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What is JCI? How is it good for us?
JCI stands for Joint Commission International. It is a US based, not-for-Profit accreditation body which sets and addresses standards for the health care provider's level of performance in key functional areas, such as patient rights, patient treatment, and infection control.

How will it help us?
JCI standards would lead us to improved patient care, safety and path of continuous quality improvement. JCI standards would lead us to improved edge. JCI accreditation is the gold standard for U.S. and European hospitals as it reflects provision of the highest levels of patient care and patient safety. The accreditation standards are listed in the fourth edition of Joint Commission International Accreditation Standards for Hospital and are functionally divided into 8 Patient centered chapters and 6 Organization Management centered chapters.

JCI Standards
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. Patients and Family Education (PFE)

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

Building a Culture of Quality improvement...
JCI calls for setting standards for quality of clinical care and patient services.
Our aim is to do the right thing, the right way, the first time every time.

Our Approach
Quality indicators (indicator of performance)
Data collected through indicators
Serve as evidence for inferences.
JCI addresses the following issues very intensively:
1. Daily assessment by a physician
2. Care of patients undergoing moderate and deep sedation
3. Pain management
4. Patient safety issue
5. Department level plan for clinical services
6. Resuscitative technique training for staff
7. Managing documents such as policies and procedures
8. A process to help patients at times of spiritual and religious needs
9. End of life care

What we achieve:
More efficient administrative processes
e.g. Lesser waiting time
Lower costs- better utilization of resources
Better quality of care
Better patient safety-reduce medication errors
Improved outcomes of care of patients
e.g. Decreased morbidity and mortality rates
Standards: Total Number: 323
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: 1134
Measurable elements are those requirements of standards which are reviewed and assigned a score during survey.

Survey: Assesses the hospitals compliance on JCI standards

International Patient Safety Goals
The Purpose of International Patient Safety Goals is to Promote specific improvements in patient safety

Goal 1: Identify Patients Correctly
Use two identifier’s other than room number

Goal 2: Improve Effective Communication
Use read back policy for verbal order and laboratory test result obtained on the phone.

Goal 3: Improve the Safety of High-alert medications
Eg., Inj. Potassium Chloride, Inj. Sodium Chloride more than 0.9%, Inj. Phosphate.
Concentrated electrolytes are not to be stored in patient ward but stored only in the IP Pharmacy.

Goal 4: Ensure Correct Site, Correct-Procedure, Correct Patient Surgery
Follow pre-surgical site marking, pre-operative checklist and time out.

Goal 5: Reduce the Risk of Health Care Associated infections
Follow the hand hygiene guidelines.

Goal 6: Reduce the Risk of Patient Harm Resulting from falls.
Safety first program

ACCESS TO CARE AND CONTINUITY OF CARE
Information about the hospital provided to the patients in patient guide book.

Removal of Barriers to care:
Language: A list of interpreters is available in all nursing stations. Physical Wheelchair / stretchers are readily available at the entrance. Lifts are available for all floors. Religious Prayer Rooms are available. Spiritual services are provided when asked for. Culturally different types of food are available. Patient’s needs to observe auspicious times for any procedures are honored.

Patient Identifiers
Use at least two patients identifiers (not to be 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 UHID</td>
<td>Name UHID</td>
<td>Unknown 1/2/3 UHID</td>
</tr>
</tbody>
</table>
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. The discharge summary contains reason for admission, diagnoses and comorbidities.
2. The discharge summary contains significant physical and other findings.
3. The discharge summary contains diagnostic and therapeutic procedures performed.
4. The discharge summary contains significant medications, including discharge medications.
5. The discharge summary contains the patient’s condition/status at the time of discharge.
6. The discharge summary contains follow-up instructions.

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)

Patient and Family Rights
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 medical care
• Information on identity of the staff taking care of them
• A second opinion
• Dignity
• Confidentiality
• Privacy
• Informed consent
• Access to medical information

Patient Responsibility
Following are the responsibilities of patients:
• 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 of their 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 smoking, noise and number of visitors.
• Accept financial responsibility for healthcare received and settle bills promptly.
Assessment of Patient

- 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 patients and the diettician sees all cases.
- Discharge planning is initiated at the time of admission.
- All patients are assessed for pain at the time of admission and in every nursing shift.

Care of Patient

Who is a vulnerable patient?
- A child below 16 years of age
- Adolescents
- Frail > 65 years
- Terminally ill
- Patients with intense or chronic pain
- Women in labor
- Women experiencing terminations in pregnancy
- Patients with emotional or psychiatric disorders
- Patients suspected of drug and/or alcohol dependency
- Victims of abuse and neglect
- Patients with infectious or communicable diseases
- Patients receiving chemo or radiation therapy
- Patients whose immune systems are compromised
- Patients on dialysis
- Patients on restraint
- Patients on life support (Comatose)

For vulnerable patient, prevention of falls is the most important precaution to be taken. The doctor identifies a vulnerable patient through a tick mark against “Safety First” in “Request For Admission” Form.

What special care is given to a vulnerable patient?

For children, there is a different history and physical examination form. Side rails are always put up on the beds of vulnerable patients. “Safety First” program is followed. A yellow “Safety First” tag is placed at the head end of their bed. ‘Plan of Care’ form is added to the medical record. Frequent assessments are done by doctor and nurses. All this is documented in the patients’ file. Like all other patients, an incident form is filled in case of something untoward happening with such a patient.

Pain Management

Assessment and reassessment of pain is documented in the initial and follow up notes. Patient and the family are educated on pain.

Pain rating scale is used for assessment of pain.

End of life Issues

- Assessment and reassessment of dying patients on disease and secondary to treatment recorded.
- Manage dying patient’s pain effectively.
- Patients are educated about pain-managed effectively.
- It is an extremely important aspect of care, assess family for psychological, spiritual and bereavement support and document this at least once.
- Care givers respite needs are also taken care of.
- Dying patients are given comfort and dignity.
DNR
Never use the word DNR. “Do not Resuscitate” (DNR) Orders are not legal.
For brain dead patient fill the “End of Life Form”

Restraint Order
Restraint order form has to be filled which is valid for 24 hours only. Document the need for restraint (restraint order) prior to applying restraint a person.

High Risk Patients and Services
Extra caution should be practiced in providing high risk services and for high risk patients, according to laid policies

- Policies and Procedure for care of emergency patients
- Policies and Procedure for care of ICU patients
- Policies and Procedure for resuscitation services and followed through-out hospital
- Policies and Procedure for blood and documented blood related products
- Policies for patients on life support
- Policies for care of dialysis patients
- Policies for use of restraint and care of patients on restraint
- Policies for care of vulnerable elderly patients and children
- Policies for care of patients undergoing moderate and deep sedation

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 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

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 arrows in all cases, where we need to denote laterality, digit or level.

Medication Management and Use Medication Policy
We have a medication policy in place to reduce medication errors.
Appropriate selection of medication for prescription is available-drug formulary.
24 hours pharmacy services are available.
Emergency medicines are available and stored.
1. Medication orders are to be written clearly in the drug chart.
2. Start and discontinuation order of any drug has to be signed, dated and timed.
3. Any wrong entry has to be crossed out with a single line and signed error.
4. Effect of medication is to be documented in the progress notes.
5. Medications are administrated at standard times other than stat orders.

6. Self medication and medication from outside are not encouraged in the hospital.
8. Label all open in use vials and pre-filled syringes.
9. All medication error to be reported.
10. All ADR need to be reported in ADR form for clinical audit.
11. All orders (including diet and nursing stands cancelled when patient under go surgery or is transferred out of ICU’s. All order including dietary order, need to be written a fresh in the situation.

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 purpose
7. Right documentation
Patient and Family Education

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.
Quality Improvement and Patient Safety
Organizational Quality Monitors:

Clinical monitors:
- Patient assessment
- Lab safety and quality control programs
- Radiology quality control programs
- Surgical procedures
- Use of anesthesia & sedation
- Use of blood and blood products
- Availability, content and use of patient records
- Use of antibiotic & other medication
- Monitoring of medication errors & near misses
- Infection control, surveillance and reporting

Managerial Monitors:
- Procurement and supply
- Patient satisfaction
- Reporting as per law and regulation
- Biomedical waste management
- Utilization management
- Needle stick injuries
- Staff satisfaction
- Risk management
- Patient demographics & clinical diagnosis
- Financial management

Quality indicators
A few of the quality indicators used as clinical monitors include:
1. Patient falls
2. Medication errors
3. Healthcare associated infections
4. Unplanned return to OT
5. Recovery room delays

Near Miss Events
A near miss is defined as any process variation which did not affect the outcome but for which a recurrence carries a significant chance of a serious adverse outcome. E.g. a post operative patient slips in the bathroom but is immediately supported by the accompanying nurse, preventing a fall.

Sentinel Events
An unanticipated occurrence involving death and/or major permanent loss of function.
Prevention and control of infections

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

Everyone can prevent infection and all of us need to be equally concerned with infection control in the hospital.

Wash hands before and after patient contact, before eating, after visiting toilet and even after touching inanimate objects like files, equipments etc.

An infection control committee has been constituted, which serves as an advisory body. An infection control manual has been compiled and is available with members of the infection control committee & at all nursing stations.
The hospital has identified procedures associated with risk of infection and has strategies to reduce infection risk:

1. **Hand Washing**
   Hand washing is the single most important factor for Infection Control. Wash hands before/after patient contact and use of toilets. Follow “Standard precautions” in the hospital.

**Hand Hygiene Technique with Alcohol-Based Formulation**

- **Duration of the entire procedure:** 20-30 seconds

1. Rub hands palm to palm;

2. Right palm over left dorsum with interlaced fingers and vice versa;

3. Palm to palm with fingers interlaced;

4. Backs of fingers to opposing palms with fingers interlocked;

5. Rotational rubbing of left thumb clasped in right palm and vice versa;

6. Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;

7. Once dry, your hands are safe.
Hand Hygiene Technique with Soap and Water

**Duration of the entire procedure:** 40-60 seconds

1. Wet hands with water;
2. Apply enough soap to cover all hand surfaces;
3. Rub hands palm to palm;
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.

2. Isolation of Patients with Communicable Disease

3. Personal Protective Equipments (PPE)

4. Waste Disposal
   Segregation of waste at source is very important and waste disposal should be done in correct color bags as per hospital policy

5. Disposal of Sharps and Needles.
   Sharp Containers
6. Biomedical Waste

**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

- **Plastics**
  - Catheter, Tubings, Cannules 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 Bloods/ Blood Products Vaccines

- **Human Tissues**
  - Human Tissues, Organs, Body part, Items Containing Blood and Body Fluid (Cotton), Solid Dressing, Solid Plaster Casts, Beddings, Discarded Medicine, Discarded Catatonic Drugs

7. Handling soiled linens
Any linen visibly soiled with blood any body fluid of a patient is to be treated as soiled. At the laundry, there is a special procedure for cleaning and disinfecting of soiled & infected linen, before sending it back to the floors.

8. Scrub policy
Avoid wearing scrubs outside restricted areas. Wear a long coat over the scrubs if you have to go out of restricted areas.

9. Handling contaminated files
If blood & body fluid is spilled onto a file, that file is to be treated as contaminated and following instructions to be done:
- Place the file in a plastic impervious yellow bag.
- Fill up an incident form.
- The nurse shall send the file to MRD where it will be photocopied, attested and that copy of the file will be sent back to the floor.

10. Kitchen
Food sanitation and handling.

11. Mortuary area

12. Engineering control
Negative pressure systems, biological hood in lab etc
Facility Management and Safety
The management and safety of the hospital facilities is an important part of quality improvement and patient safety. A safety committee has been constituted to act as an advisory body. The safety committee conducts extensive safety rounds of the facilities and offer suggestions for improvement.

A safety manual (also called the RED BOOK) has been compiled by the safety committee, which gives information on staff response to hazardous situation.

Disaster plans have also been formulated, and gives information on staff response to various “code” situations, part of which is also included in the safety manual.
Mock drills for external & internal disasters are conducted.
A policy for hazardous materials has been formulated, and must be strictly followed by all staff members.

The basic responsibilities of the staff are:
1. Handling hazardous material spills (mercury spills, formalin and cidex spill)
2. Fire safety
3. Smoking control policy

Personal Protective Equipments (PPE)
You should know that each floor has one complete set of PPE for your use in case of need. It includes gloves, goggles, face mask, apron, gumboots to use & replace.

Formalin, Cidex and other Hazardous Material Spill
Minor spills: \(<or=30cc\)
1. Place tissue paper over the spills.
2. Wear PPE
3. Place this tissue paper in the black plastic bag
4. Place this bag in another black plastic bag, and label it as “............... ” Spill.
5. Ask housekeeping to mop the area and dispose off the plastic bag.
6. Fill up the incident form

Major Spill > 30cc
1. Place tissue paper over the spill
2. Place inverted trash can over the spill
3. Inform HAZMAT team to clean up (2200)
4. Fill up Incident Form

Mercury Spill
1. All Mercury Spills are major spills.
2. They are caused by BP apparatus / thermometer break.
3. Place tissue paper over the spill.
4. Place inverted trash can over the mercury.
5. Inform HAZMAT team to clean up (call 2200)
6. Fill an Incident Form.

Material Safety Data Sheet (MSDS) - List the nature, safe use and precautions while handling hazardous Materials.
SMOKING POLICY
Hospital is a “NO SMOKING ZONE”

Fire Safety
In case of fire, Call 4400 and Remember RACE
R: Rescue
A: Alarm
C: Confine the fire
E: Extinguish or evacuate.

To use fire extinguisher Follows PASS

<table>
<thead>
<tr>
<th>P</th>
<th>A</th>
<th>S</th>
<th>S</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pull</td>
<td>Aim</td>
<td>Squeeze</td>
<td>Sweep</td>
</tr>
</tbody>
</table>

TIMELINES
Nursing Assessment: Within 24 hours
Restraint Form Validity: Within 24 hours
Restraint monitoring: Every 02 hours
Validity of Blood / Dialysis Consent Form: 30 Days
IDDR Rounds: Within 48 hours
Nutrition Assessment: Within 24 Hours
Physiotherapy Assessment: Within 24 hours

Do’s
1. Maintaining confidentiality of information pertaining to a patient. Confidentiality is a patient’s right.
2. All staff members are required to sign a “Confidentiality Agreement” Whereby they pledge to abide by the hospital policy on management of information.
3. Doctor to Doctor Communication: Read back and verify telephone orders and (limited) verbal orders.
4. Nurses and doctors to read back and verify critical test results.
5. Take Informed consents.

Don’ts
1. Do not disclose information about the patient to anyone except the patient or a person approved by the patient.
2. Do not discuss about patient in the lift. If identifiable information is being discussed, it can be a violation of confidentiality.
3. Nurses shall not take verbal medication orders from doctors except in an emergency.
4. Doctor to doctor verbal order however is allowed, with read back policy.

MANAGEMENT OF INFORMATION AND COMMUNICATION

- Safety Manual
- Red book
- ICU Manual
- Blue book
- Infection Control Manual
- Green book
- Radiation Safety
- Yellow book

- Nurses to be Conversant with Nurses Manual.
- Senior Medical Staff to be conversant with Medical Staff Bylaws and Code of Ethics.
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: “units”</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>1 mg</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>.5 mg</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., Q.D., 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>MgSO4, MSO4, 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 IU (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>

Emergency Codes:
- CODE BLUE (Cardiac Arrest) : 7700
- CODE ORANGE (Medical Emergency Team) : 6600
- CODE RED (External Disaster) : 8800
- CODE PINK (Child Abduction) : 5500
- CODE GRAY (Internal Disaster) : 3300
- CODE BROWN (Fire) : 4400
- CODE YELLOW (Poly Trauma) : 8811

CODE PURPLE (Patient Missing) : 4466
CODE GOLD (Bomb Threat) : 4455

HAZMAT (Hazardous Material) : 2200
THERE IS NO ER CODE FOR HAZMAT BUT IT IS AN IMPORTANT EXTENSION 2200, TO CALL HAZMAT TEAM, IN CASE OF SPILL EVENT

Simplified Adult BLS Algorithm

1. Unresponsive
   - No breathing or no normal breathing (only gasping)
2. Get defibrillator
3. Activate emergency response
4. Start CPR
5. Check rhythm/ shock if indicated
6. Repeat every 2 minutes