SAIDEEP
HEALTHCARE & RESEARCH PVT. LTD.

AAC

Chapter Book

CHAPTER AAC – OVERVIEW AND INDEX OF DOCUMENTS

This chapter constitutes the complete AAC (Access, Assessment and Continuity of Care) chapter manual for Saideep Healthcare & Research Pvt. Ltd. in accordance with NABH Hospital Accreditation Standards, 6th Edition. All policies, SOPs and guidelines contained herein have been formulated to meet the intent of the NABH AAC standards while being specific to the workflows, systems and patient population at Saideep Hospital.

Sr. No	Doc No	Document Title	NABH Standard	Issue / Rev
1	SDH/AAC/1-01	scope of the clinical services of each department	AAC 1.C	01/02
2	SDH/AAC/2-01	Section 1 – Master Policy: Patient Registration & Unique Identification Policy	AAC 2.A	01/02
3	SDH/AAC/02	Section 2 – SOP: OP Patient Registration	AAC 2.A	01/02
4	SDH/AAC/02	Section 3 – Registration Policy & SOP: Walk-in Diagnostic Patients	AAC 2.A	01/02
5	SDH/AAC/02	Section 4 – SOP: IP Admission Registration	AAC 2.A	01/02
6	SDH/AAC/02	Section 5 – SOP: Daycare/Short Stay Admission (<24 hours)	AAC 2.A	01/02
7	SDH/AAC/02	Section 6 – SOP: MTP Patient Registration & Confidentiality	AAC 2.A	01/02
8	SDH/AAC/02	Section 7 – SOP: Psychiatric Admission (MHCA)	AAC 2.A	01/02
9	SDH/AAC/02	Section 8 – SOP: ER Patient Registration & Identification	AAC 2.A	01/02
10	SDH/ER/01	Triage & Policy for Handling Non-Availability of Beds	AAC 2.D / COP 2.D / COP 9.D	02/02
11	SDH/AAC/02	Patient Prioritisation & Waiting Area Deterioration Management	AAC 2.E	01/02
12	SDH/AAC	Policy: Transfer-In of Referral Patients	AAC 3.A	01/02
13	SDH/AAC/01	Policy: Transfer-Out/Referral of Patients to Another Facility	AAC 3.B	01/02
14	SDH/AAC/05	Patient Assessment & Reassessment Policy	AAC 4.A, 4.B, 4.C	01/02
15	SDH/AAC/09	Guidelines for Implementing Early Warning Signs (EWS)	AAC 5.E	01/02

16	SDH/AAC/10	Policy: Cross-Referral to Other Departments/Specialties	AAC 10.F	01/02
17	SDH/AAC/11	Preventive & Promotive Care Guidelines	AAC 11.A	01/02
18	SDH/AAC/12	Master Policy: Discharge of Patients	AAC 12 / AAC 13.B / 13.C	01/02
19	SDH/AAC/12	SOPs: Discharge (Routine IP, Daycare, ER, LAMA, Transfer, Death)	AAC 12 / 13	01/02

Chapter-Level Amendment History

Sl. No	Edition No	Rev No	Date	Nature of Change
1	01	00	1 Oct 2019	First issue as per NABH Hospital Accreditation Standards – 4th Edition
2	01	01	1 Nov 2020	Minor revisions; updating Doc No.; compliance update for NABH 5th Edition
3	01	01	1 Jan 2022	No changes; review completed
4	01	02	1 Jan 2025	Amended comprehensively as per NABH 6th Edition. All registration categories separately defined. General Consent added. MTP confidentiality controls strengthened. EWS expanded. Discharge policy updated with medication reconciliation, device-specific counselling and MLC provisions.
5	01	02	1 Jan 2026	No changes; review completed

ABOUT SAIDEEP HEALTHCARE & RESEARCH PVT. LTD.

Saideep Healthcare & Research Pvt. Ltd. operates Saideep Hospital, a 260-bed multispecialty tertiary care hospital located at Ahilyanagar (formerly Ahmednagar), Maharashtra. Established with a commitment to delivering high-quality, affordable and patient-centred healthcare, the hospital serves patients from across Ahilyanagar district, Nashik, Pune and surrounding rural areas.

The hospital is situated at Viraj Estate, Yashwant Colony, Near DSP Chowk, Ahilyanagar – 414003, Maharashtra. The hospital operates under the chairmanship and managing directorship of Dr. S.S. Deepak, with clinical administration led by Dr. Hrishikesh Kalgaonkar, Chief Medical Administrator and Quality Head. For more information, visit www.saideephospital.com.

Vision & Mission

The hospital's vision is to be the most trusted destination for comprehensive, quality healthcare in Ahilyanagar and the surrounding region, delivered with compassion, clinical excellence and continuous improvement. Its mission is to provide safe, effective, evidence-based medical care that places the patient and their family at the centre of all care decisions.

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepak Chairman & Managing Director	

Scope of Clinical Services (AAC 1.C)

Saideep Hospital provides the following specialties and super-specialties:

Specialties: Anaesthesiology, Dermatology & Venereology, General Medicine, General Surgery, Obstetrics & Gynaecology, Ophthalmology, Orthopaedic Surgery, Paediatrics, Pathology, Psychiatry, Radiology, Dental Surgery.

Superspecialties: Cardiac Anaesthesia, Cardiology (including Cath Lab, Angioplasty, Pacemaker, Electrophysiology, Structural Heart Disease), Cardiothoracic Surgery, Critical Care, Medical Gastroenterology, Neonatology (NICU), Neurology (including Stroke Unit, EEG, EMG, NCV), Neurosurgery, Paediatric Surgery, Plastic & Reconstructive Surgery, Reproductive Medicine, Rheumatology, Surgical Gastroenterology, Surgical Oncology, Urology, Nephrology, Medical & Clinical Oncology.

The OPD cluster is located on the Ground &1st floor, and the Main Reception is on the ground floor. Main Reception operates 7 days a week from 8:00 AM to 8:00 PM; the IPD registration counter is used as the reception counter from 8:00 PM to 8:00 AM. The OPD clusters and desks operate Monday to Saturday from 8:00 AM to 6:00 PM. Emergency Care is available 24 hours, 365 days. Board Line: 0241-2775700 | Service Mobile: 6262900900.

OPD Location, Days and Hours of Operation

Outpatient Departments are located on the 1st floor of the hospital building; the Main Reception is located on the Ground Floor.

Area	Working Days	Timings
Main Reception (Ground Floor)	All days including Sunday	7:00 AM – 9:00 PM
OPD Cluster & Other Desks (1st Floor)	All working days (Mon – Sat)	8:00 AM – 9:00 PM
Emergency Care Unit (ECU)	24 hours, 365 days	Round the clock
Laboratory (SH)	24 hours, 365 days including Sunday	Round the clock
Radiology (X-Ray / USG)	24 hours, 365 days	Two shifts, round the clock

Board Line: 0241-2775700 | Service Mobile: 6262900900 | Website: www.saideephospital.com

Specialties and Super-Specialties Available at Saideep Hospital

Specialties

Specialty	Specialty	Specialty
Anaesthesiology	Dermatology & Venereology	General Medicine
General Surgery	Obstetrics & Gynaecology	Ophthalmology
Orthopaedic Surgery	Otorhinolaryngology (ENT)	Paediatrics
Pathology	Psychiatry	Radiology
Dental Surgery		

Super-Specialties

Super-Specialty	Super-Specialty	Super-Specialty
Cardiac Anaesthesia	Cardiology (incl. Cath Lab)	Cardiothoracic Surgery
Critical Care / MICU / ICCU	Medical Gastroenterology	Neonatology (NICU)
Neurology (incl. Stroke Unit)	Neurosurgery	Paediatric Surgery
Plastic & Reconstructive Surgery	Reproductive Medicine (ART)	Rheumatology
Surgical Gastroenterology	Surgical Oncology	Urology
Nephrology / Dialysis	Medical & Clinical Oncology	

OPD Services — Scope of Services (SDH/OPD/02)

The Main Reception at the ground floor serves as the first point of contact for patients, customers and visitors. It facilitates doctor consultations, additional investigations, pharmacy services, and guides patients to various services around the hospital.

The OPD cluster on the 1st floor includes: General Medicine OPD, Cardiology OPD, Oncology OPD, Orthopaedics & Neurology OPD, Paediatric OPD, and Organ Transplant OPD. Services include new and follow-up consultations for adults and paediatrics, OAE test, wound procedures, audiometry test, ECG, 2D echo, stress test, EEG studies, EMG studies, BERA studies, NCV, SSEP, weight, height and BMI check.

Consultant Services Available at OPD

Consultant Specialties	Consultant Specialties	Consultant Specialties
Cardiovascular & Thoracic Surgeon	Clinical Oncology Physician	Clinical & Surgical Oncologist
Dermatologist	Endocrinologist	ENT Surgeon
Gastroenterologist	General Physician	Gynaecologist
Interventional Cardiologist	Laparoscopic Surgeon	Maxillofacial Surgeon & Orthodontist
Nephrologist	Neurologist	Neurosurgeon
Orthopaedics Surgeon	Paediatrician	Plastic Surgeon
Psychiatrist	Rheumatologist	Urologist

OPD Minor and Major Procedures

Procedures available at OPD include: Minor Dressing, Major Dressing, Suturing & Removal, Plastering & Removal, PAP Smear, FNAC, Biopsy, Copper T Insertion, PV Examination, PR Examination, IUI (Intrauterine Insemination), I & D, HSG, Wound Swab Culture, Urethral Dilatation, Aspiration, Vaccination, Drain Removal.

Neurological investigations at OPD: EEG, EMG, NCV, VEP, SSEP, BERA.

Department-wise Scope of Services (SDH/AAC/09)

Clinical Service / Specialty	Scope of Services
Cardiology	Cardiology inpatient and outpatient 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 Stenting; Peripheral Intervention (DVT Thrombectomy, IVC Filter); Paediatric Intervention (ASD/VSD/PDA Device); Neuro Intervention (Carotid Artery Stenting, Intracranial Stenting, Mechanical Thrombectomy, Aneurysmal Coiling); Intra Vascular Ultrasound; Rotation Atherectomy; FFR; Electrophysiological Study; Non-invasive lab; Vascular & Cardiac Surgery Service; 2D Echo; GLS Echo; Transesophageal Echocardiography; Structural Heart Disease Interventions; Congenital Heart Disease; Valvular Heart Disease; Cardiac Exercise Stress Test; Dobutamine Stress Echo Test.
Cardiothoracic Surgery	Adult Cardiac Surgery: CABG (On Pump, Off Pump, MICS); Valve Surgery (MVR, AVR, Tricuspid Repair, Double/Triple Valve Replacement/Repair); Tumour of Heart (LA/RA Myxoma); Mediastinal Mass. Congenital Heart Malformation: ASD, VSD, PDA, Tetralogy of Fallot's, Coarctation of Aorta.
Neurology	Acute Ischaemic Stroke; Thrombolysis; Endovascular Interventional Neurology; EEG;

	Video EEG; PSG; NCS; EMG; VEP; Neuro-Ophthalmology; Neuro-ICU; Stroke Unit; Botulinum Toxin Injection. Sub-specialties: Epilepsy Surgery; Plasmapheresis for Autoimmune Neurological Disorder; Sleep Disorders.
Neurosurgery	Cerebral Strokes (haemorrhagic and non-haemorrhagic); Spontaneous Intracranial Bleeding (hypertensive, aneurysmal, vascular malformation); Brain and Spine Tumours; Degenerative Spine Diseases; Traumatic Brain, Spine and Peripheral Nerve Injuries; Hydrocephalus; Congenital Malformations of the CNS; Pituitary Tumours; Epilepsy Surgery.
Orthopaedics	General Orthopaedics; Arthroplasty Surgeries (Joint Replacement); Spine Surgery; Sports Medicine; Paediatric Orthopaedic Surgery; Traumatology Surgeries (Orthopaedic & Spine Trauma).
Obstetrics	General Obstetrics; Labour and Delivery; Management of Critically Ill Obstetric Patients; High Risk Pregnancy; Antenatal Services; Management of Foetal Abnormalities; Foetal Medicine; Infertility (ART).
Gynaecology	Minimally Invasive Surgeries; D&C, D&E; Uterine Surgeries; Tubal Surgeries; Ovarian Surgeries; Hysteroscopic Procedures. Specialty Clinics: Adolescent Gynaecology, Menopausal Clinic, Infertility Clinic, Well Women Clinic, Family Welfare Clinic, Cancer Screening.
Neonatology	Prenatal Counselling; 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; Lactation Counselling; Hearing Screen (Echo Screen); Vaccination; Development Follow-up Clinic and Early Intervention Services.
Psychiatry	Outpatient and inpatient evaluation of mental health conditions; Social work including supportive counselling, psychological assessment, education; Electroconvulsive Therapy; De-addiction Clinic; HDU (High Dependency Unit); Counselling; Psychological Assessment; Memory Clinic; Ketamine Therapy.
Medical Gastroenterology	Oesophageal, Stomach, Liver & Pancreas, Intestinal & Colon, and Anal Diseases; Obesity Clinic. Endoscopic Procedures: Gastroscopy (Diagnostic and Therapeutic);

	Colonoscopy (Diagnostic and Therapeutic); Capsule Endoscopy; ERCP.
Surgical Oncology	Biopsies; Incisional Surgeries; Excisional Surgeries; Laparotomy; Endoscopic/Laparoscopic Surgery; Breast Surgery; Skin Biopsy.
Ophthalmology	General Ophthalmology; Outpatient and Inpatient Surgical Management; Visual Testing; Pterygium Surgery; Cataract Surgery; Oculoplasty Surgery; Retina Surgery; Diabetic Retinopathy Surgery & Management; Intravitreal Management; Macular Degeneration; Anterior Segment Surgeries; Glaucoma Management.
ENT / Otorhinolaryngology	Audiometry, Tympanometry, OAE, ABR, VEMP, VHIT; Hearing Aid Evaluation and Fitting; Ear Tube Placement; Tympanoplasty; Mastoidectomy; Stapedectomy; Implantable Hearing Aids; Endoscopic Ear Surgery; Adenoidectomy and Tonsillectomy; Septoplasty and Turbinate Reduction; Endoscopic Sinus Surgery; Facial Plastic Surgery and Rhinoplasty; Surgery for Vocal Cord Diseases; Parotidectomy.
Dermatology	Outpatient & Inpatient Dermatology; Surgical, Medical and Cosmetic Dermatology; Skin Biopsy; Laser Surgery; Reconstructive Surgery; Paediatric Dermatology; Venereal Disease; Leprosy Treatment; PRP Treatment; Low Level Laser for Hair; Laser for Pigmentation; Carbon Laser; Chemical Peeling; Microneedling; Radiofrequency (Skin Tag/Mole Removal); Ear Lobe Tear Correction; Nail Surgery; NBUVB Light Therapy.
General Medicine	General Medicine; Diabetes; Hypertension; Polyarthritis; Health Checkup Programme; 30-bedded Medicine ICU for Poisoning, Snake Bite, Infective Diseases, Hepatic Encephalopathy, Renal Disease; Pathology, X-Ray, ECG, 2D-Echo, USG, PFT, TMT.
Paediatrics	Antenatal Care; Newborn Care / NICU; Well Child Visits; Adolescent Care; Paediatric Acute Care; Paediatric In-Patient Care.
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; Prostate and Urology Cancers; Stone Management; Treatment of Urinary Incontinence.
General Surgery	Surgery; Minimally Invasive Surgery; Bariatric Surgery; Colorectal Surgery;

	Hepatobiliary & Pancreatic Surgery; Breast Surgery.
Laboratory & Pathology	Haematology; Biochemistry; Immunohaematology; Serology; Immunology. (Full scope in Laboratory Services Manual — SH/MAN/01)
Radiology	Ultrasound & Colour Doppler; Interventional Radiology Procedures; MRI (co-located outsourced); CT Scan (co-located outsourced); Conventional Diagnostic Radiography. (Full scope in Radiology Services Manual — SDH/RAD/01)
Critical Care	Multi-Disciplinary Intensive Care Unit (MICU); Intensive Cardiac Care Unit (ICCU).
Anaesthesiology / Cardiac Anaesthesia	Anaesthesia; Procedural Sedation; Pain Management; Cardiac Anaesthesia.
Nephrology	Dialysis.
Rheumatology	Rheumatic Diseases; Autoimmune Diseases.
Dentistry	Digital X-ray; Scaling; Filling; Cosmetic Procedure; Smile Designing; Tooth Whitening; Root Canal Treatment; Laser-Assisted Treatment; Teeth Extraction; Wisdom Teeth Infections; Dental Implants; Paediatric Dental Care; Facial Abscess; Oral Cancer/Ulcer; Preventive, Prosthodontics, Periodontics, Endodontic, Orthodontics and Oral & Maxillofacial Surgery.

Amendment History — Scope of Services

Sl. No	Ed. No	Rev No	Date	Nature of Change
1	01	00	1 Oct 2019	First issue as per NABH Hospital Accreditation Standards – 4th Edition
2	01	01	1 Nov 2020	Minor revisions; updating Doc No.; compliance update for NABH 5th Edition
3	01	01	1 Jan 2022	No changes
4	01	02	1 Jul 2022	Comprehensive department-wise scope table added (SDH/AAC/09). All super-specialties listed.
5	01	02	1 Jan 2025	Updated and reviewed as per NABH 6th Edition.
6	01	02	1 Jan 2026	No changes

Introduction

A well-defined admissions policy and procedure at the hospital is a key to effectively achieving the patient's easy access to the hospital's in-patient services and facilities. In emergency situations an effective admissions process is critical for timely referral of patients that cannot be managed with the hospital's capabilities/resources and who are unable to meet the cost of treatments. Admissions policy and procedure also ensures seamless cooperation between the guest relations functions of the hospital like admission desk and billing office with therapeutic/care centres like the wards and intensive care units.

Purpose and Scope

The purpose of this policy is to guide the hospital staff in managing the process of admissions of the patients to the hospital through regular and emergency admission process.

Responsibilities

Medical Superintendent

The overall responsibility of implementing the policy rests with the MS of the hospital.

Manager — Customer Relations

The Manager – Customer Relations is responsible for managing the admission and billing counters and ensuring that appropriate information regarding various services and facilities are provided to the patient.

Front Office Staff

The Staff at the Admission Counter/Front Office are responsible for assisting the patient through the admissions process.

Doctors

Doctors are responsible for ordering admissions and explaining to the patients regarding the details of the condition requiring in-patient care/procedure at the hospital.

Policies

1. Admission can only be ordered by Consultants and above. Any admissions order made by any lower ranking clinicians are required to be counter-signed by a Consultant or above of the same unit.
2. 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.
1. Regular admissions are done from 8 AM to 5 PM after which all admissions shall be made through EMD only. Also during holidays (festival) the admissions are through the EMD. These admissions will be made by the EMO and patient referred to the respective departments.
2. Emergency admissions shall be accepted throughout the day at EMD reception.
3. On ordering the admissions the admitting doctor shall: explain the proposed care to patients and/or relatives; explain the expected results to patients and/or relatives; explain the possible complications to patients and/or relatives; explain the expected costs to patients and/or relatives.
4. The hospital shall not admit those patients whose condition cannot be managed at the hospital due to lack of expertise/resources. In case of emergency cases the patient may be provided first aid and then referred to an appropriate hospital as the case may be.
5. The hospital management retains the right of admission. Admission may be denied to patients who are not able to pay the requisite hospital charges and there is no availability of free/subsidised beds at that particular time.
6. 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 regulations of the hospital.
7. NON-AVAILABILITY OF BEDS: In case of wards a wait list is maintained by the Manager – Customer Relations, which will be prioritised depending on the severity of the patient's problem. In case of elective cases, once the patient is discharged, the next in the list shall be offered. In case of the critical care areas — refer to Triage & Bed Availability Policy (SDH/ER/01) and ICU policies document.

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar		Dr. S.S. Deepak	
Quality Head		Chairman & Managing Director	

ECU Admission Policy (SDH/ER/01)

- In case admission of the patient is necessary, the CMO/Consultant on duty makes the decision for admission and authorizes it. The CMO admits the patient under the specialty Consultant on duty (during peak hours) and on call basis (during non-peak hours).
- The ED nurse is informed if the patient is to be admitted.
- Admission to the ICU is approved by the attending Consultant.
- After the patient representative makes the necessary admission procedure and admission is confirmed, necessary arrangements are made to transfer the patient to the floor by the ED nurse staff on duty in collaboration with the housekeeping staff.
- The ED nurse communicates with the nurse in-charge of the floor and confirms the availability of the bed and initiates the transfer of the patient to the floor admitted.
- Patient is transferred to the floor by housekeeping staff as per patient's acuity. Monitored patients are transferred with a nurse. All documents and reports of the patient are transferred to the floor along with the patient.
- Exceptions occur in cases of life and death emergencies. The patient will be transferred to the ICU directly from the ED and registration & documentation may be postponed.

Amendment History

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar		Dr. S.S. Deepak	
Quality Head		Chairman & Managing Director	

Sl. No	Ed. No	Rev No	Date	Nature of Change
1	01	00	5 Mar 2021	First issue as per NABH Hospital Accreditation Standards – 4th Edition
2	01	01	1 Nov 2021	Minor revisions; compliance update for NABH 5th Edition
3	01	01	1 Jan 2022	No changes
4	01	02	1 Jan 2025	Reviewed as per NABH 6th Edition.
5	01	02	1 JAN 2026	No changes

1.1 Purpose

To ensure every patient accessing any hospital service is registered using a controlled process that generates/uses a Unique Hospital Identification (UHID/MRN), ensures correct patient identification, prevents duplicate records, supports continuity of care across OP, IP and ER, and ensures confidentiality and statutory compliance.

1.2 Scope

Applicable to all patient entry points including OP Registration, IP Admission Counter, ER Registration (including unknown/unidentified patients), and Walk-in Diagnostics registration. Applies to all staff involved including registration, MRD, nursing, doctors, billing, security, and IT/HIS administrators.

1.3 Definitions

- UHID/MRN: Unique Medical Record Number assigned by HIS to a patient for lifetime.
- Duplicate UHID: More than one UHID created for the same patient.
- Provisional registration: Temporary registration used in emergencies/unknown patient workflows to enable immediate care without delay.
- Not Available / Refused: Controlled options for missing demographic fields; must be supported by reason in HIS.

1.4 Policy Statements

1. Unique UHID rule: One patient shall have one UHID for lifetime; UHID shall not be reused even after death.
2. Duplicate prevention: Mandatory search for existing UHID before creating new UHID using at least two identifiers.
1. Minimum dataset: Mandatory demographic and identification dataset shall be captured for every registration, with controlled NA/Refused options.
2. Prohibition of dummy data: No dummy mobile numbers (e.g., 0000000000) shall be entered; NA/Refused must be recorded with reason.

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar		Dr. S.S. Deepak	
Quality Head		Chairman & Managing Director	

3. Data corrections: Demographic edits must be authorised, recorded with reason, and audit trailed in HIS; clinical notes/orders shall never be deleted or altered as part of demographic correction.
4. A 'General Consent' for the treatment is obtained when the patient enters the hospital, and the scope of the services are explained. This consent is obtained at the registration counter and is not used for the invasive procedures or other procedures like surgeries, anaesthesia etc. for which 'Specific Informed Consent' is used.
5. Continuity of care: OP→IP and ER→IP conversion shall retain the same UHID; new UHID creation for an existing patient is prohibited.
6. Confidentiality & privacy: Patient information shall be handled confidentially; display and verbal disclosure at counters shall be controlled; role-based access shall be maintained in HIS.
7. Treatment-first principle in ER: Emergency care shall not be delayed for registration; provisional registration is permitted.
8. Admission authority: Hospitalizations/admission (IP/Daycare) shall be only against documented advice/order of an RMP, with emergency exception where documentation is completed retrospectively.

1.5 Monitoring

The hospital shall monitor key indicators: duplicate UHID rate, % registrations with complete dataset, demographic correction requests, ID/phone/photo NA/refusal rates, and identification-related incidents/near-misses.

Amendment History

Sl. No	Edition No	Rev No	Date	Nature of Change
1	01	00	1 Oct 2019	First issue as per NABH 4th Edition
2	01	01	1 Nov 2020	Minor revisions; compliance update for NABH 5th Edition
3	01	01	1 Jan 2022	No changes
4	01	02	1 Jan 2025	Amended as per NABH 6th Edition. All categories separately defined. General Consent added.
5	01	02	1 Jan 2026	No changes

2.1 Purpose

To define a standard OP registration workflow using queue token system to ensure correct patient identification, UHID creation/retrieval, duplicate prevention, confidentiality controls, and patient guidance including patient app on boarding.

2.2 Scope

Applies to all OP registration counters/help desks, including repeat visits, new registrations, refusals/non-availability of ID/phone/photo and demographic correction workflows.

2.3 Responsibilities

Registration clerk conducts token issuance, search, registration and printing. Supervisor/MRD in-charge authorizes corrections and handles duplicates. IT ensures HIS controls and audit trails.

2.4 Procedure

1. Step 1: Queue token issuance – On arrival, patient is issued a queue token through token system and called by token number.
2. Step 2: New vs repeat identification – Patient is asked whether they visited earlier; if repeat, UHID is retrieved using prior card/bill/prescription or identifiers.
1. Step 3: Mandatory duplicate search – Before creating any new UHID, registration staff performs duplicate search using at least two combinations (name + DOB/age, mobile if available, locality/address, and ID proof if available). If suspected duplicate exists, no new UHID is created; supervisor/MRD is involved and request form is raised.
2. Step 4: Dataset capture – Mandatory fields are entered: Name, Age/DOB, Sex, Address (minimum locality/city). Phone number and photo are

captured wherever feasible; if not available/refused, NA/Refused is selected with reason. Dummy numbers are prohibited.

3. Step 5: UHID creation and OP encounter – UHID is generated by HIS and OP encounter is created with correct clinic/consultant mapping.
4. Step 6: Printing and patient guidance – Registration slip containing UHID and encounter details is printed and handed. Staff provide directions and basic information. A general consent is obtained.
5. Step 7: Patient App onboarding – Patient is encouraged to register on the HIS Patient App using email ID. App access is secured by OTP to registered mobile number. If mobile NA/refused, onboarding is recorded as not possible.
6. Step 8: File label and handover – If paper OP file exists, labels are printed and file handed to clinic desk with traceability.

2.5 Records/Outputs

- Queue token log (HIS)
- HIS registration and OP encounter record
- Printed registration slip
- Photo capture/refusal reason

Amendment History

Sl. No	Edition No	Rev No	Date	Nature of Change
1	01	00	1 Oct 2019	First issue as per NABH 4th Edition
2	01	01	1 Nov 2020	Minor revisions for NABH 5th Edition
3	01	01	1 Jan 2022	No changes
4	01	02	1 Jan 2025	Amended as per NABH 6th Edition. All categories separately defined. General Consent added.
5	01	02	1 JAN 2026	No changes

3.1 Purpose

To enable walk-in patients who require only diagnostic services (lab/radiology/ECG etc.) to be registered safely without OP consultation, ensuring correct patient identification, UHID continuity, correct test linkage and confidentiality of reports.

3.2 Procedure

Patient is registered through diagnostics reception/registration.

Staff retrieves existing UHID using duplicate search. If new, UHID is created using minimum dataset.

A general consent is obtained.

A diagnostic-only encounter is created without OP doctor encounter.

Test orders are entered and labels/requisitions are printed ensuring correct patient identifiers.

Samples/imaging are performed only after identifier match.

Reports are validated by authorized personnel and released through secure mechanisms (app/email/print) ensuring confidentiality.

Any clinical emergency signs trigger immediate ER referral.

3.3 Records/Outputs

UHID/diagnostics encounter, order entry record, label print log, sample/modality logs, report release audit trail.

Amendment History

Sl. No	Edition No	Rev No	Date	Nature of Change
1	01	00	1 Oct 2019	First issue as per NABH 4th Edition
2	01	01	1 Nov 2020	Minor revisions for NABH 5th Edition
3	01	01	1 Jan 2022	No changes
4	01	02	1 Jan 2025	Amended as per NABH 6th Edition. All categories separately defined. General Consent added.
5	01	02	1 JAN 2026	No changes

4.1 Key Control – Admission Only on Doctor Advice/Order

Hospitalization/admission shall be permitted only against documented advice/order of a Registered Medical Practitioner (treating consultant/ER medical officer).

In life-saving emergency, provisional admission may be initiated with retrospective documentation.

4.2 Procedure

1. Admissions may originate from OP, ER, direct or scheduled admissions.
2. Admission counter receives documented admission advice/order, retrieves existing UHID or creates new UHID after duplicate check.
3. A General Admission Consent is obtained. This consent is not used for invasive procedure or other procedures which require specific informed consent.
4. Identity verification is performed using at least two identifiers.
5. Demographics are confirmed and authorized updates are audit trailed.
6. Admission details including consultant, specialty, ward/bed category and payer type are recorded.
7. IP encounter/IP number is created and admission documents printed.
8. Ward nursing applies wristband with two identifiers.
9. MRD assembles and tracks file movement and daily reconciliation are done.

4.3 Mandatory Dataset

Always mandatory: UHID, patient name, age/DOB, sex, locality/city, date/time, consultant/service, ward category, attendant details.

Conditional: ID/insurance documents, MLC fields as applicable.

Amendment History

Sl. No	Edition No	Rev No	Date	Nature of Change
1	01	00	1 Oct 2019	First issue as per NABH 4th Edition
2	01	01	1 Nov 2020	Minor revisions for NABH 5th Edition
3	01	01	1 Jan 2022	No changes
4	01	02	1 Jan 2025	Amended as per NABH 6th Edition. All categories separately defined. General Consent added.
5	01	02	1 JAN 2026	No changes

5.1 Key Control: Daycare admission permitted only against documented doctor advice/order; emergency exception with retrospective documentation.

5.2 Procedure

1. Daycare admissions are planned for procedures/therapies expected to be completed within 24 hours.
2. Admission counter receives documented doctor order/advice, retrieves existing UHID, verifies identity, confirms demographics with audit trail controls, and creates Daycare/Short Stay encounter.
3. A General Admission Consent is obtained. This consent is not used for invasive procedure or other procedures which require specific informed consent.
4. Documents and labels are printed, nursing applies wristband, and after completion the daycare discharge is processed. If stay exceeds 24 hours due to clinical need, conversion to IP is performed without creating new UHID and conversion note is documented.

5.3 Mandatory Dataset

Always mandatory: UHID, patient name, age/DOB, sex, locality/city, date/time, consultant/service, ward category, attendant details.

Conditional: ID/insurance documents, MLC fields as applicable.

NICU Admission & Discharge Criteria (SDH/NICU/02)

Admission Criteria

- Birth weight of < 2000 gm
- Gestational age < 34 weeks
- Requiring positive pressure ventilation
- Respiratory distress / apnoea / seizures / feed intolerance / poor feeding / ?sepsis

- Hypoglycaemia / hypocalcaemia / hypothermia
- Intensive phototherapy
- Bleeding manifestations
- Mother in ICU
- Doctor's discretion

Inborn babies may be kept in NICU for observation for a period of up to 6 hours if they have mild respiratory distress or have required minimal resuscitation. Babies with infective diarrhoea, chickenpox, open wounds, skin lesions should not be admitted to NICU; they may be admitted in an isolated room which can be warmed.

Discharge Criteria

- Vitals stable without any support
- Maintains temperature without assistance
- Baby feeding well
- Weight gain for 3 consecutive days
- No evidence of infection
- Bilirubin within normal limits
- Health education regarding feeding, hygiene, medications etc. given to parents
- Mother confident of taking care at home

6.1 Key Control: MTP admission/procedure only on documented order/advice of authorized RMP (OBGYN); confidentiality-tagging in HIS; restricted access; secure custody logs for paper; no deletion of clinical traceability.

6.2 Procedure

1. Patient is received discreetly.
2. Registration creates UHID.
3. HIS record is marked confidential/restricted. The patient's name is not mentioned in the registration details, instead MTP Serial No./Year is used to protect anonymity.
4. Admission/procedure proceeds only on documented authorized doctor order.
5. Admission category is Daycare or IP depending on expected duration.
6. Paper documents (if any) are sealed and stored in locked custody with access register.
7. Any disclosure of identity is restricted to authorized persons under law.
8. Post-procedure record retention is ensured as per policy/statute.

7.1 Key Control: No psychiatric admission unless advised/ordered/certified by psychiatrist/doctor under correct MHCA pathway; emergency safety care allowed with earliest completion of MHCA documentation.

7.2 Admission Categories

Independent admission (adult voluntary) – MHCA Sec 86; Minor admission – Sec 87; Supported admission up to 30 days – Sec 89; Supported admission beyond 30 days – Sec 90.

7.3 Procedure (Narrative)

Independent admission: Psychiatrist evaluates and records criteria and issues admission order. Registration/admission staff processes UHID and admission encounter tagged accordingly. Discharge on request is honored with MHCA safeguards; if risk requires assessment for supported admission, discharge may be prevented up to 24 hours only as allowed.

Minor admission: NR* applies for admission. Required independent examinations are performed and documented. Admission order is issued only after satisfying criteria. Minor is accommodated separately from attendant requirements. MHRB intimation and reviews are completed within statutory timelines.

Supported admission: NR* applies. Required examinations/certifications are completed. Psychiatrist documents need, risk and least restrictive option. Supported admission duration is tracked (up to 30 days) and extensions beyond 30 days follow Sec 90 with independent examinations and Board oversight. All Board intimations and orders are retained.

7.3 Documentation Set

Admission order/certification, capacity/consent notes, NR application, independent examination notes, risk screening checklist, Board intimations/orders, observation charts and nursing notes.

(*NR = Nominated Representative)

8.1 Key Controls

Emergency care shall not be delayed for registration; provisional unknown registration allowed; no dummy mobile numbers; ER→IP/Daycare admission only on documented doctor order/advice (emergency exception with retrospective documentation); unknown naming convention and reconciliation mandatory.

8.2 Procedure

1. On arrival, triage is performed and urgent patients are treated immediately.
2. Registration proceeds in parallel at counter or bedside.
1. Existing UHID is searched and retrieved; if new patient, UHID is created after duplicate check. For unconscious/unidentified patients, provisional unknown registration is created using naming convention UNKNOWN-[M/F]-ER-[DATE]-[SEQ].
2. Minimum dataset is captured with controlled NA/refused options.
3. ER encounter is created with correct time/date.
4. Wristbands/labels are printed and applied where workflow exists.
5. Treating doctor identifies and declares MLC status, registration tags MLC in HIS and documentation proceeds as per policy.
6. If admission is required, doctor documents admission advice/order; admission counter converts to Daycare/IP using same UHID.
7. MRD tracks file movement and daily reconciliation is performed.

8.3 Records/Outputs

Triage/time of arrival, UHID/ER encounter record and reconciliation evidence, MLC tagging and registers, ER→IP/Daycare conversion records, daily reconciliation report.

Amendment History – Sections 2–8 (SDH/AAC/02)

Sl. No	Edition No	Rev No	Date	Nature of Change
1	01	00	1 Oct 2019	First issue as per NABH 4th Edition
2	01	01	1 Nov 2020	Minor revisions; compliance update for NABH 5th Edition
3	01	01	1 Jan 2022	No changes
4	01	02	1 Jan 2025	Amended as per NABH 6th Edition. All categories separately defined. General Consent added.

1.0 Purpose

To guide the staff when beds are not available for patients needing admission

2.0 Scope:

Hospital wide

3.0 Policy:

3.1 In case a bed is not available under the preferred category of the patient then for ensuring that the patient is not sent back, the patient is admitted in the category that is available provided the patient is willing for this category

3.2 Patients are at times admitted in categories other than their preference and in these cases the front office mentions that the patient needs to be shifted to the preferred category at the earliest

3.3 If the room is not available for the patient to be shifted, then he or she is charged accordingly. e.g. if the patient has opted for a ward bed but is kept in a higher category then he or she is charged for a ward bed only and in cases where the room category in which the patient is kept is lower, patient is charged for the lower category.

3.4 Clinical condition and urgency of the patient shall **override room category preference, financial considerations, or administrative convenience** in all situations.

3.5 Clinical Decision Authority

- Bed allocation: Nursing In-charge
- ICU bed allocation: Treating Consultant
- Transfer/referral decision: Treating Consultant + Duty Medical Officer
- Escalation (conflict/unavailability): Medical Administrator

4.0 Summary Guidelines

4.1 Patients shall be offered a choice of patient rooms / beds. In the event of non-availability of the room of choice, the patient shall be allotted the best alternative rooms available.

4.2 The patient shall be upgraded, and the charges shall be charged of his desired category of room

4.3 A waiting list is maintained for allocation ofpatient beds in case ofnon-availability.

4.4 Intensive care units: These beds are meant for critically ill patients.

ICU beds shall be allocated based on:

- Severity of illness
- Need for intensive monitoring/intervention
- Reversibility of condition
- Clinical judgment of treating consultant

Stable ICU patients may be shifted to lower-level care to accommodate critically ill patients.

4.5 **All patients are triaged using ESI tool and are assigned an ESI level**.

Level 1 & level 2 cases are resuscitated and stabilized in casualty and if no bed is available in the ICU, then such cases are sent to the associated hospital / nearest hospital immediately (within 30 minutes) by choice with same kind of facilities. A doctor and a nurse trained in ACLS accompany the patient during transport.

4.6 For Level 3 cases, if a bed is going to be available within 4 hours, then the patient is held in casualty and treated as per the clinical condition. If no bed is going to be availableintheICUwithin4hours,then such cases are also transferred after stabilization to the associated hospital / nearest hospital on an urgent basis (within 4 hours) by choice with same kind of facilities .A nurse trained in ACLS accompanies the patient during transport. These cases are constantly checked and if they deteriorate into level 2 or 1, they are transferred immediately.

4.7 All level 4 cases are fast tracked and treated in the casualty itself and if possible discharged. These cases can be held for up to 8 hours in the Casualty. For cases requiring admission if beds are not available in any category, then these patients are advised to get admitted to other hospitals of their choice of similar facilities. A Casualty Discharge Summary is given and the patient is discharged.

4.8 All level 5 cases are treated at OPD level only. During regular OPD hours these casesaredirectedtotherelevantconsultantoftheirchoiceandafterregular OPD hours they are managed by the Casualty Medical Officer.

4.9 Patient Communication & Consent

Patients/relatives shall be informed regarding:

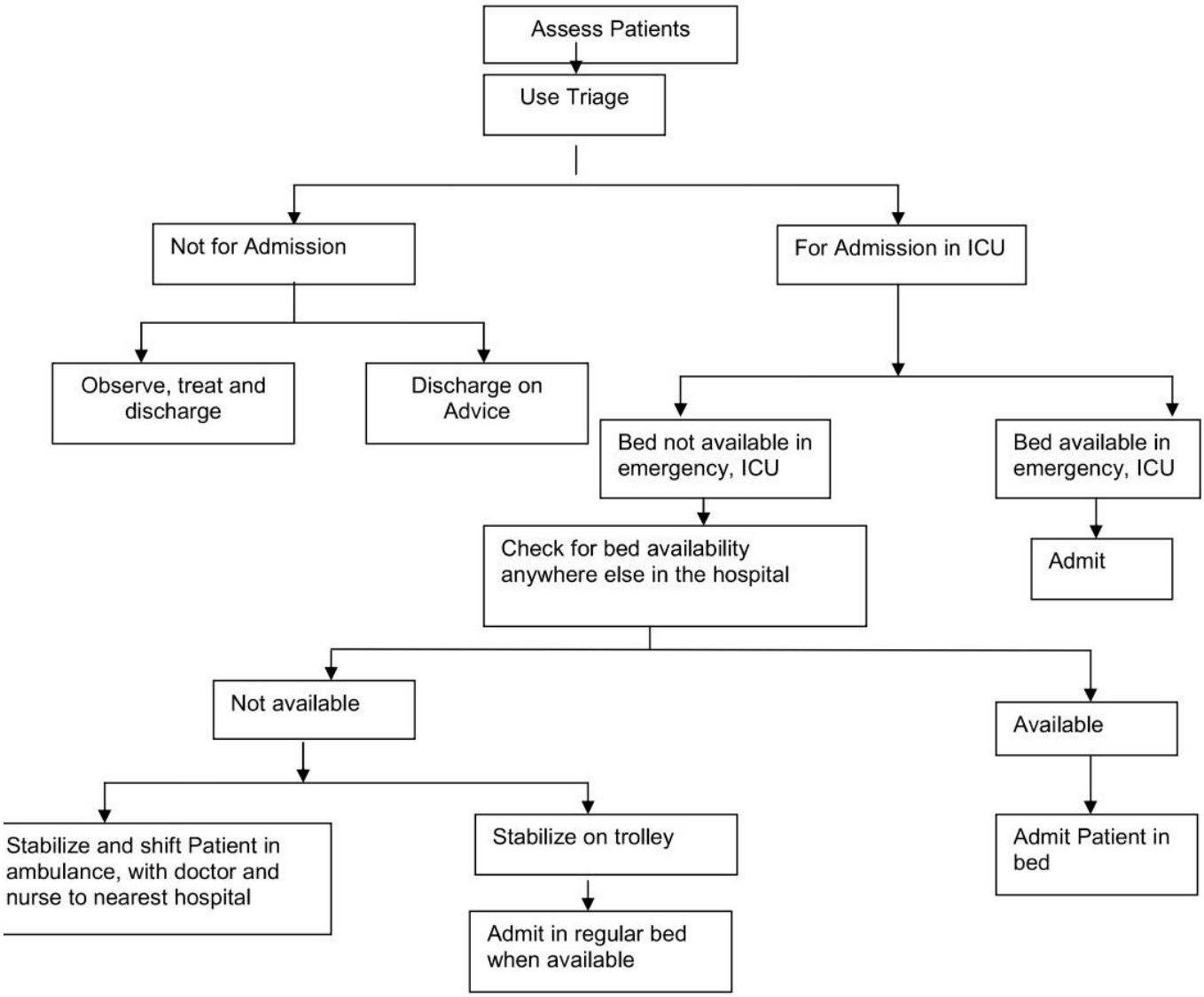
- Non-availability of beds
- Alternative options available
- Financial implications (if any)
- Transfer to another facility

Documented consent shall be obtained for:

- Transfer/referral
- Admission in alternate category

5.0 Procedure for managing patients during non-availability of beds in case of an emergency

5.0 Procedure for managing patients during non-availability of beds in case of an emergency



Recommended By	Signature	Approved By	Signature
Dr.Hrishikesh kalgaonkar		Dr.S.S.Deepak	
Quality Head		Chairman & Managing Director	

6.0 Procedure addressing shortage of beds in Intensive care

1. A call is made to CCU to check the availability of bed and if available the patient is shifted there.
2. The condition of all the patients in the CCU is checked. If stable they are shifted to the wards and the unstable patients could be provided with the vacant bed.
3. In case of the non-availability of bed, a stabilized patient is shifted to the trolley, and the unstable patient is provided the bed.
4. In case no patient can be transferred to the trolley then the new patient is stabilized and shifted into an ambulance, with a doctor and a nurse to the other hospital with similar facilities.

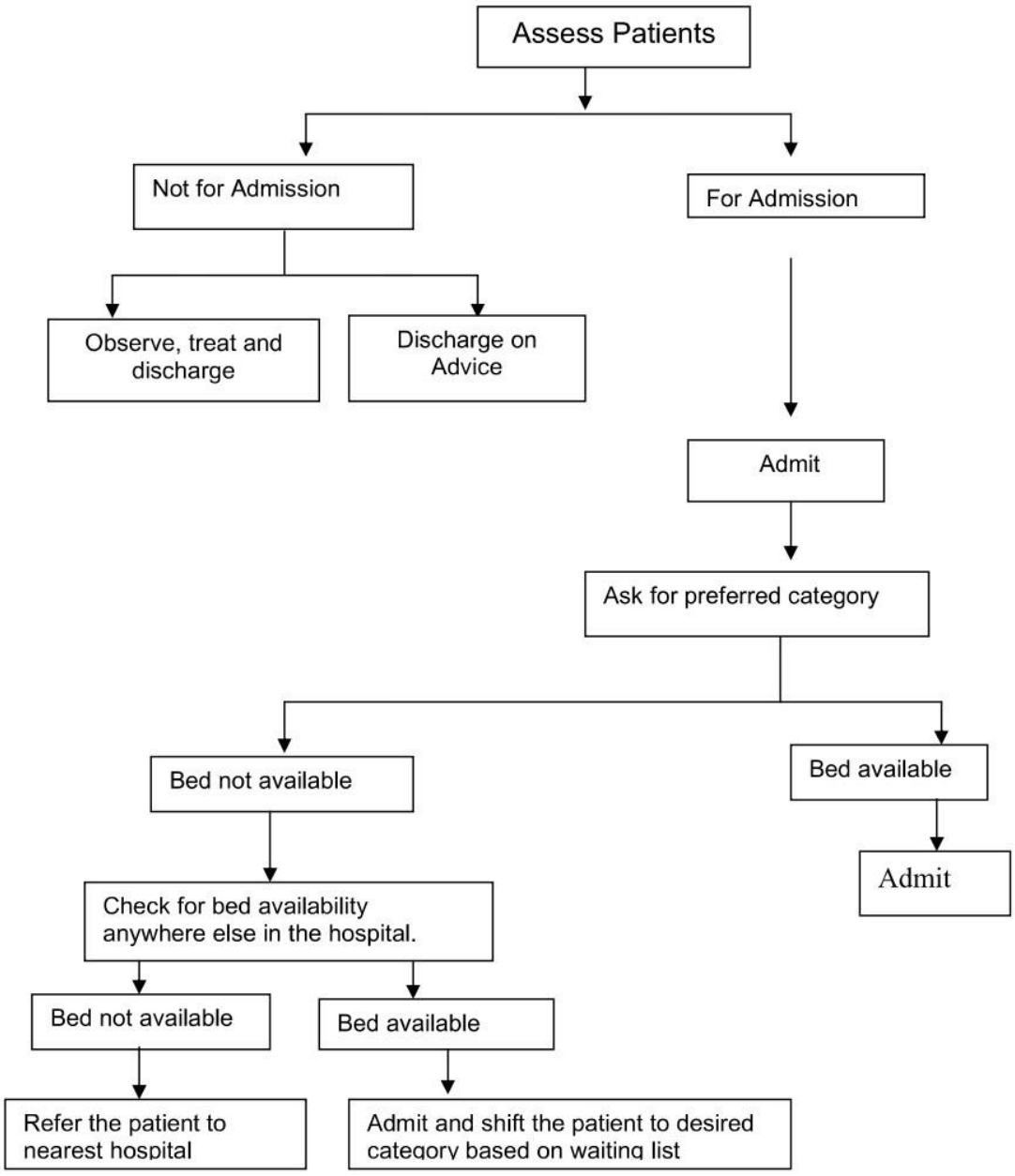
   The destined hospital is intimated prior to transfer of the patient. Also, the patient or/or relatives are given the option to select a hospital with similar facilities among the available hospitals.

   Prior to transfer:

- Receiving hospital shall be informed and acceptance confirmed
- Clinical status shall be documented
- Handover communication shall be recorded

7.0 Procedure for managing non-emergent patients during non-availability of beds

7.0 Procedure for managing non-emergent patients during non-availability of beds



Recommended By	Signature	Approved By	Signature
Dr.Hrishikesh kalgaonkar		Dr.S.S.Deepak	
Quality Head		Chairman & Managing Director	

(This policy addresses NABH 6th Edition AAC 2d, COP 2d and COP 9d)

Amendment History

Sl. No	Edition No	Rev No	Date	Nature of Change
1	01	00	1 Oct 2019	First issue as per NABH Hospital Accreditation Standards – 4th Edition
2	01	00	1 Nov 2020	Minor revision and updating for compliance as per NABH Hospital Standards 5th Edition
3	01	01	1 Jan 2022	No changes
4	01	02	1 JAN 2025	Reviewed and revised as per NABH 6th Edition. Clinical need prioritised over choice of patient for bed allocation. ESI triage system formalised. ICU allocation criteria clarified.
5	01	02	1 JAN 2026	No changes

Recommended By	Signature	Approved By	Signature
Dr.Hrishikesh kalgaonkar		Dr.S.S.Deepak	
Quality Head		Chairman & Managing Director	

	SAIDEEP HOSPITAL POLICIES	Doc No	SDH/AAC/02
		Issue No	01
		Rev No.	02
		Date of Issue	1 Jan 2026
		Pages	1
	Patient Prioritization and Waiting Area Deterioration Management		

1. Purpose

To ensure patients requiring urgent clinical attention are identified early at reception/OPD and that rapid response occurs if a patient deteriorates in the waiting area.

2. Scope

Applicable to reception counters, OPD registration areas, diagnostic reception, and waiting areas.

3. Identification of Priority Patients

Reception staff shall observe the patient during interaction and identify red flag symptoms or vulnerable patients.

Red Flag Symptoms

- Chest pain
- Difficulty breathing
- Severe abdominal pain
- Sudden weakness or paralysis
- Fainting or giddiness
- Convulsions or seizures
- Severe bleeding
- Altered consciousness

Vulnerable Patients

- Elderly patients

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepal Chairman & Managing Director	

- Pregnant women
- Infants and children
- Disabled patients
- Oncology or dialysis patients
- Post-operative patients

4. Immediate Action for Priority Patients

1. Inform triage nurse or duty doctor immediately.
2. Apply priority identification (if used locally).
1. Escort patient to emergency / clinical assessment area.
2. Complete registration later if necessary.

5. Waiting Area Deterioration Response

If a patient deteriorates while waiting (collapse, severe chest pain, breathlessness, seizure, confusion, or bleeding), the following actions must be taken immediately:

1. Call for the nearest nurse or doctor immediately.
2. Activate the emergency response / announce Code Blue if the patient is unresponsive.
3. Do not move the patient unless advised by clinical staff.
4. Keep bystanders away and maintain a clear area for emergency response.
5. Document the incident with time, nature and response.

	SAIDEEP HOSPITAL POLICIES	Doc No	SDH/AAC/02
		Issue No	01
		Rev No.	02
		Date of Issue	1 Jan 2026
		Pages	3
	Patient Prioritization and Waiting Area Deterioration Management		

Amendment History

Sl. No	Edition No	Rev No	Date	Nature of Change
1	01	00	1 Oct 2019	First issue as per NABH 4th Edition
2	01	01	1 Nov 2020	Minor revisions; compliance update for NABH 5th Edition
3	01	01	1 Jan 2022	No changes
4	01	02	1 Jan 2025	Amended as per NABH 6th Edition
5	01	02	1 JAN 2026	No changes

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepal Chairman & Managing Director	

	SAIDEEP HOSPITAL HOSPITAL MANUAL	Doc No	SDH/AAC /3
		Issue No	01
		Rev No.	02
		Date	1 Jan 2026
		Pages	1
	Policy: Transfer-In of Referral Patients to the Organisation		

1. Purpose

To establish a structured, safe, and clinically coordinated mechanism for receiving stable and unstable patients referred or transferred from other healthcare facilities, ensuring: continuity of care (COP linkage); appropriate clinical decision-making; timely assessment and initiation of treatment; safe handling of both stable and unstable patients.

2. Scope

This policy applies to: Emergency Department (primary receiving area); ICU / HDU / Wards; all clinical departments involved in receiving referred patients.

3. Policy Statement

The hospital shall ensure that all transfer-in/referral patients are: received based on available clinical information; managed through a defined triage and assessment process; provided timely and appropriate care without delay; handled in a manner that ensures continuity, safety, and documentation of care. This shall apply to both planned and unplanned transfers, including stable and critically ill patients.

4. Types of Transfer-In

- Planned Transfer: Prior communication available; clinical details shared in advance.
- Unplanned / Emergency Transfer: Patient arrives without prior intimation; limited or incomplete information.

5. Pre-Arrival Coordination (Where Applicable)

Where prior intimation is available, information shall be obtained regarding: diagnosis/provisional diagnosis; clinical condition; treatment ongoing and already given; reason for referral. Receiving unit shall: identify appropriate bed/location; prepare necessary equipment and staff; alert diagnostics or interventional units for patients requiring urgent care during the window periods.

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepak Chairman & Managing Director	

6. Preparedness of Receiving Team

- Appropriate clinical team shall be alerted
- Required equipment (oxygen, monitors, emergency drugs) shall be kept ready
- Prepare diagnostics (e.g. CT/MRI for Stroke cases) or interventional units (e.g. Cathlab for PAMI in ACS) for patients requiring urgent care during the window periods
- ICU/ward bed allocation shall be planned as per patient condition

7. Management of Unstable / Critical Patients

For critically ill patients, the hospital may: provide telephonic guidance to referring facility; OR send trained personnel with ambulance (where feasible); OR activate emergency response team prior to arrival.

8. Reception and Triage

Upon arrival: immediate triage shall be performed; patient shall be categorised based on clinical urgency; life-saving interventions shall not be delayed for documentation.

9. Initial Clinical Assessment

A qualified medical practitioner shall perform: clinical examination; assessment of stability; review of referral documents. Initial orders shall be documented promptly.

10. Continuity of Care

The hospital shall ensure: treatment already initiated is reviewed and continued/modified appropriately; no interruption in essential care during transition; all relevant clinical information from referring facility is verified, integrated into ongoing treatment. Any gaps in information shall be identified, documented, and clarified where possible.

11. Clinical Handover

If patient is accompanied by healthcare personnel, verbal handover shall be obtained. If not, available documentation shall be reviewed. Handover should include: diagnosis/provisional diagnosis; treatment given; current clinical status; pending concerns.

12. Documentation Requirements

- Referral note (if available)
- Initial assessment documentation
- Time of arrival
- Condition at arrival
- Treatment initiated

13. Feedback to Referring Facility

Where feasible, feedback shall be provided regarding: patient condition on arrival; initial management.

14. Responsibilities

- Treating/Receiving Consultant: Clinical decision-making; continuity of care
- Emergency Physician / Duty Doctor: Initial assessment; stabilisation
- Nursing Staff: Preparation and monitoring; documentation support
- Administration: Coordination of bed and logistics

15. Monitoring & Quality Indicators

The following shall be audited: time from arrival to initial assessment; completeness of referral documentation; evidence of continuity of care; adverse events during transfer-in.

16. Records

Referral records; Emergency register; Case sheets. Retention: as per Medical Records Policy.

Amendment History

Sl. No	Edition No	Rev No	Date	Nature of Change
1	01	00	1 Oct 2019	First issue as per NABH 4th Edition
2	01	00	1 Nov 2020	Minor revisions for NABH 5th Edition
3	01	01	1 Jan 2022	No changes
4	01	02	1 Jan 2025	Amended as per NABH 6th Edition
5	01	02	1 Jan 2026	No changes

1. Purpose

To ensure that transfer or referral of patients to another healthcare organisation is carried out in a safe, appropriate, and clinically justified manner, ensuring: patient safety during transfer; continuity of care; adequate stabilisation prior to transfer; appropriate communication and documentation.

2. Scope

This policy applies to: patients presenting in the Emergency Department requiring referral; admitted patients requiring transfer to another facility; patients requiring transfer for diagnostic or therapeutic procedures not available in-house.

3. Policy Statement

The hospital shall ensure that all patient transfers to external facilities are: clinically indicated and justified; undertaken with prior stabilisation; executed with appropriate transport, equipment, and trained personnel; carried out in consultation with the patient and/or family; supported by complete documentation and clinical handover.

4. Indications for Transfer

Transfer may be undertaken under the following circumstances: requirement of higher level or specialized care not available in the hospital; emergency conditions requiring referral; transfer for diagnostic or interventional procedures not available in-house; patient/family request (after counselling and documentation).

5. Decision-Making Authority

- Transfer decision shall be made by the treating consultant
- In emergency situations, by the duty medical officer / emergency physician

6. Clinical Assessment and Stabilisation Prior to Transfer

Before transfer, the patient shall be: clinically assessed and stabilised to the extent possible; airway secured (if required); intravenous access established; oxygen therapy initiated (if indicated); haemodynamic status optimised. Vital parameters shall be recorded prior to transfer.

7. Consultation with Patient / Family

The need for transfer, expected benefits, risks, and alternatives shall be explained. Informed consent shall be obtained and documented.

8. Selection of Mode of Transport

The mode of transport shall be determined based on the patient's clinical condition: basic ambulance for stable patients; advanced / critical care ambulance for unstable or ventilated patients.

9. Equipment and Monitoring During Transfer

The following shall be ensured as per patient condition: oxygen supply; suction apparatus; cardiac monitor (where indicated); infusion pumps (if required); emergency drugs and resuscitation equipment. Continuous monitoring shall be maintained during transfer, as applicable.

10. Escort Requirements

Patient Condition	Escort Required
Stable	Trained paramedic
On IV fluids / Oxygen	Staff nurse
Critically ill / Ventilated	Doctor + Nurse

All escort personnel shall be trained in Basic Life Support (BLS); critical transfers shall involve personnel trained in advanced life support.

11. Communication with Receiving Facility

Prior communication shall be established with the receiving facility. Acceptance shall be obtained wherever feasible. Relevant clinical information shall be shared.

12. Documentation and Transfer Summary

The following documents shall accompany the patient: transfer summary including diagnosis/provisional diagnosis, clinical condition at transfer, treatment given; investigation reports; medication details; consent form; referral note.

13. Clinical Handover

A structured clinical handover shall be provided to the receiving facility. Handover shall include: patient condition; treatment administered; ongoing care requirements. This ensures continuity of care across organisations.

14. Transfers for Diagnostic Purposes

Patients referred outside for diagnostic procedures shall: be assessed for fitness for transfer; be accompanied by appropriate staff if required; be monitored during transit. Relevant clinical details shall be shared with the receiving diagnostic facility.

15. Handling of Unmet Requirements

If any standard requirement (e.g., equipment, escort, delay) cannot be fulfilled, the same shall be documented with justification in the patient record.

16. Special Situations – DAMA with Transfer Intent

Risks shall be clearly explained. High-risk consent shall be obtained. Patient shall be stabilised to the extent possible prior to transfer.

17. Responsibilities

- Treating Consultant: Decision-making and documentation
- Duty Doctor / CMO: Coordination of transfer
- Nursing Staff: Preparation, escort, and documentation
- Ambulance Team: Safe transport and equipment readiness

18. Monitoring and Quality Indicators

The hospital shall monitor: documentation completeness of transfer (%); compliance with pre-transfer stabilisation; adverse events during transfer; delays in transfer.

19. Records

Transfer forms; consent forms; patient medical records; transfer register.
Retention: as per Medical Records Policy.

20. References

- NABH 6th Edition AAC 3(b)
- COP standards (continuity of care and handover)

Amendment History

Sl. No	Edition No	Rev No	Date	Nature of Change
1	01	00	1 Oct 2019	First issue as per NABH 4th Edition
2	01	00	1 Nov 2020	Minor revisions for NABH 5th Edition
3	01	01	1 Jan 2022	No changes
4	01	02	1 Jan 2025	Amended as per NABH 6th Edition. Escort table added. Diagnostic transfer and DAMA sections added.
5	01	02	1 Jan 2026	No changes

Introduction

Patient Assessment is a key process in ensuring comprehensiveness of medical and nursing care for the patients. The patient assessments form a continuous process consisting of pre-admission assessment, initial assessment on admission and periodic reassessments throughout the patient's stay at the hospital. The overall assessment process covers the patient's physical, psychological, social, and rehabilitation needs and supported by additional assessments of nutritional needs and nursing care needs of the patients to ensure a holistic and multidisciplinary care.

This document provides instruction and guidance to clinical and nursing staff on initial assessment and periodical reassessment of the patients in outpatient, inpatient and emergency settings to determine the initial treatment plans and its subsequent modifications. All HODs throughout the hospital are required to instigate action to ensure the successful implementation of the policy within their area(s) of control. This policy is distributed to all departments, units and wards through the Hospital Manual.

Purpose and Scope

The purpose of this policy is to: outline a systematic process for gathering pertinent information about each patient; establish a comprehensive information base for decision making about each patient's care; provide patients with the right care at the time it is needed.

Responsibilities

Clinical Staff: All doctors are responsible for following the procedural guidelines to ensure an appropriate and timely completion of the various assessments. Nursing Staff: Ward/Unit Nurses are responsible for tracking the timely completion of the various assessments and for notifying the responsible doctor/dieticians/health providers (Physiotherapist/Psychiatrists) in the event that required information appears to be missing or incomplete.

Policies

Patient assessment at Saideep Hospital is an ongoing process that begins before the patient is admitted and continues throughout treatment.

IN CASE OF OP

The institution follows a policy that the patient in the outpatient department information shall be received in the following manner:

- The OPD begins at 9 am. The patient on registration in the MRD shall reach the respective department himself; the case sheet shall reach the department from the MRD to the same OPD, which shall be delivered by the attender of the MRD to the OPD.
- The patient will be called in when his turn arrives. The patient shall be assessed by the doctor (consultant) as defined by the respective department. The patient may be advised any investigations and reviewed again or may be advised admission in which case the care would be as in-patient.
- Chart should be ready in OP when patient comes to outpatient department.
- In case of OPD, patient assessment shall be done within a time frame of 2 hours.

Pre-admission information as well as observations made at the time of admission will be used to determine the patient's admission unit (intensive care / wards) in the hospital. In cases of admissions for elective surgeries patients are prescribed various tests/evaluations to assess their condition/preparedness for undergoing the surgery. A detailed assessment shall be performed based on these investigations/evaluations and recorded in the OPD case sheets prior to admission of the patient.

IN CASE OF IP

Once the patient arrives on the treatment ward, an initial assessment shall be performed within 24 hours of his admission. This initial assessment may be performed in two steps:

- An initial assessment is performed by the receiving nursing staff and is recorded in the patient medical record.
- An initial assessment is done by the CMO/RMO attached with the department and is filled in the Initial examination sheet. The same is validated within 24 hours by the senior consultant from the department who countersigns the respective assessment form.

More detailed assessments to determine each patient's psychological, social, and rehabilitation needs may be conducted as per recommendations of the treating doctors.

Reassessment Policy

Patient acuity and nature of condition/disease determine the frequency of reassessment. Frequencies of reassessments also vary with care settings. For example emergency and Intensive Care patients may undergo more frequent reassessments than ward/room based patients. Reassessment of patient care needs including treatment plan review is also initiated at the following times:

- If the patient had been in the same area for more than 2 weeks, a reassessment shall be done and recorded in the case sheet.
- When there is a significant change in the patient's condition and/or diagnosis.
- When a patient is transferred from one hospital unit to another (for example shift from ICU to wards, emergency to wards).
- At regularly established intervals, as established by each department/specialty for various conditions (reassessment procedures/intervals specific to each department will be specified in their respective clinical manuals).
- At the time of discharge.

Analysis of information from these basic assessments drives initial treatment plans and continues up to discharge planning.

Procedures

A. Pre-Admission Assessment

1. Pre-admission assessment begins when a patient is recommended for admissions. The pre-admission assessment is informal in nature and is coordinated by the admitting physicians with support of OPD nursing staff and PGs.
1. In case of elective admissions especially in case of planned/elective surgeries the pre-admissions assessment consists of a list of pre-determined tests and evaluation by cardiologists/general medicine specialist for fitness for undergoing surgery.

1. The details of the assessment is documented in the OP case sheet of the patient and used for: determining the appropriateness of the admission to Hospital based on the patient's psychiatric and physical health status; determining the unit/ward for admission; as preliminary information for the receiving treatment team; circumstances which precipitated the pending admission; diagnosis(es) and medication history; additional physical health problems; legal status.

During the process the patient is also briefed about his rights as patient of Saideep Hospital and clearly educated regarding the importance of their decision making. Once the patient decides to go ahead with admission the general consent form for admission is obtained and then the patient is shifted to the area of care. The patients are expected to read the form and understand its content (in case of doubt they shall contact the front office and get their doubts cleared) and then sign it prior to their admission. This particular consent is not an informed consent.

B. Initial Assessment

1. An initial assessment will be completed by a RMO/DMO from the admitting unit within three hours of the time each patient is received by the ward staff. This initial assessment will be checked and validated within 24 hours of the patient being received in the wards by the Senior Consultant or above from the admitting department/specialty.
1. Results of the initial assessment are documented in each patient's medical record using initial assessment forms (as per department specific formats).
2. All patients admitted to the hospital will undergo a Nutritional Assessment by a dietician within 24 hours of admission.
3. A nursing assessment will be performed by the nursing staff within the shift during which the patient was received by the wards/units. Analysis of nursing assessment information results in documentation of patient strengths, a needs assessment summary, and nursing care plan.
4. In cases when patients refuse and/or patient's condition precludes obtaining a complete initial assessment, the reason for delay and plan for completion is documented in the medical record.

D. Additional Assessments & Reassessments

5. Admission assessment procedures may trigger a need to further examine actual or potential areas of need for treatment.
1. Additional patient assessments are initiated by a doctor's order and accomplished by: internal referral; and/or referrals to outside specialists/consultants.

2. Internal Referrals: Focused assessments administered by Saideep Hospital clinical and Paramedical staff include: (a) Nutritional – Dietitian; (b) Dental – licensed dentist; (c) Functional – Physiotherapy/rehabilitation staff; (d) Psychological/Psychiatric – Psychiatry staff.

E. Assessment Tools and Documentation

3. Assessment tools and formats for documentation will be developed by the clinical disciplines responsible for the specific evaluation. All evaluation tools will be approved by the department HOD prior to use with patients.
1. Formats for Nursing, Nutrition, Psychiatric, Functional and Socials will be standardised throughout the Hospital.

Monitoring

The nursing staff of each ward monitors the timely completion of the various types of assessments and coordinates with various categories of professionals for timely completion.

Related Hospital Procedures & Policies

2. Policies and Procedures for Medical Audit
1. Clinical Manuals/procedures of various departments/specialties
2. Nursing Manuals and protocols
3. Nutrition and Dietary Services Manual

NABH 6th Edition Reference: AAC 4.A – Initial assessment of outpatients, day-care, in-patients and emergency patients is done. AAC 4.B – Initial assessment is performed by qualified personnel. AAC 4.C – Initial assessment is performed within a time frame based on the needs of the patient.

Amendment History

Sl. No	Edition No	Rev No	Date	Nature of Change
1	01	00	1 Oct 2019	First issue as per NABH 4th Edition
2	01	01	1 Nov 2020	Minor revisions; compliance update for NABH 5th Edition
3	01	01	1 Jan 2022	No changes
4	01	02	1 Jan 2025	Amended as per NABH 6th Edition. OPD timing (2 hours) formalized. Nutritional assessment within 24 hours added. References updated.
5	01	02	1 Jan 2026	No changes

1. Purpose

To supplement the existing Patient Assessment & Reassessment Policy (SDH/AAC/05) with specific provisions for: communicating follow-up appointments to outpatients; monitoring and modifying the care plan during in-patient reassessments; and ensuring that all staff involved in direct clinical care document their reassessment findings.

2. Policy — AAC 5.b: Informing Outpatients of Next Follow-up

Where follow-up is clinically appropriate, every outpatient shall be informed of the date, timing and location of their next follow-up appointment before they leave the OPD. This is a Commitment-level requirement under NABH 6th Edition.

2.1 Process

1. The treating consultant documents the follow-up plan in the OPD case sheet — specifying timing (e.g., after 2 weeks, after lab results, after surgery), the consulting unit/department, and any specific conditions requiring earlier review.
2. The OPD nurse or desk associate communicates the follow-up appointment to the patient verbally and provides a written follow-up slip where the HIS generates one.
1. For patients on chronic disease management (diabetes, hypertension, oncology, nephrology, etc.), the follow-up system includes: recall/reminder calls via HIS or the Patient App; scheduling of next appointment before the patient leaves the OPD.
2. For patients referred to other departments or specialists for follow-up, the cross-referral form doubles as the follow-up instruction, and the patient is guided to register with the appropriate OPD.
3. If the patient is unable or unwilling to schedule a follow-up, the reason is documented in the case sheet, and the patient is counselled about warning signs requiring immediate return.

3. Policy — AAC 5.c: Monitoring and Modification of Care Plan During Reassessment

The care plan for every in-patient shall be actively monitored and modified during reassessments as the patient's clinical condition evolves. The care plan is a living document — not a static entry made at

the time of admission. Every significant reassessment finding that changes the clinical trajectory shall result in a documented modification to the care plan.

3.1 Process

4. During each round/visit, the treating consultant and RMO/CMO review the current care plan against the patient's clinical progress.
5. If the patient is responding as expected, a brief reassessment note confirming no change to the care plan is sufficient.
6. If the patient's condition has significantly changed — deterioration, improvement beyond expectation, new diagnosis, change in surgical plan, development of complication — the care plan is explicitly modified with: date and time; new or revised goals; changes to investigations, medications, or planned procedures; updated discharge plan and special needs; name and signature of clinician making the modification.
7. Care plan modifications triggered by EWS escalation (Zones 2, 3, 4) shall be documented within the timeframes defined in the EWS Guidelines (SDH/AAC/09).
8. Transfer between hospital units (ICU to ward; ward to ICU; ER to ward) constitutes a trigger for mandatory care plan review and update by the receiving team within 3 hours.

4. Policy — AAC 5.d: Documentation of Reassessments by Clinical Staff

All staff involved in direct clinical care are required to document their reassessment findings in the patient's medical record. This is a Commitment-level requirement. Documentation provides a traceable clinical record, enables continuity between staff shifts, and supports safe clinical decision-making.

4.1 Documentation Requirements by Discipline

Discipline	Documentation Location	Minimum Frequency
Treating Consultant	Doctor's Progress Notes / Case Sheet	Once daily for stable IP; as clinically indicated for unstable
RMO / CMO / Duty Doctor	Doctor's Progress Notes	Every round; at minimum twice daily in ICU, once daily in wards
Nursing Staff	Nursing Assessment / Vital Chart / Nursing Notes	Every shift; more frequently per EWS requirement
Dietician	Nutrition Assessment / Progress Note	At reassessment per clinical need; minimum weekly for IP
Physiotherapist	Physiotherapy Notes	Per session; at minimum at initial assessment and at discharge
Psychiatrist/Psychologist	Psychiatric Progress Notes	As clinically indicated; at minimum weekly for admitted psychiatric patients

In cases where a patient's condition precludes obtaining a complete reassessment, or where the patient refuses, the reason for the incomplete reassessment and the plan for completion shall be documented in the medical record.

	SAIDEEP HOSPITAL HOSPITAL POLICIES	Doc No	SDH/AAC/05
		Issue No	01
		Rev No.	02
		Date of Issue	1 Jan 2026
		Pages	4
	REASSESSMENT POLICY – ADDENDUM (SDH/AAC/05-S)		

NABH 6th Edition Reference: AAC 5.b – Outpatients are informed of their next follow-up where appropriate. AAC 5.c – For in-patients during reassessment the care plan is monitored and modified where necessary. AAC 5.d – Staff involved in direct clinical care document reassessments.

This document is an addendum to the Patient Assessment & Reassessment Policy (SDH/AAC/05). Read together with the main policy.

Amendment History

Sl. No	Ed. No	Rev No	Date	Nature of Change
1	01	00	1 Oct 2019	Within Assessment Policy (NABH 4th Edition)
2	01	01	1 Nov 2020	Within SDH/AAC/05; NABH 5th Edition compliance
3	01	01	1 Jan 2022	No changes
4	01	02	1 Jan 2025	Separated as addendum. OPD follow-up process formalised. Care plan monitoring and modification process defined. Reassessment documentation by discipline tabulated. Aligns with NABH 6th Edition AAC 5.b, 5.c, 5.d.
5	01	02	1 Jan 2026	No changes

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepak Chairman & Managing Director	

	SAIDEEP HOSPITAL HOSPITAL POLICIES	Doc No	SDH/AAC/05
		Issue No	01
		Rev No.	02
		Date of Issue	1 Jan 2026
		Pages	1
	Guidelines for Implementing Early Warning Signs (EWS) Systems		

Purpose

The purpose of this guideline is to implement a NHS – NEWS model based Early Warning Signs (EWS) system to identify early warning signs of change or deterioration in clinical conditions and creating an action system to initiate prompt medical and care interventions.

Scope

The EWS system shall be applicable in all in-patient wards and care units of the hospital and implemented as a part of vital monitoring of all patients.

Responsibilities

Medical Superintendent: The overall responsibility of implementing the policy rests with the Medical Superintendent of the hospital.

Procedures

Systems operating with similar levels of risk use universal means of communication that reduce the chance of failure. Saideep Hospital should be no different. Staff moving between care settings end up speaking at cross purposes, warning signs are missed, and patient care can ultimately be compromised.

Early warning score (EWS) systems are important tools in helping to identify patients at risk of deterioration – including sepsis – and in escalating them to get appropriate treatment as promptly as possible.

The EWS is founded on the premise that (i) early detection, (ii) timeliness and (iii) competency of the clinical response comprise a triad of determinants of clinical outcome in people with acute illness.

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepak Chairman & Managing Director	

The EWS is based on a simple aggregate scoring system in which a score is allocated to physiological measurements, already recorded in routine practice, when patients present to, or are being monitored in hospital. Six simple physiological parameters form the basis of the scoring system:

1. Respiration rate
1. Oxygen saturation
1. Systolic blood pressure
2. Pulse rate
3. Level of consciousness or new confusion
4. Temperature

A score is allocated to each parameter as they are measured, with the magnitude of the score reflecting how extremely the parameter varies from the norm. The score is then aggregated. The score is uplifted by 2 points for people requiring supplemental oxygen to maintain their recommended oxygen saturation.

Trigger Values

There are four trigger values for a clinical alert requiring clinician assessment based on the EWS:

- Zone 1: An aggregate MEW score of 1–5 or any vital sign in value zone 1.
- Zone 2: An aggregate MEW score of 6–7 or any vital sign in value zone 2.
- Zone 3: An aggregate MEW score of 8–9 or any vital sign in value zone 3.
- Zone 4 (MET): An aggregate MEW score of 10+ or any vital sign in value zone MET (Medical Emergency Team).

Response to EWS

Zone 1 (1–5): Should prompt assessment by a competent registered nurse or equivalent, who should decide whether a change to frequency of clinical monitoring or an escalation of clinical care is required.

Zone 2 (6–7): Should prompt a review by a clinician, usually a ward-based doctor within 60 minutes, who should urgently decide whether escalation of care to a team with critical care skills is required. If needed a plan including intervention, escalation & review timeframe is documented.

Zone 3 (8–9): Should prompt emergency assessment by a senior clinician within 20 minutes and usually transfer of the patient to a higher-dependency care area. If needed a plan including intervention, escalation & review timeframe is documented.

Zone 4 (10+): Should activate Medical Emergency or Code Blue. Airway, Breathing & Circulation should be supported, and the patient is to be shifted in the ICU if not already there.

How to Implement for In-Patients

- EWS is documented on the vitals chart as recommended.
- If warranted, action is taken and it is documented in the daily notes sheet.
- The same (EWS & action) is expected to reflect in the 'Hospital Stay' section in the 'Discharge summary'.

Recommendations

- It is recommended that the routine clinical assessment of all adult patients (aged 16 years or more) should be standardised across Saideep Hospital i.e. wards, emergency area, recovery area, ambulance, with the routine recording of a minimum clinical dataset of physiological parameters resulting in the Early Warning Score (EWS).
- The EWS should not be used in children (i.e. aged <16 years) or in women who are pregnant, because the physiological response to acute illness can be modified in children and by pregnancy.
- The EWS may be unreliable in patients with spinal cord injury (especially tetraplegia or high-level paraplegia), owing to functional disturbances of the autonomic nervous system. Use with caution.
- The EWS should be used as an aid to clinical assessment – it is not a substitute for competent clinical judgement. Any concern about a patient's clinical condition should prompt an urgent clinical review, irrespective of the EWS.

	SAIDEEP HOSPITAL HOSPITAL POLICIES	Doc No	SDH/AAC/05
		Issue No	01
		Rev No.	02
		Date of Issue	1 Jan 2026
		Pages	4
	Guidelines for Implementing Early Warning Signs (EWS) Systems		

We recommend that the EWS is used to improve the following: assessment of acute-illness severity; the detection of clinical deterioration; the initiation of a timely and competent clinical response.

- In hospital, the EWS should be used for initial assessment of acute illness and for continuous monitoring of a patient's wellbeing throughout their stay in hospital. By recording a patient's EWS score on a regular basis, the trends in their clinical responses can be tracked to provide early warning of potential clinical deterioration and provide a trigger for escalation of clinical care.
- Likewise, the recording of the EWS trends provide guidance about the patient's recovery and return to stability, thereby facilitating a reduction in the frequency and intensity of clinical monitoring towards patient discharge.
- MET Call and Code Blue incidents shall be monitored for effectiveness of EWS effective usage.

NABH 6th Edition Reference: AAC 5.E – Reassessment is done at periodic intervals. EWS system is implemented for in-patients. Reference: NHS MEWS

Amendment History

Sl. No	Edition No	Rev No	Date	Nature of Change
1	01	00	1 Oct 2019	First issue as per NABH 4th Edition
2	01	01	1 Nov 2020	For compliance as per NABH Hospital Standards 5th Edition
3	01	01	1 Jan 2022	No changes
4	01	02	1 Jan 2025	Amended as per NABH 6th Edition for effectiveness of EWS. MET Call and Code Blue monitoring added.
5	01	02	1 Jan 2026	No changes

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepak Chairman & Managing Director	

	SAIDEEP HOSPITAL HOSPITAL POLICIES	Doc No	SDH/AAC/05
		Issue No	01
		Rev No.	02
		Date of Issue	1 Jan 2026
		Pages	5
	Guidelines for Implementing Early Warning Signs (EWS) Systems		

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepak Chairman & Managing Director	

	SAIDEEP HOSPITAL HOSPITAL POLICIES	Doc No	SDH/AAC/05
		Issue No	01
		Rev No.	02
		Date of Issue	1 Jan 2026
		Pages	6
	Guidelines for Implementing Early Warning Signs (EWS) Systems		

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepak Chairman & Managing Director	

	SAIDEEP HOSPITAL HOSPITAL POLICIES	Doc No	SDH/AAC/06
		Issue No	01
		Rev No.	00
		Date	1 Jan 2026
		Pages	1

Standard: AAC 6 E, 6 F, 6 G, 6 I, 6 J ,7 A, 7 B, Refer lab Quality Manual

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepak Chairman & Managing Director	

	SAIDEEP HOSPITAL HOSPITAL POLICIES	Doc No	SDH/AAC/07
		Issue No	01
		Rev No.	00
		Date	1 Jan 2026
		Pages	1

Standard: AAC 7 E
Refer Lab Safety Manual

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepak Chairman & Managing Director	

	SAIDEEP HOSPITAL HOSPITAL POLICIES	Doc No	SDH/AAC/08
		Issue No	01
		Rev No.	00
		Date	1 Jan 2026
		Pages	1

Standard: AAC 8 E, 8 F, 8 H, 9 A, 9 E ,9 F, 9 I, Refer Radiology Department Manual

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepak Chairman & Managing Director	

1. Purpose

To ensure that patient care at Saideep Hospital is continuous, coordinated, and multidisciplinary across all phases of the patient's stay — from admission through all transfers within the hospital and until discharge — with clear accountability, structured information sharing, and standardised handover communication.

2. Scope

Applicable hospital-wide to all clinical departments, wards, ICUs, HDUs, Emergency Care Unit, OT, Labour Room, and ancillary clinical services. Applies to all categories of clinical staff — doctors, nurses, dieticians, physiotherapists, psychologists, and other paramedical staff involved in direct patient care.

3. Responsibilities

- Medical Superintendent: Overall accountability for implementation of this policy.
- Treating Consultant: Primary clinical accountability for the patient's care throughout the admission; responsible for identifying and communicating any change of responsible clinician.
- Nursing Superintendent / Ward In-Charge: Accountable for nursing coordination of care and shift handover compliance.
- Quality Head: Monitoring of compliance indicators and reporting to MQCC.

4. Policy — AAC 10.a: Qualified Individual Responsible for Patient's Care

During all phases of care — in the OPD, during admission, in the ICU, in the ward, in the ER, and at discharge — there shall be a clearly identified, qualified medical practitioner who is responsible for the overall direction of the patient's care. This individual is the primary point of clinical accountability.

4.1 Process

1. At the time of OPD consultation, the consulting doctor is the responsible clinician for that episode.

1. At the time of IP/Daycare/ER admission, the admitting consultant is the identified responsible clinician. The admitting consultant's name is documented in the IP file, HIS, and the patient's wristband encounter record.
1. In emergency situations where the admitting consultant is not immediately available, the duty CMO/RMO is the interim responsible clinician until the admitting consultant takes over. The handover between duty doctor and consultant shall be documented.
2. When a patient's care is transferred from one consultant to another (e.g., post-operative transfer, specialty change, co-management becoming primary management), the change in responsible clinician shall be documented in the medical record by both the outgoing and incoming consultant, with date, time and signatures.
3. In multi-disciplinary care, there shall always be a single identified primary consultant. Co-managing consultants contribute to care but the primary consultant retains overall responsibility.
4. For ICU patients, the ICU Intensivist/Consultant is the responsible clinician. For combined management cases, the primary and ICU consultants shall document their respective roles.

5. Policy — AAC 10.b: Coordination of Patient Care Across All Settings

Patient care at Saideep Hospital shall be coordinated across all settings — OPD, ER, wards, ICU, OT, Labour Room, and diagnostic/therapeutic services — to ensure that the patient receives seamless, uninterrupted care without gaps or duplication. Coordination is the shared responsibility of the medical, nursing, and administrative teams.

5.1 Coordination Mechanisms

- Daily ward rounds by the treating consultant coordinating all active care processes.
- Multidisciplinary team (MDT) discussions for complex cases involving multiple specialties — documented in the case sheet with attendees listed.
- HIS-based order communication ensuring all departments receive timely investigation and medication orders.
- Structured nursing shift handover ensuring ward-level coordination between nursing shifts.
- Cross-referral system (SDH/AAC/10 Cross-Referral Policy) ensuring specialist inputs are received within defined timelines.
- MRD file movement register ensuring the physical medical record follows the patient across care settings.

6. Policy — AAC 10.c: Information Sharing Among Care Providers

Information about the patient's care and response to treatment shall be shared among all members of the care team — medical, nursing, and other care providers — in a timely and structured manner. No single discipline shall operate in information isolation.

6.1 Information Sharing Mechanisms

- Medical record is the primary shared information repository. All team members document their assessments, interventions and plans in the medical record.
- HIS order and result viewing: All authorised clinical staff have role-based HIS access to view orders, results, and clinical notes.
- Nursing-to-doctor communication: Critical findings, abnormal vital signs, EWS triggers, or clinical concerns are communicated verbally and documented in the nursing notes, with the doctor's response documented.
- Doctor-to-nurse communication: Orders are entered in HIS and additionally communicated verbally for urgent interventions; verbal orders are confirmed in writing within the same shift.
- Interdisciplinary communication: Nutritional assessment findings are shared with the treating team via the dietician's note in the case sheet; physiotherapy findings via the physiotherapy note; psychological findings via the psychiatry/psychology note.
- Critical investigation results are communicated immediately as per the Critical Value Intimation mechanism (see Section 9 and AAC 10.h below).

7. Policy — AAC 10.d: Standardised Handover Communication

Saideep Hospital implements standardised handover communication at every shift change, between clinical shifts, and during all patient transfers between units/departments. Handover is a high-risk process — failure of handover communication is a recognised cause of preventable adverse events. This is a CORE standard under NABH 6th Edition.

7.1 Handover Tool — SBAR (Situation–Background–Assessment–Recommendation)

The SBAR structured communication tool is the standard handover framework used at Saideep Hospital for all clinical handovers.

SBAR Element	Meaning	What to Communicate at Saideep Hospital
S — Situation	Current status right now	Patient name, UHID, bed, admitting diagnosis, and the current clinical issue or reason for handover.
B — Background	Relevant clinical context	Date of admission, key history, significant events since admission, relevant investigations, medications.
A — Assessment	Clinical assessment	Current vital signs, EWS score, clinical stability, active concerns, pending results.
R — Recommendation	What needs to happen next	Specific actions required in the next shift/after transfer — investigations to follow up, medications to be given, review triggers, escalation criteria.

7.2 Handover Occasions and Requirements

Handover Occasion	Who Hands Over / To Whom	Documentation Requirement
Nursing shift change (every shift)	Outgoing shift nurse to incoming shift nurse, in presence of Ward In-Charge	Handover noted in Nursing Notes for all active/high-dependency patients; verbal SBAR for all others.
Doctor shift change / CMO/RMO handover	Outgoing duty doctor to incoming duty doctor	Verbal SBAR; critical patients and pending tasks documented in duty doctor handover register or HIS.
Consultant round handover to RMO/CMO	Consultant to RMO/CMO at end of round	Consultant's progress note documents key decisions; RMO/CMO acknowledges and acts.
Transfer from ER to ward/ICU	ER nursing to ward/ICU nursing; ER duty doctor to ward CMO/RMO	Verbal SBAR; ER transfer note in medical record; receiving nurse signs transfer sheet.
Transfer from ICU to ward	ICU nursing to ward nursing; ICU doctor to ward CMO/RMO	ICU transfer note; SBAR verbal; nursing transfer form signed.
Handover to OT / anaesthesia	Ward nurse to OT/anaesthesia nurse; consultant to anaesthetist	Pre-operative checklist; surgical safety checklist (WHO); verbal SBAR.
Transfer to another unit for procedure/diagnostics	Ward nurse to receiving area nurse	Verbal SBAR; patient accompaniment as per transport policy.

7.3 Bedside Handover

For high-dependency patients and any patient with EWS Zone 2 or above, nursing shift handover shall be conducted at the bedside, with the patient present where possible, using the SBAR framework. Bedside handover enables visual confirmation of the patient's condition and reduces transcription/communication errors.

8. Policy — AAC 10.g: Predictable Service Delivery and Communication of Schedule Changes

Saideep Hospital commits to delivering services in a predictable, timely and organised manner. Patients and families have the right to be informed when planned services, procedures or investigations are delayed or rescheduled.

8.1 Defined Service Timelines

- OPD consultation: Patient is seen within 2 hours of registration (or per triage priority).
- Scheduled surgical procedures: Patient and family are informed of the planned OT slot at the time of surgical consent. Any change to the OT schedule is communicated to the patient/family as soon as known, with explanation.
- Scheduled diagnostic investigations (radiology, special procedures): Appointment is communicated to the patient/ward at the time of scheduling. Changes are communicated proactively.
- Dietician assessment for IP: Within 24 hours of admission.
- Physiotherapy assessment for IP (where ordered): Within 24 hours of order.
- Discharge: Target of 4 hours from written discharge order to physical departure. Delays are communicated to patient/family with reason.

8.2 Communication of Schedule Changes

1. When a planned procedure, surgery or investigation is delayed or rescheduled, the treating team or the concerned department notifies the patient/family as soon as the change is known.
1. The reason for delay and the revised schedule (if known) is communicated clearly and without medical jargon.
2. Nurse In-Charge documents the communication in the nursing notes: time of communication, person informed (patient, attendant, or family member), and revised plan.
3. If a delay is likely to affect the patient's clinical management (e.g., delay in urgent surgery, delay in critical investigation), the treating consultant is informed immediately for clinical decision-making.

9. Policy — AAC 10.h: Monitoring of Clinical Intervention in Response to Critical Value Alert

The organisation has a mechanism to monitor whether an adequate clinical intervention has taken place in response to a critical value alert from the laboratory or imaging department. This is an Excellence-level standard. Saideep Hospital implements this through a closed-loop critical value communication and response monitoring process.

9.1 Critical Value Communication — Closed Loop Process

1. Laboratory or radiology staff identify a critical value (as per defined critical value list — refer Laboratory Services Manual and Radiology Services Manual).
1. The critical value is communicated immediately by telephone to the treating nurse/doctor. The caller confirms the result by read-back.
2. Communication details are documented: time of communication, value communicated, person informed (name and designation), and confirmation of read-back.
3. The treating nurse/doctor is responsible for informing the treating consultant immediately.
4. The treating consultant or duty CMO/RMO documents the clinical response to the critical value in the medical record: acknowledgement of value, clinical assessment, and intervention/action taken, within 60 minutes of communication.
5. Laboratory/radiology staff follow up after 60 minutes if no acknowledgement is received from the clinical team.

9.2 Monitoring Mechanism

The Quality Department conducts monthly audit of critical value communication and response records to verify: documentation of communication; read-back confirmation; clinical response documented within defined timeframe; action taken appropriate to the critical value. Results are reported to MQCC. Lapses are subject to root cause analysis and corrective action.

10. Monitoring Indicators

Indicator	Formula	Target	Frequency
Responsible clinician documented in IP file at admission	Records with consultant name at admission / Total IP admissions × 100	100%	Monthly
Change of responsible clinician documented when applicable	Documented transitions / Total consultant changes × 100	100%	Quarterly audit
Nursing bedside handover compliance (high-dependency patients)	Bedside handovers done / Total HD patient shift changes × 100	> 95%	Monthly
Critical value — clinical response documented within 60 min	Responses within 60 min / Total critical values × 100	> 95%	Monthly
Scheduled procedure delay — patient/family communicated	Communicated delays / Total delays × 100	> 95%	Monthly
MDT documentation for complex cases	Cases with MDT note / Total complex cases × 100	> 90%	Quarterly audit

NABH 6th Edition Reference: AAC 10.a – During all phases of care, there is a qualified individual identified as responsible for the patient's care. AAC 10.b – Patient care is coordinated in all care settings. AAC 10.c – Information is shared among medical, nursing and other care providers. AAC 10.d – Standardised hand-over communication is implemented. AAC 10.g – Predictable service delivery and patient/family informed of schedule changes. AAC 10.h – Mechanism to monitor clinical intervention in response to critical value alert

Amendment History

Sl. No	Ed. No	Rev No	Date	Nature of Change
1	01	00	1 Oct 2019	Continuity of care elements within Assessment and Transfer policies — NABH 4th Edition
2	01	01	1 Nov 2020	Within cross-referral and assessment policies; NABH 5th Edition
3	01	01	1 Jan 2022	No changes
4	01	02	1 Jan 2025	First standalone Continuity of Care Policy. SBAR handover tool formalised. Responsible clinician identification process defined. Critical value closed-loop monitoring added. Predictable service delivery timelines defined. Aligns with NABH 6th Edition AAC 10.a, 10.b, 10.c, 10.d, 10.g, 10.h.
5	01	02	1 Jan 2026	No changes

SAIDEEP HEALTHCARE & RESEARCH PVT. LTD.	**SAIDEEP HOSPITAL** **HOSPITAL MANUAL**	Doc No	SDH/AAC /10
		Issue No	01
		Rev No.	02
		Date	1 Jan 2026
		Pages	1
	POLICIES & PROCEDURES FOR REFERRAL OF PATIENTS TO OTHER DEPARTMENTS/SPECIALTIES (CROSS-REFERRAL)		

Purpose and Scope

The purpose of this policy is to guide the clinical staff in the process of obtaining professional opinion, co-management or takeover of patient from colleagues of other specialties/departments in support of their own treatment protocols or as a part of a multi-disciplinary case scenario.

Responsibilities

Medical Superintendent: The overall responsibility of implementing the policy rests with the Medical Superintendent of the hospital.

Policies

- The referral forms may be filled in by a RMO, but should mention the name of Consultant, on whose instruction, the referral has been requested.
- Referral should shall be requested through cross referral forms and shall indicate if the referrals are to be treated as routine (24 hours), Urgent (4 hours) or Immediate (Immediately) depending on the patient condition. For urgent and immediate category referral justification for categorisation will be noted in the cross referral form.
- In case of 'urgent' and 'immediate' referrals, the referring RMO/Sisters in-charge should inform the consultant or the MS office in case of consultant not-responding; and in turn MS office will contact the consultant to whom the referral has been addressed. In case of his non-availability the referral will be routed to alternate consultant of same specialty available to attend the referral.
- The Staff Nurse In-charge of the ward should ensure that the 'routine' referrals are informed to the consultants within one hour of the referral order being filled up. They shall note the time of informing the consultant and sign with name to record the same. In cases where the consultant cannot be reached or informs their inability to attend the referral the request would be forwarded to MS office for further coordination and action.
- The doctor honouring the referral visits the patient to the ward where he/she is admitted and does the examination.

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepak Chairman & Managing Director	

- The doctor who has honoured the referral shall give his expert opinion after examining the patient in the referral sheet and/or shall discuss with the referring doctor. In cases of takeover of the case or co-management he shall indicate the same on the doctor's progress sheet of the patient accordingly.
- All 'routine' referrals, received within the regular duty hours, should be seen on the same day. Any received after these hours, should be attended to on the morning of the next day.
- All 'urgent' referrals should be seen within four hours of receiving the referral/information.
- All 'immediate' referrals should receive immediate attention.

NABH 6th Edition Reference: AAC 10.F – Referral of patients to another department/specialties follow written guidance.

Amendment History

Sl. No	Edition No	Rev No	Date	Nature of Change
1	01	00	1 Oct 2019	First issue as per NABH 4th Edition
2	01	01	1 Nov 2020	Minor revisions; updating Doc No.; compliance update for NABH 5th Edition
3	01	01	1 Jan 2022	No changes
4	01	02	1 Jan 2025	Amended as per NABH 6th Edition
5	01	02	1 Jan 2026	No changes

	SAIDEEP HOSPITAL HOSPITAL POLICIES	Doc No	SDH/AAC/11
		Issue No	01
		Rev No.	00
		Date	1 Jan 2026
		Pages	1
	PREVENTIVE & PROMOTIVE CARE GUIDELINES		

Hospital shall make every effort to encourage Preventive and Promotive Health in staff, patients and community through multi-disciplinary approach by following measures:

1. Preventive Health Screening

- Age appropriate and disease specific health check modules are designed and advised for community.
- Defined relevant diagnostic tests are conducted under modules like Healthy Heart, Diabetes screening, Cancer screening for women over 40 years to detect non-communicable diseases at early stage or risk of developing the same. Patients are counselled on the preventive and corrective measures based on the results of the tests.

2. Lifestyle Modification Counselling

Patients are counselled for various modifications in Lifestyle such as change in Diet, Exercise to prevent disease enhancement through Diabetes Clinic, Metabolic OPD etc. COPD patients are advised Smoking cessation.

3. Immunisation

- Neonates and Paediatric patients are advised Immunisation as per the national/international guidelines.
- Adult individuals are also advised Immunisation based on various situations, e.g. seasonal variation – H1N1, community outbreak – COVID-19, Gender related risk – HPV, Disease based risk – Pneumococci in COPD patients and Age-related risk – Shingles.

4. Patient and Family Education

Patient and family are educated on Infection control measures such as Hygiene, Post-operative care of wound, Safe Medication practices, Precautions and Warning signs related to their disease process/condition.

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepak Chairman & Managing Director	

5. Behavioural Counselling

Patients are informally screened for their mental health status during the assessment in OPD and IPD consultation and will be referred to Psychologist if required. A Psychologist is also available for staff as and when required, who helps staff to cope up with Behavioural issues, Stress management etc.

6. Reminder Systems

Set up reminder systems to patients for follow-up visits and tests, so that they don't miss it.

The Hospital implements a number of ways to promote Health in patients, community and staff. Clinicians, Nursing staff, Dieticians, Physiotherapists, Psychologists all contribute to impart education on – Nutrition and healthy diet, Physical activity, Hygiene and sanitation, Stress management and mental well-being. This is implemented via:

1. Health checkup Camps
2. Awareness days and Outreach programs
1. Health talks
2. Online Informational videos
3. Educational Pamphlets and handouts

	SAIDEEP HOSPITAL HOSPITAL POLICIES	Doc No	SDH/AAC/11
		Issue No	01
		Rev No.	00
		Date	1 Jan 2026
		Pages	3
	PREVENTIVE & PROMOTIVE CARE GUIDELINES		

NABH 6th Edition Reference: AAC 11.A – Preventive and promotive care guidelines are implemented.

Amendment History

Sl. No	Ed. No	Rev No	Date	Nature of Change
1	01	00	1 Jan 2025	First issue as addendum to SDH/AAC/11. NCD screening modules defined. Mental health screening process formalised. Adult and paediatric immunisation advisory documented. Multidisciplinary health education team defined. Aligns with NABH 6th Edition AAC 11.b, 11.c, 11.d, 11.e.
2	01	00	1 Jan 2026	No Change

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepak Chairman & Managing Director	

1. Purpose

To supplement the Preventive and Promotive Care Guidelines with specific provisions for structured NCD screening, mental health screening, immunization advisory, and the multidisciplinary approach to lifestyle education — as required by NABH 6th Edition.

2. Policy — AAC 11.b: Evidence-Based, Age-Appropriate NCD Screening

Saideep Hospital defines and implements evidence-based, contextual, and age-appropriate health screening for non-communicable diseases (NCDs). Screening is offered to patients presenting to OPD, admitted patients, and through community outreach. Screening protocols are based on national guidelines (NPCDCS, ICMR) and international benchmarks (WHO) and are reviewed annually.

2.1 Defined NCD Screening Modules

Screening Module	Target Population	Key Tests / Assessments	Frequency
Healthy Heart Screening	Adults > 30 years; family history of CVD; smokers	ECG, lipid profile, random blood sugar, BMI, BP, 2D echo (if indicated)	Annual
Diabetes Screening	Adults > 30 years; overweight/obese; family history	Fasting blood sugar, HbA1c, BMI, blood pressure	Annual or as clinically indicated
Cancer Screening — Women	Women > 40 years; or as per clinical indication	Pap Smear (cervical); clinical breast examination; mammogram (> 40 years); CA-125 if indicated	Annual or per guidelines
Hypertension Screening	Adults > 18 years; routine OPD	Blood pressure measurement, BMI	Every OPD visit
Obesity / Metabolic Screening	BMI > 23 (Asian cut-off); Metabolic OPD referrals	BMI, waist circumference, lipid profile, fasting sugar, LFT, thyroid (if indicated)	Annual
COPD / Respiratory Screening	Smokers; chronic cough; occupational exposure	Spirometry (PFT), chest X-ray if indicated, smoking cessation counselling	Annual / per clinical need

Patients are counselled on the preventive and corrective measures based on the results of screening tests. Abnormal findings trigger clinical referral within the hospital. Results and referrals are documented in the patient's medical record.

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepak Chairman & Managing Director	

1. Purpose

To supplement the Preventive and Promotive Care Guidelines with specific provisions for structured NCD screening, mental health screening, immunisation advisory, and the multidisciplinary approach to lifestyle education — as required by NABH 6th Edition.

2. Policy — AAC 11.b: Evidence-Based, Age-Appropriate NCD Screening

Saideep Hospital defines and implements evidence-based, contextual, and age-appropriate health screening for non-communicable diseases (NCDs). Screening is offered to patients presenting to OPD, admitted patients, and through community outreach. Screening protocols are based on national guidelines (NPCDCS, ICMR) and international benchmarks (WHO) and are reviewed annually.

2.1 Defined NCD Screening Modules

Screening Module	Target Population	Key Tests / Assessments	Frequency
Healthy Heart Screening	Adults > 30 years; family history of CVD; smokers	ECG, lipid profile, random blood sugar, BMI, BP, 2D echo (if indicated)	Annual
Diabetes Screening	Adults > 30 years; overweight/obese; family history	Fasting blood sugar, HbA1c, BMI, blood pressure	Annual or as clinically indicated
Cancer Screening — Women	Women > 40 years; or as per clinical indication	Pap Smear (cervical); clinical breast examination; mammogram (> 40 years); CA-125 if indicated	Annual or per guidelines
Hypertension Screening	Adults > 18 years; routine OPD	Blood pressure measurement, BMI	Every OPD visit
Obesity / Metabolic Screening	BMI > 23 (Asian cut-off); Metabolic OPD referrals	BMI, waist circumference, lipid profile, fasting sugar, LFT, thyroid (if indicated)	Annual
COPD / Respiratory Screening	Smokers; chronic cough; occupational exposure	Spirometry (PFT), chest X-ray if indicated, smoking cessation counselling	Annual / per clinical need

Patients are counselled on the preventive and corrective measures based on the results of screening tests. Abnormal findings trigger clinical referral within the hospital. Results and referrals are documented in the patient's medical record.

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepak Chairman & Managing Director	

1. Purpose

To supplement the Preventive and Promotive Care Guidelines with specific provisions for structured NCD screening, mental health screening, immunisation advisory, and the multidisciplinary approach to lifestyle education — as required by NABH 6th Edition.

2. Policy — AAC 11.b: Evidence-Based, Age-Appropriate NCD Screening

Saideep Hospital defines and implements evidence-based, contextual, and age-appropriate health screening for non-communicable diseases (NCDs). Screening is offered to patients presenting to OPD, admitted patients, and through community outreach. Screening protocols are based on national guidelines (NPCDCS, ICMR) and international benchmarks (WHO) and are reviewed annually.

2.1 Defined NCD Screening Modules

Screening Module	Target Population	Key Tests / Assessments	Frequency
Healthy Heart Screening	Adults > 30 years; family history of CVD; smokers	ECG, lipid profile, random blood sugar, BMI, BP, 2D echo (if indicated)	Annual
Diabetes Screening	Adults > 30 years; overweight/obese; family history	Fasting blood sugar, HbA1c, BMI, blood pressure	Annual or as clinically indicated
Cancer Screening — Women	Women > 40 years; or as per clinical indication	Pap Smear (cervical); clinical breast examination; mammogram (> 40 years); CA-125 if indicated	Annual or per guidelines
Hypertension Screening	Adults > 18 years; routine OPD	Blood pressure measurement, BMI	Every OPD visit
Obesity / Metabolic Screening	BMI > 23 (Asian cut-off); Metabolic OPD referrals	BMI, waist circumference, lipid profile, fasting sugar, LFT, thyroid (if indicated)	Annual
COPD / Respiratory Screening	Smokers; chronic cough; occupational exposure	Spirometry (PFT), chest X-ray if indicated, smoking cessation counselling	Annual / per clinical need

Patients are counselled on the preventive and corrective measures based on the results of screening tests. Abnormal findings trigger clinical referral within the hospital. Results and referrals are documented in the patient's medical record.

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepak Chairman & Managing Director	

3. Policy — AAC 11.c: Mental Health Screening and Intervention

Saideep Hospital recognises that mental health conditions are prevalent, frequently co-exist with physical illness, and are often undetected at primary care level. All patients presenting to OPD and admitted patients shall be informally screened for mental health status. Formal mental health screening tools are used where clinically indicated.

3.1 Informal Screening

During OPD consultation and IP admission assessment, all clinicians observe for signs of depression, anxiety, substance use, or behavioural disturbance. Where concern is identified, the clinician initiates a direct inquiry using appropriate questions and refers to the Psychiatry department or the in-house Psychologist.

3.2 Formal Screening Tools

- PHQ-2 / PHQ-9 (Patient Health Questionnaire) — for depression screening in adults
- GAD-7 — for anxiety screening in adults
- CAGE questionnaire — for alcohol use disorder screening
- MINI (Mini International Neuropsychiatric Interview) — for formal psychiatric diagnosis by Psychiatrist

3.3 Intervention Pathway

1. Positive informal screen: Refer to Psychologist (for counselling/assessment) or Psychiatrist (for clinical evaluation), as clinically appropriate.
2. Staff mental health: A Psychologist is available for staff as and when required, to help staff cope with behavioural issues and stress management.
1. De-addiction services: De-addiction clinic is available within the Psychiatry department. COPD and other at-risk patients are advised smoking cessation through the Metabolic OPD and General Medicine.
2. Suicidal risk: Any patient identified as at risk of self-harm or suicide is referred to Psychiatry immediately; safety assessment and safety plan are documented.

4. Policy — AAC 11.d: Evidence-Based Immunisation Advisory

Saideep Hospital advises evidence-based, contextual paediatric and adult immunisation wherever applicable. Immunisation advisory is a clinical responsibility and is integrated into OPD consultations,

neonatal care, and preventive health programmes. The hospital follows the Indian Academy of Pediatrics (IAP) schedule for paediatric immunisation and national/international guidelines for adult immunisation.

4.1 Paediatric Immunisation

- Neonates and paediatric patients are advised immunisation as per the IAP National Immunisation Schedule and the Universal Immunisation Programme (UIP).
- Neonatology department provides immunisation advisory at birth and at every developmental follow-up visit.
- Paediatric OPD maintains an immunisation record for registered patients and provides counselling to parents at each visit.

4.2 Adult Immunisation

Adults are advised immunisation based on the following indications:

- Seasonal variation: H1N1 influenza vaccine — advised for at-risk adults, elderly, immunocompromised.
- Community outbreak: Indicated vaccines are advised as per government/public health authority directives (e.g., COVID-19).
- Gender-related risk: HPV vaccine — advised to women as per clinical guideline.
- Disease-based risk: Pneumococcal vaccine — advised for COPD, post-splenectomy, immunocompromised; Hepatitis B — advised for healthcare workers, at-risk adults.
- Age-related risk: Shingles (varicella-zoster) vaccine — advised for adults > 60 years.

Immunisation advisory is documented in the OPD case sheet or IP medical record. Immunisation given at Saideep Hospital is recorded in HIS and in the patient's immunisation card where applicable.

5. Policy — AAC 11.e: Multidisciplinary Approach to Health Education on Lifestyle Modifications

Saideep Hospital implements a multidisciplinary approach to health education, recognising that lifestyle modification requires inputs from multiple clinical disciplines and sustained engagement with patients and their families. No single discipline can address all aspects of lifestyle change.

5.1 Multidisciplinary Health Education Team

Discipline	Role in Lifestyle Education
Clinicians (Physicians, Surgeons, Specialists)	Primary counselling on disease-specific lifestyle changes; smoking cessation; alcohol cessation; weight management; disease education.
Nursing Staff	Reinforcement of medical advice; wound care and post-operative care education; medication adherence counselling; hygiene and sanitation.
Dietician	Individualised nutritional counselling; diet plans for diabetes, hypertension, renal disease, cardiac disease, obesity, malnutrition; healthy eating education.
Physiotherapist	Exercise prescription; physical activity counselling; rehabilitation; breathing exercises (COPD/post-operative); posture and ergonomics.
Psychologist / Psychiatrist	Mental health and stress management; behavioural change counselling; de-addiction support; coping skills.

5.2 Channels for Health Education Delivery

3. Individual patient and family counselling during OPD consultation and IP rounds.
4. Health checkup camps targeting the community in Ahilyanagar and surrounding areas.
5. Awareness days aligned with national/international health observances (World Diabetes Day, World Heart Day, World Cancer Day, etc.).
6. Health talks for patients, families, and community members in the hospital or at community venues.
7. Online informational videos disseminated through the hospital's digital channels and website (www.saideephospital.com).
8. Educational pamphlets and handouts available in Hindi, English and Marathi.
9. Specialty clinics — Diabetes Clinic, Metabolic OPD — providing structured lifestyle modification programmes.

NABH 6th Edition Reference: AAC 11.b – Organisation shall define evidence-based and contextual age-appropriate screening for non-communicable diseases. AAC 11.c – Mental health screening and appropriate intervention is advised for patients wherever applicable. AAC 11.d – Evidence-based and contextual paediatric and adult immunisation shall be advised wherever applicable. AAC 11.e – A multi-disciplinary approach is adopted in imparting health education on lifestyle modifications.

Amendment History

Sl. No	Ed. No	Rev No	Date	Nature of Change
1	01	00	1 Jan 2025	First issue as addendum to SDH/AAC/11. NCD screening modules defined. Mental health screening process formalised. Adult and paediatric immunisation advisory documented. Multidisciplinary health education team defined. Aligns with NABH 6th Edition AAC 11.b, 11.c, 11.d, 11.e.
2	01	00	1 Jan 2026	No Change

1. Purpose

To ensure discharge events are executed in a safe, timely, documented and legally compliant manner, ensuring continuity of care and patient rights across all clinical areas.

2. Scope

Applicable to all discharges from ER, Daycare/Short Stay, IP admissions, ICU/NICU, OT/Labour room admissions, psychiatry, MLC cases, including special discharge categories such as LAMA/DAMA and discharge in absentia.

3. Definitions

- Discharge: Formal completion of treatment episode with documentation and instructions.
- Routine Discharge: Discharge as advised by treating consultant.
- Daycare/Short Stay discharge: Discharge where stay is <24 hours.
- LAMA/DAMA: Leaving/Discharge Against Medical Advice.
- Absconding/Discharge in Absentia: Patient leaves without completion of discharge process.
- Transfer/Referral out: Transfer to another facility/higher centre.
- Discharge Summary: Clinical summary of admission episode and post-discharge plan.

4. Policy Statements (Non-negotiable)

1. Discharge shall be permitted only on documented order of treating consultant/ER medical officer.
2. Discharge documentation shall ensure correct patient identification (two identifiers), completeness, and continuity of care.
1. Discharge summary is mandatory for all IP admissions and as applicable for Daycare/Short Stay.

2. Patient discharge counselling shall be provided, including medicines, follow-up, warning signs, and care instructions (PRE alignment).
3. Medication reconciliation at discharge is mandatory.
4. Patients discharged with indwelling medical devices shall receive device-specific written instructions and follow-up/removal plan.
5. Emergency transfers shall not be delayed for billing/discharge formalities.
6. LAMA/DAMA and Absconding/Discharge in Absentia shall be managed as per defined SOPs with counselling/documentation/reporting.
7. For MLC absconding/discharge in absentia, refer Medico-Legal Manual 2026 SOP (cross reference).
8. Confidentiality shall be maintained during discharge counselling and handing over documents.

5. Discharge Event Categories

- A. Routine IP discharge
- B. Daycare/Short stay discharge
- C. ER discharge
- D. LAMA/DAMA
- E. Absconding/Discharge in Absentia
- F. Transfer/Referral out
- G. Death discharge (in-hospital)
- H. Brought dead/dead on arrival (ER)
- I. Psychiatric discharge (MHCA interface where applicable)

6. Discharge Summary – Minimum Content

- Patient identifiers (Name, UHID, IP No.)
- Date/time of admission and discharge
- Diagnosis (final/provisional)
- Key investigations and results
- Procedures/surgery done

- Clinical course and condition at discharge
- Discharge medications with dosage, duration and instructions
- Medication reconciliation documentation (continue/stop/new)
- Indwelling devices at discharge (if any) with follow-up/removal plan
- Follow-up plan and appointment
- Warning signs / emergency advice
- Diet/activity instructions
- Treating consultant name and signature

7. Monitoring Indicators (CQI)

- Discharge summary TAT compliance
- Discharge delays due to billing/documentation
- LAMA/DAMA count and reasons
- Absconding/discharge-in-absentia count
- Documentation errors in discharge summaries
- Patient complaints related to discharge process

> NABH 6th Edition Reference: AAC 12 – Discharge of patients; AAC 12.B – Discharge process is coordinated among various departments and agencies; AAC 12.C – Written guidance governs discharge of patients leaving against medical advice.

SOP 1: Routine IP Discharge

Objective: To complete planned discharge safely with full documentation, counselling, and continuity of care.

Procedure

1. Treating consultant writes discharge order with date/time in medical record/HIS.
2. Nursing initiates discharge checklist and confirms patient identification using two identifiers.
1. Pending investigations/reports are reviewed and final clinical status documented.
2. Discharge summary is prepared in standard format by treating team.
3. Medication Reconciliation (Mandatory): Treating doctor/ward team reconciles inpatient medicines with discharge prescription, documenting medicines to continue/stop/new medicines, with dose/route/frequency/duration and precautions.
4. Device-specific counselling (where applicable): If patient is discharged with indwelling medical device, written and verbal device care instructions and follow-up/removal plan are provided.
5. Discharge counselling is provided to patient/attendant (medicines, diet, activity, wound care, red flags, and follow-up).
6. Billing is completed and receipt provided as per billing policy.
7. Discharge documents are handed over: discharge summary, prescription, reports, follow-up plan.
8. MRD receives the complete file and updates movement register.

Outputs/Records

- Discharge order; Discharge checklist; Discharge summary
- Medication reconciliation record (within checklist or discharge summary)
- Device instruction sheet (if applicable); Billing settlement record
- File inward to MRD register

Special Situations – Administrative Discharge & Readmission for Tariff/Payer Category Change

This addendum is included to govern administrative discharge/readmission practices used for tariff or payer category change (e.g., insurance cover exhaustion and conversion to self-pay tariff).

Policy Statement:

9. Administrative discharge/readmission for payer/tariff category change may be performed only when required by payer rules or HIS/billing constraints.
10. Such administrative actions shall not compromise patient safety or continuity of clinical care.
11. Treating consultant/ER MO shall document a note/order stating that the discharge/readmission is administrative for payer change and that the patient continues under the same clinical episode of care.
12. Patient/attendant shall be counselled regarding the payer/tariff change and acknowledgement shall be obtained.
13. There shall be complete traceability in HIS with linkage between the two encounters/admissions and accurate date/time stamping. No record deletion is permitted.

SOP Addendum (Operational Steps): Step A: Identify payer exhaustion/payer category change requirement (TPA/Billing confirmation). Step B: Inform treating consultant; obtain written/HIS documented doctor note: 'Administrative discharge/readmission for payer category change; patient continues under same episode of care'. Step C: Counsel patient/attendant and obtain acknowledgement. Step D: Perform administrative discharge in HIS with discharge type: 'Administrative – Payer Change'. Step E: Immediately create readmission/encounter under new tariff category without interruption of clinical care. Step F: Nursing/ward handover note: 'No physical discharge; continuity maintained'. Step G: MRD to link both admissions in record index, ensuring traceability for audit/insurance.

SOP 2: Daycare / Short Stay Discharge (<24 hours)

Procedure

14. Treating consultant orders discharge with date/time.
15. Day care discharge note/procedure summary prepared.
16. Medication reconciliation performed for prescribed discharge medicines.

17. Post-procedure instructions and red flags explained to patient/attendant.
18. Device-specific advice provided if any device/drain/catheter is retained at discharge.
19. Billing completed and discharge documents handed over.
20. If patient stay exceeds 24 hours due to clinical reason, conversion to IP is documented and processed without new UHID.

SOP 3: ER Discharge

Procedure

21. ER Medical Officer documents discharge order/advice.
22. ER discharge note is provided including diagnosis, treatment given, and condition at discharge.
23. Prescription issued with medication reconciliation where patient is already on chronic medications.
24. Warning signs and follow-up/referral advice provided.
25. If referral/transfer is required, referral note and handover details are documented.

SOP 4: Transfer / Referral Out (Higher Centre Transfer)

Procedure

26. Treating consultant/ER MO documents transfer/referral order with reason.
27. Patient stabilisation is ensured prior to transfer.
28. Referral/transfer summary prepared with key clinical details, investigations and treatment.
29. Consent/information to patient/attendant documented.
30. Transfer mode arranged (ambulance as required) and handover documented.
31. Receiving facility details and communication documented.

SOP 5: LAMA / DAMA

Procedure

32. Treating consultant/ER MO counsels patient/attendant regarding risks of leaving hospital against advice.
33. Nursing and doctor document counselling in medical record.
34. LAMA/DAMA form is signed by patient/attendant and staff witness. If patient refuses signature, refusal is documented with two witnesses.
35. A discharge note/summary and prescription are provided wherever feasible.
36. Follow-up and warning signs are clearly explained.
37. HIS discharge category updated as LAMA/DAMA.

SOP 6: Absconding / Discharge in Absentia

Procedure

38. On identification of absconding, nursing informs ward incharge/ER incharge and security immediately.
39. Document last-seen time, circumstances, and efforts to locate patient within hospital.
40. Inform MRD/Administration.
41. If patient is not traced, discharge in absentia is initiated and documented; discharge time = time of absconding.
42. Discharge summary/note is prepared based on last clinical status.
43. Incident report is raised.
44. For MLC absconding/discharge in absentia: follow Medico-Legal Manual 2026 SOP including police intimation and MLC register updates.

SOP 7: Discharge on Death (In-Hospital Death)

Procedure

45. Doctor certifies death and documents cause and time.

46. Death summary prepared within defined timeline.
47. Body handover protocol followed with documentation.
48. If MLC death, police/legal procedures followed as per medico-legal manual.

SOP 8: Brought Dead / Dead on Arrival (ER)

Procedure

49. ER MO certifies brought dead/dead on arrival as per policy.
50. Documentation completed including identifiers and circumstances of arrival.
51. MLC process followed where applicable.

SOP 9: Psychiatric Discharge

Procedure

52. Psychiatrist documents discharge decision and follow-up plan.
53. Medication reconciliation and counselling provided.
54. Safety plan documented where applicable (suicidal risk).
55. Ensure safe escort/attendant arrangement where required.
56. Discharge summary provided and confidentiality maintained.

Amendment History – Discharge Policy & SOPs (SDH/AAC/12)

Sl. No	Edition No	Rev No	Date	Nature of Change
1	01	00	1 Oct 2019	First issue as per NABH Hospital Accreditation Standards – 4th Edition
2	01	01	1 Nov 2020	Minor revisions; updating Doc No.; compliance update for NABH 5th Edition
3	01	01	1 Jan 2022	No changes
4	01	02	1 Jan 2025	Amended as per NABH 6th Edition. Medication reconciliation, device-specific counselling, and MLC absconding provisions formalised. Psychiatric discharge SOP added. Administrative payer change SOP addendum added.
5	01	02	1 Jan 2026	No changes

1. Policy — AAC 12.e: Adherence to Planned Discharge

Saideep Hospital is committed to adhering to planned discharge timelines to minimise unnecessary prolongation of in-patient stay, reduce the risk of hospital-acquired infections, optimise bed utilisation, and align with the patient's and family's expectations. Discharge planning commences from the time of admission and is actively progressed throughout the patient's stay.

1.1 Process for Planned Discharge

1. At the time of initial assessment and care plan preparation, the treating team documents a provisional discharge plan including anticipated length of stay and discharge criteria.
2. The discharge plan is reviewed and updated at every consultant round. When the patient is approaching readiness for discharge, the treating consultant documents a target discharge date in the medical record.
1. The nurse in-charge is informed of the target discharge date and initiates the discharge checklist in advance.
2. Discharge is planned to take place before 12 noon wherever clinically possible, to allow bed preparation for incoming admissions and to avoid peak billing/administrative load.
3. All discharge prerequisites — discharge summary preparation, medication reconciliation, patient counselling, billing — are completed proactively and not left to initiate after the discharge order is written.
4. If planned discharge is delayed for a clinical reason (unexpected deterioration, awaiting investigation result, procedure), the reason is documented in the medical record and the patient/family is informed.
5. If planned discharge is delayed for a non-clinical reason (administrative, billing, documentation), the delay is escalated to the Ward In-Charge and the Medical Administrator for resolution. Such delays are captured in the discharge delay indicator.

1.2 Special Needs Confirmation Before Discharge

Before discharge is finalised, the nursing staff confirm that all special needs identified in the care plan (per SDH/AAC/04 — AAC 4.g) have been addressed or that a documented plan for post-discharge management of unmet needs has been communicated to the patient/family and recorded in the discharge summary.

2. Policy — AAC 12.f: Domiciliary Care Services — Scope Statement

Saideep Healthcare & Research Pvt. Ltd. does not provide domiciliary care services (home visit-based healthcare) at this time. This determination has been made on the basis of the following considered grounds:

2.1 Rationale for Non-Provision of Domiciliary Services

6. Resource constraints — staff: Saideep Hospital's clinical staffing is planned for the 260-bed in-hospital service. Diversion of clinical staff to domiciliary visits would compromise the quality and safety of in-hospital care and is not sustainable within current human resource capacity.
7. Resource constraints — equipment: Domiciliary clinical care requires portable diagnostic and therapeutic equipment (portable monitors, oxygen concentrators, infusion pumps, wound care supplies). The hospital's equipment inventory is configured for institutional use and is not available for systematic domiciliary deployment.
8. Transport and geographic constraints: The hospital serves patients from across Ahilyanagar district and surrounding areas. The distances involved, transport costs, road infrastructure variability, and inability to guarantee timely response in emergencies arising during domiciliary visits make reliable coverage impractical.
9. Absence of statutory domiciliary care standards: Currently there are no comprehensive statutory guidelines or quality standards governing domiciliary medical care delivery in Maharashtra/India that would define the minimum requirements, staff qualifications, equipment standards, and liability framework for hospital-based domiciliary services. Commencing services in the absence of such standards may expose patients to undefined risks and the hospital to consumer grievances.

The hospital remains open to reviewing this position as the regulatory framework for domiciliary care services in India evolves, resource capacity grows, and patient need in the local community is formally assessed.

2.2 Alternatives Made Available to Patients

In lieu of direct domiciliary services, Saideep Hospital ensures the following for patients requiring support after discharge:

- Comprehensive discharge counselling covering all self-care requirements at home.

- Written discharge instructions in the patient's preferred language (Hindi/Marathi/English).
- Follow-up appointment scheduling before discharge.
- Referral to community health workers or outpatient rehabilitation facilities where available.
- Helpline number provided for post-discharge queries and emergency guidance.

3. Policy — AAC 12.g: Discharge Time Monitoring and Continual Improvement

Saideep Hospital monitors discharge time, sets benchmarks, and makes continual improvement to the discharge process. Discharge time monitoring is a Commitment-level standard under NABH 6th Edition.

3.1 Definition of Discharge Time

Discharge Time = Time from written discharge order (documented in HIS by treating consultant/ER MO) to physical departure of the patient from the hospital ward/unit. This is recorded in HIS at both events.

3.2 Benchmark

Saideep Hospital sets a benchmark of 4 hours from written discharge order to physical departure for routine IP discharges. Daycare/short-stay discharges target 2 hours. ER discharges target 1 hour.

3.3 Monitoring Process

10. HIS records the time of discharge order and the time of discharge completion. The Quality Department extracts this data monthly.
11. Average discharge time, median discharge time, and percentage of discharges within the 4-hour benchmark are calculated and trended monthly.
12. Discharges exceeding the benchmark are analysed for root cause: clinical reason; documentation delay; billing/insurance delay; patient/family factors; administrative delay.
13. Root cause categories are reported to MQCC monthly. Systemic causes are subject to process improvement action with defined owner and timeline.
14. Annual benchmarks are reviewed and tightened as process improvement is demonstrated.

Indicator	Formula	Benchmark	Frequency

Average discharge time — routine IP	Sum of discharge times / Total IP discharges	≤ 4 hours	Monthly
% IP discharges within 4-hour benchmark	Discharges ≤ 4 hrs / Total IP discharges × 100	> 85%	Monthly
% Discharges delayed by non-clinical reason	Non-clinical delays / Total discharges × 100	< 5%	Monthly
Average discharge time — Daycare	Sum of daycare discharge times / Total daycare discharges	≤ 2 hours	Monthly

Amendment History

Sl. No	Ed. No	Rev No	Date	Nature of Change
1	01	00	1 Oct 2019	Discharge adherence within general discharge policy — NABH 4th Edition
2	01	01	1 Nov 2020	Within SDH/AAC/12; NABH 5th Edition compliance
3	01	01	1 Jan 2022	No changes
4	01	02	1 Jan 2025	Separated as addendum. Planned discharge process formalised. Domiciliary services scope statement with rationale added. Discharge time monitoring framework and benchmarks defined. Aligns with NABH 6th Edition AAC 12.e, 12.f, 12.g.
5	01	02	1 Jan 2026	No changes

	SAIDEEP HOSPITAL HOSPITAL POLICIES	Doc No	SDH/AAC /12
		Issue No	01
		Rev No.	02
		Date	1 Jan 2026
		Pages	1
	Policy: Patients are transported within the organisation safety Policy: patient are transported with all necessary support		

Introduction

Patient transport using trolleys and wheelchairs is a daily occurrence within the hospital. Patients are routinely transferred to diagnostic areas and procedure rooms from the ward and back. The relative of the patient is informed and then the patient is transported to the area needed. Ensuring dignity and safety of the patient during intra-hospital transport is the key in ensuring patient's overall satisfaction with the hospital.

Purpose and Scope

The purpose of this policy is to guide the hospital staff in ensuring safe transport of patients within the hospital premises and ensuring that the patient's dignity is maintained during the process.

Responsibilities

Staff Nurse / Ward In-Charge

- The staff nurse / ward in-charge will initiate patient transportation based on Doctor's orders or as per appointment schedules of the OT, Imaging and other diagnostic units.
- The staff nurse / ward in-charge will check with the concerned unit regarding the appointments and will initiate the patient transport only on confirming the appointment with the clinical unit.

Policies

The ordering consultant is responsible for patient transfer. If the patient is stable, the transfer will be done by ward boy. The bystander is also allowed to accompany him.

If the patient is unstable, having intravenous infusion, oxygen on flow, one nursing staff will accompany. If the patient is ventilated, one nurse and one paramedical staff will accompany.

Escort Requirements Summary

Patient Condition	Escort Required
Stable, ambulatory	Ward boy; bystander may accompany

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepak Chairman & Managing Director	

Stable, on IV fluids	Ward boy + bystander; nurse must be reachable
On IV infusion / oxygen flow	One nursing staff
Unstable, ventilated	One nurse + one paramedical staff (both trained in BLS)

Policies While Transporting in a Wheelchair

Conveying Patients by Wheelchair

- All wheelchairs will have a belt which can secure the patient.
- The staff who transports will be trained in Basic Life Support (BLS).
- All trolleys/chairs must be checked before use for visual defects. In case any defect is identified it must be reported immediately by the ward in-charge to the Facility Maintenance Engineer. The safety and welfare of the patient is of paramount importance.
- Some patients are not at ease while being conveyed by wheelchair and reassurance by the staff is an important factor. It is important that the staff should be conversant with the various types of wheelchairs that are in use and any features which may be special to them.
- It is important that the wheelchair should be PUSHED at all times, and NOT PULLED. Pulling the chair whilst occupied could result in the patient being 'Tipped Out'. Pushing the wheelchair is more dignified for the patient as they can see where they are going. The staff must be able to assist the patient in/out of a wheelchair, for example on or off a chair, bed or lavatory and in/out of a car.
- The staff must also know the correct methods of pushing a wheelchair down or up a step, and special care must be taken when entering lift areas. For instance, make sure the level of the floor and lift floor coincides.
- It is important that the wheelchair brakes are applied when assisting the patient into and out of the wheelchair. When 'parking' an occupied wheelchair, the ward boys/nurse should be careful not to leave the patient next to a hot radiator, in a draught or facing a wall.

Policies While Transporting in a Stretcher / Trolley

Any member of staff responsible for a patient on a trolley/chair must ensure that:

- The cot sides are raised during transportation.
- The cot sides are lowered only when the patient requires treatment/examination by staff — but raised immediately afterwards.
- If the patient trolley is of adjustable height, the trolley may be raised to workable height to facilitate treatment/movement — but lowered immediately afterwards.
- Anything that the patient may require should be placed within their reach.
- The wheels and brakes on the trolley/chair operate correctly.
- Wheelchair footplates are operating correctly.

The suggestions outlined above for wheelchair patients apply equally to patients on trolleys or in beds, except that more staff would be employed in movements of this kind. Particular care should be exercised when moving patients to whom IV infusion lines or other life support equipment is attached. Any wheelchair, trolley or bed should have its brakes applied while travelling in the lift. Every consideration should be given to the patient's safety, comfort and welfare.

All paramedical staff transporting patients shall be trained in BLS.

Patients in Lifts

While using the lift for transport of a patient on a wheelchair or trolley, members of the public will be requested not to use the same lift along with the patient. Only the accompanying hospital staff and accompanying patient family member will be allowed in the lift along with the patient.

There will be a lift operator in patient transferring lift. The lift operator is also trained in BLS. All lifts have intercom facility and access for Code Blue in case of emergency.

Labour Room — Shifting Patient to Other Units

The following protocol applies when shifting patients from the Labour Room to other hospital units (SDH/LR/4.1):

1. Assess the reason for shifting.
2. Inform the Nurse In-charge about the transfer.
1. Check the belongings of patient and keep ready for shifting.

2. Complete patient chart and make it up to date.
3. Assess patient's physical condition and determine the mode of transportation.
4. Assist in transferring patient to stretcher/wheelchair using proper body mechanism.
5. Perform final assessment of patient's activity.
6. Accompany the patient to the receiving unit.
7. Hand over all documents and belongings to the receiving nurse and ensure that the items given are recorded.
8. Complete all the documentation.

Handover of Patient During Shift Changes (Labour Room)

Handover process is done at the end of each shift by the assigned nurse to the next duty assignee in the presence of ward in-charge or shift in-charge with the following details:

- Patient chart updated with vitals / intake-output chart details / details about the assessment and reassessment + nutritional assessment + patient elimination.
- Assess patient's physical condition by going to the bedside along with the patient file.
- Medications given till that time and medications to be given in the next shift will be explained in the handover.
- Details of IV infusions / blood transfusions with proper documentation.
- Cross consultations.
- Details about the delivery process.
- Special instructions, lab reports, pending investigations, verbal orders, NPO orders if any.
- Any drug allergies reported.

Maintaining Proper Body Alignment During Transport

The following principles apply to all patient transport and positioning (SDH/LR/4.1):

- Determine need to assist the patient to various positions.
- Determine presence of IV equipment, surgical wounds, drains, or attached mechanical equipment.

- Take care of urinary catheters / IV Cannula lines.
- Determine need for extra pillows, level and position of bed.
- Take care of the pain that the patient experiences on shifting.
- Don gloves and gown as necessary.
- Assist patient to desired position for proper body alignment (use assistance of another healthcare provider if patient is unable to self-assist).
- Use the draw sheet or pull sheet.
- Adjustable trolley is used to transfer the patient.

Correct Lifting Techniques

To provide the patient and healthcare provider with knowledge to perform correct lifting techniques, thus preventing pain, stress, fatigue, trauma, and injury and to promote comfort:

- Determine need to assist in the process of lifting.
- Assess the knowledge the patient has about the process of lifting.
- Take care to minimise the pain during lifting the patient.
- Risk for injury related to improper lifting techniques should be borne in mind.
- Position will be comfortable and enhance proper body alignment at all times while performing the lifting process.
- Patient must experience minimal discomfort in attaining proper body posture for lifting.
- Use of rollers specifically designed for shifting from trolley/bed is encouraged.
- Use gloves and protective clothing wherever necessary.

Emergency Care Unit — Patient Transfers (SDH/ER/01)

A. Transfer Out of Stable Patients from ED/Ward (at request / non-availability of facilities)

9. Decision to shift out the patient is made by the Consultant/EMO/Patient or Relative.
10. Transfer-out process is initiated by the MO (ward/ED).

11. Ensure availability of bed/other required facilities with the ED–CMO of the transferring hospital. Details of the patient should be communicated.
12. Ambulance requisition form filled up; ambulance driver informed.
13. Ambulance equipment to be checked; drugs to be checked. Ambulance checklist signed by the nurse.
14. Doctor/Nurse to be arranged by the in-charge for patient care during the transfer if ambulance is provided by our hospital.
15. Check all required documents — Transfer Out form, investigation reports — to be handed over to the patient/patient attendant.
16. Details of the transferring hospital (if available) to be filled in the ED book / patient medical record.
17. Shift out the patient.

B. Transfer of Unstable Patient from ED/Ward (on request / non-availability of services)

18. Decision to shift out is made by the Consultant/CMO.
19. Transfer-out process initiated by CMO (ward/ED).
20. Ensure availability of bed/other required facilities; communicate details of the patient verbally to receiving facility.
21. Ambulance requisition form filled up; ambulance driver informed; equipment and drugs checked; ambulance checklist signed.
22. Nurse arranged by nursing in-charge for patient care during transfer.
23. Check all required documents — Transfer Out form, investigation reports — to be handed over to patient/attendant.
24. Details of the transferring hospital to be filled in ED book / patient medical record.
25. Shift out the patient.

C. Transfer Out in Case of Discharge Against Medical Advice — ED/Ward

26. Decision to shift patient is made by patient attender against medical advice.
27. Consequences of shifting patient against advice are explained to patient/patient attendant.
28. If stable: Treatment details duly entered; investigation reports handed over to patient/attendant by CMO.

29. If unstable: Same documentation done; patient is made fit to transfer first.
30. Ambulance to be arranged by the patient party.
31. Repeat vitals of the patient to be checked before the transfer.
32. Shift out the patient.

Monitoring

The various ward units will monitor the technique of transport of patients within the hospital. The Emergency Incharge will review the details of each case of transfer undertaken by the hospital. A patient transfer form is maintained during the shift. The document will be filed in the Emergency Department after being scrutinised by the Emergency Incharge.

Standard Reference

AAC 12.E and 12.G; AAC 3A–3E; COP 2F.

> *NABH 6th Edition Reference: AAC 12.E – Patients are transported within the organisation safely.*
> *AAC 12.G – Patients are transported with all necessary support.*

Amendment History

Sl. No	Ed. No	Rev No	Date	Nature of Change
1	01	00	5 Mar 2021	First issue as per NABH Hospital Accreditation Standards – 4th Edition
2	01	01	1 Nov 2021	Minor revisions; compliance update for NABH 5th Edition
3	01	01	1 Jan 2022	No changes
4	01	02	1 Jan 2025	Reviewed as per NABH 6th Edition. Labour Room transfer protocol and ECU transfer protocol integrated. DAMA transfer SOP added.
5	01	02	1 Jan 2026	No changes

	SAIDEEP HOSPITAL HOSPITAL POLICIES	Doc No	SDH/AAC /12
		Issue No	01
		Rev No.	02
		Date	1 Jan 2026
		Pages	8
	Policy: Patients are transported within the organisation safety Policy: patient are transported with all necessary support		

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepak Chairman & Managing Director	

	SAIDEEP HOSPITAL HOSPITAL POLICIES	Doc No	SDH/AAC /13
		Issue No	01
		Rev No.	02
		Date	1 Jan 2026
		Pages	1
	DISCHARGE SUMMARY –ADDENDUM : URGENT CARE INSTRUCTION &DEATH SUMMARY(SDH/AAC/13-S)		

This document is an addendum to the Master Discharge Policy (SDH/AAC/12). Read together with the main discharge policy and the discharge summary minimum content defined therein

1. Purpose

To ensure that every discharge summary includes clear, patient-understandable instructions about when and how to seek urgent care after discharge; and that in cases of in-hospital death, the death summary explicitly documents the cause of death.

2. Policy — AAC 13.d: Instructions on When and How to Obtain Urgent Care

Every discharge summary issued at Saideep Hospital must include a dedicated section on when and how the patient should seek urgent care after discharge. This is a Commitment-level standard. The purpose is to empower patients and families to recognise warning signs early and access appropriate care without delay.

2.1 Content of Urgent Care Instructions in Discharge Summary

The treating doctor shall complete the following elements in the discharge summary's urgent care/red flags section:

Warning Signs Requiring Immediate Return to Hospital / Emergency Care

The discharge summary shall list at least 3–5 specific warning signs relevant to the patient's diagnosis and condition. General and diagnosis-specific examples include:

Category	Warning Signs to Document
General / All Patients	High fever (> 38.5°C) not responding to paracetamol; sudden altered consciousness or confusion; severe pain not controlled by prescribed medications; inability to take oral fluids for > 12 hours; significant bleeding from any site.
Post-Surgical / Wound	Wound with increasing redness, swelling, warmth, discharge or opening; fever > 38.5°C after surgery; sudden severe pain at surgical site.
Cardiac	Chest pain, pressure or tightness; sudden breathlessness; palpitations with dizziness or blackout; ankle/leg swelling worsening rapidly.
Neurological	Sudden severe headache; weakness or numbness of face/arm/leg; sudden difficulty speaking or understanding speech; sudden loss of vision; seizure.
Obstetric/Post-Partum	Heavy vaginal bleeding; severe headache with visual disturbance; fever with foul-smelling discharge; severe abdominal pain.
Paediatric	High fever with rash; difficulty breathing; inconsolable crying; not feeding;

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepak Chairman & Managing Director	

	reduced urine output or no wet diaper for > 8 hours.

2.2 How to Obtain Urgent Care — Contact Information

The discharge summary shall include the following contact/access information:

- Saideep Hospital Emergency Care Unit (ECU): Available 24 hours, 365 days.
- Hospital board line: 0241-2775700
- Service mobile: 6262900900
- Address: Viraj Estate, Yashwant Colony, Near DSP Chowk, Ahilyanagar – 414003
- Instructions to go directly to the Emergency department for life-threatening symptoms, without waiting for an OPD appointment.

2.3 Format and Language

Warning signs and urgent care instructions shall be written in clear, plain language understandable to a lay person. Medical jargon shall be avoided. Where the patient's primary language is Marathi or Hindi, the nurse or treating doctor shall verbally translate the key warning signs at the time of discharge counselling. The discharge summary's language is the official record; verbal translation is supplementary.

It is good practice to contact post-operative and at-risk patients after discharge for a follow-up call to check on their status. The Outpatient department may implement recall systems for high-risk patients (per SDH/AAC/05 and SDH/AAC/11 policies).

3. Policy — AAC 13.e: Death Summary — Cause of Death

In the event of a patient's death at Saideep Hospital, the death summary (a specific form of discharge summary) shall include the cause of death as a mandatory element. This is a Commitment-level standard.

3.1 Cause of Death Documentation

1. The treating doctor or the senior doctor present at the time of death shall certify the death and document the cause of death in the medical record.
2. The death summary shall include: Immediate cause of death; Antecedent cause(s) if applicable; Underlying disease or condition.
1. Cause of death shall be documented using ICD-10 terminology where possible, and in plain clinical language for the family's copy.

2. The death summary shall be prepared within 24 hours of death on working days and within 48 hours on a holiday.
3. For cases where the cause of death is not immediately determinable (e.g., brought dead/unwitnessed death, pending post-mortem), the cause of death shall be documented as: 'To be determined — pending post-mortem examination / further investigation'. The death certificate shall be issued after the cause is established.
4. For medico-legal cases (MLC), where the death is referred for post-mortem, the cause of death in the hospital death summary is documented as 'As per Post-Mortem Examination Report'. A copy of the IP case sheet is provided to the police if demanded, as per the Medico-Legal Manual.
5. The death summary is provided to the family/legal representative of the deceased at the time of body handover, along with the death certificate.

3.2 Death Summary Minimum Content

- Patient identifiers: Name, UHID, IP Number, Age/Sex
- Date and time of admission
- Date and time of death
- Admitting diagnosis
- Summary of clinical course — key events, interventions, investigations
- Condition on last assessment before death
- Resuscitation attempted / not attempted — with documentation (DNR order if applicable)
- Cause of death — immediate cause, antecedent cause, underlying cause
- Whether MLC — if yes, police intimation details
- Name, designation and signature of certifying doctor

NABH 6th Edition Reference: AAC 13.d – Discharge summary incorporates instructions about when and how to obtain urgent care. AAC 13.e – In case of death, the summary of the case also includes the cause of death.

Amendment History

Sl. No	Ed. No	Rev No	Date	Nature of Change
1	01	00	1 Oct 2019	Death summary and discharge instructions within general discharge policy — NABH 4th Edition
2	01	01	1 Nov 2020	Within SDH/AAC/12 and SDH/AAC/09; NABH 5th Edition compliance
3	01	01	1 Jan 2022	No changes
4	01	02	1 Jan 2025	Separated as addendum. Warning signs and urgent care contact information formalised. Cause of death documentation process defined including MLC/post-mortem provisions. Aligns with NABH 6th Edition AAC 13.d, 13.e.
5	01	02	1 Jan 2026	No changes