SAIDEEP
HEALTHCARE & RESEARCH PVT. LTD.

APEX
Safety & Compliance

APEX MANUAL

Record of Amendments

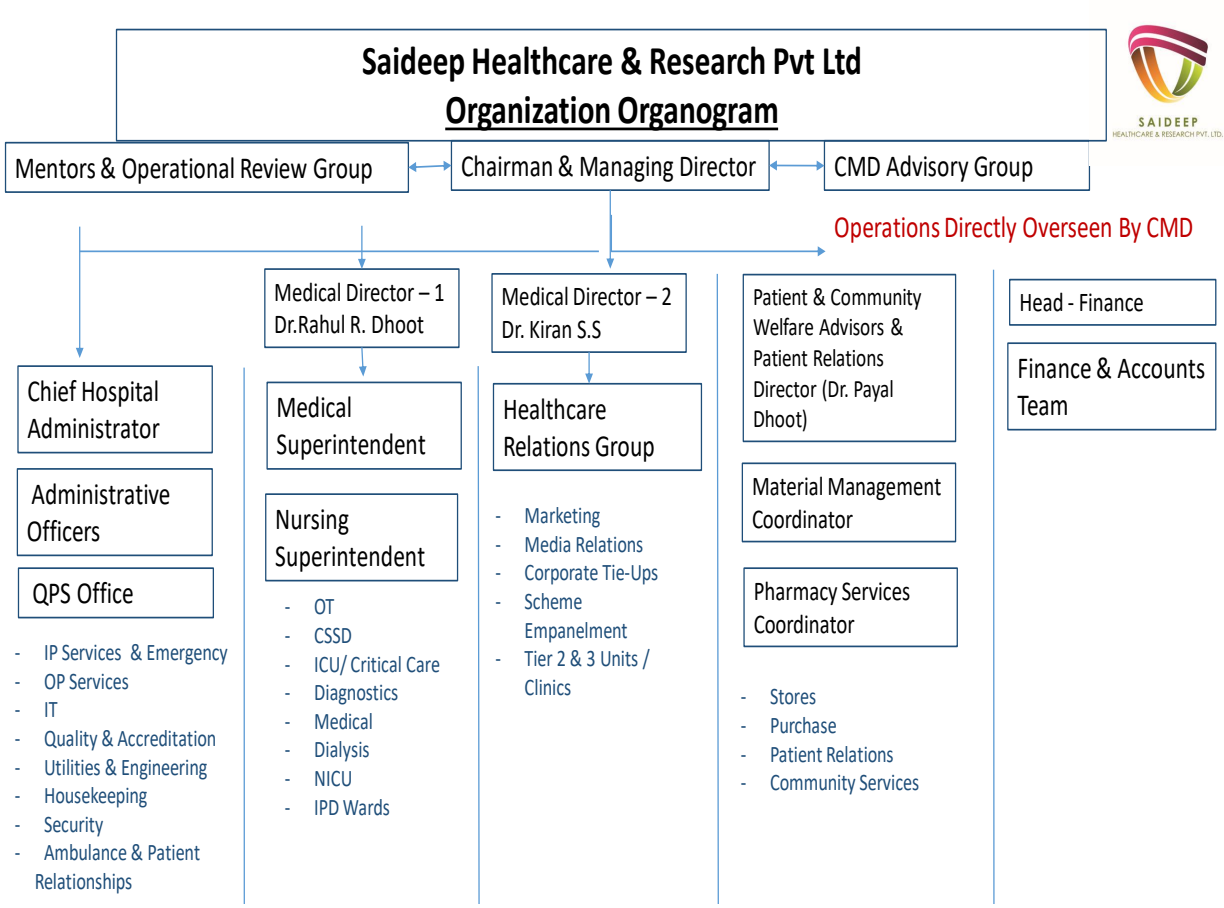
Sr.No	Page No	Clause No	Date of Amendment	Amendment Made	Reasons	Signature of Approval Authority

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

Index

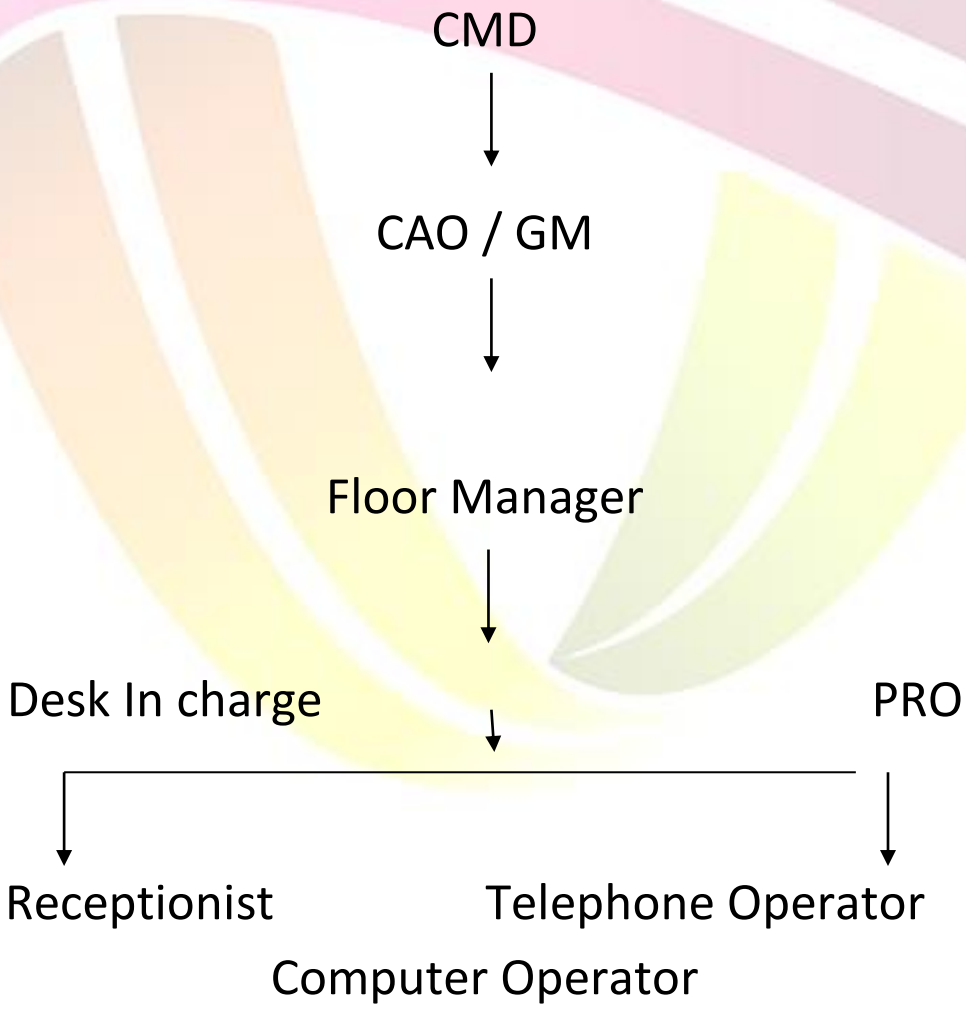
Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar		Dr. S.S. Deepak	
Chief Medical Administrator		Chairman & Managing Director	

Organongram

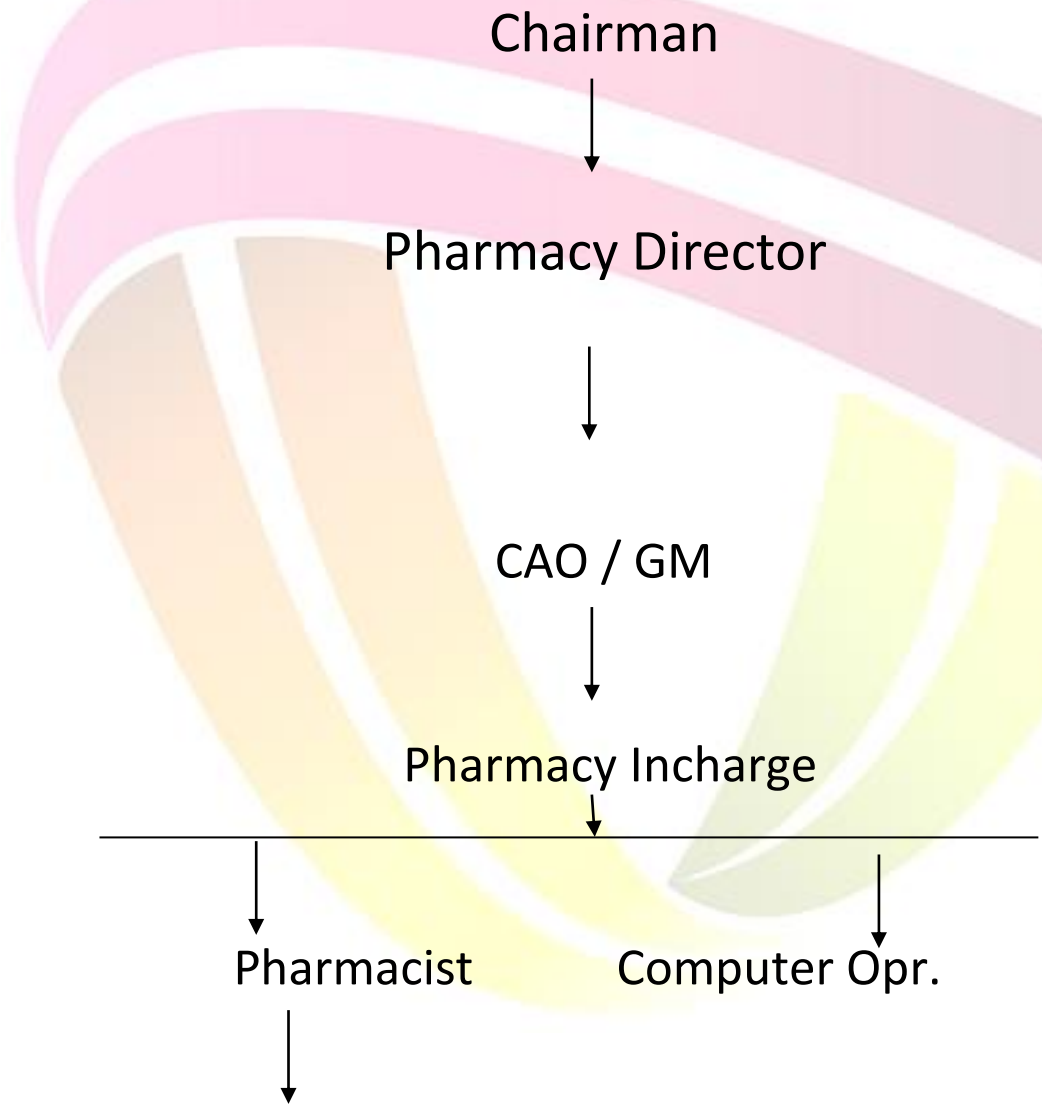


Department Wise Organgram

Front Office Organogram

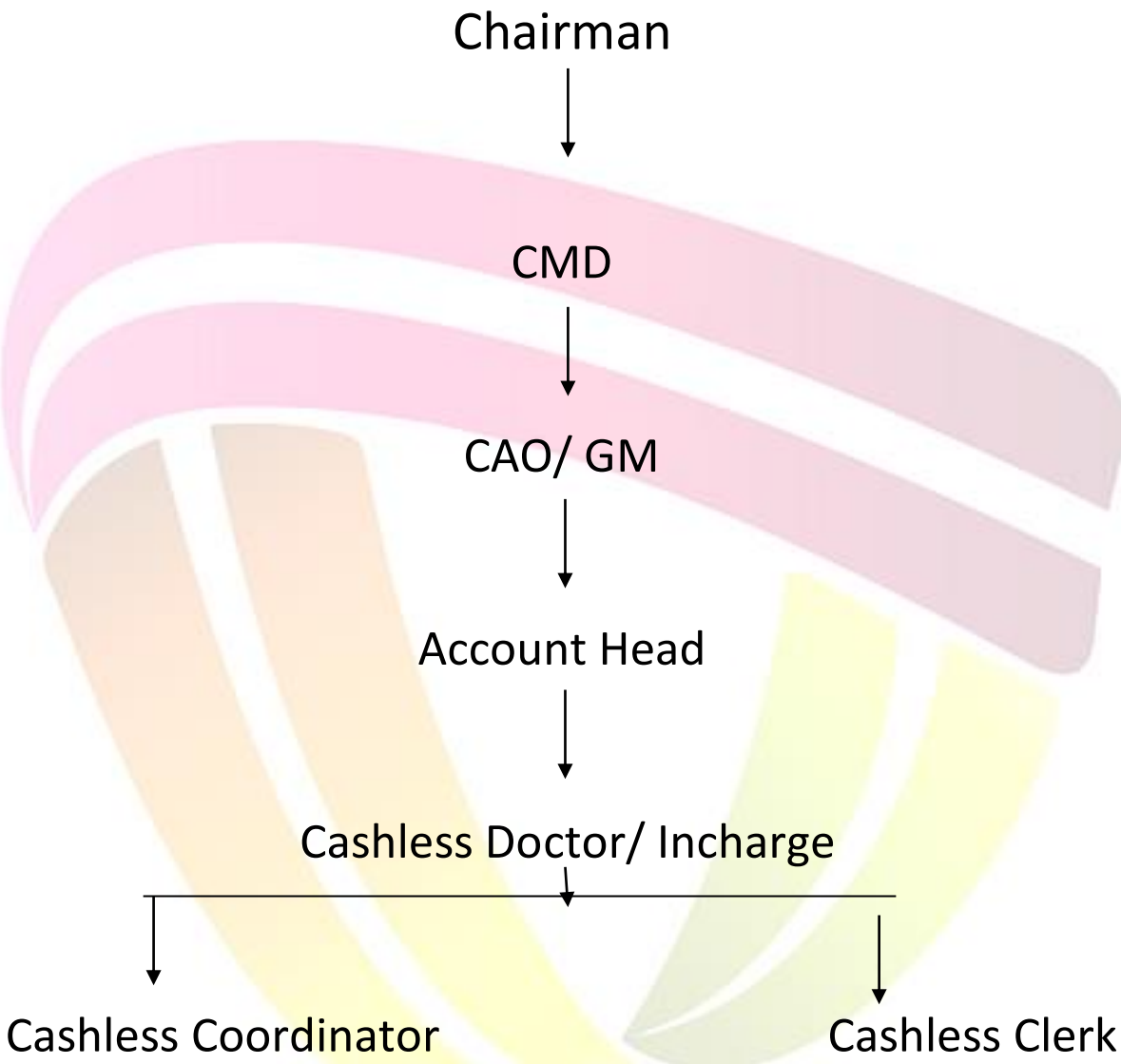


Pharmacy Dept. Organogram



Interns

Cashless Dept. Organgram



Security Dept. Organogram

Chairman

↓

CMD

↓

CAO/ GM

↓

Security In charge

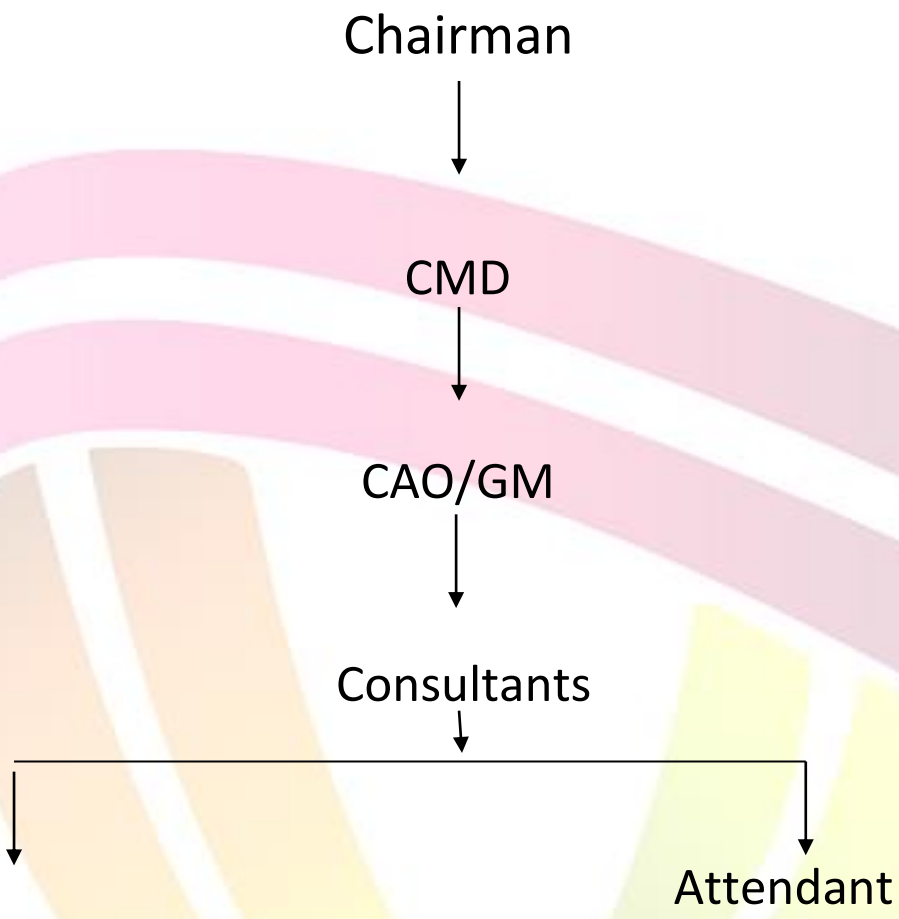
↓

Security Supervisors

↓

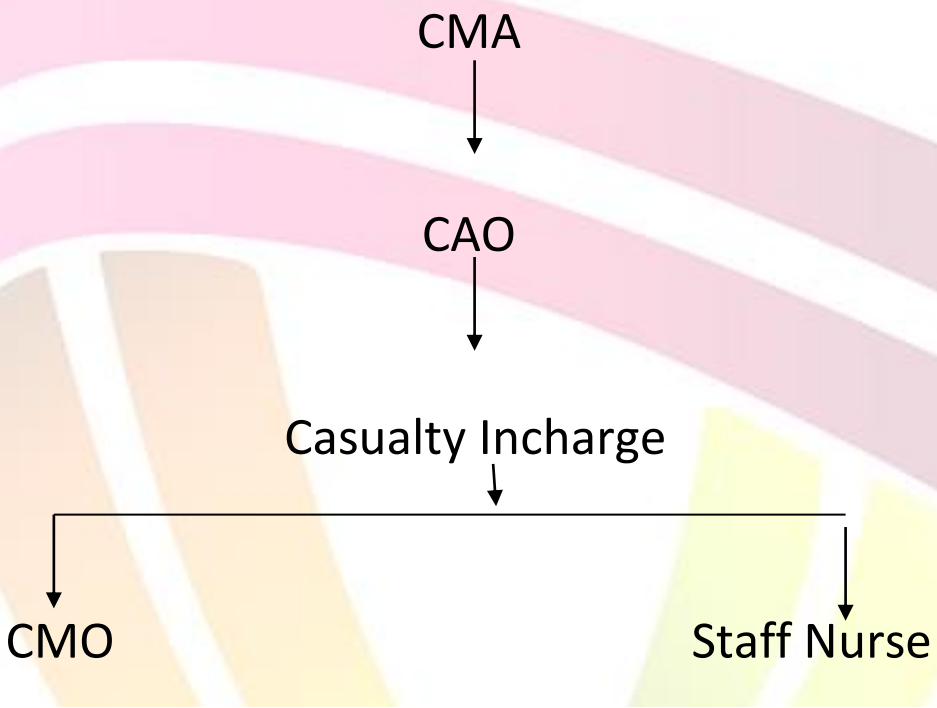
Security Guards

OPD Organogram

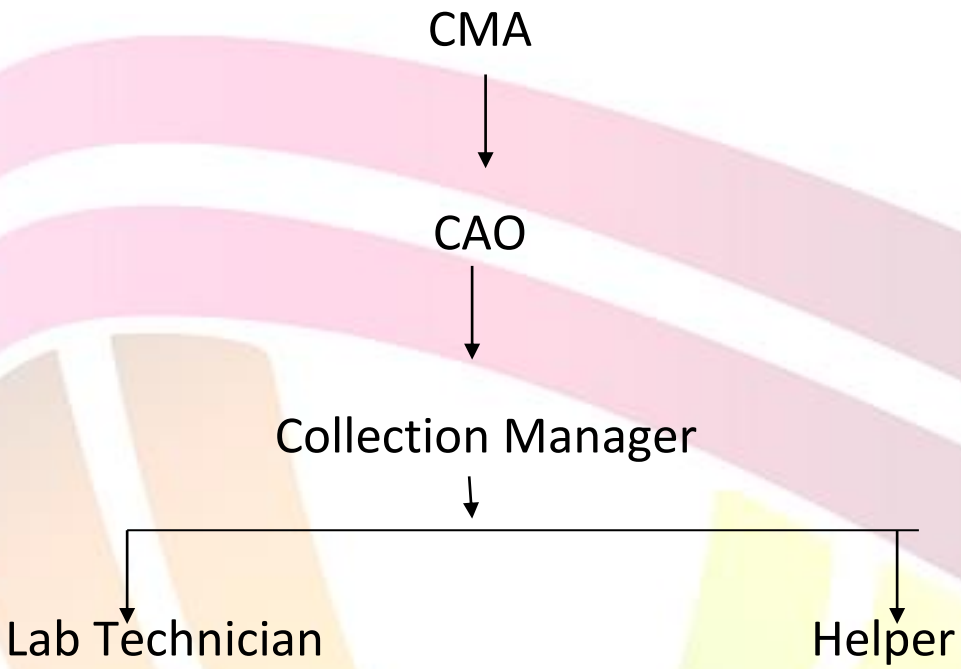


Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

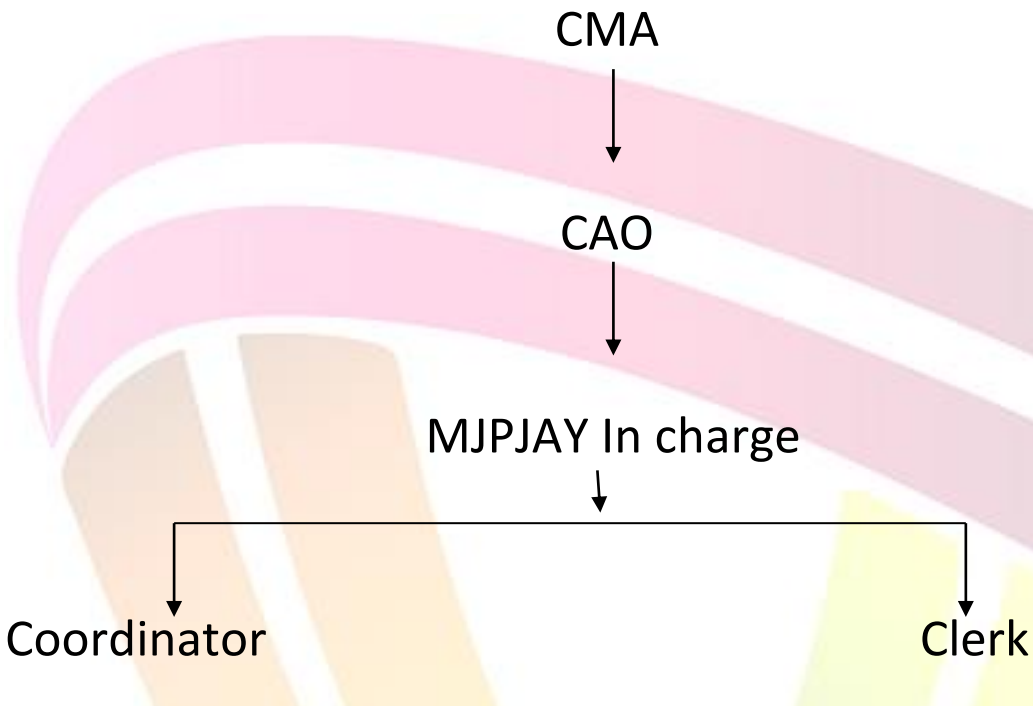
Casualty Organogram



Sample Collection Dept. Organogram

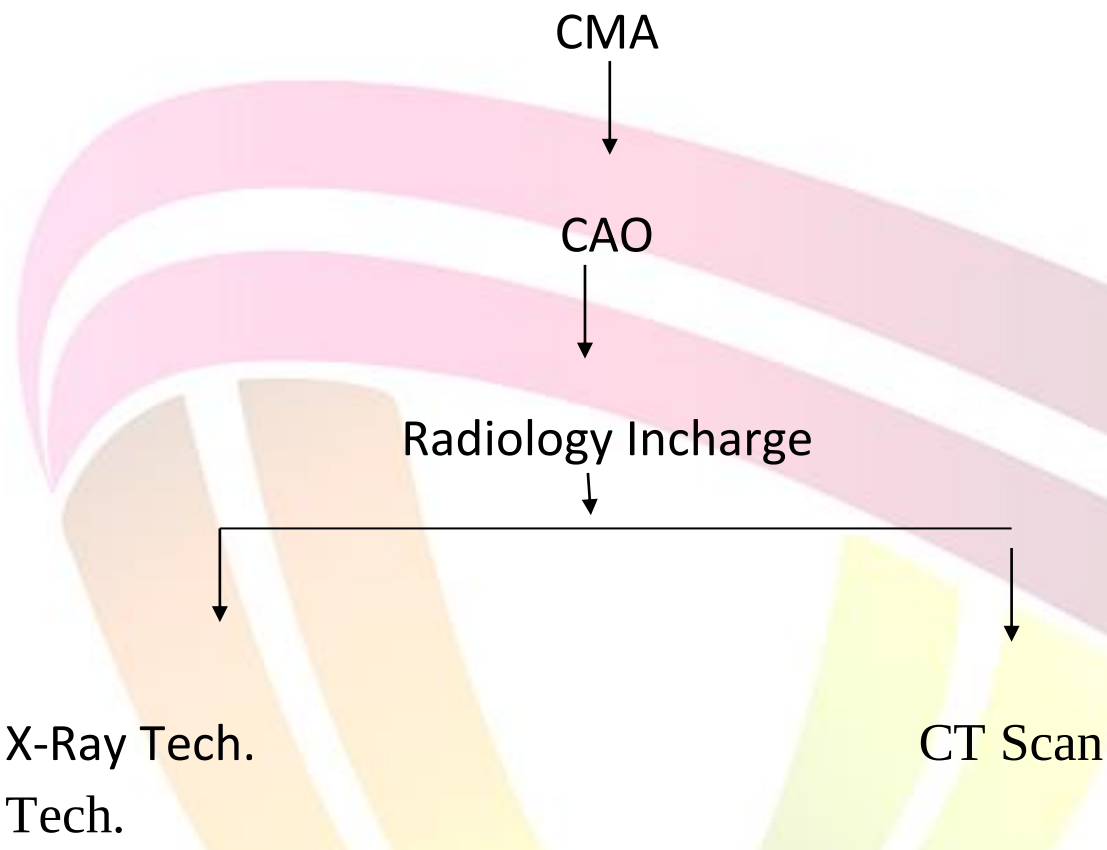


MJPJAY Dept. Organogram

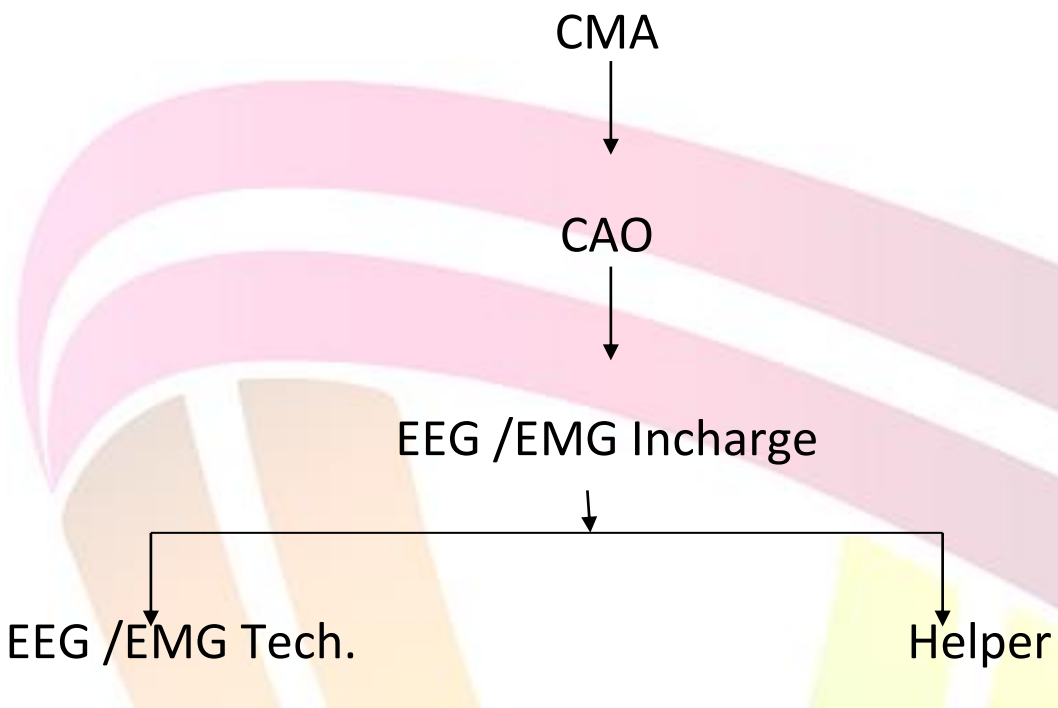


Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

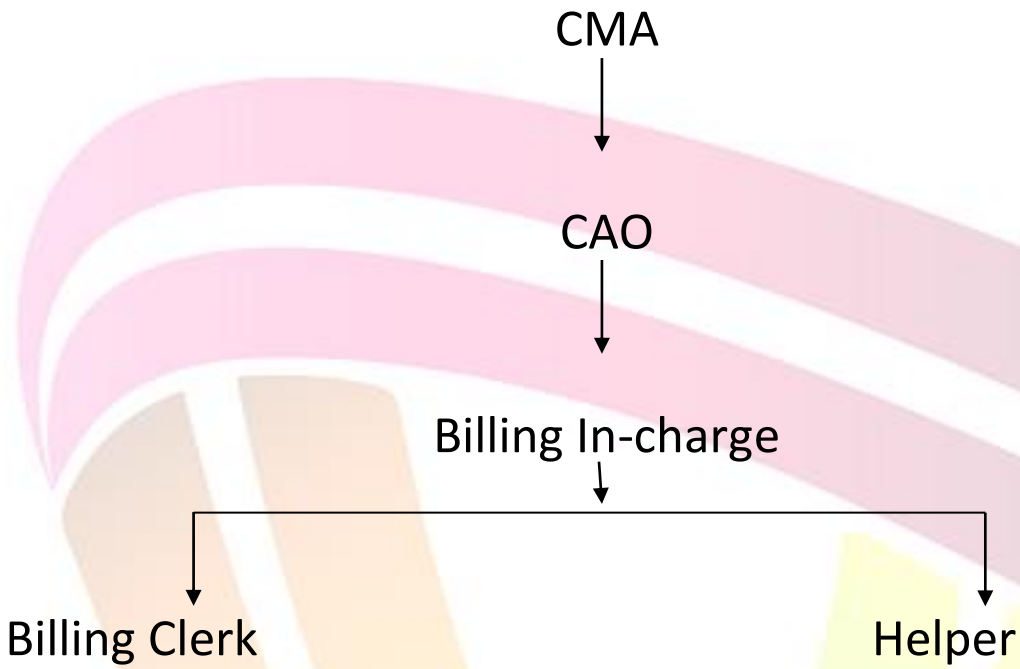
Radiology Dept. Organogram



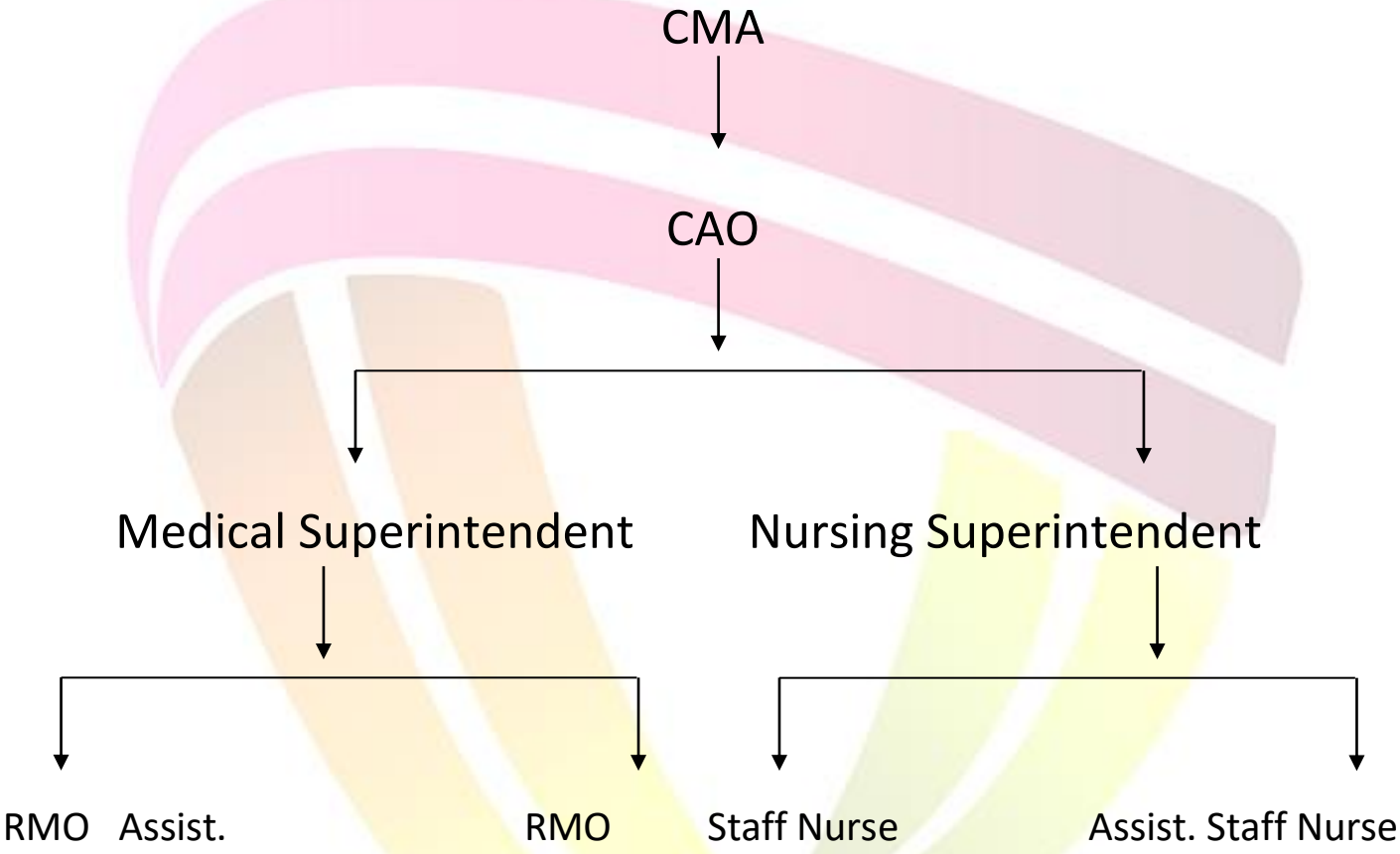
EEG/ EMG Dept. Organogram



Billing Dept. Organogram

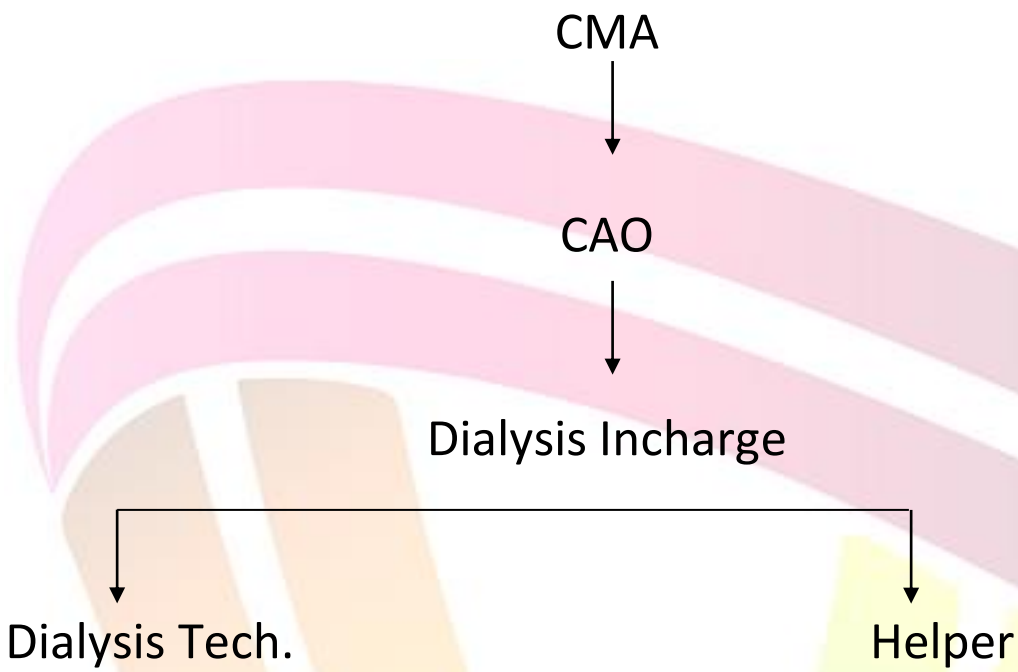


MICU/HDU/ISOLATION Organogram



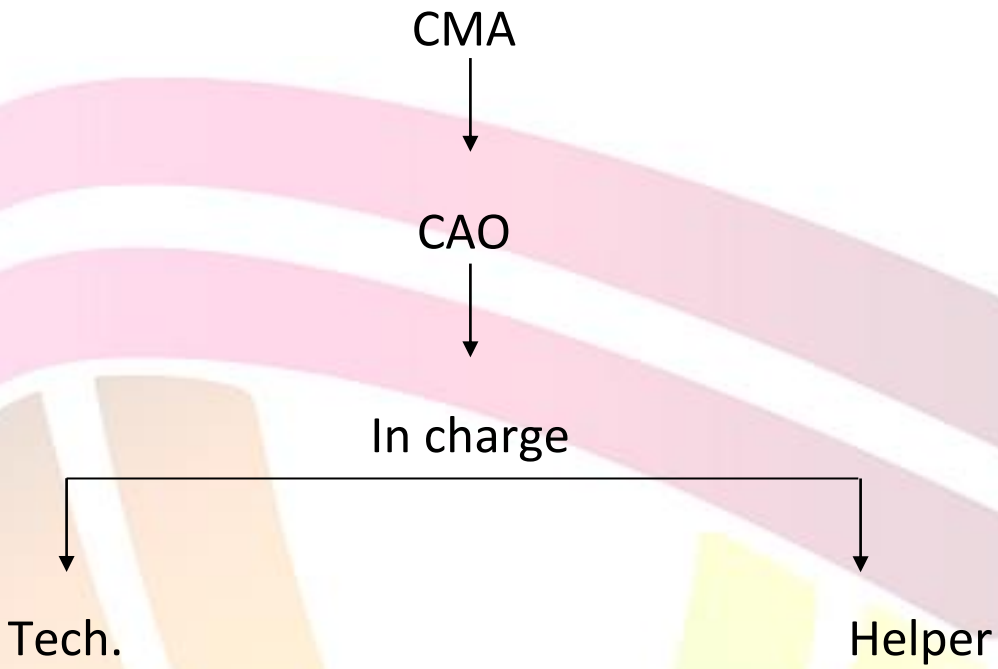
Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

Dialysis Organogram

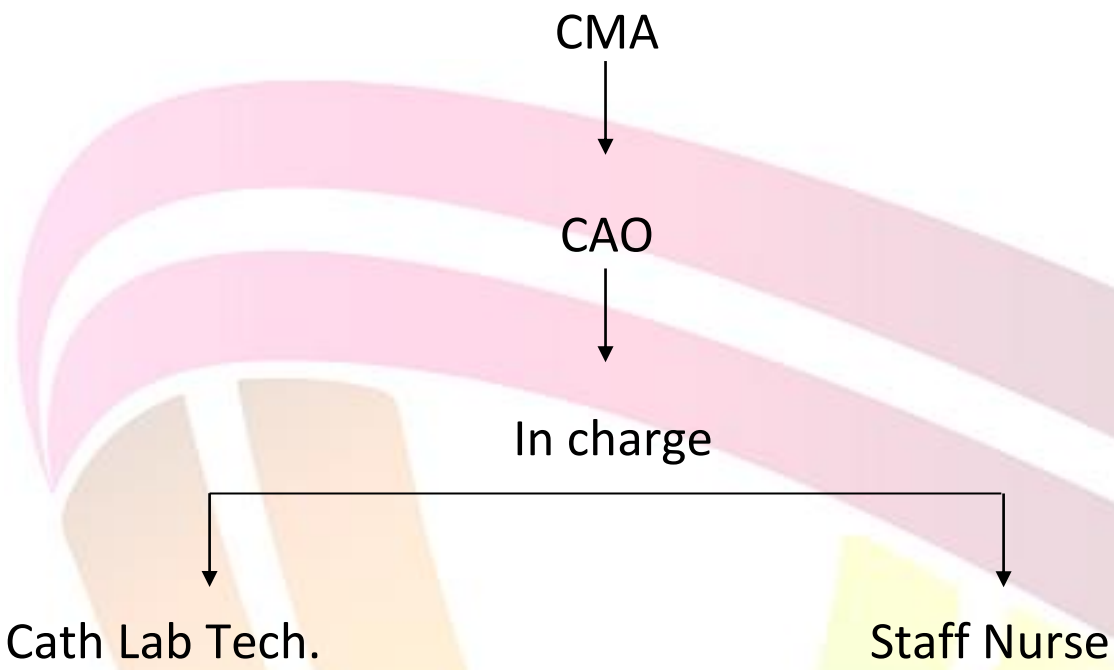


Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

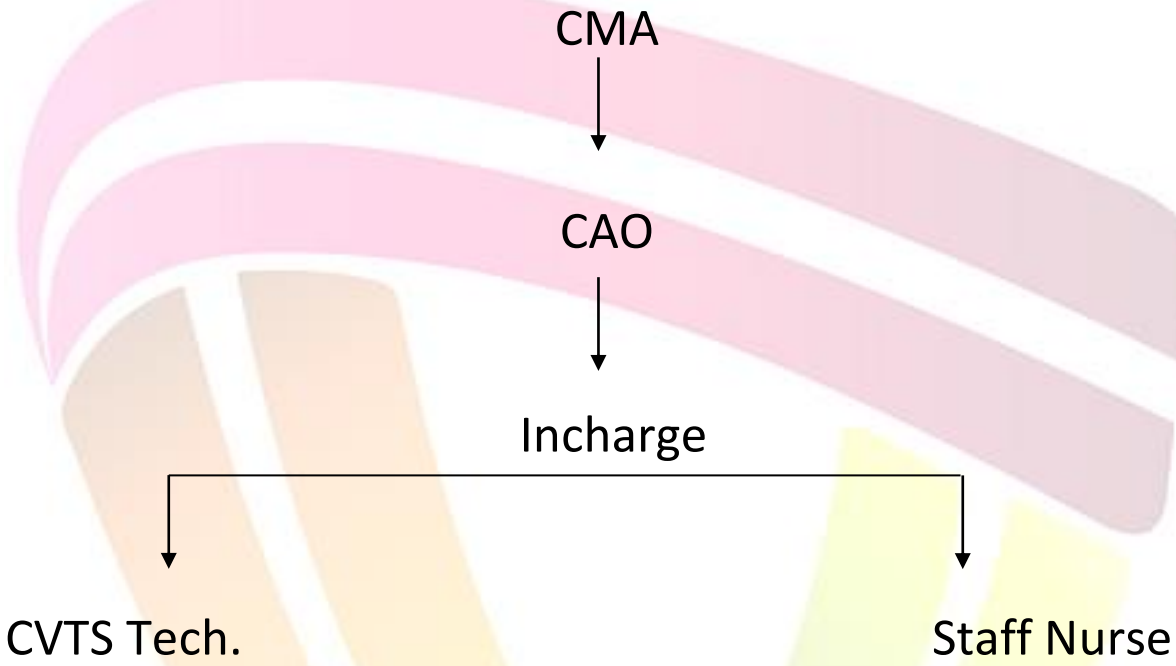
Endoscopy Dept. Organogram



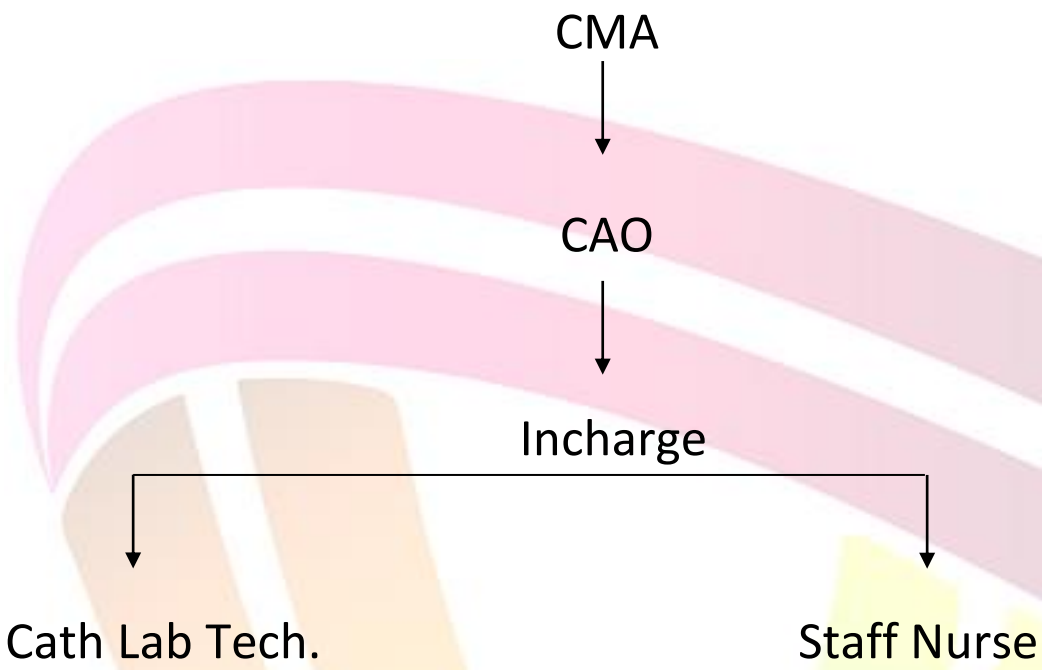
Cathlab Dept. Organogram



CVTS Dept. Organogram

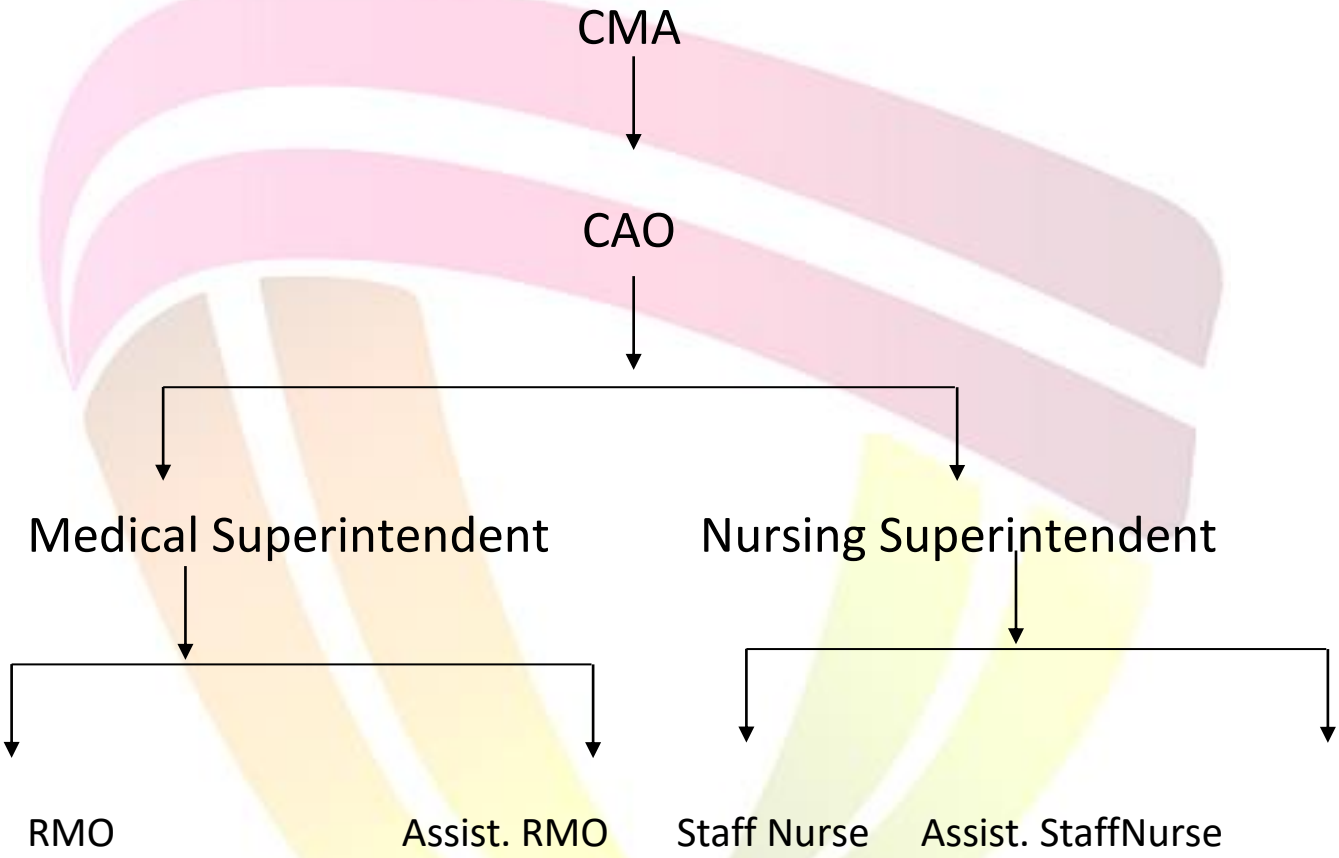


Cath Recovery Dept. Organogram

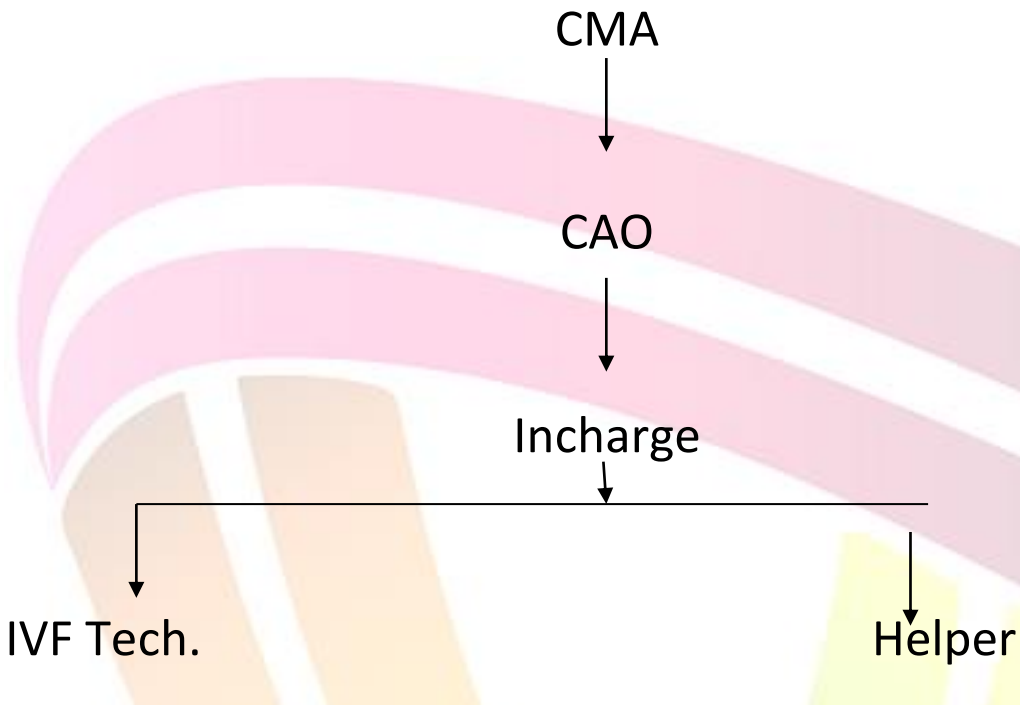


Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

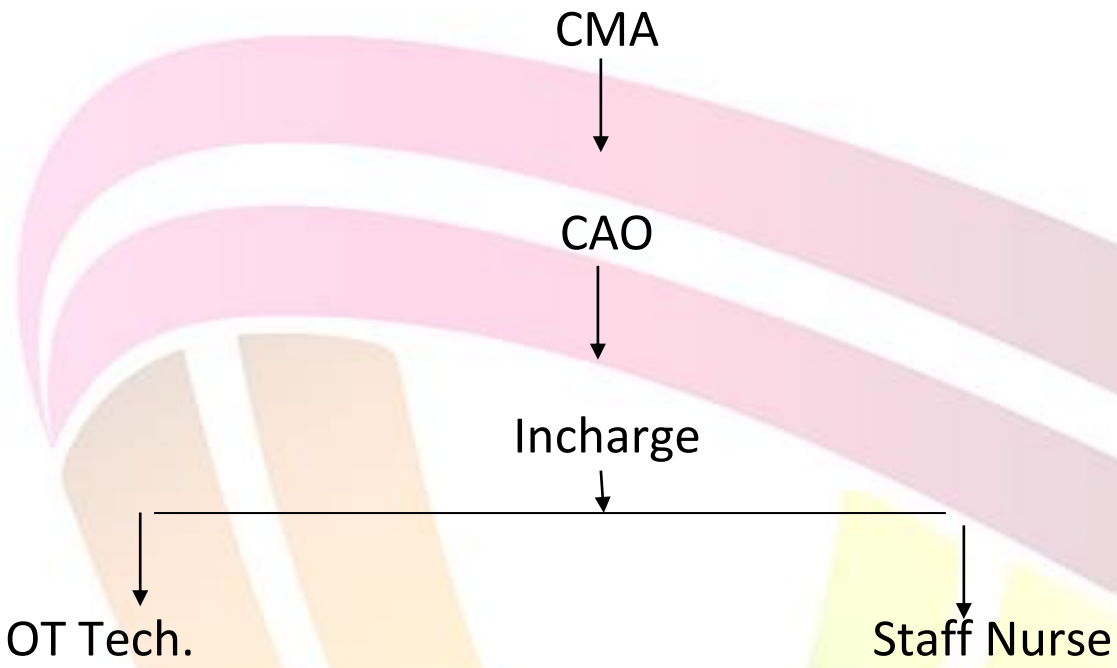
CCU /SICU Dept. Organogram



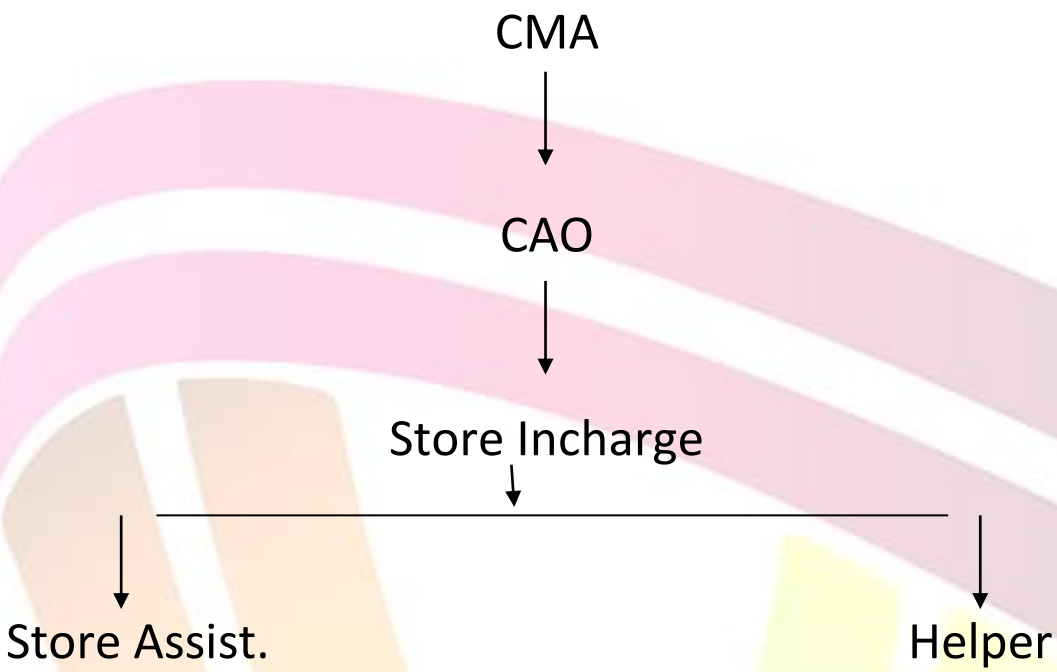
IVF Dept. Organogram



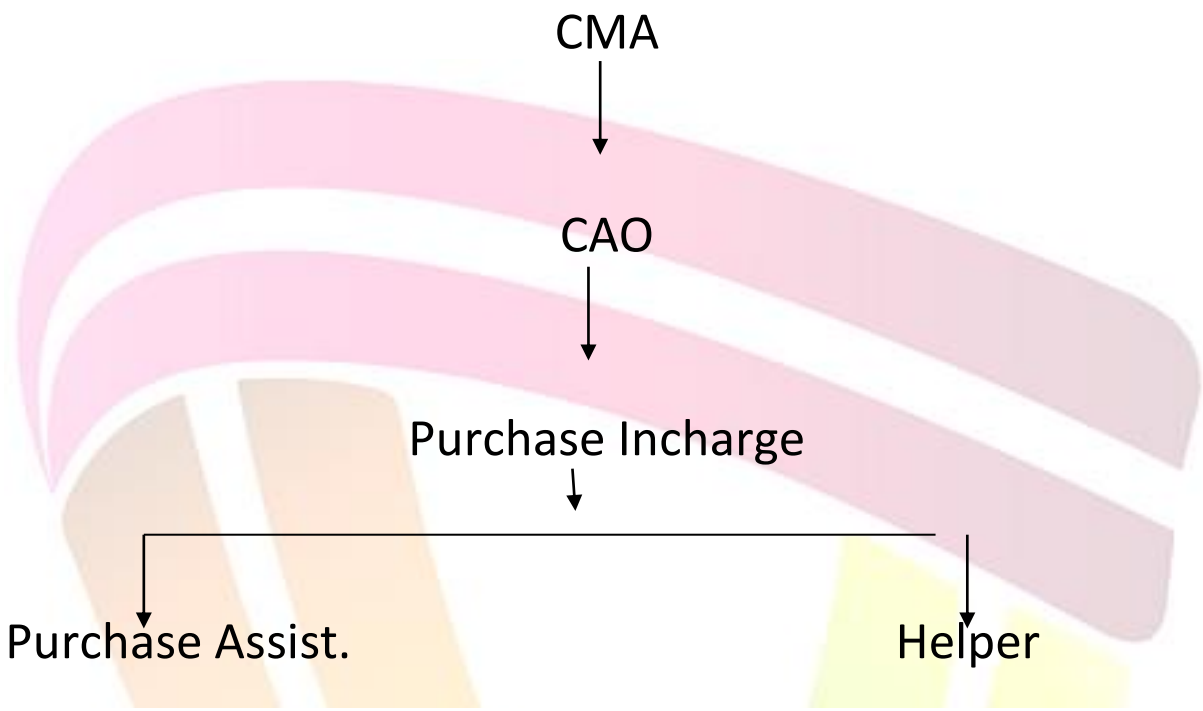
Gynac O. T. Organogram



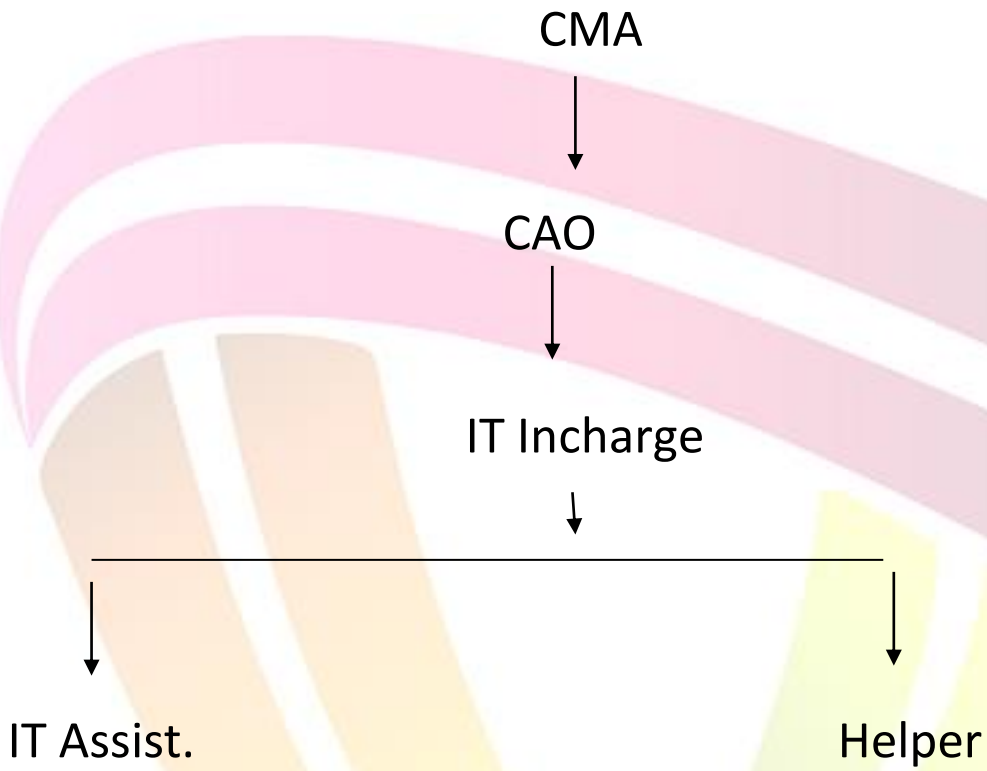
Store Dept. Organogram



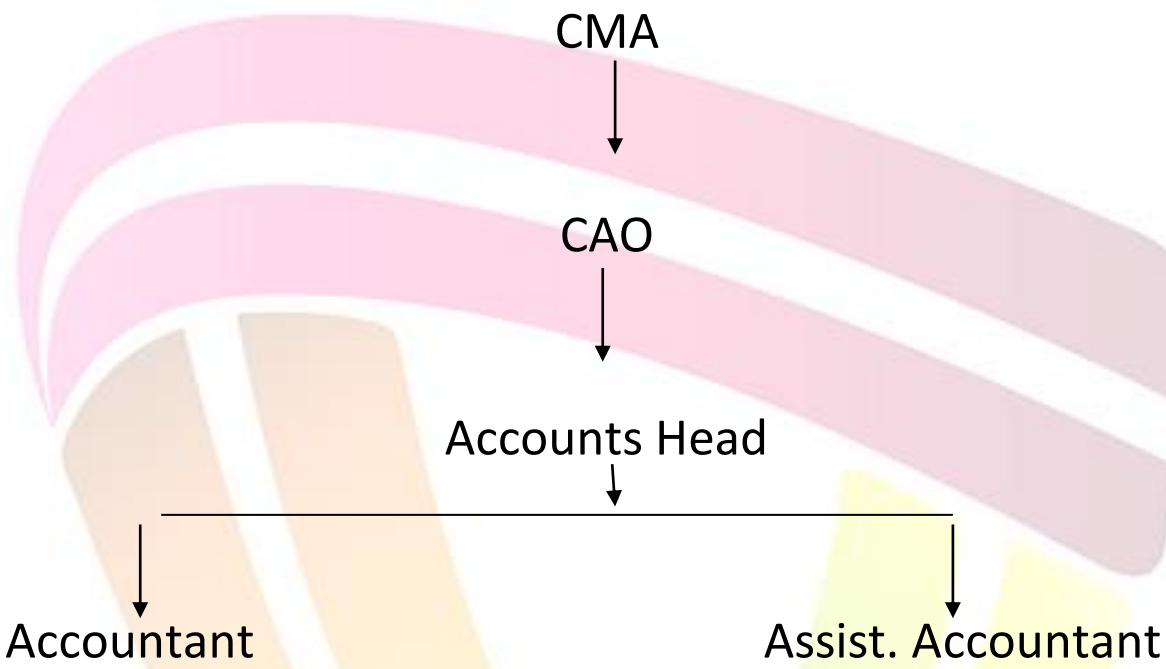
Purchase Dept. Organogram



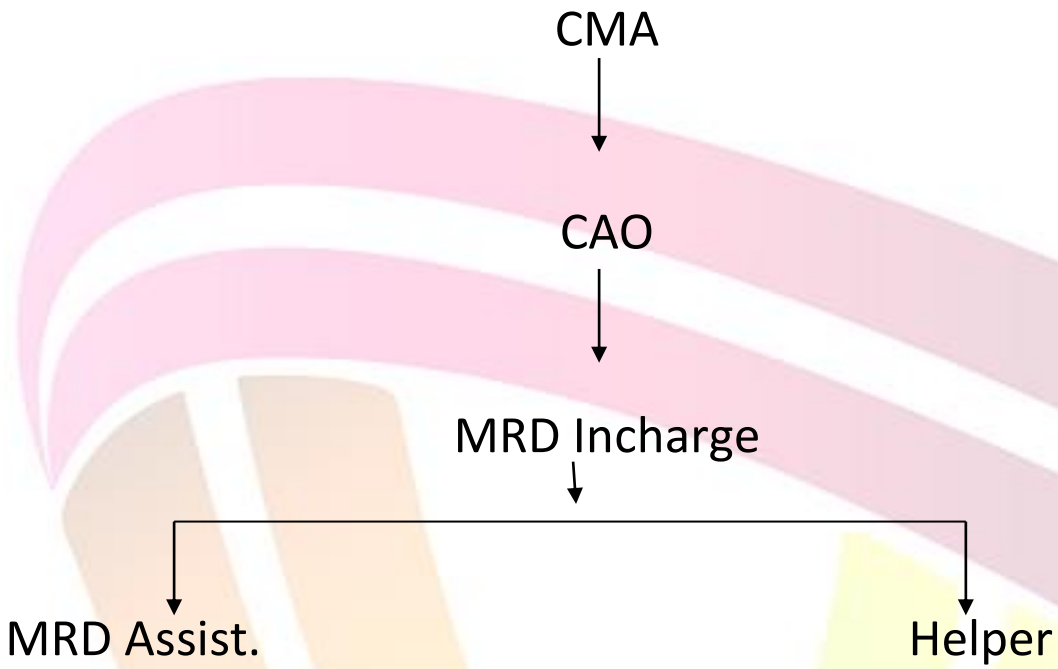
IT Dept. Organogram



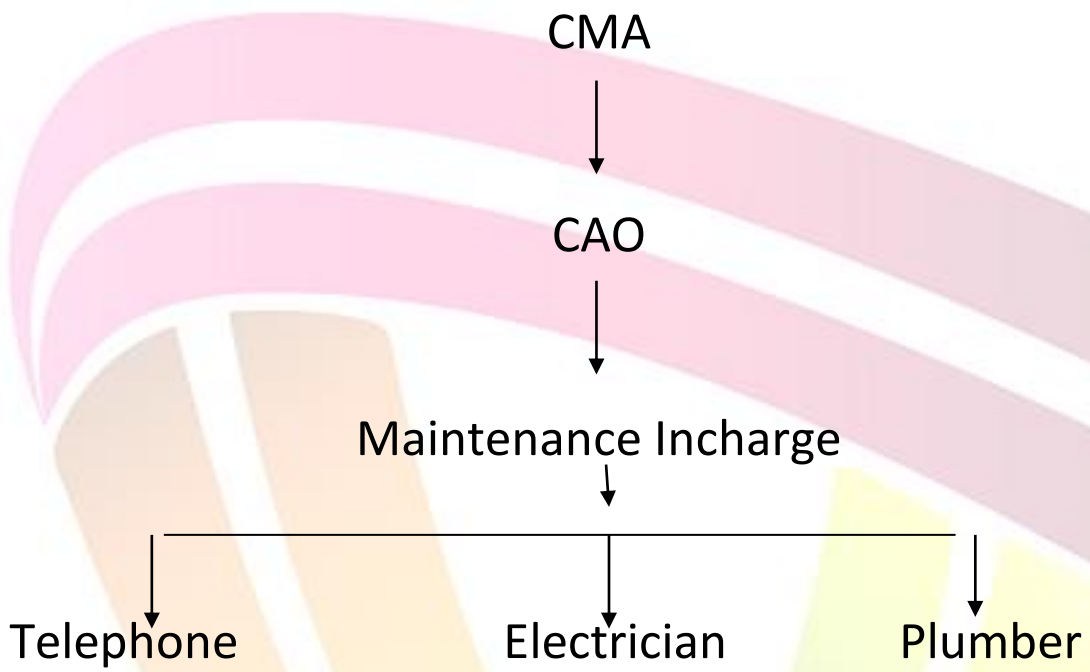
Accounts Dept. Organogram



MRD Dept. Organogram



Maintenance Dept. Organogram



Bio-Medical Dept. Organogram

CMA

↓

CAO

↓

Bio-Medical Dept. Incharge

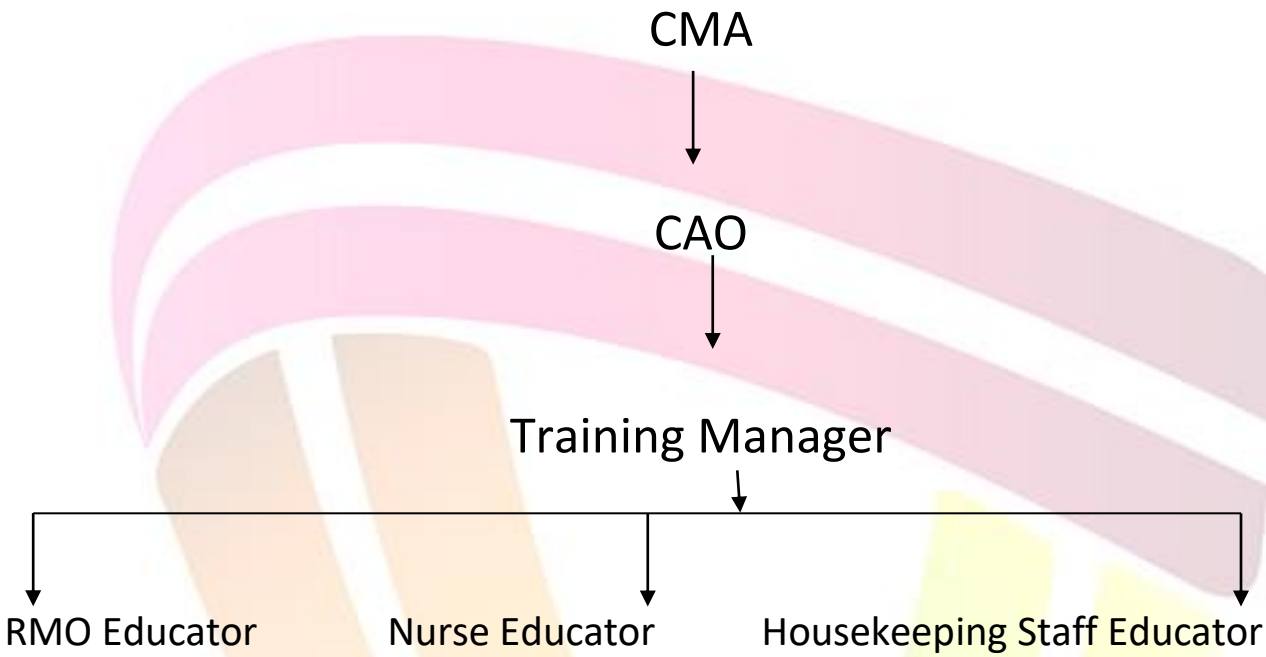
↓

Bio-Medical Engineer

↓

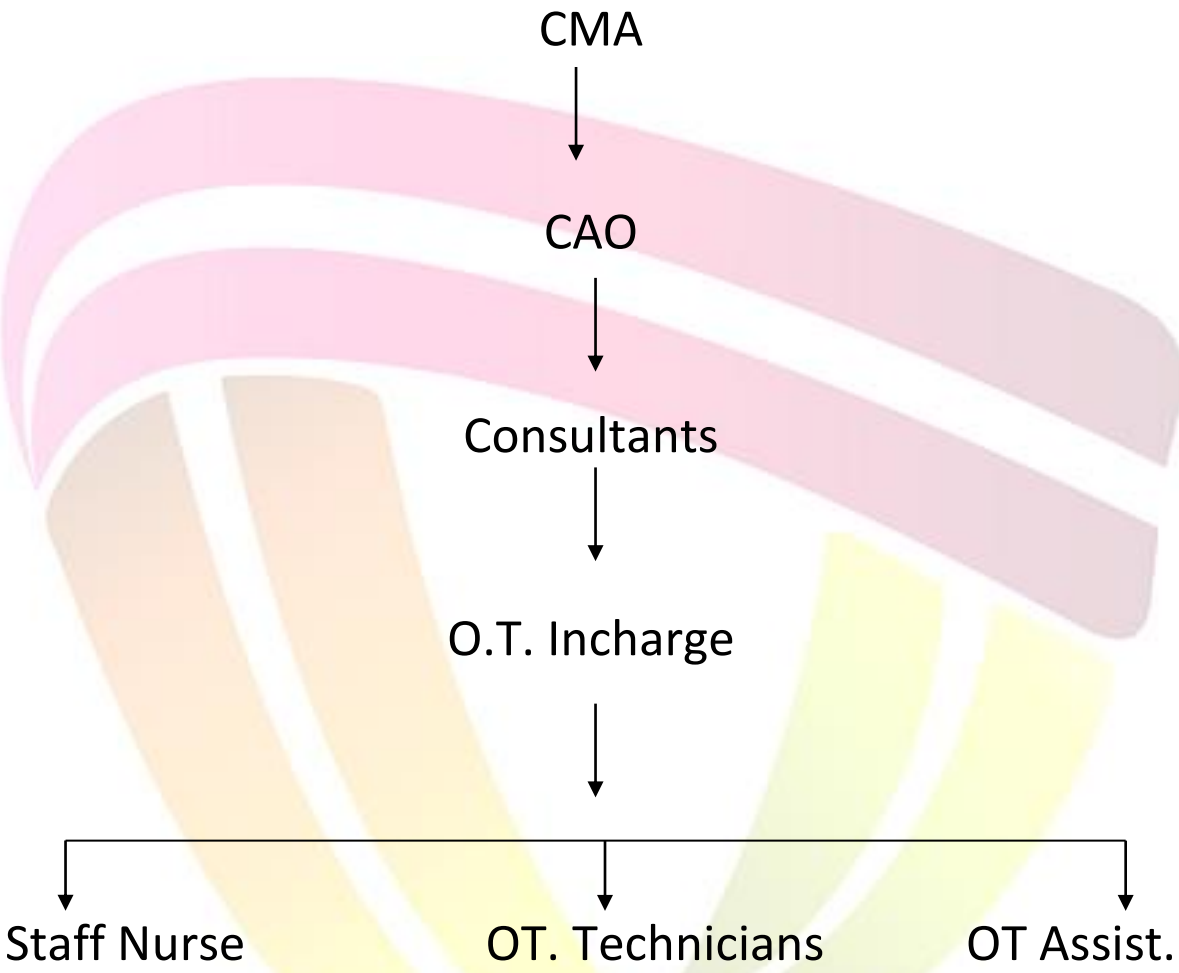
Bio-Medical Assistant Engineer

Training Dept. Organogram



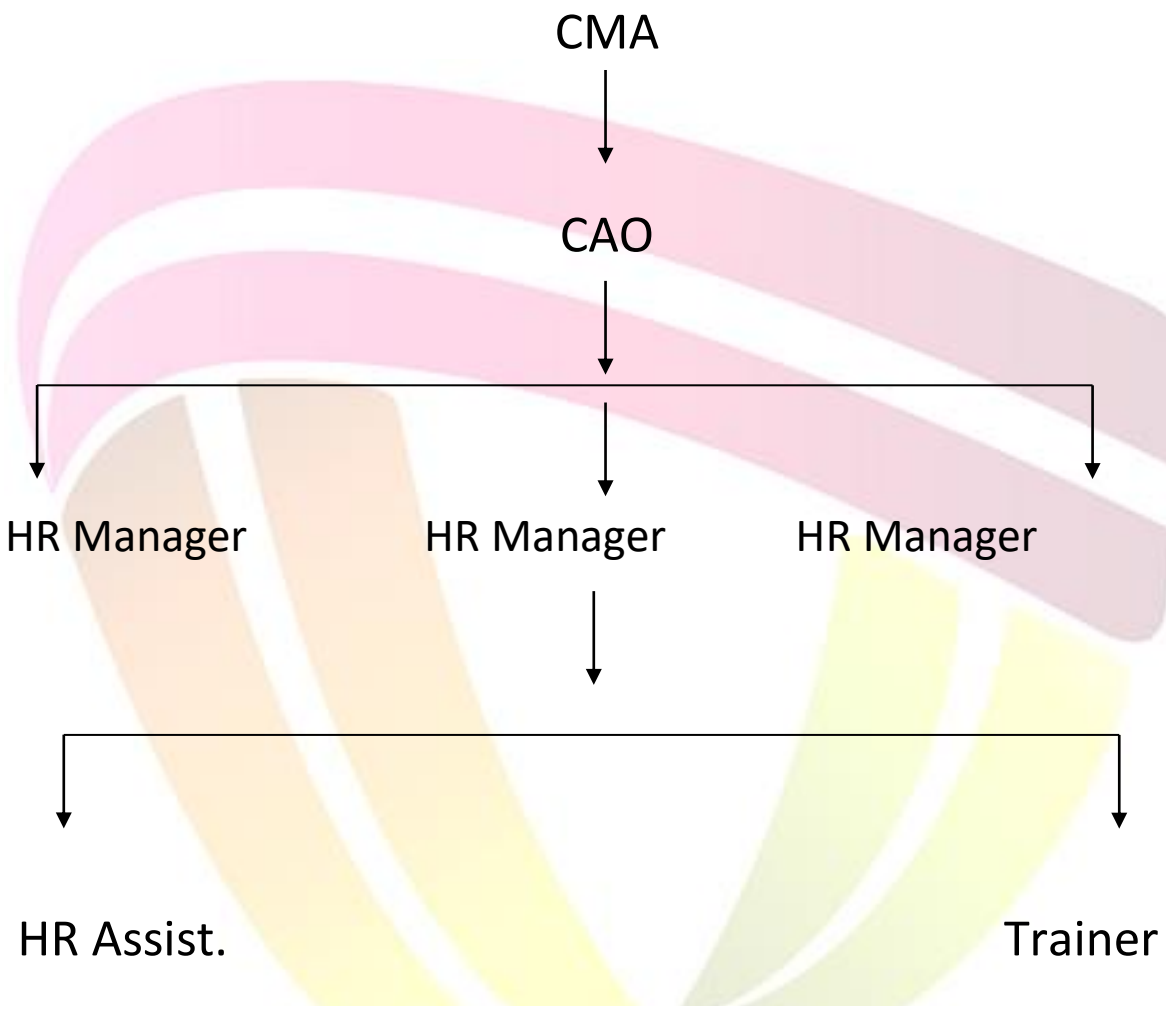
Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

Operation Theater Organogram

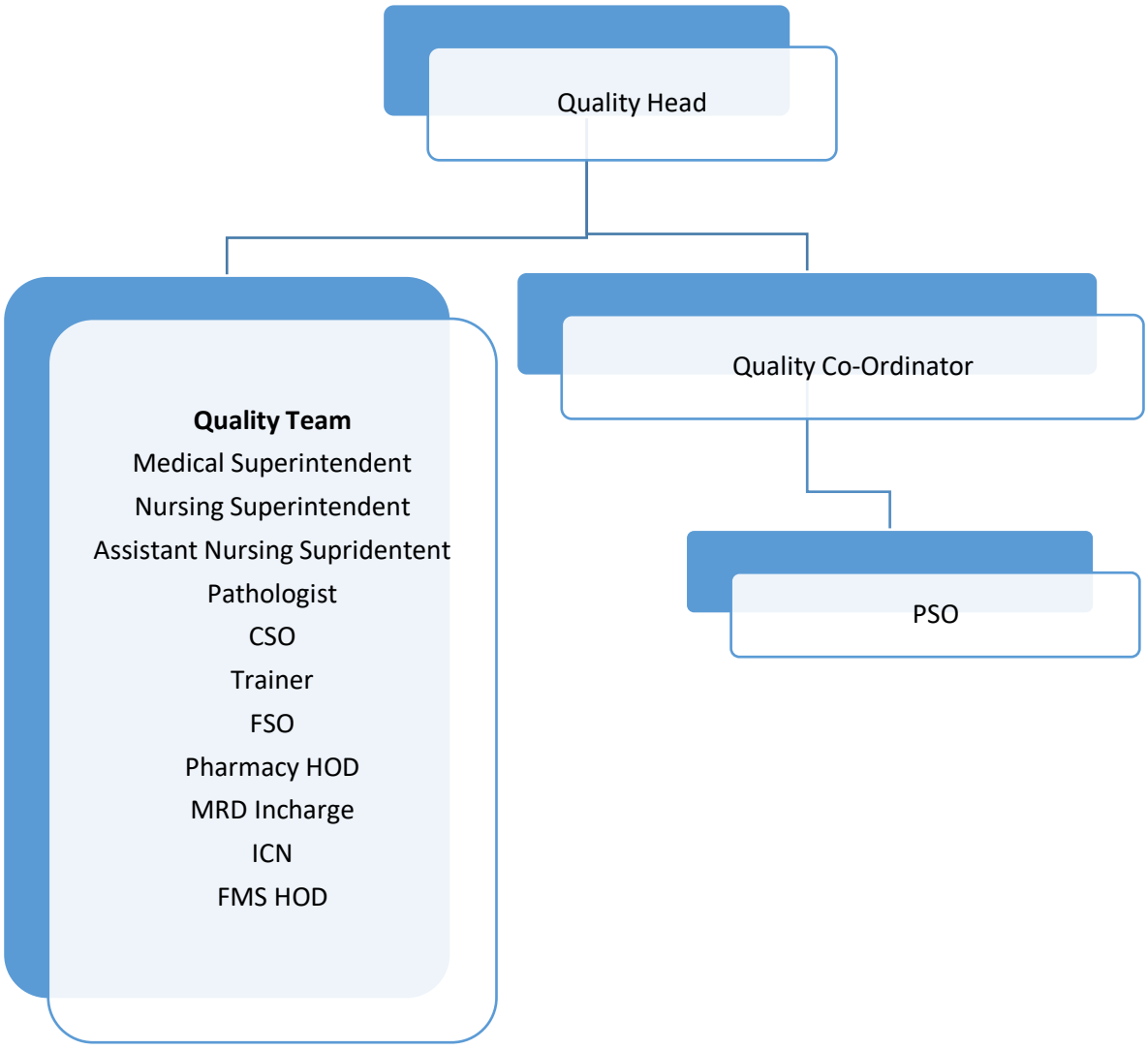


Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

HR Dept. Organogram



QUALITY DEPARTMENT



Introduction to Organization

Vision-

From being An innovative regional hospital to leading global hospital dedicated to advancing health and transforming lives through outstanding clinical quality, accessible and patient-centered care, and unmatched commitment from physicians and employees.

Mission –

Compassionate Accessible, high quality ,cost effective Healthcare. Also to Promote Health, Educate Healthcare professionals and to participate in appropriate clinical research.

Our Values:
Compassion. Respect. Inclusion. Integrity. Collaboration. Innovation.

Quality Policy& Objectives

Our Quality Policy is defined and strongly driven by the following management principles:

Build a mutually beneficial relationship with our patients, ensuring their long-term health, through the understanding of their needs and of their families as well

Achieve a balance between quality and cost
Enhance the systematic research and use of best preventive healthcare practices at all levels and ensure reliable risk management

Drive continual improvement and innovation based upon efficient processes, well-defined criteria, best practices, and surveys

Develop staff competencies, creativity, empowerment and accountability through appropriate development programs and show strong management involvement and commitment

Saideep Healthcare & Research PVT. LTD. strives to be the best provider of services in the healthcare industry. Through the use of these guiding principles, everyone in Saideep Healthcare & Research PVT. LTD. is accountable for fully satisfying our patients by meeting or exceeding their needs and expectations with best-in-class solutions and services.
Our goal is maximum patient satisfaction, always.

Policies for Ethical Management

- The Management is responsible for effective delivery of services at Saideep Hospital
- The management shall stand responsible and accountable for all the management level decisions
- The management shall accept and deal with all legal that might rise against the organization following the laws and regulations established in the nation
- All medico legal cases shall be reported to the police station and shall not be concealed in favour of any individual
- All individuals involved management and related activities Shall act, and be seen to act, with integrity and professionalism Honesty, care and due diligence Shall be integral to all activities
- Respect Shall be demonstrated for each other and for the environment
- Confidential information Shall be safeguarded
- Deliver patient care, research, education and support work with professional competence, intellectual honesty and high ethical standards
- Promote the communication of rights, responsibilities and information to foster informed decision making to provide the highest quality of care and safety
- Treat all internal and external members of the community with respect and dignity and without discrimination
- The Management sees that all participants shall not engage in any activity that may create, or appear to create, a conflict of interest, such as accepting gifts or favours, providing preferential treatment, or publicly endorsing suppliers or products or any other stake holders
- Promote a safe, secure and healthy work environment for all
- Management shall protect the Hospital's physical, electronic and intellectual property
- Management ensures that all individuals shall continuously work to improve the organization

Service Standards

- Standards of service and adequate degree of patient care can be provided to the extent proper and workable ratio between doctor to patient, nurse to patient and beds to patients are maintained, as also the extent of availability of resources and facilities. Consistent with this every possible effort will be made by this hospital to provide standard services.
- To provide access to hospital and reasonable medical care to all patients who visit the hospital / ensure availability of beds / ensure treatment of emergency cases with at most care and promptness.
- The hospital has necessary manpower / infrastructure &equipment required for providing the services mentioned in service provision and system to ensure such services is in place.
- To prescribe a workable maximum waiting time for outpatients, before they are attended to by a qualified doctor and / or specialist and continuously strive to improve upon it.
- To ensure that all major equipment in the hospital are maintained efficiently in proper working condition by issuing timely work orders for Annual Maintenance Contracts / Comprehensive Maintenance Contracts for all the major equipment
- Reliability and promptness of diagnostic investigation results is ensured by sending the samples for external quality assurance for all measuring equipment in the labs and whenever possible such reports will be made available.
- If any equipment is out of order, information regarding the same shall be displayed suitable indicating the alternate arrangements, if any, as also the likely date of decommissioning the equipment after repairs and replacement.
- To keep the hospital and its surroundings, clean, infection-free and hygienic by adhering to Swachata Guidelines for Public Health Facilities, 2015.
- All patients and visitors to the hospital will receive courteous and prompt attention from the staff and officials of the hospital in the use of its various services. The patient's rights are protected as per National Quality Assurance Standards.
- A regular system of obtaining feedback / complaints from the patients and public is in place through call center based CFMS with dedicated number (Customer Feedback Management System) / Help Desk / Complaint boxes and periodic surveys. The inputs from these are continuously used for improving the service standards
- When things go wrong or fail, appropriate action is taken on those responsible for such failures and action taken to rectify the deficiencies. Complainants will also be informed of the action taken, if requested.
- In case of likely persistence of the deficiency, the reasons for the delay in rectifying the deficiency and the time taken for rectifying the same will be displayed prominently for the information of the public.

- Special directions are given to the non-medical staff to deal with the patients and public courteously. Any breach in this regard when brought to the notice of the hospital authorities shall be dealt with appropriately.
- To Identify all condemnable items in the facility (Unserviceable / obsolete / condemned) and take necessary action for immediate condemnation / disposal
- To follow Bio-waste Disposal 2016 guidelines through proper Segregation of waste, Collection, Transportation and disposal by outsourcing agency. Monitoring of infection control practices can be done by Infection Control Committee (ICC) which has been constituted as per G.O M.S
- Hospital follows all policies, processes, programmes, committee meetings; regulatory guidelines, which have been prepared to meet the standards of NQAS.

Scope of Services

OPD Scope of Services

Definition

Range of clinical and supportive services that are provided by Saideep Hospital as a health care organization.

Policy

- The hospital shall orient all its employees regarding the scope of services
- Scope of services shall be displayed in all three blocks visible to all patients and visitors
- All displays shall be in English and Marathi

LOCATION:

Outpatient Departments are located on the 1st Floor of the hospital building and main reception is located on ground floor.

DAYS AND HOURS OF OPERATIONS:

Working Days: For Main Reception - All days (Including Sunday),

For OPD cluster & other desk - All working days (Mon – Sat)

Timing: For Main Reception - 7:00 am – 9:00 pm

For OPD clusters & other Desk: 8.00 am to 9.00pm

DEPARTMENTAL CONTACT DETAILS:

Board Line : 0241-2775700

Service Mobile : 6262900900

PURPOSE:

Desk Associate provides a predetermined location & the first points of contact where patients, customers or visitors can make enquiry and understand where they would be able to get the required services or facilities. It also describes the operational coverage of the Main Reception & Front Office / Customer Care Department.

The main purpose of outpatient department is to facilitate doctor consultations & aid with any additional investigations & pharmacy services. It also includes guiding patients about various services & various places around the hospital.

1.0 SCOPE:

It comprises of all the departments on the 1st Floor – General Medicine OPD, Cardiology OPD, Oncology OPD, Orthopaedics & Neurology OPD, Paediatric OPD, and Organ Transplant OPD. It also includes new & follow up consultation for adults and pediatrics, OAE Test , wound procedures, Audiometry test, ECG, 2D echo, Stress test, EEG studies, EMG

Scope Of Services Hospital

SPECIALITIES& SUPERSPECIALITIES

1. Anesthesiology
2. Dermatology and Venereology
3. General Medicine
4. General Surgery
5. Obstetrics & Gynecology
6. Ophthalmology
7. Orthopedic Surgery
8. Otorhinolaryngology
9. Pediatrics
10. Pathology
11. Psychiatry
12. Radiology
13. Dental Surgery
14. Cardiac Anesthesia
15. Cardiology
16. Cardiothoracic Surgery
17. Critical Care
18. Medical Gastroenterology
19. Neonatology
20. Neurology
21. Neuro Surgery
22. Pediatric Surgery
23. Plastic & Reconstructive Surgery
24. Reproductive Medicine
25. Rheumatology
26. Surgical Gastroenterology
27. Surgical Oncology
28. Urology

Department-wise Scope of Services

Clinical Service / Specialty	Scope of Services
Cardiology	• Cardiology inpatient and outpatients services • Cardiology emergency services • Heart failure clinic • Cath lab - Angiography (Coronary & Peripheral) - Angioplasty (Coronary, Peripheral, Renal) - Pacemaker (PPI/ TPI/ CRTD/ CRTP/ICD) - BMV/BPV/BAV - Coarctation of Aorta Stening - Peripheral Intervention (Peripheral Angioplasty / DVT Thrombectomy/ IVC Filter) - Pediatric Intervention (ASD/ VSD/PDA Device) - Neuro Intervention (Carotid Artery Stenting, Intracranial Stenting, Machanical Thrombectomy, Aneurysmal Coiling) - Intra Vascular Ultrasound - Rotation Athrectomy - Fractional flow reserve(FFR) - Electro Physiological Study • Non-invasive lab • Electrophysiological lab • Vascular surgery service • Cardiac surgery service • 2 D echo cardiography • GLS echo • Transesophageal echocardiography • Structural Heart disease interventions • Congenital Heart disease • Valvular Heart disease • Cardiac Exercise stress test • Dobutamine stress echo test
Surgical Oncology	• Biopsies • Incisional Surgeries • Excisional Surgeries • Laparotomy • Endoscopic Surgery / Laparoscopic Surgery • Breast Surgery Skin Biopsy

Ophthalmology	• General Ophthalmology, • Outpatient and inpatient surgical management of diseases related to the Eye • Perform and interpret various visual testing • Ptarygium surgery • Cataract surgery • Occuloplasty surgery • Retina surgery • (Medical Management) • Diabetic Retinopathy surgery & Management • Intravitreal Management • Macular degeneration and management • Anteriar Segment surgeries • Glaucoma Management
Psychiatry	• Provide outpatient and inpatient evaluation of diseases related to mental health • Social work including supportive counseling, psychological assessment, education and teaching provided to outpatient and inpatient services • Electroconvulsive therapy • De-addiction clinic • HDU (High Dependency unit) -Counselling -Psychological assessment -Memory Clinic -Ketamine therapy
Obstetrics	• General obstetrics • Labor and Delivery • Management of critically ill obstetric patients • High Risk pregnancy • Antenatal services • Management of fetal abnormalities • Fetal medicine • Infertility (ART)

Gynaecology	• Minimally invasive surgeries • D & C, D & E • Uterine Surgeries • Tubal Surgeries • Ovarian Surgeries • Hysteroscopic procedures • Specialty Clinics • Adolescent gynecology clinic • Menopausal Clinic • Infertility clinic • Well Women Clinic • Family Welfare Clinic • Cancer Screening
Radiology	• Ultrasound & Colour Doppler • Interventional Radiology procedures • Magnetic Resonance Imaging • Conventional Diagnostic Radiography
Dentistry	• Digital x-ray • Scaling • Filling • Cosmetic Procedure • Smile Designing • Tooth Whitening • Root canal Treatment • Leaser Assisted Treatment • Teeth Extraction • Wisdom Teeth Infections,Dental Implants • Primary (General) Dentistry • Specialty services • Pediatric Dental care • Facial Abscess • Oral cancer /ulcer • Preventive, • Prosthodontics, • Periodontics, • Endodontic, • Orthodontics and • Oral and maxillofacial surgery

Neonatalogy	• Prenatal Counseling • NICU • Care at Birth including Advanced Neonatal Resuscitation • Humidified High Flow Oxygen Therapy (HFNC) • Cranial Ultrasound • Non Invasive Jaundice Testing (Jaundice Meter) • Phototherapy • Kangaroo Mother Care • Support for Breast feeding (Lactation Counseling) • Hearing screen (Echo Screen) • Vaccination • Development Follow up clinic and early intervention Services
Dermatology	• Outpatients & Inpatients dermatology • Surgical Dermatology • Medical Dermatology • Cosmetic Dermatology • Skin biopsy • Laser surgery • Reconstructive Surgery • Clinical Dermatology • Pediatric Dermatology • Veneral Disease • Treatment for leprosy PRP Treatment (Platelet rich plasma) • Low Level Laser light for hairs • Laser for pigmentation • Carbon Laser • Chemical peeling • Microneedling • Radio Frequency for (Skin tag removal, mole removal) • Ear lobe tear correction • Nail Surgery • NBUVB light Therapy
General Medicine	• General Medicine • Diabetic • Hypertension • Polyarthritis • Health check up Programme • 30 beded medicine ICU for Poisoning, snake bite, Infective Diseases, Hepatic Encephalopathy, Renal disease.

	• Pathology : Xray :ECG: 2D-ECHO: USG : PFT: TMT
Pediatrics	• Antenatal Care • Newborn care / NICU • Well Child Visits • Adolescent Care • Pediatric Acute Care • Pediatric In-patient care
Neurology	• Acute Ischemic stroke • Thrombolisation • Endovascular Interventional Neurology • Diagnostic Neurology - EEG - Video EEG - PSG - NCS - EMG - VEP • Neuro ophthalmology • Neuro- ICU, Neurosurgery • Stroke unit • Botutinum toxim injection • Sub-Specialties - Epilepsy - Surgery • Plasmapheresis for Autoimmune neurological disorder • Sleep Disorders
Neurosurgery	• Cerebral strokes (haemorrhagic and non-haemorrhagic) • Spontaneous intra-cranial bleeding (hypertensive, aneurysmal rupture, vascular malformation...) • Brain and Spine Tumors • Degenerative spine diseases (disc disease, degenerative spine diseases) • Traumatic Brain, Spine and Peripheral nerve injuries • Hydrocephalus • Congenital malformations of the central nervous system • Pituitary tumors • Epilepsy surgery

Orthopedics	• General Orthopedics • Arthroplasty Surgeries (Joint Replacement) • Spine Surgery • Sports Medicine • Pediatric Orthopedic Surgery • Traumatology Surgeries (Orthopedic & Spine Trauma)
Cardiothoracic Surgery	• **Adult Cardiac Surgery** A. CABG-On Pump, Off Pump, - MICS B. Valve Surgery - MVR, AVR - Tricuspid Repair - Closed Mitral Valvotomy - Double Valve Replacement/Repair - Triple Valve Replacement/Repair C. Tumour of Heart- - LA myxoma , RA myxoma, D. Mediastinal mass • **Congenital Heart Malformation** - ASD - VSD - PDA - Tetralogy of Fallot's - Coartion of Aorta
Medical Gastro-enterology	○ **Sub-Specialty** • Oesophageal diseases • Stomach diseases • Liver & Pancreas diseases • Intestinal and Colon diseases • Anal diseases • Obesity clinic ○ **Endoscopic Procedures** • Gastroscopy (Diagnostic and Therapeutic) • Colonoscopy (Diagnostic and Therapeutic) • Capsule Endoscopy • ERCP
Anesthesiology / Cardiac Anesthesia	• Anesthesia • Procedural Sedation • Pain Management • Cardiac Anesthesia

Otorhinolaryngology / ENT	• Diagnostic Procedures • Audiometry • Tympanometry • Otoacoustic emissions testing (OAE) • Auditory brainstem testing (ABR) • Vestibular evoked myogenic potentials (VEMP) • Video head impulse testing (VHIT) • Hearing aid evaluation and fitting • Surgery and Procedures • Ear tube placement • Tympanoplasty for tympanic membrane perforations • Mastoidectomy for cholesteatoma • Stapedectomy for otosclerosis • Implantable hearing aids • Endoscopic ear surgery • Adenoidectomy and tonsillectomy • Surgery for balance disorders • Parotidectomy • Septoplasty and turbinate reduction • Endoscopic sinus surgery • Facial plastic surgery and rhinoplasty • Surgery for vocal cord diseases
Nephrology	• Dialysis
Urology	• *Open and minimally invasive radical prostatectomy* • *Urologic reconstruction* • *Laparoscopy* • *Treatment of urinary stones* • *Treatment for benign prostate hypertrophy* • *Treatment of erectile dysfunction* • *Microsurgery for infertility* • *Minimally invasive techniques to treat kidney disease* • *Treatment of urinary incontinence* • Prostrate and Urology Cancers • Stone Management
General Surgery	• Surgery • Minimally Invasive Surgery • Bariatric Surgery • Colorectal Surgery • Hepatobiliary & Pancreatic Surgery • Breast Surgery

Laboratory & Pathology	• Haematology • Biochemistry • Immunohematology • Serology • Immunology
Critical Care	• Multi-Disciplinary Intensive Care Unit • Intensive Cardiac Care Unit
Rheumatology	• Rheumatic Diseases • Autoimmune Diseases

Reference – AAC 1.C.

Committees in Saideep Healthcare & Research Pvt. Ltd.

POSH Committee

1. Objective:

The objective of the Committee is to provide protection, prevention and redressal of complaints against sexual harassment of women at Saideep Hospital and Research Pvt. Ltd.

2. Scope:

The policy is applicable to all employees, trainees, vendors, suppliers, consultants contract employees and visitors at all locations of Saideep Hospital and Research Pvt. Ltd.

3. Constitution of Internal Committee:-

Medical Director	Presiding Officer	Dr.BhagyashriRaut
Chief Administrator	Convener	Dr. H. Kalgaonkar
General Admin	Member	Mr. Vilas Kalbhor
NGO Member	Member	Dr.Priti Bhombe
Staff Nurse	Member	Mrs. SangitaGarad
HR Manager	Member	Mr.RajendraShrimandilkar
MRD Incharge	Member	Dr.Monali Gore

Quorum:

The minimum quorum for passing any resolution in the committee should be more than **50%** of the members present with chairperson mandatory.

Frequency of meeting:

Members of the committee meet every **quarter and as & when required.**

.Roles & Responsibilities:

POSHcommittee should be responsible for:

- Receiving the complaint & resolution of the complaint as per guidelines given in POSH act.
- Proper documentation of the inquiry
- All complaints shall be addressed in fair manner in keeping with the principles of naturaljustice.
- Interim Relief or punishment given must be fair, prompt, reasonable andconsistent.

Common minimum agenda:

- Review previous meeting agenda
- Discussion on any complaint received
- Discussion on variation in process for bettersafety of women employees against sexual harassment.
- Any other related issues

Terms of office for appointment:

The committee will be appointed for the period of one year. The management of the hospital will have the right to reappoint all or any of the said members and appoint new members to fill any vacancy. Minutes of the meeting would be recorded by the convener and circulated to all representatives including Director &all Dept.

Records to be maintained and period of retention

- Minutes of the meeting and the related document
- Analysis of RCA, CAPA
- The record shall be maintained for minimum three years

Code Blue Committee

Objective:

The code blue committee is formulated to provide better services when medical emergencies arise to patient requiring recovery or otherwise in need of immediate medical attention to anyone. The committee is composed of multi-disciplinary team of staff nurses and physician leaders. The committee is responsible for establishing and overseeing the policy on cardio-pulmonary resuscitation.

Scope:

Applicable to all departments of the hospital.

1	Cardiologist	Chairperson	Dr. Kiran Deepak
2	Intensivist / Anaesthetist	Convener	Dr.Raut / On Duty Intensivist Dr.PradipNangude
3	Medical Superintendent	Member	Dr. Sunil Darandale Dr.vikasLabade
4	Chief Admin	Member	Dr. H. Kalgaonkar
5	Quality Co-ordinator	Member	Ms. Shraddha Suryavanshi
6	Nursing Superintendent	Member	Mr. Santosh Sanagle Ms.SupriyaKamble
7	ACLS/ BSL Trained Staff	Member	CCU/MICU In-charge
9	PSO	Member	Ms.ShivaniKamble
10	Security In-charge	Member	Mr. Irfan Shaikh
11	MRD In charge	Member	Dr.Monali Gore

Constitution of Committee

The convener shall have the authority to invite any non-member to attend the meeting if it is deemed fit in relation to any matter being/ or to be deliberated by the committee.

Quorum:

The minimum quorum for passing any resolution in the committee should be more **than 50% of the members** present with chairperson mandatory.

Frequency of meeting:

Members of the committee **meets once a month**

Roles & Responsibilities:

Code blue committee should be responsible for:

- Ensuring adherence to the hospital resuscitation guidelines and standards
- Defining the role and composition of the resuscitation team
- Ensuring availability of resuscitation equipment for clinical use
- Ensuring the availability of appropriate resuscitation drugs
- Planning adequate provision of training in resuscitation
- Planning of AMDC (Annual Mock Drill Calendar)
- Determining requirements for and choice of resuscitation training equipment
- Preparing all policies related to resuscitation & anaphylaxis
- Conducting an audit of resuscitation drills, outcomes & implementation of resuscitation policies

Common minimum agenda:

- Review previous meeting agenda
- Discussion on variation in Mock Drill
- Discussion on variation in actual Code Blue
- Any other related issues

Terms of office for appointment:

The committee will be appointed for the period of one year. The management of the hospital will have the right to reappoint all or any of the said members and appoint new members to fill any vacancy. Minutes of the meeting would be recorded by the convener and circulated to all representatives including Director & Quality Dept.

Records to be maintained and period of retention

- Minutes of the meeting and the related document
- Analysis of RCA, CAPA
- The record shall be maintained for minimum three years

Clinical Audit Committee

Objective:

To define policy and protocols on carrying out clinical audit with an aim to improve the quality inpatient care and suggest changes as required based on the audit findings.

Scope:

Applicable to all clinical departments of the hospital.

Constitution of Committee

The convener shall have the authority to invite any non-member to attend the meeting if it is deemed fit in relation to any matter being/ or to be deliberated by the committee.

Designation		Name
Medical Director	Presiding Officer	Dr. Kiran Deepak
Chief Medical Administrator	Convener	Dr.HrishikeshKalgaonkar
Medical Director	Member	Dr.Vaishali Kiran
Medical Superintendent (Non-Clinical)	Member	Dr. Sunil Darandale
Medical Superintendent (Clinical)	Member	Dr.VikasLabade
NABH Co-ordinator	Member	Ms. Shraddha Suryawanshi
Nursing SuperintendentANS	Member	Mr. Santosh Sangale/ Ms. SupriyaKambale
PSO	Member	Ms.ShivaniKamble

All Concerned RMO & Nurse in-charge	Member	
All Specialities Doctors	Member	

Quorum:

The minimum quorum for passing any resolution in the committee should be more than **50%** of the members present with chairperson mandatory.

Frequency of meeting:

Members of the committee meets **once in two months**.

Roles & Responsibilities: The Clinical Audit Committee shall be responsible for:

To scrutinize and approve the clinic audit submitted by the auditor
To scrutinize and approve the audit pro-forma submitted by the auditor
To scrutinize and approve the audit methodology
To review and approve the audit report
To take action as required based on the audit findings

Common minimum agenda:

- Review previous meeting agenda
- Discussion on the status of ongoing clinical audits
- Discussion on deficiencies/ non compliances in clinical audits.
- Any other related issues

Terms of office for appointment:

The committee will be appointed for the period of one year. The management of the hospital will have the right to reappoint all or any of the said members and appoint new members to fill any vacancy. Minutes of the meeting would be recorded by the convener and circulated to all representatives including Director & Quality Dept.

Records to be maintained and period of retention

- List and details of all members
- The TOR of the committee
- Copy of all agendas, minutes of all meeting
- Attendance sheet
- Copy of any other correspondence to the committee members or non-members
- Copy of any study conducted for the sake of the committee

Disciplinary Committee

Objective:

Saideep Healthcare believes in promoting fairness in the treatment of associates and in the conduct of business. The policy is also aimed at ensuring that the standards of conduct are adhered with. The purpose of this policy is to provide standard guidelines for managing situations which require disciplinary action.

Scope:

Applicable to all departments of the hospital.

Constitution of Committee

The convener shall have the authority to invite any non-member to attend the meeting if it is deemed fit in relation to any matter being/ or to be deliberated by the committee.

Chief Administrator	Presiding Officer	Dr. H. Kalgaonkar
General Admin	Convener	Mr. Vilas Kalbhor
Medical Supridentent	Member	Dr.Vikas Labade Dr.Sunil Darandale
Nursing Supridentent	Members	Mr.Santosh Sangle Ms.Supriya KAmble
Quality Co-Ordinator	Member	Mrs.Shraddha suryavanshi
HR Manager	Member	Mr. Viresh Dethe
Security HOD	Member	Mr.S.M.Irfan

Quorum:

The minimum quorum for passing any resolution in the committee should be more than **50%** of the members present with chairperson mandatory.

Frequency of meeting:

Members of the committee meet **quarterly and as & when required.**

Roles & Responsibilities:

Disciplinary committee should be responsible for:

- To promotes and preserve a safe, productive and pleasant work environment, which enables associates to achieve their highest level of productivity andself-fulfilment.
- To ensure all employees meet the standards of performance and conduct, which have been established for theirjobs.
- All disciplinary matters shall be addressed in fair manner in keeping with the principles of naturaljustice.
- Disciplinary action must be fair, prompt, reasonable andconsistent and proportionate to the misconduct.

Common minimum agenda:

- Review previous meeting agenda
- Discussion on Disciplinary related activity
- Discussion on variation in process for better work environment.
- Any other related issues

Terms of office for appointment:

The committee will be appointed for the period of one year. The management of the hospital will have the right to reappoint all or any of the said members and appoint new members to fill any vacancy. Minutes of the meeting would be recorded by the convener and circulated to all representatives including Director &all Dept.

Records to be maintained and period of retention

- Minutes of the meeting and the related document
- Analysis of RCA, CAPA
- The record shall be maintained for minimum three years

Pharmaco Therapeutic Committee

Objective:

The pharmaco-therapeutics committee is formulated to ensure the policies and procedures related pharmacy services. The committee is composed of multi-disciplinary team of staff nurses and physician leaders. The committee is responsible for establishing and overseeing the antibiotics policy and other pharmacy related policy.

Scope:

Applicable to all departments of the hospital.

Constitution of Committee

The convener shall have the authority to invite any non-member to attend the meeting if it is deemed fit in relation to any matter being/ or to be deliberated by the committee.

1	Pharmacy Head	Chairperson	Dr. Kailas Jhalani
2	Chief Administrator	Member	Dr. H. Kalgaokar
3	Quality Co-ordinator	Member	Ms. Shraddha Suryavanshi
5	General Medicine	Member	Dr. S S Deepak
6	Paediatrician	Member	Dr.AnilkumarKurhade
7	Cardiology	Member	Dr. Kiran Deepak
8	General Surgery	Member	Dr.ShyamsunderKekade
9	Neurology	Member	Dr. Rahul Dhoot
10	Neurosurgery	Member	Dr.BhushanKharche
11	Anaesthesiology	Member	Dr.Sangeeta Kulkarni
12	Obstetrics & Gynaecology	Member	Dr.Vaishali Kiran
7	Orthopaedics	Member	Dr. V. N. Deshpande
8	Medical Superintendent	Member	Dr. Sunil Darandale

			Dr.VikasLabade
9	Purchase In-charge	Member	Mr. Sanjay Deshpande
10	Pharmacy In-charge	Convener	Mr. Deepak Kale
11	Nursing Superintendent	Member	Mr. Santosh Sangale Ms.SupriyaKamble
12	PSO	Member	Ms.ShivaniKamble

Quorum:

The minimum quorum for passing any resolution in the committee should be more **than 50%** of the members present with chairperson mandatory.

Frequency of meeting:

Members of the committee meets **once in three month** and as and when required.

Roles & Responsibilities:

Pharmaco Therapeutics committee should be responsible for:

- To formulate and implement the hospital formulary and update the same at regular interval
- To oversee the effective and efficient operation of the formulary system.
- To communicate the defined policies and procedures among the Doctors , Nurses and Pharmacist and other staff
- To define and establish a frame work for reporting of Adverse Drug Events.
- To insure the safe practice for prescribing, distribution, administration and the monitoring of medication.
- Planning of ATC (Annual Training Calendar)
- Insure that pharmacy services are complied with the applicable laws and regulations.
- Design and implement Narcotics drug and psychotropic substances in the hospital.

Common minimum agenda:

- Review previous meeting agenda
- Discussion on effectiveness of training.
- Discussion on Adverse Drug Events.
- Any other related issues
- Review on Pharmacy Audit.

Terms of office for appointment:

The committee will be appointed for the period of one year. The management of the hospital will have the right to reappoint all or any of the said members and appoint new

members to fill any vacancy. Minutes of the meeting would be recorded by the convener and circulated to all representatives including Director & Quality Dept.

Records to be maintained and period of retention

- Minutes of the meeting and the related document
- Analysis of RCA, CAPA
- The record shall be maintained for minimum three years

Material Management Committee

Objective:

The material management committee is formulated to ensure the policies and procedures related purchase and to guide planning, selection and installation of new equipment in hospital. The committee is composed of multi-disciplinary team of Clinical, Administration, and Pharmacy & General Store in-charge. The committee is responsible for purchase, condemnation of the medical as well as non-medical equipment.

Scope:

Applicable to all departments of the hospital.

Constitution of Committee

The convener shall have the authority to invite any non-member to attend the meeting if it is deemed fit in relation to any matter being/ or to be deliberated by the committee.

1	Chairman	Chairperson	Dr. S S Deepak
2	Director	Member	Dr. Kailas Jhalani
3	Chief Administrator	Member	Dr. H. Kalgaokar
4	Chief Financial Controller	Member	Mr. KishorPipada
5	Purchase Head (Central Store)	Convener	Mr.VinayPimparkar
6	Pharmacy In-charge (Purchase)	Member	Mr. Sanjay Deshpande
7	Pharmacy In-charge (Operations)	Member	Mr. Deepak Kale
8	Quality Co-ordinator	Member	Ms. Shraddha Suryavanshi
9	Gen Manager	Member	Mr.VilasKalbhor
10	Pharmacy In-charge	Member	Mr.Anand Bora
11	IT HOD	Member	Mr.ShivajiPulate
12	BME In-charge	Member	Ms.ShardaNimbalkar
13	FMS In-charge	Member	Mr.PrakashGadekar
14	Laundry In-charge	Member	Ms.UjwalaNagrik

Quorum:

The minimum quorum for passing any resolution in the committee should be more than **50%** of the members present with chairperson mandatory.

Frequency of meeting:

Members of the committee meets **once in a month** and as and when required.

Roles & Responsibilities: The Material Management Committees hall be responsible for:

- Value analysis. This is defined as the process by which all new technology, products and services current and proposed, are reviewed to ensure that the Hospital is receiving the optimum benefit and outcome from all moneys spent in hospital operations.
- Approve or reject new technology, products, medical devices, equipment, and services for use in the Hospital.
- Reviewing and approving both product selection and sources of purchased services to ensure the standards established by the Hospital are met and does not compromise the quality of patient care.
- This committee is accountable for reporting any savings or costs related to the decisions made.

Common minimum agenda:

- Review previous meeting agenda
- Discussion on New material purchase request
- Discussion on New vendors/Items introduced.
- Any other related issues

Terms of office for appointment:

The committee will be appointed for the period of one year. The management of the hospital will have the right to reappoint all or any of the said members and appoint new members to fill any vacancy. Minutes of the meeting would be recorded by the convener and circulated to all representatives including Director & Quality Dept.

Records to be maintained and period of retention

- Minutes of the meeting and the related document
- Analysis of RCA, CAPA
- The record shall be maintained for minimum three years

Ethics Committee- Terms of reference

Members

CMD

Director(s)

Senior Clinicians – Various Departments

Nominated Member (Academics / Research Expert)-External Member

One Social Activist / CBO Representative - External Member

Elected People Representative / Legal - External Member

Term

One year

Functioning

- The Ethics Committee (EC) will abide by the following applicable regulatory guidelines:
  - Good Clinical Practice (GCP), as per Government of India, Drugs & Cosmetics Act and rules there under, Rule 122-DAA, & Schedule Y.
  - ICMR Guidelines for Biomedical Research on Human Subjects.
  - International Conference on Harmonization (ICH) Guidelines for Good Clinical Practice and Declaration of Helsinki.
- The EC shall ensure and safeguard the rights, safety and well being of all trial subjects. Special attention shall be paid to trials that may include vulnerable subjects.
- The EC shall conduct continuing review of each on-going trial at intervals appropriate to the degree of risk to human subjects, but at least once per year.
- When a trial is to be carried out with the consent of the trial subject's legally acceptable representative, the EC shall determine that the proposed protocol and/or other document(s) adequately address the relevant ethical concerns and meet applicable regulatory requirements for such trials.
- Where the protocol indicates that the prior consent of the trial subject or the subject's legally acceptable representative is not possible, the EC shall determine that the proposed protocol

and/or other document (s) adequately address the relevant ethical concerns and meet applicable regulatory requirements for such trials (i.e., in emergency situations).

- The EC shall review both the amount and method of payment to subjects to defray expenses and/or compensation for any loss of income of the participant, and to ensure that this does not amount to coercion, undue influence, misrepresentation or fraud, on the trial subjects. Payments to a subject shall be on a prorated basis, and not wholly contingent on completion of the trial by the subject.
- The EC shall ensure that information regarding payment to subjects, including the methods, amounts, and schedule of payment to trial subjects and compensation in case of trial related injury or illness, is set forth in the written informed consent form and any other written information to be provided to subjects. The method of prorating payment shall be specified.

Structure and Roles

The EC shall be multi-disciplinary and multi-sectoral in composition.
The EC will be constituted in the following pattern:

(i) A Chairperson
(ii) A Member Secretary
(iii) 5-15 members from the following background:
- Basic Medical Scientists
- Clinician
- Legal expert
- Social Scientist / representative of non-governmental voluntary agency /philosopher / ethicist / theologian or a similar person
- Lay person from the community

The EC shall have representation of both genders
The Chairperson of the EC will be from outside the institution.
The Member Secretary will belong to the same institution and shall conduct the Business of the committee

Procedure for membership appointment

- The head of the hospital will nominate the members of EC, who collectively have the qualifications and experience to review and evaluate the science,medical aspects, and ethics of the proposed trial
- Conflict of interest will be avoided when making appointments, but where unavoidable there will be transparency with regards to such interest

- EC may invite subject experts as independent consultants who may provide special review of selected research protocols, if need be. They will not take part in decision making process which will only be made by the members of the EC.
- Term for EC member will be for 2 years
- Appointment of member can be renewed on the basis of contribution
- Member can discontinue from membership of EC after giving at least one month advance notice
- Member can be disqualified if there is long period of non availability or inadequate contribution
- All members should maintain absolute confidentiality of all discussions during the meeting and sign a confidentiality form
- Conflict of interest should be declared by members of the EC

Quorum requirements

- Minimum 5 members are required to compose the quorum without which a decision regarding the research shall not be taken. Chairperson and Member secretary should also be present for review of each protocol along with these 5 members
- No quorum should consist entirely of members of one profession.
- Quorum will include at least one representative from the following group:
  - One basic medical scientist (preferably one pharmacologist)
  - One clinician
  - One legal expert or retired judge
  - One social scientist/ representative of non-government organization/Philosopher/ ethicist/theologian or a similar person
  - One lay person from the community
- All decisions will be taken in meetings and not by circulation of project proposals.

Infection Control Committee – Terms of Reference

Purpose

In order to establish and implement policies and procedures for effective infection control and prevention in the hospital

Members

Director -
Medical Superintendent
Medical Administrator
Representative from Microbiology Department
Representatives from Clinical Departments
Quality Coordinator
Nursing Superintend
Infection Control Officer
HIC Nurse

Structure of Committee and roles

Chairperson

The committee shall be headed by Chairperson elected by members whom shall overlook the functioning of the committee and system

Secretary

Elected secretary shall be responsible for coordination of meetings, documentation of minutes and communication of decisions to respective members.
They shall also coordinate with quality department regarding the functioning of committee

Hospital Infection Control Officer

Elected Member and appointed by the committee .He/ she shall guide and coordinate all the infection control practices recommended by the committee. He/she shall ensure the decisions of HIC committee shall be implemented. Refer to Infection Control Manual for detailed job description

Frequency of meeting

Every month

Responsibilities and Functions

- To formulate infection control policies and procedures to publish Hospital Infection Control Manual
- To establish a practical system for identifying, reporting and evaluating infection in inpatients, selected outpatients and discharged patients.
- To establish policy criteria for distinguishing between nosocomial and community acquired infections
- To develop a hospital antibiotic policy.
- To develop guidelines for segregation and disposal of hospital wastes.
- To establish a mechanism to investigate and identify the reservoir, source, and method of transmission of each outbreak of nosocomial infection and institute appropriate measures to limit further spread from identified sources of contagion.
- To establish and implement institution-wide policies and procedures.
- To review and evaluate written policies and procedures pertinent to infection control (on asepsis, isolation and sanitary techniques) for all services on an annual basis and revised wherever necessary.
- To review all Healthcare Epidemiology departmental policies annually.
- To establish a system for reporting, evaluating and maintaining records of infections among patients and personnel and the ongoing collection and analytic review of data and action taken with subsequent dispersion of this data throughout the hospital.
- To review the types of surveillance and reporting programmes implemented by Infection Control.
- To provide input into the Hospital Employee Health Programme.
- Maintain functional compliance with infection control policies and procedures.
- Reviews the types of surveillance and reporting programmes implemented by Infection Control.
- Reviews standard criteria for reporting all types of infections.
- Reviews department and infection control policies and procedures every 2 years and recommends revisions to management.

- Evaluates and approves the applicability and appropriateness of all action(s) taken to prevent and control infections based on records and reports of infections and infection potential among patients and hospital personnel.
- Report's findings and recommendations through committee minutes to others
- The committee will report to the [Quality Management Committee] through forwarding the recordings of proceedings of the meeting.
- Follows up to ensure compliance with recommendations made to eliminate hazardous situations.
- Consults with other hospital staff as needed to implement an effective infection control programme.
- Individual members report relevant findings, investigations, infection control problems, etc the staff of the division / department they represent.

Related Documents

Infection Control Manual

Medical Record Audit Review Committee

Purpose

This committee provides instruction and guidance on medical documentationandvarious issues pertaining to Medical record

Members

- Medical Superintendent
- Quality co-ordinator
- Resident Medical Officers
- Representative from various clinical departments
- Nursing Superintendent
- Senior Staff Nurses

Structure of Committee and roles

Chairperson

The committee shall be headed by Chairperson elected by members whom shall overlook the functioning of the committee and system

Secretary

Elected secretary shall be responsible for coordination of meetings, documentation of minutes and communication of decisions to respective members.
They shall also coordinate with quality department regarding the functioning of committee

Frequency of Meeting

Once in 3 months

Roles and Responsibilities

- To prepare the policies pertaining to medical documentation
- To develop and design various forms and formats used in medical documentation
- To facilitate, guide and advice for sustaining a regular, objective, explicit and effective method of quality assurance through a system based on peer review.
- To examine, review and suggest remedial measures for any complaints (written/verbal) regarding medical care.
- To examine and review case(s) of longer stay then benchmark and/or specific issue in the hospital, as a routine practice.
- To guide and advise upon review and documentation of existing clinical practices.
- Performing Medical System Audits through conduct of random review of medical / surgical cases handled by the hospital using a retrospective audit of case sheets; to ensure that the treatment and care provided confirmed to the various systems and protocols established by the hospital for treatment, diagnosis, care and administration.
- Performing Medical Documentation System Audit;
- Periodic reviews of medical records (active and discharged patients) based on a representative sample based on statistical principles.
- The review should focus on timeliness, legibility and completeness of medical records.
- Taking corrective and preventive measures based on the findings; including interacting with various clinicians / departments to improve the medical documentation system.

Related Documents

Medical Record Audit Analysis reports

IMS policies and procedures

Quality Management Committee

Purpose

Quality Management committee shall be responsible for continuous quality improvement initiatives.

Members

- Director – In-Charge Quality & Patient Safety
- Medical Superintendent
- Medical Administrator
- Quality Coordinator
- Nursing Superintend
- Representatives from Clinical Departments
- Nurses

Structure of Committee and roles

Chairperson

The committee shall be headed by Chairperson elected by members whom shall overlook the functioning of the committee and system

Secretary

Elected secretary shall be responsible for coordination of meetings, documentation of minutes and communication of decisions to respective members.
They shall also coordinate with quality department regarding the functioning of committee

Frequency of meeting

Once in a month

Responsibilities and functions

- Planning of the quality management system
- Establishment, monitoring and review of quality indicators
- Ensuring the availability of resources as required by the quality management system

- Conducting management reviews
- Reviewing non-conformances related to services
- Reviewing internal audit reports
- Analysis of data on process and service measurements
- Analysis of patient satisfaction data and complaints
- Ensuring timely corrective and preventive actions
- Ensuring continual improvement of the quality management system.

The Convener will circulate the agenda of each meeting at least a week before the meeting. Each committee meetings will have the following reports presented to the committee as a part of the regular proceedings;

- Report on Medication Errors / Adverse Drug Events
- Report of Patient Safety / General Safety Incidents
- Report of HAI's and Infection Control Activities –
- Report on Patient Satisfaction Surveys & Complaint Analysis –
- Report on Incidents / Issues related to Blood and Blood Products including Transfusion Reactions
- Report on Incidence Report Analysis / Risk Management Assessment / Statutory Compliance
- Sentinel Event Analysis Reports
- Report of Internal Audits
- Report on Employee Satisfaction and Training & Development Activities
- Report on Utilization of Services & Facilities –Associate Director/Quality in charge

Related Documents

CQI Chapter Policies

Safety Committee

Purpose

The safety committee role is to establish and maintain a progressive patient safety program to provide safe and effective care to the patient of Saideep Hospital by creating an environment conducive

Members

- Director – In-Charge Quality & Patient Safety
- Medical Administrator
- Quality Coordinator
- Representatives from Clinical Departments
- Nurses
- Facility Management In-Charge
- Biomedical Engineer
- Designated Hospital Safety Officer
- Radiology Safety Officer
- Laboratory Safety Officer
- Fire Safety officer
- Security In-Charge

Structure of Committee and roles

Chairperson

The committee shall be headed by Chairperson elected by members whom shall overlook the functioning of the committee and system

Secretary

Elected secretary shall be responsible for coordination of meetings, documentation of minutes and communication of decisions to respective members.
They shall also coordinate with quality department regarding the functioning of committee

Frequency of meeting

Once in three month

Responsibilities and functions

- Coordinates development, implementation and monitoring of the safety plans and policies
- Promote a culture of safety throughout the hospital through staff education programme and trainings; and internal campaigns through workplace posters, awards and incentives.
- Conduct patient education materials for educating patients and families on their role in ensuring safety at the hospital.
- Conduct a thorough safety inspection of the campus once a year; to mapping potential safety risks to patients and employees. The documented findings of the safety inspection will be submitted to Quality Management Committee with suitable recommendations for actions.
- Conduct root-cause analysis for all reported safety related incidents and ensure appropriate corrective and preventive actions.
- Analyze all reported Sentinel Events (safety related) and plan and ensure corrective and preventive actions.
- Review and update the list of sentinel events (safety related) periodically based on the emerging studies published
- Issue and circulate sentinel event (safety related) alerts to all departments / units of the hospital.
- Compile performance statistics for safety related indicators and analyze the same for trends. The report of the analysis done shall be submitted to the Hospital Management Committee.
- Overlook Laboratory and Radiation safety practices
- Conducting mock-drills for fire and other identified hospital emergencies

Related Documents

Safety Manual
Laboratory Safety Manual
Radiation Safety Manual

Transfusion Committee - Terms of Reference

Purpose

The committee shall be responsible for defining and monitoring rational use of blood and blood products

Members

- HOD Pathology/ Blood Bank Officer, Convener.
- Medical Superintendent.
- Senior Consultant General Surgery
- Senior Consultant CTVS
- Senior Consultant OB/GYN
- Representative from various clinical departments
- In charge of BSU

Structure of Committee and roles

Convener

The committee shall be headed by Chairperson elected by members whom shall overlook the functioning of the committee and system

Secretary

Elected secretary shall be responsible for coordination of meetings, documentation of minutes and communication of decisions to respective members.
They shall also coordinate with quality department regarding the functioning of committee

Frequency of meeting

Once in two month

Responsibilities and functions

- To establish broad policies for blood transfusion therapy.
- Develop criteria audits of transfusion practice

- Enhance quality patient care through objective assessment of ongoing blood and blood component therapy.
- Review and analyze the statistical reports of the transfusion services.
- Audit blood use with emphasis on the following:
  - Blood products transfused
  - Adverse reactions
  - The transmission of infectious diseases and other adverse effects of blood transfusion.
- Review the findings of problem areas and evaluate their improvement.
- Promote continuing education in transfusion practices for the hospital staff.
- The assessment of safety and adequacy of the blood supply.
- Annual review of the written policies and procedures of the hospital transfusion services to ensure they conform to the standards set by the NACO and MSACS
- Submit reports to the hospital organizations in charge of the overall quality assessment program. This includes recommendation for improvement or corrective actions when needed.

Related Documents

Blood Bank Quality Manual

Blood Bank Standard Operating Procedure

Statutory and Regulatory requirements

The following are the statutory and regulatory requirements applicable

- Plan Approvals / Occupancy Certificates – Hospital Buildings
- No objection certificate from the Chief Fire officer.
- License under Bio- medical Management and handling Rules, 2019.
- No objection certificate under Pollution Control Act - Air / Water (prevention and control of pollution) act, 1981.
- AERB – Radiology, Cardiology, Dental, Surgery
- PNDT – USG, Amniocentesis
- MTP Licence
- Psychiatry / Mental Health Licence
- BSU Licence
- Licence Narcotics and Psychotropic substances Act.
- Bulk Drug Licence – Central Pharmacy
- Retail drug licenses
- Vehicle registration certificates – Ambulance and Hospital Vehicles
- PAN
- GST
- PF Registration
- ESI registration
- Explosives Licence – Liquid Oxygen Plant
- HT Licence (Electrical)
- Licence for DG Installation
- FSSAI Licence - Canteen.
- Lift Licences

Access Assessment and Continuity of care Policies

24.1 Policy for Admission & Registration

Purpose

To guide the registration and admissions of patients

Scope:

Scope of registration includes all patients in OPD, IPD, Diagnostic and Emergency Department.

This policy shall be applicable to all kinds of admission:

- Planned Admission
- Unplanned Admission
- Emergency

Abbreviation

- CMO –Casualty Medical Officer
- OPD - Out Patient Department
- IPD - In Patient Department
- MLC - Medico Legal Cases

Definition

Registration

Process by which the patient is added to the list of data pool of the hospital so that a reference can be made as the registration number becomes the identifier of that patient in present as well in future.

Unidentified patient

Patient coming or brought to the hospital, whose details (name, address etc.) cannot be identified are termed as unidentified patients.

Policy for registration and admission

- Hospital shall register and admit those patients that match the scope of the facilities.

- Admissions shall not be denied due to religion, nationality, caste or creed as long as the patients are willing to comply to the rules and regulation of the
- The hospital will register a patient according to the process laid down in SDH/AAC/01.
- All patients are registered with a unique registration number (Hospital Number).
- Registration shall be done for OPD consultation, Investigations and Emergency care.
- Emergency care has to be provided 24 hrs a day and 365 days a year.
- All admissions made by a doctor under a particular unit will be considered as admission by the unit. The unit head would be responsible for all admissions made by the unit.
- Regular admissions are done from 8 AM to 5 PM after which all admissions shall be made through Casualty only.
- During holidays (festival) the admissions are through the Casualty
- In case of confusion as to whether to register or not, Medical Superintendent / Medical Administrator shall be contacted.
- Registration and admission of undefined patients shall be done according to SDH/AAC/01
- In case of unidentified patient brought to the hospital, he/she shall be registered in emergency and as MLC case. The registration detail of such patients shall clearly show the unidentified status of the patient. The identification details shall be updated as soon as the identification of the patient is confirmed

Policy during non availability of beds

- Saideep Hospital has a waiting list policy for managing bed during non availability
- Non critical patients are hold in casualty observation area in case beds are not available and
- Shifting beds to different class of accommodation shall be strictly on first come first serve basis
- In case the HCO has no critical care beds available and there is no provision to arrange by shifting a stabilized patient they shall be transferred to another HCO

24.2 Policy for transfer and referral for patients

Purpose

To assist the relevant personnel on the patient transfer process
To safely transfer of the patient to the outside facility

Definition

Unstable patients - Any patients whose vital signs (heart rate, blood pressure, respiratory rate, oxygen saturation, level of consciousness) are compromised. E.g. In cases of Polytrauma, shock, Status epilepticus, malignant arrhythmia and impaired level of consciousness.

Stable patient – Any patient who has normal vital signs, and absence of any immediate threat of life or limb or vision and who is not in any acute physiological distress

Policy for Transfer of Patients

- Unstable patients are only transferred in ACLS supported ambulances
- Stable patients could be transported in ambulance without life supporting facilities
- Transfer out of unstable patients for any services that is not available in the hospital shall always accompany a ACLS Trained personnel in the ambulance
- The patient's family members shall be informed about the risk involved in such transfers
- Transfer of unstable patients against medical advice will not be entertained by hospital and patients family members shall do that in their own responsibility
- The Causality Medical officer or Treating doctor shall communicate regarding such transfers to desired hospital and shall make necessary arrangements in order to avoid possible delays in patient care
- A treatment summary or discharge summary is prepared and given to patients before transfer
- The hospital shall always keep a duty list for persons to accompany during such transfers
- The Casualty department sends Ambulance for transfer in of patients from a different facility.
- Bed availability for admission shall be checked before sending the ambulance
- The type of ambulance and accompanying personnel shall be decided on the condition of patient.
- Transfer in could be for treatment or diagnostic tests as well

Procedure for Transfer in and Transfer out of patients

Refer to SDH/AAC/02

24.3 Policy on Initial Assessment and Re assessment of Patients

Purpose

To follow a uniform protocol for initial clinical assessments of patients requiring healthcare service in OPD, IPD and Emergency services and to ensure all patients admitted are monitored continuously to evaluate the clinical progress and in order to ensure correct line of treatment based on changes

Policy

- Initial Assessment shall be performed for outpatient, inpatient and emergency patients

- Initial Assessment Shall be done in customised initial assessment formats for various departments
- Every initial Assessment shall contain at least presenting complaints, vital signs, general examination and concerned
- Doctors Initial Assessment shall be performed by treating consultant directly or one of his team member
- Detail Initial Assessment of Patients admitted in rooms and wards shall be recorded within 24 hours after their admission
- Detail Initial Assessment of Patients admitted to high dependency units shall be performed with in 1 hour after admission
- Initial Assessment in Emergency departments shall be done immediately on the arrival of the patient and not later than half an hour after arrival based on triaging decision
- In case of Re-admission in 7 days detailed initial assessment need not be re-written .Reference of latest initial assessment could be mentioned
- Nurses Initial Assessment is mandatory for IP Patients to identify nursing needs of the patient. This shall be separate from doctors initial assessment
- Doctors shall screen patient for nutritional assessment for OP patients and if patient require specific nutritional assessment they shall be referred to dietician
- Dietician shall cover nutritional assessment for all In patients
- A plan of care with objective shall be developed after initial assessment
- Plan of Care shall be verified and signed by consultant in charge within 24 hours
- After initial assessment all patients are periodically reassessed
- Patients are reassessed to determine their response to treatment and to plan further treatment or discharge
- Out Patients are reassessed during follow up visits and next follow up visits are informed
- Every In patient shall be assessed by the treating doctor at least once a day
- Subsequent assessment shall be performed by other doctors of the team as per the requirement of the patient
- For in patients plan of care is monitored and modified according to findings of reassessment
- All reassessment are documented in case sheet
- Documentation includes findings of general examination ,systemic examination and changes quantified, any other parameter specific to the specialty and as advised by consultant in charge
- Patient's vitals shall be monitored every 6 hours or as per doctor's orders and shall be documented.

Procedure for Initial Assessment and Re assessment of Patients

Refer to SDH/AAC/03

24.4 General Policy on Laboratory Services

Purpose

To define a guideline for Laboratory services that commensurate clinical services provided by the hospital

Definition

Critical results

A lab value that must be reported immediately to care provider, which may require urgent therapeutic action

Policy

- The scope of laboratory services at Saideep Hospital are made available to commensurate to the services of the Hospital and to the quantum of patient input. The laboratories covers all activities related to the following departments in connection with test/investigation for diagnostic purpose
    - Clinical Biochemistry
    - Clinical Pathology and Haematology
    - Histopathology
    - Microbiology and Serology
    - BSU
- The laboratory is working under the active participation of well experienced personnel.
- The Lab Directoris well qualified by virtue of documented training, expertise and experience consistent with applicable laws and regulations.
- There shall be responsible medical officers in charges for each laboratory whom shall report to Lab Director
- The respective heads will identify the lab staff to perform the test.
- All staffs have adequate and appropriate training, experience, and skills and are oriented to their work. Technical staff is periodically trained for better experience.
- Lab Test orders shall come from OP, IP and Emergency Patients.
- For Out patients they shall directly approach laboratory to give specimens and collect results
- For In patients and emergency patients specimen shall be sent from respective department.

- Procedure for ordering Test, Specimen collection safe transportation is reflected in Laboratory Manuals and clinical SOPs. Refer to SDH/AAC/04
- All Samples shall be identified with unique hospital number
- The time frame for stat tests and regular tests are defined by the respective laboratories (refer SDH/LSOP/01, SDH/LSOP/02,SDH/LSOP/03,SDH/LSOP/04)
- The critical results are reported to the respective unit members or the treating doctor depending on who is available on the telephone as soon as possible.
- All critical results intimated shall be recorded. Refer to SDH/LSOP/01, SDH/LSOP/02,SDH/LSOP/03,SDH/LSOP/04 for formats of recording
- There is a well-defined laboratory quality assurance programme for each unit which is carried out effectively and regularly. Refer to Laboratory Quality Assurance Manuals SDH/LQM/01,SDH/LQM/02,SDH/LQM/03,SDH/LQM/04
- Quality Assurance program address internal quality control and external quality assurance
- There is a well defined laboratory safety program to ensure a safe working environment. Refer to Laboratory Safety ManualSDH/LSM/01
- The laboratory personnel are provided with safety devices like apron, gloves, and masks.
- Periodic training is given on both issues (quality and safety) to the existing laboratory personnel (details – refer – laboratory quality and safety manual) and also to the new recruits in the laboratory before they are allowed to perform and report themselves.
- All test that are outsourced shall have an Memorandum of Understanding which ensure quality of delivered services

24.5 General Policy on Imaging Services

Purpose

To define a guideline for imaging services that commensurate clinical services provided by the hospital

Definition

Critical results: A finding that must be reported immediately to care provider, which may require urgent therapeutic action

Policy

- The scope of imaging services at Saideep Hospital are made available to commensurate to the services of the Hospital and to the quantum of patient input. It includes
  - □ MRI Scan □ USG □ X-Ray
  - □ CT Scan □ Mammography □ Angiography

- Imaging Services shall comply with all legal requirements

- The Radiation Safety officer Appointed by institute shall be responsible all safety and quality initiatives with respect to imaging services
- Radiation signage shall be displayed where ever applicable
- X ray warning message for pregnant ladies shall be displayed outside all X ray units
- All USG units shall have display as per PNDT act
- The department shall have adequately qualified and trained staff to perform and supervise investigations
- The department shall have qualified radiologist who could interpret the investigations
- All patients will be identified with hospital number and their full name
- All patient transfers shall be done according to SDH/AAC/05 to guide safe transportation of patients
- Turnaround time for imaging results is defined
- Critical results are defined and it shall be intimated to treating doctor or one of their team members.
- All results shall be reported in a standardized manner
- All test that are outsourced shall have an Memorandum of Understanding which ensure quality of delivered services
- There is an established radiology quality assurance program. Refer toSDH/RSM/01, SDH/AAC/06
- There is established radiation safety program. Refer to SDH/RSM/02

24.6 Policy for multidisciplinary continuous care of patient

Purpose

To ensure that the patient care is planned and continuously delivered with multidisciplinary inputs

Policy

- There shall be a treating consultant under whom the patient is admitted
- They shall be responsible for the patient and their decisions regarding clinical care shall be final
- At all point direct care shall be only delivered by a qualified doctor, nurse or a paramedical staff.
- When students are involved in patient care it shall be only under supervision
- All communications with respect to patient care shall be documented and authorised
- Information about patient's care and responds to treatment is shared among medical nursing and other care providers
- Information exchanges during each shift, transfers shall be documented refer to Documentation procedure SDH/IMS/03
- All inter departmental transfers shall be done in a safe manner according to SDH/AAC/02
- The patient record shall be treated with at most care to ensure confidentiality
- Case sheet shall be made available to the authorised care providers to facilitate the exchange of information

- When required for opinion, co management or take over patient shall be referred to other departments or specialties
- All patient referrals to other departments shall be made and addressed according to procedure mentioned in SDH/AAC/07

24.7Discharge Policy

Purpose

To provide guideline for the discharge of patients admitted to hospital

Policy

- The treating doctor shall determine the readiness for discharge during reassessments
- The discharge process is planned in collaboration with other doctors involved in patient care
- The discharge process is planned in collaboration with patient or family members
- All discharged patient shall receive a detailed discharge summary verified by treating doctor
- All Medico Legal cases shall be informed to police
- Patients who are discharged after day care shall also receive discharge summary
- Patients who are leaving against medical advice and patients who are discharged on request are also provided discharge summaries
- Such Patients are interviewed by Medical Social workers to identify the reason for discharge
- All discharge Summary shall incorporate following contents
  - ✓ Patients Name and Unique Identification Number
  - ✓ Reasons for Admission, Significant Findings and diagnosis
  - ✓ Information regarding investigation results, procedure performed, medication administered and other treatment given
  - ✓ Follow up advice, medications and other instructions
  - ✓ Condition of the patient at the time of discharge
  - ✓ Instructions about when and how to obtain urgent care
  - ✓ In case of death summary shall contain reason for death
- All discharges shall be done according to procedure defined. Refer to SDH/AAC/08

25. Care of Patients

25.1 Uniform Care Policy

Purpose

To provide guideline instruction for ensuring uniform care of the patient.

Definition

Uniform Care

Patient with same health problems shall receive same quality of health care throughout the organisation, irrespective of the category of wards. Every patient shall be provided with uniform clinical care irrespective of cast, creed, religion, region, paying capacity, category of bed or behaviour of patient with staff

Policy

- All patients approaching the hospital for medical treatment will receive care appropriate to their healthcare need and scope of services provided by the hospital.
- Every patient admitted under this hospital shall have a consulting physician according to their choice, who bears the responsibility of complete & uniform clinical care of the patient.
- The primary treating consultant can refer the patient to other clinical specialty either within the hospital or to the identified external healthcare institutions if the patient's medical need demand the same
- Any patient seeking emergency medical services shall be screened & first aid care to be provided if required. Afterwards according to the patient's condition & choice, admission procedure shall be done.
- A general consent form shall be taken for all patients, those who are admitted.
- All medico-legal cases shall be informed to the police.
- Patient assessment shall be done under the respective wards & the detailed treatment plan will be communicated to the patient by the consulting physician.
- All procedures shall be performed with an informed consent from the patient or their immediate relation
- The clinicians may resort to evidence based medicine which is the conscientious, explicit and judicious use of current best evidence in making clinical decision about the care of individual patients.

25.2 General policy on Emergency Services

Purpose

Provide guidelines for provision of prompt emergency care which is guided by applicable

Definition

Medico Legal case (MLC)

Medico-Legal Case: can be defined as a case of injury or ailment, etc., in which investigations by the law-enforcing agencies are essential to fix the responsibility regarding the causation of the said injury or ailment. In simple language it is a medical case with legal implications for the attending doctor where the attending doctor, after eliciting history and examining the patient, thinks that some investigation by law enforcement agencies is essential

Policy

- All emergency cases shall be received in casualty
- All emergency cases received shall undergo initial assessment as mentioned in Initial assessment procedure SDH/AAC/03
- Registration of patients including unidentifiable patients shall be done according to registration and administration procedure SDH/AAC/01
- Designated Triaging officer shall perform triaging according to triaging criteria mentioned in Emergency Department Manual SDH/EDM/01
- Senior Most Nurse on duty shall act as triaging officer
- All patients approaching casualty shall receive care according hospital policies and procedure mentioned in Casualty Department Manual SDH/EDM/01
- Medico Legal cases shall be duly documented according to requirements prescribed by existing regulatory framework
- Casualty Staff shall be trained in BLS at least
- The department shall conduct orientation and periodic on the job training on departmental procedures
- All patients shall be provided a treatment summary while leaving

25.3 Policy on Ambulance Services

Purpose

To ensure seamless functioning of ambulance services to support the clinical services provided by hospital

Policy

- The ACLS &BLSambulances used are internal.
- The ambulance service provides the first point of access to health care for a wide variety of patient conditions, ranging from life-threatening emergencies to chronic illness and social care.
- Ambulance shall operate complying to all statutory requirements

- Vehicle coordinator shall be responsible for periodic maintenance and renewals pertaining to Ambulances
- Assigned personnel shall check the ambulance on daily basis
- Emergency medications and equipments in ACLS ambulances are checked daily basis by CCU staff
- Before each despatch emergency drugs and equipments shall be checked prior to dispatch
- Ambulance coordination and operation shall be performed as mentioned in Ambulance Service Operation Manual SDH/COP/01

25.4 Policy for use of uniform resuscitation

Purpose

To ensure uniform resuscitation care throughout the organization. It is the policy of the hospital to have a code blue team available 24 hours a day. Code Blue team has been called by the unit in charge to provide advanced cardiac life support/paediatrics support whenever it is required in the wards.

Policies

- All the policies and procedures shall be dictated by Cardio Pulmonary Resuscitation (CPR) committee
- Each code blue situation shall be handled as described in code Blue Manual SDH/COP/02
- A dedicated public alarming system is implemented for alarming emergencies
- Display of code blue number in all patient areas
- Paediatric code blue situations shall not be notified through public alarming instead paediatric code blue team shall be notified
- Crash cart with all necessary life saving drugs and equipments is available on each floor and earmarked locations and accessible to all patient areas as mentioned in SDH/COP/02
- Contents of crash kart are uniformly maintained in all units. Crash contents are defined in SDH/COP/02
- Crash cart is kept sealed and used only during medical emergencies
- Constitution of a code blue team to uniformly provide resuscitation in all patient areas.

- The team members are certified in Advanced cardiac life support and basic cardiac life support
- Code blue team functions in all areas except Casualty O.T.s & ICUs where on duty doctors and skilled nurses shall manage resuscitation
- CPR committee members co-ordinate the functioning and trainings required for resuscitation activities.
- Provision of training on basic life support to all nursing, medical staff during induction training
- It is ideal that all staff nurses are BLS or ACLS certified
- The CPR committee conducts a mock drill in case there is no code blue events for 4 weeks
- A code blue reporting formto collect information regarding cardiac resuscitation provided for further analysis by the CPR committee
- Post event analysis is performed during each meeting
- Corrective and preventive actions shall be taken in case of any deviations

25.5 Policy for Nursing Services

Purpose

To ensure the availability of uniform nursing care for all patients in the hospital based on their needs

Policy

- Nursing Services shall be provided in a standard format
- Nursing Care shall be uniform and continuous
- Nursing care is aligned and integrated with overall patient care.
- Nurses are empowered to take nursing-related decisions to ensure timely care of patients.
- All Nursing related procedures shall be performed as directed in Nursing Manual SDH/NSM/01
- These procedures shall be developed with respect to current standards of nursing services and practice, relevant regulations and purposes of the services.
- Each Patient admitted shall undergo a detailed initial nursing assessment

- A documented individualised patient-focused nursing care plan for each patient shall be developed based on initial assessment to achieve appropriate outcomes
- All patients shall be continuously to assessed to evaluate the outcome of the care of patient
- The care plan shall be modified whenever required
- Adequate nurses shall be assigned based on the requirement. Assignment could be patient-acuity based.
- Care provided by nurses is documented in the patient record. All documents handled by nurses are mentioned in Nursing Manual SDH/NSM/01

25.6 Policy for performance of clinical procedures

Purpose

To provide guidelines for handling patient undergoing various clinical procedures of invasive and non-invasive nature for the purpose of diagnosis or treatment which are not amounting to surgeries.

Policy

- Guidelines for performing various procedures shall be mentioned in respective department manuals. For example all Nursing procedures shall be mentioned in Nursing ManualSDH/NSM/01
- All procedures shall adhere to minimum requirements as mentioned in SDH/COP/03
- Only qualified personnel order, plan, perform and assist in performing procedures.
- All measures are taken to prevent adverse events like wrong site, wrong patient and wrong procedure as mentioned in SDH/COP/03
- Informed consent is taken by the personnel performing the procedure as mentioned in procedure of informed consent SDH/PRE/02
- The consent shall be taken by the person performing the procedure or a member of his/her team. In case the procedure is being done by a person in training, it shall specify the same. All such procedures shall be supervised by the treating doctor.
- Adherence to standard precautions and asepsis is adhered to during the conduct of the procedure.
- Patients are appropriately monitored during and after the procedure. At a minimum this shall include pulse, blood pressure and respiratory rate.
- Procedures are documented accurately in the patient record according to procedures of medical documentation SDH/IMS/03
-

25.6 Policy for Rational use of Blood and Blood Products

Purpose

To ensure the rational use of blood and blood products

Policy

- Blood and blood components shall be used rationally
- Blood and blood products shall be used rationally and only on advice of the treating physician.
- Informed consent shall be obtained whenever use of blood or blood products is contemplated.
- Drugs and Cosmetic Act as applicable to blood bank shall be followed. National Aids Control Program of India, Guidelines for the Appropriate Use of Blood, shall be followed.
- Blood must be available as per given time frame
- Emergency use in less than 1 hour
- Planned use within 24 hours.
- Family education for blood donation shall be established.
- Staff shall be trained for blood transfusion & family education for blood donation.
- All transfusion reactions (minor and major) shall be reported to the blood bank in writing and record made in the patient's medical record also
- The Transfusion Committee shall review and analyze blood transfusion reactions for preventive and corrective actions and recorded accordingly for implementation.
- Rational use of blood and blood components shall be followed as described in procedure for rational use SDH/COP/04
- Blood transfusions shall be performed as per Procedure for blood transfusion SDH/COP/05
- Provision of Blood / blood components in emergency situations and standard procedures are defines in Blood StorageUnit Manual SDH/BSU/01

25.7 Policy for care of patients in intensive care units

Purpose

To guide care of patients in intensive care units and high dependency units

Policy

- Patients in high dependency units shall receive care according to defined criteria mentioned in procedure for care of patients in high dependency unitsSDH/COP/06
- For patients who are on ventilator support care shall be delivered in 1 Nurse for 1 patient Ratio
- For patients who are not on ventilator support care shall be delivered in 1 Nurse for 2 patients Ratio
- For CTVS ICU staff Patient Ratio shall be maintained 1:1 always
- In case of bed shortage allocation shall be based on policy of non availability of beds
- Infection control practices shall be implanted as mentioned in infection control Manual
- Quality Assurance program shall be implanted as mentioned in quality Assurance program in Quality Manual SDH/QM/01
- Admissions and discharge shall be based on defined criteria mentioned in procedure for care of patients in high dependency units SDH/COP/06
- Regular In house Training shall be provided to staff in these parameters

25.8 Policy for Vulnerable Patients

Purpose

To identify the vulnerable group(s) of patients visiting / admitted in the hospital and to

- Reduce the risk of falls and abuse.
- Create awareness about vulnerability amongst care providers.
- Offer extra care to such patients in a safe and secure environment.

Definitions

Vulnerable patient

Those patients who are prone to injury and disease by virtue of their age, sex, physical, mental and immunological status,e.g. infants, elderly, physically- and mentally-challenged, those on immunosuppressive and/or chemotherapeutic agents.

Policy

- All Patients who has risk for injury or any other harm due to physical, mental or immunological status shall be considered as vulnerable
- All vulnerable patients shall be assessed for risk of fall and other risks relevant to them
- Care plan shall incorporate interventions specific to their vulnerability
- The hospital environment shall be safe and secure environment and the safety committee shall conduct periodic facility audit to ensure the effective compliance of the same. Guidelines for facility safety in Hospital Safety Manual SDH/SFM/01
- Assessment and care of vulnerable patients shall be done as per care of vulnerable patients SDH/COP/07
- Consent for Vulnerable patients shall be obtained from their family members as mentioned in informed consent policy SDH/PRE/02
- All Staff shall be trained in identification, Assessment and care for vulnerable patients

25.9 Policy for obstetric services

Purpose

Provide guidelines on obstetric services provided in the hospital

Policy

- Assessment of obstetric cases shall be performed as mentioned in initial assessment procedure SDH/AAC/03 and care of obstetric cases SDH/COP/08
- The following high-risk cases are managed in this hospital
  - ✓ Recurrent Pregnancy Loss
  - ✓ Gestational Diabetes Mellitus
  - ✓ Pregnancy Induced Hypertension

- ✓ Intra uterine growth restriction
- ✓ Pre term Labour
- ✓ Heart Disease Complicating Pregnancy
- ✓ Renal Disease Complicating Pregnancy
- ✓ Auto Immune Diseases
- ✓ Placenta Previa & Placental Abruption
- ✓ Infective Diseases in Pregnancy

- Antenatal visits shall be recommended as per national guidelines or based on the condition of patient
- Antenatal Services shall contain at least assessment ,immunization and diet counselling
- During each visit patient shall be reassessed on defined parameters mentioned in SDH/AAC/03
- Appropriate pre natal, perinatal and post natal monitoring shall be performed and documented
- Staff shall be provided adequate in-service training for care of obstetric patients

25.Policy for care of paediatric services

Purpose

To guide the paediatric care Services

Policy

- Paediatric care shall be provided in three different segments
  - ✓ Wards
  - ✓ Paediatric Intensive Care Unit (PICU)
  - ✓ Neonatal Intensive care Unit (NICU)
- Care of paediatric patients shall be delivered as per General Procedure for care of paediatric patients SDH/COP/09, Paediatric Clinical Manual SDH/PM/01, Neonatal ICU Clinical Manual SDH/PM/02
- Initial Assessment of all paediatric patients shall include nutritional, growth, psychosocial and immunization assessment

- Care shall be delivered adhering to national guidelines
- Staff who are competent based on qualification, experience and training shall only care for paediatric patients
- The hospital has play rooms, feeding rooms and pet therapy for the special needs of children
- The parents or family members shall be educated about nutrition, immunization and safe parenting
- All who involve the paediatric care shall adhere to procedures for prevention of child abduction and child abuse mentioned in SDH/COP/10 and patient safety program SDH/CQI/01
- Use of ID tags is important for correct identification and prevention of abduction
- Surveillance cameras are installed in critical location like in front of NICU

25.11Policy for care of patients undergoing moderate sedation

Purpose

Provides guidelines for administration of moderate sedation and monitoring of patients who are on moderate sedation

DEFINITION:

Moderate Sedation/ Analgesia: A drug-induced depression of consciousness during which patients respond purposefully to verbal commands either alone, or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained**.**

Policy

- Use of moderate sedation shall be strictly adhering to procedure for use of moderate sedation SDH/COP/11
- All procedures as defined in informed consent procedure SDH/PRE/02using moderate sedation shall be done after taking informed consent from patients of patients legal representative
- Only a Doctor or a Nurse competent shall administer sedation and anaesthesia medications

- Patient shall be monitored during and after administration of sedation
- Discharge from recovery area shall be done only on predefined criteria which is explained in SDH/COP/11
- Staff shall be aware of the criteria for transfer from recovery area
- Emergency resuscitation services shall be provided as indicated in code blue manual

25.12 Policy for administration of Anaesthesia

Purpose

Provides guidelines for administration and use of anaesthesia

Policy

- Use and administration of anaesthesia shall be done according to defined procedure for administration of Anaesthesia SDH/COP/12
- Patients who are for anaesthesia shall have a pre anaesthetic check up by a qualified anaesthetist.
- Pre Anaesthetic check up shall be done for both elective and emergency cases
- This shall be done either in the Anaesthesia department or at the patient's bedside
- During Pre Anaesthesia check up the patient shall be provided detailed counselling regarding the anaesthesia procedure which will educate patient and/or, family on the risks, benefits, and alternatives of anaesthesia by the anaesthesiologist.
- Informed consent for administration of anaesthesia is obtained by the anaesthesiologist
- An Anaesthesia plan shall be developed based on pre-anaesthesia check up
- The plan should mention the pre-medications, type of anaesthesia, the drug(s) to be used for induction and the drug to be used for maintenance. It should also mention about other concomitant medications and IV fluids, special monitoring requirements where appropriate and anticipated post-anaesthesia care
- Patients shall be monitored during anaesthesia and post anaesthesia on parameters mentioned in SDH/COP/12
- The anaesthesiologist applies defined criteria to transfer the patient from the recovery area mentioned in SDH/COP/12

- Infection control guidelines shall be followed as per hospital infection control manualSDH/ICM/01
- Adverse Anaesthetic events are reported to analyse and take preventive actions

25.13 Policy for Surgical Procedures

Purpose

Provides guidelines for performing surgeries and surgical care

Policy

- Surgical care shall be delivered adhering to procedure of surgical care SDH/COP/13
- Surgical patients have a preoperative assessment and a provisional diagnosis documented prior to surgery by the operating surgeon.This shall be applicable for both routine and emergency cases.
- All surgeries shall be performed only after taking an informed consent is obtained as mentioned in consent procedure SDH/PRE/02
- Patient shall be identified with full name and hospital number in order to prevent adverse events like wrong site, wrong patient and wrong surgery. All Patient shall have Yellow id band for all patient who are undergoing surgery
- Only doctors who are privileged to perform surgeries shall perform the procedures that they are entitled to perform. Refer to Credential and Privileging of Doctors AIMS/HRM/.
- Post surgery care shall be delivered as suggested in SDH/COP/13

- Patient, personnel and material flow conforms to infection control practices refer to Infection control Manual SDH/ICM/01for details
- A quality assurance programme is followed for the surgical services as mentioned in quality Manual SDH/QM/01

25.14 Policy for use of restrains

Purpose

Guide the use of both physical and chemical restrains and care of patients who are on restraints

Policy

- Use of restraints is only allowed in defined circumstances in procedure for use of restrains SDH/COP/14
- A doctor can only order restraint. These include both physical and chemical restraint measures.
- Each restrain order is maximum valid up to 24 hours
- Reason for restrain shall also be documented
- The family members or legal representative shall give consent for use of restraints. They shall be educated on the need of restraints
- All patients who are on restraints shall be monitored in defined frequency and for defined parameters mentioned in SDH/COP/14
- Staff shall be trained on use of restrains
- Doctors and staff shall evaluate the possibility of releasing the restrain and de restrain the patient at the earliest

25.15Policy for pain management

Purpose

Provide guidance for pain assessment and management of pain.

Policies

- All the patients shall be screened for pain by the doctor or the nurses.
- Where ever required detailed pain assessment is done and after interventions patients shall be continuously monitored for the results or change in pain level. Refer to Procedure for pain Management SDH/COP/15
- Patients with pain undergo detailed assessment and periodic re-assessment with defined and appropriate pain scales.Refer to Procedure for pain Management SDH/COP/15
- The pain assessment shall include intensity of pain (can be done using a pain-rating scale), pain character, frequency, location, duration and referral and/or radiation.
- The assessment should be done in an objective manner so that it facilitates regular reassessment.
- Patient and family shall be educated on various pain management techniques, where appropriate.

25.16 Policy for rehabilitative services.

Purpose

Provide a guideline for the provision of rehabilitative services.

Policy

- Rehabilitative services are providedalignedwith the organisational requirements based on its scope of services.
- Such services are provided to both Out Patients and In Patients

- Care is guided by functional assessment and periodic re-assessment which is done and documented by qualified individuals. For details refer to SDH/PRM/01
- Care shall be provided adhering to infection control and safe practices
- Adequate safety precautions shall always be taken in order to ensure safety of patients
- Equipments management shall be done in close coordination with biomedical engineering department as per their protocols
- Rehabilitative services are provided by a multidisciplinary team.
- Resuscitation services shall be covered as per the code blue procedure

25.17 Policy for all research activities.

Purpose

Provide guidelines all research activities

Policy

- All research activities shall be done in compliance with national and international guidelines.
- The organisation has an ethics committee to oversee all research activities.
- An ethics committee is framed in the hospital to monitor activities undertaken by various providers. Refer to Ethics Committee TOR
- The committee has the powers to discontinue a research trial when risks outweigh the potential benefits.
- Patients' informed consent is obtained before entering them in research protocols.
- This is done in a language that the patient understands.

- Patients are assured that their refusal to participate or withdrawal from participation will not compromise their access to the organisation's services.
- For details refer to procedure for conducting research activities SDH/COP/16

25.18 Policy for nutritional therapy.

Purpose

Provide guidelines nutritional assessment and reassessment for all inpatient

Policy

- All in patients shall be screened for special nutritional requirements
- Nutritional assessment shall be done by a dietician for all patients found at risk during nutritional screening.
- Assessment shall be performed as defined in SDH/DTM/01
- A dietician shall do the assessment of the patient in consultation with the clinician and advice regarding food.
- Patients receive food according to their clinical needs.
- Clinicians Staff nurses and dieticians shall ensure the patients consumes food as recommended. This could be through cross verification with family
- There is a written order for the diet as mentioned in Dietary Department Manual
- Nutritional therapy is planned and provided in a collaborative manner by the doctors and the dieticians.
- The composition of parenteral nutrition is decided by doctors on individual patient'scondition and requirement
- The dietician shall prepare this in the form of a diet sheet and patient shall receive food accordingly.
- The dietician shall ensure that this is planned in consultation with the treating doctor and the patient/patient's relative after taking into regard the patient's food habits (veg/non-veg) and likes and dislikes.

- When families provide food, they are educated about the patient's diet limitations.
- Food is prepared, handled, stored and distributed in a safe manner in all food preparation units.

25.19 Policy for the end of life care.

Purpose

Provide guidelines the end of life care for terminally ill patients

Policy

- The organisation shall provide end of life care to terminally ill-admitted patients according to procedure defined in SDH/COP/17
- Shall provide appropriate pain and palliative care according to the wishes of the family and patient as mentioned in Procedure for pain management SDH/COP/17
- Sensitively addressing such issues as autopsy and organ donation
- Staff shall respect the patient's values, religion, and cultural preferences
- Staff shall involve the patient and family in all aspects of care
- Staff shall take all measures to respond to the psychological, emotional, spiritual, and cultural concerns of the patient and family (where possible).
- These also address the identification of the unique needs of such patient and family.
- The religious and socio-cultural beliefs of patients/ family shall be addressed and respected.
- Symptomatic treatment is provided and where appropriate measures are taken for alleviation of pain.
- The emphasis shall be on providing symptomatic treatment of such patients and to prevent complications to the possible extent.
- The patient and/or family shall be involved while taking all such decisions. To the extent possible (and as per the law), the patient and/or family's choices shall be respected.

26 Policy of Management of Medication and Pharmacy Services

Purpose

Provides a general guidelines for management of medication right from purchase to utilization for patients

Policy

- All policies and procedures with respect to pharmacy services and medication management shall be developed and designed with concurrence of Drugs and Therapeutic Committee. For Terms of reference of the committee refer
- All the procedures with respect to use of medication and its management is incorporated in Medication Usage Manual
- Medication usage in the hospital shall be in accordance with the existing legal framework and best pharmacy practices
- There is a approved formulary used in the organizations
- Management of formulary shall be done as defined in SDH/MOM/01
- The Purchase of these medications shall be done adhering to Purchase procedure mention in SDH/MOM/02
- The purchase procedure SDH/MOM/02 also explains the procedure involved in acquisition of medical supplies and consumables and implantable prosthesis and medical devises
- Purchase of all drugs mentioned in formulary shall be made from approved vendors
- Purchase of drugs that receives temporary approval could be made from local vendors or vendors who are not included in approved list
- The Purchase is done based on the procurement policies by the Pharmacy Purchase Division.
- The Purchase Division In charge is basically responsible for coordinating the purchase procedures.
- The procurement is done based on the laws of the land considering all legal view points.
- The pharmaceutical knowledge will be applied while ordering for the drugs.
- All routine purchases are made when the stock value reaches the re order level

- Pharmacy department shall only store and distribute drugs mentioned in Hospital formulary which shall be approved by Drugs and Therapeutic Committee.
- Storage of drugs shall be done as defined in SDH/MOM/03
- All medications shall be stored according to manufactures guidelines
- Medicines which is to be kept between 2- 8 degree Celsius shall be kept in refrigeration
- There shall be minimum stock level for each stock keeping unit
- Hospital shall store medications in a clean safe and secure environment
- There shall be measures to prevent rodent attacks in the storage area.
- Unauthorized access is not allowed in pharmacy store or inside the storage areas.
- All the inventory shall be classified using AB analysis and FSN analysis
- Inventory shall be transferred according to FIFO First in First Out Basis
- Narcotic Drugs Shall be kept under Double Lock
- Sound Alike Look Alike Dugs shall be Identified and kept separately
- High Risk Medications are identified and Stored separately
- Prescription shall be only made on drugs enlisted in formulary.
- Sample medications shall not be stored in retail pharmacies
- All prescription shall comply to minimum criteria for prescription and process is defined in SDH/MOM/04
- All prescriptions made shall be rational and safe
- Drugs and therapeutic committee conducts periodic prescription audit to identify gaps in prescription practices and areas for scope for improvement
- Medications are available for patient in following units
  - Pharmacy I-
  - Pharmacy II-
  - Pharmacy III-

Pharmacy IV-

- Pharmacy I shall be open 24 hours to ensure uninterrupted pharmacy services. Other Pharmacies are only open from 9 AM to 5 PM on week days
- Apart from pharmacies stock medications shall be kept in all IP units and Operation theatre
- Whenever drugs are dispensed from any unit they shall adhere to guidelines given in SDH/MOM/05
- Upon notification of drug recall, the identified products will be removed from stock as per SDH/MOM/06
- Medication administration to patients shall be done adhering to procedure mentioned in SDH/MOM/07
- Patients shall be monitored after administration of medications as explained in SDH/MOM/08. Any adverse reactions or errors shall be reported to quality department
- All the adverse drug reactions are reported to Pharmaco vigilance committee whom shall analyze the event and take necessary corrective and preventive actions
- Medication errors are corrected immediately and reported to quality department
- Narcotic and Psychotropic drug usage shall be controlled. Stocking and inventory of narcotic drugs in approved units shall be under close vigilance. Procedure mentioned in SDH/MOM/09 provide guidelines for the use of narcotic drugs
- Chemotherapeutic agents shall be used with at most care. These are classified as high risk drugs. Prescription, usage, administration and disposal of cytotoxic drug waste is described in SDH/MOM/10
- Guidelines for purchase and handling of radioactive drugs is given in SDH/MOM/11
- Guideline for the use of implantable prosthesis and medical devices is mentioned in SDH/MOM/12
- Process for acquiring medical supplies and consumables is mentioned in SDH/MOM/02
- Sound Inventory control practices are taken for the management of all inventories of medicines and medical consumables

27 Policies for Patient and Family Rights, Responsibilities and Education

Purpose

Provide guidelines to protect patient and family rights defined

Policy

- Patient and Family Rights and responsibilities are defined and displayed prominently in all three blocks. Refer to SDH/PRE/01
- The displays are in Marathi and English
- Patient and Family Rights and Responsibilities are informed during Pre Admission Counselling for In Patients
- Each and every employee of the hospital and the leaders shall be well versed with patient rights and they shall protect every one of them
- Violations are recorded when observed or reported and reviews and corrective and preventive measures are taken. Violations are identified though complaints reported, grievance submitted and on observations during audit
- Patient and Family Members shall be educated on the elements mentioned in SDH/PRE/03
- Patients shall be informed about the expected cost
- Tariff lists shall be available to patients on request
- Patients and Family members shall be informed about the financial implications when there is a change in patient condition
- Each patient or bystanders have right to prefer a complaint. There is a well established complaint redressal procedure which is explained in SDH/PRE/04

28 Policy for involving patient and family in care delivery

Purpose

Provide guidelines in involving patient and family members in care panning and delivery process and thereby making them to take informed decision

Policy

- The patient and/or family members are explained about the proposed care including the risks, alternatives and benefits.
- The patient and/or family members are explained about the expected results by the treating physician or his team member
- The patient and/or family members are explained about the possible complications if any
- The care plan is prepared and modified in consultation with patient and/or family members.
- During the preparation of the care plan the patient and/or family members are explained about the various treatment options, risks and benefits. Patient and family members are given opportunity to express their feedback and concerns during consultations and reassessments
- The care plan respects and where possible incorporates patient and/or family concerns and requests.
- The religious, cultural and spiritual views of the patient and/or family shall be considered during the process of care delivery.
- The patient and/or family members are informed about the results of diagnostic tests and the diagnosis.
- The patient and/or family members are explained about any change in the patient's condition.

29 Policy for taking consents

Purpose

Provide guidelines on various consents that are taken from patient

Policy

- Care shall be provided to any patient with their consent only
- Informed consent shall be taken for all high risk procedures

- Procedure for taking consent SDH/PRE/02 incorporates the list of situations where informed consent is required and the process for taking informed consent.
- Informed consent includes information regarding the procedure, risks, benefits, alternatives and as to who will perform the requisite procedure in a language that they can understand.
- Informed consent is taken by the person performing the procedure or his team member.
- General consent for treatment is obtained when the patient enters the organisation.
- With the general consent the patient gives consent to take treatment in the hospital, undergo necessary diagnostic evaluations, routine blood test and medical management. Invasive procedures and high risk procedures are not in the scope of general consent
- SDH/PRE/02 describes who can give consent when patient is incapable of independent decision making.

30Policy for Infection control in Hospital

Purpose

Provides a general outline to the Hospital infection control program

Policy

- The hospital has a well defined comprehensive infection control program with the objective of reducing or eliminating risk for infection to patients, visitors and hospital employees
- The programme includes an action plan to control outbreaks of infection, disinfection/sterilisation activities, biomedical waste (BMW) management, and training of staff and employee health.
- The infection control program is defined and coordinated by Infection control Committee which meets every month. Refer to Terms of Reference Infection Control Committee
- All the policies and procedures with respect to infection control is compiled as Hospital Infection Control Manual .Refer to SDH/HIC/01

- Al policies and procedures are defined considering best practices and accepted national and international guidelines
- The infection prevention and control programme is a continuous process and updated at least once in a year.
- Hospital infection control committee appoints infection control officer who shall guide infection control nurses for periodic surveillance to capture and infection prevention and control data
- Quality Improvement programs are conducted incorporating the elements of infection control in it
- The infection control committee shall submit their finds and reports to Quality Coordinator on a Regular Basis

31 Policies on Continuous Quality Improvement Program

Purpose

Provide guidelines for continuous Quality Improvement Program in the Hospital

Policy

- There is a structured quality improvement program which is documented in Quality Manual. Refer SDH/QM/01
- Quality Improvement program identifies opportunity for improvement through Audits evaluation of Quality indicators etc
- Quality Improvement Program is updated every year
- All quality Improvement shall be under supervision of quality coordinator and Continuous Quality Improvement Committee. Refer to CQI committee Terms of Reference
- Patient Safety Program is documented in SDH/CQI/01
- Key indicators are tracked and monitored as explained in quality Manual SDH/QM/01
- Trend Analysis of key indicators shall be done on quarterly basis
- Management shall support quality improvement initiatives by earmarking funds
- Clinical Audit system are done in cycles as defined in guidelines for clinical audit SDH/CQI/02

- There is an established incident reporting system where are events are reported and analysed for corrective and preventive action. Refer to procedure for incident reporting SDH/CQI/03
- The sentinel Events are defined in SDH/CQI/03
- All sentinel events reported shall be analyzed intensely
- Corrective and preventive actions are taken for all incidents and sentinel events reported

31 Policy for governance

Purpose

Provides guidelines on responsibility of Management

Policy

- The organization has defined its mission, vision and values and it is displayed across in the organization
- All the staff shall be oriented towards vision and mission
- Directors shall approve strategic plans, operational plans and budgets every year
- Those responsible for governance monitor and measure the performance of the organisation against the stated mission through management review meetings. Minutes of such meetings shall b e recorded
- There is an established organogram for the hospital. All the reporting lines shall be followed as mentioned in organorgram
- Senior leaders are appointed in each department whom shall report the departmental functioning to management in the organisation.
- Management support safety initiatives and quality-improvement plans.
- Management support research activities.
- Management address the organisation's social responsibility by free camps and outreach programs
- Those management inform the public of the quality and performance of services through News letters and displays of its certification and accreditation

- There is a checklist for all statutory requirements and licences which is tracked for periodic updating of licences
- Scope of Services for each department is defined in SDH/ROM/01
- Administrative procedures for hospital is defined in HR Manual
- Ethical Management of organization is explained in policy of ethical Management
- Code of Medical Ethics is given in SDH/ROM/02
- Employee Rights and responsibilities are explained in SDH/ROM/03
- All outsourced services shall be monitored for its quality. Refer to Quality Manual SDH/QM/01
- The organization ensures proactive risk management in both clinical and non clinical areas.
- System for reporting failures is explained in SDH/ROM/04

32 Policy on Facility Management and safety

Purpose

To provide guidelines regarding safety and facility management including engineering services

Policy

- Safety committee is responsible for developing safety protocols and evaluate the safety aspects in the organization. Refer to Safety Committee Terms of Reference
- Policies and procedure that enhance safety in the hospital is compiled into safety manual Refer to SDH/SFM/01
- For Laboratory safety Program refer to SDH/LSM/01
- For Radiology Safety Program refer to SDH/RSM/01
- There is a defined Patient Safety program which is explained in SDH/CQI/01
- The hospital shall ensure a risk free environment for all patients and bystanders. Patient safety devices are installed across the organization
- The hospital shall strictly follow NO smoking policy
- There are internal and external sign postings in the organisation in both English and Malayalam
- Potable water and electricity shall be made available round the clock.

- Alternate sources for electricity and water are provided as backup for any failure/shortage.
- Testing of Water is done as mentioned in SDH/ICM/01.
- There are designated engineers and their departments whom shall responsible for the maintenance of all the facilities.
- Department of civil Engineering shall look into environmental maintenance as well
- Electrical engineering and Biomedical engineering department shall maintain respective assets
- There is a documented operational and maintenance (preventive and breakdown) plan for each department Refer to Specific department documents
- Response times are monitored from reporting to inspection and implementation of corrective actions using complaint registers
- All Equipment are selected, rented, updated or upgraded by a collaborative process. Refer to Engineering Department Manuals SDH/MEM/01,SDH/BEM/01
- All Equipments are inventoried and proper logs are maintained as required.
- There is a maintenance plan for water management,electricalsystems,heating, ventilation and air-conditioning,piped medical gas, compressed air and vacuum installation and plan for fire-related equipment.
- There is a documented procedure for equipment replacement and disposal mentioned in Purchase Manual and Biomedical Engineering Department Manual
- Documented procedures govern procurement, handling, storage, distribution, usage and replenishment of medical gasesSDH/SFM/01
- Medical gases are handled, stored, distributed and used in a safe manner.

- Fire Emergency Management and Fire preparedness is mentioned in Safety Manual. Refer to SDH/SFM/01
- Potential non-fire emergency situations are identified them and course of action is established and communicated to staff. Refer to SDH/SFM/01
- Mock drills shall be conducted periodically
- The disaster management plan is explained in safety manual
- Hazardous materials are identified within the organisation and each department has dedicated files for MSDS

33 Policies on Human Resource Management

Purpose

Provide guidelines on management of employees of the organization, their welfare and safety

Policy

- The Human resource planning shall be done every year as defined in planning guidelines which will supports the organisation's current and future ability to meet the care, treatment and service needs of the patient. Refer to SDH/HRM/01
- Human Resource planning shall match the strategic and operational plan of the organisation.
- The organisation shall always maintain an adequate number and mix of staff to meet the care, treatment and service needs of the patient. This shall be based on the MCI and INC guidelines.
- The job specification and job description shall be clearly defined for each category of staff and shall be issued at the time of joining
- Antecedents of the potential employee shall be verified with regards to criminal/negligence background with the previous employer.

- In case of fresher joining this could be verified with their conduct certificate or Head of the institute where they completed the education
- All recruitments shall be done adhering to the documented procedure for recruitment.SDH/HRM/02
- Recruitment is undertaken in accordance with statutory requirements, where applicable.
- The laid-down recruitment procedure shall be adhered to. The entire process shall be documented which will ensure transparency of the recruitment process
- Every staff member entering the organisation is provided induction training based on the guidelines mentioned in Guidelines for Training SDH/ HRM/03
- Minimal contents and structure of Induction Training is defined in the guidelines
- Induction training shall be given within 15 days of the staff joining.
- Ongoing programme for professional training and development of the staff shall also be conducted as per guidelines for training SDH/ HRM/03
- Training records shall be updated in personal file
- Feedback of training program shall be taken where ever applicable. Refer to SDH/ HRM/03. This shall be used for improving the
- Training shall beconducted when job responsibilities change or when new equipment is introduced.
- Trainings on use of new equipments shall be delivered by a representative from the manufacturing company or biomedical engineers
- An appraisal system is designed for evaluating the performance of an employee exists as an integral part of the human resource management process. Refer to SDH/ HRM/04

This document provides details on disciplinary procedures taken in the hospital.

- The employees are told of the system of appraisal at the time of induction.
- Appraisal shall be conducted with reference to Job Descriptions and Job Responsibilities
- The appraisal system is used as a tool for further development. Training Needs are identified with appraisal
- Appraisal shall be conducted once in a year
- Results and outcomes of appraisal goes into employee file
- Thereare two dedicated committees disciplinary action committees and grievance handling committees whom shall deal with such issues of employees. Refer to Terms of reference of committees
- Employee Grievances shall be addressed as per the procedure for grievance handling. Refer to SDH/HRM/05
- SDH/HRM/06 explains in detail minor and major misconduct, penalties and the procedure involved in handling a disciplinary action.
- The disciplinary policy and procedure is based on the principles of natural justice.
- There is a provision for appeals in all disciplinary cases.
- There shall be a designated appellate authority to consider appeals in disciplinary cases.
- Anti-sexual harassment committee shall look in to issues related to sexual harassment in the hospital. Refer to committee Terms of Reference
- The policies and procedures are informed to all categories of staff of the organisation and shall be incorporated in induction training.
- All employees are provided an opportunity to express their grievance and appeal

- Health needs of employees are taken care by the organization. Refer to guidelines for management of employee health SDH/HRM/07
- Apart from personal file each employee shall have a health record.
- Contents of employee file is furnished in a checklist form in each file
- A pre-employment medical examination is conducted on all the employees.
- Health problems of the employees are taken care of
- Regular health checks of staff dealing with direct patient care are done at least once a year and the findings/results are documented in health record of the employee
- Occupational health hazards are adequately addressed. Staff are provided adequate personal protective equipments in order to prevent work place exposure
- Exposure to bio hazardous fluids and needle stick injuries shall be dealt procedure for management of exposure and needle stick injuries in Infection control Manual SDH/ICM/01
- Process for credentialing and privileging of medical professionals and nurses is explained in SDH/HRM/08
- Only privileged Medical professionals provide patient care without supervision
- The education, registration, training and experience every medical professionals is documented and updated periodically in the file
- All informationfurnished appropriately verified when possible.
- The privileges are communicated to them as well as to other departments

Policy on Management of information

Purpose

To provide guidelines on information management chapter is to ensure data and information meet the organisation's needs and support the delivery of quality care and service.

Policy

- The information needs of the organisation are identified and are appropriate to the scope of the services being provided by the organisation.
- Information needs are met both via paper records and HIS
- AIMS/IMS/01 explains the type of information the frequency of data collection and the person responsible.
- Information is collected , stored and exchanged according to existing regulatory guidelines
- All information management and technology acquisitions are in accordance with the documented policies and procedures.
- The needs for software and hardware solutions are defined as per the information requirements and future necessities in SDH/IMS/01
- The system of releasing the relevant information to the authority as per statutory norms is also explained in SDH/IMS/01
- The organisation has processes in place for effective management of data.
- Formats for data collection are standardised.
- Procedures for timely and accurate dissemination of data is documented in SDH/IMS/02
- Procedures for storing and retrieving data is documented in SDH/IMS/02
- Every patient has a complete and accurate medical record .

- Every medical record has a unique identifier which will be the hospital number generated at the time of registration
- Procedure for making entries in medical record and authorisations is explained in SDH/IMS/03
- Entry in the medical record is named, signed, dated and timed.
- All entries should be documented immediately but no later than one hour of completion of the assessment/procedure.
- The contents of medical record are identified and documented in SDH/IMS/03
- The record provides a complete, up-to-date and chronological account of patient care.
- Patient's record is available for 24 x 7
- Accessibility to the MRD and to its Hospital Information System is controlled
- SDH/IMS/04 explains procedure for maintaining confidentiality, integrity and security of records, data and information. It also explains how entries in the patient record are corrected or overwritten.
- SDH/IMS/05 explains the procedure that safeguards of data/record against loss, destruction and tampering.
- Privileged health information is used for the purposes identified or as required by law and not disclosed without the patient's authorisation.
- SDH/IMS/06 explains the procedure on how to respond to patients/physicians and other public agencies requests for access to information in the medical record in accordance with the local and national law.
- AIMS/IMS/07 explains the procedures for retention time of records, data and information.
- It is in consonance with the local and national laws and regulations.

- The destruction of medical records, data and information shall be accordance with the policy
- Medical record Audit committee ensures the review of medical records. Refer to committee Terms of Reference
- Along with medical record committee which will review the discharged files the quality team shall review the completeness of running case sheets.

Policy for control of Documentation

Purpose

Provide guidelines for the control, revisions and issue of documents

Policy

Documentation System

The Documentation will have the following framework.

- Apex Manual which contains ,Introduction to HCO chapter wise policies with respect to NABH standards ,policies on various committees' Terms of Reference
- Chapter wise Procedures
- Infection Control Manual,
- Safety Manuals
- Quality Manuals
- Department wise operating Manual

Preparation and issue of Documents

- All Hospital related documents should be controlled at preparation, approval and issue stage.
- The preparation, approval and issue authority for various documents are given as below.

	Document	Preparation and Recommendation	Approval
1.	Hospital Apex Manual	Quality Team	Director

2.	Chapter wise Procedures	Prepared in Consultation with end users and recommended by Quality Coordinator	Director
3.	Infection Control Manual	Prepared by HIC Committee Members and Recommended Quality Coordinator	Director
4.	Safety Manual	Prepared by Safety Committee Members and Recommended Quality Coordinator	Director
5.	Laboratory Safety Manual	Prepared in Consultation with end users and recommended by Lab Director	Director
6.	Laboratory Operating Procedures and Quality Manual	Prepared in Consultation with end users and recommended by Lab Director	Director
7.	Department wise operating Manual	Prepared in Consultation with end users and recommended by Quality Coordinator	Director

Copies

The document copies with respect to Hospital document shall be given as below.

Master Copy

Master Copy is the copy with the original signatures. This copy shall be available with Director. It shall bear a stamp seal as “MASTER COPY” on reverse of the pages.

Controlled Copy

Its circulation is controlled and bears stamp seal as “CONTROLLED COPY” on each page. Whenever any revision is made in any one of the documents, all the Controlled Copy Holders shall be issued with the amendments, to be incorporated and attested by issuing authority Quality Coordinator

Uncontrolled Copy

Uncontrolled Copy means all those copies that need not be controlled for distribution and revision status. It bears stamp seal as "UNCONTROLLED COPY".

Obsolete Copy

"Obsolete Copy" is an obsolete version of the Master Copy. It bears stamp seal as "OBSOLETE".

Issue / Distribution of Documents:

- Quality Coordinator shall decide the distribution of each document and the same shall be recorded in the Document Distribution List
- Distribution could be physical copies which is controlled or through Hospital information system in electronic form
- All documents that needs to be distributed in multiple points and which requires many papers for distribution shall be distributed in electronic form
- Quality Coordinator has the authority for issue of documents, arrange to get requisite number of copies (as per Document Distribution List) and then stamp them as 'CONTROLLED COPY'.
- Quality Coordinator shall issue the documents and take the acknowledgement from the copyholder as per the distribution sheet in the Document Issue / Acknowledgement Register
- Quality Coordinator shall maintain a Master List of Documents which shall be updated after receiving the acknowledgement from the authorized copyholders. The authorized custodian of documents shall also maintain a Master List of Documents held by him/her.
- The initial issue status of the entire document is "version 01"

Revisions

- The Quality team in consultation with the end users evaluates the need for revision at least once a year
- If there is any of the clauses requires to be amended the documented is revised
- The revisions of any document carry "version (01+n) where n is the number of revision done.
- Any HOD may raise a request for need for document change through a Document Change Request and shall submit the request to the Quality Coordinator

- Quality Coordinator shall scrutinize the nature and reason for change and shall decide on incorporating the change.
- The amended document shall have its revision status changed to the next revision number. Effective date for implementation is shall also to be noted.
- The recipients of the amended documents shall hand over the “OBSOLETE” documents to Quality Coordinator.
- Quality Coordinator shall destroy all the obsolete copies except his/her copy, and he/she shall file the same in a separate file after stamping the document as “OBSOLETE” for