Nepal Medical Council: GOOD CLINICAL PRACTICE – quality indicators (2079.03.15 BS)

1. **Informed consent**
   a. Informed consent must be in the language that is understandable by the patient and/or family as far as possible.
   b. Audio/video recording of the counseling is encouraged. However, audio/video records should not replace the written informed consent.
   c. The consent should document date, patient's demographic details, diagnosis, outline of procedure, all known risks and complications of the procedure, including the possibility of death if any.
   i. While it may not be necessary to write down the natural history of the untreated disease in the consent form, it is important to explain it to the patient and or the family.
   d. The consent should be signed by the patient himself or the next of kin available and must be countersigned by the treating doctor. Please mention your NMC number after the signature.
   i. If the patient cannot sign, you can get the patient's fingerprint.
   e. For other points of informed consent, please see " NMC code of ethics and professional conduct 2017"
2. **Hospital records**
   a) Patient's record should include date and time of admission, provisional diagnosis, final diagnosis, history and clinical exam findings, procedure notes, if any, progress notes on a daily basis.
   b) Discharge summary should reflect a final diagnosis, procedures if any, course in the hospital and discharge medications.
   c) Every record must be signed and dated properly by the person writing the record.
   d) Hospital records must be maintained safely and confidentially for minimum of 5 years, and should be made available when asked by Nepal Medical Council/ or other competent authorities of Nepal.
   e) Hospital records should be provided to the patient and on her\his next of kin upon their request.
   f) Digital record is strongly encouraged.
3. **Prescription writing:**
   a) Must be written legibly and preferably in upper case with proper dosing instructions.
   b) A working diagnosis is mandated before prescribing medicines.
   c) Writing generic names is highly encouraged.
   d) Clear identification (full name, NMC Number) of the prescriber is mandatory.
4. **Use of checklist before surgical procedures:**
   a. Established global checklists like WHO surgical checklist and ASA risk stratification of patients before surgery should be completed.
   b. Any other additional checklist developed by the institution or national specialty societies.
5. **Death Certificate (DC):**
   a. Should develop a standard format for the death certificate using the WHO template as minimum standard.
   b. Should clearly mention the immediate, antecedent and contributory causes of death. Please note that cardiopulmonary arrest is not the cause of death and cannot be listed as such.
   c. A physician should not issue DC if the patient is brought dead. All suspected unnatural deaths should be notified to the police for possible investigation.
   d. DC should be issued by the attending physician with proper identification who has attended the patient at least once during hospitalization before death.
6. **Continuous Professional Development:**
   a. NMC urges all doctors to be updated in the respective field of their practice. Please enroll yourself into the CPD system of NMC.

Request to all hospitals:

7. Ethics Committee
    b. Every hospital should have an ethics committee to oversee practice related issues in the hospital.
    c. The Ethics Committee should perform the clinical audits monthly/ bimonthly and review all deaths and near misses.
8. Incident reporting system:
    Each hospital should have a system of recording any adverse event during the course of treatment and the incident reviewed.

9. All patients presenting to the Emergency Room should be stabilized and treated promptly regardless of the financial status of the patient.

10. Every hospital should have an active infection prevention and control team.

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