PC.18.1 The hospital implements the national clinical practice guidelines, pathways, and protocols that are consistent with current evidence- based practice.

PC.18.2 Clinical practice guidelines, pathways, and protocols are updated at least every two years and as required with emphasis on the most common diagnoses.

PC.18.3 Clinical practice guidelines, pathways, and protocols are documented in the patient's medical record.

Standard Intent:

The hospital should identify priority clinical care services or areas for whom standardization of care is critical, for example, management of patients presenting with chest pain, abdominal pain, stroke and etc. The use of practice guidelines, clinical protocols or pathways, that are evidence based, for those priority services enables staff to provide safe integrated patient care with the least available resources and time and ensures better outcomes. Such guidelines and protocols should be reviewed at least every 2 years to ensure its relevance and up to date status. The use of practice guidelines, pathways and protocols should be documented in the patients' files.

PC.19 The hospital ensures uniform patient care processes during invasive interventions.

PC.19.1 The hospital implements a policy for the assessment and management of patients undergoing invasive procedures.

PC.19.2 The policy defines all essential requirements that must be documented in the patient's medical record including, but are not limited to:

- PC.19.2.1 Date and time of the procedure.
- PC.19.2.2 Name, designation and signature of the physician performing the procedure and the names of all assistants.
- PC.19.2.3 Location of the procedure.
- PC.19.2.4 Nature and indication of the procedure.
- PC.19.2.5 Any anesthesia or analgesia used with dosage and type.
- PC.19.2.6 Patient monitoring.
- PC.19.2.7 Procedure outcome.
- PC.19.2.8 Complications
- PC.19.2.9 Laboratory specimens.
- PC.19.2.10 Specific post procedural orders.

PC.19.3 Invasive procedures are documented in the patient's medical record (or in an appropriate form) as per the policy.

Standard Intent:

Because invasive intervention carries a high level of risk, the hospital must develop a policy to guide the process from the planning till the end of the procedure, including

documentation of the procedure and monitoring the patient status including the elements mentioned in sub standards PC.19.2.1 through PC.19.2.10.

PC.20 Provision of care is continued, integrated, and coordinated.

PC.20.1 Information about the patient's care and response to treatment is shared between medical, nursing, and other care providers (e.g., patient rounds, multidisciplinary teams, case management for patients requiring complex care).

PC.20.2 The patient's medical record is available to the authorized care providers to facilitate the exchange of information.

PC.20.3 Information about patient care and progress is exchanged during change- of- shift reporting (handover), between shifts, and during transfers and referrals between healthcare providers.

Standard Intent:

Continuity of care is enhanced when all patient-care providers have the information needed from the patient's current and past medical experiences to help in decision making, and, when multiple decision makers are providing care, these decision makers agree on the care and services to be provided. The patient's record(s) is a primary source of information on the care process and the patient's progress and thus is an essential communication tool. For this information to be useful and to support the continuity of the patient's care, it needs to be available during inpatient care, for outpatient visits, and at other times as needed and kept up to date. Medical, nursing, and other patient care notes are available to all of the patient's health care practitioners who need them for the care of the patient. For patient care to appear seamless, the hospital needs to design and to implement processes for continuity and coordination of care among physicians, nurses, and other healthcare practitioners in all hospital settings.

PC.21 Physician orders are documented in a consistent location within the medical record.

PC.21.1 There is a physician's order form where physicians document all orders relating to the patient care.

PC.21.2 Only physicians are allowed to write in the physician order form (except for telephone and verbal orders).

PC.21.3 Physician orders include medications and non-medication orders.

PC.21.4 All orders are acknowledged by the nurse in charge of the patient, dated and timed.

Standard Intent:

Physician orders must be documented in the patient record. Such as orders for laboratory testing, administration of medications, specific nursing care instructions, type of nutrition therapy, need for rehabilitative therapy, and the like. Such orders are ordered by individuals qualified to do so. Such orders must be easily accessible if they are to be acted on in a timely manner. Locating orders on a physician order form.