of consent noted above.

- ii. The procedural anaesthetist must still discuss the proposed treatment with the patient to ensure that all appropriate preparation has occurred. The need for this interview must be considered when sedative premedication is to be given.
- iii. Those involved with the consent process are individually responsible for appropriate documentation.

**6. Examples of Risk** which might be discussed with the person giving consent include:

- i. Common adverse effects of general anaesthesia, which include fatigue, altered mental state, sleep disturbance, nausea, vomiting, sore throat and/or bruising from vein- puncture.
- ii. Less common but not rare adverse effects such as "Spinal Headache due to Epidural Block or Spinal Tap etc. and Dental Trauma due to intubation.
- iii. Rare adverse effects which are unpredictable, such as anaphylaxis, awareness, neurological damage or death in healthy people.
- iv. Adverse effects which are related to pre -existing disease, such as death in a patient with recent myocardial infarction undergoing emergency surgery.

Table 18: Sample Anaesthesia Consent Form

<b>Anaesthesia Consent Form</b>
<b>Basic Information:</b>
Patient's Name: _____ Sex: _____
Medical Record Number: _____ Date of Birth: _____
Name of anaesthetist: _____
<b>I. Proposed Type of Anaesthesia Technique (explain briefly in non-medical terms):</b>
1. Surgical intervention to be administered by the surgeons:
2. Proposed anaesthesia technique(s): General _____ Regional _____ Nerve Block _____
<b>II. Physician's<sup>93</sup> Statements</b>
1. I have adequately assessed the patient's physical condition prior to the anaesthesia.
2. I have given a verbal explanation to the patient, in a way that the patient can understand, concerning the anaesthesia intervention to be carried out, as following: <ul style="list-style-type: none"> <li>i. <i>Anaesthetic procedure</i></li> <li>ii. <i>Anaesthesia-related risks</i></li> <li>iii. The potential adverse symptoms following the anaesthesia</li> </ul>
I have rendered the patient with supplementary information regarding the anaesthesia
3. I have also provided the patient with sufficient time to inquire about the following questions concerning the anaesthesia to be undertaken in this surgery, and I have answered these questions as below:
Signature of anaesthetist: _____

<sup>93</sup> The word "Physician" used in general term. Here it means the anaesthetist. In case of doubt he may obtain opinion from other relevant consultant.

Date: _____ / _____      Time: _____ : _____
<b>III. Patient's Statements</b>
<ol style="list-style-type: none"> <li>1. I understand that the anaesthesia procedure is necessary for undertaking this surgery in order to alleviate pain and fear during the operation.</li> <li>2. The anaesthesia doctor has explained the risks and procedure of anaesthesia to me.</li> <li>3. I fully understand the information provided relating to the anaesthesia.</li> <li>4. I had addressed my concerns and doubts regarding the anaesthesia to the anaesthesia doctor who has given me satisfactory responses.</li> </ol>
<b>IV. Relationship to the Patient:</b>
Authorized Signature: _____ Relationship to Patient: _____
Address: _____ Tel No.: _____
Date: _____ / _____ / _____      Time: _____ : _____
Witness: _____ Signature of Witness: _____
Date: _____ / _____ / _____      Time: _____ : _____
<b>Note: Please specify the relationship to the patient if the authorized signer is not the patient himself/herself. Please leave the space blank if witness is not required.<sup>94</sup></b>

**Ind 110. An immediate pre-operative (pre-induction) re-evaluation is documented.**

**Survey Process:**

The intent of this standard is to compare the findings and management plan in the formal pre-anaesthesia assessment with the immediate pre-operative anaesthetic assessment and to see if the management of the patient is changed if required. The immediate pre-anaesthesia repeat evaluation should be documented on the anaesthesia record that becomes part of the patient’s medical record.

**Scoring:**

- If the immediate pre-induction re-evaluation is documented in all records, then score as **fully met.**
- If the immediate pre-induction re-evaluation is not documented in all records, then score as **not met.**

<b>GUIDELINES</b>
<p><b><u>Anaesthetic Plan</u></b></p> <p>The plan should mention the pre-medications, type of anaesthesia i.e. GA, regional or local, the drugs to be used for induction and the drug to be used for maintenance. It should also mention about other concomitant medications and IV fluids, special monitoring requirements with appropriate and anticipated post-anaesthesia care. However, the plan and the anaesthesia professionals should be responsive to the condition of the patient on the Operation Table and any</p>

<sup>94</sup> Retrieved from [http://140.116.59.230:8080/opc/anaesthesia .pdf](http://140.116.59.230:8080/opc/anaesthesia.pdf)

changes made in the Anaesthesia Plan must be documented with justification.

The pre-anaesthesia assessment should identify any risks and determines the appropriate anaesthetic approach (for example, a patient with multiple back injuries or surgeries might not be a safe candidate for a spinal anaesthesia or a patient with chronic obstructive pulmonary disease might not be a safe candidate for inhalation anaesthesia).

**Ind 111. During anaesthesia, monitoring includes regular and periodic recording of heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation, airway security and patency, and level of anaesthesia.**

#### **Survey Process:**

This standard is surveyed by observation. While visiting the operating theatre look for the presence and fully functional equipment that supports all the requirements in this standard.

#### **Scoring:**

- This indicator should default to a score of **fully met** unless a majority of the survey team agrees that there are significant deficiencies in the hospital's ability to monitor patients during anesthesia (for example, only one monitor for two or more rooms such that some patients are not monitored).

## **GUIDELINES**

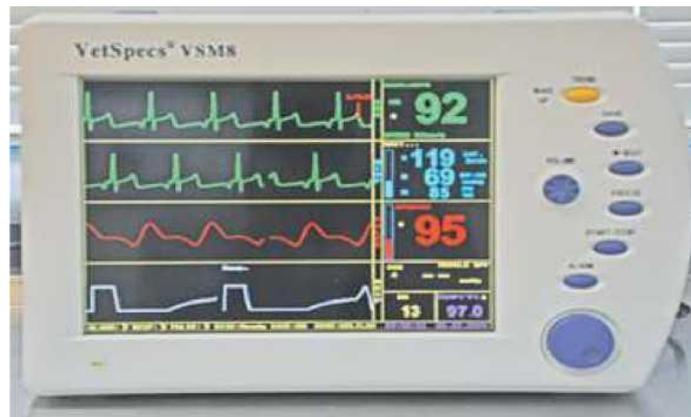
### **Monitoring in Anaesthesia**

(The patient is monitored since there are rapid changes in the patient status during anaesthesia.

The following parameters need to be monitored and recorded on the **Monitoring Sheet**:

1. Patient Heart rate
2. Cardiac Rhythm
3. Respiratory rate
4. Arterial Blood Pressure
5. Oxygen Saturation
6. Airway Security
7. Patency
8. Level of Anaesthesia
9. Evaluation of the Circulatory Function
10. Temperature (in case clinically significant changes in body temperature are intended, anticipated or suspected).

**Figure 21: Vital Sign Monitor**



In case of regional anaesthesia, instead of end tidal carbon dioxide, the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs.

The anaesthesiologist shall be present throughout the procedure. In addition, certain other parameters may be monitored on a case-to-case basis. The cardiac rhythm may be monitored on a monitor during the procedure, and the rhythm as well as rhythm abnormalities shall be documented. System shall be measured by an oxygen analyzer with a low oxygen concentration limit alarm in use.

**Blood oxygenation:** During all anaesthetics, a quantitative method of assessing oxygenation such as pulse oximetry shall be employed. When the pulse oximeter is utilized, the variable pitch pulse tone and the low threshold alarm shall be audible to the anaesthetist or the anaesthesia care team personnel. Adequate illumination and exposure of the patient are necessary to assess color.

## **1. Ventilation**

### **i. Objective**

To ensure adequate ventilation of the patient during all anaesthetics.

### **ii. Methods**

- a. Every patient receiving general anaesthesia shall have the adequacy of ventilation continually evaluated. Qualitative clinical signs such as chest excursion, observation of the reservoir breathing bag and auscultation of breath sounds are useful. Continual monitoring for the presence of expired carbon dioxide shall be performed unless invalidated by the nature of the patient, procedure or equipment. Quantitative monitoring of the volume of expired gas is strongly encouraged.
- b. When an endotracheal tube or laryngeal mask is inserted, its correct positioning must be verified by clinical assessment and by identification of carbon dioxide in the expired gas. Continual end tidal carbon dioxide analysis, in use from the time of endotracheal tube/laryngeal mask placement, until extubation/removal or initiating transfer to a postoperative care location, shall be performed using a quantitative method such as capnography, capnometry or mass spectroscopy. When capnography or capnometry is utilized, the end tidal carbon dioxide alarm shall be audible to the anaesthetist or the anaesthesia care team personnel.
- c. When ventilation is controlled by a mechanical ventilator, a device that is capable of

detecting disconnection of components of the breathing system, the device shall remain in continuous use. The device must give an audible signal when its alarm threshold is exceeded.

- d. During regional anaesthesia (with no sedation) or local anaesthesia (with no sedation), the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs. During moderate or deep sedation, the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs and monitoring for the presence of exhaled carbon dioxide unless precluded or invalidated by the nature of the patient, procedure, or equipment.

## **2. Circulation**

### **i. Objective**

To ensure the adequacy of the patient's circulatory function during all anaesthetics.

### **ii. Methods**

- a. Every patient receiving anaesthesia shall have the electrocardiogram continuously displayed from the beginning of anaesthesia until preparing to leave the anaesthetizing location.
- b. Every patient receiving anaesthesia shall have his/her arterial blood pressure and heart rate determined and evaluated at least every five minutes.
- c. Every patient receiving general anaesthesia shall have, in addition to the above, circulatory function continually evaluated by at least one of the following: palpation of a pulse, auscultation of heart sounds, monitoring of a tracing of intra-arterial pressure, ultrasound peripheral pulse monitoring, or pulse plethysmography/oximetry.

## **3. Body Temperature**

### **i. Objective**

To aid in the maintenance of appropriate body temperature during all anaesthesia.

### **ii. Methods**

- a. Every patient receiving anaesthesia shall have their temperature monitored when clinically significant changes in body temperature are anticipated or suspected.
- b. Under extenuating circumstances, the responsible anaesthetist may waive some of the predetermined requirements. It is recommended that when this is done, it should be so stated (including the reasons) in a note in the patient's medical record.

***Note that "continual" is defined as "repeated regularly and frequently in steady rapid succession" whereas "continuous" means "prolonged without any interruption at any time."***

**Ind 112. No anaesthetic is administered unless the identity of the patient is guaranteed.**

### **Survey Process:**

The surveyor should look for a system for safe Identification of patients (Patients ID system)<sup>95</sup> and confirm that the administration of anesthesia is preceded by confirming the identity of the patient.

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<sup>95</sup> For all patients the system employed must be permanently with the patient and fail-safe.

### Scoring:

- If the identification of the patient is clearly observable and fail-safe for all patients and staff confirm identity prior to induction, then score as **fully met**.
- If there is no “fail-safe” system of identification or any patient’s identity is not confirmed, then score as **not met**.

## GUIDELINES

### **Identity of the Patient**

Every hospital should develop a safe patient ID system and confirm that the administration of anaesthesia is preceded by confirming the identity of the patient. There are many instances when patient misidentification can occur, including invasive procedures, medication administration, transfusion of blood/blood products, and matching pathology specimens to the correct patient. There are some Recommended Practices that are meant to contribute to the efforts of patient safety and reduce the risk of patient misidentification. The following are the Recommended Practices related to the proper identification of the surgical patient and recognizing the mistakes that can be made in order to prevent operating on the wrong patient.

### **Standard Practices<sup>96</sup>**

The patient should have at least two corroborating patient identifiers as evidence to confirm identity. The use of two patient identifiers improves the reliability of the patient identification process and decreases the chance of performing the wrong procedure on the wrong patient. Examples of acceptable patient identifiers include:

1. Name
2. Assigned identification number
3. Telephone number
4. Date of birth
5. Social security number
6. Address

The patient's room number should not be used as a patient identifier; room numbers are not person-specific identifiers, since patients can be moved from room to room.

**Ind 113. Each patient's post-anaesthetic status is monitored and documented.**

### **Survey Process:**

Review representative sample medical records<sup>97</sup> of patients in the recovery area or who have been there previously. There should be documented evidence of post-anesthetic monitoring that includes at least: i. Blood pressure, ii. Pulse rate, iii. Respiratory status, iv. Level of consciousness, and v. Pain.

<sup>96</sup> Strelec, S. R. (1996). Anaesthesia and surgery: Not always a one sided affair. American Society of Anaesthetists Newsletter, 60. From [http://www.asahq.org/Newsletters/1996/06\\_96/feature4.htm](http://www.asahq.org/Newsletters/1996/06_96/feature4.htm)

<sup>97</sup> Surveyors should decide the representative sample size according to work load/size of the hospital.

## Scoring:

- If all reviewed records document the above requirements, then score as **fully met**.
- If even one record does not document all the requirements, then score as **not met**.

## GUIDELINES

### **Post Anaesthesia Monitoring**<sup>98</sup>

1. This shall be done in the recovery area/OT and at least include monitoring of vitals till the patient recovers completely from anaesthesia and shall be done by an anaesthetist. If the patient's condition is unstable and he/she requires ICU care, the same shall be monitored there.
2. There should be documented evidence of Post-Anaesthesia Monitoring that includes at the least:
  - i. Blood pressure
  - ii. Pulse rate
  - iii. Respiratory status
  - iv. Oximetry
  - v. Level of consciousness
  - vi. Pain
3. Additional considerations are as follows:

A post-anaesthesia care unit (PACU) sometimes referred to as post-anaesthesia recovery or PAR, is a vital part of hospitals, ambulatory care centers, and other medical facilities. It is an area, normally attached to OT suites, designed to provide care for patients recovering from anaesthesia, whether it be general anaesthesia, regional anaesthesia, or local anaesthesia.

The essential activities of PACU Staff include:

  - i. Monitoring vital signs (heart rate, blood pressure, temperature and respiratory rate)
  - ii. Managing post-operative pain.
  - iii. Treating symptoms of Postoperative Nausea and Vomiting (PONV)
  - iv. Treating post anaesthesia shivering
  - v. Monitoring surgical site(s) for excessive bleeding, discharge, swelling, hematoma, redness etc.
4. These common activities may often need supplementing with more intensive care or treatment which may require:
  - i. Preparation and education for the use of Patient Controlled Analgesia (PCA) units.
  - ii. Preparation and establishment of IV, epidural or perineural infusions.
  - iii. Preparation and establishment of invasive monitoring such as arterial lines, central venous lines etc.

***Note: Unless complications occur, most patients will only stay in the PACU for a few hours, before returning home or to another department of the hospital.***
5. All patients who have received general anaesthesia, regional anaesthesia or monitored anaesthesia care shall receive appropriate post-anaesthesia management.
6. A PACU or an area which provides equivalent post-anaesthesia care (for example, a surgical ICU) shall be available to receive patients after anaesthesia care. All patients who receive

<sup>98</sup> Standards For Postanaesthesia Care, Committee of Origin: Standards and Practice Parameters, (Approved by the ASA House of Delegates on October 27, 2004, and last amended on October 21, 2009).

anaesthesia care shall be admitted to the PACU or its equivalent except by specific order of the anaesthetist responsible for the patient's care.

7. The medical aspects of care in the PACU (or equivalent area) shall be governed by policies and procedures which have been reviewed and approved by the Department of Anaesthesiology.
8. A patient transported to the PACU shall be accompanied by a member of the anaesthesia care team who is knowledgeable about the patient's condition. The patient shall be continually evaluated and treated during transport with monitoring and support appropriate to the patient's condition.
9. Upon arrival in the PACU, the patient shall be re-evaluated and a verbal report provided to the responsible PACU nurse by the member of the anaesthesia care team who accompanies the patient.
10. The patient's status on arrival in the PACU shall be documented.
11. Information concerning the preoperative condition and the surgical/anaesthetic course shall be transmitted to the PACU nurse.
12. The member of the anaesthesia care team shall remain in the PACU until the PACU nurse accepts responsibility for the nursing care of the patient in writing. The patient's condition shall be evaluated continually in the PACU.
13. The patient shall be observed and monitored by methods appropriate to the patient's medical condition. Particular attention should be given to monitoring oxygenation, ventilation, circulation, level of consciousness and temperature. During recovery from all anaesthetics, a quantitative method of assessing oxygenation such as pulse oximetry shall be employed in the initial phase of recovery. This is not intended for application during the recovery of the obstetrical patient in whom regional anaesthesia was used for labour and vaginal delivery.
14. An accurate written report of the PACU period shall be maintained. Use of an appropriate PACU scoring system is encouraged for each patient on admission, at appropriate intervals prior to discharge and at the time of discharge.
15. General medical supervision and coordination of patient care in the PACU should be the responsibility of an anaesthetist.
16. There shall be a policy to assure the availability in the facility of a physician capable of managing complications and providing cardiopulmonary resuscitation for patients in the PACU.
17. A physician is responsible for the discharge of the patient from the post-anaesthesia care unit.
18. When discharge criteria are used, they must be approved by the Department of Anaesthesiology and the medical staff. They may vary depending upon whether the patient is discharged to a hospital room, to the ICU, or home.
19. In the absence of the physician responsible for the discharge, the PACU nurse shall determine that the patient meets the discharge criteria. The name of the physician accepting responsibility for the discharge shall be noted on the record.

**Ind 114. A qualified individual applies defined criteria to transfer the patient from the recovery area.**

#### **Survey Process:**

Look first for the written criteria for shifting/ transfer /discharge of patients from the recovery area. Then while reviewing the records, determine if an anesthetist or other qualified person with

appropriate training<sup>99</sup> has ordered shifting / transfer / discharge of patients from the recovery area.

**Scoring:**

- If there is an observable documented process by a qualified individual that ensures the safe transfer of post anesthetic patients and it is practiced, then score as **fully met.**
- If there is non-compliance to any of the above criteria, then score as **not met.**

## GUIDELINES

### **Transfer from the Recovery Area**

The HCE should document these criteria which should be based on physiologic parameters and in consonance with good clinical practices.

Every recovery room should have well-defined criteria for the discharge of patients to the general ward or other clinical areas. The following criteria must be fulfilled:

1. The patient is fully conscious without excessive stimulation, able to maintain a clear airway and exhibits protective airway reflexes.
2. Respiration and oxygenation are satisfactory.
3. The cardiovascular system is stable with no unexplained cardiac irregularity or persistent bleeding. The specific values of pulse and blood pressure should approximate to normal pre-operative values or be at an acceptable level commensurate with the planned postoperative care. Peripheral perfusion should be adequate.
4. Pain and Emesis should be controlled and suitable analgesic and anti-emetic regimens prescribed.
5. Temperature should be within acceptable limits. Patients should not be returned to the ward if significant hypothermia is present.
6. Oxygen and intravenous therapy, if appropriate, should be prescribed.
7. Shifting from the recovery room is the responsibility of the anaesthetist. If the discharge criteria are not achieved, the patient should remain in the recovery room and the anaesthetist informed. An anaesthetist must be available at all times when a patient who has not reached the criteria for discharge is present in the recovery room.
8. If there is any doubt as to whether a patient fulfills the criteria, or if there has been a problem during the recovery period, the anaesthetist who administered the anaesthetics (or another anaesthetist with special duties in the recovery room) must assess the patient. After medical assessment, patients who do not fulfill the discharge criteria may be transferred to an ICU.

### **Handing over to Ward Staff**

Patients should be transferred to the ward accompanied by a suitably trained member of staff and a caretaker. The anaesthetic record, together with the recovery and prescription charts, must accompany the patient. The recovery nurse must ensure that full clinical details are relayed to the ward nurse with particular emphasis on problems and syringe pump settings.

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<sup>99</sup> This may include nurses who have received documented training

## Ind 115. All adverse anaesthesia events are recorded and monitored.

### Survey Process:

Ask for the report(s) of any anesthesia related adverse events. Review the analysis and any corrective action that is specified. If there have been no adverse events, which is unlikely unless a new service, validate that there is a process to identify the event and to intensively analyze it, including recommended corrective actions.

### Scoring:

- If there has been an adverse anesthesia event and there is evidence of meaningful evaluation/analysis and appropriate action if warranted, then score as **fully met.**  
or if there has been no adverse anesthesia event but the hospital has a process to identify such events and also has a process to analyze these, then also score as **fully met.**
- If there was an anesthesia related adverse occurrence and it was not either reported or analyzed, or if there is no process to analyze an adverse event if it were to occur, then score as **not met.**

## GUIDELINES

### Transfer from the Recovery Area Documenting and Monitoring of Adverse Anaesthesia Events

All such events are documented and monitored for the purpose of taking corrective and preventive action. There should be a documented process to identify the event and to intensively analyze it, including recommended corrective actions.

Precisely because anaesthesia care has become so safe in terms of the reduction of major intra - operative anaesthesia accidents, very few anaesthesia practitioners today have any first-hand experience dealing in real time with a major anaesthesia adverse event. While from an overall anaesthesia patient safety statistical perspective, this fact is highly desirable, it also functionally represents a new danger. There is absence of experience, training, or even thought about what to do in the extremely unlikely, but yet still possible, event of coming face-to-face with an intra-operative anaesthesia catastrophe. This deficit might prevent definitive action that can help the specific patient in a particular incident and patients in general who can benefit by lessons learned from that adverse incident.

#### **The Basic Plan<sup>100</sup>**

Upon recognition that a major adverse anaesthesia event is in progress or has occurred:

1. Get help and mobilize according to the protocol.
2. The primary caregiver(s) should continue patient care. Except in the very unusual circumstance that the anaesthesia provider becomes ill or disabled or is so shocked by the realization of the accident that s/he cannot function, s/he should devote full attention to direct clinical care rather than to the necessary organizational and administrative considerations.
3. Immediately designate an Incident Supervisor (e.g., a senior practitioner, department leader) who:

<sup>100</sup> Eichhorn, J.H. Patient perspectives personalize patient safety. APSF Newsletter Winter 2005-06; 20:61-66.

- i. Assumes overall direction and control of the event.
  - ii. Organizes help and assigns tasks.
  - iii. Verifies that the incident has ended and there is no immediate recurrence (e.g. correct intubation and ventilation in the prototype example, continued availability of tank oxygen after a central oxygen supply failure, etc.)
  - iv. Involves consultants and advisors as indicated, including specifically the Chief/Chair of Anaesthesiology or appropriate designee, and any others who may help with care or recovery, such as neurologists, cardiologists, etc.
  - v. Coordinates and facilitates communications.
  - vi. Alter nothing (no cleaning, no disassembly, no repair); if it appears likely or even possible that an equipment failure (anaesthesia machine ventilator, bubble detector on a rapid infuser, or whatever) contributed to an accident, it may be indicated that an inspection/testing session should be conducted involving the real-time participation of representatives of the involved practitioners, the equipment manufacturers, the equipment maintenance personnel, facility administration, and involved insurance companies/attorneys.
  - vii. Discard nothing; sometimes the solution to a mystery can later be discovered in unexpected tiny details, such as an empty or missing or extra medication vial that suggests an accidental wrong drug administration may have caused the accident.
  - viii. Lock away all of the above (this may be difficult in a busy facility, be reasonable, for example, if it is accepted by all involved that there was an unrecognized esophageal intubation involving apparent human error, it would be possible to release the OR and its equipment for use the next day and dispose of the trash).
4. Contact the care facility's administrator and risk manager (possibly also the practitioner's attorney if indicated).
  5. Arrange immediate comfort and support for patient and/or family. Share as much information as possible.
  6. Designate a Follow-up Supervisor (who may or may not be the same as the Incident Supervisor) who will:
    - i. Verify that the elements of this protocol have been applied.
    - ii. Consider whether to organize a group debriefing (e.g., the day of the event or the following day) involving all those present during the event, and function as assigned if indicated (note that there may be medico-legal implications of this and appropriate advice of counsel may be indicated).
    - iii. Maintain ongoing communications with all involved caregivers and patient representatives, coordinating and facilitating as much integration as possible.
    - iv. Pursue the accident investigation in conjunction with involved quality assurance and risk management systems and personnel; eventually prepare a report as indicated, particularly focusing on lessons learned and actions needed to help prevent similar accidents in future and participate in any peer-review activities conducted regarding the event.
  7. Document everything:
    - i. Put strictly objective narrative entries in the medical record and incident report (but these can include background details on the involved thinking, such as, for example, the indication for invasive monitoring based on symptoms and signs of congestive heart failure).
    - ii. If possible make additional detailed (including subjective impressions or value judgments)

personal notes for later use created specifically while sitting with an attorney (personal or from the practitioner's insurance carrier) who keeps them as attorney-client work product.

8. Try to review formal reports submitted by the institution to the authorities, both in order to know what they contain and also to add your observations or commentary if indicated.
9. Continue involvement after the event when the patient survives:
  - i. Talk to surgeons and consultants about care; make suggestions as indicated.
  - ii. Be visible, supportive, and not defensive with all involved.
  - iii. Communicate as much as possible.

### **Implications**

Note that lack of communication from caregivers and facilities involved in the immediate and longer-term aftermath of major anaesthesia accidents leads to great distress and even pain from the patient/family survivor's perspective.

### **Guidelines for Action Following an Adverse Anaesthesia Event<sup>101</sup>**

**Objectives:** To limit patient injury from a specific adverse event associated with anaesthesia and to ensure that the causes of the events are identified so that a recurrence can be prevented.

**Protocol:** When a patient has died or has been injured from causes suspected to be related to anaesthesia management, the following should occur;

#### **Immediate**

1. The primary anaesthetist/anaesthesiologist should concentrate on continuing patient care. The primary anaesthetist/anaesthesiologist should notify a physician responsible for supervision of anaesthesia activities in the relevant patient care area, e.g., Anaesthesia Clinical Director or the Team Leader, as soon as possible (at least before the anaesthetist transfers direct responsibility for that patient). The person so contacted will direct the process of immediate prevention of recurrence (if necessary), events documentation and continued investigation or will delegate responsibility to someone other than the primary anaesthetist or consultant anaesthetist. The individual performing these tasks is designated as the incident supervisor.

**Rationale:** Information vital to reconstructing events may be accidentally discarded. The highest priority for the primary caregivers must be the care of the patient, so responsibility for administrative and investigate activities must be assigned to others. Typically, an anaesthetist supervising a primary anaesthetist/anaesthesiologist should not be the incident supervisor. However, out of normal working hours, a primary or supervising anaesthetist may choose to act as incident supervisor and may exercise discretion in calling for assistance or advice.
2. Anaesthesia equipment or supplies associated with the case, whether thought to be materially involved or not, should be sequestered before subsequent use. Nothing must be altered or discarded. The primary anaesthetist/anaesthesiologist or incident supervisor shall immediately contact the hospital individual responsible for management of anaesthesia equipment and supplies (equipment supervisor). The equipment supervisor or his designee shall supervise the impoundment of involved supplies and equipment (including the anaesthesia machine) in consultation with the hospital Risk Manager. A preliminary decision to continue the usage of urgently needed equipment may be made, following a safety inspection, at the discretion of the

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<sup>101</sup> Cooper J.B, Cullen D.J, Eichhorn J.H, Holzman R.S., Philip J.H. (1993). Administrative guidelines for response to an adverse anaesthesia event. *Journal of Clinical Anaesthesia* 1993; 5:79-84).

incident supervisor in consultation with the hospital Risk Manager.

Rationale: Equipment or supplies involved in the event may be accidentally altered or discarded, preventing determination of cause.

3. The incident supervisor or attending anaesthetist should contact the hospital Risk Manager immediately following the anaesthetic event for additional administrative support.  
Rationale: Individual caregivers will rarely be experienced in dealing with an adverse occurrence. The Risk Manager can advise on the ways to communicate information to the patient or to the patient's family in a way that is forthright and comforting, but which does not unintentionally alarm, misinform, or render judgment.
4. The primary anaesthetist/anaesthesiologist and other individuals involved must document relevant information about the incident.
5. The primary anaesthetist/anaesthesiologist, after discussion with the incident supervisor, must write relevant information about what happened and what actions were taken on the patient's medical record. Do not erase or obscure information on the record. If a correction is necessary, lightly cross out the original; initial and date. Additions to and explanations of notations on the record can be made, for example, to explain issues where professional judgment was involved.
6. The primary anaesthetist/anaesthesiologist must complete and file an incident report as soon as practical.
7. Others individuals involved in the incident should document their observations soon after the event. The documentation should be returned to the hospital Patient Care Assessment Coordinator or other appropriately designated individual.
8. When writing about the events.
  - i. State only the facts as you know them.
  - ii. Do not make judgments about causality or responsibility
9. Do not use judgmental terms or phrases.
  - i. Give the highest priority to continue involvement in follow-up care of the patient.
  - ii. Consult early and frequently with the surgeon.
  - iii. Immediately call upon other consultants who may help improve long term care or recovery.

#### **Follow-up Investigations**

The HoD shall be informed of each adverse event and will designate who shall supervise the event follow-up and investigation beyond the immediate actions. The follow-up supervisor shall:

1. Notify the individuals involved of their responsibilities as defined in this document.
2. Be responsible for assuring that procedures are followed to the extent necessary, reasonable and possible.
3. Maintain communication with those who are providing continuing anaesthesia care, providing guidance and advice as needed.
4. Ensure that information regarding the adverse event is communicated through the proper channels to the departmental quality assurance program.
5. The need to maintain equipment sequestration shall be determined by the incident follow-up supervisor and the individual responsible for managing anaesthesia technology.
6. If it is unlikely the equipment was related to the event, the equipment can be returned to service after routine inspection.

7. If it is possible that the equipment was related to the event, the following procedures should be implemented and supervised by the individual responsible for managing anaesthesia technology or his designee:
  - i. Store the equipment in a secure location. Label it DO NOT DISTURB.
  - ii. Document its physical condition and notable features as received and record its identification, e.g., serial number.
  - iii. Do not alter or inspect the equipment in any way that could affect further investigation.
  - iv. Conduct a thorough inspection of the equipment in the presence of the primary anaesthetist/consultant anaesthetist, the insurance carrier, hospital Risk Manager, equipment manufacturers or any of their designees.
  - v. Continue to verify and document medical care provided to the patient following the event.

### **Summary of Responsibilities for Adverse Event Protocol**

1. Primary Anaesthetist/Anaesthesiologist must concentrate on continuing care.
2. Do NOT discard supplies or apparatus or tamper with equipment.
3. Document events in the patient's record.
4. Do NOT alter the record.
5. Stay involved with follow-up care.
6. Contact consultants as needed.
7. Submit a follow-up report.
8. Document continuing care in the patient's record. Incident supervisor, e.g., Anaesthesia Clinical Director, Team Leader should advise the primary anaesthetist/anaesthesiologist and other personnel involved.
9. Verify close contact with the surgeon and other consultants.
10. Contact the hospital Risk Manager.
11. Contact the manager for anaesthesia equipment or an alternate.
12. HoD or Clinical Director should directly supervise or delegate responsibility for incident investigation.
13. Anaesthesia equipment manager or an alternate must assure impounding of equipment, if necessary, and determine appropriate disposition of equipment.
14. If pharmaceuticals or supplies were involved which may create hazard to other patients, contact pharmacy, materials management, nursing or other departments.
15. Supervise continuing investigation of equipment or supplied -related issues or contact the manufacturer if appropriate.
16. The follow-up Supervisor should notify the individuals involved of their responsibilities as defined in this document.
17. Be responsible for assuring that procedures are followed to the extent necessary, reasonable and possible.
18. Maintain communication with those who are providing continuing anaesthesia care, providing guidance and advice as needed.
19. Ensure that information regarding the adverse event is communicated through the proper channels to the department quality assurance program.

**Ind 116. The pre-anaesthesia assessment results in formulation of an anaesthetic plan for each patient, which is documented.**

**Survey Process:**

Review and validate the anesthesia plan is based on the pre-anesthesia assessment results. An anesthesia plan for a patient is prepared on the basis of Pre-anesthesia assessment in which any risks are identified and appropriate anesthesia approach is determined and documented.

**Scoring:**

- If there is documented anesthesia plan based on pre-anesthesia assessment by anesthetist then score as **fully met**.
- If the anesthesia plan is not based on Pre-anesthesia assessment then score as **not met**.

**GUIDELINES**

**Anaesthetic Plan**

The plan should mention the pre-medications, type of anaesthesia i.e. GA, regional or local, the drugs to be used for induction and the drug to be used for maintenance. It should also mention about other concomitant medications and IV fluids, special monitoring requirements with appropriate and anticipated post-anaesthesia care. However the plan and the anaesthesia professionals should be responsive to the condition of the patient on the Operation Table and any changes made in the Anaesthesia Plan must be documented with justification.

The pre-anaesthesia assessment should identify any risks and determines the appropriate anaesthetic approach (for example, a patient with multiple back injuries or surgeries might not be a safe candidate for a spinal anaesthesia or a patient with chronic obstructive pulmonary disease might not be a safe candidate for inhalation anaesthesia).

## Assessment Scoring Matrix

**Standard 26. COP 5: Policies and procedures guide the administration of anaesthesia.**

Indicator 106-116		Max Score	Weightage (Percentage)	Score Obtained
Ind 106.	An anaesthesiologist is available along with qualified staff to take care of patients from evaluation till handing over patient to ward after surgery.	10	100	
Ind 107.	There is a documented policy and procedure for the administration of anaesthesia.	10	100	
Ind 108.	All patients for anaesthesia have a pre-anaesthetic assessment and an anaesthetic plan formulated by a qualified individual.	10	100	
Ind 109.	Informed consent for administration of anaesthesia is obtained by a qualified member of the anaesthetic team.	10	100	
Ind 110.	An immediate pre-operative (pre-induction) re-evaluation is documented.	10	100	
Ind 111.	During anaesthesia, monitoring includes regular and periodic recording of heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation, airway security and patency, and level of anaesthesia.	10	100	
Ind 112.	No anaesthetic is administered unless the identity of the patient is guaranteed.	10	100	
Ind 113.	Each patient's post-anaesthetic status is monitored and documented.	10	100	
Ind 114.	A qualified individual applies defined criteria to transfer the patient from the recovery area.	10	100	
Ind 115.	All adverse anaesthesia events are recorded and monitored.	10	100	
Ind 116.	The pre-anaesthesia assessment results in formulation of an anaesthetic plan for each patient, which is documented	10	100	
<b>Total</b>		110	-	

## Standard 27. COP-6: Policies and procedures guide the care of patients undergoing surgical procedures.

### Indicators (117-126):

#### Ind 117. The surgery-related policies and procedures are documented.

#### Survey Process:

There are written policies that include pre-operative, intra-operative and postoperative care. Staff members are aware of the policies and procedures and there is observable evidence that they are being applied.

#### Scoring:

- If there are written policies for pre-operative, intra-operative and postoperative care, and these are implemented then score as **fully met**.
- If there is non-compliance to any of the above, then score as **not met**.

### GUIDELINES

#### Policies, Procedures and Documentation

The HCEs shall develop Operational Policies and Procedures clearly describing the key processes of the Operating Room (OR) and/or the department, the responsibility of the staff and expected results. Record/document should provide accurate information for analysis and evaluation.

The policies shall explicitly declare Operating Rooms/Operating Theaters (OTs) as Restricted Areas allowing only the concerned personnel to enter them, to keep the environment clean and infection free. There should be clearly visible boards displaying "Restricted Area". The HCE shall notify that only designated staff and patients who need surgical procedure are permitted in the OR/OT after identification and following the prescribed protocols.

1. Written up-to-date procedures are available, followed by staff and include, but are not limited to, the following:
  - i. Signage declaring the OT as a restricted area and identification of persons allowed in the OT.
  - ii. Sterilization and identification of sterilized OT equipment.
  - iii. Separation and transport of dirty linen.
  - iv. Pre-operative assessment and instructions.
  - v. Routine equipment check and preparation.
  - vi. Annual review of functioning equipment in line with the services offered by the OT.
  - vii. Transportation of clients/patients from the ward to the OT and back.
  - viii. Transferring of patient onto a stretcher/chair from within the OT and not allowing a Stretcher/Chair from outside into the OT.

- ix. Admission to the Operating Department.
  - x. Identification of clients/patients.
  - xi. Identification of operation site.
  - xii. Recovery.
  - xiii. Inoculation injury.
  - xiv. Staff protection against exhaust from anaesthetic gases.
  - xv. Post-operative care.
  - xvi. Handover procedures for pre-operative and post-operative clients/patients.
  - xvii. Diathermy use.
  - xviii. Tourniquet use.
  - xix. X-ray use.
  - xx. Laser use.
  - xxi. Swab, needle and instrument count.
  - xxii. Infected clients/patients.
2. It is mandatory to maintain the following records in the OT:
- i. Anaesthesia Register
  - ii. Surgeon's Register
  - iii. Prosthesis Register
  - iv. Electro medical equipment inventory
  - v. Sterilization of Equipment and Linen Record
  - vi. Record of correct swab/instrument count
  - vii. Controlled Drugs
  - viii. Biopsy Specimens Register
  - ix. Record of weekly/monthly analyses of surgeries (including the ICD-10 Code)
  - x. Schedule for operations of the next day
  - xi. Maintenance of stock levels of drugs and consumables (Stock Register)
  - xii. Duty Roster
  - xiii. List of all OT Staff with their Qualifications
  - xiv. Job Descriptions (JDs) of all OT Staff
  - xv. Operation Theatre Management Committee (OTMC) Quarterly Minutes of Meetings
  - xvi. OT Waste Disposal Record

**General Management of Operation Room/Theatre:**

Each OR/OT/Suite is managed by an OR/OT Manager, who shall be an anaesthetist or a suitably qualified and registered senior OT nurse/technician or senior OT assistant in order of preference.

**Job Description of OR/OT In charge:**

**1. Job Summary**

The OT in-charge shall be responsible for maintaining the standard of the OT/Suite to meet all the functional requirements, in the highest quality manner.

**2. Scope**

The OT in-charge shall be responsible for the overall administrative in-charge of the OT, Pre-OP and Post-OP Wards/Rooms.

**3. Duties/Responsibilities**

- i. To ensure regular upkeep, functionality and maintenance of physical infrastructure and

equipment of the OT e.g., anaesthesia machines, diathermy machines, ventilators and other electro-medical equipment, at all times.

- ii. To ensure the regular supply of medicines/anaesthetics/consumables and positive stock of other essential commodities in the OT as per requirement.
- iii. Give technical advice to the OTMC for the purchase of new equipment/instruments, as and when required.
- iv. To supervise the OT Staff including Staff Nurses, OTAs, Surgical Orderly/Porter and Cleaning Staff, to ensure their performance as per their JDs, SOPs and SMPs. The strength of the team is determined by the number of functioning operating theatres and operative workload of the HCE.
- v. To ensure compliance of SOPs on IC and WM in the OTs, Pre and Post -Operative Wards.
- vi. To ensure that sterilization services of the theatre are adequate and correctly performed to prevent cross infections.
- vii. Attend OTMC meetings as per schedule at least once in the first week of every quarter.

The OTMC shall arrange appropriate tools/registers in the theatre for establishing OR/OT - MIS and maintain all the relevant records in safe custody for any future reference.

Tools/registers for this purpose include, but are not limited to, the following:

#### **1. Surgeon's Register:**

The Surgeon's Register is intended for recording the essential details of the surgical procedure undertaken by the operating surgeon.

**Purpose:**

To serve as the permanent record of surgical procedures and important findings/events.

To serve as a tool for assessing and providing annual data about the number and quality of procedures conducted in the given OT.

**When Recorded:** Immediate post-op period

**Responsibility of:** Surgeon or 1st Surgical Assistant

#### **2. Anaesthesia Register:**

The Anaesthesia register is intended for recording the essential details of the anaesthesia provided to patients.

**Purpose:**

- i. To serve as the permanent record of anaesthetic services provided to patients.
- ii. To serve as a tool for assessing and providing annual data about the number and types of anaesthetic services provided in a particular OR/OT.

**When Recorded:** Following complete recovery from anaesthesia

**Responsibility of:** Anaesthetist

#### **3. Stock Register for Electro-medical Equipment:** It is intended for recording the movement of electro-medical theatre equipment in and out of the operating theatre store.

**Purpose:**

- i. To serve as the permanent record of electro-medical-equipment received by and distributed from the OT store.
- ii. To serve as a tool for assessing and providing annual data on stock positions of electro-medical theatre equipment in the OT store.

**When Recorded:** On every transaction, relevant entries are made in the register accordingly. The inventory register is validated after a physical check of the equipment every year.

**Responsibility of:** The OT store-keeper/OTA for maintaining the store.

4. Prosthesis Register: An implant is defined as a device intended to be introduced into a surgically or naturally formed cavity of the human body to continuously assist, restore, or replace the function of an organ system or structure of the human body for more than one year.

**Purpose:**

- i. To serve as the permanent record of prosthesis received by and distributed from the OT store.
- ii. To serve as a tool for assessing and providing annual data on stock positions of prosthesis in the OT store.

**When Recorded:** Every time a transaction is made, relevant entries are made in the register accordingly.

**Responsibility of:** The OT store-keeper/OTA responsible for maintaining the stock.

A stock register for the implants should be maintained and staff should be able to confirm that implants are available prior to the day of surgery. Availability of implants will be re - confirmed prior to transfer of the patient from the pre-op Holding Area into the OT on the day of surgery. The latest time for confirmation of implant availability will be in the OT, prior to induction of anaesthesia.

The OTMC, comprising of the Head of Anaesthesia and Surgical ICU, in-charge OT and respective Heads of all surgical departments, will review and approve a list of surgical procedures with mutual consultation annually, keeping in view the availability of qualified staff, equipment and other essential inputs and processes. Copies of the revised list will be circulated among the committee members and communicated to the relevant staff of the respective departments.

**Anaesthesia Services are provided by Qualified, Registered and Experienced Anaesthetists:**

Anaesthesia services are to be provided by qualified anaesthetists in the HCE. The minimum selection criteria for the post of anaesthesiologist includes a major or minor diploma registered with the PMDC.

**Job Description of Anaesthetist In charge:**

**1. Job Summary**

Responsible for maintaining a high standard of anaesthesia services in all functioning OTs of the HCE at all times.

**2. Scope**

The Anaesthetist In-charge will be responsible for the overall administrative and technical oversight of the Anaesthesia Department and Intensive Care Unit (ICU). Along with his/her colleagues and other staff (anaesthesia and ICU staff/assistants), he/she ensures an optimum level of patient care during the perioperative period in the OT, Recovery Room or Post Anaesthesia Care Unit (PACU) and ICU, to achieve the desired outcome as per the HCE's stated policies.

### **3. Duties/Responsibilities**

The following duties and responsibilities serve only as guidelines and may be adopted by the individual HCE after making necessary modifications best suited to its circumstances:

#### **i. General**

- a. To manage, supervise and facilitate the smooth functioning of anaesthesia services, during elective as well as emergency operative procedures, performed in the OT 24/7.
- b. To ensure that all the patients on the operative list are examined pre-operatively, a day before they are scheduled for surgery and assessment of anaesthesia fitness and written instructions with regards to specific pre-operative instructions are provided to the duty staff.
- c. To finalize the OT list after certification of the fitness of patients needing general or spinal anaesthesia.
- d. To administer anaesthesia with the best of skills and care, observing the SOPs and SMPs to ensure safe induction and smooth recovery.
- e. To communicate necessary information to the operating surgeon regarding the general condition of the patients before, during and after the operation/procedure.
- f. To ensure that patients remain pain free and under full relaxation pre- operatively as well as during the immediate post-operative period.
- g. To ensure that sufficient stock of life saving drugs and anaesthesia gases are available in the OT at all times.

#### **ii. Teaching**

Teaching and training Medical, Nursing and Paramedical Staff as per departmental /specialty requirements/protocols and work instructions.

#### **iii. Supervisory**

- a. Supervise the functioning of Staff Nurses and paramedical staff of the Anaesthesia Department and ICU.
- b. Supervising and managing activities of post-graduate students of anaesthesiology (if applicable).

#### **iv. Representation**

To present the management issues in the meetings of OTMC, or matters requiring urgent attention to the Medical Superintendent/Medical Director (MS/MD)

#### **v. Reports and Returns**

Submit departmental Statistics to MIS through MS/MD.

#### **vi. Medico-Legal**

Follow pertinent SOPs on the subject whenever needed.

#### **vii. Quality Control/Conformance to Standards**

Comply with service deliverance as provided in the MSDS and SOPs especially on IC, WM and SMPs.

#### **viii. Performance Evaluation**

To write Objective Performance Evaluation Reports of subordinate staff based on achievements against set targets and JDs.

#### **ix. Skills**

Have good communication skills and be computer literate with a capability to work on common/routine components of the Microsoft Office Package.

#### **x. Attitudes and Personal Qualities**

Pleasant, caring and conscientious in handling the patients with extreme care.

**Note: Physical, mental and psychological fitness will be mandatory for the candidates.**

### **24/7 Anaesthesia Services**

The HCE shall ensure that an anaesthetist supported by a designated, suitably trained member of staff (OTA, anaesthesia technician) is present for all surgical procedures 24/7 in the OT Department. Elective surgical procedures are performed during the routine working hours, usually from 8 am to 2 or 4 pm, while emergency procedures are conducted throughout the day. Facilities with more than one theatre or increased operative workload may require more than one anaesthetist to provide adequate coverage to the elective list of procedures but one anaesthetist may be sufficient to provide coverage to the emergency procedures. Duties of anaesthesia assistants and OT staff are rotated to cover 24 hours.

### **Anaesthesia Support Team**

1. The consultant anaesthesiologist is supported by a designated team of anaesthesia and OT technicians for the delivery of proper anaesthetic services. These qualified technicians may range from graduates to diploma holders.
2. Graduates are those who have successfully completed four years training of Medical Technology in Anaesthesiology and acquired a degree, whereas Diploma holders are those having successfully completed one-year training in Anaesthesiology from any accredited institute/hospital and obtained a diploma from appropriate Registering/regulating bodies such as the Khyber Pakhtunkhwa Medical Faculty etc. The strength of the team would depend upon the operative workload and number of functioning theatres in the HCE.

### **Job Description of Consultant Surgeon:**

Following duties and responsibilities only serve as guidelines and may be adopted/modified as per the requirement of the HCE to meet the specific needs:

***Figure 22: A view of Surgery in Progress***



#### **1. Job Summary:**

Responsible for a high standard of surgical work in the HCE and any outreach services assigned.

#### **2. Scope:**

The visiting surgeon shall ensure smooth service delivery by him/herself and through staff and

colleagues. The extent of the work includes: attending patients in surgical OPD and admitting those requiring 24 hours surveillance, care or surgical intervention, planning and performing surgeries on specific/notified days and providing post-operative care. Teaching through lectures/tutorials and bedside coaching is also imparted as per requirement in accordance with the stated policy of the HCE.

N.B: The consultant shall be obliged to perform any other professional assignment as per requirement of the HCE/direction from the MS/MD. He/she should exhibit a sound physical, psychological and mental fitness to undertake the responsibilities demanded by the position.

### **3. Duties and responsibilities:**

For consultants who are also In-charge of the surgical Unit

#### **i. General**

- a. Administrative and Technical in charge of Surgical Unit and its Human Resource.
- b. To remain available during working hours for routine/emergency cases and teaching.
- c. To be second on call after working hours.
- d. To ensure attendance of the subordinate staff through the registrar.
- e. To check punctuality of the staff attached to his/her section.
- f. To check whether the cleanliness and up keep of the wards has been ensured by the SR/Sister in charge.
- g. Coordinate and supervise scheduled functioning of various surgeons of his unit.
- h. To supervise the upkeep and maintenance of all medicines, stores and electro-medical equipment present in the ward and OT by the SR/Sister in charge.
- i. To supervise timely replenishment of stocks of medicines and other supplies.
- j. To prepare recommendations for the purchase of new equipment.
- k. To supervise working of subordinate staff and check their performance as per JDs, SOPs and SMPs.

#### **ii. Preventive**

- a. To supervise the enforcement of IC and WM practices in the OPD, Wards and OTs and ensure compliance.
- b. To ensure that instruments/equipment being used in the OTs for surgeries are properly sterilized.
- c. To ensure that all staff participating in the surgery is physically well protected.

#### **iii. Health Promotional**

To develop IEC material for the patient to provide information about conditions requiring surgery, injury prevention and ways to promote physical health.

#### **iv. Curative/Clinical**

- a. Overall responsible for the smooth functioning of the Surgical OPD and care provided to admitted patients in the surgical beds/unit.
- b. To attend patients in Surgical OPD with his/her team on the specified/notified time and days, as per the HCE Policy.
- c. To attend all the surgical patients screened by junior colleagues and referred from elsewhere.
- d. To plan and perform surgeries on specified days and time as per the HCE policy.
- e. To perform emergency surgeries on patients admitted through the A&E Department, as and when required.

- f. To countersign post-operative notes and instructions, documented by the first assistant.
- g. To visit each patient, admitted under his/her supervision, at least once per day and subsequently as and when required, according to the patient's condition.
- h. To ensure that the treatment prescribed to the patients is being properly administered.

**v. Rehabilitative**

To recommend physiotherapy and other rehabilitative measures as indicated.

**vi. Participation in Community Health Activities**

To participate in community health activities and help formulate public policy in this regard.

**vii. Teaching and Research**

- a. Teaching and training Medical, Nursing and Paramedical Staff as per requirement and institutional policy.
- b. To write and supervise research articles based on the local experiences, at least once in a year.

**viii. Performance Evaluation**

- a. To evaluate the performance of subordinate staff based on achievements against set targets.
- b. To write performance evaluation reports of subordinate staff.

**ix. Representation**

- a. To inform the HCE administration about the administrative issue/s requiring remedial action.
- b. To submit a progress report annually and inquiry reports as required by the administration of the HCE.
- c. To follow SOPs regarding Medico-Legal Cases/Reports (MLC/MLR).

**x. Quality Control/Conformance to Standards**

- a. To ensure that SOPs and SMPs related to the assignment are strictly followed by him/herself and his/her team.
- b. To ensure that JDs have been provided and understood by the staff.
- c. To ensure that services are delivered in accordance with the MSDS and SOPs especially on IC, WM and SMPs.

**xi. Skills**

- a. Skilled to perform all minor and major general surgical procedures/ operations with precision.
- b. Have good communication skills and computer literate with capability to work on common/routine components of Microsoft Office Package

**xii. Attitudes and Personal Qualities**

- a. To be pleasant, caring and conscientious in handling the life and limb of patients with extreme care.

**xiii. Visiting Consultant Surgeon**

- a. A visiting consultant surgeon is mandated to provide surgery, assistance and advice generally in accordance with a signed agreement.
- b. Currently employment on contract basis is not practiced in the public sector HCEs, whereas it is the usual mode of recruitment in the private sector. In order to protect the rights of both patients and consultants, the HCE management and consultants

should be legally bound to have a written agreement/contract between them.

- c. Such an agreement may be developed to suit the specific requirements of a particular HCE. Regular employees of both public and private health facilities do not come under the purview of such contracts.

**A signed agreement with the HCE offering more comprehensive services ensures provision of necessary surgeries.**

Surgical patients in need of higher-level care not available in a particular HCE may be referred to a specialized facility offering a specific service. Such referrals in the public sector do not require any formal agreement but to ensure un-interrupted continuum of care in the private sector, an agreement defining terms and conditions is required between the two institutions and inked by the respective authorities.

**Performance Audit**

Regular Performance Audit of the surgical unit is carried out by a person or a committee formally notified by the HCE. Findings of the audit shall be documented and the information shall be shared with the OTMC and the HCE's Quality Assurance (QA) Committee. The audit shall take into account issues relating to optimum operating theatre utilization, efficiency and productivity.

The purpose of a performance audit of the OT is to maximize operational efficiency at the cost of minimum resources.

The OTMC should Aim at:

1. Ensuring patient safety and the highest quality of care.
2. Providing surgeons with appropriate access to the OT.
3. Maximizing the efficiency of OT by optimum utilization of staff and materials.
4. Decreasing patient delays.
5. Enhancing satisfaction among patient and staff.

Timely planning by the OT staff will maximize focus on the care, safety and satisfaction of patients and the HCPs. However, in case of poor planning and management, the staff may waste efforts and resources to rush cases, reschedule surgeries and get involved in other damage controlling measures, thus compromising full attention to the patient.

An OT in-charge/manager must select the criteria, key performance indicators (KPIs), or a set of benchmarks to assess overall functioning of the OT. An analytic tool used to rate surgical suites in order to quantify the efficiency levels of the OT is as on the following page:

*Table 19: Format for Scoring/Quantifying Performance of OT*

Measurements	Poor performance	Medium Performance	High Performance
Start-time tardiness (mean tardiness for elective cases/day)	>60 min	45-60 min	<45 min
Contribution margin (mean) per operating room hour	<Rs.1,000/hr	Rs. 1-2,000/hr	>Rs. 2,000/hr
Turnover Time (for all cases mean time from previous patient out of the OT to next patient in the OT including setup and cleanup)	>40 min	25-40 min	<25 min

Prediction Bias (bias in case duration estimates per 8 hours of operating room time)	>15 min	5-15 min	<5 min
Prolonged turnover (% turnovers lasting more than 60 minutes)	>25%	10-25%	<10%

### Information for Planning

In order to ensure that the performance audit of OTs is meaningful, the HCEs shall establish and maintain a robust "Theatre Information System", integrated into all theatres and covering all specialties. Although maintaining manual records of OT utilization assessment will suffice for gauging performance of staff, feeding the data into computer software can greatly enhance the quality and utilization of data for quality improvement. The OT MIS will help to determine the most appropriate staffing levels and shift patterns. However, care must be taken to maintain staff strength and shift patterns that are both practical and manageable. A sample "Operation Theatre Efficiency Measurement Tool" to be used for the OR/OT audit, with information recorded by the theatre staff, is provided ahead.

*Table 20: Operating Theatre Efficiency Measurement Tool*

Performance measure	Yardstick
Ratio of actual session hours used to planned hours	Targets set by (OTMC)/year (Should Ideally be >90%)
Ratio of number of sessions held to number planned	Same
Number of cancelled operations as percentage of original list	Same
Net operating hours starting or finishing late or early	Same
% of operations cancelled by the hospital on the day for non-clinical reasons, where patients were offered another date within 28 days	Same
% of operations cancelled by the hospital on the day for non-clinical reasons where patients who were treated within 28 days	Same
Excess staffing costs (poor, medium and high performance)	Same (recommended <5%)
Start-time tardiness (mean tardiness for elective cases/day) (poor, medium and high performance)	Same (recommended <45%)
% workdays PACU admission delays (poor, medium and high performance)	Same (recommended <10%)
Prolonged turnover- % turnovers lasting > 60 min (poor, medium and high performance)	Same (recommended <10%)
Ration of actual session hour used to planned hour	Same
Out-of-hours work	-
Percentage of all cases that are undertaken out of hours	Same

Percentage of emergency cases having perioperative deaths	Same
Planning	-
Number of electives in patient theatre cases per 1000 elective inpatients admissions referred for surgery	Same
Number of elective day case theatre cases per 1000 elective day cases referred for surgery	Same
Number of emergency theatre cases per 1000 emergency cases referred for surgery	Same

Any changes required to be practiced or introduced for provision of services by the HCE in light of the result of the audits, are discussed with all the concerned staff before implementation. The outcome of the audit shall be shared with the OTMC, which modifies strategy and prepares an implementation plan in the light of its report. The QA Committee of the health facility reviews both the audit report and the OTMC plan and suggests amendment/s in the existing safety and quality guidelines, if deemed necessary.

**The OTMC will hold a meeting at least once every quarter to:**

Assess utilization, performance, efficiency and productivity of OTs in light of the audit report.

1. Discuss any changes that may be required to improve equipment safety and quality of care in view of guidelines by the QA Committee.
2. Discuss issues requiring urgent intervention and recommend remedial actions.
3. Review and approve the list of new surgical procedures and required equipment to be procured.
4. Set performance targets for the next quarter.

**Sterilization and identification of Sterilized OT Equipment and Linen:**

The HCE shall have a uniform policy for sterilization, transportation, and identification of sterilized equipment in all functioning OTs. Instruments after use are cleaned, decontaminated, sterilized and stored in controlled environment either in the Central Sterilization Services Department (CSSD) or are processed within the OT, providing there is a separate space for this activity. Overall policies regarding disinfection, sterilization and the recommended physical layout are discussed in Section 2.5 dealing with Hospital Infection Control (HIC).

It shall be mandatory for the HCE to provide safe and adequate facilities and equipment to meet the needs and volume of patients undergoing procedures in the ORs/OTs. The following points must be observed;

1. The HCE shall ensure that ORs/OTs are not accessible to the general public.
2. Hazard and/or warning notices shall be clearly displayed before restricted and high-risk areas.
3. There shall be a clear separation of "dirty" areas and OT/s.
4. Changing facilities shall be provided for the OT staff to ensure that persons only wearing the theatre dress enter the OT/s.
5. It shall be further ensured that the person/s entering the theatre do not cross "dirty" areas. Leaving the OR/OT in the theatre dress shall be strictly prohibited and in case of any verifiable emergency departure, the dress shall be changed for re-entering

**Ind 118. Documented policies and procedures address the prevention of adverse events like wrong site, wrong patient and wrong surgery.**

**Survey Process:**

This is a critically important patient safety issue. Review a representative sample of medical records of patients who had surgery, look for the following implemented and documented processes: marking of the surgical site when there is the possibility of bilateral confusion, a pre-operative checklist to ensure that ALL documents (X-rays, medical records, etc.) and needed equipment is available, and a "time out" prior to induction of anesthesia to ensure that ALL members of the surgical team are in agreement that this is the correct patient; this is the correct procedure for this patient, and that this is (if relevant) the correct side/site. This process should be led and duly authenticated by the surgeon.

**Scoring:**

- If ALL 3 requirements (marking when relevant, use of a checklist, and a "time-out" recorded) are used and documented in the medical record, then score as **fully met**.
- If ANY of the three requirements are not documented in the medical record, then score as **not met**.

**GUIDELINES**

**Prevention of Adverse Events**

In order to ensure patient safety, care shall be taken and "Time Out" protocols shall be used to avert potential blunders regarding operating on the wrong site, wrong patient and performing the wrong procedure.

***Identification of clients/patients:***

**Purpose**

To establish the identity of the patient and match the correct patient for an intended clinical procedure on the correct site.

**Scope**

The SOP applies to establishing patient identity and confirming consent prior to any clinical activity including withdrawal of blood sample, introduction of oral/parenteral medication, performance of medical imaging and non-invasive/invasive and non-surgical/surgical procedures in the OT. In case of a surgical procedure, patient/client identification process also includes the verification of correct side/site of surgery. The SOP shall also be applied for reviewing imaging or other investigations in the OT.

**Procedure**

The identification processes are applicable differently in different settings and staff shall apply Patient Identification Procedure (PIP) as appropriate to the setting and intended clinical activity. Responsibility for ensuring the correct patient for a specific clinical activity/procedure generally lies with all staff concerned with the care of the patient. However, the surgeon and nurse responsible

to assist the procedure are ultimately responsible for the verification of proper identification of the patient.

In order to ensure that the correct patient undergoes the correct clinical activity/procedure on the correct site, the following five fundamental points need to be verified immediately prior to the procedure in the OT.

#### **TIME OUT Protocol**

1. Confirming **identification** of the patient.
2. Checking and confirmation of **consent** by the patient.
3. Checking the **Correctness of Procedure or Surgery** to be performed.
4. Marking of the **Correct Site** for surgery or other invasive procedures, as applicable.
5. Verification that **diagnostic images** (and/or other relevant test results) are available and are correct, as applicable.

Patients shall be encouraged to actively participate in the identification process. Staff shall explain to the patient the importance of repeatedly asking about identification, reassuring that this measure is to ensure patient's safety. For example, the patient can be explained that:

1. To ensure your safety, each time you are moved within the hospital or before having any treatment, you need to tell your name and DoB to make sure you are the correct person and get the correct treatment.
2. For an un-conscious patient or infant, name tags (as bracelets or wrist bands) shall be applied at the time of admission to facilitate identification process and shall be referred to each time any clinical activity is intended.

In case of any discrepancy, the intended clinical activity must not proceed until it has been resolved. Any member of the treating team can ask to stop the procedure in case there are any concerns.

#### **Marking the Site for Surgery or other Invasive Procedures**

Site marking is essential in cases where there is potential for error involving left/right distinction, multiple structures (e.g. fingers/toes, lesions) or levels (e.g. spine). In such cases the site should be marked:

1. With an indelible skin marker where practical using initials, 'yes' or a line representing the proposed incision. Using 'X', shall be avoided as this may be interpreted incorrectly.
2. While marking the site/side, the patient should be awake, aware and involved if possible and should occur before the patient enters the operating/procedure room.

**Note:** an exception may be made for paediatric patients who may be marked under anaesthesia to avoid causing distress. In this instance, the correct site/side must be confirmed verbally by a parent/guardian, where possible.

3. The site must be marked, and initialled, by the person performing the procedure (or another senior team member who has been fully briefed about the operation or procedure).
4. Skin preparation and draping, once appropriate marking has been completed, must be documented in the clinical record.
5. A patient's refusal to have the site marked must also be documented in the clinical record.

**The patient should have at least two corroborating identifiers as evidence to confirm identity**

Using two patient identifiers improves the reliability of the patient identification process and decreases the chance of performing wrong procedure on the wrong patient. Examples of acceptable patient identifiers include:

1. Name
2. Assigned identification number
3. Telephone number
4. DoB
5. Social security number
6. Address
7. Photograph

Prior to starting the surgical procedure, patient identification must be cross checked to verify correct patient, correct procedure to be performed, and correct surgery site.

**All patients undergoing a surgical procedure should wear an identifying marker.**

1. The wristband should be placed on the wrist of the non-operative/non-affected side of the body.
2. If the wristband is required to be removed, it is recommended to be placed with the patient chart in order to be immediately replaced on the wrist at the end of the procedure, or a new wristband is obtained and placed with the patient chart for immediate placement on the wrist.

**Note: Verifying the correct operative site is the responsibility of the surgical team members.**

## **Ind 119. Surgical patients have a pre-operative assessment and a provisional diagnosis documented prior to surgery.**

### **Survey Process:**

Review a representative sample of medical records of patients who underwent surgery to determine if a pre-operative assessment (surgeon's history and physical examination or pre - operative note) is present and that a pre-operative provisional diagnosis was documented.

### **Scoring:**

- If there is a pre-operative history and physical examination or a pre-operative note by the surgeon that includes a provisional pre-operative diagnosis, then score as **fully met.**
- If there is a pre-operative history and physical examination or surgeon's note, but no preoperative provisional diagnosis, then score as **partially met.**
- If there is no pre-operative history and physical examination or surgeon's note, then score as **not met.**

## **GUIDELINES**

### **Pre-Operative Assessment**

It shall be mandatory that all elective patients are assessed pre-operatively on a Pre-Operative Assessment Form covering the following;

1. Diagnosis

2. Required Surgical Procedure

3. Fitness for undergoing the required surgical procedure

The assessment will be completed in the OPD/respective unit for which patients will be referred to various physicians/anaesthetists for expert advice to bring their co-morbidities such as hypertension, ischemic heart disease, diabetes mellitus etc. within acceptable control.

**Ind 120. An informed consent is obtained by an authorized member of the surgical team prior to the procedure.**

**Survey Process:**

Review the same representative records as in Indicator 101 to determine if an informed consent was obtained and documented in the medical record. The informed consent must include evidence that the patient was educated/informed. This is surveyed in the same way as policies and procedures for the administration of anesthesia.

**Scoring:**

- If all the reviewed medical records document an informed consent (a signed form or a note by the surgeon, then score as **fully met**.
- Since this is a significant medico-legal issue, if ANY of the reviewed records does not have documentation of informed consent, then score as **not met**.

**GUIDELINES**

**Informed Consent for Surgery**

It is mandatory that the patient/next of kin have the need for the surgery/procedure explained to them in detail, along with how it will be carried out and the pros and cons of the procedure/operation. It is essential that the consent is taken (preferably) by the surgeon him/herself or one of the doctors from his team, after properly introducing him/herself and explaining the requirement of the operation/procedure. The consent shall be taken on Informed Consent for Surgery Form.

Details regarding informed consent of the patient have been discussed in Section 2.9 covering Patient's Rights and Education.

**Ind 121. Persons qualified by law are permitted to provide treatment and/or perform the procedures that they are entitled to perform.**

**Survey Process:**

The surveyors should ask for the number and type of services provided by the hospital and ensure that the relevant specialist is available for treating patients accordingly. Look for registration with PMDC as specialist and ask for documents that demonstrate a process to validate the qualifications, experience and registration status of physicians / surgeons to ensure that they are legally permitted and competent to perform specific procedures. The scope of clinical practice shall be defined and

documented for all surgeons and performance monitored through the recording of adverse outcomes and peer review.

**Scoring:**

- If the relevant specialists, as per PMDC registration, including physicians and surgeons are available for all services provided by hospital to treat the patients and perform procedures, then score as **fully met**.
- If the relevant specialists, as per PMDC registration, including physicians and surgeons are not available for all services provided by hospital to treat the patients and perform procedures, then score as **not met**.

**GUIDELINES**

**Authorization to Perform Procedures**

It is the prime duty of all inclusive: the HCE's Executive staff, governing body and the HR Department, to ensure that the credentials of the doctor/surgeon/professionals are correct and required and/or the declared qualification should be properly verified by at least the PMDC, CPSP and/or any other recognized regulatory body in the country. A Credential Verification Form is required to be maintained by the HR Staff.

*Table 21: Sample Credential Verification Form*

<b>CREDENTIAL VERIFICATION FORM</b>
Serial No. _____
Name of Healthcare Provider: _____
Designation: _____
Registration Valid Until: _____
Verified By: _____

The surgeon/proceduralist should be allowed to practice only after necessary verification of his/her credentials and requisite experience as required, and the HCE shall also issue a notification to this effect.

*Table 22: Sample Incumbency List*

No.	Name	Qualifications	Appointment	Remarks
1.	Prof. Dr. (HOD Surgery)	MBBS, FRCS	Prof. of	
2.	Dr. (Registrar)			
3.	Dr. (PG Trainee)			

Signatures and Stamp of Hospital Administrator

**Ind 122. A brief operative note is documented by the surgeon or a doctor in the surgical team prior to transferring the patient out of the recovery area.**

**Survey Process:**

Review the same representative medical records as noted for Ind 100. Determine if there is a documented operative note that was recorded and signed prior to the patient being transferred from the recovery area. Also, while in the recovery area, review the medical records of patients who are about to be transferred out of the recovery area to determine if an operative note signed by the surgeon is in the medical record.

**Scoring:**

- If there is an operative note and it was documented in the medical record prior to transfer from the recovery area, then score as **fully met.**
- If there is either no operative note, or it was completed after the patient was transferred out of the recovery area, then score as **not met.**

**GUIDELINES**

**Post-Operation Notes**

Operation notes are recorded in the patient chart immediately following surgery and the same is entered in the OT Register/EMR. This note provides information about the procedure performed, post-operative diagnosis and the status of the patient before shifting and shall be documented by the surgical assistant, countersigned by the operating surgeon. The record includes the following given on a Post-Operative Note Format;

1. Date and duration of operation.
2. Anatomical site/place where surgery is undertaken.
3. The name of the operating surgeon/s, operating assistants including scrub nurse and the name of the consultant.
4. Number of prosthetics used.
5. Details of the sutures used.
6. Swab count.
7. The ICD-10 Coded diagnosis made and the procedure performed.
8. Description of the findings.
9. Details and serial and instrument count.
10. Immediate post-operative instructions.

It is mandatory for the surgeon or his first assistant to put down everything he does in the OR to the patient/client during a surgical procedure. As the record may have lot of bearing on the patient's health in future, it is important not to leave anything essential. A typical Operating note delineates all such aspects to ensure that every necessary detail is entered, as is described in the following sample operating note format. It has three major sections; the first two are filled by the operating surgeon or his first assistant and the 3rd section is filled by the scrub nurse.

Table 23: Template for Operating Note

<b>Operating Note</b>	
<b>Section-I:</b>	
Patient's Name _____	Age/Sex _____
Bed/Room No. _____	
Date of admission _____	Admission No. _____
Date of Operation _____	
Emergency/OPD No. _____	
Referring Consultant _____	
Pre-op diagnosis _____	(ICD Code: _____)
Post-op diagnosis _____	(ICD Code: _____)
Surgeon _____	
Assistant/s _____	
Anesthetist/s _____	
Anesthesia given _____	
Name of the procedure _____	(ICD Code: _____)
Duration of procedure _____	
<b>Section-II: To be filled by Surgeon or First Assistant</b>	
<b>1. Procedure:</b> The procedure describes all steps from skin incision (or entry of endoscope) till the closure of wound (or removal of scope)- name of the procedure is also mentioned (if known). It must also mention the following: <ul style="list-style-type: none"> <li>A. Anatomical site surgery performed.</li> <li>B. All types of sutures used and the layers of tissues closed by them.</li> <li>C. Sites and types of drains inserted.</li> <li>D. Type and serial no of prosthesis used.</li> </ul>	
<b>2. Findings:</b> <ul style="list-style-type: none"> <li>A. Must describe all that is found relevant to the pathological nature and extent of disease.</li> <li>B. Must also mention if encountered any unexpected pathology or intra -operative complication.</li> </ul>	
<b>3. Post- op instructions:</b> <ul style="list-style-type: none"> <li>A. Whether to send patient/client back to ward/room or ICU from Recovery Area.</li> <li>B. Any specific instructions to be followed immediately in the recovery area.</li> <li>C. Instructions for next 24- 48 hours (specific management and treatment).</li> <li>D. Instructions regarding pathological specimen - specific test required - from where.</li> </ul>	
<b>Surgeon's/first assistant's signature</b>	
<b>Section-III: To be filled by scrub nurse</b>	
<ul style="list-style-type: none"> <li>1. Intra operative estimated blood loss</li> <li>2. Intra operative IV fluid/blood transfused</li> <li>3. Intra operative urine output (if catheterized)</li> <li>4. Whether swab and instrument count was complete</li> </ul>	
<b>Scrub nurse name and signature</b>	

**Anaesthetic Records contain:**

1. Date and duration of anaesthesia.
2. Operation performed.
3. Name of the anaesthetist, anaesthesia assistant and, where relevant, the name of the consultant anaesthetist responsible.
4. Pre-operative assessment by the anaesthetist.
5. Drugs and doses given during anaesthesia and route of administration.
6. Monitoring data.
7. Intravenous fluid therapy.
8. Post-anaesthetic instructions.
9. Any complications or incidents during anaesthesia.
10. Signatures of anaesthetist and anaesthesia assistant.

Perioperative monitoring and evaluation is carried out by the anaesthesia team and the record is maintained for future reference. Provision of safe and effective anaesthesia demands proper and thorough perioperative assessment and care of every patient and to choose the type of anaesthesia best suited to the patient's instant need and requirement. This is continued in four phases:

1. Pre-anaesthesia period
2. Intra operative period
3. Immediate post-surgical period (up to 36 hours)
4. Post-operative period

Pre-Anaesthesia Assessment is usually initiated an evening before the patient is put on the list by the concerned anaesthetist, who may ask for more tests before giving his/her final approval for the surgical plan. Comprehensive evaluation of the patient shall entail taking into account the patient's past medical and surgical history as well as the outcome of complete systemic physical examination and necessary investigations.

**Ind 123. The operating surgeon or the surgical assistant<sup>102</sup> documents the post-operative plan of care.**

**Survey Process:**

Review representative sample of records as noted for **Ind 101** and validate that the surgeon or the surgical assistant has written post-operative orders.

**Scoring:**

- If there are post-operative orders, then score as **fully met.**
- If there are no post-operative orders, then score as **not met.**

GUIDELINES
<p><b><u>Post-Operative Plan of Care</u></b></p> <p>Postoperative care includes, care given during the immediate postoperative period, both in the OR</p>

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<sup>102</sup> Medical practitioner directly involved with the surgical procedure

and post-opt recovery area, as well as during the days following surgery.

The postoperative care aims to ensure smooth and uneventful recovery after the surgical procedures. The plan shall include advice on IV fluids, medication, care of wound, nursing care and observing for any complications, etc. A good outcome includes adequate pain management and recovery without complications (such as Surgical Site Infection (SSI), perioperative myocardial infarction, venous thromboembolism, post-operative pneumonia). It promotes healing of the surgical incision and returns the patient to a state of health. Another objective of postoperative care is to assist patients in taking responsibility for regaining optimum health.

Postoperative care involves assessment, diagnosis, planning, intervention, and outcome evaluation. The extent of postoperative care required depends on the pre-operative health status of the individual and type of surgery. Patients admitted to the hospital may require days or weeks of postoperative care by hospital staff before they are discharged. Post-OP recovery area should be adequately staffed.

### **1. Post-operative Care in Recovery Room**

The patient is transferred to the Recovery Room or PACU after recovery from the effects of anaesthesia.

### **2. First 24 hours**

After the patient is transferred from the post-op recovery area, the nurse taking charge over his or her care should quickly assess the patient's overall condition and carefully read and follow the post-operative instructions written by the surgeon and anaesthetist. As a routine, the following parameters of patients who underwent general or spinal anaesthesia or received intra-venous sedation, are frequently monitored and assessed every 15 to 30 minutes depending upon the patient's overall status during first 24 hours and management instituted, if required, in consultation with the doctor on call:

- i. Neurological, respiratory and circulatory status.
- ii. Any pain and nausea (any need for medication).
- iii. Body temperature (any need a warming blanket or warmed IV fluids or cold sponging).
- iv. The status of incision, any drainage tubes.
- v. Fluid intake and urine output (the doctor on duty should be notified if the patient has not urinated in 6-8 hours after surgery).

Effective preoperative counselling has a positive impact on the first 24 hours after surgery. It shall be ensured that patients and attendants are communicated the importance of the following information pertaining to post-operative period:

- i. Respiratory exercises prevent post-op pneumonia.
- ii. Movement is imperative for preventing blood clots, (sequential compression devices are recommended for patients who are not able to sit up in bed due to the surgery).
- iii. Pain should be kept under control to allow breathing and movement. (The patient should be encouraged to splint any chest and abdominal incisions with a pillow to decrease the pain caused by coughing and moving).
- iv. Patients need to be kept NPO (Nothing per Oral i.e. nothing by mouth) if ordered by the surgeon, at least until the return of cough and gag reflexes.
- v. Patients often have a dry mouth following surgery, which can be relieved with oral sponges dipped in ice water or lemon ginger mouth swabs.

vi. Patients should have easy access to call bell or lights to call staff.

Patients who are discharged home after a day surgery procedure are given prescriptions for their pain medications, and are responsible for their own pain control and respiratory exercises. Their families (or caregivers) should be included in preoperative counselling so that they can assist the patient at home. The patient should be reminded to call his or her physician if any complications or uncontrolled pain arise. These patients are often managed at home on a follow-up basis by a hospital-connected visiting nurse or homecare service.

### **3. After 24 hours**

- i. Routine monitoring continues but is less frequent (every 4-8 hours, if the patient is stable).
- ii. The patient should be sitting up in a chair at the bedside and ambulating with assistance by this time. Respiratory exercises continue and limited oral intake may be permitted as per surgeon's instruction and gradually increased.
- iii. The patient is monitored for any evidence of potential complications, such as deep vein thrombosis (DVT), pulmonary embolism, wound dehiscence and paralytic ileus etc. In case of any complication the surgeon should be notified immediately.
- iv. Patients should receive a great deal of information regarding postoperative care including educational materials such as handouts and video tapes so that they have a clear understanding of what to expect postoperatively.

### **4. Aftercare**

Aftercare should ensure that patients are comfortable either in the bed or chair and their dressings are changed in time. Patients are given the opportunity to ask questions and to learn certain techniques/exercises to be performed once they return home.

### **5. Handing over of post-operative patient in PACU to ward staff**

Patients should be accompanied by a suitably trained staff and porter during transfer to the ward. The anaesthetic record, recovery note and prescription charts must accompany the patient. The recovery nurse must ensure that full clinical details are relayed to the ward nurse with particular emphasis on problems and syringe pump setting (if in place).

### **6. Procedures for pre-operative and post-operative handover of the patients**

Continuity of information through different shifts of duty staff posted in surgical departments is vital to the safety of patients. With the increase in the number of individuals caring for patients, the need of handing over comprehensive clinical information is of critical importance. Good handover does not happen by chance and requires concerted and coordinated effort by both the incoming and outgoing members of the team. Broad guidelines regarding proper handover and improved outcome are as under:

- i. Shifts must coordinate.
- ii. Adequate time must be allowed.
- iii. Handover should have clear leadership.
- iv. Information technology support may be provided.
- v. Sufficient and relevant information should be exchanged to ensure patient safety.
- vi. Junior members of the team are adequately briefed about the clinically unstable patients.
- vii. Tasks not yet completed should be clearly understood by the incoming team.

## 7. Action to be taken subsequent to Handover

- i. Prioritizing the tasks.
- ii. Puffing plans for further care into place.
- iii. Review unstable patients more frequently.

The changing patterns of work in the HCEs have created a need for improved handover of clinical responsibility and information. In order to maintain high standards of clinical care, developing protocols for effective and safe handover, enhanced training and good communication amongst the staff are essential to protect the safety of patients when shifts are introduced.

Formal handover shall be part of good professional practice as a failure in this process, or poor-quality handover, is a significant risk to patients.

It is the shared responsibility of the staff and the HCE to ensure safe continuity of information and responsibility between the changing shifts, as it influences the delivery of care to the patient for the whole shift.

## Ind 124. A quality assurance program is followed for the surgical services.

### Survey Process:

Review any documentation such as minutes of a Quality Improvement Committee or minutes of Surgical Department meeting or research projects that demonstrates that quality indicators of surgical care are defined and are being monitored.

### Scoring:

- If there is documented evidence that some aspects /indicators of the quality of surgical care are being monitored, then score as **fully met**.
- If there is no monitoring of surgical care, then score as **not met**.

## GUIDELINES

### Surgical Quality Assurance Program

Quality Assurance (QA) in surgical services shall be an integral part of the overall QA program of the organization. It shall focus on post-operative complications, e.g. bleeding, post-operative infections, rational use of antibiotics etc.

#### 1. Salient features of the QA Programme in a surgical department

- i. Provide efficient services and support to the surgical department.
- ii. Provide adequate infrastructure for effective and efficient surgical services.
- iii. Provide a hygienic environment reducing nosocomial infection.
- iv. To impart surgical skills to doctors and nurses.
- v. Scheduling the procedures on a 'first come first serve' basis/need basis.
- vi. Conducting all planned surgeries in routine working hours (e.g. 9.00 am to 5.30pm).

#### 2. Inventory management

- i. An adequate inventory of emergency medicines and consumables shall be maintained.
- ii. Routine requisitions to the stores shall be carried out on a daily basis as per the day allotted.

- iii. An inventory register for operating instrument sets and individual instruments, mentioning the date of purchase, shall be maintained.

### **3. Equipment maintenance**

A log book of all equipment with respect to their date of purchase, preventive maintenance, repairs conducted etc. shall be maintained.

### **4. Staffing schedules**

Monthly duty schedules ensuring availability of adequate staff shall be projected.

### **5. Policies to ensure Quality**

- i. Duration of time for the OTs to be operational for planned surgeries (ideally 9.00am to 5.30pm) shall be notified.
- ii. OTs shall be adequately staffed with qualified personnel in terms of Medical, Nursing and Paramedical staff (OT technicians/ assistants etc.).
- iii. Floors of OTs shall be antistatic for the safety of patients as well as staff.
- iv. OTs shall be shared by surgical departments for optimum utilization.
- v. Visitors or patients shall not be allowed in the OT except with explicit permission from the OT in charge.
- vi. Assistant Surgeons not employed with the HCE shall not be allowed to assist in the OT and in case of need, the Operating surgeon shall seek prior permission from the OT In charge.
- vii. The OT assistant shall be informed by the operating surgeon well in advance for any specific requirement for a particular surgery to make the necessary arrangement.
- viii. Any death of patient in the OT should be informed to the Doctor In charge and the body should be handed over to the relatives or police only after completing the medico-legal formalities, if any.

### **6. Process Prior to Procedure**

- i. Check for all required diagnostic reports.
- ii. Check for the patient's clinical record.
- iii. Written and informed consent from patients/relatives.
- iv. Written and informed consent from spouse to be obtained in case of procedures involving reproductive organs.
- v. Recheck if the right patient is being sent for the appropriate procedure.
- vi. Check for preoperative preparation.
- vii. Check all the equipment and consumables required for the surgery and anaesthesia.

### **7. Regulations**

- i. Weekly fumigation of the theatre complex and whenever 20 or more cases are conducted in a single day or an infected case has been operated upon in an OT.
- ii. Disinfecting/washing all the instruments immediately after each procedure.
- iii. Calibrating all the machines as per standards by the Operation Theatre Assistant (OTA0/nurse before the OT starts for the day.
- iv. All the persons entering the sterile area of the theatre premises will change to sterile clothes and foot wear - separate for the OT.

- v. The OTA/Nurse shall ensure daily that all the lines of the medical gases, oxygen, suction etc. are functional.
- vi. Procedures to be done on a first come first serve basis.
- vii. The OTA will ensure dispatch of the dirty linen to the Sterilization Department before the OT closure at the end of the day.
- viii. The OTA will ensure dispatch of all the instrument trays to the CSSD before the OT closure at the end of the day.
- ix. The OTA/nurse will ensure cleaning of the theatre complex every day after routine hours.

## **8. Safety and Security Check List**

The OTA will ensure that the safety and security measures are strictly followed for the following according to detailed Checklists for each developed by respective specialists:

- i. Infection control
- ii. Fire hazards
- iii. Electric points and electric equipment
- iv. Pilferage
- v. Any wear and tear of equipment
- vi. Any damage or loss of operative instruments
- vii. Entry of unauthorized people in the OT complex
- viii. Leakage of medical gases
- ix. Use of mobile phones

## **9. Cleaning**

### **i. Between operations**

- a. Wrap wet, soiled and infected linen in red plastic bags and put them on the trolley for taking linen to the Sterilization Department.
- b. Collect all dry linen and put into the canvas laundry bags to be transported to the Sterilization Department.
- c. Wet mop the floor of the theatres and scrub with effective disinfectant.
- d. If the surgery was that of an infected case, fumigate the respective theatre.

### **ii. Daily**

- a. Sweep and wet mop all theatres.
- b. Wipe down all walls.
- c. Clean and disinfect castor and wheels on the furniture.
- d. Sweep and wet mop offices, lounges, bath, and storage rooms.
- e. Wipe OT light and fixtures with clean wet cloth.
- f. Clean windows and mirrors.
- g. Clean scrub sink, and soap dispensers.

### **iii. Weekly (when the OT is non-operational)**

- a. Remove portable equipment from the room.
- b. Clean overhead light and all fixed fixtures with soap solution and a wiper.
- c. Clean equipment before they are replaced in the room with soap and disinfectant. While replacing the equipment, roll the wheels across towel saturated with the same solution.

- d. Clean doors, hinges, glass inserts and rinse with disinfecting solution.
- e. Wipe down wall with clean sponge mop soaked in disinfecting solution.

**10. Internal Audit**

**i. OT Sister in-Charge/OTA**

- a. Ensure completeness of all the record.
- b. Post-operative notes are complete.
- c. Ensure that the preoperative preparations are proper.
- d. All the instruments and equipment are checked routinely by the OT staff.
- e. Cleaning and fumigation of the OT is done as per prescribed SOPs.
- f. Trained staffs are available for assistance.
- g. Keep a check on the medicines and consumables used.
- h. Patient is haemo-dynamically stable before shifting out of the OT.

**11. Management Information Systems**

The following data and statistics should be regularly generated to evaluate the productivity, efficiency, and quality of surgical activity:

- i. Intra-operative and post-operative morbidity record of individual surgeons.
- ii. Number of surgeries performed by individual surgeons.
- iii. Swab culture reports.
- iv. Quantity of medicines and consumables used.
- v. Theatre utilization review for optimum utilization.

A comprehensive surgical checklist incorporating everyday QC and highlighting key processes/ areas needing absolute attention shall be developed and used to ensure QC, patient safety and good surgical outcome in surgical departments. A surgical checklist adapted from WHO is given below:

*Table 24: Sample Surgical Checklist*

Before Induction of Anaesthesia		Yes	No	Not Applicable
1.	Site, procedure and consent?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Is the site marked?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Is the anaesthesia machine and medication check complete?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Is the pulse oximeter on the patient and functioning?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Does the patient have a known allergy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Difficult airway or aspiration risk?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7.	Risk of >500ml blood loss (7ml/kg in children)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Before Skin Incision</b>				
1.	Confirm all team members have introduced themselves by name and role.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Confirm the patient's name, procedure, and where the incision will be made.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Has antibiotic prophylaxis been given within the last 60 minutes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Anticipated Critical Events

#### 1. For Surgeon:

- a. What are the critical or non-routine steps?
- b. How long will the case take?
- c. What is the anticipated blood loss?

#### 2. For Anaesthetist:

Are there any patient-specific concerns?

#### 3. For Nursing Team:

- a. Has sterility (including indicator results) been confirmed?
- b. Are there any issues concerning equipment?
- c. Is essential imaging displayed?
  - Yes
  - Not applicable

### Before patient leaves operating room

#### 1. Nurse Verbally Confirms:

- a. The name of the procedure.
- b. Completion of instrument, sponge and needle counts.
- c. Specimen labelling (read specimen labels aloud, including patient name).
- d. Whether there are any equipment problems to be addressed.

#### To Surgeon, Anaesthetist and Nurse:

What are the key concerns for recovery and management of this patient?

This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged.

## Ind 125. The surgical quality assurance programme includes surveillance of the operation theatre environment.

### Survey Process:

The following evidence should be reviewed: i. Infection control surveillance, ii. Medical equipment maintenance, and iii. Cleaning of the theatres between cases. The results of these surveillance activities should be documented and tabled at the relevant committee meetings and minutes recorded.

### Scoring:

- If there is evidence that the safety and cleanliness of the operation theatre environment is evaluated, then score as **fully met**.
- If the safety and cleanliness of the operating theatre is not evaluated as above, then score as **not met**.

## GUIDELINES

### Surveillance of Operation Theatre Environment

The details about QA and surveillance of the OT environment have been discussed in Indicator No. 109, however the following factors merit special consideration;

#### Surveillance activities include:

1. Daily monitoring of humidity and temperature.
2. At least monthly monitoring of pressure differential.
3. At least a six month monitoring of integrity of filter.
4. Medical equipment maintenance.\*
5. In addition to this, efficacy of the OT cleaning and disinfection processes shall be monitored. Monitoring of humidity and temperature at least thrice daily at regular intervals by a designated staff of the OT maintenance team is considered important for patients as well as staff comfort. Similarly, a regular monthly check of the OT pressure differential and negative air pressure vented to the OT and a twice daily environmental cleaning of OTs should be done. Do not waste chemicals; only remove the dust with moist cloth, use chemicals/disinfectants only when contaminated with blood or body fluids.

#### Caring for floors:

1. Use only vacuum cleaners.
2. Do not use a broom.
3. Use a mop and keep it dry.
4. A simple detergent reduces flora by 80%.
5. Addition of disinfectant reduces to 95%.
6. In busy hospitals counts raise in 2 hours. However only 1% is pathogenic. Counts depend on the number of persons and only people needed for procedures should enter the theatres. Unnecessary movements disturb the flora. Most important component of bacteria is water; dry areas cause natural death.

**Care of Walls and Roofs of OTs:**

Frequent cleaning has little effect; do not disturb these areas unnecessarily. Do not use ceiling fans as they cause aerosol spread. Clean only when remodeling or dust is accumulated.

**Sterilization and Disinfection Policies:**

1. An Infection Control (IC) team shall be notified by the HCE.
2. The IC team decides the policies.
3. Educate the staff on methods and policies in hospital safety and hygiene.

**Surveillance for Microbes:**

Bacteriological surveillance testing at regular intervals is not warranted and is only conducted in case of modification of OTs or in case of any unforeseen increase of incidence of infection for any particular OT as per decisions of the ICC with specific inputs from Microbiologist. *Roles of SSIS Committee (Ind. 118), OTM Committee (Ind. 109), IC Committee (Ind. 153), IC Team (Ind. 154), ICO/ICN (Ind. 155), CQI Committee and QI Program Activities (Ind. 52) are referred to for further details regarding Bacteriological Surveillance.*

**Between Procedures in the OTs:**

1. Operation tables and theatre equipment to be cleaned with disinfectant solution and detergent.
2. In case of spillage of blood/body fluids, disinfect with bleaching powder/chlorine solution.
3. Waste to be discarded in prescribed plastic bags.
4. Bio hazard waste should not be allowed to accumulate in the OT.

**Procedure at the end of Day:**

1. Table tops, sinks, and door handles all to be cleaned with detergent/low level of disinfectant.
2. Floors to be cleaned with detergents and warm water.
3. Final mopping with disinfectant like phenol in the conc. 1:10 is recommended.

**\*Medical Equipment Maintenance:**

All electro medical equipment also needs to be regularly cleaned and disinfected after use.

**Ind 126. The surveillance programme also includes monitoring of surgical site infection rates.**

**Survey Process:**

This should be found in the minutes of an Infection Control Committee. Specifically look for evidence that the infection rates are physician / surgeon, procedure, and room specific as aggregate rates without organizing the data into categories are of little use. Determine the action that arises from the reports and determine if this is able to influence the rate of infection.

**Scoring:**

- If there is data about surgical site infections and it is segregated into individual physicians /

surgeon, procedures, and rooms, with evidence that remedial management has been initiated, then score as **fully met.**

- If there is data about surgical site infections, but only in the aggregate without specific analysis, then score as **partially met.**
- If there is no data about surgical site infections, then score as **not met.**

## GUIDELINES

### **Monitoring of Surgical Site Infection Rate**

Monitoring of Surgical Site Infection (SSI) rate is an integral part of effective surgical services feedback and is incorporated as one of the major performance indicators for quality assurance programme for surgical services. SSI is the second most common type of nosocomial infection acquired by the patients. These infections are responsible for increased hospital costs, increased mortality rates, increasing length of stay and consequently increased risk of harm to the patient.

Monitoring of the SSI rate advocates a preventive strategy through proper investigation, identification and rectification of the issue as soon as possible. It is imperative that each and every case of SSI be comprehensively put on paper for further review by the designated Surgical Site Infection Surveillance (SSIS) Committee of the hospital. Therefore, a robust documentation should be mandatory with daily follow ups and a well-prepared preventive guide lines for SSI needs to be in place, in the QA plan.

## Assessment Scoring Matrix

**Standard 27. COP 6: Policies and procedures guide the care of patients undergoing surgical procedures.**

Indicator 117-126		Max Score	Weightage (Percentage)	Score Obtained
Ind 117.	The surgery-related policies and procedures are documented.	10	100	
Ind 118.	Documented policies and procedures address the prevention of adverse events like wrong site, wrong patient and wrong surgery.	10	100	
Ind 119.	Surgical patients have a pre-operative assessment and a provisional diagnosis documented prior to surgery.	10	80	
Ind 120.	An informed consent is obtained by an authorized member of the surgical team prior to the procedure.	10	100	
Ind 121.	Persons qualified by law are permitted to provide treatment and/or perform the procedures that they are entitled to perform.	10	100	
Ind 122.	A brief operative note is documented by the surgeon or a doctor in the surgical team prior to transferring the patient out of the recovery area.	10	100	
Ind 123.	The operating surgeon or the surgical assistant documents the post-operative plan of care.	10	100	
Ind 124.	A quality assurance program is followed for the surgical services.	10	100	
Ind 125.	The surgical quality assurance program includes surveillance of the operation theatre environment.	10	100	
Ind 126.	The surveillance program also includes monitoring of surgical site infection rates.	10	80	
<b>Total</b>		100	-	

## 2.8 Management of Medications (MOM)

### 03 Standards & 21 Indicators

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Medication errors are one of the most common healthcare issues, with a number of preventable drug-related injuries occurring in hospitals each year. Medication errors are also among the most frequently reported types of adverse events. Medication management standards help hospitals support patient safety and improve the quality of care by creating a system for selecting, procuring, storing, ordering, transcribing, preparing, labelling, dispensing, administering and monitoring medications. The following standards are designed to reduce practice variations, errors and misuse; encourage monitoring of the efficiency, quality and safety of medication management processes; promote the use of evidence-based good practices; and standardize processes throughout the hospital.

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## Standard 28. MOM-1: Policies and procedures exist for the prescription of medications.

### Indicators (127-133):

#### Ind 127. Documented policies and procedures exist for the prescription of medications.

#### Survey Process:

Review pharmacy and medication policies that relate to prescribing staff, administering staff and pharmacy staff. The important issue is that the policies explicitly define i. How medication orders/prescriptions must be written in the in-patient record and on an outpatient form, ii. Which staff can prescribe and which staff can administer. The policy should also inform what is done when the order or prescription is not accepted because of confusion about the order.<sup>103</sup>

#### Scoring:

- If there are policies for prescription/ordering of medications and the policy explicitly defines what is done when the prescription/order is not clear, then score as **fully met**.
- If there are policies for prescription/ordering of medication, but the policy does not define what is to be done when the prescription/order is not clear, then score as **partially met**.
- If there are no observable policies, then score as **not met**.

### GUIDELINES

#### SOPs on Prescription of Medications

In HCEs, only Medical Doctors and Dental Surgeons are authorized for Prescription Writing in their own fields. The following need to be complied with;

1. Authorized Physicians and prescribers (registered with PMDC) should prescribe in Public and Private settings and drugs should only be administered against a **Written Order** of a Physician.
2. Medicine prescribed by an outside medical doctor will not be administered in the hospital settings, except in case a patient is a long-term old case of an illness and he is on maintenance therapy; these drugs can be administered in the hospital with the approval of the treating Consultant. Use of the patient's own medication should be discouraged on account of abundance of counterfeit medications in the market. The patient's own medications should only be dispensed if not in hospital formulary. These drugs must be inspected by the Pharmacy Department to ensure that these are still valid and not deteriorated.
3. No drug will be administered to a patient without a valid prescription of the treating doctor. In an emergency when a consultant is contacted on the phone and the drug is prescribed by him, the medicine may be given to the patient under the signature of the locally available treating doctor and this should be authenticated by the Prescribing Consultant within 24 hours.

<sup>103</sup> Example - contraindicated due to other drugs prescribed or allergy, adult dose for child or restricted; wrong patient name or illegible.

4. The HCE should have a mechanism to oversee all drug related activities i.e. the HCE should have a multidisciplinary group or committee consisting of senior physicians from all major clinical disciplines, pharmacists and nurses; it could be called "**Drug Committee, Pharmacy and Therapeutic Committee**" or "**Formulary Committee**". It should oversee all activities related to medications in the hospital e.g.,
  - i. How medication orders/prescriptions must be written, including where they must be written in: the in-patient record or on an outpatient form.
  - ii. Which staff can prescribe and which staff can administer medicines. The policy should also inform what is to be done when the order or prescription is not accepted because of confusion about the order.
5. Elements of drug orders or prescriptions must be defined as follows;
  - i. Name.
  - ii. Age of the Patient.
  - iii. Any known allergies or contraindications; if no allergy is known then it states 'NKA'; information must not be omitted.
  - iv. In the paediatric population, **Weight** is mandatory.
6. Drugs must be written legibly and clearly, preferably according to the Generic Name, Brand name can be used in brackets.
7. Directions must be clearly stated. 'As directed' or 'when needed' must be avoided and should be qualified e.g. "Take one or two tablets for pain or headache" cautioning "Not to be taken empty stomach" and "Take one Capsule every 6 hours for five days" in case of an antibiotic course for chest infection etc.
8. The hospital must have approved abbreviations.

## Ind 128. The HCE formally determines who can write orders.

### Survey Process:

There should be a policy that identifies practitioners who may write medication orders in the medical record or on a prescription. However, determine if any other professionals who should not have been authorized (such as midwives, anaesthetic nurses, emergency nurses, dental assistants/technicians, podiatrists and psychologists) are permitted to write prescriptions or order medication. The policy should delineate which practitioners can prescribe restricted classes of drugs. For example chemotherapy or very expensive drugs or unlicensed drugs used as part of a research programme.

### Scoring:

- If there is a policy and the clinical staff members are fully aware of who may write orders and this is supported by evidence in the medication chart, then score as **fully met**.
- If there is evidence of any confusion or the policy is not clear about who (which professionals) is permitted to order or prescribe medication, then score as **not met**.

## GUIDELINES

### Medical Staff Authorized to Prescribe

Only a registered Medical Practitioner (Medical and Dental) is authorized to write prescriptions/prescribe medicines on their own, in accordance with the parameters of the hospital

formulary.<sup>104</sup> A patient specific direction is an instruction given by an independent prescriber to another professional to administer a medicine to a specific patient.

## Ind 129. Orders are written in a uniform location in the medical records.

### Survey Process:

While reviewing medical records, determine if medication orders are uniformly written in the same location in the patients' record across the various wards in the healthcare establishment.

### Scoring:

- If all of the medication orders are in the specified area of the reviewed medical record, then score as **fully met**.
- Since this is a common source of "oversight" errors, if any orders are not in the designated location, then score as **not met**.

## GUIDELINES

### Uniformity of Documentation

Each patient care plan includes written orders by individuals qualified to order and record patient orders, for example diagnostic tests orders for laboratory testing, orders for surgical and other procedures, medications orders, nursing care orders, and nutrition therapy orders.

*Figure 23: Sample Medical Record Form*



A uniform location in the patient's medical record or on a common order sheet, which is then transferred to the patient's medical record periodically or at discharge, facilitates understanding the specifics of an order, when the order is to be carried out, and who is to carry out the order. It also creates easy accessibility to the orders so that orders can be acted upon in a timely manner. Efforts must be made that Medication Orders are at least transcribed and shall be reviewed by the pharmacist before administration of the dose. Data shows that most errors occur at the point of transcription i.e. what the physician has prescribed and what has been dispensed and administered. Hospital staff should be aware and practice hospital policy which, amongst other policy statements,

<sup>104</sup> UK Medicines Act 1968 and Prescription Only Medicines (Human Use) Order 1997.

also states policies based on which orders must be uniformly written at specified sections on forms and then placed sequentially. Diagnostic imaging and clinical laboratory test orders must provide a clinical indication/rationale. There are exceptions in specialized settings, such as EDs and ICUs, where orders are to be located in the patient's medical record in a different manner.<sup>105</sup>

### **Ind 130. Medication orders are clear, legible, dated, timed, named / stamped and signed.**

#### **Survey Process:**

While reviewing medical records, determine if all medication orders are legible, dated, timed, named, and signed. Determine what is done if a medication order is not legible. The score is based on the cumulative findings of all the records reviewed.

#### **Scoring:**

- If ALL orders are legible, dated, timed, named, and signed, then score as **fully met.**
- If only 1-2 orders (max 20%) are not timed, then score as **partially met.**
- If 3 or more orders are not legible, dated, timed, named, and signed, then score as **not met.**

## **GUIDELINES**

### **Clarity of Medication Orders**

All medication orders are to be prescribed in writing which should be dated, timed and signed by the prescribing doctor. There must be a written physician's order for prescription and non - prescription medications. The prescriber must also note if the patient has any known allergies, contraindications and body weight, particularly for the paediatric population. Diagnosis is becoming an integral part of the medication prescription, due to 'drug to drug', 'drug to disease' interaction. The pharmacist should have an access to medication history i.e. preadmission medication, to avoid therapeutic duplication and to ensure continuity of therapy.

To have a complete Prescription Order (**annexures O<sub>1</sub> – O<sub>3</sub>**), the following eight items must be included:

The client's full name and parentage etc.

1. Weight
2. Allergies/Contraindications
3. The date of the order
4. Name of the medication
5. Dosage and administration information
6. Route of administration
7. Physician's Signature & Name or/and Stamp (containing name of Physician)

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<sup>105</sup> Joint Commission International (2010), Joint Commission International Accreditation Standards For Hospitals 4th ed. JCI, USA.

## Ind 131. Policy on verbal orders is documented and implemented.

### Survey Process:

Interview nurses and other personnel who receive verbal orders. Observe a staff member receiving a verbal order. The policy and practice should clearly describe the process including writing down the verbal order and reading it back to ensure that it was clearly understood by both, the person who gave the order and the person who received the order.

### Scoring:

- If there is a clear policy and practice for verbal orders, then score as **fully met.**
- If there is a policy but the process is not consistently followed, then score as **partially met.**
- If there is neither a policy nor a practice to verify verbal orders then score as **not met.**

## GUIDELINES

### SOPs on Verbal Orders

1. Verbal orders should only be used in exceptional circumstances. The diagnosis and health status as evaluated and documented by a doctor must be available if the prescribing doctor is not the one who made the initial assessment.
2. Only one stat dose may be prescribed verbally.
3. Verbal orders shall initially be taken by a Nurse, and repeated to a second Nurse.
4. The Nurse receiving the order must record the order on the drug treatment sheet. The entry is to be in red ink and should also include the time, date, name of prescriber and the Nurse's signature, as well as the second Nurse's signature.
5. The Nurse should repeat the order to the doctor to ensure that the details are correct.
6. The drug treatment sheet is to be countersigned by the doctor who gave the verbal order at the earliest possible time, within 24 hours.
7. If they are in any doubt, the Registered Nurse should seek clarification from the doctor until they are satisfied about the correctness of the:



8. The medication is now to be administered as per the Administration of Medication Procedure and the Medication Policy.
9. A verbal order should be reconfirmed if the nurse believes that it may compromise the patient's care and treatment.

10. NO Verbal Orders for High Alert Medications and High Risk Medications.<sup>106</sup> HCEs should declare their own list, based upon its usage of drugs, of High Risk and High Alert drugs e.g. (KCL, Magnesium Sulfate, Concentrated and Hypertonic Sodium Chloride etc.)<sup>107</sup>

### Ind 132. The hospital defines a list of high-risk medication.

#### Survey Process:

Review the list defining the high - risk medicine which must be readily available to staff. The list of high-risk medications must include at least: concentrated electrolytes such as KCl, chemotherapy, very high cost drugs, look alike medications, sound alike medications, biogenic products and psychotropics etc.

#### Scoring:

- If the hospital has a written list of-high risk medications, then score as **fully met.**
- If the hospital has a list of high-risk medications, but it does not include both look alike or sound alike medications, then score as **partially met.**
- If there is no list of high-risk medications, then score as **not met.**

## GUIDELINES

### Defining and Listing of 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.

Although any medication used improperly can cause harm, high-alert medications cause harm more commonly and the effect they produce is likely to be more serious and lead to the patient's suffering, and additional costs associated with care of these patients.

Known **Safe Practices** can reduce the potential hazard and harm. Although the list of high-risk medications includes many, but some of them have been associated more frequently with harm, such as anticoagulants, narcotics and opiates, insulin, concentrated electrolytes e.g. KCl, chemotherapeutics and sedatives etc. The most common types of harm associated with these medications include hypotension, bleeding, hypoglycemia, delirium, lethargy, and bradycardia.<sup>108</sup>

### Ind 133. High-risk medication orders are verified prior to dispensing.

#### Survey Process:

Interview both pharmacy and nursing staff since the safety issue is not just dispensing, but also administration.

<sup>106</sup> Check JCIA Manual 4th Edition or website [www.ismp.org](http://www.ismp.org) to get a complete list of medications.

<sup>107</sup> Emergency Orders and Verbal Orders (For Medication) Procedure - West Coast District Health Board.

<sup>108</sup> Institute for healthcare improvement (2013), *High alert medication safety* Retrieved from <http://www.ihl.org/explore/highalertmedicationsafety/pages/default.aspx>

## Scoring:

- If there is a clear practice (based on interviews with pharmacy and nursing personnel) of verifying the order for high-risk medications, then score as **fully met**.
- If there is no formally defined process, or if there is no list of high risk medications (Ind 124), then score as **not met**.

## GUIDELINES

### **Double-Checking SOP**

Caregivers should be mandated to Double Check all High-Risk Medications before administering. Double-Checking SOP is given below;

1. Independently comparing the Label and Product Contents in hand versus the written order or pharmacy-generated Medication Administration Record (MAR).
2. Independently verifying any calculations for doses that require preparation (e.g., any time the medication is not dispensed in the exact patient-specific unit).
3. Assuring the accuracy of infusion pump programming for continuous intravenous infusions of medications.
4. A Certificate to the effect that the Nurse/Dispenser has actually verified the High-risk Medication Order before administration, has to be inserted in the record of the patient and signed by the administering professional.

***Note: Manual double checks are not always the optimal error reduction strategy and may not be practical for every High Alert Medication administration (i.e., at small hospitals during the night shift, and in ORs.<sup>109</sup>***

### **Circumstances Increasing Risks/Errors in High Risk Medications**

1. Poorly handwritten medication orders.
2. Verbal directions/orders.
3. Similar product packaging.
4. Similar medication name.
5. Improper packaging leading to improper route of administration e.g. Oral liquid in IV syringe, Topical products stored in IV vials.
6. Storage of products with similar names in the same location.
7. Similar abbreviations.
8. Improper storage of concentrated electrolytes.
9. Branded Products i.e. "Auto Dispensing Modules" are to be avoided.

### **Strategies to Avoid Errors Involving High Risk Medications<sup>110</sup>**

#### **1. Medication arrangement:**

- i. Avoid storing look-alike, sound-alike (LASA) drugs next to each other (example: instead of storing by generic name (e.g. vincristine and vinblastine) store drugs by brand name (e.g. Oncovin and Velban).
- ii. Limit/eliminate high risk drug storage in Pyxis (i.e. list and store separately).

<sup>109</sup> University of Wisconsin Hospital & Clinics. UWHC Hospital Policy #8.33, High Alert Medications.

<sup>110</sup> University of Kentucky/ UK Health ca re. High Risk Medications Retrieved from <http://www.hosp.uky.edu/pharmacy/departpolicy/PH04-17.p df>.

**2. Formulary selection:**

Minimize LASA formulary combinations.

**3. Tallman lettering:**

- i. All medicines should be written in capital letters to eliminate illegible hand writing.
- ii. Labelling to emphasize differences in medication names (example: hydroxyzine vs. hydralazine).

**4. Computerized Prescriber Order Entry (CPOE):**

- i. Eliminates illegible handwriting.
- ii. Reduces opportunities for misinterpretation of verbal orders.

**5. LASA drugs could still be confused by Nurses/Dispensers:**

- i. System alerts are in place to safeguard selection.
- ii. Bar coding can serve as a double check system during medication, selection, preparation, and prior to administration.
- iii. Scanning a bar coded medication just prior to administration can detect many types of medication errors before they occur.

**6. Alert notes:**

- i. Highlighted stickers on packaging.
- ii. Pop-up messages attached to LASA drugs.
- iii. Highlighted drug storage areas.

## Assessment Scoring Matrix

### 2.8 Management of Medication (MOM)

**Standard 28. MOM 1: Policies and procedures exist for the prescription of medications.**

Indicator 127-133		Max Score	Weightage (Percentage)	Score Obtained
Ind 127.	Documented policies and procedures exist for the prescription of medications.	10	<b>80</b>	
Ind 128.	The HCE formally determines who can write orders.	10	<b>100</b>	
Ind 129.	Orders are written in a uniform location in the medical records.	10	<b>100</b>	
Ind 130.	Medication orders are clear, legible, dated, timed, named / stamped and signed.	10	<b>80</b>	
Ind 131.	Policy on verbal orders is documented and implemented.	10	<b>80</b>	
Ind 132.	The Hospital defines a list of high-risk medication.	10	<b>80</b>	
Ind 133.	High-risk medication orders are verified prior to dispensing.	10	<b>100</b>	
<b>Total</b>		70	-	

## Standard 29. MOM-2: Policies and procedures guide safe storage and dispensing of medications.

### Indicators (134-137):

#### Ind 134. Documented policies and procedures guide safe storage and dispensing of medications.

#### Survey Process:

The policies including at least: safe storage practices, matching the order with the correct patient and medication, confirming look alike drugs, and labelling.

#### Scoring:

- If there are policies and procedures and there is evidence that they are implemented, then score as **fully met**.
- If there are policies and procedures, but implementation is inconsistent, then score as **partially met**.
- If there are no policies and procedures or if none have been implemented, then score as **not met**.

### GUIDELINES

#### Storage and Dispensing Policy

Storage/warehousing is an important aspect of the total drug control system. Proper environmental control (i.e., proper temperature, light, and humidity, conditions of sanitation, ventilation, and segregation) must be maintained wherever drugs and supplies are stored. Storage areas must be secure; fixtures and equipment used to store drugs should be constructed so that drugs are accessible only to designated and authorized personnel. Safety is also an important factor, and proper consideration should be given to the safe storage of poisons and flammable compounds. External medications should be stored separately from internal medications. Medications must be stored in a refrigerator containing only medicines, and items other than drugs should be kept in a separate refrigerator.

#### **Drug Storage Site Inspections**

A minimum of quarterly inspections shall be carried out, under the direction of the pharmacist, of all medication storage areas within the hospital. A **Written Record** shall verify that **Safe Storage Practices** including the following are implemented:

1. The storage is properly maintained using stacks, bin cards and inventory control documents.
2. Medications are stored securely in the ward and available to the authorized personnel only.
3. Narcotic and controlled drugs are stored with proper measures of security.
4. Standards of neatness and cleanliness are consistent with good medication handling practices.
5. Reconstituted medications are properly labelled with expiry and preparation date.
6. Illegible labels are replaced.
7. Liquid bottles are clean and free of spills.

8. The patient's own medications are stored securely and separately.
9. Disinfectants and drugs for external use are stored separately from internal and injectable medications.
10. Medications are stored properly and medications requiring special environmental conditions for stability are properly stored.
11. Non-pharmaceuticals are stored separately from medications in the medication room fridge.
12. Expired or obsolete medications are not stocked.
13. Medications no longer required are returned to the pharmacy.
14. Medications are not overstocked.
15. Medications which may be required on an urgent or emergency basis are in adequate supply and readily available (Emergency Box, Crash Carts).
16. Medication room door/cart is closed when supervised and locked when unsupervised.

**Dispensing** shall be restricted to the Pharmacist or Pharmacy Technicians under the direction and supervision of the Pharmacist.

1. An automatic **Stop-Order Procedure** shall be developed for antibiotics, narcotics and other classes of drugs for which a limited duration of therapy is desirable. There shall be a system in place to notify the physician of the impending expiration of the duration of prescribed medication to ensure appropriate patient reassessment.
2. **Stat Orders** shall be processed and dispensed according to specific written procedures in accordance with hospital policy.
3. **Multi-Dose Vials** are dated upon first puncture; their maximum use should be defined.
4. The Pharmacist may **Substitute Therapeutically Equivalent Products** without consulting with the prescriber, provided the substitution has been approved by the hospital authorities (i.e. therapeutic interchange, equivalent oral dosage form substitution, dosage interval substitution, etc.) This should be clearly defined by the hospital like ACE inhibitors, Cephalosporin, Flouroquinolines. Mostly it is the generic substitute.
5. A **Prescription Drug Order** must be **communicated directly to a Pharmacist**, or when recorded, in such a way that the Pharmacist may review the Prescription Drug Order as transmitted. If transmitted orally or electronically, the prescription drug order shall be filed and maintained on paper of permanent quality by the pharmacist.

**Ind 135. The policies include a procedure for medication recall.**

#### **Survey Process:**

While visiting the pharmacy, review the procedure for medication / drugs recall. If there had been a recall, review the documentation of how it was done.

#### **Scoring:**

- If there is a procedure for medication recall, then score as **fully met.**
- If there is no procedure, then score as **not met.**

## GUIDELINES

### Medication Recall Procedure

Recall is a process<sup>111</sup> for withdrawing or removing a pharmaceutical product from the pharmaceutical distribution chain because of defects in the product, complaints of serious adverse reactions to the product and/or concerns that the product is or may be counterfeit. The recall might be initiated by the manufacturer, wholesale license holder, regulatory agency or Department of Health. A statement by a practitioner can be the reason for recall. Recall might be initiated as a result of reports or complaints on quality or safety of a pharmaceutical product referred to the Licensee from a variety of sources. The reports or complaints may be referred by manufacturers, wholesalers, retailers and hospital pharmacies, research institutes, medical practitioners, dentists and patients. Recall might also be initiated as a result of analysis and testing of samples of pharmaceutical products by the manufacturers and/or by the Department of Health (DoH). Recall of pharmaceutical products manufactured overseas might be initiated by the local or overseas health authorities, or from information received directly from such authorities.

Certain information is essential to permit assessment of the validity of the report of quality defects, safety or efficacy problem with pharmaceutical products, the potential danger to consumers and the action appropriate to the situation.

An Adverse Drug Reaction Form as per the specimen format given below can be used to report problems;

*Table 25: Pharmaceutical Product Problem Reporting Form*

<b>Pharmaceutical Product Problem Reporting Form</b>		
DETAIL OF THE PROBLEM		
Reporting Institution (institution reporting the problem of Pharmaceutical Product to DoH)		
Name of contact	Position/Occupation	
Organization		
Address		
E-mail address		
Tel: (Office)	(Mobile)	Fax:
Pharmaceutical product problem occurred in _____ (location)		
Nature of the problem		
Date of receiving complaint		
Source of Complaint	a) Patient      b) Customer      c) Retailer d) Self-inspection Other: _____	
Number of similar reports received _____		
Description of the problem (use separate sheet if space is inadequate)		
Results of tests/investigation on suspect or other samples		

<sup>111</sup> Department of Health Hong Kong, China. (2011). Pharmaceutical Products Recall Guidelines

Has manufacturer/distributor been contacted? _____ No _____ Yes (please write down their names)		
Other relevant information (attach photocopies, package insert and press release of oversea authority of the product if any)		
<b>DETAIL OF THE PRODUCT</b>		
Name of the product (as in product registration certificate)		Registration number
Active Ingredients and Strength		
Indications		
Dosage form		Pack Size
Batch number		Expiry Date
<b>Manufacturer</b>		
Name		
Address		
Tel	Fax	Manufacture Date
Quantity of the batch manufactured		Date and quantity released
Quantity on hold		Quantity distributed: local overseas
<b>Importer</b>		
Name		
Address		
Tel.	Fax	Import date
Quantity of the batch imported		Date and quantity released
Quantity on hold		Quantity Distributed: Local Re-exported
<b>Local Distributors (please attach distribution list)</b>		
No. of local distributors		
Name		
Address		
Contact Person		Tel (office & mobile)
Quantity on hold		Quantity distributed: Local Re-Exported
<b>Exporter</b>		
Has the product been exported outside _____ (Location)? a) Yes b) No		
If yes, specify the exported countries.		
Name of Reporter: _____		Post: _____
Contact No. (Mobile): _____		Date: _____
Signature of Reporter: _____		
Recall must be reported to the Department of Health within 24 hours of receipt of the complaint or report for investigation. The abovementioned Pharmaceutical Product Problem Reporting Form, together with opinions on toxicological or therapeutic hazards, and the action proposed by the authorities/organization should be referred onto the Department of Health.		

**Ind 136. Expiry dates are checked and documented prior to dispensing.**

**Survey Process:**

This is best surveyed by observation. While visiting emergency, outdoor, indoor, pharmacy/dispensary

and store(s) check a sample of medications for their expiry date. Check the procedure how the stocks are kept/used to ensure rotation.

**Scoring:**

- If no expired medications are found, then score as **fully met.**
- If there is any expired medication found, then score as **not met.**

## GUIDELINES

### Monitoring of Expiry Dates

The Pharmacy Department is responsible for conducting physical examinations of all medication to ensure their being intact and in date at the time of use. The pharmacy in-charge shall ensure implementation of the following SOPs for the Monitoring of Expiry Dates;

1. The orders for responsibility to check the Expiry Dates on Daily/Monthly/ Quarterly/Yearly basis should exist.
2. Once a drug is re-packaged in a separate container there is a reduction in the shelf life of the product, therefore, original expiry dates should not be used. It is the responsibility of the re-packaging technician to inspect these products for date of manufacturing and then proposed expiry.
3. Expired stock or products which expire within a month are pulled from the shelves and the purchasing cell notified of the need for additional stock.
4. The pharmacists and pharmacy technicians in the dispensing areas are responsible for the inspection of all drugs products in the working stock. Each technician will have a portion of the stock from the central pharmacy assigned for monthly inspection. A visual inspection for deterioration and expiry date shall be a normal part of the dispensing and checking procedure.
5. All expired repackaged products shall be pulled from the shelves and held in a segregated area for disposal.
6. All expired drugs which are in the original package shall be stored in a segregated area in the stockroom and will be processed as per hospital policy.

## Ind 137. Labelling requirements prior to dispensing are implemented.

**Survey Process:**

The hospital should have defined what is to be included on the label. When being dispensed directly to the patient this should include at least: i. Patient's name, ii. Generic and proprietary name of medication, iii. Concentration (dose/ strength), iv. Directions for use, v. Prescribing practitioner and vi. Date of dispensing. When dispensed to a patient care unit, the label should include ALL the above information. Check a representative sample of dispensed medications to determine how they are labelled.<sup>112</sup>

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<sup>112</sup> It is recognized that the establishment of appropriate systems may require a negotiated implementation time frame in some institutions.

### Scoring:

- If ALL medications are appropriately labelled, then score as **fully met**.
- Since this is an important patient safety issue, if any are not completely labelled, then score as **not met**.

## GUIDELINES

### **Labelling and Packing Rules**

The Government of Pakistan Drugs (Labelling and Packing) Rules of 1986 govern the manner of labelling of pharmaceutical products and the hospital pharmacy shall ensure compliance of these labelling requirements and conformance to the terms and conditions of the contract agreement and before acceptance of received supplies.

HCPs shall label all medications, medication containers (syringes, medicine cups, basins), or other solutions. This ensures safe medication practices and addresses a recognized risk point in the safe administration of medications in perioperative and other procedural settings. Errors, sometimes tragic, have resulted from medications and other solutions removed from their original containers and placed into unlabeled containers.

A standardized method<sup>113</sup> for labelling all medications will minimize errors. Anytime one or more medications are prepared but are not administered immediately, the medication syringe/vial will be labelled with drug strength, date, time and secured in such a way that it can be readily determined that the contents are intact and have not expired. At a minimum, all medications are labelled with the following information:

### **Medication Labelling Checklist**

1. Patient's Name.
2. Medication name, strength (concentration), and amount.
3. Expiry date when not used within 24 hours.
4. Expiry time when expiry occurs in less than 24 hours.
5. The date prepared and the diluents, for all compounded IV admixtures and parenteral nutrition solutions.

When preparing medications for multiple patients, or when the person preparing the medications is **NOT THE PERSON** administering the medication, the label must include the "**Patient name**".

In surgical or other procedural settings (radiology, other imaging services, endoscopy units, and patient care units) where "bedside" procedures are done, when medications are drawn up and put on the sterile field for **use during that specific procedure, at a minimum**, the label will include the following:

### **Bedside Medication Labelling Check List**

1. Medication name.
2. Medication strength (concentration).
3. Medication amount (if not apparent from the container).
4. Expiry date is required if the medication will not be used within 24 hours.

<sup>113</sup> Department of Pharmacy Policies and Procedures. (2011). Medication Labeling. Retrieved from <http://pharmacy.uams.edu/PNP/PNP523.htm>

5. Expiry time is required if the expiry will occur in less than 24 hours.

6. Date prepared and the preparer's initials.

7. Any remaining medication must be discarded immediately after the case/procedure.

If, during the perioperative or peri-procedural process, a solution or medication is poured, drawn into a syringe, or otherwise used from its original container and immediately administered, or disposed of in some fashion, labelling is not required.

## Assessment Scoring Matrix

**Standard 29. MOM 2: Policies and procedures guide the safe storage and dispensing of medications.**

Indicator 134-137		Max Score	Weightage (Percentage)	Score Obtained
Ind 134.	Documented policies and procedures guide the safe storage and dispensing of medications.	10	80	
Ind 135.	The policies include a procedure for medication recall.	10	100	
Ind 136.	Expiry dates are checked and documented prior to dispensing.	10	100	
Ind 137.	Labelling requirements prior to dispensing are implemented.	10	100	
<b>Total</b>		40	-	

## Standard 30. MOM-3: There are defined procedures for medication administration.

### Indicators (138-147):

**Ind 138. Medications are administered (dispensed) by those who are permitted by law and authorized to do so.**

#### Survey Process:

Review the law, authorization and then review a representative sample of medical records to validate that only those permitted by law have administered medication.

#### Scoring:

- If all drugs are administered by authorized staff, then score as **fully met.**
- If there is an evidence of medication administered by someone not authorized to do so, then score as **not met.**

### GUIDELINES

#### Authorization to Administer the Drugs/Medications

Administering a medication to treat a patient requires specific knowledge and experience. Each HCE is responsible for identifying those individuals with the requisite knowledge and experience, and who are also permitted by licensure, certification, laws or regulations to administer medications (PMDC Ordinance 1962, PMDC Amendment Act 2012, PNC Ordinance, Pharmacy Council Act, Khyber Pakhtunkhwa Medical Faculty Act, Pakistan Injured Person Act etc.) An organization may place limits on medication administration by an individual, such as for controlled substances or radioactive and investigational medications. In emergency situations, the organization identifies any additional individuals permitted to administer medications. A Specimen for Listing of Professionals Authorized to Administer the Drugs/Medications is provided below;

*Table 26: Specimen List of Professionals Authorized to Administer Drugs/Medications*

List of Professionals Authorized to Administer Drugs/Medications			
No.	Particulars of Professionals	Authorization PMDC/PNC/FPAHS	Validity Date
1.			
2.			
3.			
4.			
5.			
Signatures of Administrator HCE _____ Date _____			

## Ind 139. Prepared medications are labelled prior to preparation of a second drug.

### Survey Process:

Observe a nurse or an anesthetist preparing medication and verify that each medication is labelled prior to preparing the next one.

### Scoring:

- If all drugs are labelled prior to preparing subsequent medications, then score as **fully met**.
- If one or more violations of this requirement are noticed, then score as **not met**.

## GUIDELINES

### **Instant Labelling**

Prepared medicines are labelled immediately upon preparation, including, at minimum;

1. Patient's full name and a second patient identifier (e.g., medical record number, DOB).
2. Full generic drug name.
3. Drug administration route.
4. Total dose to be given.
5. Total volume required to administer this dosage.
6. Date of administration.
7. Date and time of preparation.
8. Date and time of expiration when not for immediate use.

### **Immediate use must be defined by institutional policy (e.g. use within 2 hours):**

Practitioners/institutions are not expected to be in full compliance with this standard if they currently have electronic systems that are unable to meet these labelling requirements. Appropriate changes should be implemented as soon as possible to ensure that electronic labels integrate all of these elements.

Practitioners/institutions that administer intrathecal medication maintain policies specifying that intrathecal medication will ***not be prepared during preparation of any other agents.***<sup>114</sup>

## Ind 140. Patient is identified prior to administration.

### Survey Process:

Review the policy and procedure. It should include the requirement for at least 2 separate ways of positively identifying the patient. Then interview a nurse to find out what is done in practice when administering medication and observe how the nurse identifies the patient. Patients should have a system of identification that is reliable and is with them at all times.<sup>115</sup>

<sup>114</sup> American Society of Clinical Oncology. (2011). ASCO-ONS Standards for Safe Chemotherapy Administration.

<sup>115</sup> For ALL patients the system employed must be permanently with the patient and fail-safe.

### Scoring:

- If 2 identifiers are routinely used, then score as **fully met**.
- If this practice is not uniformly followed (1 or more examples where there is failure to follow the procedure), then score as **not met**.

## GUIDELINES

### **Identification of Patient being Administered Medication**

In order to make sure that you are about to administer medications to the right individual, you have to know the individual. Even when you know the individual well, mistakes can happen. Sometimes, when medications are being administered to more than one individual in a setting, or if you prepare medications for more than one individual at a time, you can be distracted and give the medications to the wrong individual. So authorized Person/Nurse administering the medication should identify the patient every time and reflect on the patient's record.

### **Avoid Serious Mistakes by Complying with the following SOPs;**

1. Prepare medication for one individual at a time.
2. Give the medication to the individual as soon as you prepare it.
3. Do not talk to others and ask them not to talk to you when you are giving medication.
4. Do not stop to do something else in the middle of giving medications.
5. Pay close attention at all times when you are giving medications.
6. Must compare the individual's name on the prescription label, the medication order and the medication log. Make sure that they match. If they do not match, or if there is any doubt about whether you are giving the medication to the right individual, **ASK QUESTIONS!**

If you make a mistake, follow the SOPs for reporting medication errors. You may need to call the individual's physician, or take the individual to the emergency room for evaluation.<sup>116</sup>

## **Ind 141. Medication is verified from the order prior to administration.**

### Survey Process:

Observe nurses or doctors preparing medication and verify that the medication order was readily available and the type of medication was checked prior to preparing the medication.

### Scoring:

- If there is clear evidence that the order was checked by name, then score as **fully met**.
- If any example of medication not being checked against the order is seen, then score as **not met**.

## GUIDELINES

### **Medication Verification Instructions**

In order to ensure that right medication is being administered, the ahead mentioned points converted to a Checklist, should be used;

1. Read the medication label carefully (remember that some medications have more than one

<sup>116</sup> BDS Medication Administration Curriculum Section IV 2011

name: a brand name and at least one generic name).

2. Check the spelling of the medication carefully. If there is any doubt about whether the medication name is correct, stop and call the pharmacist before you give the medication.
3. Read the medication order carefully. Make sure that the medication name on the order matches the medication name on the label.
4. Read the medication log carefully. Make sure that the medication name on the label, the medication order and medication log match before giving the medication.
5. Look at the medication. If there is anything different about the size, shape or color of the medication, call the pharmacist before you give it. It could be that you have been given a different generic brand of the medication. But sometimes when a medication looks different it means that you have the wrong medication.
6. All high-risk medications which are known to cause serious reactions, should be checked for hypersensitivity reactions before administration (intra dermal check) e.g. Penicillin, ATS etc.

**Note: Prescription drugs shall be dispensed only pursuant to a valid prescription or a valid order. A pharmacist shall not dispense a prescription which the pharmacist knows or should know is not a valid prescription.**

## Ind 142. Dosage is verified from the order prior to administration.

### Survey Process:

Observe nurses or doctors preparing medication and verify that the medication order was readily available and the dose was checked prior to preparing the medication.

### Scoring:

- If there is clear evidence that the order was checked for dose, then score as **fully met.**
- If ANY example of dosage of medication not being checked against the order is seen, then score as **not met.**

## GUIDELINES

### Dosage Verification

The **right dose** is **how much** of the medication you are supposed to give the individual at one time. To determine the dose, you need to know the **strength** of each medication. In the case of liquid medications, you need to know the strength of the medication in each liquid measure. The dose equals the strength of the medication multiplied by the amount.

Ensure the following **Dose Verification SOPs** by comparing the Dose on the:

1. Prescription Label
2. The Medication Order
3. The Medication Log

**ALERT!** Always ask the pharmacist about any order that requires administering more than 3 tablets or capsules of the same medication in one dose. This could be an over-dosage!

## Ind 143. Route is verified from the order prior to administration.

### Survey Process:

Observe nurses or doctors preparing medication and verify that the medication order was readily available and was checked for route of administration prior to preparing the medication. The route means how and where the medication goes into the body.

Ensure the following Route Verification SOP by comparing the Route on the:

1. Prescription Label
2. Medication Order
3. Medication Log

### Scoring:

- If there is clear evidence that the order was checked for route of administration, then score as **fully met**.
- If ANY example of route of administration of medication not being checked against the order is seen, then score as **not met**.

## GUIDELINES

### **Route Verification**<sup>117</sup>

The route means how and where the medication goes into the body. Most medication is taken into the mouth and swallowed, but others enter the body through the skin, rectum, vagina, eyes, ears, nose, and lungs, through an NG-tube or by injection. The use of multiple routes of administration in one prescription must be avoided for the same high-risk medicine (e.g. IV/Oral).

Sometimes mistakes happen when you are giving several medications by different routes at the same scheduled time. For example, you may be giving an eye drop and an eardrop to the same individual at the same time. If you become distracted, you could accidentally put the eardrops in the individual's eye. This would be a very serious mistake.

When measuring and administering medicine doses, ensure required devices are used according to manufacturers' specifications and that they are used according to their stated purpose.

Ensure that strengths of medicines are clearly visible in terms of the dosage unit or dose per volume of liquid e.g. mg/ml. Ensure the following **Route Verification SOP** by comparing the Route on the:

1. Prescription Label
2. Medication Order
3. Medication Log

Additional care is taken when administering the following dosage forms:

1. Transdermal patches
2. Modified release oral medicines
3. Inhaled Medicines
4. Parenteral fluids.

<sup>117</sup> NSW Government. (2012). High Risk Medicines Management. Retrieved from [http://www.health.nsw.gov.au/policies/pd/2012/pdf/PD2012\\_003.pdf](http://www.health.nsw.gov.au/policies/pd/2012/pdf/PD2012_003.pdf)

## Ind 144. Timing is verified from the order prior to administration.

### Survey Process:

Observe nurses or doctors preparing medication and verify that the medication order was readily available and was checked for timing prior to preparing the medication.

### Scoring:

- If there is clear evidence that the order was checked for timing, then score as **fully met.**
- If ANY example of timing of medication not being checked against the order is seen, then score as **not met.**

## GUIDELINES

### Timing Verification

The general principles are that it is very important for medication to be given at the time of day that is written on the medication order. Some medications must be administered only at very specific times of the day. For other medications, the time of day that you give the medication is less critical. For example, some medications must be given before meals, one hour after meals or at bedtime in order to work best.

If no specific time is written on the medication order, ask the pharmacist about the best time of day to give the medication. Write this down on the medication log.

The **Dispensing Time SOPs** for Standardized Dose Administration throughout the hospital is that medications must be given as per guidelines of the Institute for Safe Medication Practices<sup>118</sup> for both Time-critical Scheduled Medication and Non-Time-critical Scheduled Medication. For the latter it is within 2 hours of the time that is listed on the medication log. This means that you have 1 hour before and 1 hour after it is due to administer the medication in order to be on time with medication administration.

## Ind 145. Medication administration is documented.

### Survey Process:

On the same representative medical records as in Ind 130, review the physician order then verify that ALL administered medications are documented in the record.

### Scoring:

- If ALL administered medications are documented, then score as **fully met.**
- If only 1-2 (cumulative from findings in ALL representative records a max 20%) examples of failure to document administration are observed, then score as **partially met.**
- If more than 3 documentation failures are observed, then score as **not met.**

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<sup>118</sup> <https://www.ismp.org/resources/guidelines-timely-medication-administration-response-cms-30-minute-rule>

## GUIDELINES

### Documentation of Medication

The following instructions must be acted upon for proper documentation;

1. Each time a medication is administered, it must be documented and signed with full name/stamp.
2. Medication must be documented at the time of actual administration.
3. All documentation required for the patient, must be completed on the medication log individually and not all together as a batch.
4. Documentation should be done in BLUE or BLACK ink.
5. NO PENCIL or WHITE OUT can be used.
6. NEVER OVER WRITE documentation.
7. In case of a mistake in documenting the medication log, CIRCLE the MISTAKE and write a note on the log to explain what happened.
8. Double check documentation done by you after finishing the medication process and again at the end of the duty.
9. Coordinate with a colleague to have documentation done by you double-checked for you, ask him/her to go over your medication log documentation to make sure that it is complete and vice versa.

## Ind 146. Policies and procedures govern patient's self-administration of medications.

### Survey Process:

Review the policy on self-administration. Interview a nurse to see if the policy is understood and speak with a patient to determine if they understand the instructions they have been given.

### Scoring:

- If there is a policy and it is understood, then score as **fully met.**
- If there is no policy or if nurses are unaware of the policy and procedure, then score as **not met.**

## GUIDELINES

### SOPs for Self-Administration of Medicines

Self-Administration of Medicines (SAMs)<sup>119</sup> is very useful as it enables patients in the hospital to manage their medication under supervision of health professionals in a way that mirrors their home situation and allows an assessment of the way they will cope after discharge.

The HCEs should adopt the following SOPs;

1. The SAM, either those brought into the organization or those prescribed or ordered within the organization, is known to the patient's physician and noted in the patient's record.
2. The organization controls the availability and use of medication samples.
3. Every patient entered in the self-administration scheme is given a Medicine Information Card

<sup>119</sup> Self-Administration of Medicines Policy Doncaster and Bassetlaw Hospitals ([www.dbh.nhs.uk](http://www.dbh.nhs.uk))

approved by the Drug and Therapeutics Committee which carries the following information:

- i. The name and strength of the medicine.
  - ii. The reason for taking the medicine.
  - iii. The time and dose of the medicine.
  - iv. Any special directions relating to the medicine.
  - v. Possible significant common side-effects of the medicine.
4. The Medicine Information Card is completed by the person assessing the patient, using the in-patient prescription chart as a guide. This information is checked by another trained nurse/pharmacist, or pharmacy technician to ensure it is transcribed accurately.
  5. The information given to the patient is reinforced verbally at the point the Medicine Information Card is handed over, and is checked and further reinforced on a continual basis.
  6. Patients will receive the manufacturer's Patient Information Leaflet with their medicines.
  7. The in-patient prescription chart is checked by the nurse for any changes at least once a day and the Medicine Information Card updated as necessary.
  8. Patients entered in the self-medicine scheme may continue to administer their medicines pre-operatively, but must be given clear guidance on any medicine that must be omitted on the day of operation.
  9. All medicines self-administered by patients must be presented and labelled in a form that provides all the information necessary for the patient to self-administer without risk of error. This is achieved in one of two ways:
    - i. Patients' own medicine may be reused for self-administration provided they meet the requirements of the HCE Policy for Safe and Secure Handling of Medicines.
    - ii. Individually dispensed items from the pharmacy will be supplied from the Pharmacy Department fully labelled for use by the patient and will include the manufacturer's Patient Information Leaflet.
  10. The quantity of medicine supplied will be sufficient to cover the patient's anticipated length of stay plus a further fourteen days' supply following discharge.
  11. Any dosage alteration to a SAM by a prescriber must be brought to the attention of a nurse and pharmacist at the earliest opportunity to allow re-labelling/re-supply and alteration of the Medicine Information Card to occur.
  12. Any discontinuation of a SAM must be brought to the attention of a nurse and pharmacist at the earliest opportunity to allow the medicine to be removed from the cabinet.

## **Ind 147. Policies and procedures govern patient's medications brought from outside the hospital.**

### **Survey Process:**

Review the policy and procedure. Usually this requires the pharmacy to verify specifically what the medication is. Also, it is common that the hospital retains the medication but does not use it during the patient's stay in the hospital.

### **Scoring:**

- If there is an implemented policy on medication brought from the outside, then score as **fully met.**

- If there is no policy or it is not implemented, then score as **not met.**

## GUIDELINES

### **SOPs on Patient's Own Drugs**

Every medicine that is brought into hospital by a patient and is either prescribed for them by their registered medical practitioner or purchased for them by others is classified as Patient's Own Drugs (POD). The following is the SOP which should be adhered to;

Any medicines remaining at home should, if possible, be brought in by relatives as soon as possible. If consent is granted, the drugs should be locked in the locally agreed POD storage area for assessment by the Pharmacist.

#### **1. Consent**

- i. Drugs brought in from home remain the patient's property and verbal consent for their use or destruction must be obtained by the admitting nurse, pharmacist or doctor. Where it is not possible for a patient to consent, a relative or attendant may assent on the patient's behalf. This should be documented in the patient's notes. Please note if patient gives the consent, hospital is still legally accountable if there is a problem with the patient's own medication. So the hospital should devise a safe and clear-cut policy on the use of POD.
- ii. If the patient/attendant does not agree to use the PODs in the ward, the medicines must be stored in the ward in a locked cupboard and returned to the patient on discharge with clear instructions as to their use. If any drugs are considered unsatisfactory for use, the pharmacist should inform the patient/attendant of the risks associated with poor quality medicines or poor labelling. This should be documented in the patient's medical notes.

#### **2. POD Assessment:**

Only medicines that can be positively identified will be accepted for use. (Exceptions: POD trained staff may authorize the use of: unlabeled inhalers, eye drops and loose blister strips, provided the appropriate guidelines are followed). The responsible pharmacist, registered nurse, mental health practitioner or registered medical practitioner must be satisfied with the general condition of the product and its packaging and labelling. PODs which are not currently prescribed or whose directions do not correspond with the prescription should be stored in the POD overflow cupboard or other secure drug storage cupboard. The ward pharmacist should be informed at the next available opportunity and a note should be left in the doctor's communication book. Any discontinued items should be removed immediately.

#### **3. During Routine Opening Hours:**

PODs will be checked in the wards. If they are suitable the prescription chart will be marked 'POD' by the pharmacist or pharmacy technician, initialed, dated and the number of tablets noted in the pharmacy box on the prescription chart. The POD will have a green sticker affixed to the container, which will be signed, dated and endorsed with the quantity and strength by the pharmacist if they are suitable for use or reissue. The pharmacist will only endorse the chart when they have assessed the PODs.

#### **4. Out of Pharmacy Hours**

- i. PODs will be checked by a registered nurse or pharmacist. Any medication which has been

checked should have a ward POD sticker attached which should be signed and dated by the assessing nurse. The pharmacist or pharmacy technician will re-check these PODs on their next visit.

- ii. Unsuitable medicines will be returned to the Pharmacy Department for assessment by pharmacy staff and if necessary a new supply organized by the clinical pharmacist or by the technician on their next round.

**5. Supply of PODs:**

The PODs will only be used in hospital when they are passed by the doctor or pharmacist. All regular medicines will be dispensed from the hospital Pharmacy Department. Ward stock bottles or in-patient supplies must never be stored in the patient's cabinet unless labelled with full instructions for use.

## Assessment Scoring Matrix

**Standard 30. MOM 3: There are defined procedures for medication administration.**

Indicator 138-147		Max Score	Weightage (Percentage)	Score Obtained
Ind 138.	Medications are administered (dispensed) by those who are permitted by law and authorized to do so.	10	100	
Ind 139.	Prepared medications are labelled prior to preparation of a second drug.	10	100	
Ind 140.	Patient is identified prior to administration.	10	100	
Ind 141.	Medication is verified from the order prior to administration.	10	100	
Ind 142.	Dosage is verified from the order prior to administration.	10	100	
Ind 143.	Route is verified from the order prior to administration.	10	100	
Ind 144.	Timing is verified from the order prior to administration.	10	100	
Ind 145.	Medication administration is documented.	10	80	
Ind 146.	Policies and procedures govern patient's self-administration of medications.	10	100	
Ind 147.	Policies and procedures govern patient's medications brought from outside the Hospital.	10	100	
<b>Total</b>		100	-	

## 2.9 Patient Rights and Education (PRE)

### 03 Standards & 12 Indicators

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The HCE shall define patient and family rights and responsibilities as per the guidelines provided by the KP HCC. The staff is aware of these and is trained to protect patients' rights. Patients are informed of their rights and educated about their responsibilities at the time of admission. They are informed about the disease, the possible outcomes and are involved in decision making. The costs are explained in a clear manner to the patient and/or family. Patients are educated about the mechanisms available for addressing grievances.

**A Client/Patient Rights and Responsibilities Charter, as given at annexure P, is displayed in all client/patient areas.**

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## Standard 31. PRE-1: A documented process for obtaining patient and/or family consent exists for informed decision making about their care.

### Indicators (148-151):

**Ind 148. General Consent for treatment / declaration on admission is obtained, patient and family members are informed of its scope.**

#### Survey Process:

Review representative sample of medical records (this can be done simultaneously with review for other reasons). Determine if ALL records contain a general consent. Also determine if the content of the general consent is made clear to the patient and/or family.

#### Scoring:

- If ALL records have a documented general consent, then score as **fully met**.
- Since this is a medico-legal issue, if ANY record does not have a general consent, then score as **not met**.

### GUIDELINES

#### Scope of General Consent

The client has the right to have correct information about his/her health status (unless explicitly requested not to do so), proposed treatment plan and all related issues in general. This information should be conveyed by the attending staff in a clear way and appropriate language. The client should have sufficient information to help him/her understand the issue and have informed decisions regarding treatment and management. A proposed format of General Consent Form is as given below:

*Table 27: General Consent Form for Treatment*

#### **GENERAL CONSENT FOR TREATMENT**

Patient Name: \_\_\_\_\_ S/O, D/O.W/O \_\_\_\_\_

Patient Birth Date: \_\_\_\_\_ NIC: \_\_\_\_\_ Next of kin: \_\_\_\_\_

Address: \_\_\_\_\_

##### **1. Treatment:**

I request and authorize the provision of treatment and related Healthcare Services to me by \_\_\_\_\_ Hospital/Physician/authorized designees. This may include routine diagnostics and medications.

##### **2. Rights and Responsibilities:**

I have been informed by the Hospital about my Rights and Responsibilities i.e. what I am to expect from the hospital/staff and how I/my attendants are expected to conduct while in the hospital and in other aspects relevant to hospital/staff.

**3. Valuables:**

I understand that \_\_\_\_\_ Hospital is not responsible for my/my attendant’s valuables or personal articles.

**4. Release of Information:**

I understand that the confidentiality of all medical records will be protected to the full extent of the law. I authorize \_\_\_\_\_ Hospital to release all information from my medical record, as applicable, to:

- i. Payers, organizations or insurance companies which are responsible, in whole or in part, for obtaining insurance benefits for me, for billing and/or paying my physician(s) bill, and for filing appeals of denial of benefits, so that the physician may be paid for the services provided to me;
- ii. Independent auditors or review agencies retained by any third-party payers and insurers to analyze the charges for services rendered to me.
- iii. In order to improve service and provide valuable input, I also authorize \_\_\_\_\_ Hospital to release my demographic information to organizations retained by them for customer satisfaction surveys.

**5. Payment:**

I assign and authorize payment, for any treatment and all services rendered, directly to \_\_\_\_\_ Hospital from my insurance company or third-party payer including, but not limited to commercial health insurance, automobile no-fault insurance and workers disability compensation insurance etc. In consideration of the professional services provided or to be provided to me, I agree to pay all charges not covered by my insurance company or any applicable health benefit including, but not limited to, deductibles, co-payments, non-covered services. I understand that it is my personal responsibility to pay \_\_\_\_\_ Hospital all charges for services rendered despite of any disputes or disagreements between my insurance company and myself.

**I have read the consent form or it has been read to me and I am satisfied that I understand its contents. My questions have been answered to my satisfaction.**

By signing this form, I acknowledge that I have been offered and/or received the \_\_\_\_\_ Hospital Patients Charter and shall abide by it.

\_\_\_\_\_  
(Signature and Thumb Impression of Patient/Legal Guardian/Patient Advocate/Parent/Next of Kin- encircle One)

(Date) \_\_\_\_\_

**Ind 149. The hospital has listed those situations where Specific Informed Consent is required.**

**Survey Process:**

Review any written policy or list of situations where specific informed consent is required. Then review medical records of representative sample of patients who should have (by hospital policy) a specific informed consent to validate that it is documented in the record. This would include consent related to procedures and therapies with particular concern for anesthesia, surgery, sterilization, termination of pregnancy and high-risk medications.

### Scoring:

- If ALL reviewed records contain / document an informed consent, then score as **fully met**.
- Since this is also a medico-legal issue, if ANY records do not contain / document informed consent, then score as **not met**.

## GUIDELINES

### Scope of Informed Consent

Although the Client/Patient's general consent is obtained for the proposed care or treatment, a written consent is mandatory for any invasive procedures or operations.

The client's informed consent is a prerequisite to carry out any medical intervention and the patient has the right to refuse or to halt a medical intervention.

In different situations of health care provision or involvement of the client in any research activity, the mode of consent and action will be:

1. When a patient is unable to express his or her will and a medical intervention is urgently needed, the consent of the patient may be presumed, unless it is obvious from a previous declared 'Expression of Will' that consent would be refused in the situation.
2. When the consent of a legal representative is required and the proposed intervention is urgently needed, that intervention may be made if it is not possible to obtain the representative's consent in time.
3. When the consent of a legal representative is required, patients (whether minor or adult) must nevertheless be involved in the decision-making process to the fullest extent which their capacity allows.
4. If a legal representative refuse to give consent and the physician or other provider is of the opinion that the intervention is in the interest of the patient, then in case of a non-emergency situation, the decision must be referred to a court or some form of arbitration.
5. In all other situations where the patient is unable to give informed consent and where there is no legal representative or representative designated by the patient for this purpose, appropriate measures should be taken to provide for a substitute decision making process, taking into account what is known and, to the greatest extent possible, what may be presumed about the wishes of the patient.
6. The consent of the patient is required for the preservation and use of all substances of the human body. Consent may be presumed when the substances/body part are to be used in the current course of diagnosis, treatment and care of that patient.
7. The informed consent of the patient is needed for participation in clinical teaching.
8. The informed consent of the patient is a prerequisite for participation in scientific research. All protocols must be submitted to a proper ethical review committee. Such research should not be carried out on those who are unable to express their will, unless the consent of a legal representative has been obtained and the research would likely be in the interest of the patient.

As an exception to the requirement of involvement being in the interest of the patient, an incapacitated person may be involved in observational research which is not of direct benefit to his or her health provided that, that person offers no objection, that the risk and for burden is minimal, that the research is of significant value and that no alternative methods and other research subjects are available.

**Ind 150. Informed Consent includes Information on Risks, Benefits, and Alternatives and as to who will perform the requisite procedure in a language that they can understand.**

**Survey Process:**

This standard relates to the "informed" part of Informed Consent. Review the same representative sample of records as for Ind 141 above to verify if the required information is included and documented.

**Scoring:**

- If ALL records contain / document consent comprising the above information, then score as **fully met**.
- Since this is also a medico-legal issue, if ANY records do not contain / document consent comprising the above information, then score as **not met**.

**GUIDELINES**

**Information about Risks, Benefits and Alternatives**

It is the responsibility of the healthcare service provider that he/she should take the time to explain/discuss with the patient and his/her attendant about the:

1. Health status/clinical facts
2. Diagnosis of the problem
3. Proposed management plan
4. Expected outcome
5. Costs (expected)
6. Risks
7. Preferences/choices of patients
8. Follow up to the clients/patients
9. Right to read own medical record/file

After giving information about diagnosis, management and follow-up, the HCP should check to ensure that client/patient has understood the advice. Obtaining this feedback is vital in assessing to what extent the instructions have been understood.

Treating clients/patients with respect, actively listening to them, asking questions about their choices/preferences, praising, explaining diagnosis and management, describing the follow-up plan, and taking feedback about their understanding of the given advice/choice are all very important components of health care delivery.

The person performing the procedure shall be responsible for the entire consent process including providing explanation and taking the signature. A team member can take consent on behalf of the person performing the procedure, but their name and designation must be clearly mentioned in the chart.

When the patient does not speak or understand the predominant language of the community, the hospital will make efforts to ensure that proper interpretation is done if it is possible to provide an appropriate interpreter for the same.

The informed consent process adheres to statutory norms including:

1. Taking consent before the procedure
2. At least one independent witness signing the form.
3. Taking consent every time (especially for procedures which the patient has to undergo their whole lives). However, the repeat consent could be verbal for the same procedure e.g. dialysis.
4. Taking a fresh consent (for the new procedure) in case the procedure has to be changed during course of treatment/procedure.
5. Appropriate information is provided to clients/patients and their families, in a way that they can understand, on the proposed treatment, the costs, the risks and benefits of the proposed treatment or investigation, and the alternatives available.
6. Clients/Patients and their families are fully informed about the client's/patient's health status, including the clinical facts about their condition, unless there is an explicit request not to disclose a particular information to the patient/relatives.

Table 28: Sample Consent Form

<b>Patient's Informed Consent to Treatment or Investigation</b> {To be filled by Treating Consultant} (Page 1 of 2)	Name of HCE:	Patient's Reg. No.
	Patient's name:	
	CNIC#:	
	S/O, D/O, W/O:	
	Age:	Sex:
	Address:	
	Diagnosis:	
<b>Declaration of Doctor/Proceduralist (to be completed by the clinician obtaining consent)</b>		
<b><i>Tick the boxes or cross out and initial any changes or information not appropriate to the stated procedure</i></b>		
1. I have informed the patient of the treatment options available, and the likely outcomes of each treatment option, including known benefits and possible complications. (State options)		
<hr/> <hr/> <hr/> <hr/>		
2. I have recommended the treatment/procedures/investigations noted below on this form.		
3. I have explained the treatment/procedures/investigations, identified below, and what is entailed for the patient.		
4. I have provided the patient with information specific to the procedure identified. The patient has been asked to read information provided and ask the doctor/proceduralist questions about anything that is unclear.		
5. I have provided to the patient an identifiable copy of the information which has been kept on the patient's medical record.		
6. Information provided to the patient includes:		
<b>Open access procedures</b>		
I have given the patient opportunity to discuss the proposed procedure, benefits and risks, both general and specific, and the risk of not having the procedure.		

**Other procedures**

I have discussed the alternative procedures, benefits and risks, both general and specific, and the risks of not having the procedure.

**Treatment/procedure/investigation**

List the treatment/procedures/investigation to be performed, noting correct side/correct site

This procedure requires:

- a) General and/or Regional Anaesthesia    b) Local Anaesthesia    c) Sedation

An anaesthetist will explain the risk of general or regional anaesthesia to the patient at least 12 hours prior to the treatment.

**Disclosure of material risks****Signature of doctor/proceduralist obtaining consent**

Material risks or specific risks particular to this patient that have arisen as a result of our discussions are:

Full name (please print) \_\_\_\_\_

Position/Title \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Signature of doctor/proceduralist having overall responsibility of treatment (if different)**

Full name (please print) \_\_\_\_\_

Position/Title \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Please Note: A separate consent form (signed by the patient/relative) for blood transfusion as per relevant protocols is mandatory.

<b>Patient Consent to Treatment or Investigation</b>  (Page 2 of 2)	Name of HCE:	Patient's Reg. #:
	Patient's name:	
	CNIC#:	
	S/O, D/O, W/O:	
	Age:	Sex:
	Address:	
	Diagnosis:	

**Patient's declaration**

Please read the information carefully and tick the following to indicate you have understood and agreed with the information provided to you. Any specific concerns should be discussed with your doctor or proceduralist performing the procedure **prior to signing the consent form**.

1. The doctor/proceduralist has explained my medical condition and prognosis to me. The doctor/proceduralist also explained the relevant diagnostic, treatment options that are

available to me and associated risks, including the risks of **not** having the procedure.

2. The risks of the procedure have been explained to me, including the risks that are specific to me and the likely outcomes. I have had an opportunity to discuss and clarify any concerns with the doctor or proceduralist.
3. I **understand** that the result/outcome of the treatment/procedure cannot be guaranteed.
4. I **understand** that if I am treated as a public patient, no guarantee can be provided that a particular doctor/proceduralist will perform the procedure, and that the doctor/proceduralist performing the procedure may be undergoing Post Graduate training under supervision of the consultant. (The hospital should define that a PG trainee is authorized to perform a procedure in which year and whether supervised or unsupervised).
5. I **understand** that tissue samples and blood removed as part of the procedure or treatment will be used for diagnosis and common pathology practices (which may include audit, training, test development and research), and will be stored or disposed of sensitively by the hospital.
6. I **understand** that a photograph, if taken during Examination/procedure or treatment, will be used for academic purposes only and that too ensuring confidentiality and privacy.
7. If a staff member is exposed to my blood, I **consent to** a sample of blood being collected and tested for infectious diseases. I understand that I will be informed if the sample is tested, and that I will be given the results of the tests.
8. I **agree** for my medical record to be accessed by staff involved in my clinical care and for it to be used for approved quality assurance activities, including clinical audit.
9. I **understand** that if immediate life-threatening events happen during the procedure, I will be treated accordingly.
10. I **understand** that I have the right to change my mind at any time before the procedure is undertaken, including after I have signed this form. I understand that I must inform my doctor if this occurs.
11. I consent to undergo the procedure/s or treatment/s as documented on this form.
12. I consent to a blood transfusion, if needed       Yes     No

**Please Note: A separate consent form for blood transfusion as per relevant protocols is also to be signed.**

Patient's full name: \_\_\_\_\_

Patient's signature: \_\_\_\_\_

Date/Time: \_\_\_\_\_

Parent/guardian signature: \_\_\_\_\_

Date/Time: \_\_\_\_\_

(if desired for mature minor)

**Interpreter's declaration**

Specific language requirements (if any): \_\_\_\_\_

Interpreter services required:       Yes       No

I declare that I have interpreted the dialogue between the patient and health practitioner to the best of my ability, and have advised the health practitioner of any concerns about my performance.

Interpreter's signature: \_\_\_\_\_

Date: \_\_\_\_\_

Full name (please print): \_\_\_\_\_

**Confirmation of consent at pre-admission or admission to hospital**

I confirm that the request and consent for the operation/procedure/treatment above remains current.

Patient's signature: \_\_\_\_\_

Date/Time: \_\_\_\_\_

(Patient/Person responsible)

**Ind 151. The policy describes who can give consent when patient is incapable of independent decision-making.**

**Survey Process:**

Review the policy to determine who is authorized to give consent in addition to the patient when the patient is incapable of independent decision making.

**Scoring:**

- If there is a policy describing who, other than the patient, may give informed consent, then score as **fully met**.
- If there is no policy, then score as **not met**.

**GUIDELINES**

**Policy Regarding Consent for Incapacitated Patient**

The HCE shall take into consideration the statutory norms. This would include taking of consent from next of kin/legal guardian. The order of preference is; spouse, son, daughter, brother, sister, parents. However, in case of unconscious/unaccompanied patients the treating doctor can take a decision in life-saving circumstances.

## Assessment Scoring Matrix

**Standard 31. PRE 1: There are defined procedures for medication administration.**

Indicator 148-151		Max Score	Weightage (Percentage)	Score Obtained
Ind 148.	General Consent for treatment / declaration on admission is obtained, Patient and Family Members are Informed of its Scope.	10	100	
Ind 149.	The Hospital has listed those situations where Specific Informed Consent is required.	10	100	
Ind 150.	Informed Consent includes Information on Risks, Benefits, and Alternatives and as to who will perform the requisite procedure in a language that they can understand.	10	100	
Ind 151.	The policy describes who can give Consent when patient is incapable of independent decision-making.	10	100	
<b>Total</b>		40	-	

## Standard 32. PRE-2: Patient and families have a right to information on expected costs.

### Indicators (152-155):

**Ind 152. There is uniform category specific Pricing Policy in a given setting (outdoor/In door/diagnostics).**

#### Survey Process:

Visit the finance or billing office and review the policy and verify that it is uniformly applied to the respective categories of patients / for various categories of procedures/ interventions / treatments.

#### Scoring:

- If the policy is uniformly applied across the categories of patients and for the respective interventions / treatments, then score as **fully met.**
- If there is evidence that it is not uniformly applied, then score as **not met.**

### GUIDELINES

#### Tariff Policy

There should be a Tariff/Billing policy which defines the charges to be levied for various activities/procedures. The policy shall be clearly activity/procedure based.

**Ind 153. The Tariff List is available to patients.**

#### Survey Process:

Review the tariff/ charges list and then ask how it is made available to a patient. Customarily this is only upon the patient's request. However, the tariff list may be posted in the outpatient areas as well as in the billing office. Patients should be made aware that the tariff / charges list is available on demand.

#### Scoring:

- If there is evidence that the tariff list is readily available to patients, then score as **fully met.**
- If there is no procedure to make it available to patients, then score as **not met.**

### GUIDELINES

#### Tariff List

The HCE shall ensure that there is an updated tariff list and that this is available to patients when required. The HCE shall charge as per the tariff list without any hidden costs whatsoever. Any additional charge should also be enumerated in the tariff and the same communicated to the patients with a clear and justified explanation. Tariff rates should be uniform and transparent. The

Reception Area/Almoner Department/Account Section and wards display information about the tariff policy of the HCE which shall include:

1. The rights of the clients/patients.
2. Services and facilities available in the hospital.
3. Costs of services.
4. Feedback and complaints pathways.

### **Ind 154. Patients and family are educated about the estimated costs of treatment.**

#### **Survey Process:**

Review the process used to inform/educate the patient and/or family about the estimated costs / charges. Also determine if this is done by someone who is authorized.<sup>120</sup>

#### **Scoring:**

- If there is a process to inform patients and/or families about the estimated costs and it is done by an Authorized person, then score as **fully met.**
- If there is a process to inform patients and/or families about the estimated costs but it is not done or is done by an unauthorized person, then score as **partially met.**
- If there is no process, then score as **not met.**

## **GUIDELINES**

### **Information about Estimated Cost of Treatment**

The patient and/or family members are explained about the expected costs.

Patients should be given an estimate of the expenses on account of the treatment/investigations to be performed in different settings, preferably in a written form. This estimate shall be prepared on the basis of the treatment/management plan. For example, a family attending the hospital for antenatal care must be informed about the cost of prospective C-Section, in case the SVD does not take place. Similarly, a patient requiring long term care such as cases of chronic illnesses/cancerous diseases should also be informed of the likely expenses.

It could be prepared by the OPD/Registration/Admission staff in consultation with the treating doctor.

### **Ind 155. Patients and family are informed about the financial implications when there is a change in the patient condition or treatment setting.**

#### **Survey Process:**

Review the process. Determine what prompts informing the patient and/or family about the financial implication when there is change in the treatment setting on the basis of patient condition and also

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<sup>120</sup> A person authorized by the management should have adequate knowledge for satisfying the patients/relatives.

determine who makes the decision and who provides the information.

**Scoring:**

- If there is a consistent process, including when it is done, who makes the decision, and who provides the information, then score as **fully met.**
- If there is a process, but there are no clear guidelines of when it is done, then score as **partially met.**
- If there is no process, then score as **not met.**

**GUIDELINES**

**Information about Financial Implications**

When patients are shifted from one setting to another, typically to and from ICUs, other specialized care facilities, the financial implications must be clearly conveyed to them.

## Assessment Scoring Matrix

**Standard 32. PRE 2: Patient and families have a right to information on expected costs.**

Indicator 152-155		Max Score	Weightage (Percentage)	Score Obtained
Ind 152.	There is uniform category specific Pricing Policy in a given setting (outdoor/Indoor/diagnostics).	10	<b>100</b>	
Ind 153.	The Tariff List is available to patients.	10	<b>100</b>	
Ind 154.	Patients and family are educated about the estimated costs of treatment.	10	<b>80</b>	
Ind 155.	Patients and family are informed about the financial implications when there is a change in the patient condition or treatment setting.	10	<b>80</b>	
<b>Total</b>		40	-	

## Standard 33. PRE-3: Patient Rights for Appeals and Complaints.

### Indicators (156-159):

**Ind 156. The hospital informs the patient of his/her right to express relevant concern or complain either verbally or in writing.**

#### Survey Process:

Review the process about informing the patient of his / her right to complain and determine how policies are implemented.

#### Scoring:

- If there are processes to handle appeals/ complaints and the record substantiate dealing of the appeals according to the policies, then score as **fully met**.
- If there are processes to handle appeals but no record available how the policies are implemented, then score as **partially met**.
- If there is no appeal process, then score as **not met**.

### GUIDELINES

#### Right to Express Concern or Complain

An institutionalized, accessible and transparent grievance redress mechanism must be in place. The information as how to lodge a complaint must be clearly displayed in the local language at prominent places.

Complaint is an expression of client dissatisfaction and a way of feedback on the quality of care which needs a response. Every Healthcare facility should inform the clients/patients about their right to complain and the complaint handling procedures. A complaint may be written or verbal and be lodged by the patient, his/her attendants or a legally authorized person. Various ways should be adopted, for example:

1. Display the message clearly in the local language at prominent places in the facility such as registration desk, waiting area, OPDs, main entrance and private rooms etc.
2. Pertinent information may be made available in the form of leaflets/brochures at appropriate places.
3. Client feedback/satisfaction must be sought on a prescribed but simple format at the time of discharge. (Format attached at **annexure Q**).

**Ind 157. There is a documented process for collecting, prioritizing, reporting and investigating complaints, which is fair and timely.**

#### Survey Process:

Review the process of collecting, prioritizing, reporting and investigating complaints and determine

through records how the policies are implemented.

**Scoring:**

- If there are processes for collecting, prioritizing, reporting and investigating complaints and records that the policies are implemented, then score as **fully met.**
- If there are processes for collecting, prioritizing, reporting and investigating complaints but no record available on how the policies are implemented, then score as **partially met.**
- If no processes for collecting, prioritizing, reporting and investigating complaints, then score as **not met.**

**GUIDELINES**

**Complaint Management Procedure**

To become a quality driven service, a facility should encourage the clients and their family members to freely raise and discuss their views, concerns or complaints with the concerned staff. These dialogues help and serve as opportunities for improvement. Every HCE must have a documented grievance redressal procedure, entailing collecting, prioritizing, investigating, resolving and reporting complaints. A proposed format for the Complaint Management Procedure is given at **annexure R**. The complaints against service providers that carry client's perspective should be handled first by the manager/concerned HoD/unit. For example, the OPD in-charge should tackle the complaints, verbal or written, related to the OPD and should take remedial action there and then. In case actions are beyond his/her mandate he/she, must refer it to the Complaint Cell.

A Complaint Cell should be established at every hospital and resourced properly. The complaint cell shall essentially comprise of a core staff and be headed by a manager appointed by the HCE and be supported by a team of experts, the Complaint Management Committee (CMC). The department/specialist against whom a complaint is received/under investigation will not be part of the committee for that particular case. The CMC may co-opt an expert for assistance. Every complaint must be thoroughly investigated and documented. The complaint cell will maintain department wise records of complaints investigated and actions taken. A record of the Complaint Register must lie in the office of the MS or In-charge of the health facility, with the complete number and details of complaints received and action taken.

The detailed policy of the HCE for documentation of the processes should define credible and transparent mechanism for receiving and handling complaints against the functioning of the HCE and practice of its staff. This mechanism should be used fairly and timely for collecting, prioritizing, reporting and investigating complaints. To ensure that measures for patient complaint system are effective and efficient, they should be well-targeted and focused to address the identified problems.

**Ind 158. The hospital informs the patient of the progress of the investigation at regular intervals and informs about the outcome.**

**Survey Process:**

Review the process and determine how the policies are implemented. Review files that include all the elements associated with managing a complaint and demonstrate the progressive follow-up with complainants.

### Scoring:

- If there are processes to inform the patients about the progress of the investigation and the outcome, and records reflect that the policies are implemented, then score as **fully met.**
- If there are processes to inform the patients about the progress of the investigation and about the outcomes but no record available on how the policies are implemented, then score as **partially met.**
- If there are no processes to inform the patients about the progress and the outcome of the investigation, then score as **not met.**

## GUIDELINES

### **Information about Progress of Investigation and Outcome**

It is important that client/patient is informed of the level at which the complaint can be handled. This duty should be clearly entrusted to a designated staff member of the complaint cell/department of the HCE. The client should be kept informed about the progress of the investigation at regular intervals, in case these are prolonged, and also of the outcome. This will help to build the credibility of the process/facility.

**Ind 159. The hospital uses the results of complaints investigations as part of the quality improvement process.**

### Survey Process:

Review the process and documentation to identify and observe actual examples of changes in the policy and procedure that have been made as a result of complaints analysis.

### Scoring:

- If there is a quality improvement process which uses complaint-handling data and reports in this regard are available, then score as **fully met.**
- If there is a quality improvement process to use complaint handling data but no evidence available how that data was used for improvement, then score as **partially met.**
- If there is no quality improvement process about using complaint-handling data, then score as **not met.**

## GUIDELINES

### **Feedback and Quality Improvement**

Transparency of decisions must be ensured and the verdicts of inquiries should not be biased in favor of the facility staff. If professional misconduct or negligence is involved then it should be forwarded to the professional regulatory body at the appropriate level, by the in charge of the HCE. Most importantly the result of the inquiry should be taken in a positive manner and an executive committee of the HCE should ensure that the remedial measures suggested by the CMC as an outcome of the inquiry should be implemented/enforced for the improvement of the system forthwith.

Feedback from clients includes both compliments (satisfaction) and complaints (dissatisfaction)

about quality of care. Client/patients feedback should be valued, as this would help the HCE to improve quality of services.

The hospital should have mechanisms to obtain feedback as an on-going process. The feedback mechanisms should be culturally appropriate and feasible and may include:

1. A suggestion/complaint box at the facility that may be used by the literate clients.
2. Periodic clients exit interviews.
3. Key informant interviews on periodic basis (within community).
4. Mystery client survey.
5. Focus group discussions.

HCEs should devise a method and frequency of feedback mechanisms to seek the experiences of clients about the quality of care. The HCE management should decide on a method for itself, depending upon its needs and resources. However, a hospital should allocate sufficient resources, as these will be required to hire people for conducting and analyzing such exercises.

## Assessment Scoring Matrix

### Standard 33. PRE 3: Patient Rights for Appeals and Complaints.

Indicator 156-159		Max Score	Weightage (Percentage)	Score Obtained
Ind 156.	The hospital informs the patient of his/her right to express relevant concern or complain either verbally or in writing.	10	80	
Ind 157.	There is a documented process for collecting, prioritizing, reporting and investigating complaints, which is fair and timely.	10	80	
Ind 158.	The hospital informs the patient of the progress of the investigation at regular intervals and informs about the outcome.	10	80	
Ind 159.	The hospital uses the results of complaints investigations as part of the quality improvement process.	10	80	
<b>Total</b>		40	-	

## 2.10 Hospital Infection Control (HIC)

### 02 Standards & 09 Indicators

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Prevention of Healthcare Associated Infections (HAIs) represents one of the major safety initiatives a hospital can undertake. A large number of patients admitted to hospitals acquire infections that were not related to the condition for which they were hospitalized, which results in a considerable number of deaths and add to treatment costs. These standards provide the framework for hospitals to develop and implement plans to prevent and control infections by using an integrated approach across all programs, services and settings. The standards call on healthcare establishments to educate and collaborate with leaders throughout the hospital, including physicians, to participate in the design and implementation of an effective Infection Control Program.

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## **Standard 34. HIC-1: The hospital has a well-designed, comprehensive and coordinated infection control programme aimed at reducing/eliminating risks to patients, visitors and care providers.**

### **Indicators (160-165):**

**Ind 160. The hospital infection control programme is documented which aims at preventing and reducing risk of nosocomial infections.**

#### **Survey Process:**

There is a written hospital infection control plan that entails at least: i. The surveillance activities, ii. Hand hygiene procedures, iii. Isolation procedures and iv. The responsibilities and authorities of an Infection Control Committee.

#### **Scoring:**

- If there is a documented infection control plan that includes at least surveillance activities, hand hygiene procedures, isolation procedures, and the responsibilities and authorities of an Infection Control Committee, then score as **fully met**.
- If there is a documented plan but it does not define the authority of the committee, then score as **partially met**.
- If there is either no written plan, or it does not include at least 3 of the 4 requirements above, then score as **not met**.

## **GUIDELINES**

### **Documented Hospital Infection Control (HIC) Program**

It is required that the HCE must have a documented HIC Program which aims at preventing and reducing the risk of nosocomial infections. National<sup>121</sup> and International Guidelines, scientific knowledge, professional bodies and statutory requirements shall be considered for developing an IC program. CDC and WHO guidelines should be used as reference documents.

#### **Each Healthcare Facility must;**

1. Develop an IC Program (or use the national guidelines) to ensure the wellbeing of both patients and staff.
2. Develop an Annual Work Plan (AWP) to assess and promote good healthcare; appropriate isolation, sterilization and other practices; staff training and epidemiological surveillance.
3. Provide sufficient resources to support the IC program.
4. Ensure that risk prevention for patients and staff is a concern of everyone in the facility, and

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<sup>121</sup> Pakistan National Infection Control Guidelines, 2006.

must be supported by the senior administration.

**Salient Components of the Infection Control Program are;**

1. Basic measures for infection control, i.e. standard and additional precautions.
2. Education and training of healthcare workers.
3. Protection of healthcare workers, e.g. immunization, post exposure prophylaxis.
4. Identification of hazards and minimizing risks.
5. Routine practices essential to IC such as aseptic techniques, use of single use devices, reprocessing of instruments and equipment, antibiotic usage, management of blood/body fluid exposure, handling and use of blood and blood products, sound management of medical waste.
6. Effective work practices and procedures, such as environmental management practices including management of hospital/clinical waste, support services (e.g., food, linen), use of therapeutic devices.
7. Incidence monitoring.
8. Outbreak investigation.
9. Surveillance.
10. IC in specific situations.
11. Research.

Of these the **first 8 are absolutely essential** regardless of the size of the facility or resources since they directly determine the quality and nature of the care that is provided. In addition to implementing basic measures for infection control, healthcare facilities should prioritize their IC needs and design their programs accordingly.

For sustained effectiveness, the IC program will have to be comprehensive, include surveillance and prevention activities and staff training. It must also be able to draw upon effective support at national and regional levels.

**Organization of an Infection Control (IC) Program:**

The primary responsibility lies with the Medical Superintendent/hospital who should:

1. Establish an Infection Control Committee (ICC) which will in turn appoint an IC team.
2. Provide adequate resources for effective functioning of the IC program.
3. An IC team (or an officer in smaller facilities) with dedicated and protected time which can enforce rules and attend to daily needs of the program in real time.

Hospital IC plan should address interalia the following important components:

**Nosocomial Infection Surveillance:**

Surveillance is a systematic, active on-going observation of the occurrence and distribution of a disease within a population and of the events that increase or decrease the risk of the disease occurrence. The primary role of surveillance is to monitor Nosocomial Infection Rate as the first step to identify local problems and priorities, and evaluate the effectiveness of IC activity. Surveillance, by itself, is an effective process to decrease the frequency of hospital-acquired infections.

**1. Objectives**

The ultimate aim of surveillance programme is the reduction of nosocomial infections and the cost of treatment whereas the specific objectives include:

- i. To improve awareness of the clinical staff and other hospital workers (including

administrators) about nosocomial infections and antimicrobial resistance so that they may appreciate the need for preventive action.

- ii. To monitor trends: incidence and distribution of nosocomial infections, prevalence and, where possible, risk-adjusted incidence for intra- and inter-hospital comparisons.
- iii. To identify the need for new or intensified prevention programmes, and evaluate the impact of prevention measures.
- iv. To identify possible areas for improvement in patient care, and for further epidemiological studies (i.e. risk factor analysis).

## **2. Strategy**

A surveillance system must meet the following criteria:

- i. **Simplicity**, to minimize costs and workload, and promote unit participation by timely feedback.
- ii. **Flexibility**, to allow changes when appropriate.
- iii. **Acceptability**, (e.g. evaluated by the level of participation, data quality).
- iv. **Consistency**, (use standardized definitions, methodology).
- v. **Sensitivity**, although a case-finding method with low sensitivity can be valid in following trends, as long as sensitivity remains consistent over time and cases identified are representative.
- vi. **Specificity**, requiring precise definitions and trained investigators.

## **3. Implementation at the hospital level**

The HCE must ensure that a valid surveillance system with specific objectives for units, services, patients, specific care areas and defined time lines for all partners: e.g. clinical units, laboratory staff, Infection Control Practitioner (ICP)/nurse, and administration is in place and functioning. Initially, discussion should identify the information needs, and the potential for the chosen indicators to support implementation of corrective measures (what or who is going to be influenced by the data). This discussion will focus on key elements including:

- i. The patients and units to be monitored (defined population).
- ii. The type of infections and relevant information to be collected for each case (with precise definitions).
- iii. The frequency and duration of monitoring.
- iv. Methods for data collection.
- v. Methods for data analysis, feedback, and dissemination.
- vi. Confidentiality and anonymity.

## **4. Organization For Efficient Surveillance**

Nosocomial infection surveillance includes data collection; analysis and interpretation, feedback leading to interventions for preventive action, and evaluation of the impact of these interventions. The Infection Control Officer (ICO)/physician and/or nurse from the IC team must be a trained professional specifically responsible for surveillance, including training of personnel for data collection. A written protocol must describe the methods to be used, the data to be collected (e.g. patient inclusion criteria, definitions), the analysis that can be expected, and preparation and timing of reports.

The optimal method is dependent on hospital characteristics, the desired objectives, resources available (computers, investigators) and the level of support of the hospital staff (both administrative and clinical). The surveillance system must report to hospital administration, usually through the ICC, and must have a dedicated budget to support its operation.

## **5. Priority Infections and Their Definitions**

Surveillance of infectious conditions requires strict definitions. In many cases there are no universally agreed definitions therefore the infection rate will vary with the definition used. For this reason, comparisons can be made between units or institutions only if the same set of definitions is used and applied in exactly the same way. It is often more meaningful and more useful to use surveillance data from a single institution to measure trends over time, either to alert staff to increasing problems or to monitor the effectiveness of interventions.

## **6. Surveillance Methods**

Simply counting infected patients (numerator) provides only limited information which may be difficult to interpret. Further data is necessary to fully describe the problem on a population basis, to quantify its importance, to interpret variations, and to permit comparisons. Risk factor analysis requires information for both infected and non-infected patients. Infection rates, as well as risk-adjusted rates, can then be calculated. Hospitals shall imply a combination of passive and active surveillance techniques to control nosocomial infection.

## **7. Outcome of Surveillance**

An effective surveillance system must identify priorities for preventive interventions and improvement in quality of care. By providing quality indicators, surveillance enables the IC programme, in collaboration with patient care units, to improve practice, and to define and monitor new prevention policies. The ultimate aim of surveillance is to decrease nosocomial infections and reduce costs.

## **8. Evaluation of Surveillance**

Surveillance is a continuous process which needs to evaluate the impact of interventions to validate the prevention strategy, and determine if initial objectives are attained.

A surveillance system must be continuing if it is to be credible. Periodic contacts with staff will also help to maintain a high level of compliance. Once the surveillance system is functioning, validation of the surveillance methods and data should be undertaken at regular intervals.

## **9. Principal Points For Surveillance of Nosocomial Infections**

- i. Valid quality indicators (risk-adjusted rates, etc.)
- ii. Effective, timely feedback (rapid, useful)
- iii. Appropriate implementation of interventions
- iv. Evaluation of the impact of interventions by continued surveillance (trends), and other studies

## **10. Infection Control Practices**

Infection control practices can be grouped in two categories;

- i. Standard Precautions: Transmission of infections in healthcare facilities can be prevented and controlled through the application of basic IC precautions which can be grouped into Standard Precautions, that must be applied to all patients at all times, regardless of diagnosis or infectious status.
- ii. Additional Precautions, which are specific to modes of transmission or transmission - based i.e. airborne, droplet and contact.

### **Standard Precautions:**

Treating all patients in the healthcare facility with the same basic level of "standard" precautions involves work practices that are essential to provide a high level of protection to patients, healthcare workers and visitors.

These include the following:

1. Hand washing and antisepsis (hand hygiene).
2. Use of Personal Protective Equipment (PPE) when handling blood, body substances, excretions and secretions.
3. Appropriate handling of patient care equipment and soiled linen.
4. Prevention of needle prick/sharp injuries.
5. Environmental cleaning and spills-management.
6. Appropriate handling of waste.

#### **1. HAND HYGIENE**

Appropriate hand washing can minimize micro-organisms acquired on the hands by contact with body fluids and contaminated surfaces. Hand washing breaks the infection transmission chain and reduces person-to-person transmission. All healthcare personnel and family caregivers of patients must practice effective hand washing. Patients and primary care givers need to be instructed in proper techniques and situations for hand washing.

Compliance with hand washing is, however, frequently sub-optimal. Reasons for this include: lack of appropriate equipment; low staff to patient ratios; allergies to hand washing products; insufficient knowledge among staff about risks and procedures; the time required; and casual attitudes among staff towards bio-safety.

#### **Purpose:**

Hand washing helps to remove micro-organisms that might cause disease. Washing with soap and water kills many transient micro-organisms and allows them to be mechanically removed by rinsing. Washing with antimicrobial products kills or inhibits the growth of micro-organisms in deep layers of the skin. Use of alcohol-based gel is the preferred method of hand cleansing.

#### **Types of Hand Washing:**

**Simple hand washing** is usually limited to hands and wrists; the hands are washed for a minimum of 10 - 15 seconds with soap (plain or antimicrobial) and water.

**Hand antisepsis/decontamination** removes or destroys transient micro-organisms and confers a prolonged protective effect. It may be carried out in one of the following two ways;

- i. Wash hands and forearms with antimicrobial soap and water, for 15-30 seconds (following manufacturer's instructions).
- ii. Decontaminate hands with a waterless, alcohol-based hand gel or hand rub for 15-30 seconds. This is appropriate for hands that are not soiled with protein matter or fat. Immersion of hands in bowls of antiseptics is not recommended.

**Surgical hand antisepsis** removes or destroys transient micro-organisms and confers a prolonged effect. Hands and forearms are washed thoroughly with an antiseptic soap for a minimum of 2-3 minutes and are dried using a sterile towel. Surgical hand antisepsis is required before performing invasive procedures.

## **Facilities and Materials Required For Hand Washing**

### **Running water**

Access to clean water is essential. It is preferable to have running water, large washbasins having anti-splash devices, hands-free controls requiring little maintenance.

When running water is not available use either a bucket with a tap, which can be turned on and off, a bucket and pitcher, or 60% - 90% alcohol hand rub.

### **Materials Used For Hand Washing/Hand Antisepsis:**

Use plain or antimicrobial soap depending on the procedure.

Plain Soap: Used for routine hand washing, available in bar, powder or liquid form. Antimicrobial

Soap: Used for hand washing as well as hand antisepsis.

- i. If bar soaps are used: Use small bars with soap racks that can be drained.
- ii. Do not allow bar soap to sit in a pool of water as it encourages the growth of some microorganisms such as pseudomonas.
- iii. Clean dispensers of liquid soap thoroughly every day.
- iv. When liquid soap containers are empty they must be discarded, not refilled with soap solution.

Specific antiseptics recommended for hand antisepsis:

- i. 2%-4% chlorhexidine
- ii. 5%-7.5% povidone iodine
- iii. 1% triclosan
- iv. 70% alcoholic hand rubs

Waterless, alcohol-based hand rubs: with antiseptic and emollient gel and alcohol swabs, which can be applied to clean hands. Dispensers should be placed outside each patient room.

### **Facilities for Drying Hands:**

- i. Disposable towels, reusable single use towels or roller towels, which are suitably maintained, should be available.
- ii. If there is no clean dry towel, it is best to air-dry hands.
- iii. Equipment and products are not equally accessible to all HCEs. Flexibility in products and procedures, and sensitivity to local needs will improve compliance.
- iv. In all cases, the best possible procedure should be instituted.

### **Hand Washing Instructions:**

- i. Remove jewelry (rings, bracelets) and watches before washing hands.
- ii. Ensure that the nails are clipped short (do not wear artificial nails).
- iii. Roll the sleeves up to the elbow.
- iv. Wet the hands and wrists, keeping hands and wrists lower than the elbows (permits the water to flow to the fingertips, avoiding arm contamination).
- v. Apply soap (plain or antimicrobial) and lather thoroughly.
- vi. Use firm, circular motions to wash the hands and arms up to the wrists, covering all areas including palms, back of the hands, fingers, between fingers and lateral side of fifth finger, knuckles, and wrists. Rub for minimum of 10-15 seconds.
- vii. Repeat the process if the hands are very soiled.
- viii. Clean under the fingernails.
- ix. Rinse hands thoroughly, keeping the hands lower than the forearms.
- x. If running water is not available, use a bucket and pitcher.
- xi. Do not dip your hands into a bowl to rinse, as this re-contaminates them.

- xii. Collect used water in a basin and discard in a sink, drain or toilet.
- xiii. Dry hands thoroughly with disposable paper towel or napkins, clean dry towel, or air dry them.
- xiv. Discard the towel if used, in an appropriate container without touching the bin lids with hand.
- xv. Use a paper towel, clean towel or your elbow/foot to turn off the faucet to prevent recontamination.
- xvi. A general procedure for hand washing is given in the figure below and must be conducted over at least one full minute using antiseptics, hand rubs, gels or alcohol swabs for hand antisepsis.
- xvii. Apply the product to the palm of one hand. The volume needed to apply varies by product.
- xviii. Rub hands together, covering all surfaces of hands and fingers, until hands are dry.
- xix. Do not rinse.
- xx. When there is visible soiling of hands, they should first be washed with soap and water before using waterless hand rubs gels or alcohol swabs.
- xxi. If soap and water are unavailable hands should first be cleansed with detergent containing towelettes, before using the alcohol-based hand rub, gel or swab.

**Figure 24: Hand Washing Steps Summarized**



**A surgical scrub** is performed before each surgical procedure with the aim of removing and killing the transient flora and decreasing the resident flora in order to reduce the risk of wound contamination if surgical gloves become damaged. It ensures the removal or killing of transient micro-organisms and a substantial reduction and suppression of the resident microbial flora. Agents are the same as for the hygienic hand wash.

## **2. Personal Protective Equipment (PPE)**

Adequate and appropriate PPE, soaps, and disinfectants should be available and used correctly. These should be available at the point of use and the organization shall ensure that it maintains an adequate inventory and stock of items.

Using PPE provides a physical barrier between micro-organisms and the wearer and offers protection by helping to prevent micro-organisms from:

- i. Contaminating hands, eyes, clothing, hair and shoes.
- ii. Being transmitted to other patients and staff.

**PPE includes:**

- i. Gloves
- ii. Protective eye wear (goggles)
- iii. Masks
- iv. Aprons
- v. Gowns
- vi. Boots/shoe covers
- vii. Caps/hair covers

**PPE should be used by:**

- i. Healthcare workers who provide direct care to patients and who work in situations where they may have contact with blood, body fluids, excretions or secretions.
- ii. Support staff including medical aides, cleaners, and laundry staff in situations where they may have contact with blood, body fluids, secretions and excretions.
- iii. Laboratory staff, who handle patient specimens.
- iv. Family members who provide care to patients and are in a situation where they may have contact with blood, body fluids, secretions and excretions.

**Principles for use of PPE:**

PPE reduces, but does not completely eliminate, the risk of acquiring an infection. It is important that it is used effectively, correctly, and at all times where contact with blood and body fluids of patients may occur. Continuous availability of PPE and adequate training for its proper use are essential. Staff must also be aware that use of PPE does not replace the need to follow basic IC measures such as hand hygiene.

The following principles guide the use of PPE:

- i. PPE should be chosen according to the risk of exposure. The healthcare worker should assess whether they are at risk of exposure to blood, body fluids, excretions or secretions and choose their items of personal protective equipment according to this risk.
- ii. Avoid any contact between contaminated (used) PPE and surfaces, clothing or people outside the patient care area.

**Examples of use of PPE:**

- i. Discard the used PPE in appropriate disposal bags, and dispose off as per the policy of the hospital.
- ii. Do not share PPE.
- iii. Change PPE completely and thoroughly wash hands each time you leave a patient to attend to another patient or another duty.

**3. Patient care equipment**

Handle patient care equipment soiled with blood, body fluids secretions or excretions with care, in order to prevent exposure to skin and mucous membranes, clothing and the environment. Ensure all reusable equipment is cleaned and reprocessed appropriately before being used on another patient.

#### **4. Prevention of needle prick/sharps injuries**

Take care to prevent injuries when using needles, scalpels and other sharp instruments or equipment. Place used disposable syringes and needles, scalpel blades and other sharp items in a puncture-resistant container with a lid that closes and is located close to the area in which the item is used. Take extra care when cleaning sharp reusable instruments or equipment. Never recap or bend needles. Sharps must be appropriately disinfected and/or destroyed as per the national standards or guidelines.

#### **5. Cleaning of the hospital environment**

Routine cleaning is important to ensure a clean and dust-free hospital environment. There are usually many micro-organisms present in "visible dirt", and routine cleaning helps to eliminate this dirt. Administrative and office areas with no patient contact require normal domestic cleaning. Most patient care areas should be cleaned by wet mopping. Dry sweeping is not recommended. The use of a neutral detergent solution improves the quality of cleaning.

Hot water (80°C) is a useful and effective environmental cleaner. Bacteriological testing of the environment is not recommended unless seeking a potential source of an outbreak. Any areas visibly contaminated with blood or body fluids should be cleaned immediately with detergent and water.

Isolation rooms and other areas that have patients with known transmissible infectious diseases should be cleaned with a detergent/disinfectant solution at least daily. All horizontal surfaces and all toilet areas should be cleaned daily.

#### **6. Management of Healthcare Waste**

- i. Uncollected, long stored waste or waste routing within the premises must be avoided.
- ii. A sound waste management system needs to be developed and closely monitored.

#### **Additional Precautions (transmission- based)**

Additional (transmission-based) precautions are taken while ensuring Standard Precautions are maintained. Additional precautions include:

1. Airborne precautions
2. Droplet precautions
3. Contact precautions

#### **Isolation Procedures**

Isolation for the control of infection (Infection Control Measures Against Viral Infections) is used to prevent infected patients from infecting others (source isolation), and/or prevent susceptible patients from being infected (protective isolation). The methods of physical protection are:

1. Barrier nursing - special nursing procedures which reduce the risks of person to person transmission, especially by direct contact or by fomites.
2. Segregation into single rooms, cubicles, or plastic isolators - which reduces airborne spread to and from patients, and facilitates nursing techniques.
3. Mechanical ventilation - which reduces the risks of airborne spread by removing bacteria from the patient's room and by excluding bacteria present in the outside air from the room.

The transfer of infection by the airborne route can be controlled only by confining the patients in a single room, whether source or protective isolation. On the other hand, diseases spread by contact

such as enteric fever, depends primarily on barrier nursing. The term isolation is commonly used in the sense of segregation of the patient in a single room. Barrier nursing is one of the basic components of patient isolation and can be used on its own or together with the other components.

There are various **types of isolation** offering different **degrees of protection**:

1. **High security isolation units:** These are usually part of an infectious diseases hospital. Total environmental control is usually achieved by the use of negative pressure plastic isolators. These units are designed for treating viral pathogens such as Lassa, Marburg, and Ebola fevers.
2. **Infectious diseases hospitals:** These units are usually separate from other hospitals but may be situated in the premises of a general hospital with separate ventilation and nursing staff.
3. **General hospital isolation units:** These provide source isolation facilities for hospital-acquired infections; they also provide facilities for protective isolation and for the screening of patients with suspected infections before admission to a general ward or transfer to a communicable diseases unit.
4. **Single rooms of a general ward:** These provide less secure source isolation than the above because of the close proximity to other patients and sharing of nursing and domestic staff with a general ward. Their value in protective isolation depends on the type of patient in the general ward, on the thoroughness of barrier nursing, on whether the room is self-contained (with WC), and on the type of ventilation used.
5. **Barrier nursing in open wards:** This can be effective in controlling infections transferred by contact but not by air.
6. **Isolators in open wards:** Plastic enclosures for individual patients have been shown to be of value as a form of protective isolation for high risk patients and of source isolation for infected patients.
7. **Ultra-clean wards:** Experimental units have been set up in specialized centers for organ transplantation, treatment of leukaemia and other diseases associated with extreme susceptibility to infection.

## Ind 161. The hospital has an Infection Control Committee.

### Survey Process:

Review the plan and the minutes of the meeting of the Infection Control Committee. The membership should include at least doctors and nurses.

### Scoring:

- If there is an Infection Control Committee with minutes of meetings and it includes at least doctors and nurses, then score as **fully met**.
- If there is no committee, or it only includes doctors, then score as **not met**.

## GUIDELINES

### Notification of Infection Control Committee

To provide a forum for multidisciplinary input, cooperation, and information sharing, the Management of the HCE must notify the Infection Control Committee (ICC) with its Composition and Responsibilities as given below;

1. Wide representation from the relevant departments: e.g.
  - i. Management (Medical Superintendent/Administrator or AMS/DMS)
  - ii. Medical Specialist
  - iii. Surgical Specialist
  - iv. Microbiologist
  - v. Operation theatre in-charge
  - vi. Infection Control Nurse
  - vii. Pharmacist
  - viii. In Charge CSSD
  - ix. In Charge Maintenance
  - x. In Charge Catering
  - xi. In Charge Housekeeping
  - xii. In Charge Sanitary services
  - xiii. Bio-Medical/Civil Engineer
  - xiv. In Charge Training
2. One member of the committee should be elected as the chairperson (who should have direct access to the head of the hospital administration, to promote program visibility and effectiveness).
3. Must meet regularly on Quarterly basis.
4. In case of an emergency, such as on an outbreak of disease, this committee must be able to meet earlier than quarterly on emergent basis.
5. Appoint an ICP (health care worker trained in the principles and practices of infection control, e.g. a doctor/physician, microbiologist or a nurse) as secretary.
6. Secretary of the ICC will be responsible for taking notes and preparing minutes of each meeting and reminding the Chairperson to follow up on the recommendations.
7. Oversee, monitor and evaluate the performance of the IC program and team.
8. Enforce compliance with basic IC standards.
9. Review and approve a yearly program of activity for surveillance and prevention.
10. Assess and promote improved practice at all levels of the health facility.
11. Ensure appropriate staff training in IC and safety management, provision of safety materials such as PPE and products.
12. Oversee training of health workers.
13. Oversee the development of facility specific IC manual, if needed.
14. Review epidemiological surveillance data and identify areas for intervention.

## **Ind 162. The hospital has an Infection Control Team.**

### **Survey Process:**

Customarily the team consists of a doctor, a nurse, a laboratory scientist/technician/paramedic, someone from housekeeping, and a safety officer. However, the appropriate membership of an infection control team will depend on the scope of services of the hospital. The role of the team is to respond to, and inform, the findings of the Infection Control Committee (Ind 152, 153) and make periodic infection control rounds in the hospital to verify that infection control policies and procedures are effectively followed and documented.

**Scoring:**

- If there is a team that meets regularly and its membership is reasonable, then score as **fully met**.
- If there is a team but it consists of only one discipline (nurse, doctor, etc.) or it meets rarely, then score as **partially met**.
- If there is no team or no meeting has taken place, then score as **not met**.

**GUIDELINES****Notification of Infection Control Team**

1. An IC team will be put together with responsibility for the day-to-day activities of the IC program. Ideally 2 members (Infection Control Officer [ICO] and/or Infection Control Nurse [ICN]) should suffice as IC Team Leader 1 and 2 for most facilities although in smaller facilities this could mean a single person (part or full time) with additional IC responsibilities. These professionals may be administratively part of another unit (e.g. a microbiology laboratory, medical or nursing administration, public health services). The optimal structure shall include one Ward Nurse or other suitably trained Paramedic from each ward/department, sanitation staff and waste disposal staff but it will vary with the type, needs, and resources of the facility.
2. The In-Charge ICO/ICN is required to enforce approved IC practices directly by the ward/departmental staff as needed and enjoy a direct daily/incidental reporting relationship with senior administration.
3. The team is responsible for the day-to-day functions of IC, as well as preparing the daily/monthly/quarterly/yearly work plan for review by the infection control committee and administration.
4. These teams/individuals should be notified/put on rosters by the HCE and should have scientific and technical support/responsibilities, e.g. surveillance and research, developing and accessing policies and practical supervision, evaluation of material and products, overseeing sterilization and disinfection, ensuring the sound management of medical waste and the implementation of training programs.
5. HCEs must have access to specialists in IC, epidemiology, and infectious disease, including physicians and infection control practitioners. Often this would mean that such access may be arranged so that these resources are available at district or provincial levels in resource constrained situations.

**Ind 163. The hospital has designated qualified infection control nurse(s) for this activity.**

**Survey Process:**

Review the job description of the infection control nurse or nurses to determine the required qualifications. Then review the HR file/s for this individual(s) to validate if the qualifications match the requirements of the job description.

**Scoring:**

- If the qualifications of the individual(s) match the requirements in the job description, or if there are only minor variances (such as a little less experience than prescribed in the job description,

then score as **fully met**.

- This standard should be scored as **not met**, if the job description and qualifications of the infection control personnel do not match.

## GUIDELINES

### **Infection Control Nurse / Infection Control Officer**

1. The criteria for designating shall either be the qualification or training or preferably a combination of both. It is preferable for ICO/ICN to have undergone a short-term training program on IC nursing by a recognized institution. The nurse/officer in charge of IC is a member of the ICC and leads the IC Team for ensuring implementation of IC SOPs.
2. Responsibilities of ICO/ICN
  - i. Develop/adapt and get IC Manual endorsed.
  - ii. Disseminate SOPs of IC based on the IC Manual.
  - iii. Coordinate and conduct training activities related to IC.
  - iv. Enforce minimum IC standards.
  - v. Identifying and Investigating nosocomial infections.
  - vi. To collaborate with the microbiologist on surveillance of infection and detection of outbreaks due to improper sterilization of instruments.
  - vii. To liaise between Sterilization Department and clinical departments for detection and control of Hospital Acquired Infection (HAI).
  - viii. Carry out the surveillance program and monitor and manage critical incidents.
  - ix. Ensuring compliance with local and national regulations.
  - x. Liaison with public health and with other facilities where appropriate.
  - xi. Providing expert consultative advice to staff health and other appropriate hospital programmes in matters relating to transmission of infections.
  - xii. Compile periodic (at least 3 monthly) reports of hospital infections.
  - xiii. Report directly to the MS or Hospital Administrator and the ICC.

**Ind 164. The establishment has appropriate consumables, collection and handling systems, equipment and facilities for control of infection.**

### **Survey Process:**

Observe the clinical areas and check for the presence and use of hand washing facilities in ALL care and treatment areas. Determine if there is i. Hand washing soap/liquid, ii. Gloves, iii. Masks, iv. Sharps collection containers, v. Single use syringes and vi. A full system of waste management from the point of generation to the point of destruction. Adequate cleaning equipment and appropriate consumables should be readily available and the staff trained to use it effectively.

### **Scoring:**

- If there is full system of hospital infection control including all above mentioned elements from 1-6, serve all care and treatment areas, then score as **fully met**.
- If any one of the elements in the hospital infection control from 1-6 above is not compiled with, then score as **not met**.

## GUIDELINES

### Resources/Facilities for Infection Control<sup>122</sup>

Requirement of various materials will depend on the workload of the healthcare facility. The calculation of the daily requirement of gloves, gowns, masks, etc., helps in organizing the everyday logistics, and annual planning. An example to this calculation is given as follows:

*Table 29: Calculation of Materials for Infection Control*

Disposable Gloves		
Number of staff using gloves	S =	
Average number of gloves pairs used per staff per day	Id =	
Total number of gloves pairs used daily	Sd =	Sd = S x Id
Disinfectants		
Number of locations that need disinfectants	S =	
Average amount ( <i>nos. or liters</i> ) of disinfectants used per location per day	Id =	
Total amount ( <i>nos. or liters</i> ) of disinfectants used daily	Sd =	Sd = S x Id

**Some general** considerations are given below:

1. Use of protective clothes, shoes, gloves and masks has been described in Ind No. 152.
2. Gloves should be worn when handling bedpans and urinals. The contents should be disposed of directly into the sluice or bedpan disinfector. The bedpan or urinal should then be heat disinfected and dried. A bedpan washer/disinfector and a high temperature washing-up machine should be available in the ward.
3. All clinical waste should be disposed of in a color-coded bag for incineration.
4. Disposable or autoclavable equipment should be used whenever possible. Essential items of patient care such as sphygmomanometers and stethoscopes should be left in the room and disinfected when the patient is discharged or before being used on another patient. Hard surfaces may be disinfected by wiping with a phenolic or hypochlorite solution. Other equipment may be disinfected by wiping with 70% alcohol. Sphygmomanometer cuffs may be disinfected by low temperature steam. Thermometers should be kept in the isolation room until the patient is discharged.
5. Needles and syringes should be disposable and placed in a hardened container which is sealed before disposal.
6. Linen from infected patients should be placed in a color-coded linen bag for transfer to the laundry. Linen which may present a hazard to the laundry staff e.g. hepatitis B should first be sealed in labelled bag.

<sup>122</sup> National Guidelines on Injection Safety, Device Control and Hospital Waste Management, 2008

7. Disposable items may be used when a dishwasher heating the items to over 80°C is not available. Food should be placed in polythene bags and discarded with ward waste.
8. **Immunization** against Viral hepatitis and Tetanus is recommended for all personnel handling waste and infectious material with Hepatitis B vaccination/immunoglobulin if a hospital employee has not been vaccinated against Hepatitis B.
  - i. Hep. B results show insufficient antibodies, Hep. B immunoglobulin must be administered within 72 hours.
  - ii. If sufficient antibodies are present, a Hep. B vaccination booster will only be required.
  - iii. A Tetanus injection will be required if not received within the last 5 -10 years.
  - iv. HIV/Hep. C results must be collected (in person) within 7 days.
    - a. Follow-up blood tests (after 1st initial blood test)
    - b. Further blood tests will be required for
  - v. Hepatitis B                      3 months after injury (titer levels)
  - vi. Hepatitis C                    3 months after injury, then 6 months
  - vii. HIV                              3 months after injury, then 6 months

**Ind 165. All staff involved in the creation, handling and disposal of medical waste shall receive regular training and ongoing education in safe handling of medical waste.**

**Survey Process:**

Identify the staff who conducts training in infection control and review the training manual. Speak with a range of staff involved with the generation, handling and management of medical waste to determine their level of training and applied knowledge. This should include the staff hired on temporary or short-term basis. The system employed by the healthcare establishment should encompass the full process on site and include what happens once the waste leaves the site. Adequate systems, facilities, safety equipment/consumables and training should be observable.

**Scoring:**

- If there is evidence that training takes place at induction, when new waste management systems are introduced, or when new consumables or equipment related to medical waste management are employed, then score as **fully met**.
- If training takes place when some of the above factors prevail then score as **partially met**.
- If no training takes places, then score as **not met**.

<b>GUIDELINES</b>
<p><b><u>Training in Safe Handling of Medical Waste</u></b></p> <ol style="list-style-type: none"> <li>1. Health administrators should be oriented towards the importance of the IC program. Healthcare workers should be equipped with requisite knowledge, skills and attitudes for good IC practices. The ICC should:               <ol style="list-style-type: none"> <li>i. Assess training needs of the staff and provide required training through awareness</li> </ol> </li> </ol>

- programs, in-service education and on-the-job training.
- ii. Organize regular training programs for the staff for essential IC practices that are appropriate to their job description.
  - iii. Provide periodic re-training or orientation of staff.
  - iv. Review the impact of training.
2. All staff who work in areas where infectious waste is handled, is trained on the hazards of waste, management of waste and IC. All staff shall be trained in and use procedures for different types of waste;
- i. Collection
  - ii. Segregation at source
  - iii. Storage
  - iv. Transportation
3. Hospital waste in Pakistan is regulated by the Hospital Waste Management Rules, 2005. According to the rules, every hospital shall be responsible for the proper management of the waste, through developing a 'Hospital Waste Management Plan'. The plan will be facility specific, containing a list of activities, quantify of required materials with cost and timeline. Development of the plan is the responsibility of Waste Management Officer (a designated member of the Hospital Waste Management Team (WMT), detail are given under relevant Section. The plan will be reviewed and finalized by the Hospital WMT and should aim to:
- i. Protect public health and safety.
  - ii. Provide a safer working environment.
  - iii. Minimize waste generation and environmental impacts of waste treatment/disposal.
  - iv. Ensure compliance with legislative requirements.

*Clinical and municipal waste is segregated at the point of source in colour coded bins, as given at Annexure S.*

## Assessment Scoring Matrix

**Standard 34. HIC. 1: The Hospital/HCE has a well-designed, comprehensive and coordinated infection control programme aimed at reducing/ eliminating risks to patients, visitors and care providers.**

Indicator 160-165		Max Score	Weightage (Percentage)	Grading/ Score
Ind 160.	The hospital infection control programme is documented which aims at preventing and reducing risk of nosocomial infections.	10	80	
Ind 161.	The hospital has an Infection Control Committee.	10	100	
Ind 162.	The hospital has an infection control team.	10	80	
Ind 163.	The hospital has designated a qualified infection control nurse(s) for this activity.	10	100	
Ind 164.	The establishment has appropriate consumables, collection and handling systems, equipment and facilities for control of infection.	10	100	
Ind 165.	All staff involved in the creation, handling and disposal of medical waste shall receive regular training and ongoing education in safe handling of medical waste.	10	80	
<b>Total</b>		60	-	

## Standard 35. HIC-2: There are documented procedures for sterilization activities in the hospital/HCE.

### Indicators (166-168):

**Ind 166. There is adequate space available for sterilization activities.**

#### Survey Process:

The definition of "adequate" includes enough space (or at least physical barriers) to ensure separation of 'clean' and 'dirty' areas.

#### Scoring:

- If there is adequate space including clear separation of 'clean' and 'dirty' areas with adequate barriers, then score as **fully met**.
- If there is no separation, then score as **not met**.

### GUIDELINES

#### Documented Layout and Processes

1. The definition of 'adequate' includes enough space (or at least physical barriers) to ensure separation of 'clean' and 'dirty' considering the workload. The defined Sterilization department/area should have provision to physically separate the functions of cleaning, processing, sterile storage and distribution. This includes suitable location, proper layout and separation of clean and dirty areas. Sufficient space as recommended by the Original Equipment Manufacturer (OEM) shall be available to ensure that the activities can be performed properly. It is preferable to have separate areas for receiving, washing, cleaning, sterilization, packing, sterile storage and dispatch. This entire layout is required to be documented and displayed like a Layout Map.
2. Each HCE needs to develop a programme for the implementation of good IC practices. ICC, besides other functions also oversees the provision of sterile supplies to the Facility.
3. **Central Sterilization Services Department (CSSD)**  
A CSSD is vital for an effective Infection Control and Prevention program. The expertise and knowledge of CSSD personnel is important to ensure high standards of sterilization. CSSD typically comprises of four major areas to accomplish the functions of sterilization; collection/washing/packaging, sterile processing, sterile storage, and sterile distribution.  
In the disinfection area, reusable equipment, instruments, and supplies are cleaned and disinfected using manual or mechanical cleaning processes and chemicals.  
From the washing area, clean items are moved to the assembly/packaging area. Instruments and OT linen are then packed with indicators, sterilized in the sterilization section, storage and issue/dispatch. The sterile packs should be stored in well ventilated clean stores ready for dispatch to the wards and OT. Collection should be regular and there should be a written record of receipt and delivery. This helps to monitor the use and the loss of instruments.

#### 4. Layout of the CSSD

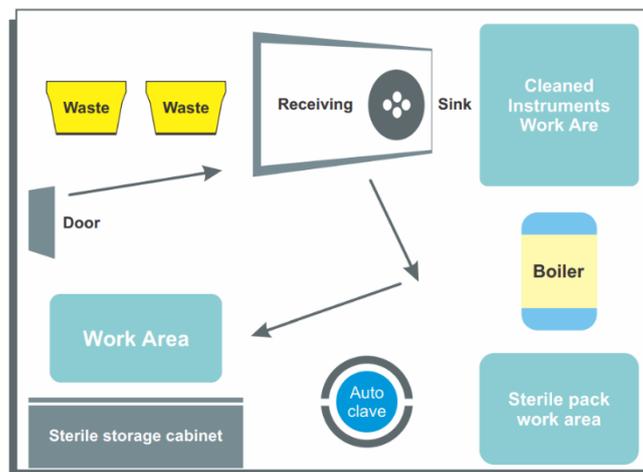
Ideally, physical barriers should separate dirty and clean areas in the reprocessing room. However, if this is not possible due to shortage of space or funds, the same room can be used with partitions, provided that:

- i. The air moves from the clean area to the dirty area to avoid cross-contamination.
- ii. Both areas have separate storage facilities.
- iii. There are adequate hand disinfection facilities.
- iv. SOPs are established to ensure that soiled objects never cross paths with clean, sterilized, or high-level disinfected instruments and other items.
- v. The doors are kept closed in the reprocessing rooms in order to minimize dust contamination and to eliminate insects.
- vi. There is separate equipment for each area.
- vii. The staff works in either area, never in both.

**Figure 25: Sample Layout of CSSD**



**Figure 26: Sample of CSSD Workflow**



## **5. Workflow of the CSSD**

In the ward, dirty re-usable instruments are collected and put into clearly labelled containers and delivered to the CSSD. Cotton wool and dress ing should be discarded as clinical waste for incineration. The dirty instruments are then received in the dirty area of the CSSD. All equipment is first washed in hot water and detergent either mechanically or manually. Manual washing requires the use of appropriate protective clothing such as heavy-duty gloves, plastic aprons, and eye-protection. The equipment is then inspected for cleanliness and damage. Instruments are then packed into individual trays for use in wards and autoclaved and/or disinfected as required. The packaged trays are then inspected to ensure that they are dry and then sorted for collection for use in wards. The sterile packs should be stored in well-ventilated rooms ready for dispatch to the wards. Collections should be regular and there should be a written record of receipt and delivery.

## **6. Disinfection/Sterilization of Instruments**

It is mandatory for healthcare workers to disinfect soiled medical instruments before using them on other patients. Sterilization of medical instruments prevents the spread of infectious diseases and is the first sterilization process to protect patients from contaminants like HIV and Hepatitis C that can live on instruments. Liquid bleach, as well as isopropyl and ethyl alcohol, are extremely effective in disinfecting medical instruments if a hospital grade germicidal cleanser is not available.

### **SOPs for Disinfection**

- i. Place your washbasins and supplies in a cleaning station or utility room. Decide which chemical you will use to disinfect the medical instruments - germicidal spray, liquid bleach or alcohol. These are all highly effective disinfectants and the medical community approves of them.
- ii. Put on your protective wear - gloves, goggles, mask and apron. Gloves should be the heavy-duty utility style for handling sharp instruments like scalpels and knives. Dispose of gloves and use a new pair if they tear during the disinfecting process.
- iii. Spray each individual instrument heavily with germicidal spray and disinfect one piece at a time. Allow each item to stay for two minutes in the washbasin. Place the instruments into a separate basin of clean water to rinse. Dried blood or fluids on instruments may require an additional application of germicidal spray and light scrubbing with a toothbrush for removal.
- iv. In case of liquid bleach, mix one ounce of bleach with one quart of boiled water in a washbasin and add the soiled medical instruments. Allow the instruments to stay in the bleach solution for five minutes to kill any infectious organisms. Remove the instruments and check for any remaining blood or fluids. Use a toothbrush to remove any visible contaminants left on the instruments and rinse the instruments with clean water in a separate basin.
- v. In case of using isopropyl or ethyl alcohol, place the soiled instruments in the washbasin, pour alcohol into a spray bottle and spray the instruments thoroughly. Use a toothbrush to remove any dried fluids. Apply more spray and scrub vigorously if the contaminant is still visible on the object. Place the instruments into another basin and rinse with clean water.

## **7. Cleaning Instruments with Sterile Water**

While using medical equipment or instruments that need to be sterilized for safety and disinfection, use a solution of sterile water to ensure that all bacteria and viruses are killed and

eliminated from the instrument or the tool. Using a mix of enzymatic detergent and sterile water can assist you in effectively cleaning and eliminating unwanted microbes from surgical and medical tools and equipment.

#### **SOPs for Cleaning Instruments with Sterile Water**

- i. Remove debris and residue from the instruments by rinsing them under sterile water and using a toothbrush or other scrubbing tools.
- ii. Mix proper amounts of sterile water and enzymatic detergent in a clean container large enough to hold the instruments. The proper ratio of enzymatic detergent and sterile water will be determined and followed as per manufacturer instructions
- iii. Place the instruments in the container with the enzymatic detergent and sterile water formula, making sure that they are fully covered by the solution.
- iv. Soak the tools in the solution for 20 minutes to effectively sterilize the instruments before reuse.

### **Ind 167. Regular validation tests for sterilization are carried out and documented.**

#### **Survey Process:**

This is an important patient safety issue. Review the process/procedure to validate that complete sterilization has occurred. This should be uniformly done on each "batch" that is sterilized. There are several methods that can be used (such as color change strips). Whatever method is used, it must be effective and documented. Observe that the date of sterilization and expiry are clearly indicated on the packaging.

#### **Scoring:**

- If there is a process/procedure to verify that complete sterilization has occurred, it is used for ALL "batches" that are sterilized, it is documented and production/ sterilization and expiry dates are indicated, then score as **fully met.**
- If it is only done on a random sample, and dates are not fully indicated then score as **partially met.**
- If there is no process/procedure, or if it is rarely (once a day) used, or if it is not documented, or dates are not indicated, then score as **not met.**

## **GUIDELINES**

### **Record of Validation Tests**

Documented processes/procedures should be there to provide guideline for complete sterilization. This should be uniformly done on each "batch" that is sterilized. There are several methods that can be used (such as color change strips). Every method used must be documented and effective. The date of sterilization and expiry are clearly indicated on the packaging. This should be done by accepted methods, e.g., bacteriologic, strips, etc. Engineering validations like Bowie Dick tape test and leak rate test need to be carried out. WHO recommends each load to have number, content description, temperature, pressure and time-record chart, physical/chemical tests daily, weekly biological tests and steam processing.

**Ind 168. There is an established procedure for recall in case of breakdown in the sterilization system.**

**Survey Process:**

Review any written recall procedure employed in case of breakdown of sterilization system. If an actual breakdown had occurred, review how the recall was implemented. Check to see if staff members are aware and receive training in the procedure.

**Scoring:**

- If a written recall procedure exists and staff is aware of it, then score as **fully met.**
- If there is no written recall procedure, then score as **not met.**

**GUIDELINES**

**Breakdown Recall**

The HCE should develop and have a written recall procedure and the staff members should be trained on these procedures. The HCE shall ensure that the sterilization procedure is regularly monitored and in the eventuality of a breakdown it has a procedure for withdrawal of such items. A batch processing system with date and machine number for effective recall should be in place. Whenever a breakdown in the sterilization system is noted, all packs sterilized by the faulty machine should immediately be called back from the respective area where the sterile packs has been supplied. The packs called back should be sent for re-sterilization using a proper machine/technique.

The ICC shall ensure that institutional policies are consistent with provincial/national guidelines (if existing) and conduct IC audit periodically (e.g., at least monthly in areas where materials are reprocessed to ensure policy compliance). Breaches in policy should be documented and corrective action instituted.

## Assessment Scoring Matrix

**Standard 35. HIC 2: There are documented procedures for sterilization activities in the Hospital/HCE.**

Indicator 166-168		Max Score	Weightage (Percentage)	Score Obtained
Ind 166.	There is adequate space available for sterilization activities.	10	<b>100</b>	
Ind 167.	Regular validation tests for sterilization are carried out and documented.	10	<b>80</b>	
Ind 168.	There is an established procedure for recall in case of breakdown in the sterilization system.	10	<b>100</b>	
<b>Total</b>		30	-	

**PART 3**  
**ANNEXURES**

### 3. Annexures

#### ANNEXURE A: Summary Assessment Scoring Matrix

Functional Area		Max Score	Required Score	Score Obtained
2.1	Responsibilities of Management (ROM)	170	168	
2.2	Facility Management and Safety (FMS)	120	106	
2.3	Human Resource Management (HRM)	100	92	
2.4	Information Management System (IMS)	120	114	
2.5	Continuous Quality Improvement (CQI)	140	134	
2.6	Access, Assessment, and Continuity of Care (AAC)	170	160	
2.7	Care of Patients (COP)	440	428	
2.8	Management of Medication (MOM)	210	198	
2.9	Patient Rights and Education (PRE)	120	108	
2.10	Hospital Infection Control (HIC)	90	82	
<b>Total</b>		<b>1,680</b>	<b>1,590</b>	

## ANNEXURE B: Health Related Laws in Khyber Pakhtunkhwa

No.	Health Related Laws
1.	Pakistan Medical Commission Act, 2020
2.	Khyber Pakhtunkhwa Food Safety & Halal Food Authority Act, 2014
3.	The Khyber Pakhtunkhwa Healthcare Commission Act, 2015
4.	The Khyber Pakhtunkhwa Public Procurement Regulatory Authority Act 2012
5.	The Khyber Pakhtunkhwa Consumer Protection (Amendment) Act, 2017
6.	The Khyber Pakhtunkhwa Blood Transfusion Safety Authority Act, 2016
7.	The Khyber Pakhtunkhwa Environmental Protection Act, 2014
8.	Pakistan Nursing Council (Amendment) Act, 2021
9.	Allopathic System (Prevention of Misuse) Rules, 1968
10.	Pharmacy Act, 1967
11.	The Unani Ayurvedic And Homoeopathic Practitioners Act, 1965
12.	The Allopathic System (Prevention of Misuse) Ordinance, 1962
13.	Khyber Pakhtunkhwa Hospital Waste Management Rules, 2018
14.	Injured Persons Act, 2004
15.	Khyber Pakhtunkhwa Injured Persons and Emergency (Medical Aid) Act, 2014

## ANNEXURE C: Joining Report

EMPLOYEE DETAILS	
Name	
Phone Number Home:	Mobile Number:
Email ID:	
Residential Address:	
Date of Joining	
EMPLOYEE'S JOINING CONFIRMATION	
I _____ do hereby confirm that I have accepted your offered job as _____ in _____ Department and have accordingly joined with effect from _____.	
(Employee Signature)	(Date)
EMPLOYEE'S JOINING VERIFICATION	
The date of joining mentioned above is correct.	
Verified By:	
Name: _____	Designation: _____
Signature: _____	Date: _____
Note: Submission of this REPORT is mandatory. A copy of this report will be sent to the Accounts Department.	

## ANNEXURE D: Statement of Ethics

<b>Guideline 1</b>	We do not make misleading claims for our services or criticize our competitors before clients. We only believe in servicing our client's needs to the best of our efforts.
<b>Guideline 2</b>	We perform our work according to the specified quality standards.
<b>Guideline 3</b>	We avoid conflicts of interest either of a financial or personal nature; these could compromise the objectivity and integrity of our work.
<b>Guideline 4</b>	We exercise our professional judgment impartially while taking any decisions related to work, keeping all pertinent facts, relevant experience and the advice of our management in mind.
<b>Guideline 5</b>	We hold the affairs of our clients in the strictest confidence. We do not disclose propriety information obtained in the course of work or derive benefit from using information outside the company.
<b>Guideline 6</b>	We act with courtesy and consideration towards all with whom we come into contact in the course of our professional work.
<b>Guideline 7</b>	We do not accept any favors, gifts or inducements, including undue hospitality and entertainment, from the clients. The only expectations would be if the gifts are of promotional nature (diaries, calendars, etc.) or of a nominal value, the indulgence of which would not damage the company's reputation.
<b>Guideline 8</b>	We are fully committed to the principle of equality and non-discrimination on the grounds of disability, sex, age, race, color, ethnicity, origin or marital status. We do not indulge in any intimidation and harassment of any sort at work.
<b>Guideline 9</b>	We will communicate with our clients and its representative in an effective and timely manner.
<b>Guideline 10</b>	We would be perceived by clients and other thought leaders as setting the standards in client focus and client service among professional service companies.

### Declaration

I have read and understood the "Statements of Ethics" and stand committed to it.

Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Joining: \_\_\_\_\_

## ANNEXURE E: Confidentiality Agreement

In the course of your work at \_\_\_\_\_ Hospital you are likely to receive, from time to time, information which is not in the public domain. You are reminded that such information must be kept confidential and release of such information could lead to termination of employment, civil or criminal prosecution.

All memoranda, notes, reports and other documents will remain part of the Hospital's confidential records. Such confidential information must at all times be kept in a secure place on the Hospital's premises and disclosed to others only in accordance with our duties as an employee of \_\_\_\_\_. Inventions, copyrights and other intellectual property, when conceived, developed or made during employment by the Hospital, or within one year thereafter, shall be regarded as made by employee solely and exclusively for the benefit of the Hospital. These shall not be disclosed to others without the Hospital's written consent, and shall be the sole and exclusive property of the Hospital.

The employee agrees to make prompt and full written disclosure of such inventions, copyrights and other intellectual property, and when requested by the Hospital to do so, either during or after employment.

By signing this agreement you confirm that you will comply with these requirements and you further undertake to preserve, even after you cease to be an employee, the confidentiality of information received by you during your employment at \_\_\_\_\_ .

I hereby confirm that I accept the set out above.

Signed: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Joining: \_\_\_\_\_

## ANNEXURE F: Reference Form

Kindly provide us the detail of at least 2 people, other than relatives, who have knowledge of your work experience and/or education.

Name of Candidate: \_\_\_\_\_ Position: \_\_\_\_\_

Reference 1	
Name:	Designation:
Company Name:	Address:
Telephone # (Home):	Telephone # (Office):
Mobile #:	Email:
Fax:	Other:

Reference 2	
Name:	Designation:
Company Name:	Address:
Telephone # (Home):	Telephone # (Office):
Mobile #:	Email:
Fax:	Other:

Reference 3	
Name:	Designation:
Company Name:	Address:
Telephone # (Home):	Telephone # (Office):
Mobile #:	Email:
Fax:	Other:

Reference 4	
Name:	Designation:
Company Name:	Address:
Telephone # (Home):	Telephone # (Office):
Mobile #:	Email:
Fax:	Other:

# ANNEXURE G: Health Questionnaire Form

(To be filled by the employee)

Employee Name: \_\_\_\_\_ Designation: \_\_\_\_\_

Please read the following questions carefully and answer each question in Yes or No. If the answer to any question is "Yes", please give full detail.

No.	Question	Answer
1.	Have you ever been advised by a physician to have medical treatment or surgery/ procedure/investigation for any of the following: <ol style="list-style-type: none"> <li>1. Heart disease</li> <li>2. High blood pressure</li> <li>3. Diabetes</li> <li>4. Kidney disease</li> <li>5. Cancer or brain tumor</li> <li>6. Back pain including any muscular problem</li> <li>7. Digestive problems</li> <li>8. Liver disease including hepatitis B</li> <li>9. AIDS</li> </ol>	
2.	Do you have any health problem due to smoking	
3.	Are you currently taking any treatment or medication or awaiting medical investigations, laboratory test, treatment or surgery	
4.	Have you been absent from work due to medical reasons for a continuous period of a week or more during the last 2 years	
5.	Other (please specify)	

Please give detail of any "Yes" answer to the above questions in the following form.

Q#	Type of Disease	Date (from)	Date (to)	Treatment from (Name and address of Doctor)

### DECLARATION:

I hereby declare that what has been stated above is true and complete to the best of my knowledge and if found that I have some health problem then I could be sent to the hospital, recommended by the HR Department, for complete checkup and test. In case of wrong information, I could be terminated from employment.

Signature: \_\_\_\_\_ Date of Joining: \_\_\_\_\_

# ANNEXURE H: Orientation Checklist

Employee's Name: \_\_\_\_\_ Designation: \_\_\_\_\_

Department: \_\_\_\_\_ Date: \_\_\_\_\_

In order to avoid duplication of the instructions, the Information checked ( ) below has been given or explained to the employee by the HR department.

<b>Introduction:</b>		<b>Time Schedule:</b>	
Company Introduction	( )	Work Schedule/Lunch timings	( )
Mission & Vision	( )	Attendance & Punctuality	( )
Corporate Values	( )	Public Holidays	( )
Organizational Structure	( )	Leave	( )
<b>Employment:</b>		<b>Employee Relations:</b>	
Recruitment & Selection	( )	Violation of company rules	( )
Appointment Letter issued	( )	Disciplinary Policy	( )
Confidentiality Agreement signed	( )	Internal Communication	( )
Statements of Ethics signed	( )	Employee Records	( )
Probation & Confirmation	( )	Code of Conduct	( )
Resignation /Termination	( )		
<b>Compensation &amp; Benefits:</b>		<b>Career Development:</b>	
Job Description issued	( )	Performance Management System	( )
Medical Facility	( )	Promotion/increments	( )
Parking Facility	( )	Training	( )
Provident Fund	( )		

<b>Others:</b>	
Other Benefits	( )
Tour of the company	( )
Issuance of Employee Handbook	( )
<b>Salary Administration:</b>	
Salary Process	( )
Email address sent for addition	( )
Advance Salary	( )
Outstation Travel	( )

**How satisfied are you with the orientation process?**

- a) Not Satisfied    b) Improvement Needed    c) satisfied  
1. Very Satisfied    e) Outstanding

**Additional Comments/Suggestions:**

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**Orientation Conducted by:**

Employee's Signature: \_\_\_\_\_

Supervisor's Signature: \_\_\_\_\_

## ANNEXURE I: Patient Record Template

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Unique ID	Date	Time	Visit#	Name	Parentage	Age	Sex	Weight	Ph.	Add.	Allergy	Symptom	Finding	Provisional/ Diagnosis

Note: Column Nos. are only for reference.

## ANNEXURE J: Weeding of Old Record

	<b>Type of Record</b>	<b>Period of retaining</b>
<b>Official Record</b>	Personal Files, Services books, Financial Record auditable and non-auditable, excisable/non-excisable record.	In accordance with the Government of Khyber Pakhtunkhwa Financial Rules or as per necessity, whichever is later.
<b>Medical Record</b>	Patient charts, Reports, X-Ray, CT Scan MRI, Pathology reports OPD Registers.	03 Years or later as per necessity.
<b>Medico-legal</b>	Medico-Legal report/registers	12 years or later as per necessity.
<b>Demographic Record</b>	Birth and Death record	Birth and Death Registers to be kept forever.

## ANNEXURE K: List of Tests

<p><b>Cardiology</b></p> <ol style="list-style-type: none"> <li>1. Total Cholesterol</li> <li>2. LDL-C</li> <li>3. HDL-C</li> <li>4. Triglyceride</li> <li>5. C-reactive protein</li> <li>6. Fibrinogen</li> <li>7. Homocysteine</li> <li>8. Fasting Insulin</li> <li>9. Ferritin</li> <li>10. Lipoprotein(a) - Lp(a)</li> <li>11. Calcium Heart Scan</li> <li>12. Cardiac catheterization and angiography</li> <li>13. Echocardiography (echo)</li> <li>14. Electrocardiogram (ECG or EKG)</li> <li>15. Electrophysiology study (EP study)</li> <li>16. Holter monitor and event recorder</li> <li>17. MUGAscan</li> <li>18. Stress testing</li> <li>19. Thallium and sestamibi (Cardiolite) scans</li> <li>20. Tilt Table Testing</li> <li>21. Transesophageal echocardiography (TEE)</li> <li>22. Ultrafast CT scan</li> <li>23. Cardiac MRI</li> <li>24. Creatine kinase (total)</li> <li>25. Creatine kinase (MB fraction)</li> <li>26. Troponin I and T</li> <li>27. Myoglobin</li> <li>28. Lactate dehydrogenase</li> </ol>	<p><b>Thyroid Tests</b></p> <ol style="list-style-type: none"> <li>1. <b>Thyroid hormones</b> <ol style="list-style-type: none"> <li>A. Thyroid-stimulating hormone</li> <li>B. Total thyroxine</li> <li>C. Free thyroxine</li> <li>D. Total triiodothyronine</li> <li>E. Free triiodothyronine</li> </ol> </li> <li>2. <b>Carrier proteins</b> <ol style="list-style-type: none"> <li>A. Thyroxine-binding globulin</li> <li>B. Thyroglobulin</li> <li>C. Other binding hormones</li> </ol> </li> <li>3. <b>Protein binding function</b> <ol style="list-style-type: none"> <li>A. Thyroid hormone uptake</li> <li>B. Other protein binding tests</li> </ol> </li> <li>4. <b>Mixed parameters</b> <ol style="list-style-type: none"> <li>A. Free thyroxine index</li> </ol> </li> <li>5. <b>Structure parameters</b> <ol style="list-style-type: none"> <li>A. Secretory capacity (GT)</li> <li>B. Sum activity of peripheral deiodinases (GD)</li> <li>C. TSH index</li> </ol> </li> </ol>
<p><b>Assay used for blood screening</b></p> <ol style="list-style-type: none"> <li>1. Immunoassays (IAs)             <ol style="list-style-type: none"> <li>A. Enzyme immunoassays (EIAs)</li> <li>B. Chemiluminescent immunoassays (CLIAs)</li> </ol> </li> <li>2. Haemagglutination (HA)/particle agglutination (PA) assays</li> <li>3. Rapid/simple single-use assays (rapid tests)</li> </ol>	<p><b>Liver Function Tests</b></p> <ol style="list-style-type: none"> <li>1. Proteins</li> <li>2. Albumin</li> <li>3. Globulin</li> <li>4. Total Protein</li> <li>5. Enzymes</li> <li>6. Total Bilirubin</li> <li>7. Alkaline Phosphatase</li> <li>8. GGTP</li> <li>9. LDH</li> </ol>

<ol style="list-style-type: none"> <li>4. Nucleic acid amplification technology (NAT) assays.</li> <li>5. The following tests are mandatory on all units of blood collected for transfusion:</li> <li>6. ABO group and Rh type</li> <li>7. Serologic test for syphilis, HIV and Hepatitis B and C</li> </ol>	<ol style="list-style-type: none"> <li>10. SGOT (also called AST)</li> <li>11. ALT (SGPT)</li> </ol>
<p><b>Renal Function tests</b></p> <ol style="list-style-type: none"> <li>1. Routine urinalysis</li> <li>2. Creatinine clearance test</li> <li>3. Urea clearance test</li> <li>4. Urine osmolality test</li> <li>5. Urine protein test</li> <li>6. Blood urea nitrogen test (BUN)</li> <li>7. Creatinine test</li> <li>8. Other blood tests like urine sodium, potassium, chloride, calcium, glucose, etc.</li> </ol>	<p><b>Transplantation Tests</b></p> <ol style="list-style-type: none"> <li>1. Matching blood group</li> <li>2. Matching tissue type</li> <li>3. Testing for viruses</li> <li>4. Electrocardiogram (ECG)</li> <li>5. Echocardiogram (echo)</li> <li>6. Chest X-ray</li> </ol>
<p><b>Electrolyte Tests</b></p> <ol style="list-style-type: none"> <li>1. Ca (Calcium)</li> <li>2. P04</li> <li>3. Mg (Magnesium)</li> <li>4. K (Potassium)</li> <li>5. Na (Sodium)</li> <li>6. CO2 (Bicarbonate)</li> <li>7. Cl (Chloride)</li> </ol>	<p><b>Paediatrics</b></p> <ol style="list-style-type: none"> <li>1. Albumin</li> <li>2. Bilirubin</li> <li>3. Complete blood count (CBC)</li> <li>4. Electrolyte tests</li> <li>5. Fecal fat test</li> <li>6. Fecal occult blood test</li> <li>7. Hydrogen breath test</li> <li>8. Lactose tolerance test</li> <li>9. Liver enzymes</li> <li>10. Prothrombin time (PT) test</li> <li>11. Stool culture</li> <li>12. Urea breath test</li> </ol>
<p><b>Gastroenterology Tests and Procedures</b></p> <ol style="list-style-type: none"> <li>1. Abdominal Angiogram</li> <li>2. Abdominal Ultrasound</li> <li>3. Abdominal X-rays</li> <li>4. Barium Enema</li> <li>5. Barium Swallow</li> <li>6. Cholecystography</li> <li>7. Colonoscopy</li> <li>8. CT Scan of Liver and Biliary Tract</li> <li>9. CT Scan of the Abdomen</li> <li>10. CT Scan of the Pancreas</li> </ol>	<p><b>Tests in ICU</b></p> <ol style="list-style-type: none"> <li>1. EUC Electrolytes (Sodium/Potassium/Chloride)/Urea/Creatinine</li> <li>2. Arterial Blood Gas - ABG</li> <li>3. Liver Function Tests - LFTs</li> <li>4. Full Blood Count - FBC</li> <li>5. Coagulation Studies - Coags</li> <li>6. Blood sugar level - BSL</li> <li>7. Urinalysis</li> <li>8. Pathology Tests to identify possible infection</li> </ol>

<ul style="list-style-type: none"> <li>11. Endoscopic Cholangiopancreatography</li> <li>12. Esophagogastroduodenoscopy</li> <li>13. Gallbladder Scan</li> <li>14. Laparoscopy</li> <li>15. Liver Biopsy</li> <li>16. Liver Scan</li> <li>17. Pancreas Scan</li> <li>18. Sigmoidoscopy</li> <li>19. Upper Gastrointestinal Series</li> </ul>	<ul style="list-style-type: none"> <li>9. Blood Cultures</li> <li>10. MSU - mid stream urine test</li> <li>11. Sputum Specimen</li> <li>12. Wound Swabs</li> <li>13. CSF - Cerebrospinal Fluid</li> <li>14. Other body fluids</li> </ul>
<p><b>Oncology Tests</b></p> <ul style="list-style-type: none"> <li>1. AMAS - Anti-malignin antibody screen test</li> <li>2. Biological Terraine Assessment (BTA)</li> <li>3. Cancer Marker Tests, which include: <ul style="list-style-type: none"> <li>A. Alpha fetoprotein (AFP)</li> <li>B. CA 15.3</li> <li>C. CA 19.9</li> <li>D. CA125</li> <li>E. Carcinoembryonic antigen (CEA)</li> </ul> </li> <li>4. CBC Blood test</li> <li>5. Dark field Microscopy</li> <li>6. DR-70</li> <li>7. Electro Dermal Screening (EDS)</li> <li>8. Endoscopic ultrasound</li> <li>9. Lymphocyte Size Analysis</li> <li>10. Maverick Monitoring Test (MMT)</li> <li>11. Positron Emission Tomography - PET scan</li> <li>12. Thermography</li> <li>13. Whole Body CT Scans</li> </ul>	<p><b>Additional tests to detect specific cancers:</b></p> <ul style="list-style-type: none"> <li><b>1. Tests for Bladder Cancer:</b> <ul style="list-style-type: none"> <li>A. These tests include the bladder-tumor-associated antigen test (BTA™), the BTA stat test, the BTA TRAK* test, the fibrin/fibrinogen degradation products test (FDP™), and the NMP22™ assay</li> <li>B. New protein test</li> </ul> </li> <li><b>2. Tests for Breast Cancer:</b> <ul style="list-style-type: none"> <li>A. Acuity ductoscopy</li> <li>B. Amas test</li> <li>C. Cancer Marker Tests - CA 15.3 and CA125</li> <li>D. DR-70</li> <li>E. Ductal lavage</li> <li>F. Mammography/Thermography - Computed Tomography Laser Mammography and Full Field Digital Mammography</li> <li>G. Thermography T/Tn Antigen Test</li> <li>H. Ultrasound or sonogram</li> <li>I. Other Imaging Methods. These include: <ul style="list-style-type: none"> <li>(i) Scintigraphy</li> <li>(ii) MRI</li> <li>(iii) PET scan</li> <li>(iv) Magnetic resonance (MR) elastography</li> </ul> </li> <li>J. Additional Tests to see if cancer has spread:</li> <li>K. Mammotome® Breast Biopsy System</li> </ul> </li> <li><b>3. Tests for Colon/Colorectal Cancer:</b> <ul style="list-style-type: none"> <li>A. Carcinoembryonic antigen (CEA)</li> <li>B. Hemoccult Test</li> <li>C. PreGen-26</li> </ul> </li> </ul>

	<p><b>4. Tests for Lung Cancer:</b></p> <ul style="list-style-type: none"> <li>A. Sputum cytology</li> <li>B. PET Scans</li> <li>C. CA125, DR-70, and the T/Tn antigen test</li> </ul> <p><b>5. Tests for Ovarian and Cervical Cancer:</b></p> <ul style="list-style-type: none"> <li>A. CA125 levels</li> <li>B. DR-70</li> <li>C. Pap Smears/PAPNET</li> <li>D. Ampersand Medical's InPath™ System is a biomolecular-based technology for screening for cervical dysplasia and cervical cancer</li> <li>E. Positron emission tomography with a glucose analog (PET-FDG)</li> </ul> <p><b>6. Cancer Marker for Nasopharyngeal Cancer:</b></p> <ul style="list-style-type: none"> <li>A. EVP</li> </ul> <p><b>7. Cancer Marker for Pancreatic/Stomach Cancer:</b></p> <ul style="list-style-type: none"> <li>A. CA 19.9</li> <li>B. DR-70</li> </ul> <p><b>8. Tests for Prostate Cancer:</b></p> <ul style="list-style-type: none"> <li>A. The Digital Rectal Exam (DRE)</li> <li>B. PSA - Prostate Specific Antigen</li> <li>C. Beckman Coulter's Hybritech free PSA (fPSA) test</li> <li>D. PSA density test</li> <li>E. Telomerase Test</li> </ul> <p><b>9. Tests for Thyroid Cancer</b></p> <ul style="list-style-type: none"> <li>A. CEA markers can also help detect Medullary thyroid cancer (MTC)</li> <li>B. DMSAscan</li> <li>C. DR-70</li> </ul>
<p><b>Haematology Tests</b></p> <ol style="list-style-type: none"> <li>1. BCR-ABL</li> <li>2. Bleeding Time</li> <li>3. Bone Marrow Aspiration</li> <li>4. CD4/8 counts</li> <li>5. Chimerism studies</li> <li>6. Chromosome studies for hematological investigation</li> <li>7. Coagulation factor assay</li> <li>8. Glandular Fever screen (Paul Bunnell, infectious mononucleosis, EBV)</li> </ol>	<p><b>Neurological Diagnostic Tests and Procedures</b></p> <ol style="list-style-type: none"> <li>1. Laboratory screening tests of blood, urine, or other substances</li> <li>2. Genetic testing, which include the following: <ul style="list-style-type: none"> <li>A. Amniocentesis</li> <li>B. Chorionic villus sampling or CVS</li> </ul> </li> <li>3. Uterine ultrasound</li> <li>4. X-rays of the patient's chest and skull</li> <li>5. Fluoroscopy</li> </ol>

<ul style="list-style-type: none"> <li>9. Glucose-6-phosphate dehydrogenase screen (G6PD)</li> <li>10. Flaemoglobinopathy screen (includes HbA2, HbF quantitation)</li> <li>11. Flemosiderin</li> <li>12. Fleinz bodies</li> <li>13. Heparin Assay (Anti-Xa)</li> <li>14. Heparin Induced Thrombocytopenia test (urgent)</li> <li>15. HLA-B27</li> <li>16. Immunohaematology Tests</li> <li>17. INR</li> <li>18. JAK2 mutation</li> <li>19. Leukaemia immunophenotyping</li> <li>20. Lupus anticoagulant</li> <li>21. Lymphocyte subsets (B, T, NK cell counts)</li> <li>22. Malarial parasites</li> <li>23. Plasma viscosity</li> <li>24. Platelets</li> <li>25. Platelet Aggregation</li> <li>26. Platelet Function Studies</li> <li>27. Protein C</li> <li>28. Protein S</li> <li>29. Prothrombin gene mutation</li> <li>30. Pyruvate kinase, red cell</li> <li>31. Red cell mass/plasma volume estimation</li> <li>32. Red cell osmotic fragility</li> <li>33. Reticulocytes</li> <li>34. Sickle Cell screen</li> <li>35. APTT ratio - Therapeutic Heparin Ratio</li> <li>36. B12 (vitamin B12)</li> <li>37. APTT ratio (activated partial thromboplastin time ratio)</li> <li>38. APC resistance</li> <li>39. Antithrombin activity</li> <li>40. White Cell Enzymes</li> <li>41. Von Willebrand screening</li> <li>42. Thrombophilia screen</li> <li>43. Thrombin time</li> <li>44. Therapeutic Heparin Ratio</li> <li>45. Thalassemia screen</li> <li>46. T lymphocyte subsets</li> <li>47. Schilling Test</li> </ul>	<ul style="list-style-type: none"> <li>6. Diagnostic tests used to diagnose neurological disorders</li> <li>7. Angiography</li> <li>8. Biopsy</li> <li>9. Brain scans</li> <li>10. Cerebrospinal fluid analysis</li> <li>11. Computed tomography</li> <li>12. Discography</li> <li>13. Intrathecal contrast-enhanced CT scan (also called cisternography)</li> <li>Electroencephalography.</li> <li>14. Electromyography or EMG</li> <li>15. An EMG is usually done in conjunction with a nerve conduction velocity (NCV) test</li> <li>16. Electronystagmography (ENG)</li> <li>17. Evoked potentials (also called evoked response)</li> <li>18. Auditory evoked potentials</li> <li>19. Visual evoked potentials</li> <li>20. Somatosensory evoked potentials</li> <li>21. Magnetic resonance imaging (MRI)</li> <li>22. Myelography</li> <li>23. Positron emission tomography (PET)</li> <li>24. Single photon emission computed tomography (SPECT)</li> <li>25. Thermography</li> <li>26. Ultrasound imaging</li> </ul>
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<p><b>Orthopedics</b></p> <ol style="list-style-type: none"> <li>1. Arthrography</li> <li>2. Blood Tests</li> <li>3. Bone Scan</li> <li>4. Computed Tomography (CT Scan)</li> <li>5. Discography</li> <li>6. Doppler Ultrasound</li> <li>7. Dual-Photon Absorptiometry</li> <li>8. Dual-Energy X-ray Absorptiometry</li> <li>9. Electromyography</li> <li>10. Flexibility Tests</li> <li>11. Intrathecal Contrast Enhanced CT Scan</li> <li>12. Joint Aspiration and Analysis</li> <li>13. Laboratory Studies</li> <li>14. Magnetic Resonance Imaging (MRI)</li> <li>15. Muscle Tests</li> <li>16. Nerve Conduction Study (NCS)</li> <li>17. Peripheral Bone Density Testing</li> <li>18. Quantitative Computed Tomography</li> <li>19. Radiographs (X-rays)</li> <li>20. Range of Motion Testing</li> <li>21. Single Photon Absorptiometry</li> <li>22. Stress Tests</li> <li>23. Ultrasonography</li> <li>24. Venography</li> </ol>	<p><b>Rheumatology</b></p> <ol style="list-style-type: none"> <li>1. CBC</li> <li>2. ESR</li> <li>3. CRP</li> <li>4. RF</li> <li>5. ANA</li> <li>6. Uric acid</li> <li>7. HLAB27</li> <li>8. SFA</li> </ol>
<p><b>List of Emergency Tests After Office Hours, Weekends and Public Holidays</b></p> <ol style="list-style-type: none"> <li>1. BUSE (Blood urea serum electrolytes)</li> <li>2. Blood sugar</li> <li>3. Urine FEME (for suspected acute appendicitis, molar, and ectopic pregnancy, urinary tract infection)</li> <li>4. Infant serum bilirubin (total)</li> <li>5. Serum/plasma calcium</li> <li>6. Urine serum amylase (for suspected pancreatitis case)</li> <li>7. Urine pregnancy test (for ectopic pregnancy and choriocarcinoma)</li> <li>8. Urine parquet</li> <li>9. Cerebrospinal fluids (CSF) for cell count, sugar, protein, chloride, smear for GC organism, AFB, Cryptococcus and culture.</li> <li>10. Throat swab for C. diphtheria.</li> <li>11. Eye swab for gonococcus in neonates</li> <li>12. Hanging drop for cholera suspect</li> <li>13. Blood film for malaria parasites.</li> <li>14. Hemoglobin</li> <li>15. Total white cell count (for suspected acute appendicitis)</li> <li>16. Platelet count</li> </ol>	

17. Packed cell volume (in severely burnt case)
18. Prothrombin Time (PT)
19. Partial Prothrombin Time (PTT)
20. Fibrinogen Degradation Product (FDP)
21. Fibrinogen level (semi-quantitative)
22. Blood cross-matching for possible immediate transfusion

# ANNEXURE L: Memorandum of Understanding for Outsourcing Diagnostic Services

(Between ABC Hospital & XYZ Laboratory)

This Memorandum of Understanding (MOU) is a voluntary agreement between the above listed hospital and Clinical Laboratory to provide diagnostic services for indoor/outdoor patients or at the time of disaster or other emergency situation on the following terms and conditions.

## A. Services:

- i. The XYZ Laboratory agrees to provide Services for Facility on an as-needed basis and in accordance with all applicable federal, provincial and local laws, rules and regulations, as well as any applicable policies.
- ii. Services shall include, but are not limited to, the following:
  - a) Histopathology
  - b) Microbiology
  - c) Hematology
  - d) Biochemical testing
- iii. The Lab and its employees shall maintain all required Registration and license from Khyber Pakhtunkhwa Health Care Commission and other regulatory bodies as applicable.
- iv. The Lab shall also maintain quality assurance system as prescribed by the Khyber Pakhtunkhwa Health Care Commission / other accreditation bodies.
- v. The lab will ensure the provision of all lab test within Lab premises as list provided by Hospital. (Attach Annex-I)
- vi. It is certified that the incharge of ABC lab is a qualified pathologist (name of Pathologist) having post-graduation in pathology subject and registered with PMDC, Registration #  
----- . (Attach Annex- II)
- vii. The PMDC Registration of Pathologist is valid up to and it will be responsibility of Pathologist to renew PMDC Registration before expiry.
- viii. The Lab Shall be responsible to provide Diagnostic services round the clock 24/7 and have sufficient qualified staff in each shift to perform the test precisely under the supervision of qualified pathologist (name of Pathologist) (duty roaster of MLTs with name, qualification and PMF Reg. No.) (Attach Annex-III)
- ix. The Diagnostic Lab Shall be responsible to provide services as per agreed SOPs of (a) Sample Collection (b) Sample labelling for identification (c) Handling (d) safe transportation (e) processing (f) safe disposal of specimen. (Attach Annex-IV)
- x. If the hospital staff will collect the sample, then it will be the responsibility of HCE to follow the SOPs of Sample collection, Labelling and safe Transportation.
- xi. The Diagnostic lab shall be responsible to provide tests result within the agreed time frame of emergency & indoor /outdoor patients to the HCE. (Attach Annex-V) and Lab will ensure to maintain the record accordingly.
- xii. The lab Shall also define the critical values of diagnostic tests and provide any critical results of the patients referred by HCE immediately to the concerned doctor telephonically, SMS/ what's App, Lab will also maintain the record of critical results by recording time and name of doctor provided the result.
- xiii. The lab will maintain the record of all tests (EMR / Manual) at least for three years. In

- case of Medico-legal result will be kept safe up to 12 years or till the decision of case.
- xiv. The Lab will provide and also display tariff list within the lab to inform the cost of diagnostic tests to the patients and their families. (Attach Annex- VI)
  - xv. The Lab will establish Complaint management system. If any patient has complaint about Laboratory arrangements or employees behavior, then he should have a right to lodge complaint to lab incharge accordingly.

**B. Service Orders:**

Every specimen must be sent to the laboratory with the appropriate test requisition form dually signed by a qualified consultant/ Medical officer.

**C. Payments:**

All kind of payments for diagnostic services provided to the referred patient will be paid by the patient/ attendants in advance or any other mode/agency already defined, in term of cash or at the time of collection of lab test results. ABC hospital will not be held responsible for any kind of payment by XYZ Lab unless specified otherwise as special arrangements.

**D. Confidentiality:**

Privacy and confidentiality of the Patient/Client will be ensured by the Laboratory.

**E. Termination:**

Notwithstanding anything herein to the contrary, this Agreement may be terminated at any time as follows:

- a. By mutual agreement of the Parties; or
- b. With cause by the Lab or Facility upon the default by the other of any term, covenant or condition of this Agreement, where such default continues for a period of ten (10) business days after the defaulting Party receives written notice thereof from the other Party specifying the existence of the such default; or
- c. Without cause by the lab or Facility upon at least thirty (30) days prior written notice to the other Party in which case the Agreement shall terminate on the future date specified in such notice.

<p><b>Name &amp; Address of Hospital</b></p> <p>Name of authorized staff:</p> <p>Designation:</p> <p>Signature:</p> <p>Date:</p>	<p><b>Name &amp; Address of Laboratory</b></p> <p>Name of authorized staff:</p> <p>Designation:</p> <p>Signature:</p> <p>Date:</p>
<p><b>Witness No. 1</b></p> <p>Name:</p> <p>Designation:</p> <p>Signature:</p> <p>Date:</p>	<p><b>Witness No. 2</b></p> <p>Name:</p> <p>Designation:</p> <p>Signature:</p> <p>Date:</p>

All Documents, Annexures should be dually signed by both the parties.

# ANNEXURE M: Memorandum of Understanding for Outsourcing Diagnostic Services

(Between ABC Hospital & XYZ Radiological Diagnostic Center)

This Memorandum of Understanding (MOU) is a voluntary agreement between the above listed hospital and Radiology center to provide diagnostic services for indoor/outdoor patients or at the time of disaster or other emergency situation on the following terms and conditions.

## A. Services:

- i. The XYZ Radiology center agrees to provide Services for Facility on an as-needed basis and in accordance with all applicable federal, provincial and local laws, rules and regulations, as well as any applicable policies.
- ii. Services shall include, but are not limited to, the following:
  - a. Plain X-Rays
  - b. Contrast X-Rays (if applicable)
  - c. USG (if applicable)
  - d. CT Scan (if applicable)
  - e. MRI (if applicable)
- iii. The Radiology center and its employees shall maintain the required Registration and license from Khyber Pakhtunkhwa Health Care Commission and other regulatory bodies as applicable.
- iv. The Radiology center shall also maintain quality assurance system as prescribed by the Khyber Pakhtunkhwa Health Care Commission / other accreditation bodies.
- v. The Radiology center will ensure the provision of all diagnostic tests within Radiology center premises as list provided by Hospital. (Attach Annex-I)
- vi. It is certified that the incharge of Radiology center is a qualified Radiologist (name of Radiologist) having post-graduation in Radiology subject and registered with PMDC, Registration #. (Attach Annex- II)
- vii. The PMDC Registration of Radiologist is valid up to and it will be responsibility of Radiologist to renew PMDC Registration before expiry.
- viii. The Radiology center shall be responsible to provide Diagnostic services round the clock/ 24/7 and have sufficient qualified staff in each shift to perform the test precisely under the supervision of qualified Radiologist (name of Radiologist) (duty roaster of RG with name, qualification and PMF Reg. no,) (Attach Annex-III)
- ix. The Radiology center shall be responsible to provide services as per agreed SOPs of (a) Patient identification (b) safe transportation. (c) Safe disposal of nuclear waste (as applicable). (Attach Annex-IV)
- x. The Radiology center shall be responsible to provide tests result within the agreed time frame of emergency & indoor /outdoor patients to the HCE. (Attach Annex-V) and Radiology center will ensure to maintain the record accordingly.
- xi. The Radiology center shall also define the critical values of diagnostic tests and provide any critical results of the patients referred by HCE immediately to the concerned doctor telephonically, SMS / WhatsApp. Radiology center will also maintain the record of critical results by recording time and name of doctor provided the result.
- xii. The Radiology center will maintain the record of all tests (EMR / Manual) at least for

- three years.
  - xiii. The Radiology center will provide and also display tariff list within the Radiology center to inform the cost of diagnostic tests to the patients and their families. (Attach Annex- VI)
  - xiv. The Radiology center will establish Complaint management system. If any patient has complaint about Radiology center arrangements or employees behavior, then he should have right to lodge complaint to Radiology center incharge accordingly.
  - xv. Arrangement of backup support/resuscitations must be available in case of any anaphylactic /untoward incidence following contrast procedure.
- B. Service Orders:
- Every diagnostic test must be sent to the Radiology center with the appropriate test requisition form dually signed by a qualified consultant/ Medical officer.
- C. Payments:
- All kind of payments for diagnostic services provided to the referred patient will be paid by the patient/ attendants in advance or any other mode/agency already defined, in term of cash or at the time of collection of lab test results. ABC hospital will not be held responsible for any kind of payment by XYZ Radiology unless specified otherwise as special arrangements.
- D. Confidentiality:
- Privacy and confidentiality of the Patient/Client will be ensured by the Radiology center.
- E. Consent:
- Consent of the patient/attendant will be obtained for all invasive/Contrast procedures.
- F. Termination:
- Notwithstanding anything herein to the contrary, this Agreement may be terminated at any time as follows:
- a. By mutual agreement of the Parties; or
  - b. With cause by the Radiology center or Facility upon the default by the other of any term, covenant or condition of this Agreement, where such default continues for a period of ten (10) business days after the defaulting Party receives written notice thereof from the other Party specifying the existence of the such default; or
  - c. Without cause by the Radiology center or Facility upon at least thirty (30) days prior written notice to the other Party in which case the Agreement shall terminate on the future date specified in such notice.

<b>Name &amp; Address of Hospital</b>	<b>Name &amp; Address of Laboratory</b>
Name of authorized staff:	Name of authorized staff:
Designation:	Designation:
Signature:	Signature:
Date:	Date:

<b>Witness No. 1</b>	<b>Witness No. 2</b>
Name:	Name:
Designation:	Designation
Signature:	Signature:
Date:	Date:

All Documents, Annexures should be dually signed by both the parties.

## ANNEXURE N: Physical Status Classification & Scoring

### AMERICAN SOCIETY OF ANAESTHESIOLOGISTS (ASA)

<b>ASA Physical Status 1</b>	A normal healthy patient
<b>ASA Physical Status 2</b>	A patient with mild systemic disease
<b>ASA Physical Status 3</b>	A patient with severe systemic disease
<b>ASA Physical Status 4</b>	A patient with severe systemic disease that is a constant threat to life
<b>ASA Physical Status 5</b>	A moribund patient who is not expected to survive without the operation
<b>ASA Physical Status 6</b>	A declared brain-dead patient whose organs are being removed for donor purposes

- If the surgery is an emergency, the physical status classification is followed by "E" (for emergency) for example "3E".
- Class 5 is usually an emergency and is therefore usually "5E".
- The class "6E" does not exist and is simply recorded as class "6", as all organ retrieval in brain-dead patients is done urgently.

**(These definitions appear in each annual edition of the ASA Relative Value Guide.)**

# ANNEXURE O<sub>1</sub>: Prescription Sample 1

SHAM HOSPITAL

Dr. X.Y.Z

M.B.B.S, FRCP, FCPS Child Specialist

Ph: 0423-0000000 Cell: 0300-00000

Ref. No. (Unique Identifier) \_\_\_\_\_ Time \_\_\_\_\_ Date/s \_\_\_\_\_ No. of Visit \_\_\_\_\_

Patient Name \_\_\_\_\_ S/o, D/o, W/o \_\_\_\_\_

Age \_\_\_\_\_ Sex \_\_\_\_\_ Weight (kg) \_\_\_\_\_ Contact No. \_\_\_\_\_

Address \_\_\_\_\_

Allergies \_\_\_\_\_

Symptoms \_\_\_\_\_

Findings \_\_\_\_\_

Provisional/Diagnosis \_\_\_\_\_



**(Signature & Stamp)**

24/7 Emergency Call Number 01010101

OPD Consultation Days xyz OPD Consultation Timings 00:00 to 00:00

## ANNEXURE O<sub>2</sub>: Prescription Sample 2

DEF Hospital, UVW Road, Peshawar

041-0000000/ 0300-0000000000

Ref. No. (Unique Identifier) \_\_\_\_\_ Time \_\_\_\_\_ Date/s \_\_\_\_\_ No. of Visit \_\_\_\_\_

Patient Name \_\_\_\_\_ S/o, D/o, W/o \_\_\_\_\_

Age \_\_\_\_\_ Sex \_\_\_\_\_ Weight (kg) \_\_\_\_\_ Contact No. \_\_\_\_\_

Address \_\_\_\_\_

Allergies \_\_\_\_\_

Symptoms \_\_\_\_\_

Findings \_\_\_\_\_

**Signature with Name**

**Stamp**

# ANNEXURE O<sub>3</sub>: Prescription Sample 3



Dr. X.Y.Z  
M.B.B.S, FRCP, FCPS Child Specialist  
Ph: 0423-0000000 Cell: 0300-00000

Ref. No. (Unique Identifier) \_\_\_\_\_ Time \_\_\_\_\_ Date/s \_\_\_\_\_ No. of Visit \_\_\_\_\_  
Patient Name \_\_\_\_\_ S/o, D/o, W/o \_\_\_\_\_  
Age \_\_\_\_\_ Sex \_\_\_\_\_ Weight (kg) \_\_\_\_\_ Contact No. \_\_\_\_\_  
Address \_\_\_\_\_  
Allergies \_\_\_\_\_  
Symptoms \_\_\_\_\_  
Findings \_\_\_\_\_  
Provisional/Diagnosis \_\_\_\_\_



(Signature & Stamp)

# ANNEXURE P: KP HCC Charters for Patients and HCEs

## KP HCC CHARTER FOR PATIENTS & OTHERS

### Part A: Rights of Patients and Others

A patient/client or his career, as the case may be, or any other person to whom healthcare services are being rendered, shall have a right to:

1. Health, well-being and safety;
2. Easy access to registration/help desk to get registered and be guided to the respective services as per requirement;
3. Special arrangements for elderly people and disabled to have easy access to required health services;
4. Be attended to, treated and cared for with due skill, and in a professional manner for the accepted standard of health in complete consonance with the principles of medical ethics;
5. Be made aware of the full identity and professional status of the Healthcare Service Provider(s) and other staff providing services;
6. Be given information to make informed choices about his healthcare and treatment options and/or to give informed consent, in terms and in a language that he understands;
7. Seek second opinion when making decisions about his healthcare, and may be assisted by the Healthcare Establishment/healthcare service provider in this regard;
8. Accept or refuse any treatment, examination, test or screening procedure that is advised to him, exceptions being in cases of emergencies and/or mental incapacity in accordance with the relevant law;
9. Personal health information to be kept secure and confidential;
10. Access his own medical records, including but not limited to, comprehensive medical history, Examination(s), investigation(s) and treatment along with the progress notes, and obtain copies thereof;
11. Not to be discriminated against because of age, disability, gender<sup>1</sup>, marriage, pregnancy, maternity, race, religion, cultural beliefs, color, caste and/or creed;
12. Expect that any care and/or treatment being received is provided by duly qualified and experienced staff;
13. Expect that the healthcare service provider or the Healthcare Establishment, as the case may be, has the capacity and required necessary equipment in order and working condition, for rendering the requisite services, including but not limited to treatment;
14. Receive emergency healthcare, unconditionally. However, once the emergency has been dealt with, he may be discharged or referred to another Healthcare Establishment [emergency requiring healthcare, is a situation threatening immediate danger to life<sup>2</sup> or severe irreversible disability, if healthcare is not provided urgently];
15. Be treated with respect, empathy and dignity irrespective of age, disability, gender, marriage, pregnancy, maternity, race, religion, socio-economic status, cultural beliefs, color, caste and/or creed;
16. Be treated in privacy and with dignity, and have his religious and cultural beliefs respected throughout the duration of care, including but not limited to, taking history, examination or adopting any other course of action;
17. Be made aware of procedures for complaints and resolution of disputes and conflicts;

18. File a written complaint to the concerned healthcare service provider, official of the Healthcare Establishment or such other organization/person, as the case may be and be associated throughout the progress of the complaint and its outcome;
19. Seek compensation if he has been harmed by, including but not limited to maladministration, malpractice, negligent treatment, or failure on the part of a healthcare service provider or any staff/employee or others rendering services at the Healthcare Establishment;
20. Be informed and to refuse to participate in research, or any project dealing with his disease, care and treatment;
21. Be accompanied by a family member or career, as the case may be, particularly in cases of children, females, elderly and disabled. The healthcare service provider and/or the Healthcare Establishment, as the case may be, are to ensure that in cases of children and females in the immediate post anesthesia phase, a female staff shall be present until a family member or career can join the patient/client, The healthcare service provider and/or the Healthcare Establishment, as the case may be, are also to ensure that in cases of children and females an authorized family member or a career or if not so possible, at least a female staff is present during physical examination and investigation procedures where physical contact and or exposure of body part(s) is required.
22. Expect that the Healthcare service provider, the Healthcare Establishment, and/or such other person rendering similar services, as the case may be, shall not misuse nor abuse their fiduciary position *vis-a-vis* him or his career(s) or family members, as the case may be, for undue favor(s) including but not limited to sexual favor(s) or any other undue or uncalled for reward or privileges in terms of professional fee or gifts etc.
23. Be informed as early as possible regarding cancellation and/or postponement of any appointment, surgery, procedure, treatment or meeting, as the case may be;
24. Be made aware of the costs, fee and/or expenses, prior to the consultation, treatment or other services, and/or operation/procedure, as the case may be, and receive payment receipt(s) for the same;
25. Be given written instructions regarding his treatment, including instructions at the time of discharge;
26. Examine and receive an explanation for the bill(s) regardless of the source of payment;
27. End of life care;

Nothing in this Charter prevents any organization/healthcare service provider/Healthcare Establishment from recognizing additional rights of the Patient/Client and/or the career, as the case may be. The purpose of this Charter is to inculcate and invigorate in the community the understanding and recognition of the fact that health, care and/or treatment is a right of an individual even when he is unborn and the same continues from his cradle to coffin.

This document will be reviewed annually or earlier, as deemed appropriate by the Khyber Pakhtunkhwa Healthcare Commission, in view of its experiences, through a consultative process involving patients, former patients, family members, related professionals, staff and other stakeholder groups.

#### **Explanatory Notes**

1. Gender includes male, female, transgender and intersex individuals.
2. Life, in the context of mental emergency, includes those of others.

3. End of Life Care includes healthcare, not only of patients in the final hours or days of their lives, but more broadly, care of all those with terminal illness or terminal condition that has become advanced, progressive and incurable. Accordingly, it may so happen that no treatment may be advisable and or given but the care should continue, keeping in view the ethics of the profession.

### **Part B: Responsibilities of Patients and Others**

The patient/client or career, as the case may be, is responsible to the Healthcare Establishment, its staff or the Healthcare Service Provider for: -

1. Providing, accurate and complete information, to the best of his knowledge, regarding medical history, including but not limited to, present medical condition and complaints, medications, allergies and special needs, past illnesses, prior hospitalizations etc., as is required;
2. Reporting unexpected changes in his condition;
3. Adhering to the treatment plan prescribed to him;
4. Keeping appointments and when he is going to be late or is unable to do so for any reason, notify the concerned about the same, as soon as possible;
5. Taking responsibility for his actions if he refuses treatment or does not follow the given instructions;
6. Ensuring that the financial obligations of his care are fulfilled as promptly as possible;
7. Following the Healthcare Facilities' Rules and Regulations relating to patient care and conduct of others, including careers and or visitors;
8. Behaving in a courteous and polite manner which is non-threatening;
9. Refraining from conducting any illegal activity while he is at their premises;
10. Informing of any change of address and other requisite information.

# KP HCC CHARTER FOR HEALTH CARE ESTABLISHMENTS

## **Part A: Rights of Healthcare Establishments/Healthcare Service Providers**

The Healthcare Establishment or the Healthcare Service Provider, as the case may be, shall have the right to:

1. Collect accurate and complete information from the patient/client or career, to the best of his knowledge, regarding medical history including but not limited to, present medical condition and complaints, medications, allergies and special needs, past illnesses, prior hospitalizations etc., as is required;
2. Require the patient/client to follow treatment instructions, including the written instructions explained at the time of discharge;
3. Require all patients to abide by its rules and regulations regarding admission, treatment, safety, privacy and visiting schedules etc.;
4. Limit visiting hours and number of visitors in the best interest of the patient/client and that of the others in the Healthcare Establishment;
5. Limit number of careers in the best interest of the patient/client, and that of the others, while keeping in view the special needs of particular patients, for example, minor children, women, elderly and/or seriously ill patients;
6. Be timely notified by the patient/client regarding cancellation of appointment, consultation, procedure, surgery, etc. or delay in his arrival at the Healthcare Establishment;
7. Require the patient/client and/or career(s) to cooperate with Healthcare Establishment staff in carrying out assessments, prescribed investigations and treatment procedures.
8. Require from the patient/client or careers and visitors, as the case may be, to understand the role and dignity of the Healthcare Establishment, its staff and/or the Healthcare Service Provider, as the case may be, and treat them with due respect at all times;
9. Report and take legal action against the patient/client and/or his career(s), visitors, in case of harassment of its staff, damage to its property and disturbance to other patient(s), as the case may be;
10. Demand abstinence from the use of violent and disruptive behaviors or language abuse and take appropriate legal action in case of breach;
11. Prohibit smoking and/or substance/drug abuse on the premises and take appropriate legal action in case of breach;
12. Limit its liability for misplacement or theft of valuables and belongings of the patient/client, career and visitor;
13. Be paid for all services rendered to the patient/client, either personally or by the career or through the third party, e.g. insurance company.
14. Be notified of any change of contact, address and other details of the patient/client, as the case may be;
15. Ask for information from the patient/client regarding its services for the purposes of improving the healthcare services/systems within the Healthcare Establishment;
16. Maintain and utilize the data collected from the patient/client, subject to the principles and law relating to confidentiality, for the purposes of improving the healthcare services/systems within the Healthcare Establishment;

17. Ensure that while using the available facilities and equipment, due care and caution is taken by the patient/client and/or their careers and visitors, as the case may be.

The Khyber Pakhtunkhwa Healthcare Commission while recognizing the fact that each Healthcare Establishment is a "House of Hope" where advice and treatment, including other services, are rendered to the public at large, has developed this Charter of Rights for all Healthcare Establishments/Healthcare Service Providers in the Province of Khyber Pakhtunkhwa. All these rights are to be exercised with a view to make better services available to the masses.

The Khyber Pakhtunkhwa Healthcare Commission further assures that it stands committed to the cause of the Healthcare Establishments/Healthcare Service Providers in the exercise of these rights and shall always be ready and willing to support in the implementation and enforcement of the rights envisaged herein.

This document will be reviewed annually or earlier, as deemed appropriate by the Khyber Pakhtunkhwa Healthcare Commission, in view of its experiences, through a consultative process involving patients, former patients, family members, related professionals, Healthcare Establishments/Healthcare Service Providers, staff and other stakeholder groups.

### **Part B: Responsibilities of Healthcare Establishments/Healthcare Service Providers**

The Healthcare Establishment or the Healthcare Service Provider, as the case may be, shall be responsible for:

1. Ensuring the safety of patient/client.
2. Establishing such systems which enable easy access to services as are required by the patient/client.
3. Maintaining the services being provided through fully competent professionals.
4. Establishing systems to ensure that the rights of the patient/client and others are enforced and fully protected.
5. Adopting open policies regarding its procedures in relation to treatment of the patients/clients including but not limited to, their care and complaints etc.
6. Invigorating in their staff including but not limited to, Consultants and other professionals rendering services at the Healthcare Establishment, the importance and thorough practice of professional ethics.
7. Complying with all the governing laws, rules and regulations while operating, maintaining and rendering services.

# ANNEXURE Q: Template of Client Satisfaction Proforma

## CLIENT SATISFACTION PROFORMA

Name of Hospital: \_\_\_\_\_ Unit/Ward/OPD: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Dated: \_\_\_\_\_

No.	Questions	Response	
1	<b>Are you satisfied with the health services available and behavior of Health Care Providers at Hospital?</b>	Yes	No
2	<b>If YES, how? (You can circle more than one response and write below)</b>	1. Complete information provided. 2. No physical complication at the time of service. 3. Services available when needed. 4. Medicines available. 5. Services are not costly. 6. Convenient to reach the facility. 7. Staff is courteous. 8. Relevant staff is available. 9. Female staff is available. 10. I recovered after treatment. 11. Other (specify)	
3	<b>If NO, why? (You can circle more than one response and write below)</b>	1. Issues of confidentiality. 2. Issues of privacy. 3. Lack of attention. 4. Inadequate information provided. 5. Physical complication at the time of service. 6. I was asked to come another time. 7. Medicines not available. 8. Medicines are costly. 9. Services are costly. 10. The facility is too far away from my home. 11. Waiting time is too long. 12. Staff is discourteous/Unsatisfactory behavior. 13. Staff is not competent. 14. Relevant staff NOT available. 15. Female staff NOT available/Gender difference. 16. I suffered from side effects of the treatment. 17. Language barrier in communication with HCP. 18. Other (specify)	
4	<b>Are you satisfied with the techniques used by care providers for diagnosis and treatment purpose?</b>	Yes	No
5	<b>Reasons for non-satisfaction</b>	1. Procedures are painful 2. Culturally not acceptable	

		3. Past experience not good 4. Other (specify)	
<b>6</b>	<b>Are you satisfied with the environment of the health facility?</b>	Yes	No
<b>7</b>	<b>Reasons for non-satisfaction</b>	1. Unhygienic 2. No separate facility for females regarding a) Waiting area b) Toilet c) Examination space 3. Other (specify)	

## ANNEXURE R: HCE Complaints Management

### 1. OBJECTIVE

To ensure that complaints are handled in a standardized manner at all Health Care Establishments (HCEs) in Khyber Pakhtunkhwa.

### 2. SCOPE

This document provides general guidelines to HCEs to develop or improve their Complaint Management Systems.

### 3. RESPONSIBILITY

The responsibility of complaints handling rests with the HCP; however, all staff members of the establishment are responsible for providing the necessary support.

### 4. DISPLAY OF INFORMATION

- A. Inform the patient of his/her right to express his/her concern or complain either verbally or in writing.
- B. This shall be done by clearly displaying the following information, in Urdu, at the entrance, help desk, every department and at the back of admission and discharge slips:

آپ کو ہسپتال کی سروس کے متعلق تحریری یا زبانی شکایات کرنے کا حق حاصل ہے۔ آپ اپنی شکایات ہسپتال کے منتظم کو دفتر یا ٹیلی فون نمبر پر کر سکتے ہیں یا استقبالیہ ہیلپ ڈیسک / ریسپشن پر موجود شکایات رجسٹر میں اپنی شکایات درج کر سکتے ہیں۔

### 5. COMPLAINT HANDLING

- A. Put into place a documented process for collecting, prioritizing, reporting and investigating complaints, which is fair and timely.

#### B. Registration

- (i) A number of Complaint Registers shall be maintained by each HCE, one of which shall be available at istaqbaliah/help desk/reception, round the clock.
- (ii) Each Complaint Register shall have:

- A 3" X 4" white chit pasted on the cover page with the following:

**Complaint Register No. (Register No./Total number of Complaint Registers)**  
Opened on: **(Mention date as XX-XX-XXXX)**

- The following certificate on the inner side of the cover page:

"It is certified that this register contains \_\_\_\_\_ pages; each page has been numbered (at the top centre), stamped with the HCE seal (at top right corner) and initialed by me."

Date: XX-XX-XXXX (Signature and Name of Authorized Person)

- The following page format:

1	2	3	4	5	6	7	8	9	10
No.	Date	Complainant's Name	CNIC No.	Contact No.	Address	Detail of the Complaint	Signature/thumb impression of the complainant	Date seen & Signature Manager	Date seen & Signature CEO

**Column 2-8 shall either be filled by the complainant or someone else (whom the complainant trusts) on his/her behalf.**

- Every written or verbal complaint directly made to the HCE/Authorized Person shall be entered in the register within 24 hours.

### C. Processing

- A Complaint Processing Register shall be maintained by each HCE.
- The Complaint Processing Register shall have:
  - A 3" X 4" white chit pasted on the cover page with the following:

<b>Complaint Processing Register</b>
Opened on: (Mention date as XX-XX-XXXX)

- The following certificate on the inner side of the cover page:

"It is certified that this register contains \_\_\_\_\_ pages; each page has been numbered (at the top centre), stamped with the HCE seal (at top right corner) and initialed by me."

Date: XX-XX-XXXX (Signature and Name of Authorized Person)

- The following page format:

1	2	3	4	5	6	7	8	9	10
No	Complainant's Name	Contact No,	Description of the Complaint	Priority	Detail of the Investigation	Date(s) Complainant contacted	Outcome	Date Complainant informed	Quality improvement Policy or Procedure Change

- No. of the complaint shall be the same on both the registers.
- Enter important point of the complaint in the register. Take notice of allegations and requests made.
- Assign priority according to the nature of the complaint.
- Investigate in an impartial manner.
- Keep the time factor in mind because any undue delay will reflect poorly on the management.

## **6. COMMUNICATION**

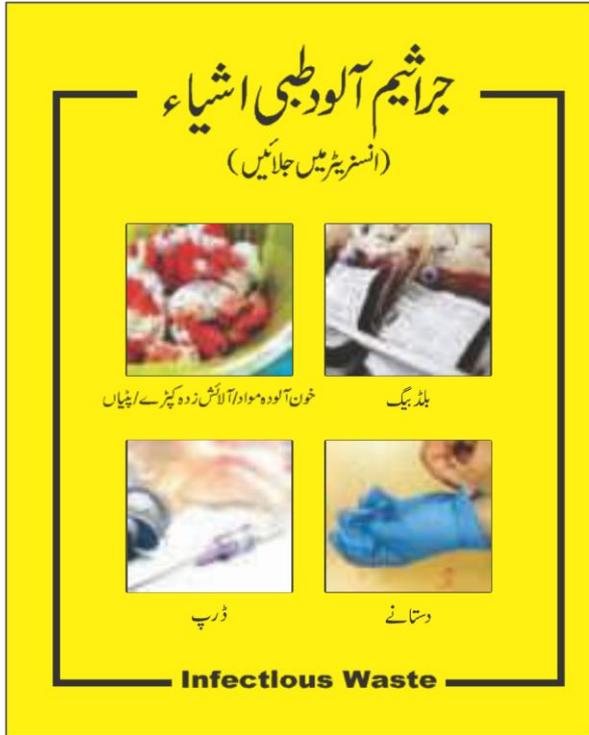
- A. Inform the complainant about the progress of the investigation at regular intervals and inform him/her about the outcome.
- B. Stay in contact with the complainant and regularly update him/her about the progress made in investigation.
- C. Record the outcome of the investigation and inform the complainant accordingly.
- D. Don't indulge in argumentation. Be polite and empathetic.

## **7. QUALITY IMPROVEMENT**

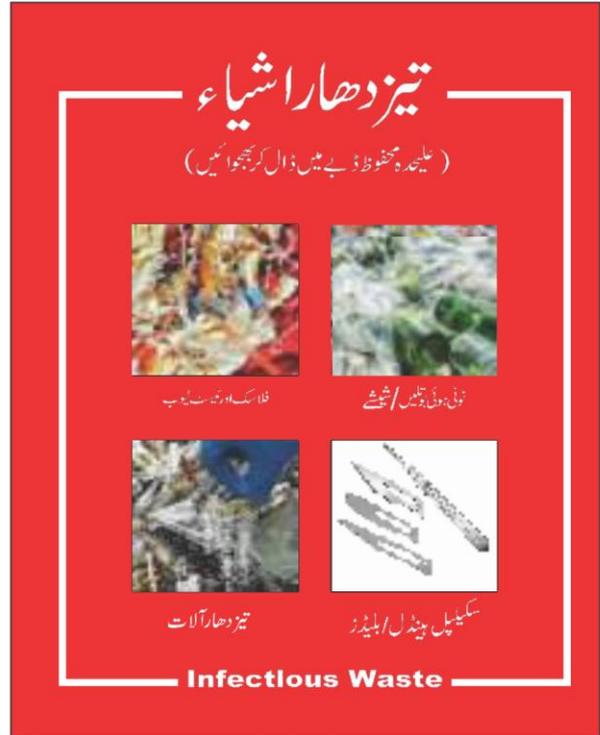
- A. Use the results of the complaints investigation as part of the quality improvement process.
- B. The registers should be perused by the Chief Executive of the establishment, at least once a month.
- C. Make necessary changes in policy and procedures to improve the quality of healthcare services.

## ANNEXURE S: Segregation of Waste (both Clinical & Municipal) for Disposal

### 1. Yellow Colour



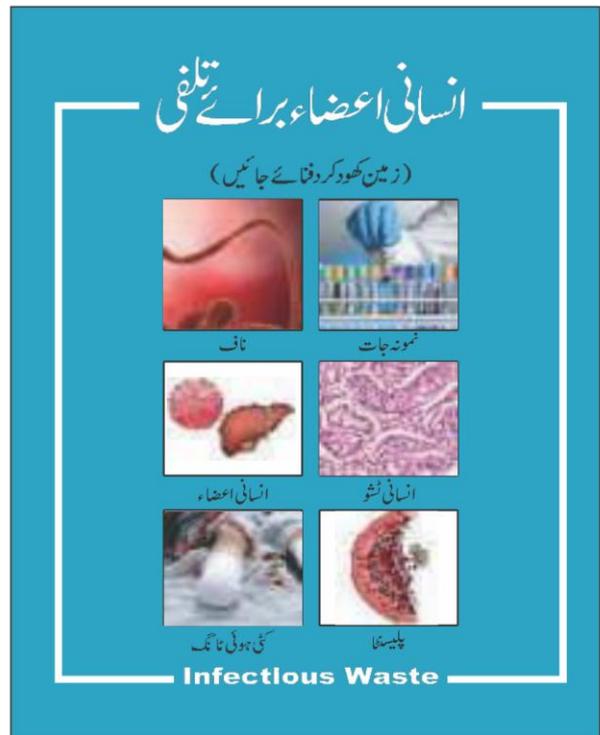
### 2. Red Colour



### 3. White Colour



### 4. Light Blue







The Khyber Pakhtunkhwa Health Care Commission (KP HCC) has the legal mandate (Khyber Pakhtunkhwa Health Care Commission Act, 2015) to regulate the health care services in both public and private sectors in the province. The objective is to improve and maintain quality of healthcare, and ensure safety of patients and healthcare providers. The Health Care Establishments (HCEs) are assessed against set standards for this purpose. It is mandatory for the HCEs, including primary, secondary and tertiary levels to acquire license from the KP HCC through the implementation of the Minimum Service delivery Standards.



## Khyber Pakhtunkhwa Health Care Commission

 Phase-V, Hayatabad, Khyber Pakhtunkhwa, Peshawar, Pakistan.

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 [www.hcc.kp.gov.pk](http://www.hcc.kp.gov.pk)