What is JCI Accreditation?

Joint Commission International Accreditation is a voluntary process in which an entity separate and distinct from the health care organization which assesses the health care organization to determine if it meets a set of requirement (standards) designed to provide a visible commitment by an organization to improve the safety and quality of care which is optimal and achievable.

It is an effective quality evaluation and management tool for ensuring a safe care environment which helps continuous improvement process to reduce risk to patient and staffs.

Who are JCI?

Joint Commission International is a U.S. based not for profit accreditation body which sets and designs standards and processes to create a culture of ethics, safety and quality within an organization that strive to continually improve patient care processes and results.

Benefits of JCI

Joint Commission International teaches and leads us to:

- Improve patient trust by improving patient safety, quality and care.
- Provide a safe and efficient work environment that contributes to staff satisfaction
- Listen to patients and their families, respect their rights, and involve them in the care process as partners; and
- Helps establish collaborative leadership that sets priority for and continuous leadership for quality and patient safety at all levels.
JCI Standards (5th Edition)

Accreditation Participation Requirements (APR): 12
Chapters Total Number: 16
- Patient Centered Chapters: 8
- Organization Management Chapters: 6
- Academic Medical Center Hospital Chapters: 2

Standards: Total Number: 304
Standards are set around the important functions; they are common to all healthcare organizations.
Intent statement: Easy explanation of the standards
Measurable Elements: Total number: 1218
Measurable elements are those requirements of standards which are reviewed and assigned a score during survey.
Survey: Assesses the hospitals compliance on JCI standards

Chapter Details

I. Accreditation Participation Requirements
Accreditation Participation Requirements (APR)-Introductory
II. The Patient Centered Standards are:
1. International Patient Safety Goals (IPSG)
2. Access to Care and Continuity of Care (ACC)
3. Patient and Family Rights (PFR)
4. Assessment of Patients (AOP)
5. Care of Patients (COP)
6. Anesthesia and Surgical Care (ASC)
7. Medication Management and Use (MMU)
8. Patient and Family Education (PFE)

III. The Organization Management Standards are:
9. Quality Improvement and Patient Safety (QPS)
10. Prevention and Control of Infections (PCI)
11. Governance, Leadership, and Direction (GLD)
12. Facility Management and Safety (FMS)
13. Staff Qualifications and Education (SQE)
14. Management of Information (MOI)

IV. The Academic Medical Center Hospital Standards are:
15. Medical Professional Education (MPE)
16. Human Subjects Research Programs (HRP)

(** Please note that section IV is not relevant for AHD)
Purpose and Goal of JCI Accreditation Initiatives

The **Purpose** is to give Apollo Hospitals Dhaka international fame by setting **Goals** which stimulate demonstration of continuous, sustained improvement in healthcare organization by applying international consensus standard, International Patient Safety Goals and Data Measurement Support.

**JCI addresses the following issues very intensively:**

1. International Patient Safety Goals
2. Patient & Family Education
3. Patient & Family Rights & Responsibilities
4. Pain Management
5. Quality Indicators & Monitoring
6. Hand Wash & Prevention and Control of Infection
7. Fire Safety and Emergency Codes
8. Removal of Barriers to Care
9. Patient Identifiers
10. Care of High Risk Patients (Vulnerable patients)
11. Restraint Order
12. Rights of Drug administration
13. Discharge Planning & Components of Discharge Summary
14. Time Out
15. Biomedical Waste Disposal
16. Personal Protective Equipments (PPE)
17. HAZMAT, Lab, Radiation, Facility Safety  
18. DNR (Do Not Resuscitate)  
19. End of Life Care  
20. Hospital Mandatory Trainings  

**Accreditation Participation Requirements (APR):**  
"a TRANSPARENT practice": Mandates which are rational for requirements evaluation methods and consequences of non-compliance accreditation process and maintaining an award.

<table>
<thead>
<tr>
<th>T</th>
<th>Timely</th>
<th>submission of data and information</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>Reports</td>
<td>(within 15 days) of any changes in hospital profile or information</td>
</tr>
<tr>
<td>A</td>
<td>Accurate</td>
<td>and complete information through all phases of accreditation</td>
</tr>
<tr>
<td>N</td>
<td>Notifies</td>
<td>the public of concerns about patient safety and care</td>
</tr>
<tr>
<td>S</td>
<td>Submits</td>
<td>accurate representation of accreditation status</td>
</tr>
<tr>
<td>P</td>
<td>Participates</td>
<td>in Library of Measures</td>
</tr>
<tr>
<td>A</td>
<td>Allow</td>
<td>JCIs board and staff to observe the onsite survey</td>
</tr>
<tr>
<td>R</td>
<td>Reporting</td>
<td>from individual concerned about the hospital without retaliatory action</td>
</tr>
<tr>
<td>E</td>
<td>Endow</td>
<td>with patient care in an environment that poses no risk</td>
</tr>
<tr>
<td>N</td>
<td>Notify</td>
<td>review of original authenticated results and reports</td>
</tr>
<tr>
<td>T</td>
<td>Translation</td>
<td>and interpretation service arrangements during audit days</td>
</tr>
<tr>
<td>IPSG 1</td>
<td><strong>Identify Patients Correctly</strong></td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>---------------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Use two identifiers; Name and UHID for both IPD and OPD. For unknown/comatose patient brought in ER identify as unknown 1 or 2.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IPSG 2</th>
<th><strong>Improve Effective Communication</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(i) Use read back and verify policy for verbal order and laboratory test result obtained on the phone and the process (for handover communication).</td>
</tr>
<tr>
<td></td>
<td>(ii) Comply to handover communication policy.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IPSG 3</th>
<th><strong>Improve the Safety of High-alert medications</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Eg.. Inj. Potassium Chloride, Inj. Sodium Chloride more than 0.9%, Inj. Magnesium sulphate equal to or more than 50% are not to be stored in patient ward but stored only in the IP Pharmacy.</td>
</tr>
<tr>
<td></td>
<td>Look alike and sound alike medications are stored with proper labeling with tallman method.</td>
</tr>
<tr>
<td>IPSG 4</td>
<td>Ensure Correct Site, Correct-Procedure, Correct Patient Surgery Follow pre-surgical site marking with a downwards arrow, pre-operative checklist and time out in OT and Bedside procedures.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>
| IPSG 5 | Reduce the Risk of Health Care Associated infections  
Follow the WHO 2009 hand hygiene guidelines. |
| IPSG 6 | Reduce the Risk of Patient Harm Resulting from falls.  
"Safety First Program" |
## CHAPTER TWO

### ACCESS TO CARE AND CONTINUITY OF CARE (ACC):

Information about the hospital provided to the patients in “In Patient Guidebook”.

### Removal of Barriers to care:

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Language</td>
<td>A list of interpreters is available on all nursing stations.</td>
</tr>
<tr>
<td>Physical</td>
<td>Wheelchairs/Stretchers are readily available at the entrance. Lifts available for all floors. Handicapped Toilets at MHC, Emergency Department</td>
</tr>
<tr>
<td>Religious</td>
<td>Prayer Places, are available within the precinct. Spiritual Services are provided when asked for.</td>
</tr>
<tr>
<td>Cultural</td>
<td>Different types of food choices are available. Patients’ needs to observe auspicious time for any procedures are honored.</td>
</tr>
</tbody>
</table>
Patient Identifiers

Use at least two patients identifiers (not the patients room number) whenever taking blood samples, administering medications, or blood products.

<table>
<thead>
<tr>
<th>They are for Inpatients</th>
<th>For Outpatients</th>
<th>For comatose patient in the emergency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Name</td>
<td>Unknown1/2/3</td>
</tr>
<tr>
<td>UHID</td>
<td>UHID</td>
<td>UHID</td>
</tr>
</tbody>
</table>

Color Coding in Disaster Triage:

- **Red**: Most urgent (patient needs to be seen immediately)
- **Yellow**: Urgent
- **Green**: Non Urgent
- **Black**: Dead

Routine Triage

Hospital emergency room currently uses a 3-tier triage system. The 3-tier system is based on the following classifications:

- Level 1 (immediate)
- Level 2 (very urgent)
- Level 3 (urgent)
Discharge Planning
Discharge planning is done at the time of admission so that a patient’s needs even after discharge can be planned well ahead in time. This improves the quality of patient care and decreases readmissions due to lack of availability of vital equipment at home, after discharge.

Components of Discharge Summary
1. Reason for admission, diagnoses and comorbidities.
2. Significant physical and other findings.
3. Diagnostic and therapeutic procedures performed.
4. Significant medications, including discharge medications.
5. The patient’s condition/status at the time of discharge.
6. Follow—up instructions.
CHAPTER THREE

PATIENT AND FAMILY RIGHTS (PFR):

Patient’s Rights and Responsibilities have been defined and are actively informed to the patients and families. Management ensures strict compliance with patient’s right and responsibilities. All violations of the policy are reviewed by the top management and actions are taken or prevent such incident in the future.

Following are the Rights of a Patient:

- Right to information & knowledge
- Right to seek to reduce physical, language and cultural barriers
- Right to personal values & beliefs
- Right privacy and confidentiality
- Right to protection of valuables
- Right to participate in care process
- Right to medical care and treatment
- Right to refuse / discontinue treatment
- Right to respectful compassionate care at the end of life
- Right to complain and participate in the process
- Right to knowledge about their rights and responsibilities
- Right to general and informed consent
Followings are Patient Responsibility

- To participate, to the best of their ability in making decisions about their treatment and to comply with the agreed plan of care.
- To ask question to physician or other care providers when they do not understand any information or instructions.
- To be considerate of others receiving and providing care and also to observe facility policies and procedures, including those regarding noise, number of visitors and outside food and flowers.
- Accept financial responsibility for healthcare received and settle bills promptly.
- I Understand that smoking is prohibited for admitted patients and our attendants in the hospitals premises and pledge to follow.
- All foreigner patients getting admitted are required to provide photocopy of the first three pages of their passport.
- Patient and attendant also ensure to carry out the responsibility to see that no hospital property and human life are harmed by their actions.

Review of Patient Rights and Responsibilities – Informed Consent

The consultant or his/her designee shall be responsible for informing the patient and/or the surrogate decision maker about the following:

1. The patient’s condition;
2. The proposed treatment(s);
3. Potential benefits and risks;
4. Possible alternatives;
5. The likelihood of success/outcomes;
6. Possible problems related to recovery;
7. Possible results of non-treatment; and
8. The staff members primarily responsible for care of the patient.
Followings are Patient Responsibility

- To participate, to the best of their ability in making decisions about their treatment and to comply with the agreed plan of care.
- To ask question to physician or other care providers when they do not understand any information or instructions.
- To be considerate of others receiving and providing care and also to observe facility policies and procedures, including those regarding noise, number of visitors and outside food and flowers.
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2. The proposed treatment(s);
3. Potential benefits and risks;
4. Possible alternatives;
5. The likelihood of success/outcomes;

Restraint Order

- Restraint consent and order is required which is valid for 24 Hours only. Restraint monitoring shall be done every 2 hours by nursing.
- Need for restraint is documented.

Do not Resuscitate

Do Not Resuscitate (DNR) orders are not legal in our country.

Core Principles of End of Life Care

- The hospital shall respect the dignity of patient and family
- The hospital shall be sensitive and respect the wishes of patient and family
- The hospital shall use the most appropriate measures consistent to patient choices
- The hospital shall give maximum importance to alleviation of pain and other physical symptoms of patient
- The hospital shall assess and manage psychological, social, spiritual & religious issues related to the patient
- The hospital shall provide services of religious persons, when required
- The hospital shall offer continuity of care, particularly pertaining to palliative treatment as a part of end of life care of patient.
CHAPTER FOUR

ASSESSMENT OF PATIENT (AOP):

- All patients are assessed by a doctor and the history and physician examination form filled within 24 hours of admission.
- The nursing admission assessment is also done within 24 hours.
- Nutritional screening is done for all inpatients and the dietician sees all cases.
- The patients on dialysis are assessed monthly and if required earlier.
- Discharge planning is initiated at the time of admission.
- All patients are assessed for pain at the time of admission (Refer the Pain Management Practice Guideline; WHO 3 step analgesic ladder).
- Comprehensive assessment of the patient (H&P) is completed prior to planned surgery.
- Signature with date and time at the end of the H&P (Mandatory).
- Specialized assessment forms are used for special population/vulnerable patient.

Medicine Reconciliation / Current Medication List

- It is a process to document all medications that the patient is receiving at the time of admission and to decide which medications need to be continued during hospital stay.
Early screening for discharge planning

- In the H&P, the discharge planning should be there for:
  - Social support needed at home
  - Home equipment anticipated
  - Physiotherapy at home anticipated
  - Wound care needs anticipated at home

Education needs assessment

- Education needs are assessed during Interdisciplinary Team Round.

Components of H & P (Physician)

- Allergy
- Source of History
- Chief Complaints
- History of Present illness
- Medical, Gynecological & Surgical History
- Current Medication History
- Social & Family History
- History of Abuse & Neglect
- General & Systemic Examination
- Pain Assessment
- Infectious Disease Risk Assessment
- Functional screening
- Psychological Assessment
- Nutritional Screening
- Discharge planning
- Diagnosis with Plan of care
### Interdisciplinary Team Round

<table>
<thead>
<tr>
<th>Participants</th>
<th>Things patient should know</th>
<th>Things caregiver should seek</th>
</tr>
</thead>
</table>
| **Doctor**               | Plan of Care
                        | Pain Management plan
                        | Discharge Plan                                                   | Pain Assessment
                        | Medication Management  | **Nurse**               | Safety Precautions
                        | Infection Control Issues | Care of Skin & Devices |
                        | Restraint Management
                        | Type of Precaution(I.C.) | Care of Skin & Devices |
                        | Ability to Learn and understand                                  |
| **Operation (CCO & IP**  | Cost of Treatment
                        | Patient Rights & responsibilities
                        | Family Rights & Duties                                          | Social Assessment on Admission
                        | Executives**)                                                   | Orientation & Barriers |
| **Dietician**            | Type of Diet
                        | Food & Drug Interactions                                         | Nutritional Assessment
                        | Planning & Counseling                                           | Planning & Counseling |
| **Physiotherapist**      | Type of Activity for Daily Living
                        | Benefits of Exercise                                             | Functional Assessment
                        | Planning & Counseling                                           | Planning & Counseling |

Patient and Family education is given by all participants as required.

### Vulnerable Patients:

1. Children below 15 years
2. Elderly above 65 years
3. Patients with physical disabilities
4. Terminally ill
5. Patients with intense or chronic pain
6. Women in labor
7. Women experiencing terminations in pregnancy
8. Patients with emotional or psychiatric disorders
9. Patients suspected of drug and/or alcohol dependency
10. Victims of abuse and neglect
11. Patients with infectious or communicable diseases
12. Patients receiving chemotherapy
13. Patients whose immune systems are compromised

All such patients require specialized assessments. For vulnerable patient, prevention of falls is one of the most important precautions to be taken. There are 17 “Safety First” zones in our hospital.

What special care is given to a vulnerable patient?

- For pediatric age group, there is a different history and physical examination form.
- For elderly, patients with chronic pain, Women in labor, Women experiencing terminations in pregnancy, Patients with infectious or communicable diseases, Patients receiving chemotherapy, an additional specialized assessment form is used.
- All patients are assessed for probable abuse or neglect, psychological illness, drug or alcohol dependency.
- End of Life care is provided to the terminally ill patients with comfort and dignity. The families are counseled and cultural, religious needs are addressed.
- Standard safety precautions are taken for all patients and vulnerable patients for fall are managed with “Safety First” program. A yellow “Safety First” tag is placed at the head end of their bed.
- Frequent assessments are done by nurses. All this is documented in the patient’s file. Like all other patients, an incident form is filled in case of something untoward happening with such a patient.
### Vulnerable Patients few important categories are mentioned below

<table>
<thead>
<tr>
<th>VULNERABLE GROUP</th>
<th>POINT OF FIRST CONTACT</th>
<th>ASSESSMENT</th>
<th>CARE</th>
<th>EDUCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 15 years</td>
<td>1. Secure with parents / guardian</td>
<td>1. Pediatric or Newborn Assessment.</td>
<td>1. Implement Safety First</td>
<td>1. Safety First Brochure (Pink Slip)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. OP Assessment</td>
<td>2. Child Security</td>
<td></td>
</tr>
<tr>
<td>&gt; 65 years</td>
<td>1. Identify Barriers.</td>
<td>1. Additional Geriatric Assessment</td>
<td>1. Geriatric Care.</td>
<td>Safety First Brochure (Pink Slip)</td>
</tr>
<tr>
<td></td>
<td>2. Provide Assistance</td>
<td>2. ADL &amp; Assessment by Physiotherapist</td>
<td>2. 24h Attendant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Assess</td>
<td></td>
<td>2. 24h Attendant</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4. Psychological Consultation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>for patient &amp; family</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5. Spiritual and religious needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Immediate Admission</td>
<td>Obtain consent</td>
<td>Fluid and medication</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Monitored transport</td>
<td>Monitor condition CTG</td>
<td>Fetal condition</td>
<td></td>
</tr>
<tr>
<td>Termination of</td>
<td>1. Secure patient</td>
<td>Maintain Partograph</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy</td>
<td>2. Immediate Admission</td>
<td>Obtain consent</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Monitored transport</td>
<td>Monitor condition CTG</td>
<td></td>
<td></td>
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<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For ** Patient in Labor**, **Termination of Pregnancy**, 
- Maintain Partograph
- Obtain consent
- Monitor condition CTG

For **Patient in Labor**, **Termination of Pregnancy**:
- Pain relief
- Medication
- Psychological counseling

**Physically Challenged Patient**, **Terminally ill Patients**:
- 1. Implement Safety First
- 2. Child Security
- 1. Geriatric Care
- 2. Safety First
- 3. 24h attendant

**VULNERABLE GROUP** Patient in Labor, Termination of Pregnancy **Counseling.**
CHAPTER FIVE

CARE OF PATIENT (COP)

Measurable Goal

Purpose
1. Provide individualized care
2. Promote patient and family participation
3. Plan care that is realistic and measurable
4. Select evidenced based care
5. Communicate the plan of care

Goals
- Must be patient centered
- Must reflect the patient’s highest level of functioning
- It is a prediction of the resolution of a problem
- It is a prediction of the resolution of a problem
- Each goal is written with a time limitation, which depends on the nature of the problem
  - Short term
  - Long term
- 1. Are written in terms of “patient will ….. “
Pain Management

Assessment and Reassessment of pain is documented in the initial and follow up notes. Patient and the family are educated on pain. Age specific Pain rating scale is used for assessment of pain.

**CoMent:**

**Findings**

Document the Pain Score

- **FLACCS for children up to ≤3 Years**
- **NIPS for neonates & under (0-1yrs)**

**PAIN SCORING**

- NO PAIN: Pain Score = 0
- MILD PAIN: Pain Score = 1
- MODERATE PAIN: Pain Score = 2-3
- SEVERE PAIN: Pain Score = 4-5

**Interventions**

- **No Interventions**
- **Non-Opioids**
  - Simple analgesics
  - Topical Ointments
- **Weak Opioids**
  - ± Non-Opioids
  - ± Adjuvants
- **Rapidly titrate short acting Opioids**
  - ± Non Opioids
  - ± Adjuvants

**Re-Assessment**

- **NA**
- To be done by the Nurse
- To be done by the Nurse if pain not controlled, notify Doctor
- To be done by the Doctor

**Re-Assessment Timelines**

- 30 Minutes - 1 Hr.
- 30 Minutes - 1 Hr.
- Within 30 minutes

**Document the Pain Score**

- Within 30 minutes

**PAIN MANAGEMENT PRACTICE GUIDELINES**

**WE FOLLOW WHO 3 STEP ANALGESIC LADDER**

- **UNCONTROLLED PAIN**
  - which has not been adequately controlled through the optimum use of Opioids, Non-Opioids and adjuvant treatment
  - Reassess diagnosis
  - Referral to Pain Specialist / Anaesthetist for Invasive Intervention

Reassessment / Patient education to be given at all levels of pain scoring.

In case of severe pain (pain score 4-5) involve anesthesiologist after authorization from primary consultant.
Emergency Patient

<table>
<thead>
<tr>
<th>Staffing</th>
<th>Emergency Physician; Nurses; Paramedic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competency</td>
<td>Physician – ACLS &amp; PALS; Nurses – BLS &amp; PALS; Paramedic – BLS &amp; PALS</td>
</tr>
<tr>
<td>Process</td>
<td>Initial Triage Accident &amp; Emergency Assessment</td>
</tr>
<tr>
<td>Document</td>
<td>Focus on A&amp;E; History and Examination, consents for procedures, Medication management &amp; critical care</td>
</tr>
<tr>
<td>Monitoring</td>
<td>Vitals monitored during stay as required &amp; prior to discharge</td>
</tr>
<tr>
<td>Equipment</td>
<td>As per need – ECG; Defibrillator, Pulse Oximeter, Ventilator</td>
</tr>
</tbody>
</table>

** Staffs are required to demonstrate competency in the equipments **
Code Blue

**Staffing**
- Code Blue Team – Doctors (Cardiology, Int. Medicine, Emergency) Paramedic, Nursing, Administrative staff

**Competency**
- All staff – Basic CPR, At least one trained in ACLS

**Process**
- Start BLS algorithm – CPR; Call 7700; Code Blue Team take over Use Crash cart, Defibrillator, O2 as required

**Document**
- Code Blue Sheet Document the entire process and Transfer notes

**Monitoring**
- Physiological Vital Parameter; No Separate Consent

**Equipment**
- Pulse Oximeter; ECG monitor; Defibrillator; Crash Cart and Oxygen Cylinder
Basic Life Support (Flow Diagram)

1. Unresponsive (no breathing or only gasping)
   - Activate emergency response system
   - Get AED/defibrillator or send second rescuer (if available)

2. Check pulse: DEFINITE pulse within 10 seconds?
   - Define Pulse

3. No Pulse
   - Give 1 breath every 5 to 6 seconds
   - Recheck pulse every 2 minutes
   - Define Pulse
   - Begin cycles of 30 COMPRESSIONS and 2 BREATHS

4. AED/defibrillator ARRIVES
   - Check rhythm

5. Shockable rhythm?
   - Give 1 shock
   - Resume CPR immediately for 2 minutes
   - Check rhythm every 2 minutes; continue until ALS providers take over or victim starts to move

6. Not Shockable
   - Resume CPR immediately for 2 minutes

Note: The boxes bordered with dashed lines are performed by healthcare providers and not by lay rescuers.

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Blood Transfusion

**Staffing**
- Physician and Nursing

**Competency**
- Nurse competency in IV therapy

**Process**
- Take consent, Check blood, Check Vitals at initiation, after 5 minutes, then every 15 minutes for first hour, then every 30 minutes till end.

**Document**
- Consent; Reason; Rate of Infusion; Pre Transfusion check; sign and date

**Monitoring**
- Monitor and report transfusion reaction if any;

**Equipment**
- Blood transfusion set, 18G Cannula

**Blood Transfusion Reaction**
- Stop transfusion; call Doctor Consultant and Blood Bank Consultant. Start IV Fluid.
- Fill incident report take blood sample from other hand Clotted and EDTA; Urine and Blood for Culture; Send the blood bag for review to Blood Bank
Dialysis

Staffing: Consultant; physician; dialysis technician and nurses

Competency: Trained and competent staff
Privileges for Consultant

Process: Complete H&P - Nephrology; Complete routine dialysis records

Document: Consent every 30 days

Monitoring: Pre ad post dialysis weight, access, vitals at hourly basis

Equipment: Haemodialysis machine; Single use dialyzers
Restraint Patients

**Staffing**
- Ward or ICU Physician and Nurses

**Competency**
- Nurses training in monitoring restraint
- Know type of restraints

**Process**
- Consent – 24 hrs; Doctor’s Order; Patient & Family Education; record intake output

**Document**
- Complete H&P; Document reason of restraint; Complete Restraint Flow Sheet

**Monitoring**
- Monitor 2 hr. – Area, Fluid & Output
- Evaluate need of restraint with in 24 hrly

**Equipment**
- Specialized restraint types, when required
## Chemotherapy Patients

<table>
<thead>
<tr>
<th>Staffing</th>
<th>Follow Consultant’s prescription; Pharmacist to Mix; therapy initiated in presence of Physician. Trained Chemotherapy Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competency</td>
<td>Consultant with privileges to prescribe; Pharmacist – Chemo mixing training, Nurse trained in Chemotherapy administration and monitoring.</td>
</tr>
<tr>
<td>Process</td>
<td>Complete H&amp;P for Oncology BMA calculation must; Rate of Infusion</td>
</tr>
<tr>
<td>Document</td>
<td>Consent; H&amp;P – Diagnosis, Cycle, BMA based Drug order, Mixing &amp; monitoring record</td>
</tr>
<tr>
<td>Monitoring</td>
<td>At Start, every 15 minutes for first hour then Every 30 minutes till end</td>
</tr>
<tr>
<td>Equipment</td>
<td>Biological Safety Cabinet For Drug mixing; others as required</td>
</tr>
</tbody>
</table>
Comatose Patients

**Staffing**
- Critical Care Consultant; Physician; Nurses

**Competency**
- Training in Critical Care; Competency Evaluation for all staff; ACLS

**Process**
- Admission Discharge Criteria; care Bundles; Plan of Care; Pain in comatose

**Document**
- Complete H&P; Consent for Critical Care; Document sedation agent

**Monitoring**
- ICU Chart component monitoring Pain; End of Life; Bundles

**Equipment**
- Central Monitor, Bed side Monitors, ECG monitor, Ventilator, Syringe and infusion pumps
Infectious Patient

- **Staffing**: Physician, Nurse, Infection control Nurse All Trained in Negative Pressure Room
- **Competency**: Staff be trained in handling Infectious disease patients – Precautions & N95 mask
- **Process**: Complete H&P, Specialized assessment forms, need for isolation assessment, Proper PPE
- **Document**: Assessment and special precaution taken
- **Monitoring**: Assessment & Reassessment of patient
- **Equipment**: Specialized negative pressure rooms Disinfection and Sterilization
Immuno compromised Patients

- **Staffing**: Consultant; Physician; Nurses and Technician
- **Competency**: Consultant Privileges; Evaluation for the technical, physician and nursing staff
- **Process**: H&P and specialized assessment form for Oncology patients
- **Document**: Plan of Care and routine follow up Consent and patient education
- **Monitoring**: Daily reassessment and monitoring during Procedure as in chemotherapy
- **Equipment**: As required isolation is given or provided
Diet and Nutrition

- All nutritional products are appropriately stored and prescribed
- Diet plan – Doctors write the diet orders

**Liquid diet** –

1. Diet Order
2. Laminar Hood composition
3. Prepare and dispense
4. Best before 2 hours
5. Label with Name, UHID no, Time and Date of preparation and best before for use

**Must DO's**

**A. History and Physical – for Physicians and Nursing**

1. Timeliness should be strictly followed
2. All columns and rows have to be filled up
3. Pain Assessment has to be completed. If patient has pain, please do the pain scoring. Evaluate the following:
   - What causes pain?
   - What makes it better? Worse?
   - Where does the pain radiate? Is it in one place? Does it go anywhere else?
   - Did it start elsewhere and now localized to one spot?
How severe is the pain on a scale of 0 - 5?
Time pain started? How long did it last?
Other questions to ask and look for.... Any medication or allergies? Does it hurt on deep inspiration? Activity @ onset? Any history of pain? Any recent trauma?

4. Examination findings should be completed
5. Current medication History
6. Write all medication orders in drug chart
7. Write all non drug orders in non drug order chart
5. Legibility – kindly write in legible handwriting
6. Use Approved Abbreviation Only (provided in all U Drives)
7. Consultant and physicians Sign with date and time in History & Physical Form is mandatory.

B. Progress Note: - Physicians
What to write (for all points, compile issues identified from different discipline. Don’t avoid issues on diet /physiotherapy / psychological status, when relevant)–
- Relevant history
- Current problems
- Current Findings or post procedure follow up
- Current lab & diagnostic reports
- Major medications that are part of the planning, either to stop, continue or add
- Any procedure planned
- Expected Outcome / Goal
- Follow up
C. Key Documentation - Physician
Blood Transfusion, Chemotherapy and Dialysis Notes
- Write “Rate of infusion”
- Write about the PRN / SOS indication in the Drug Chart
- Medication or STOP orders should be dated and timed with ID

Don’ts
1. Don’t write any order in progress notes
2. Don’t write any unapproved abbreviation
3. Don’t stop any medication without sign and date, time
4. Don’t overwrite in medication chart
5. Don’t cut any writing without signing and cut with a single line
## ANESTHESIA AND SURGICAL CARE (ASC)

### Defining Surgery:
Those procedures that investigate and/or treat diseases and disorders of human body through cutting, removing, altering or insertion of diagnostic therapeutic scopes is defined as surgery.

### Moderate Sedation – IV or Per Oral Medication

<table>
<thead>
<tr>
<th>Staffing</th>
<th>Anesthetist only can administer; Nurse needs to monitor throughout</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competency</td>
<td>Anesthetist with privileges – ACLS; Pediatric cases – privileges &amp; PALS</td>
</tr>
<tr>
<td>Process</td>
<td>Complete H&amp;P; Complete Pre-sedation checklist</td>
</tr>
<tr>
<td>Document</td>
<td>Pre sedation checklist; Intra Sedation Vital parameters and Post Sedation Plan</td>
</tr>
<tr>
<td>Monitoring</td>
<td>Physiological Vital Parameter; Document Intra Procedure 15 min / 30 minutes for 1 hrs</td>
</tr>
<tr>
<td>Equipment</td>
<td>Pulse Oximeter; ECG monitor – if required</td>
</tr>
</tbody>
</table>
Pre Anesthesia Process:
- Education on the risks, benefits, and alternatives of anesthesia shall be followed during the consent process for the anesthesia
- The anesthesiologist or another qualified individual provides the education.

Pre-Anesthesia Assessment
- Includes comprehensive assessment of the patient at least a day prior to anesthesia
- Kindly refer cases to the anesthetist for completion of pre-anesthesia check up – even if your patient gets admitted on day of surgery

Intra Operative Anesthesia Process
- Pre Induction assessment is done by the anesthetist inside the OT just prior to induction of anesthesia agent.
- Benefits are to review the vitals prior to induction and see if there are any variation from the pre anesthesia check up findings It also allows to collate all laboratory, investigation parameters prior to anesthesia.

The anesthesia care of each patient is planned. The plan is documented.

Documentation of Anesthesia Plan can be done in the pre-anesthesia check up notes
1. The patients shall be monitored for the temperature, blood pressure, central venous, pressure, pulse rate every 5 minutes and documented.
2. Document all blood transfusion and medication provided – please sign and write time.
3. The monitoring for positioning on table, respiratory rate, gases provided, oxygen saturation, blood loss and urine output shall be done continuously and shall be documented every 15 min / 30 minutes for 1 hrs during the procedure / surgery.

**Post Anesthesia Plan / Recovery**

1. The patients shall be monitored for the temperature, blood pressure, central venous pressure, pulse rate monitoring continuously and documented every 05 mins.
2. Document all blood transfusion and medication provided – please sign and give time.
3. Discharge from recovery area is done using modified aldrete recovery room scoring system.

**Written Surgical Report**

- Description of the surgical procedure, findings, and any surgical specimens
- A postoperative diagnosis
- Complications & Blood Loss
- The Post Surgical Physician and Nursing Plan need to be available before the patient leaves the post anesthesia recovery area
- **Labels of implants has to be pasted in appropriate areas**
- **A post operative diagnosis has to be mentioned – this is mandatory as differences in pre operative and post operative diagnosis is monitored as quality indicator**
Review of Anesthesia and Surgical Care

Surgical Safety Initiatives
- Defining Scope of Services for Theatres
- Address Issues at IPSG 1, 2, 3, “4”, 5, 6
- Addressing priorities in skin preparation & antisepsis
- Remove hair with clippers
- Address Strategic Priorities in Instruments & Sterilization
- Give appropriate antibiotics; Give antibiotics within 60 minutes prior to incision; Re-dose appropriately
- Addressing Priorities – Nullify risk of retention of foreign body
- Keep patients warm; Maintain normoglycemia

Time out

Prior to the start of any surgical procedure, conduct a final verification process such as a “Time Out” to confirm the correct patient, procedure and site using active communication technique.

Time Out MUST verify:
1. Correct patient
2. Correct side and site (Marked)
3. Correct patient position for procedure
4. Presence of implants and/or special equipment.
Surgical Site marking

- Surgical Site Marking is done using only downwards arrows in all cases
- Where we need to denote laterality, digit or level

Anesthesia and Surgical Care

- Pre anesthetic assessment and documentation mandatory
- Care-planned and documented
- Risks, complications, options etc are discussed with patient and family members
- Separate consent of anesthesia is obtained
- Anesthesia used is documented
- Physiological status during anesthesia is monitored and recorded
- Post anesthesia status is documented
- Discharge or transfer from recovery is done using established aldrete criteria

Surgical Care

- Patients surgical care is planned and recorded
- Risks, benefits, potential complication and options discussed with patient and family and documented
- Surgery done is recorded: Pre-op and post-op diagnosis and operation notes are written clearly
- Care after surgery is planned and documented
CHAPTER SEVEN

MEDICATION MANAGEMENT AND USE (MMU)

- **Sample Medications** are not allowed in the hospital
- **Home medications** are not allowed in the hospital premises
- Nurses are authorized to administer the medication – **no self medication is allowed**
- All medications, which are **recalled** needs to be **returned** to pharmacy immediately

**Medication Process**

A. We have a medication management policy for effective medication management & to reduce medication errors.
B. 24 hour’s IP pharmacy services are available.
C. Emergency medicines are available and stored (Floor Stock, Blue Bag, Crash Cart).
   - Medication orders are to be legible in specified page of drug chart.
   - Start and discontinuation or change order of any drug has to be signed, dated and timed.
   - Any wrong entry has to be crossed out with a single line and signed error.
   - Effect of medication is to be documented in the progress notes.
   - Medications are administrated at standard times other than stat orders.
   - Nurses signature & time is must on administration.
   - Label all open in use vials and pre-filled syringes.
● All medication error to be reported.
● All ADR need to be reported in ADR form for clinical audit.
● All orders (including diet and nursing stands cancelled when patient undergo surgery or is transferred out of ICU’s).
● All order including dietary order, need to be written a fresh in the situation.

Storage of Medication and Nutritional Product:
- All medicines and Nutritional products are kept in Safe and Clean, Humidity free Environment
- **Room and Refrigerator Temperature** to be monitored two times daily
- Drugs shall be **kept under lock** in Floor Stock, Bed side lockers and emergency crash trolley
- **Expiry checking** once in a month and daily checking by nursing. Remove before 3 months of expiry

Prescription Writing
- Individuals who are permitted are identified to carry out the orders
- Medications are to be written legibly in specified form, dated, timed & signed
- Verbal orders are not acceptable except in life saving situations
- Document “STOP” orders legibly with your signature, dated and timed appropriately

Drug Dispatch:
- All medicines are checked by Pharmacist before dispensing
- All drugs – dispatch within 90 minutes & all emergency drugs – dispatch within 30 minutes
Nurses will administer the medicines after cross checking:

1. Right patient
2. Right drug
3. Right dose
4. Right time
5. Right route
6. Right documentation

A. Medication Error

Medication error is any preventable event, that may cause or lead to inappropriate medication use or patient harm, while the medication is in the control of the health care professional, patient or consumer.

Near Miss of Medication Error

A Medication Error which has a potential to cause injury or harm and that was detected and corrected before it reached the patient.

B. Adverse drug reaction (ADR):

An ADR is any noxious, unintended, undesirable or unexpected response to drug that occurs at doses used in humans for prophylaxis, diagnosis or therapy, excluding therapeutic failure.

Non Drug Orders

- Write all Non Drug Orders in Doctor Instruction Sheet
- Please provide date and time
- Write the diagnosis in the lab and radiology requisition
PATIENT AND FAMILY EDUCATION (PFE)

Patient and family should be educated about their disease process, proposed plan of care and effect of treatment. Patient and family should be educated based on the individuals learning preferences, privileges, cultural values, reading and language skills.

Educate patients on:
1. How to take medication safely
2. How to prevent falls
3. Food drug interactions
4. Nutrition
This must be documented in the case record.

Evaluate
1. The patient’s and family’s beliefs and values;
2. Their literacy, educational level, and language;
3. Emotional barriers and motivations;
4. Physical and cognitive limitations; and
5. The patient’s willingness to receive information.
CHAPTER NINE

QUALITY IMPROVEMENT AND PATIENT SAFETY (QPS)

QAD is to increase customer confidence and a hospital’s credibility, to improve work processes and efficiency, and to enable the company to better compete with other healthcare organizations in terms of patient safety and continuous quality improvement activities.

Quality Process
### Quality Indicators:

The essential elements of a credible data validation process shall include the following:

- Re-collecting the data by a second person not involved in the original data collection
- Using a statistically valid sample of records, cases, and other data
- Comparing the original data with the recollected data
- A 90% accuracy level is a good benchmark
- When data elements are found not to be the same, noting the reasons (for example, unclear data definitions) and taking corrective actions

### Data Validation:

<table>
<thead>
<tr>
<th>CATEGORY OF INDICATORS</th>
<th>NUMBER OF QI MONITORED</th>
</tr>
</thead>
<tbody>
<tr>
<td>QUALITY IMPROVEMENT AND PATIENT SAFETY (QIPS)</td>
<td></td>
</tr>
<tr>
<td>- Clinical &amp; Managerial Indicator</td>
<td>35 (Clinical 21, Managerial 14)</td>
</tr>
<tr>
<td>- LOM (Library of Measures, suggested by JCI)</td>
<td>5 (Clinical 5)</td>
</tr>
<tr>
<td>- CP &amp; CPG</td>
<td>23 (16 CPG, 7 CP)</td>
</tr>
<tr>
<td>DKQPs (Department Key Quality Parameters)</td>
<td>75 (Managerial)</td>
</tr>
<tr>
<td>ACE (APOLLO CLINICAL EXCELLENCE @ 25)</td>
<td>26 (Clinical)</td>
</tr>
<tr>
<td>RACE (Rocket ACE)</td>
<td>26 (Clinical)</td>
</tr>
<tr>
<td>APOLO LIGHT HOUSE</td>
<td></td>
</tr>
<tr>
<td>- AQP (APOLLO QUALITY PLAN)</td>
<td>20 (Clinical)</td>
</tr>
<tr>
<td>- INCIDENT REPORT</td>
<td>10</td>
</tr>
<tr>
<td>VOC (Voice of the Customer)</td>
<td>69 (Managerial)</td>
</tr>
<tr>
<td>ER Codes</td>
<td>3 Clinical Outcome</td>
</tr>
<tr>
<td>IPSG</td>
<td>12 (Clinical)</td>
</tr>
<tr>
<td>Total number of Indicators being monitored…</td>
<td>305+</td>
</tr>
</tbody>
</table>
**Quality Tools:**

- Fish Bone Diagram
- Pareto Chart
- Symmetric Histogram
- Histogram
- Pie Chart

**Sentinel Event:**

Apollo Hospitals Dhaka defines its Sentinel Event as an unanticipated death or Major permanent loss of function, not related to the natural course of the patient's illness or underlying condition. The event is one of the following:

i. an unanticipated death, including, but not limited to,
- death that is unrelated to the natural course of the patient’s illness or underlying condition
- death of a full-term infant; and
- suicide;

ii. wrong-site, wrong-procedure, wrong-patient surgery;
iii. transmission of a chronic or fatal disease or illness as a result of infusing blood or blood products or transplanting contaminated organs or tissues;
iv. infant abduction or an infant sent home with the wrong parents; and
v. rape, workplace violence such as assault or homicide of a patient, staff member, practitioner, medical student, trainee, visitor, or vendor while on hospital property.

The Quality Assurance Department screens the sentinel event and completes a root cause analysis that does not exceed 45 days from the date of the event or when made aware of the event.

**Near Miss:**
Near Miss is any process variation which did not affect the outcome but for which a recurrence carries a significant chance of a serious adverse outcome.

**Serious Adverse Events include –**
- Major Hemolytic transfusion reactions
- Serious adverse drug even and medication errors,
- Major discrepancies between preoperative and postoperative diagnoses
- Adverse events during moderate or deep sedation and anesthesia use
The Incident Report

Any employee identifying/experiencing the incident, or the employee to whom the incident is first reported, shall be responsible for initiating the Incident Report upon completion of the Incident.

Report Form:

1. The form shall be acknowledged by the HOD/Manager/Executive.
2. After screening the Incident Report shall be forwarded to the office of Quality Assurance for necessary actions within 48 hours.

Investigation into an Incident:

A Root Cause Analysis (RCA) shall be carried out by Quality Assurance Department for all Sentinel events, as well as for events where the occurrence has a significant potential for undermining the public’s confidence in the organization.
CHAPTER TEN

PREVENTION AND CONTROL OF INFECTIONS (PCI)

Infection control is everyone’s responsibility.....

Standard Infection Control Precautions (SICPs) are the basic infection prevention and control measures necessary to reduce the risk of transmission of micro-organisms from recognised and unrecognised sources of infection. These are intended for use by all staff, in all care settings, at all times, for all individuals whether infection is known to be present or not to ensure the safety of those being cared for, staff and visitors in the care environment.

1. Hand Hygiene

Hand hygiene is considered to be the single most important practice in reducing the transmission of infectious agents, including Healthcare Associated Infections (HAI), when providing care.

Before performing hand hygiene:

- Expose forearms;
- Remove all hand/wrist jewellery;
- Ensure finger nails are clean, short and that artificial nails or nail products are not worn; and
- Cover cuts or abrasions (if any) with a waterproof dressing.
Performing Hand Hygiene:
Hand hygiene should be performed:
- Before touching a patient;
- Before clean/aseptic procedures;
- After body fluid exposure risk;
- After touching a patient; and
- After touching a patient’s immediate surroundings.

The five moments for hand hygiene in health care

Fig: Your 5 Moments for hand hygiene
Alcohol Based Hand Rubs (ABHRs) should be used for hand hygiene which is available to staff as near to point of care as possible.

How to Handrub?

RUB HANDS FOR HAND HYGIENE! WASH HANDS WHEN VISIBLY SOILED

Duration of the entire procedure: 20-30 seconds

1a. Apply a palmful of the product in a cupped hand, covering all surfaces;
1b. Rub hands palm to palm;
2. Palm to palm with fingers interlaced;
3. Right palm over left dorsum with interlaced fingers and vice versa;
4. Backs of fingers to opposing palms with fingers interlocked;
5. Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;
6. Rotational rubbing of left thumb clasped in right palm and vice versa;
7. Once dry, your hands are safe.

Fig: How to Hand Wash
How to Handwash?

WASH HANDS WHEN VISIBLY SOILED! OTHERWISE, USE HANDRUB

Duration of the entire procedure: 40-60 seconds

0. Wet hands with water;
1. Apply enough soap to cover all hand surfaces;
2. Rub hands palm to palm;
3. Right palm over left dorsum with interlaced fingers and vice versa;
4. Palm to palm with fingers interlaced;
5. Backs of fingers to opposing palms with fingers interlocked;
6. Rotational rubbing of left thumb clasped in right palm and vice versa;
7. Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;
8. Rinse hands with water;
9. Dry hands thoroughly with a single use towel;
10. Use towel to turn off faucet;
11. Your hands are now safe.

Hands must be washed with liquid soap and water if:

- Hands are visibly soiled or dirty;
- Exposure to spore forming organisms such as Clostridium difficile or a gastro-intestinal infection e.g. norovirus, is suspected or known.

Fig: How to Hand Wash
2. Personal Protective Equipment (PPE)

PPE provide adequate protection to staff against the risks associated with the procedure or task being undertaken. PPEs include gloves, apron/ gowns, mask, and eye protection (goggles).

**Gloves must be:**
- Worn when exposure to blood and/or other body fluids is anticipated/likely;
- Changed immediately after each patient and/or following completion of a clinical procedure or task;
- Changed if a perforation or puncture is suspected;
- Hand hygiene must be performed after gloves change/ removal.

**Aprons must be:**
- Worn to protect uniform or clothes when contamination is anticipated/likely e.g. when in direct care contact with a patient

**Full body disposable gowns must be:**
- Worn when there is a risk of extensive splashing of blood and/or other body fluids e.g. for care of barrier nursing patients and in the operating theatre; and
- Changed between patients and immediately after completion of a procedure.

**Surgical face masks must be:**
- Worn if splashing or spraying of blood, body fluids, secretions or excretions onto the respiratory mucosa is anticipated/likely;
- It should be used only when indicated and while using it must be properly worn (fully covering the mouth and nose);
• And removed or changed;
  □ at the end of a procedure/task;
  □ if the integrity of the mask is breached, e.g. from moisture build-up after extended use
  or from gross contamination with blood or body fluids.

**Eye/face protection must be:**

• Worn if blood and/or body fluid contamination to the eyes / face is anticipated / likely by
  members of the surgical theatre team and always during Aerosol Generating Procedures (AGP)

### 3. Patient Placement/Assessment for infection risk

The potential for transmission of infection or infectious agents should be assessed at the patient’s entry
to the care area and should be continuously reviewed throughout their stay and this should influence
placement decisions in accordance with clinical/care need. The assessment for isolation requirement
is as follows:

<table>
<thead>
<tr>
<th>Isolation requirement</th>
<th>Patient placement</th>
</tr>
</thead>
<tbody>
<tr>
<td>No need</td>
<td>Patient choice</td>
</tr>
<tr>
<td>Protective</td>
<td>Single private</td>
</tr>
<tr>
<td><strong>Source</strong></td>
<td></td>
</tr>
<tr>
<td>Airborne</td>
<td>Negative pressure room</td>
</tr>
<tr>
<td>Droplet</td>
<td>Single private</td>
</tr>
<tr>
<td>Contact</td>
<td>Single private (preferred) or corner bed in ward</td>
</tr>
</tbody>
</table>

Avoid unnecessary movement of patients between care areas.
4. Respiratory Hygiene and Cough Etiquette

Respiratory hygiene and cough etiquette is designed to contain respiratory secretions to prevent transmission of respiratory infections:

- Cover the nose and mouth with a disposable tissue when sneezing, coughing, wiping and blowing the nose;
- Dispose of all used tissues promptly into a waste bin;
- Wash hands with liquid soap and water after coughing, sneezing, using tissues, or after contact with respiratory secretions or objects contaminated by these secretions; and keep contaminated hands away from the mucous membranes of the eyes and nose;
- If tissues are not available, cover your nose and mouth with your shoulder or arm.

5. Management of Care Equipment

Care equipment can become contaminated with blood, other body fluids, secretions and excretions and transfer infectious agents during the delivery of care. Care equipment is classified as either:

**Single-use** - used once then discarded. Must never be reused even on the same patient. (The only exceptions are as per hospital SUD policy.)

**Single patient use** - for use only on the same patient.

**Reusable invasive equipment** - used once then decontaminated e.g. surgical equipment.

**Reusable non-invasive equipment** - reused on more than one patient following decontamination between each use e.g. commode, patient trolley.

All sterilized packaged items must be checked for visible contamination, expiry dates and that the package is intact.
Decontamination of reusable non-invasive care equipment must be undertaken:
- between each use;
- after blood or body fluid contamination;
- at regular predefined intervals as part of an equipment cleaning protocol;
- before disinfection; and
- before inspection, servicing or repair.

All reusable non-invasive equipment must be rinsed and dried following decontamination then stored clean and dry.

For further details, please see PCI Manual

6. Handling soiled linens
- Clean linen should be stored in a clean, designated area, preferably an enclosed cupboard.
- For all used linen (often referred to as soiled linen): ensure a laundry receptacle is available as close as possible to the point of use for immediate linen deposit.
- Any linen used during patient transfer e.g. blankets, should be appropriately segregated at the point of destination.

Do not:
- rinse, shake or sort linen on removal from beds;
- place used linen on the floor or any other surfaces e.g. a locker/table top;
- re-handle used linen once bagged;
- overfill laundry receptacles; or
- place extraneous items in the laundry receptacle e.g. used equipment /needles.
For all infectious linen i.e. linen that has been used by a patient who is known or suspected to be infectious and/or linen that is contaminated with blood or other body fluids e.g. faeces; place directly into a yellow bag and secure; then place in a laundry receptacle; or if the item(s) is heavily soiled and unlikely to be fit for reuse following laundering then dispose of as healthcare waste.

Store all used/infectious linen in a designated, safe, lockable area whilst awaiting uplift.

7. Control of the Environment

It is the responsibility of the person in charge to ensure that the care area is safe for practice and this includes environmental cleanliness /maintenance. The care environment must be:

- free from clutter to facilitate effective cleaning;
- well maintained and in a good state of repair; and
- clean and routinely cleaned in accordance with the hospital cleaning protocol.

8. Management of blood and body fluid spillage

Spillages of blood and other body fluids are considered hazardous and must be dealt with immediately.

9. Waste Disposal

Segregation of waste at source is very important and waste disposal should be done in correct color bags as per hospital policy. For the disposal of sharps use sharp box.
For other waste disposal use colour coded bins as follows.

- **Hospital Waste**
  - General Waste
    - General Waste, Non-infected Plastic Materials (Plastic Papers), Disposables, Cardboards, Metal Containers, Waste Generated from Offices
  - Glass Ware
    - Glass Ware Items
    - Catheter, Tubings, Cennules syringes, Plastic IV Bottle, Used Gloves, IV Sets infected plastic waste. Specimen containers, Wash Generated From Laboratory, Culture of Micro organom, Used or Discarded Bags of Blood/ Blood Products Vaccines
  - Plasctics
    - Human Tissues, Organs, Body part, Items Containing Blood and Body Fluid (Cotton), Solid Dressing, Solid Plaster Casts, Beddings, Discarded Medicine, Discarded Catatonic Drugs
  - Human Tissues
10. Occupational Exposure Management (including sharps)

There is a potential risk of transmission of a Blood Borne Virus (BBV) from a significant occupational exposure and staff needs to understand the actions they should take when a significant occupational exposure incident takes place.

A significant occupational exposure is:

- A percutaneous injury for example injuries from needles, instruments, bone fragments, or bites which break the skin; and/or
- Exposure of broken skin (abrasions, cuts, eczema, etc); and/or
- Exposure of mucous membranes including the eye from splashing of blood or other high risk body fluids.
Response to Accidental Inoculation with blood & body fluids and Needle Stick Injury

Management of Accidental Inoculation:

Accidental Inoculation injury incident

Perform first aid to the exposed areas immediately

Is skin/tissue affected?

YES

- Encourage the area to bleed
- Do not suck the damaged skin or tissue
- Wash/irrigate with running water and soap
- Cover the area if necessary

NO

Are eyes/mouth Affected?

YES

- Rinse/irrigate copiously with water
- Use eyewash facility if available nearby
- If contact lenses are worn, remove then irrigate

NO

- Report/document the incident to staff clinic or ER after office hours and during holidays and ensure that any corrective actions or interventions are undertaken
- Ensure that the item that caused the injury is disposed

Fig: Management of Accidental Inoculation injuries flow chart
B. The Quality Indicators of PCI are
1. Central Line Associated Blood Stream Infections (CLABSI)
2. Ventilator Associated Pneumonia (VAP)
3. Catheter Associated Urinary Tract Infection (CAUTI)
4. Surgical Site Infection (SSI)
CHAPTER ELEVEN:

GOVERNANCE, LEADERSHIP AND DIRECTION (GLD)

Organogram:
## Emergency Codes and Responses

### Fire Safety:

<table>
<thead>
<tr>
<th>Smoke Detector</th>
<th>Gas shut off valve</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detects smoke</td>
<td>Only Nurses are authorized to close the valves in case of fire</td>
</tr>
<tr>
<td>Conventional Type</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sprinkler</th>
<th>Hallways</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 68 deg Celsius</td>
<td>Keep passage clear</td>
</tr>
<tr>
<td></td>
<td>Keep trolley in one side only</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FHC (Fire Hose Cabinet)</th>
<th>Stairways</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivery Hose (15 meters)</td>
<td>No clutter,</td>
</tr>
<tr>
<td>Branch Pipe</td>
<td>Emergency lights for evacuation,</td>
</tr>
<tr>
<td>Hose Reel (30 meters)</td>
<td>Follow Fire Exit signage</td>
</tr>
<tr>
<td>Fire Hydrant</td>
<td></td>
</tr>
<tr>
<td>Stretcher</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>External Fire Tender Bay</th>
<th>When confronted with a fire, use the acronym RACE to remember the correct procedures to follow:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hydrant Point</td>
<td>Rescue those in immediate danger.</td>
</tr>
<tr>
<td>Hose Real Box for providing water</td>
<td>Alarm others in the area by activating the nearest fire alarm. Call out “CODE RED”. Dial for help to explain details and give exact location.</td>
</tr>
<tr>
<td>Required for external fire fighting.</td>
<td>Confine the area of fire by closing all doors to rooms/areas.</td>
</tr>
<tr>
<td></td>
<td>Extinguish the fire if small, or Evacuate.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fire Alarm</th>
<th>Fire Extinguisher:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Break Glass Variety</td>
<td>Follow the acronym PASS to use a fire extinguisher:</td>
</tr>
<tr>
<td>Hooter</td>
<td>Pull the pin.</td>
</tr>
<tr>
<td></td>
<td>Aim the nozzle at the base of the fire.</td>
</tr>
<tr>
<td></td>
<td>Squeeze the handle.</td>
</tr>
<tr>
<td></td>
<td>Sweep the nozzle from side to side.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Smoke Door</th>
<th>● Send oxygen cylinder for refill when it shows 50 mark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contains smoke horizontally</td>
<td>● Secure cylinders; use appropriate cover dress for cylinders</td>
</tr>
<tr>
<td>To be kept closed when fire and smoke happens</td>
<td>● Storage does not exceed the 18” sprinkler head limit</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Code Red</strong></td>
<td>External disaster like 1. Accident with mass casualty 2. Natural Calamity 3. Epidemics 4. Bomb blasts/terrorist activities</td>
</tr>
<tr>
<td><strong>Code Blue</strong></td>
<td>A potentially life threatening situation requiring a response of a team of designated clinicians. Usually a cardiac arrest</td>
</tr>
<tr>
<td><strong>Code Brown (Fire)</strong></td>
<td>Fire, smoke or order of something burning</td>
</tr>
<tr>
<td><strong>Code Yellow</strong></td>
<td>Medical Emergency Poly Trauma: a situation that may predispose to patient's clinical deterioration and medical emergency other than cardiac arrest</td>
</tr>
<tr>
<td><strong>Code Grey</strong></td>
<td>Internal disaster like 1. Building collapse 2. Ceiling collapse 3. Internal pipeline burst etc.</td>
</tr>
<tr>
<td><strong>Code Pink</strong></td>
<td>An infant/child is missing or is known to have been abducted/kidnapped</td>
</tr>
<tr>
<td><strong>Code Purple</strong></td>
<td>Patient is missing from the ward unit</td>
</tr>
<tr>
<td><strong>Code Gold</strong></td>
<td>Security Threat. Verbal and Physical escalation situation work place violence</td>
</tr>
<tr>
<td><strong>HAZMAT</strong></td>
<td>Hazardous spill which is likely to cause unknown effects, injury, illness or harm to the environment</td>
</tr>
</tbody>
</table>
HAZMAT

What Is A Material Safety Data Sheet (MSDS)?

A document that describes the properties of a product, any physical and health hazards associated with the product, precautions of safe handling, storage and spill control. The MSDS lists Personal Protective Equipment (PPE) that should be used in order to work with the material safely. Fire and first aid procedures are also listed on the MSDS.

What are Hazardous Materials?

- Hazardous materials are chemical substances which, if released or misused, can pose a threat to the environment, life or health.
- Industry, agriculture, medicine, research, and consumer goods use these chemicals.
- Hazardous materials come in the form of explosives, flammable and combustible substances, poisons, and radioactive materials.
**Hazmat Stickers**

| 4. Rapidly vaporize and burn at atmospheric temperature and pressure |
|---|---|
| 3. Inflammable when ignited | 2. Inflammable when heated moderately |
| 1. Inflammable when preheated several times | 0. Materials don’t burn |

| 4. Lethal – can lead to death |
| 3. Serious or Permanent Damage |
| 2. Temporary Damage |
| 1. Minor Irritation |
| 0. No damage |

**Special Consideration** including violent reactions with water; special disposition requirement; acid or alkali agents; agents with radiation risks
Fundamentals of Handling Hazardous Material

- Ensure proper inventory list of all Hazardous Materials in respective area
- Ensure proper storage guidelines
- Protect workers from exposure during work and spill
- Ensure usage of correct receptacles for Hazardous Material Waste
- Use Spill Management Guidelines to handle spills
- Please go through MSDS before using any chemical

Personal Protective Equipment Cupboards

1. Personal protective Equipment shall contain the following:
   - Gumboots
   - Goggles
   - Helmet
   - Mask
   - Industrial gloves

2. The key will be kept in the nearby ward or the department and a spare with House keeping department.
What is Major Spill

- **Quantity**
  - More than 30 ml of liquids
  - More than 30 grams of solid

- **Concentration**
  - High concentrated Acid or Alkali

- **Characteristics of Spill**
  - Flammable / Ignitable – can lead to fire
  - Toxicity- can lead to inhalational or skin injury
  - Corrosive – damage to skin and eyes
  - Substances like mercury spill.

Spill Management

What will you do in case of chemical splash on eye/body?

Any eye injured due to acid or chemical splash, do the following

- Keep the eye open in front of the perforated fountain for 15 - 20 minutes
- Rush to emergency for medical advice
- Any chemical splash over the body, rush to the eye shower area and pull the handle under the eye shower (we have 7 eye shower in AHD) for 15 -20 minutes
- Rush to Medical advice
1. How do you respond to Blood Spill?
- Put appropriate signage in the area
- Major Spill: Call 2200 (Hazmat activation) / cover the area with gauge / pads soaked in 1% Sodium Hypochlorite. Keep it for 30 minutes. In case of Minor Spill call unit Housekeeping.
- Hazmat Team shall clean the spill with appropriate PPE

2. How do you respond to Chemical Spill?
- Immediately clear the area. Limit access to essential personnel only.
- Major Spill: Call 2200 (Hazmat activation) Department; if there is threat to life or damage of property, ensure steps of safety. In case of Minor Spill call unit Housekeeping.

3. How do you respond to Cytotoxic drug Spill?
- Call Housekeeping and Pharmacy department

Radiation Safety Checklist
- Wear the TLD badges at work
- Know the recent TLD values
- Do not fold lead apron; look for PM tag
- Thyroid and Gonad Shields to be used
- Periodic fluoroscopy – Lead apron & other devices
- Quality (radiation) controls for all equipments
- Annual Health Check for all radiation workers to be completed

- Appropriate Signage in radiation area
- Obtain Obstetric history for all women prior to radiation
- Radiation Safety Officer – Md. Nahid Hosain
- Inform overexposure and injuries
# Laser Safety Guidelines

<table>
<thead>
<tr>
<th>Class</th>
<th>Alert</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1</td>
<td>Dermatology OT</td>
</tr>
<tr>
<td>Class 2</td>
<td></td>
</tr>
<tr>
<td>Class 2M</td>
<td></td>
</tr>
<tr>
<td>Class 3B</td>
<td></td>
</tr>
<tr>
<td>Class 4</td>
<td></td>
</tr>
</tbody>
</table>

Selection of eyewear should be based on:
- wavelength(s) being used
- radiant exposure;
- maximum permissible exposure (MPE);
- optical density of eyewear;
- visible light transmission requirements;
- adequate peripheral vision; prescription lenses; and
- comfort.
General Instruction

- Current arrangements require all users of dermatology and OT departments using lasers to have a "Laser Eye Test" annually.
- A medical examination by a qualified specialist should be carried out immediately after an apparent or suspected injurious ocular exposure.

Ladder Safety Guidelines

- Check before using ladder; don’t use wooden & damaged ladders – tag defective
- Steps and rung – tight and secure; settle ladder properly with stakes or stout boards; use both hands going up down
- Do not lean from ladders, use ladders in front of open door
- Do not use ladder in high winds, keep it free from water, grease, oil, wet paint or slippery materials
- Do not carry bulky loads; do not overreach, do not slide down,
- Do not use ladder in front of any door or traffic area
- Do not use metal ladders with electric equipment
- Do not use ladder if you are on medication or alcohol
Electrical Safety Guidelines

- All repairing jobs shall be carried by electrician or biomedical engineers
- **Wire Safety** - Wires with poor and deteriorated insulation shall not be used
- **Switch Safety** - Staff shall switch off and disconnect any equipment that sparks or stalls
- **Personnel Safety** -
  - Staff shall wear safety shoes & PPE where required
  - “MEN WORKING” signboards shall be placed on all switches before commencing work or Implement Lockout
  - Rubber mats shall be placed in front of electrical switch boards
- **Fire Safety** - Staff shall not use water on live electrical equipment / wires in case of fire, sand or blanket shall be used instead. Use CO₂ Fire Extinguishers Only.

Facility Review – General Points

Is smoking allowed in any hospital building?
- No

What would happen in the event of an electrical power failure?
- All areas are equipped with emergency power to operate essential equipments; the electricity supply is usually back within 20 seconds.

What would you do if there were a medical equipment failure?
- Remove the equipment from service
- Tag the equipment according to policy
- Contact the Medical Technology Department
- Facility Management Department
- Raise an incident report.
CHAPTER THIRTEEN

STAFF QUALIFICATION AND EDUCATION (SQE)

Consultant / Other Doctors
1. Have a copy of your annual updated privileges
2. List of privileges need to be present at procedural areas
3. Updated CV, JD, Registration & Training Certificate need to be current
4. Know the benchmarks for Annual Evaluation
5. Training: Mandatory Safety Trainings (eg. Fire, Hazmat, BLS/ACLS/PALS)
6. Complete Annual Health Check & Vaccination
7. Know your rights and carry out your responsibilities.

Staff
1. Know your departmental organization chart
2. Keep a copy of your signed job description; know your KRA, KPI /Competency score; was competency evaluated for your current job?
3. Participate and sign in your appraisal
4. Provide HR with updated CV (along with changed personal information), JD, additional certificates, registration which are current
5. Complete Annual Health Check & Vaccination
6. Participate in Mandatory Trainings, Drills; did you do your eg. BLS, Fire, Hazmat & Biomedical Training and other functional training and took part in evaluation process?
7. Know your rights and carry out your responsibilities.
A thorough and accurate medical record is evidence that the doctor provided appropriate care and can be strong evidence that the physician complied with the standard of care.
Key to Best Practice in Documentation

- H & P and OT notes to be counter signed by consultant
- All signatures to carry the name, ID, date and time
- All case records are to be filled completely with no column left unfilled
- All drug chart entries to be made and signed by the physician with date and time
- Non drug orders to be documented in the appropriate section of non-drug order form
- Draw single lines across errors
- Use not applicable where necessary while filling forms
- Draw line across unused spaces

Important Books

<table>
<thead>
<tr>
<th>Safety Manual</th>
<th>Red book</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICU Manual</td>
<td>Blue book</td>
</tr>
<tr>
<td>Infection Control Manual</td>
<td>Greenbook</td>
</tr>
<tr>
<td>Radiation Safety</td>
<td>Yellow book</td>
</tr>
</tbody>
</table>
# Dangerous Abbreviation or Dose Designation
**NOT TO BE USED in Medical Record.**

<table>
<thead>
<tr>
<th>MUST USE</th>
<th>MEANING</th>
<th>DO NOT USE</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>mcg</td>
<td>Microgram</td>
<td>μg</td>
<td>μg can be mistaken for mg</td>
</tr>
<tr>
<td>Spell out: &quot;units&quot;</td>
<td>Units</td>
<td>U or u</td>
<td>Could be read as a zero (0) or a four (4)</td>
</tr>
<tr>
<td>1mg</td>
<td>DO NOT Use trailing zero</td>
<td>1.0 mg</td>
<td>Misread as 10 times amount intended if decimal point is not seen</td>
</tr>
<tr>
<td>0.5 mg</td>
<td>Do use leading zero</td>
<td>.5mg</td>
<td>Misread as 10 times amount intended if decimal point is not seen</td>
</tr>
<tr>
<td>q day, daily Every Other Day</td>
<td>Every day, Every other day</td>
<td>q.d., QD, q.o.d, Q.O.D.</td>
<td>Mistaken for each other The period after the Q can be mistaken for an “I” and the “O” can be mistaken for an “I”</td>
</tr>
<tr>
<td>Spell out: “Morphine”, “Magnesium Sulfate”</td>
<td>“Morphine”, Sulfate Magnesium Sulfate IU for International Units</td>
<td>MgsSO₄, MS IU</td>
<td>Can mean “Morphine Sulfate” or “Magnesium Sulfate”</td>
</tr>
<tr>
<td>Spell out: “International Units”</td>
<td></td>
<td></td>
<td>Mistaken for IV(intravenous or 10(ten))</td>
</tr>
<tr>
<td>ml</td>
<td>c.c. for cubic centimeters</td>
<td>c.c</td>
<td>Mistaken for U(units) when written poorly</td>
</tr>
</tbody>
</table>
1. All Patient Care Units:

- All patients have ID tags, legible and used
- Color coded cover for linen; clean & dirty linen separated
- Stain free:- Mattresses, curtains, bed linens, food trolley
- Sharps containers secured, no sharps lying out
- Call bell within reach, working and checked
- Water in humidifier changed daily, date & time written
- Grab bars placed in wash room, call bell working
- Hazmat Item labeled, spill kits available
- General environment- cleanliness, roominess
- Hand wash available, are used
- Crash Cart, medicine cupboards and lockers locked
- Biomedical Equipment tags for PM available & current
- Hallways clear for egress, trolley stored in one side
- Floor is not cracked; No dampness in ceilings
- Fire Extinguishers in place, PM tag available
- Oxygen Shut off valves, labeled and operational
- Weight & height machine calibrated, PM done
- Side rails up; patient transported with safety belts
2. Documentation: (Unit Binders)

- Floor Plan
- Scope of services
- SOP’s if applicable
- List of trainings
- Narcotics List and list of consultant signatures
- List of Junior Doctor Signatures
- List of Nurses Signatures
- Job Descriptions
- Quality Indicators and graphs
- PATIENT FEEDBACK ATR if any major complaint
- INCIDENT REPORT – ATR
- List of approved abbreviations
- DO NOT USE ABBREVIATIONS LIST
- List of Interpreters
- List of Religious Leaders
- Critical Test Reporting Policy
- Look Alike & Sound Alike Drugs List
3. Records: (Unit Binders)
- Competency records
- Training records
- Glucometer check records
- Narcotic records
- Refrigerator/defibrillator records
- Crash Cart check records
- Oxygen cylinder check records
- Impress stock record
- Support documents for recording of all quality indicators
- Patient files completed and kept in locked drawers

4. Food and Beverage:
- Food trays in hallways
- Wear Hair cap
- Temperature check
- What to do when hand gets cut
- Fridge Temp log, temp to maintain, what to do when temperature not within range
- Nothing on floor and till ceiling
- Open items have dates
- No drips from AC/cooler
- MSDS for cleaning materials—where and what
- Open bags secure
- Separate clean & dirty dishes
- Separate dry store, utility store and liquid area.

5. General Guidelines:
- Obstructions of horizontal egress corridor.
- Door to Storeroom should close properly.
- Fire doors of stairwell should close properly.
- Storage on top shelf should be less than 18 inches from ceiling or sprinkler system and nothing on floor.
- Dietary walk in freezer door should function properly.
- AHU to remain locked.
Developed and designed by Accreditation & Compliance Office Apollo Hospitals Dhaka.
Apollo Hospitals Dhaka

Emergency Hotline : 10678
Ambulance : 01714-090000
Appointment : (02)-8845242,

01841 APOLLO, 01729 APOLLO
01612 APOLLO, 01971 APOLLO

APOLLO Signifies : 276556
CALL CENTER : 09606276555
01713064593
01911555555

E-PABX : (02)-8401661)
09606276556

FAX : (02)-8401679

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Dhaka-1229, Bangladesh
www.apollodhaka.com