PATIENT SAFETY GUIDELINE FOR HEALTH CARE PROFESSIONAL

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FORWARD

The second edition of the Patient Safety Guideline is the foundation of good patient care. The first edition was prepared in 2013. The safety is a touchstone and guidance to the care that is provided to the patient.

There are evidences that, while health care bring enormous benefit to us, errors are common and patients are frequently harmed.

This guideline is prepared to improve the patient safety practices in the health care settings as safety is critically important for both patients and health care professionals. This will ensure patient safety during the process of care and maintain patient centered care in every aspect of intervention in the healthcare settings.

This guideline includes the addition of Safe Clinical Blood Transfusion. This guideline will provide health professionals with knowledge that will assist in providing good care.

(Dr. Pandup Tshering)
Director General

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INTRODUCTION

The safety of patients and health care service has become a global concern. In the UK, for instance, one incident of patient harm is reported every 35 seconds (WHO, 2017). In the developing countries, factors such as overcrowding, shortage of equipment and supplies, shortage of staff, poor hygiene and sanitation, disinterested leadership and flawed process of care have contributed to unsafe patient care.

Realizing that patient safety is one of the key indicators of quality of care, several strategies such as capacity building, awareness, policy development and procedural changes have been implemented since then. However, there are still a lot to be done in the area of patient safety. Therefore, it is of paramount importance to continue with patient safety practices in the health care settings. Safety practices entails providing optimum level of infection control, prevention of medical error, surgical safety, equipment and the environmental safety in the hospital that transcend from the time patients are admitted until their discharge. The demand for such care has increased by many folds due to emerging and re-emerging diseases, addition of newer medical problems and increased patient awareness. This manual has been updated to keep abreast of these developing events, strengthen the existing services and to provide quality care.

Purpose

The purpose of this guideline is to:

- Ensure patient safety
- Provide patient satisfaction
- Minimize human errors
- Improve standard of care
- Provide cost effective care

1. PATIENT IDENTIFICATION

The goal

For correct identification of the patient during the process of medical treatment and care

Rationale

1. To reliably identify the individual as the person for whom the service or treatment is intended

Process

1. Involve patients in the process of patient identification.
2. For all registration, hospital registration number should be tagged with CID details
3. Use at least three patient identifiers including registration number/CID number in all the process of diagnosis and treatment
4. Label containers used for blood and other specimens after cross checking with patient's file and patient's identification.
5. Provide clear protocols for identifying patients who lack identification and for distinguishing the identity of patients with the same name. Non-verbal approaches for identifying comatose or confused patients should be developed and used.
6. Provide wristbands for all patients going for any procedures and for all mothers and babies for deliveries and babies admitted at NICU.
7. Babies without CID, hospital registration number should be tagged with mother's CID.

2. SAFE MEDICATION

1. Rationale

1.1. To prevent and reduce medication error

1.2. To ensure the five rights of the medication

1.3. To ensure proper documentations.

2. Process

2.1. Use labeled medication tray.

2.2. Qualified health professional should prepare and administer drugs.

2.3. Administration of medication at the designated area by following:

Right patient: Check patient's ID for name, age, sex and registration number before drug administration. Check for any history of drug allergy from patient's file or from patient/attendant. Reconfirm the medication with the prescribers.

Right drug: Check patient's ID for name, age and Reg. No. before drug administration. Recheck patient's medications as per the prescription.

Right dose: Calculate the required dose of drug as prescribed for the patient.

Right route: Inform patient about drug administration and check the route for administration (Intravenous/Oral and Intramuscular). Ask if he/she had meals (For empty stomach medications)

Right time: Administer medication at the specific time without delay. Reconstitute the medication as per manufacturers' recommendations.

Right Health education: Educate the patient and party regarding the indications, Side effects and contraindications of medications and reporting if any.

Document- Sample signature

2.4. Any prefilled syringe of drug should be labeled.

2.5. Drugs once reconstituted should be used within 24 hrs or as per manufacturer's instructions.

2.6. Proper disposal of unused opened medication should be done as per the medical waste management guidelines.
2.7. The unused narcotic should be immediately disposed off in presence of a witness
(Second health professional) and documented in the narcotic consumption/controlled drug (CD) register.
2.8. All the medication brought from home by the patient should be monitored by the health professional if he is self-administering a drug during the hospital stay.
2.9. Chemotherapy drugs should be prepared by trained staff after wearing complete personal protective equipment (PPE)
2.10. Drug administration should be documented and signed.
2.11. Resuscitation tray with drugs and equipment must be kept ready
2.12. Monitor Adverse Drug Reactions (ADR) (self-reporting of ADR by the health professionals or even the patients should be encouraged)
2.13. Monitor medication errors (self-reporting should be encouraged. Staff involved should be counseled and not punished)
2.15. Adhere to drug preparation and administration checklist.

DRUG PREPARATION & ADMINISTRATION CHECKLIST

Ward/Unit: ______________________ Month: ________________________

	Date	
Sl.No	**Drug Preparation**	**Y/N**
1	Wash hands/use hand rub before drug preparation.	
2	Prepare drugs in designated area.	
3	Calculate the required dose of drug as prescribed	
4	Double check the dose by second nurse for high alert medications (sedatives, chemotherapy, concentrated electrolytes) and narcotic drugs.	
5	Prepared drugs are labeled clearly for patient identification, name and strength of drug, time and date of preparation.	
	Drug Administration	
1	Check patient's ID for name and age and Reg. No. before drug administration.	
2	Check patient's medicines for right drug, dose, route, time and patient.	
3	Reconfirm any history of drug allergy from patient's file or from patient/attendant.	
4	Inform patient about drug administration.	
5	Asks if he/she had meals (For empty stomach medications)	
6	Documents administration at bed side	
7	Monitor patient for any adverse drug reaction after drug administration.	
8	Any incidence of ADR is documented and reported to clinical pharmacist.	

Audited By: Name________________________ Signature_________- Date__________

2.16. Observe, Document and Report adverse reactions immediately- Monitor patient for any adverse effect especially after drug administration. Any incidence of Adverse Drug Reactions should be documented and reported to clinical pharmacist.

ADVERSE DRUG REACTION REPORTING FORM

If you are suspicious that an adverse reaction may be related to drug or a combination of drugs, PLEASE COMPLETE THIS FORM and send it to the nearest Pharmacovigilance Centre/Drug Regulatory Authority.

A: PATIENT INFORMATION

1.Patient Details Patient name or registration no:--- -Age/Sex: Weight (if Known)---Ward/Dept/Unit
2. Relevant Tests/Laboratory Data (If any):
3. Other Relevant Information(Including Pre-existing medical conditions viz. allergies, pregnancy, alcohol use, renal dysfunction, diabetes etc):

B. Suspected drug(s)

Drug Name (both brand & generic)	Batch no. & Exp. date	Strength	Route	Dose	Date started	Date Stopped

C. Suspected Drug Reaction (s)

Please describe the reaction & any treatment given	Date reaction started:-------------------- Date reaction stopped:------------------- Outcome: ☐ Recovered ☐ Recovering ☐ Continuing ☐ Others(specify)

Do you consider the reaction to be serious? Yes No

If yes, please indicate the reaction is considered to be serious (tick all that is appropriate)

- ☐ Patient died due to reaction
- ☐ Prolonged hospitalization
- ☐ Life threatening
- ☐ Involved persistent or significant disability
- ☐ Medically significant, give details:

____

D. OTHER MEDICATIONS (INCLUDING SELF-MEDICATION, HERBAL AND TRADITIONAL MEDICINES)

DID THE PATIENT TAKE ANY OTHER MEDICINES PRIOR TO THIS REACTION: YES ☐ NO ☐

DRUG NAME (Both Generic and Brand)	Dosages	Route	Date Started	Date Stopped

E. Reporter details:

Name_____________________________

Designation____

Name of ward/dept/unit____

Signature: ____

Send this form to National Pharmacovigilance (DRA), Telephn:33707, Fax:335803, email:ndem@dra.gov.bt or to the nearest Regional Pharmacovigilance centre. Thank you for taking the time to fill in this report

FOR OFFICIAL USE BY DRA:

Date of receipt of the report_____________________ Receive by:__________________

Report ID NO.____________________________ Product MAH:

Action taken:

'

3. SAFE CLINICAL BLOOD TRANSFUSION

Goal: Ensure Safe Blood Transfusion

Rationale: To prevent and reduce errors and reactions during clinical blood transfusion

Process

1. Collect pre-transfusion blood sample for blood grouping and cross matching using standard procedures.
2. Carry out standard pre-transfusion patient identification and obtain baseline vital signs for blood transfusion.
3. Follow standard process of documenting blood requisition form for issuance of required blood unit.
4. Follow standard procedure for collection and transportation of the blood/blood components.
5. Verify that the right blood is issued for the right patient from the blood bank.
6. Get written consent for blood transfusion after informing the patient/guardian on the benefits and risks associated with blood transfusion.
7. Follow standard procedure for administration of blood and blood components.
8. Follow standard process of monitoring patient during blood transfusion.
9. Recognize signs and symptoms of acute blood transfusion adverse reaction and follow immediate nursing intervention.
10. Follow standard procedure for reporting errors and reactions during clinical blood transfusion.
11. Maintain standard process of documentation during blood transfusion.

Attachments

1. Blood Request Form.
2. Documentation Form
3. Reaction Form
4. Checklist
5. Blood Report Form

4. SURGICAL SAFETY AND SURGICAL SAFTETY CHECK LIST (SSCL)

PURPOSE

Standardization of process with the aid of checklist, to be able to assess, interpret and prevent potentially adverse event from occurring in the surgical procedure.

SCOPE

Surgical safety is applicable to all the healthcare delivery facilities where the patient undergoes surgical procedures or postsurgical care. Safety during surgery is the responsibility of all healthcare workers providing services to the surgical patients.

DEFINITION

Checklist coordinator: Nurse involved in the patient's surgery (Circulating nurse) who will check the entire requirement that need to be completed.

Safe surgery: This term may be used keeping in mind the whole surgical process. This includes preoperative identification of the patient, site and side to be operated, the surgeon, surgical technique, type of surgery planned and performed, type of sample sent for histopathology, counts of surgical instruments, mops, gauze pieces and needles.

Sign-In: Before the induction of anesthesia.

Time-Out: Before making the surgical incision

Sign-Out: Before transferring the patient out of the operation theater.

PROCESS

Ten essentials of safe surgery suggested by WHO safe surgery guidelines (WHO SSG)

In order to minimize unnecessary loss of life and serious complications, operating teams have 10 basic, essential objectives in any surgical case.

1. The team will operate on the correct patient at the correct site.
2. The team will use methods known to prevent harm from administration of anesthetics, while protecting the patient from pain.
3. The team will recognize and effectively prepare for life threatening loss of airway or respiratory function.

4. The team will recognize and effectively prepare for risk of high blood loss.
5. The team will avoid inducing an allergic or adverse drug reaction for which the patient is known to be at significant risk.
6. The team will consistently use methods known to minimize the risk for surgical site infection.
7. The team will prevent inadvertent retention of instruments and sponges in surgical wounds.
8. The team will secure and accurately identify all surgical specimens.
9. The team will effectively communicate and exchange critical information for the safe conduct of the operation.
10. Hospitals and public health systems will establish routine surveillance of surgical capacity, volume and results.

Name of the Health Center:..

(Surgical Safety Checklist)

Patient Name: ……………………Age/sex………..Reg. No /CID. ……………………......

Department ……………….OR. No.......………

Proposed procedure: ………………………………………………………………………………………

SIGN IN: Before induction of anesthesia (Anesthetist, Surgeon, Nurses)		**Tick**	**TIME OUT: Before skin incision (Anesthetist, Surgeon, Nurses)**	**SIGNOUT: Before patient leaves operating Room (Anesthetist, Surgeon, Nurses)**	
Tick	PATIENT HAS CONFIRMED		SURGICAL TEAM READY: *SURGEON/S, ANESTHETIST/S , NURSES AND TECHNICIANS*	**Tick**	THE NAME OF THE PROCEDURE RECORDED
	SITE		YES		**THAT INSTRUMENTS:** SPONGE AND NEEDLE COUNTS ARE CORRECT (NOT APPLICABLE)
	PROCEDURE		NO		SPECIMEN LABLED WITH PATIENT NAME AGE/SEX, REG.NO., ID/NO., AND RECORDED IN HPE BOOK
	CONSENT		SITE		ANY EQUIPMENTS PROBLEMS TO BE ADRESSED AT THE END OF THE PROCEDURE?
	SITE MARKED/NOT APPLICABLE		DIAGNOSIS		ANY ADVERSE EVENTS THAT REQUIRES REPORTING
	ANESTHESIA TEAM READY		PROCEDURE		NO

DOES PATIENT HAVE A:			**NURSING TEAM REVIEW**: STERLITY, EQUIPMENTS ISSUES OR ANY OTHER CONCERNS?		YES *(PLEASE FILL UP INCIDENT REPORTING FORM AND SUBMIT TO CONCERNED AUTHORITY)*
Tick	KNOWN ALLERGY?	**TICK**	HAS ANTIBIOTIC PROPHYLAXIS GIVEN WITHIN THE LAST 60 MINUTES?	**REMARKS**	
	NO		YES		
	YES		NOT APPLICABLE		
Tick	DIFFICULT AIRWAY/ASPIRATIO N	**TICK**	IS ESSENTIAL IMAGING DISPLAYED?		
	NO		YES		
	YES, AND EQUIPMENT/ASSISTA NCE AVAILABLE		NOT APPLICABLE	**NAME AND SIGNATURE**	
Tick	IS BLOOD REQUIRED	**TICK**	**ANESTHETIST/ SURGEON/NURSE**	ANESTHETIST	
	NO		AGREED TIME OUT	SURGEON:	
	YES		REFUSED TIME OUT	CIRCULATING NURSE:	

5. PREVENTION OF PRESSURE ULCER

Goal

1. To prevent, manage and reduce incidence of pressure ulcer

Rationale

1. To identify the patients at risk of developing pressure ulcer
2. To prevent the development of pressure ulcer.
3. To monitor and evaluate incidences of pressure ulcer.
4. To prevent or delay complications associated with pressure ulcer.

Process

1. Assess patient during admission for **High Risk group** using Norton Scoring System and subsequently on daily basis.
2. Provide pressure sore preventive aids (air mattress, commode chair and cushion/padding if available) for high risk group, and use position changing chart to record the position changed with date and time.
3. Communicate and educate patient/ family on prevention and care of pressure ulcer
4. Teach and demonstrate to the family/attendant on rationale behind the need for 2 hourly positions change.
5. Assess the nutritional status and identify any special requirement and inform hospital dietitian accordingly.
6. Ensure that communication between multi-disciplinary team (physician, dietitian and physiotherapist), patient and family are effective to facilitate continuity of preventive care.
7. If pressure ulcer already developed depending on stage follow Standard Procedure for ulcer management

NORTON SCORE FOR PRESSURE SORE

Instruction for use

1. Identify the most appropriate description of the patients (4, 3, 2, and 1) under each of the five headings (A to E) and total the result.
2. Record the 'Score' with its' date and time in the patients' notes or on a chart.
3. Assess daily or whenever any change in the patients' condition

A 'score' of 14 and below denotes need for intensive care. i.e. 2 hourly changing of posture and use of pressure-relieving aids

NOTE: When edema of the sacral area had been present, a rise of score above 14 does not indicate less risk of a lesion.

Scoring System

Key: A+B+ C+D+E………………………… (Total score of 14 and below = At Risk)

A Physical condition	B Mental condition	C Activity	D Mobility	E Incontinent
Good – 4	Alert - 4	Ambulant – 4	Full - 4	Not- 4
Fair – 3	Apathetic – 3	Walk/help – 3	Slightly limited - 3	Occasionally-3
Poor – 2	Confused – 2	Chair bound - 2	Very limited- 2	Usually/urine-2
Very Bad-1	Stuporous -1	Bedfast – 1	Immobile -1	Doubly-1

The pressure Score Risk calculator (Nursing Times, 1979), based on the Norton Scoring System

Pressure Ulcer Prevention & Management Chart : Changing Position

JDWNRH, Thimphu Bhutan

Name____________________ **DOB/ Sex**____________________ **Ward**____________

Medical Dignosis____________________ **Nortem Score**________ **Date of Admission/Trans in :**__________

Tick If Patient is with Pressure Ulcer. Developed From Home ( ) Ward ( ) Trans in ( ) Other Hospital ( )

Name of the Trans in Ward________________ **or Other Hospital** ____________________

Date/Time	9 AM (LL)	11 AM (S)	1 PM (RL)	Pressure Ulcer	3 PM (S)	5 PM (LL)	7 PM (S)	Pressure Ulcer	9 PM (RL)	1AM (S)	5 AM (RL)	Pressure Ulcer
				Site (s):				Site (s):				Site (s):
				Grade (s):				Grade (s):				Grade (s):
				Site (s):				Site (s):				Site (s):
				Grade (s):				Grade (s):				Grade (s):
				Site (s):				Site (s):				Site (s):
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				Grade (s):				Grade (s):				Grade (s):
				Site (s):				Site (s):				Site (s):
				Grade (s):				Grade (s):				Grade (s):

LL: Left Lateral, S: Supine, RL: Right Lateral Position

6. PATIENT FALL PREVENTION PROTOCOL

6.1. Goal

6.1.1. To prevent fall while they are in the hospital.

6.2. Rationale

6.2.1. To identify patients at risk of falling
6.2.2. To reduce incidences of falls
6.2.3. To provide prompt interventions

6.3. Process

6.3.1. Orient patient and care providers to surroundings
6.3.2. Identify at risk patients and educate accordingly
6.3.3. Ensure safety attendant
6.3.4. Do safety round for at risk patients in inpatient department
6.3.5. Conduct fall assessment for all the trans-in and new admission patient
6.3.6 Fall risk assessment should be done whenever there is change in the health status of the patient
6.3.7 All the transfer trolley should have side railing to prevent fall patient score for risk of fall shall be conveyed during intra hospital transfer for at risk patients at the time of handing taking over
6.3.8 Assist in providing physical or chemical restraint as per physician advice for restless/ aggressive patients
6.3.9 Encourage all ambulatory patients to use skid proof footwear
6.3.10 Maintain clean walking surfaces
6.3.11 Use wet floor signs
6.3.12 Use bed rails for at risk patients
6.3.13 Place ambulatory assistive devices within easy reach for the required patients
6.3.14 All personnel will be responsible for eliminating environmental hazards
6.3.15 Ensure clutter-free, well-lit environment
6.3.16 Maintains close observation of at risk patient at all times
6.3.17 incident of fall should be reported for corrective and preventive measure

Nursing fall risk assessment, diagnoses and interventions are based on use of the Morse Fall Scale (MFS) (Morse, 1997). MFS subscales include assessment of:

Morse Fall Risk Assessment		
Risk Factor	**Scale**	**Score**
1. History of falling; immediate or within 3 months	No	0
	Yes	25
2. Secondary diagnosis	No	0
	Yes	15
3. Ambulatory aid	None, bed rest, wheel chair, nurse	0
	Crutches, cane, walker	15
	Furniture	30
4. IV/Heparin Lock	No	0
	Yes	20
5. Gait/Transferring	Normal, bed rest, immobile	0
	Weak	10
	Impaired	20
6. Mental status	Oriented to own ability	0
	Forgets limitations	15

Risk Level	**MFS Score**	**Action**
Low Risk	0 – 24	None
Moderate Risk	25-45	Refer SOP
High Risk	45 and Higher	Refer SOP

7. SAFE PATIENT HAND OVER AND CHECKLIST

Rationale:

1.To transfer the professional responsibility and accountability of care of patients or group of patients to another person or group during change of shift within the ward or transfer of patient to another ward.

1. To achieve efficient and effective communication of clinical information when the patient care is transferred for continuity of care.

Process:

1. All the staff on duty should be involved for the handing taking of patients in the ward during shift change.
2. Nurse to nurse handover during the transfer of patient to another ward.
3. All patients getting transferred to other unit should be escorted and handed over by the nurse on duty.
4. Handing and taking should take place at the bedside however personal and confidential matter should be handed over at the duty station.
5. Handing and taking should be done in a professional manner, supervised by the senior staff and relevant information should be conveyed through written and verbal modes.
6. Ensure that there is effective communication and coordination among individuals and departments responsible for providing care.
7. Spend sufficient time in providing information regarding the patient's status and documentation.
8. Handing and taking over session should include the following:
   - Patient's details
   - Presenting Complaints
   - Significant history(past medical history)
   - Medication and treatment plan
   - Pending investigation and reports, planned procedures and all relevant information.
   - Nursing care requiring prompt follow up(patient who are unstable or whose clinical status is deteriorating)
   - Any allergy to drugs, food and history of transfusion reaction.
9. In addition to above requirement, transfer of critically ill patients should be stabilized before any transfer and should be accompanied by a doctor/ competent nurse with all the emergency resuscitative equipment

CHECKLIST FOR PATIENT HANDING AND TAKING OVER : NURSE TO NURSE		YES	NO
1	**Patient Identification:** Name, Age, Sex, Bed. No		
2	Date and time of admission or transfer		
3	Admitting/Treating doctor		
4	Referred / Trans in case from		
5	Diagnosis and Past Medical History		
6	Number of hospitalized days/ post procedure days		
7	Pending investigation and report, planned procedures and all relevant information		
8	Vital signs, intake and output chart, physician order, blood transfusion		
9	Findings of Nursing Assessment (For Holistic Nursing care) • Systemic Assessment Findings • Daily Pain Assessment Score and Interventions • Daily Pressure Ulcer Scores and Interventions • Daily Fall Risk Scores and Interventions • Wound Assessment/New Development and Interventions • Medicines and Food Allergies and Interventions • Others____________________		
10	Nursing Diagnosis		
11	Ongoing Nursing Care Process (Nursing Interventions)		
12	Pending Nursing Care Plans		
13	Health Education Provided and Pending Health Educations		
14	Medication Information		
15	Intradepartmental consultations and special advice		
16	Lines and tubing, date of insertion and advice • IV line • Foley's catheter • Ryle's tube • Others____________________		
17	**Procedure/ Surgery** • Informed written consent form • Pre-op, post-op checklist • Investigation reports collected • Mental preparation • Part preparation (surgical sites) • NPO • Pre-medication • Any special advice/ any allergy to drugs and food. • Pre and post surgical patient education • Standby transfusion advice		
Let patient know your shift is over and someone else is taking over			

SAFE HANDING AND TAKING OF PATIENTS		**Process:**	**Rationale:** All the staff on duty should be involved for the handing taking of patients in the ward during shift change.
All patients getting transferred to other unit should be escorted and handed over by the nurse on duty.	Handing and taking should take place at the bedside however personal and confidential matter should be handed over at the duty station.	Handing and taking should be done in a professional manner, supervised by the senior staff and relevant information should be conveyed through written and verbal modes.	Ensure that there is effective communication and coordination among individuals and departments responsible for providing care.
Spend sufficient time in providing information regarding the patient's status and documentation.	Handing and taking over session should include the following:	Patient's details	Presenting Complaints
Significant history(past medical history)	Medication and treatment plan	Pending investigation and reports, planned procedures and all relevant information.	Nursing care requiring prompt follow up(patient who are unstable or whose clinical status is deteriorating)
Any allergy to drugs, food and history of transfusion reaction.	In addition to above requirement, transfer of critically ill patients should be stabilized before any transfer and should be accompanied by a doctor/ competent nurse with all the emergency resuscitative equipment.		

To achieve efficient and effective communication of clinical information when the patient care is transferred for continuity of care.	Process:	All the staff on duty should be involved for the handing taking of patients in the ward during shift change.	Nurse to nurse handover during the transfer of patient to another ward.

8. PATIENT SAFETY INCIDENT REPORTING

Goal:

To reinforce JDWNRH policy of Incident Reporting wherein incident occurred must be recorded, investigated and monitored in an attempt to identify trends, patterns and learn from them to prevent recurrence.
Or (choose either of two)

To maintain a safe environment by correcting situations that caused or could likely cause injury and to ensure that a similar or more serious incidents does not happen again.

Rationale

- To trigger a rapid response and to mitigate any harmful consequences of the incident.
- Alerts administration to the need for investigation and potential claim.
- Enables necessary correction to be implemented to prevent recurrences in future.
- Act quickly to change policy and procedures that appears to be the cause of the incident.
- Alert administration should any explanation or support is required by the patient/family.
- To create culture of quality improvement by collecting quality observations.

Process

Despite the best intentions of competent and caring professionals, many incidents result from an inadequate or complex system. There must be a no-blame culture and be supportive of staff to report incidents and near misses. A systems approach, rather than an individual approach will be taken in investigating incidents. Following step-wise incident procedures will be followed:

1. **Identification of incident:** Incident may be identified in number of ways: direct observation, team discussion, complaint and audit or chart review at the time of incident or any time after the incident. Person identifying the incident has to ensure that reporting occurs.

2. **Immediate Action:** after incident is identified, immediate action may be required to mitigate the harmful consequences of the incident.

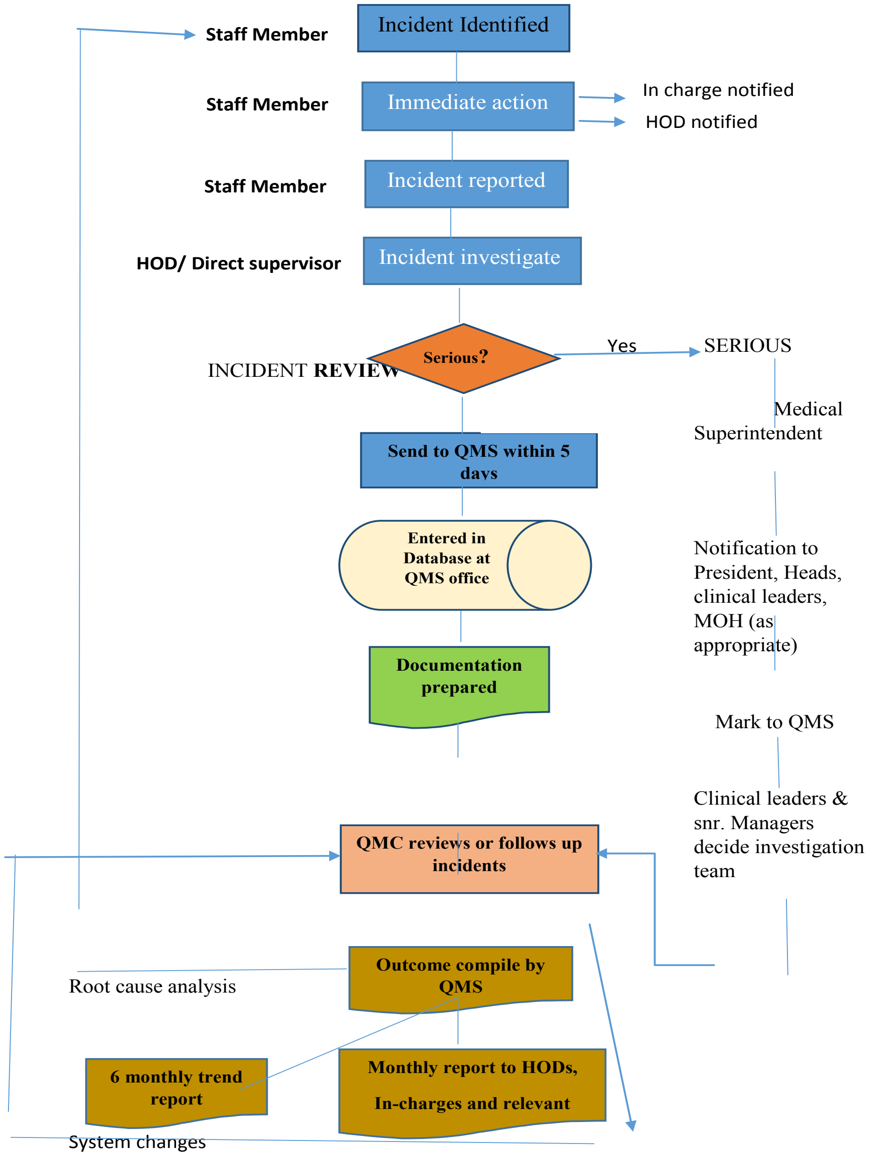
3. **Reporting and Notification:** Incident reporting shall occur within the same working day as it occurred or was identified. JDWNRH Incident Reporting Form will be completed by the staff person identifying the incident. Follow Incident Reporting policy and procedure guideline while completing the form. The incident form will be submitted to immediate supervisor (In-charge / Head of Department) responsible for acting on notification and notify Quality Management Services to record in the incident database.

4. **Investigation:** The immediate supervisor who receives incident report will complete the investigation of the event, document and report their findings within **five days** of the occurrence.

5. **Post investigation**: Serious cases are notified to Medical Superintendent (MS) with a copy of the filled incident form. MS will further notify to the President, clinical leaders as appropriate and QMS. MS and concerned clinical leaders will decide to form team for further investigation and root cause analysis. Less serious cases are directly sent to QMS. Incidents received from both MS and other departments will be recorded in the incident database, prepare the paper for review during the monthly QMC meeting by QMS.

6. **Review and Monitoring for System improvement:** Quality Management Committee will review and evaluate each incident and make recommendations on system improvement when indicated to ensure the ongoing quality of service provision. Where further action is recommended, this will be monitored by QMS until completed. The incident review outcomes document will be communicated with concerned staff/unit/department for timely feedback along with summary of monthly incidents outlining any relevant emerging issues, recommended actions for discussion and decision.

INCIDENT REPORTING PROCESS FLOW CHART	Procedure No. JDWNRH 06—01-001



Incident Report Form

Name of Reporting Person:	Location of Incident ☐ Ward ☐ OT ☐ ER ☐ Hospital campus ☐ Others ________________
Designation:	
Phone No.	
Date reported:	

Name of Person Involved:	Person involved (Tick as appropriate) ☐ Patient ☐ Patient Attendant ☐ Staff ☐ Visitor Others _________________
Address:	
Phone No:	
Hospital no. (if any):	
Date of incident: Time:	

Types of Incidents (Tick as appropriate)
☐ Fall (bed, chair, uneven surface, wet surface, fall while ambulating) ☐ Allegation of abuse/neglect (Physical, sexual, verbal, threat, argument) ☐ Accidental injury ☐ Missing or damaged property ☐ Exposure to blood or body fluid (needle stick, blood, saliva/spitting, urine/feces, open wound) ☐ Surgical event (wrong body part, wrong patient, wrong procedure on wrong patient, retained instrument in patient discovered after surgery/procedure) ☐ Treatment complications (medication errors and adverse medication reaction) requiring significant medical intervention ☐ Procedure error (lab tests, clerical, result reporting, safety) ☐ Contraband (weapon, illicit drugs) ☐ Fire or Environment Emergency ☐ Others (suicide death, suicide attempt, homicide) _____________________________

Summary of incident (be specific, precise and detailed possible) use additional sheet if required   Findings of Internal Investigation   Corrective Actions

Notification ☐ Notified supervisor ☐ Taken/consulted to Physicians ☐ Notified Police ☐ Notified Parents or Next of Kin ☐ Staff debriefing/training ☐ Reported to QMS ____________________(Date) ☐ Other (specify):	Signature of Reporter: Name & Signature of Supervisor:
Notify to: Quality Management Services at 330152 for record and further deliberations if required	

Quality Management Services Use only Date notified:______________________________ Entry in Database: ___________________________ Name & signature:

9. PREVENTION OF HOSPITAL ACQUIRED INFECTION (HAI)

9.1. Goal:

To minimize the risk and reduce the incidence of hospital acquired infection

9.2. Rationale:

1. To ensure compliance with infection Control Guidelines
2. To ensure compliance with evidence based practices on prevention of HAI

9.3. Process:

1. Reinforce and strengthen use of infection control and medical waste management guidelines
2. Provide adequate resources
3. Monitor strict compliance to infection control practices eg hand hygiene
4. All health professionals are responsible for infection prevention and control activities.
5. All health professionals are regularly updated with the current practices in infection control to prevent HAI.
6. Regularly monitor and evaluate hospital acquired infections
7. Implement evidence based practices to prevent central line associated bloodstream infections.(CLABSI), catheter-associated urinary tract infections (CAUTI) and Ventilator associated pneumonia (VAP)
8. Follow standard for safe Operation(OR) practice to minimize the incidence of SSI
9. Rational use of antibiotic for an infection as per existing Policies and guideline.
10. Incident reporting
11. Surveillance
12. Notify the outbreak to relevant multi stake holders

VAP bundles	**CLABSI bundles**	**CAUTI bundles**
Elevate head end at 30˚- 40˚	Hand hygiene	Hand hygiene
Daily sedation vacation	Optimal catheter site (Avoid femoral lines)	Avoid unnecessary urinary catheter
Daily assessment of readiness to extubate	Use of maximal barrier precaution, Hub cleaning	Insert urinary catheter using aseptic technique
Peptic ulcer disease (PUD) prophylaxis Oral care	Effective antiseptic skin preparation using 70% alcohol or 2% chlorexidine	Position of the Urobag should be lower than the pelvic region.
Deep vein thrombosis (DVT) prophylaxis	Transparent dressing	Review urinary catheter necessity daily and early removal.
-	Daily review of line site	Follow closed system
-	Early removal	Regular emptying of the drainage bag

10. CARE OF MEDICAL EQUIPMENT AND DEVICES

Goal:
To provide safe and reliable medical devices to the patients

Rationale

1. To ensure selection and purchase of high quality medical equipment and devices
2. To maintain the functionality , reliability and safety of medical equipment and devices
3. To prevent damage, reduce the cost of maintenance , increase durability and life span of medical equipment and devices
4. To increase awareness of incident that potentially involve harm to medical devices
5. To implement incident reporting system from medical equipment and devices error
6. To prevent disruption of regular services
7. To coordinate and maintain shared responsibilities among users, management, BES and manufacturer/vendor
8. To ensure medical equipment and devices are safely used for the patients

Process

1. Include safety standards and criteria during evaluation , selection and for accepting donated medical equipment
2. Medical equipment and devices are received and stored appropriately at organization sites
3. Plan and implements a program for quality inspection, testing and maintain related documents accordingly
4. Medical equipment and devices issued to units /wards are appropriate to meet the individual's need for care and services
5. The medical equipment and devices to be operated by skilled/trained/experienced users only
6. All medical equipment and devices to be operated as per the standard operating procedure/environment given by the manufacturer
7. Required to send the non functional medical equipment and devices to the Biomedical Engineering Section (BES) along with duly filled form provided by BES

8. Maintain medical equipment maintenance register in the wards and units to monitor safety and reliability of repaired medical equipment
9. Provides timely maintenance, replacement or backup equipment when appropriate in coordination with procurement and management
10. Provide 24 hours emergency services by BES during breakdown of medical equipment and devices
11. Provides regular hands on trainings on cleaning, handling, maintenance and operation of medical equipment to the users by the BES/vendor/manufacturers
12. Maintain and report incidents for corrective and preventive action(incident report form)
13. Develop SOP on handling, maintenance, cleaning, disinfection and sterilization of medical equipment and its parts and accessories by BES

REFERENCES

Guidance on the creation of **bundles** for prevention of surgical site infections.

Approaches for Preventing **Healthcare-Associated Infections**: **Healthcare-Associated Infections**

Healthcare associated infections and pathogens

Patient Safety Guidelines for the Healthcare Professional (2013). Ministry of Health

Infection Control and Medical Waste Management Guideline. Ministry of Health 2006