

COP

Chapter Book



 SAIDEEP HEALTHCARE & RESEARCH PVT. LTD.	SAIDEEP HOSPITAL HOSPITAL MANUAL	Doc No	SDH/COP/01
		Issue No	01
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	Policy on Uniform Care of Patients		

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

Policy:

1. All patients approaching the hospital for medical treatment will receive care appropriate to their health care need and scope of services provided by the Hospital.
2. Quality of medical care will be same in all care settings of the hospital and no discrepancy of any sort will be followed in the provision of medical care.
3. Incase required the primary treating consultant of the patient may consult other care providers available within the hospital for patients care related issues.
4. Any treatment order initiated by a hospital's clinician different from the primary treating consultant of the patient will be countersigned by the primary treating consultant within 24hours.
5. It is further ensured that the care and treatment orders are legibly signed, named, timed and dated by the concerned doctors and nurses, the main idea being that the authors of these orders are identifiable by all and the chronology of care process is maintained.
6. Laboratory facilities, OT facility, Diagnostics, Nursing Care are uniformly provided to all patients irrespective of category of patients.

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7. Patients response to treatment, his/her health status, further treatment plan etc will be discussed among the clinical and nursing staff involved in provision of care to the patient.
- 8 The primary treating consultant can refer the patient to other clinical specialty either within the hospital or to the identified external health care institutions if the patients' medical need demand the same (Refer Policy on Referral of Patients)
9. The clinicians may resort to evidence based medicine which is the conscientious, explicit and judicious use of current best evidence in making clinical decision about the care of individual patients.
10. SDH has the policy for delivering uniform care to all patients irrespective of the care setting right from the admission to discharge for IPD cases, in OPD services and emergency services.
11. Clinical practice guidelines are adopted to guide patient care whenever possible.

Clinicians are encouraged to consider the following points in using evidence based medicine for the provision of optimum care to the patients which are

- a. Convert information need into answerable questions.
- b. Track down the best evidence to answer the question (with maximum efficiency).

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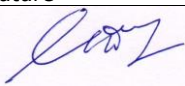
c. Critically appraise the evidence for its validity and usefulness.

d. Integrate appraisal results with clinical expertise and patient values.

e. Evaluate outcomes.

NABH Standards: COP 1 a

Sl. No	Current Revision			Nature of Change
	Edition No	Revision No.	Date	
1	01	00	1 Oct 2019	First issue as per NABH Hospital Accreditation Standards – 4 th Edition
2	01	01	1 Nov 2020	Minor Revisions, updating Doc No. and updating for compliance as per NABH Hospital Standards 5th Edition
3	01	01	1 Jan 2022	No changes.

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4	01	02	1 Jan 2025	Amended as per the 6 th Edition.
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AMENDMENT HISTORY

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TELEMEDICINE

‘The delivery of health care services, where distance is a critical factor, by all health care professionals using information and communication technologies for the exchange of valid information for diagnosis, treatment and prevention of disease and injuries, research and evaluation, and for the continuing education of health care providers, all in the interests of advancing the health of individuals and their communities.’

TELE HEALTH

The delivery and facilitation of health and health-related services including medical care, provider and patient education, health information services, and self-care via telecommunications and digital communication technologies

REGISTERED MEDICAL PRACTITIONER

‘A Registered Medical Practitioner [RMP] is a person who is enrolled in the State Medical Register or the Indian Medical Register under the Indian Medical Council Act 1956.’ [IMC Act, 1956]

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Purpose

The purpose of these guidelines is to give practical advice to doctors so that all services and models of care used by doctors and health workers are encouraged to consider the use of telemedicine as a part of normal practice. These guidelines will assist the medical practitioner in pursuing a sound course of action to provide effective and safe medical care founded on current information, available resources, and patient needs to ensure patient and provider safety.

These telemedicine guidelines will help realize the full potential of these advancements in technology for health care delivery. It provides norms and protocols relating to physician-patient relationship; issues of liability and negligence; evaluation, management and treatment; informed consent; continuity of care; referrals for emergency services; medical records; privacy and security of the patient records and exchange of information; prescribing; and reimbursement; health education and counseling.

These guidelines will provide information on various aspects of telemedicine including information on technology platforms and tools available to medical practitioners and how to integrate these technologies to provide health care delivery. It also spells out how technology and transmission of voice, data, images and information should be used in conjunction with other clinical standards, protocols, policies and procedures for the provision of care. Where clinically appropriate, telemedicine is a safe, effective and a valuable modality to support patient care. Like any other technology, the technology used for telemedicine services can be abused. It has some risks, drawbacks and limitations, which can be mitigated through appropriate training, enforcement of standards, protocols and guidelines,

These guidelines should be used in conjunction with the other national clinical standards, protocols, policies and procedures.

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1. Definition of Telemedicine

World Health Organization defines telemedicine as

“The delivery of health-care services, where distance is a critical factor, by all health-care professionals using information and communications technologies for the exchange of valid information for diagnosis, treatment and prevention of disease and injuries, research and evaluation, and the continuing education of health-care workers, with the aim of advancing the health of individuals and communities.”

Definition of Telehealth

NEJM Catalyst defines telehealth as “The delivery and facilitation of health and health-related services including medical care, provider and patient education, health information services, and selfcare via telecommunications and digital communication technologies.”

In general, telemedicine is used to denote clinical service delivered by a Registered medical practitioner while telehealth is a broader term of use of technology for health and health related services including telemedicine.

Scope

Within the broad paradigm of telemedicine, these guidelines will be published under the IMC Act and are for privileged access only. These guidelines are designed to serve as an aid and tool to enable RMPs to effectively leverage Telemedicine to enhance healthcare service and access to all the guidelines are meant for RMPs under the IMC Act 1956

- The guidelines cover norms and standards of the RMP to consult patients via telemedicine
- Telemedicine includes all channels of communication with the patient that leverage Information
- Technology platforms, including Voice, Audio, Text & Digital Data exchange

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EXCLUSIONS:

The guidelines specifically explicitly exclude the following:

- Specifications for hardware or software, infrastructure building & maintenance Data management systems involved; standards and interoperability
- Use of digital technology to conduct surgical or invasive procedures remotely
- Other aspects of telehealth such as research and evaluation and continuing education of healthcare workers
- Does not provide for consultations outside the jurisdiction of India

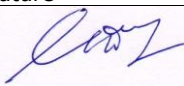
2. Technology Used & Mode of Communications

Multiple technologies can be used to deliver telemedicine consultation. There are 3 primary modes: Video, Audio, or Text (chat, messaging, email, fax etc.) Each one of these technology systems has their respective strengths, weaknesses and contexts, in which, they may be appropriate or inadequate to deliver a proper diagnosis.

It is therefore important to understand the strengths, benefits as well as limitations of different technologies. Broadly, though telemedicine consultation provides safety to the RMP from contagious conditions, it cannot replace physical examination that may require palpation, percussion or auscultation; that requires physical touch and feel. Newer technologies may improve this drawback.

STRENGTHS AND LIMITATIONS OF VARIOUS MODES OF COMMUNICATION

Mode	Strengths	Limitations
VIDEO:	• Closest to an in person-	• Is dependent on high

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Telemedicine facility, Apps, Video on chat platforms, Facetime etc.	consult, real time interaction Patient identification is easier - RMP can see the patient and - discuss with the caregiver Visual cues can be perceived - Inspection of patient can be carried out	quality internet connection at both ends, else will lead to a sub optimal exchange of information Since there is a possibility of abuse/misuse, ensuring privacy of patients in video consults is extremely important
AUDIO: Phone, VOIP, Apps et	- Convenient and fast - Unlimited reach - Suitable for urgent cases - No separate infrastructure required - Privacy ensured - Real-time interaction	- Non-verbal cues may be missed - Not suitable for conditions that require a visual inspection (e.g. skin, eye or tongue examination), or physical touch - Patient identification needs to be clearer, greater chance of imposters representing the real patient
TEXT BASED:	Convenient and quick	Besides the visual and

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Specialized Chat based Telemedicine Smartphone Apps, SMS, Websites, messaging systems e.g. WhatsApp, Google Hangouts, FB Messenger	- Documentation & Identification may be an integral feature of the platform - Suitable for urgent cases, or follow-ups, second opinions provided RMP has enough context from other sources - No separate infrastructure required - Can be real time	physical touch, text-based interactions also miss the verbal cues - Difficult to establish rapport with the patient - Cannot be sure of identity of the doctor or the patient.
ASYNCHRONOUS: Email Fax, recordings etc.	- Convenient and easy to document No specific app or download requirement - Images, data, reports readily shared - No separate infrastructure required - More useful when accompanied with test reports and follow up and second opinions	- Not a real time interaction, so just one-way context is available, relying solely on the articulation by the patient - Patient identification is document based only and difficult to confirm - Non-verbal cues are missed - There may be delays because the Doctor may not see the mail immediately

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3. Guidelines for Telemedicine in India

The professional judgment of a Registered Medical Practitioner should be the guiding principle for all telemedicine consultations: An RMP is well positioned to decide whether a technology-based consultation is sufficient or an in-person review is needed. Practitioner shall exercise proper discretion and not compromise on the quality of care. Seven elements need to be considered before beginning any telemedicine consultation (see panel)

Seven Elements to be considered before any telemedicine consultation

- 1 Context
- 2 Identification of RMP and Patient
- 3 Mode of Communication
- 4 Consent
- 5 Type of Consultation
- 6 Patient Evaluation
- 7 Patient Management

3.1 TELEMEDICINE SHOULD BE APPROPRIATE AND SUFFICIENT AS PER CONTEXT .

3.1.1 The Registered Medical Practitioners should exercise their professional judgment to decide whether a telemedicine consultation is appropriate in a given situation or an in-person consultation is needed in the interest of the patient. They should consider the mode/technologies available and their adequacy for a diagnosis before choosing to proceed with any health education or counseling or medication. They should be reasonably comfortable that telemedicine is in the patient's interest after taking a holistic view of the given situation.

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3.1.2 Complexity of Patient's health condition Every patient/case/medical condition may be different, for example, a new patient may present with a simple complaint such as headache while a known patient of Diabetes may consult for a followup with emergencies such as Diabetic Ketoacidosis. The RMP shall uphold the same standard of care as in an in-person consultation but within the intrinsic limits of telemedicine.

3.2 IDENTIFICATION OF THE REGISTERED MEDICAL PRACTITIONER AND THE PATIENT IS REQUIRED.

3.2.1 Telemedicine consultation is should not be anonymous: both patient and the RMP need to know each other's identity.

3.2.2 An RMP should verify and confirm patient's identity by name, age, address, email ID, phone number, registered ID or any other identification as may be deemed to be appropriate. The RMP should ensure that there is a mechanism for a patient to verify the credentials and contact details of the RMP

3.2.3 For issuing a prescription, the RMP needs to explicitly ask the age of the patient, and if there is any doubt, seek age proof. Where the patient is a minor, after confirming the age, tele consultation would be allowed only if the minor is consulting along-with an adult whose identity needs to be ascertained.

3.2.4 An RMP should begin the consultation by informing the patient about his/her name and qualifications.

3.2.5 Every RMP shall display the registration number accorded to him/her by the State Medical Council/MCI, on prescriptions, website, electronic communication (WhatsApp/ email etc.) and receipts etc. given to his/her patients

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3.3 MODE OF TELEMEDICINE

3.3.1 Multiple technologies can be used to deliver telemedicine consultations. All these technology systems have their respective strengths, weaknesses and contexts in which they may be appropriate or inadequate in order to deliver proper care.

3.3.2 Primarily there are 3 modes: Video, Audio or Text (chat, images, messaging, email, fax etc.). Their strengths, limitations and appropriateness as detailed in Section 2 need to be considered by the RMP.

3.3.3 There may be situations where in order to reach a diagnosis and to understand the context better; a real-time consultation may be preferable over an asynchronous exchange of information. Similarly, there would be conditions where an RMP could require hearing the patient speak, therefore, a voice interaction may be preferred than an email or text for a diagnosis. There are also situations where the RMP needs to visually examine the patient and make a diagnosis. In such a case, the RMP could recommend a video consultation. Considering the situation, using his/her best judgment, an RMP may decide the best technology to use to diagnose and treat.

3.4 PATIENT CONSENT .

Patient consent is necessary for any telemedicine consultation. The consent can be Implied or explicit depending on the following situations:

3.4.1 If, the patient initiates the telemedicine consultation, then the consent is implied

(Implied Consent: In an in-person consultation, it is assumed the patient has consented to the consult by his/her actions. When the patient walks in an OPD, the consent for the consultation is taken as implied. Like an in-person consultation, for most of the teleconsultations the consent can be assumed to be implied because the patient has initiated the consultation.)

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3.4.2 An Explicit patient consent is needed if:

A Health worker, RMP or a Caregiver initiates a Telemedicine consultation.

3.4.3 An Explicit consent can be recorded in any form. Patient can send an email, text or audio/video message. Patient can state his/her intent on phone/video to the RMP (e.g. “Yes, I consent to avail consultation via telemedicine” or any such communication in simple words). The RMP must record this in his patient records.

3.5 EXCHANGE OF INFORMATION FOR PATIENT EVALUATION

RMPs must make all efforts to gather sufficient medical information about the patient’s condition before making any professional judgment.

3.5.1 Patient’s Information –

An RMP would use his/her professional discretion to gather the type and extent of patient information (history/examination findings/Investigation reports/past records etc.) required to be able to exercise proper clinical judgment.

- This information can be supplemented through conversation with a healthcare worker/provider and by any information supported by technology-based tools.

- If the RMP feels that the information received is inadequate, then he/she can request for additional information from the patient. This information may be shared in real time or shared later via email/text, as per the nature of such information. For example, an RMP may advise some laboratory or/and radiological tests to the patient. In such instances, the consult may be considered paused and can be resumed at the rescheduled time. An RMP may provide health education as appropriate at any time.

- Telemedicine has its own set of limitations for adequate examination. If a physical examination is critical information for consultation, RMP should not proceed until a physical

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examination can be arranged through an in-person consult. Wherever necessary, depending on professional judgement of the RMP, he/she shall recommend:

- Video consultation
- Examination by another RMP/ Health Worker ;
- In-person consultation
- The information required may vary from one RMP to another based on his/her professional experience and discretion and for different medical conditions based on the defined clinical standards and standard treatment guidelines.
- RMP shall maintain all patient records including case history, investigation reports, images, etc. as appropriate.

3.6 TYPES OF CONSULTATION: FIRST CONSULT/ FOLLOW-UP CONSULT .

There are two types of patient consultations, namely, first consult and the follow-up consult.

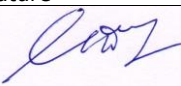
An RMP may have only a limited understanding of the patient seeking teleconsultation for the first time, when there have been no prior in-person consultation. However, if the first consult happens to be via video, RMP can make a much better judgment and hence can provide much better advice including additional medicines, if indicated.

On the other hand, if a patient has been seen in-person earlier by the RMP, then it is possible to be more comprehensive in managing the patient.

3.6.1 First Consult means

The patient is consulting with the RMP for the first time; or

The patient has consulted with the RMP earlier, but more than 6 months have lapsed since the previous consultation; or

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The patient has consulted with the RMP earlier, but for a different health condition•

3.6.2 Follow-Up Consult(s) means

The patient is consulting with the same RMP within 6 months of his/her previous in person consultation and this is for continuation of care of the same health condition. However, it will not be considered a follow up if:

There are new symptoms that are not in the spectrum of the same health condition; and/or

RMP does not recall the context of previous treatment and advice

3.7 PATIENT MANAGEMENT: HEALTH EDUCATION, COUNSELING & MEDICATION .

3.7.1 If the condition can be appropriately managed via telemedicine, based on the type of consultation, then the RMP may proceed with a professional judgement to

- Provide Health Education as appropriate in the case; and/or
- Provide Counseling related to specific clinical condition; and/or
- Prescribe Medicines

3.7.2 Health Education: An RMP may impart health promotion and disease prevention messages. These could be related to diet, physical activity, cessation of smoking, contagious infections and so on. Likewise, he/ she may give advice on immunizations, exercises, hygiene practices, mosquito control etc

3.7.3 Counseling: This is specific advice given to patients and it may, for instance, include food restrictions, do's and don't's for a patient on anticancer drugs, proper use of a hearing aid, home physiotherapy, etc to mitigate the underlying condition. This may also include advice for new investigations that need to be carried out before the next consult.

3.7.4 Prescribing Medicines

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Prescribing medications, via telemedicine consultation is at the professional discretion of the RMP. It entails the same professional accountability as in the traditional in-person consult. If a medical condition requires a particular protocol to diagnose and prescribe as in a case of in-person consult then same prevailing principle will be applicable to a telemedicine consult.

RMP may prescribe medicines via telemedicine ONLY when RMP is satisfied that he/ she has gathered adequate and relevant information about the patient's medical condition and prescribed medicines are in the best interest of the patient

Prescribing Medicines without an appropriate diagnosis/provisional diagnosis will amount to a professional misconduct

Specific Restrictions

There are certain limitations on prescribing medicines on consult via telemedicine depending upon the type of consultation and mode of consultation. The categories of medicines that can be prescribed via tele-consultation will be as notified in consultation with the Central Government from time to time. The categories of medicines that can be prescribed are listed below:

List O: It will comprise those medicines which are safe to be prescribed through any mode of tele-consultation. In essence they would comprise of

1. Medicines which are used for common conditions and are often available 'over the counter'. For instance, these medicines would include, paracetamol, ORS solutions, cough lozenges etc

2. Medicines that may be deemed necessary during public health emergencies.

List A: These medications are those which can be prescribed during the first consult which is a video consultation and are being re-prescribed for re-fill, in case of follow-up.

This would be an inclusion list, containing relatively safe medicines with low potential for abuse. It is a list of medication which RMP can prescribe in a patient who is undergoing follow-up consult, as a refill.

List B: Is a list of medication which RMP can prescribe in a patient who is undergoing follow-up consultation in addition to those which have been prescribed during in-person consult for the same medical condition.

Prohibited List: An RMP providing consultation via telemedicine cannot prescribe medicines in this list. These medicines have a high potential of abuse and could harm the patient or the society at large if used improperly

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Medicines listed in Schedule X of Drug and Cosmetic Act and Rules or any Narcotic and Psychotropic substance listed in the Narcotic Drugs and Psychotropic Substances, Act, 1985

3.6.4.2 Issue a Prescription and Transmit

- If the RMP has prescribed medicines, RMP shall issue a prescription as per the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations and shall not contravene the provisions of the Drugs and Cosmetics Act and Rules.
- RMP shall provide photo, scan, digital copy of a signed prescription or e-Prescription to the patient via email or any messaging platform
- In case the RMP is transmitting the prescription directly to a pharmacy, he/ she must ensure explicit consent of the patient that entitles him/her to get the medicines dispensed from any pharmacy of his/ her choice

3.7 DUTIES AND RESPONSIBILITIES OF A RMP IN GENERAL

3.7.1 MEDICAL ETHICS, DATA PRIVACY & CONFIDENTIALITY

3.7.1.1 Principles of medical ethics, including professional norms for protecting patient privacy and confidentiality as per IMC Act shall be binding and must be upheld and practiced.

3.7.1.2 Registered Medical Practitioner would be required to fully abide by Indian Medical Council (Professional conduct, Etiquette and Ethics) Regulations, 2002 and with the relevant provisions of the IT Act, Data protection and privacy laws or any applicable rules notified from time to time for protecting patient privacy and

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confidentiality and regarding the handling and transfer of such personal information regarding the patient. This shall be binding and must be upheld and practiced

3.7.1.3 Registered Medical Practitioners will not be held responsible for breach of confidentiality if there is a reasonable evidence to believe that patient's privacy and confidentiality has been compromised by a technology breach or by a person other than RMP. The RMPs should ensure that reasonable degree of care undertaken during hiring such services.

3.7.1.4 Misconduct It is specifically noted that in addition to all general requirements under the MCI Act for professional conduct, ethics etc, while using telemedicine all actions that willfully compromise patient care or privacy and confidentiality, or violate any prevailing law are explicitly not permissible.

Some examples of actions that are not permissible:

- RMPs insisting on Telemedicine, when the patient is willing to travel to a facility and/or requests an in-person consultation
- RMPs misusing patient images and data, especially private and sensitive in nature (e.g. RMP uploads an explicit picture of patient on social media etc)
- RMPs who use telemedicine to prescribe medicines from the specific restricted list RMPs are not permitted to solicit patients for telemedicine through any advertisements or inducements

3.7.1.5 Penalties: As per IMC Act, ethics and other prevailing laws

3.7.2 MAINTAIN DIGITAL TRAIL/ DOCUMENTATION OF CONSULTATION

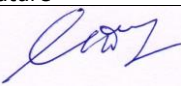
It is incumbent on RMP to maintain the following records/ documents for the period as prescribed from time to time:

3.7.2.1 Log or record of Telemedicine interaction (e.g. Phone logs, email records, chat/ text record, video interaction logs etc.).

3.7.2.2 Patient records, reports, documents, images, diagnostics, data etc. (Digital or non-Digital) utilized in the telemedicine consultation should be retained by the RMP.

3.7.2.3 Specifically, in case a prescription is shared with the patient, the RMP is required to maintain the prescription records as required for in-person consultations.

3.7.3 Fee for Telemedicine Consultation

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3.7.3.1 Telemedicine consultations should be treated the same way as in-person consultations from a fee perspective: RMP may charge an appropriate fee for the Telemedicine consultation provided.

3.7.3.2 An RMP should also give a receipt/invoice for the fee charged for providing telemedicine based consultation

4. Framework for Telemedicine

This section lays out the framework for practicing telemedicine in 5 scenarios:

1. Patient to Registered Medical Practitioner
2. Caregiver to Registered Medical Practitioner
3. Health Worker to Registered Medical Practitioner
4. Registered Medical Practitioner to Registered Medical Practitioner
5. Emergency Situations

Essential Principles: -

- The professional judgement of a Registered Medical Practitioner should be the guiding principle: an RMP is well positioned to decide whether a technology-based consultation is sufficient, or an in-person review is needed. Practitioner shall exercise proper discretion and not compromise on the quality of care

- Same principles apply irrespective of the mode (video, audio, text) used for a telemedicine consultation. However, the patient management and treatment can be different depending on the mode of communication used

. - RMP should exercise his/her professional discretion for the mode of communication depending on the type of medical condition. If a case requires a video consultation for examination, RMP should explicitly ask for it

- The RMP can choose not to proceed with the consultation at any time. At any step, the RMP may refer or request for an in-person consultation

- At any stage, the patient has the right to choose to discontinue the teleconsultation

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4.1 CONSULTATION BETWEEN PATIENT AND REGISTERED MEDICAL PRACTITIONER

Specifically, this section details with the key elements of the process of teleconsultation to be used in the First consults and Follow up consults when a patient consults with an RMP.

In these 2 situations, the patient initiates telemedicine consultation and thereby consent is implied

4.1.1 First Consult: Patient to Registered Medical Practitioner

4.1.1.1 First Consult means

1. The patient is consulting with the RMP for the first time; or
2. The patient has consulted with the RMP earlier, but more than 6 months have lapsed since the previous consultation; or
3. The patient has consulted with the RMP earlier, but for a different health condition

4.1.1.2 Tele-Consultation Process

The flow of the process is summarized in the Figure 1 and the steps are detailed below.

1. Start of a Telemedicine Consultation for First Consult
 - The telemedicine consultation is initiated by the patient (For example, a patient may do an audio or video call with a RMP or send an email or text with a health query)
 - RMP accepts to undertake the consultation
2. Patient identification and consent
 - RMP should confirm patient identity to his/her satisfaction by asking patient's name, age, address, email ID, phone number or any other identification that may be reasonable
 - Telemedicine consultation should be initiated by the patient and thereby consent is implied

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3. Quick assessment:

- The patient's condition needs to be quickly assessed by the RMP based on available inputs and RMP uses his professional discretion if emergency care is needed, to decide if emergency care is needed.
- If the condition of the patient merits emergency intervention, then advice for first aid/ immediate relief is provided and guidance is provided for referral, as appropriate.

If the condition does not merit an emergency intervention, the following steps are undertaken:

4. Exchange of Information for Patient Evaluation

- The RMP may ask the patient to provide relevant information (complaints, information about any other consults for the same problem, available investigation and medication details, if any). The patient shall be responsible for accuracy of information shared by him/her with the RMP.
- If the RMP feels that the information provided at this stage is inadequate, then he/she shall request for additional information from the patient. This information may be shared in real time or shared later via email/text, as per the nature of such information. The consultation may be resumed at a rescheduled time after receipt of the additional information (this may include some laboratory or radiological tests). In the meantime, the RMP may provide health advice as appropriate.
- If the RMP is satisfied that he/she has adequate patient information for offering a professional opinion, then he/she shall exercise one's professional judgment for its suitability for management via telemedicine.
- If the situation is NOT appropriate for further telemedicine consultation, then the RMP should provide Health advice/ Education as appropriate; and/or refer for in-person consultation.

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5. Patient Management

If the condition can be appropriately managed via telemedicine, then the RMP may take a professional judgement to either:

- Provide *Health Education* as appropriate in the case; and/or
- Provide *Counseling* related to specific clinical condition, *including advice related to new investigations that need to be carried out before next consult*; and/or
- Provide *specific treatment by prescribing medicines* as in List O (which are over the counter drugs or others as notified). Additional medicines (as per List A) can also be prescribed if the ongoing tele-consultation is on video

4.1.2 Follow-up Consult: Patient to Registered Medical Practitioner

In a follow-up consultation, since the RMP-patient interaction has already taken place for the specific medical condition under follow-up, there is already an understanding of the context, with availability of previous records. This allows a more definitive and secure interaction between the RMP and the patient.

4.1.2.1 Follow-Up Consult means

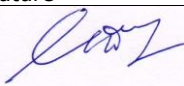
The patient is consulting with the RMP within 6 months of his/her previous in-person, and this consultation is for continuation of care of the same health condition. Follow-up can be in situations of a chronic disease or a treatment (e.g. renewal or change in medications) when a face-to-face consultation is not necessary. Examples of such chronic diseases are: asthma, diabetes, hypertension and epilepsy etc

4.1.2.2 Tele-Consultation Process

The flow of the process is summarized in Figure 2 and the steps are detailed below:

1. Start of a Telemedicine Consultation for Follow Up

- Patient may initiate a follow up consult with a RMP for continuation of his/her ongoing treatment or for a new complaint or complication arising during the course of the ongoing treatment using any mode of communication. For e.g.,

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the patient may do an audio or video call with a RMP or send him/her an email or text message with a specific health query

- RMP accepts to undertake the consultation

2. Patient identification and consent

- RMP should be reasonably convinced that he/she is communicating with the known patient, for e.g. if the patient is communicating with RMP through the registered phone number or registered email id
- If there is any doubt RMP can request the patient to reinitiate the conversation from a registered phone number or email id or should confirm patient identity to his/her satisfaction by asking patient's name, age, address, email ID or phone number. [Details in the section 3.2]
- Patient initiates the Telemedicine consultation and thereby consent is implied

3. Quick Assessment for Emergency Condition

If the patient presents with a complaint which the RMP identifies as an emergency condition necessitating urgent care, the RMP would then advice for first aid to provide immediate relief and guide for referral of the patient, as deemed necessary.

4. In case of routine follow-up consultation, the following would be undertaken:

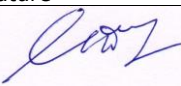
If the RMP has access to previous records of the patient, he/ she may proceed with continuation of care.

RMP shall apply his/her professional discretion for type of consultation based on the adequacy of patient information (history/examination findings/Investigation reports/past records).

If the RMP needs additional information, he/ she should seek the information before proceeding and resume tele-consultation for later point in time.

5. Patient Management

- If RMP is satisfied that he/she has access to adequate patient information and if the condition can be appropriately managed by tele-consultation, he/she would go ahead with the tele-management of the patient.
- If the follow-up is for continuation of care, then the RMP may take a professional judgement to either:
- Provide health education as appropriate in the case; or

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- Provide counseling related to specific clinical condition *including advice related to new investigations that need to be carried out before next consult*;
- And/or Prescribe Medications. The medications could be either of the below:
- If the follow up is for *continuation of care for the same medical condition*, the RMP would re-prescribe original set of medications for a refill (List A of medications, which has been previously prescribed for the patient).
- If the RMP considers addition of a new drug, as an 'add-on' medication to optimize the underlying medical condition, then the RMP can prescribe medications listed under List B.
- If the follow-up consult is for a new minor ailment necessitating only 'over the counter' medications or those notified for this purpose, medications under List O can be prescribed.
- If the follow-up consult reveals new symptom pertaining to a different spectrum of disease, then the RMP would proceed with the condition as enunciated in the scenario for a first-time consultation (4.1.1).

4.2 CONSULTATION BETWEEN PATIENT AND RMP THROUGH A CAREGIVER

4.2.1 For the purpose of these guidelines "**Caregiver**" could be a family member, or any person authorized by the patient to represent the patient.

4.2.2 There could be two possible settings:

1. Patient **is present** with the **Caregiver** during the consultation.

2. Patient **is not present** with the **Caregiver**. This may be the case in the following:

2a. Patient is a minor (aged 16 or less) or the patient is incapacitated, for example, in medical conditions like dementia or physical disability etc. The care giver is deemed to be authorized to consult on behalf of the patient.

2b. Caregiver has a formal authorization or a verified document establishing his relationship with the patient and/or has been verified by the patient in a previous in-person consult (explicit consult).

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CONSULTATION BETWEEN HEALTH WORKER AND RMP

For the purpose of these guidelines, “Health worker” could be a Nurse, Allied Health Professional, Mid-Level Health Practitioner, ANM or any other health worker designated by an appropriate authority

Proposed Set up

- This sub section will cover interaction between a Health Worker seeking consultation for a patient in a public or private health facility.
- In a public health facility, the mid-level health practitioner at a Sub-center or Health and wellness center can initiate and coordinate the telemedicine consultation for the patient with a RMP at a higher center at district or State or National level. Health and Wellness centers are an integral part of comprehensive primary health care.
- This setting will also include health camps, home visits, mobile medical units or any community-based interaction.

Tele-Consultation Process

The flow of the process is summarized in Figure 3 and the steps are detailed below:

1. Start of a Telemedicine Consultation through a Health Worker/RMP

- The premise of this consultation is that a patient has been seen by the Health worker
- In the judgment of the health worker, a tele-consultation with a RMP is required
- Health Worker should obtain the patient’s informed consent
- Health worker should explain potential use and limitations of a telemedicine consultation
- He/she should also confirm patient identity by asking patient’s name, age, address, email ID, phone number or any other identification that may be reasonable
- Health Worker initiates and facilitates the telemedicine consultation.

2. Patient Identification (by RMP)

- RMP should confirm patient identity to his/her satisfaction by asking patient’s name, age, address, email ID, phone number or any other identification that may be reasonable

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- RMP should also make their identity known to the patient

3. Patient Consent (by RMP):

- RMP should confirm the patient's consent to continue the consultation

4. In case of Emergency,

- The Health Worker would urgently communicate about the underlying medical condition of the patient to the RMP.
- If based on information provided, if the RMP identifies it as an emergency condition necessitating urgent care, he/she should advice for first aid to be provided by the Health Worker for immediate relief and guide for referral of the patient, as deemed necessary.

In case, the condition is not an emergency, the following steps would be taken:

5. Exchange of Information for Patient Evaluation (by RMP)

- ✚ The Health Worker must give a detailed explanation of their health problems to the RMP which can be supplemented by additional information by the patient, if required.
- ✚ The RMP shall apply his professional discretion for type and extent of patient information (history/examination findings/Investigation reports/past records) required to be able to exercise proper clinical judgment.
- ✚ If the RMP feels that the information provided is inadequate, then he/she shall request for additional information. This information may be shared in real time or shared later via email/text, as per the nature of such information. For e.g., RMP may advice some laboratory or/and radiological tests for the patient. For such instances, the consult may be considered paused and can be resumed at the rescheduled time. RMP may provide health education as appropriate at any time.

6. Patient Management

- Once the RMP is satisfied that the available *patient information is adequate* and that the case is *appropriate for management via telemedicine*, then he/she would proceed *with the management*. Health worker should document the same in his/her records.
- The RMP may take a professional judgement to either:
- Provide health education as appropriate in the case,

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- Provide counseling related to specific clinical condition *including advice related to new investigations that need to be carried out before next consult*;
- And/or prescribe medications.
- as prescribed for use in guidelines from time to time for a particular cadre of Health Workers.

5.2 Role of Health Worker:

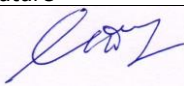
In all cases of emergency, the Health Worker must seek measures for immediate relief and first-aid from the RMP who is being tele-consulted. Health worker must provide the immediate relief/first aid as advised by the RMP and facilitate the referral of the patient for appropriate care. The Health Worker must ensure that patient is advised for an in-person interaction with an RMP, at the earliest.

For patients who can be suitably managed via telemedicine, the Health Worker plays a vital role of

- ✚ Reinforcing the health education and counseling provided by the RMP
- ✚ Providing the medicine prescribed by the RMP and providing patient counseling on his/her treatment.

4.4 REGISTERED MEDICAL PRACTITIONER TO ANOTHER RMP/ SPECIALIST . .

- ✚ Registered Medical Practitioner might use telemedicine services to consult with another RMP or a specialist for a patient under his/her care. Such consultations can be initiated by a RMP on his/her professional judgement.
- ✚ The RMP asking for another RMP's advice remains the treating RMP and shall be responsible for treatment and other recommendations given to the patient.
- ✚ It is acknowledged that many medical specialties like radiology, pathology, ophthalmology, cardiology, dermatology etc. may be at advanced stages of adoption of technology for exchange of information or some may be at early stage. Guidelines support and encourage interaction between RMPs/ specialists using information technology for diagnosis, management and prevention of disease.
- ✚ **Tele-radiology** is the ability to send radiographic images (x-rays, CT, MRI, PET/CT, SPECT/CT, MG, Ultrasound) from one location to another.
- ✚ **Tele-pathology** is use of technology to transfer image-rich pathology data between distant locations for the purposes of diagnosis, education, and research.

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- ✚ **Tele-ophthalmology** access to eye specialists for patients in remote areas, ophthalmic disease screening, diagnosis and monitoring.

4.5 EMERGENCY SITUATIONS . .

In all telemedicine consultations, as per the judgment of the RMP, if it is an emergency situation, the goal and objective should be to provide in-person care at the soonest. However critical steps could be life-saving and guidance and counseling could be critical. For example, in cases involving trauma, right advice and guidance around maintaining the neck position might protect the spine in some cases. The guidelines are designed to provide a balanced approach in such conditions. The RMP, based on his/ her professional discretion may

- ✚ Advise first aid
- ✚ Counseling
- ✚ Facilitate referral

In all cases of emergency, the patient **MUST** be advised for an in-person interaction with a Registered Medical Practitioner at the earliest

5. Guidelines for Technology Platforms enabling Telemedicine

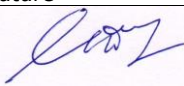
This specifically covers those technology platforms which work across a network of Registered medical practitioners and enable patients to consult with RMPs through the platform

5.1 Technology platforms (mobile apps, websites etc.) providing telemedicine services to consumers shall be **obligated to ensure** that the consumers are consulting with **Registered medical practitioners** duly registered with national medical councils or respective state medical council and comply with relevant provisions

5.2 Technology Platforms shall conduct their **due diligence** before listing any RMP on its online portal. Platform must provide the **name, qualification and registration number, contact details of every RMP** listed on the platform

5.3 In the event some non-compliance is noted, the technology platform shall be required to **report** the same to BoG, in supersession to MCI who may take appropriate action

5.4 Technology platforms based on **Artificial Intelligence/Machine Learning are not allowed to counsel the patients or prescribe any medicines** to a patient. Only a RMP is

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entitled to counsel or prescribe and has to directly communicate with the patient in this regard. While new technologies such as Artificial Intelligence, Internet of Things, advanced data science-based decision support systems etc. could **assist and support a RMP** on patient evaluation, diagnosis or management, the final prescription or counseling has to be directly delivered by the RMP

5.6 Technology Platform must ensure that there is a proper mechanism in place to address any queries or grievances that the end-customer may have

5.7 In case any specific technology platform is found in violation, BoG, MCI may designate the technology platform as blacklisted, and no RMP may then use that platform to provide telemedicine

6. Special responsibilities of Board of Governors in supersession to Medical Council of India (BoG-MCI)

6.1 Any of the drug-lists contained in Telemedicine Practice Guidelines can be modified by the Board of Governors in super-session of the Medical Council of India/Medical Council of India from time to time, as required.

6.2 The Board of Governors in super-session of the Medical Council of India may issue necessary directions or advisories or clarifications in regard to these Guidelines, as required.

6.3 The Telemedicine Practice Guidelines can be amended from time to time in larger public interest with the prior approval of Central Government [Ministry of Health and Family Welfare, Government of India].

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Flow Charts

Figure 1: Flow chart for teleconsultation for first consults

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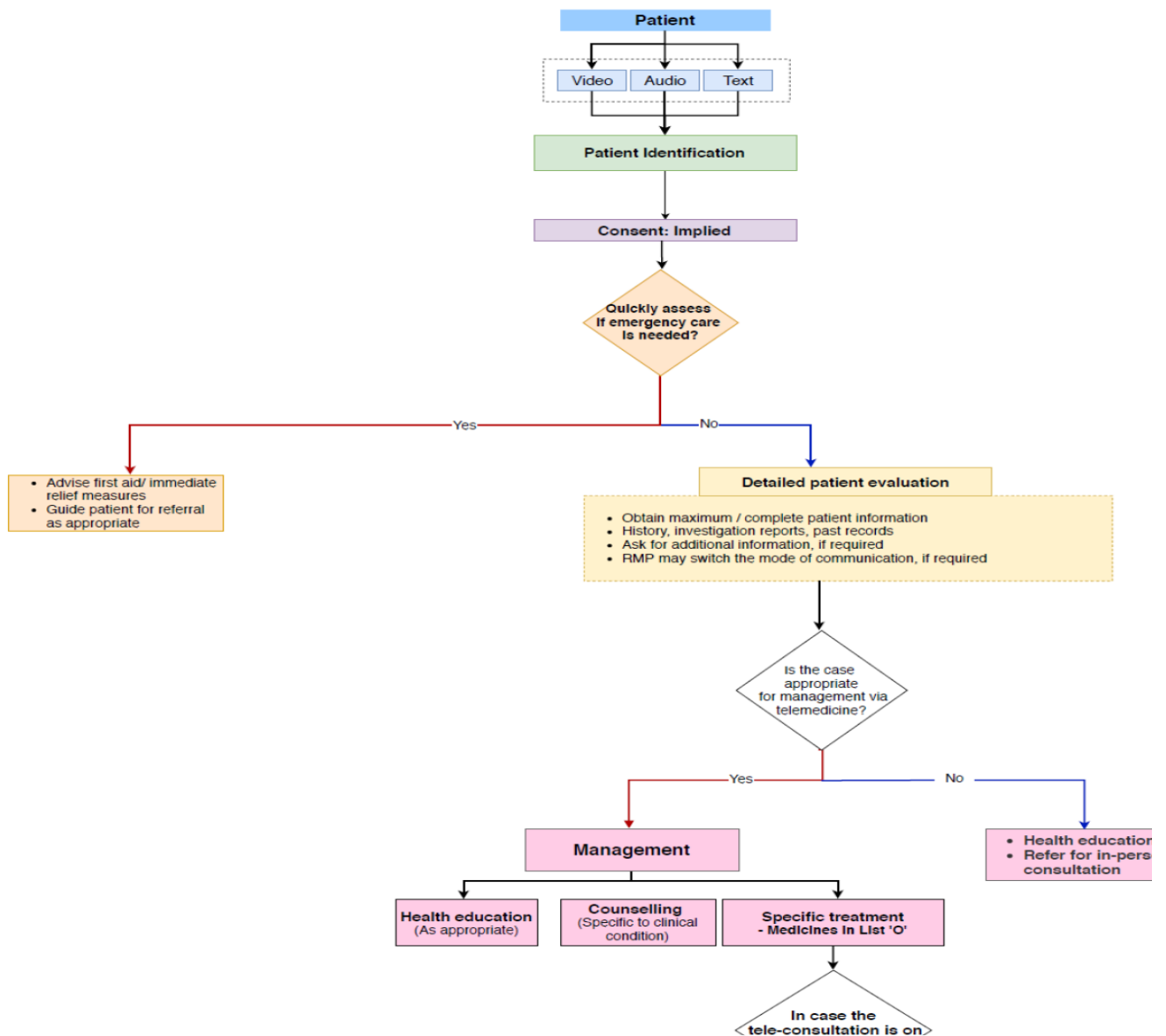
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Consult:
and Registered Medical Practitioner (RMP)

At any stage, the patient has the right to choose to discontinue the teleconsultation



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Annexures

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MEDICINE LISTS.

List O

Common over-the counter medications such as

-  Antipyretics: Paracetamol
-  Cough Supplements: Lozenges,
-  Cough/ Common-cold medications (such as combinations of Acetylcysteine, Ammonium Chloride, Guaifensen, Ambroxol, Bromhexene, Dextromethorphan)
-  ORS Packets
-  Syrup Zinc
-  Supplements: Iron & Folic Acid tablets, Vitamin D, Calcium supplements
-  Etc

Medications notified by Government of India in case from time to time on an Emergency basis

-  Such as Chloroquine for Malaria control for a specific endemic region, when notified by Government

List A

First Consult Medications (Diagnosis done on video mode of consultation) such as

-  Ointments/Lotion for skin ailments: Ointments Clotrimazole, Mupirocin, Calamine Lotion, Benzyl Benzoate Lotion etc
-  Local Ophthalmological drops such as: Ciprofloxacin for Conjunctivitis, etc
-  Local Ear Drops such as: Clotrimazole ear drops, drops for ear wax etc..
-  Follow-up consult for above medications

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Follow-up medications for chronic illnesses for ‘re-fill’ (on any mode of consultation) such as medications for

-  Hypertension: Enalapril, Atenolol etc
-  Diabetes: Metformin, Glibenclamide etc
-  Asthma: Salmeterol inhaler etc
-  Etc

List B

On follow-up, medications prescribed as ‘Add-on’ to ongoing chronic medications to optimize management such as for hYpertension: Eg, add-on of Thiazide diuretic with Atenolol

-  Diabetes: Addition of Sitagliptin to Metformin
-  ETC

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	Policy for Crowd Management		

JCI Standard LD.04.03.11: The hospital manages the flow of patients throughout the hospital

Prevention of patient over-crowding is planned, and crowd management measures are implemented

Introduction: According to the Australasian College for Emergency Medicine (ACEM) **access block** is defined as "the situation where patients are unable to gain access to appropriate hospital beds within a reasonable amount of time, no greater than 8 hours" and 'overcrowding' refers to "the situation where ED function is impeded by the number of patients waiting to be seen, undergoing assessment and treatment, or waiting for departure, exceeding the physical or staffing capacity of the department"

1. Initial causes of crowding:

- Fewer ED beds
- Growing ED volumes
- Unnecessary visits or visits for conditions that could be addressed at the primary care/ambulatory care level
- Delay in decision making for getting admitted by the patient/relatives for various non-clinical reasons

2. Crowding occurs when the number of patients exceeds treatment space capacity

- It impedes efforts of ED personnel to provide care to patients, stretching resources, delaying treatment and leading to poorer patient outcomes. It also causes patients to leave prior to being evaluated by a physician or other provider, and may lead to ambulance diversion. Due to the unscheduled nature of emergencies, ED crowding will probably never be completely eliminated, but efforts can be made to mitigate boarding of patients and the crowding which boarding creates.
- *ED crowding correlated with bottlenecks in hospital flow, and specifically identified ED **boarding of inpatients** as a primary contributor to crowding. Crowding creates operational inefficiency in the ED, and has particularly concerning consequences on critically ill patients, where compliance with sepsis bundles has been adversely affected. It has been associated with delay (or failure) to administer antibiotics in community acquired pneumonia, poor analgesia management in patients with severe pain, increased medical errors, and increased in-hospital mortality.*

Recommended By	Signature	Approved By	Signature
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Quality Head		Chairman & Managing Director	

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- ED boarding increases length of stay (LOS) for all patients, leading to decreased staff and patient satisfaction. The experience of boarding in ED hallways leads to lower satisfaction scores for ED care, and is predictive of low satisfaction scores for the entire hospital stay. Crowding also decreases access to emergency services, leading to increased walkout and left without being seen (LWBS) rates, and increased ambulance diversion events. Significant opportunity costs ensue as revenue from potential patients is turned away for lack of space or inefficient bed turnover.

3. Measures to prevent patient over-crowding in the emergency department:

A. Effective and standardized triage of all patients visiting ED: The hospital ED as a policy uses a standardized triage system to facilitate early initiation of the medical treatment based on 'Emergency Severity Index' from Level-1 to Level-5.

B. Community Emergency Department Overcrowding Score (CEDOCS): To score in every shift especially during a surge and analyze sp as to plan and allocate adequate resources.

Also the following data is to be analyzed for better insights

- Time to provider (TTP) : From ED arrival to initial assessment in ED
- Dwell time: Duration of boarding in the ED awaiting an inpatient bed
- Overall ED LOS
- Left without being seen (LWBS)

C. Appointing Bed coordinators and a Bed Director (who can mobilize additional resources in real time to augment hospital capacity to address emergency department throughput problems): All floor managers are given a responsibility to keep track of ADT (Admission-Discharge-Transfer) activities in real time and coordinate among themselves to expedite bed allocation according to the needs of the patients.

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D. Early in-patient discharge policy: Clinicians are encouraged to plan discharges (preferably decided 24 hours prior) and floor staff is expected to execute the procedure before 12PM. 75% of the total planned discharges should be completed between 12PM and 4PM.

E. Full capacity protocols: NABH Standard AAC 2d: The hospital has a written guidance which addresses managing patients during non-availability of beds, this should be used whenever there is a surge of cases and bed allocation is not possible according to their clinical needs within the stipulated time.

CEDOCS Score for Emergency Department Overcrowding: Estimates severity of overcrowding in community emergency departments.

When to use: ED is using these scores every shift, or at times on shift with drastic changes in crowding (large influx of patients, for example), this activity is carried out for a fortnight in every quarter. If the scores indicate persistent overcrowding then the scoring is done more frequently.

Pearls/Pitfalls:

- CEDOCS was created as an improved analysis over the NEDOCS scoring system; both assess and quantify ED overcrowding.
- CEDOCS was developed specifically with community emergency departments in mind.
 - NEDOCS only targeted large, academic trauma centers.
- Interestingly, its score was calibrated by comparing “busy-ness” to ratings by emergency physicians and emergency department charge nurses.
- CEDOCS is calibrated to score 0-100, but usually the score is doubled so it can be compared to NEDOCS (0-200).
- CEDOCS appears to be valid at EDs with at least 18,000 patients per year.

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Points to keep in mind:

- These scores are “best guess” estimates to objectify over-crowding but will not always be able to account for all causes of over-crowding.
 - For example, as mentioned by its authors, “‘psych patients awaiting admission’ were not a problem in the particular hospitals in the original NEDOCS study but have become more of a recent problem in community-based hospitals.”

Why use: Providing an objective, quantitative score can help EDs and their hospitals provide appropriate resources to the ED and rest of the hospital to reduce delays in care and boarding, which have been shown to have significant impacts on patient morbidity and mortality.

FORMULA

CEDOCS Score = $-29.53 + (3.14 \times \text{critical care patients in the ED}) + (0.52 \times \text{waiting time of longest admitted patient}) + (1.14 \times \text{number of patients in waiting room}) + (20.55 \times \text{ratio of total ED patients to number of ED beds}) + (0.00124 \times \text{ED visits per year}) + A + B + C + D$ (additional variables based on ED visits per year) as follows:

Threshold	Additional variables*
If ED visits per year $\geq 18,811$	$A = - [(1.09 \times 10^{-12}) \times (\text{ED visits per year} - 18,811)^3]$
If ED visits per year $\geq 43,012$	$B = [(8.18 \times 10^{-12}) \times (\text{ED visits per year} - 43,012)^3]$
If ED visits per year $\geq 49,466$	$C = - [(8.18 \times 10^{-12}) \times (\text{ED visits per year} - 49,466)^3]$
If ED visits per year $\geq 67,273$	$D = [(1.08 \times 10^{-12}) \times (\text{ED visits per year} - 67,273)^3]$

*Include all variables in scoring where “ED visits per year” is greater than or equal to the threshold. If “ED visits per year” does not meet the threshold requirement, count variable as 0. For example, if ED visits per year is $\geq 43,012$, final CEDOCS Score = CEDOCS Score + A + B.

Note: Final CEDOCS Score is multiplied by the scaling factor specified. If no scaling factor or a scaling factor of 0 is specified, final CEDOCS Score is multiplied by 2.

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FACTS & FIGURES

Score interpretation:

Level	Score	Interpretation
Level 1	1-20	Not busy
Level 2	21-60	Busy
Level 3	61-100	Extremely busy but not overcrowded
Level 4	101-140	Overcrowded
Level 5	141-180	Severely overcrowded
Level 6	181-200	Dangerously overcrowded

REFERENCE – COP 2.B

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Chapter: COP 2 C

Emergency care is provided in consonance with statutory requirement including medio legal cases as per written guidance.
Refer ER Manual & Medico Legal Manual

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	Policy on Triage and handling patients during non - availability of beds		

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.

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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

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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 of patient beds in case of non-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.

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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 available in the ICU within 4 hours, 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.

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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 cases are directed to the relevant consultant of their choice and after regular 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:

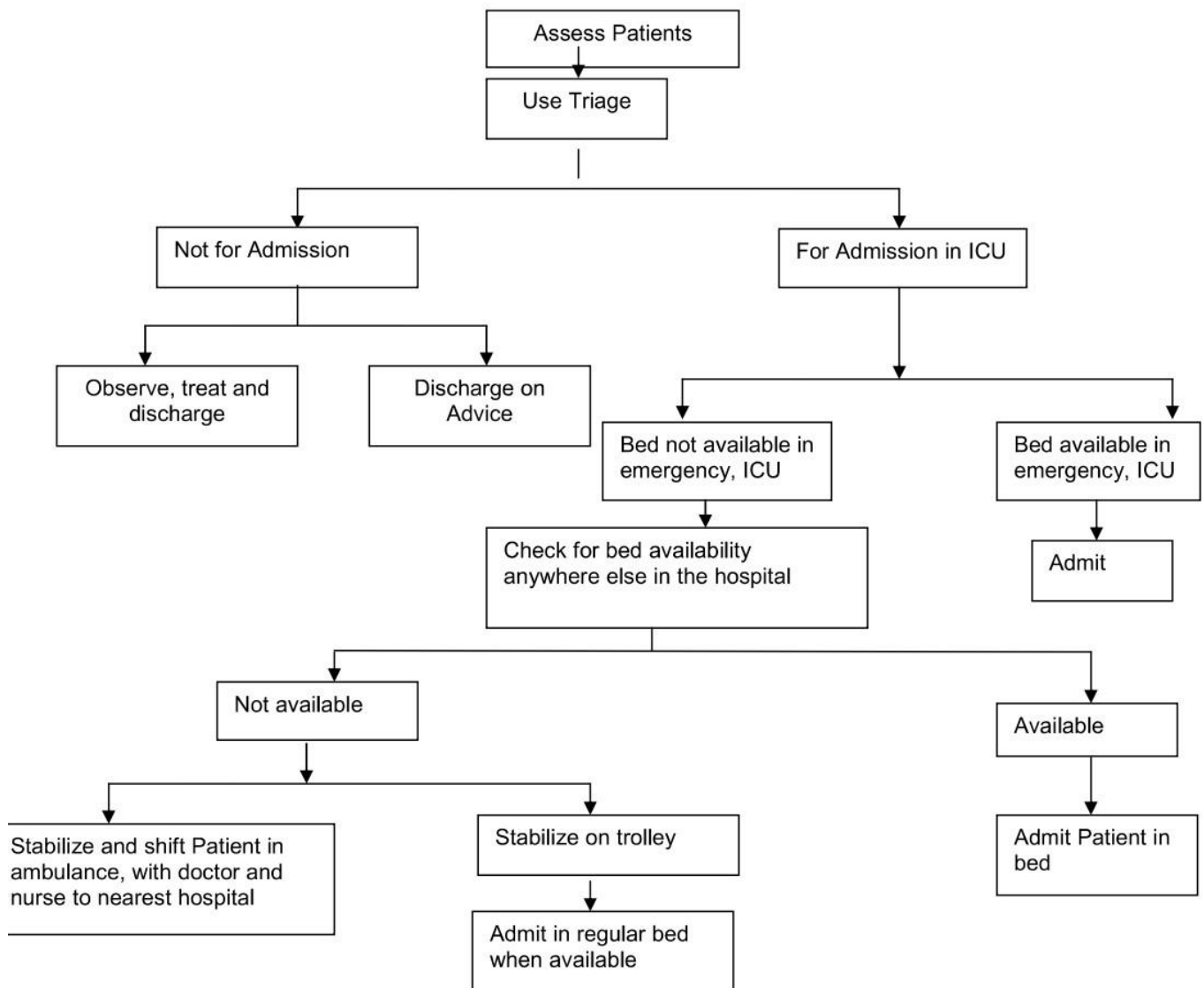
- Transfer/referral
- Admission in alternate category

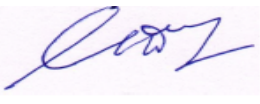
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5.0 Procedure for managing patients during non-availability of beds in case of an emergency

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



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6.0 Procedure addressing shortage of beds in Intensive care

1. A call is made to ICU to check the availability of bed and if available the patient is shifted there.
2. The condition of all the patients in the ICU 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:

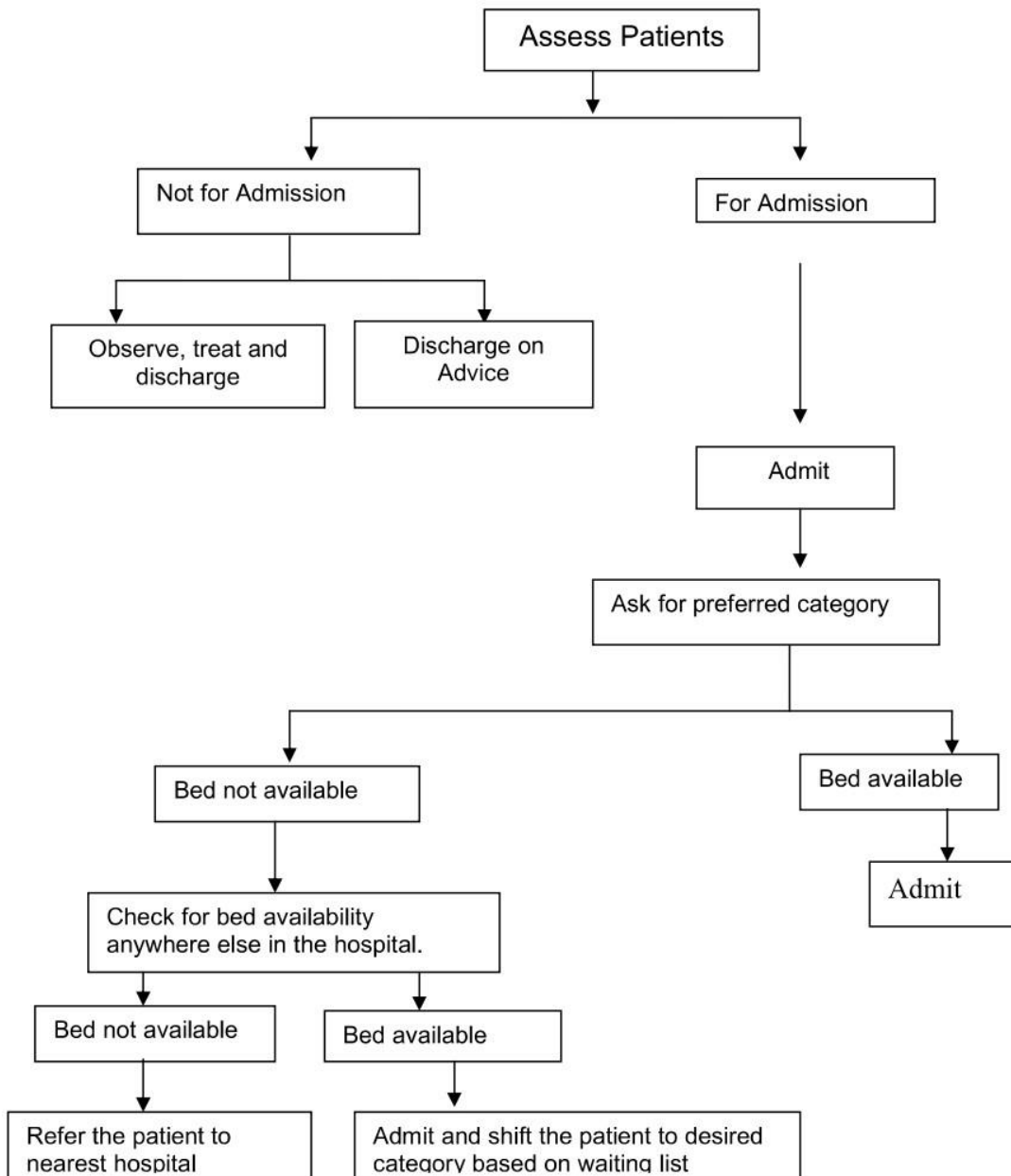
- Receiving hospital shall be informed and acceptance confirmed
- Clinical status shall be documented
- Handover communication shall be recorded

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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



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(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

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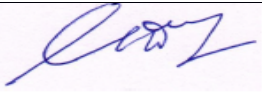
Document Title : QAP ER

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SHRPL QAP POLICY:

Quality Assurance Programme in ER:

S. No.	Quality Objective	Performance Indicator	Responsibility	Measurement criteria	
				Criteria	Frequency
1	Service Quality	Average time taken for initial assessment of patients coming to emergency	Emergency In charge	Sum of time taken for initial assessment of all patients who assessed emergency services in a period / Total Number of Patient who assessed emergency services in that period.	Monthly
		Return to the emergency department for the same complaints	Emergency In charge	Rate the return to emergency department with in 72 hrs *100/ Total No Of ER Patients	Monthly

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REFERENCES: NABH 6TH EDITION COP 2h

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Document Title : Managing Brought Dead Cases			

PURPOSE AND SCOPE

This policy and procedure aims to guide the process of managing Brought Dead Cases

RESPONSIBILITIES

Medical Director

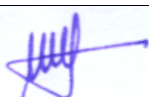
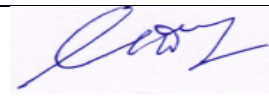
The overall responsibility of implementing the policy rests with the MD of the hospital.

HOD – Emergency Care Unit

Is responsible to ensure that the policies pertaining to MLC are ensured

POLICIES

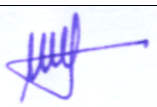
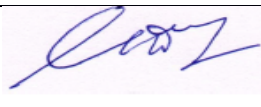
- Register all brought dead cases as medico-legal cases and should be intimated to police.
- On arrival, the Emergency Medical officer should examine the patient thoroughly. Medico Legal Case has to be registered.
- After complete examination and confirmation by clinical evaluation and electrocardiographic examination, death is confirmed, the individual should be declared as Brought in Dead (BID) and the accompanying relatives/friends must be explained. Care should be taken to ensure the presence of security staff at the time of declaration of death. The local police should be informed immediately as a policy. The police will do the further disposal of the dead body after inquest. The Emergency Medical Officer will render necessary assistance.

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Document Title : Managing Death and Dead Bodies			

PURPOSE AND SCOPE

To guide ECU staff of handling situations of death and dead bodies

RESPONSIBILITIES

Medical Director

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

HOD – Emergency Care Unit

Is responsible to ensure that the policies pertaining to handling of death and dead bodies are followed

POLICIES

- When a patient is brought to ECU and dies immediately after, it is referred as 'Dead on Arrival'. If the clinical history, clinical presentation and investigations (if any) correlate and the CMO/concerned consultant have confirmed the cause of death then a 'Cause of Death' certificate (Form no. 4) is issued.
- In case of maternal deaths, infant deaths or any case which is a medico-legal case, they are referred for a post mortem examination and relevant steps to intimate the district hospital and the police department is followed.
- The death certificate is issued with cause of death mentioned only as 'As per Post- Mortem Examination'.
- Death of a patient is handled carefully with concern without complacency. Counseling of next of kin with sympathy is given at most importance.
- All help in shifting the body from the hospital is extended to the next of kin. The dead body is released as soon as possible after completion of all formalities.
- Care should be taken while moving the dead body by causing minimal disturbance to the adjoining patients and their relatives.

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Document Title : Managing Death and Dead Bodies			

- Acknowledgement for receipt of the body and the Death Certificate is obtained from Next of Kin/Legal representative.
- Handing-over of the body is a solemn occasion and it is ensured that hospital staff takes due care and concern in this respect.
- Due arrangements are made if preserving the body in the mortuary is found necessary.

Security staffs of the hospital are present till the departure of the deceased and ensure orderliness in handing over the body to the next of kin.

References: NABH 6th EDITION COP 2 i

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DOCUMENT TITLE : AMBULANCE COMMUNICATION PROTOCOL			

AMBULANCE COMMUNICATION PROTOCOL

1.0 PURPOSE

To establish a **structured, reliable, and continuous communication system** for ambulance services, ensuring:

- Timely activation and deployment of ambulance services
- Effective coordination between hospital departments and ambulance team
- Real-time clinical communication during patient transport
- Continuity of care between referring, transporting, and receiving teams

This protocol ensures compliance with **NABH COP 3.f and COP 3.g**, which mandate a defined communication system covering the entire patient transport process.

2.0 SCOPE

This protocol applies to:

- All ambulance-related activities including:
 - Patient pickup (Transfer-in)
 - Patient transfer-out (Referral)
 - Inter-facility transport
 - Emergency transport
- All staff involved:

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- Reception / Call handling staff
- Emergency / Casualty team
- Treating consultants
- Ambulance team (doctor, nurse, driver)

3.0 POLICY STATEMENT

The hospital shall ensure that:

- A **defined communication pathway** exists for all ambulance services
- Communication is **initiated at first contact and maintained throughout transport**
- Clinical information is **accurately transmitted, updated, and documented**
- The ambulance team remains **connected with the hospital at all times during transport**

The communication system shall be **two-way, continuous, and documented**, ensuring safe patient transport and effective clinical decision-making.

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4.0 CALL RECEIPT AND ACTIVATION PROCESS

4.1 Call Receipt

- All ambulance requests are received at the **Reception / Central Call Desk**
- The receiving staff shall:
 - Record caller details
 - Record patient location
 - Identify nature of request

4.2 Call Escalation

- The call is immediately directed to the **Casualty / Emergency Department**

The emergency team shall:

- Categorize the call as:
 - Transport only
 - Transfer-in to hospital
 - Transfer-out to another facility
- Assess:
 - Severity of patient condition
 - Urgency of transport
 - Distance and logistics

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- Requirement of ALS support

4.3 Decision Making

- The **Duty Doctor / Emergency Physician** shall:
 - Decide on ambulance deployment
 - Determine type of ambulance (BLS / ACLS)
 - Decide requirement of escort staff

5.0 COMMUNICATION WITH AMBULANCE TEAM

- The ambulance driver and ambulance team shall carry **dedicated mobile communication devices**
- The Casualty shall communicate:
 - Patient details (if available)
 - Pickup location
 - Clinical urgency
 - Required equipment and manpower
- The ambulance team shall acknowledge the call and confirm readiness

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6.0 PRE-TRANSPORT CLINICAL COMMUNICATION

6.1 Transfer-In Patients

- Information shall be obtained from referring source:
 - Diagnosis / provisional diagnosis
 - Current clinical condition
 - Treatment given
 - Stability status
- This information shall be:
 - Communicated to the ambulance team
 - Used for preparation of equipment and intervention

Aligns with AAC 3A (Transfer-in policy)

6.2 Transfer-Out Patients

- Communication shall be established with receiving facility:
 - Acceptance confirmation obtained
 - Clinical details shared
- The ambulance team shall be briefed regarding:
 - Patient condition
 - Expected complications
 - Required monitoring

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Aligns with AAC 3B (Transfer-out policy)

7.0 COMMUNICATION DURING TRANSPORT

- Continuous communication shall be maintained between:
 - Ambulance team
 - Casualty / treating doctor
- Communication shall include:
 - Patient condition updates
 - Vital parameters
 - Interventions performed

7.1 Clinical Guidance

- The treating consultant / duty doctor may provide:
 - Instructions for drug administration
 - Airway management guidance
 - Emergency intervention advice
- Communication shall be:
 - Clear
 - Timely
 - Documented

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7.2 Responsibility During Transport

- The **medical personnel in the ambulance** shall:
 - Take immediate clinical decisions
 - Execute interventions
- Telephonic guidance shall support but not replace on-site clinical judgement

8.0 MANAGEMENT OF CLINICAL DETERIORATION

- In case of deterioration:
 - Ambulance team shall immediately inform:
 - Casualty
 - Treating doctor
- Based on communication:
 - Decision may be taken to:
 - Continue transport
 - OR divert to nearest appropriate facility
- The decision shall be:
 - Documented
 - Communicated to relatives and hospital

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9.0 HANDOVER COMMUNICATION

Upon arrival at receiving facility:

- Structured clinical handover shall be given including:
 - Diagnosis
 - Treatment provided
 - Clinical status during transport
 - Interventions performed
- Acknowledgement from receiving team shall be obtained

10.0 DOCUMENTATION REQUIREMENTS

The following shall be documented:

- Time of call received
- Time of ambulance dispatch
- Communication details with referring/receiving facility
- Clinical updates during transport
- Time of arrival and handover
- Name/designation of personnel involved

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11.0 COMMUNICATION SYSTEM REQUIREMENTS

- Ambulance shall be equipped with:
 - Mobile communication device
 - Continuous connectivity
- The system shall ensure:
 - Uninterrupted communication
 - Rapid escalation
 - Real-time clinical coordination

12.0 RESPONSE TIME

- Ambulance shall be mobilized within a **defined time frame** based on urgency
- Delays, if any, shall be documented with reasons

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13.0 TRAINING AND COMPETENCY

- All personnel involved shall be trained in:
 - Communication protocol
 - Emergency coordination
 - Documentation requirements
- Regular drills shall be conducted

14.0 MONITORING AND QUALITY INDICATORS

The hospital shall monitor:

- Response time compliance
- Communication documentation completeness
- Adverse events during transport
- Delays in ambulance activation

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15.0 LINKAGES

This protocol is linked with:

- AAC 3A – Transfer-in of patients
- AAC 3B – Transfer-out of patients
- COP 3 – Ambulance services
- Emergency and Code Blue policies

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AMENDMENT HISTORY

SI No	Current Revision			Nature of Change
	Edition No	Revision No.	Date	
1	01	00	1 Oct 2019	First issue as per NABH Hospital Accreditation Standards – 4 th Edition
2	01	00	1 Nov 2020	Minor Revisions, updating Doc No. 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	No changes review completed.
5	01	02	1 Jan 2026	No changes.

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Disaster Management Plan – Internal & External Disasters

DISASTER MANAGEMENT PLAN



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Disaster Management Plan – Internal & External Disasters

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2. Objectives
3. Scope
4. Overview of the hospital
 - I. Current Human Resources
 - II. Critical Departments
5. HDMC Members
6. Introduction Of Disaster Types
7. HDICC Roles & Responsibilities
8. HIRS
 - I. Planning
 - II. Communication Team
 - III. Safety & Security
 - IV. Logistic & Supply
 - V. Documentation
 - VI. Organogram
9. Triage
10. Training
11. Recovery

Annexure1

Annexure2

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Disaster Management Plan – Internal & External Disasters

➤ Purpose

To establish a written procedure for handling of disasters both external and internal; to ensure both services to community in times of external disaster, to ensure safety to patients and staff during internal disasters and to ensure continuing care to patients already admitted to the hospital in both situations

➤ Objectives

- To define the probable types of disaster events the hospital may face based on a risk identification and analysis process of the hospital with a view of proactively preparing for management of same.
- To optimally prepare the staff, institutional resources and structures of the hospital for effective performance in different disaster situations.
- To define the disaster management structure to be established during disaster and define their roles and responsibilities.
- To define the training and other preparation exercises to be undertaken by the hospital periodically to equipment, test and ensure optimum readiness to handle various disaster events.

➤ Scope

To provide actionable plans for disaster Preparedness, Response and Recovery corresponding to the Pre Disaster Phase, Disaster Phase and Post Disaster Phase respectively.

➤ Overview of the hospital

General hospital saideep is a silent crusader in the field of community services in its own dedicated way. It is the biggest and the most well equipped non Govt. hospital in Ahilyanagar.

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➤ Current Human Resources at Saideep Hospital

SR.No.	Existing Human Resource Capacity	Number
1	Departments	61
3	Doctors	63
4	Administrative Staff	216
5	Para Medical Staff	57
6	Nursing Staff	204
7	Supporting Staff BVG	130
8	Consultant	94

➤ Critical departments

SR.	Critical departments	Remarks
1	Emergency Department's	ED,EOT, OBG ,Neurosurgery ,Trauma surgery
3	Intensive Care Unit	SICU,ICCU,MICU, Cathlab, NICU
4	Operation Theater	6
5	CSSD	1
6	Maternity	24Hr. Maternity Services
7	Radiology	24 Hr. X-ray ,CT Scan , MRI , USG

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Disaster Management Plan – Internal & External Disasters

➤ HDMC Member:

Name of Member	Designation
Dr.S.S.Deepak	Chairman
Dr.Venktesh Mule	General Manager Operations
Dr.Hrishikesh Kalgaonkar	Senior Manager Of Clinical Services
Dr.Sunil Darandale/Dr.Vikas Labade	MCO
Mr. Vilas Kalbhor	Facility Manager
Mr.Vinay Pimparkar	Purchase Officer
Mr. Santosh Sangale	CNS
Mrs.Renuka Sonawane	Quality Co-Coordinator
Mr.Sanjeew Dayma	Public Relation Officer
Mr.Kishor Pipada	Account HOD
Dr.Nandkishor Mantri	Cashless HOD
Mr.Prakash Gadekar	Engineering HOD
Mr.Irfan Shaikh	Security HOD
Mr.Shivaji Pulate	Information Technology
Mr.Rajendra Shrimandilkar	Human Resource
Mr.Deepak Kale	Pharmacy In charge
Mr. Akshay Navale	Fire Safety Officer
Ms. Tejal Garje	Training Manager
Ms.Srushti Munot	Admin
Mr.Yogesh Bhadange	Housekeeping HOD
Dr.Monali Gore	MRD In-charge
Mr.Khillare Permeshwar	SR. Biomedical Engg.
Mrs.Vanita Labade	Lab
Mr.Satish Damale	Casualty Nursing In charge
Mr.Dipak Kale	Pharmacy Manager

The HDMC shall be responsible for:

- Drafting and endorsement of the hospital disaster management plan;
- Operationalization , review and updating the plan;
- **Conducting regular drills, at least two table top exercises and one drill on an annual basis;**
- Ensuring all staff are sensitized on the plan through dissemination meetings;
- Ensuring all new staff have disaster management training;
- Ensuring all the Head of Departments (HOD's) and In-Charges of Wards/Departments develop job-cards (detailing actions during emergencies) for every staff member as per the roles and responsibilities.

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Disaster Management Plan – Internal & External Disasters

Command Centre:-

HIRS ROLE	POSITION
Incident Commander	On duty senior staff
Deputy Incident Commander	On duty senior staff

Operation Section Chief:-

HIRS ROLE	POSITION
Operation In charge	On duty senior staff

Medical Care Branch:-

HIRS ROLE	POSITION
Casualty medical Officer	On duty senior staff

Support Services Branch:-

Laboratory	On duty senior staff
Radiology	On duty senior staff
Linen & Laundry	On duty senior staff
Dietary Service	On duty senior staff
CSSD	On duty senior staff
Housekeeping	On duty senior staff
Maintenance	On duty senior staff
Transportation	On duty senior staff

Finance Section:-

Finance	On duty senior staff
Claim	On duty senior staff

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Disaster Management Plan – Internal & External Disasters

➤ Identification of Probable types of Disasters in Ahilyanagar District

Saideep Hospital team has identified the following disasters as probable based on the HIRA process followed as part of the Risk Management process under the hospital Patient Safety Program.

Probable Disasters

No	Type	Event
1	External	1. Road / Rail Accidents 2. Industrial Accidents 3. Weapon / Explosive Related Accidents 4. Festival Related Accidents 5. Civil Disorder 6. Fire 7. Military Related Accidents 8. Medical Biological accidents 9. Extreme Heat 10. Earthquakes
2	Internal	1. Mob Violence Against Hospital 2. Fire 3. Medical Gas/ Chemical Failure 4. Infrastructure Failure 5. IT Failure

1. HOSPITAL DISASTER INCIDENTS COMMAND CENTER

During a disaster, the SDH team will establish a Hospital Disaster Incident Command Centre (HDICC) for prompt mobilization and coordination of personnel, equipment and supplies. Since disasters are situations where the normal operations of the hospital are, or have potential, to rapidly become overburdened to the extent that additional measures and resources must be mobilised in order to necessary medical care and maintain hospital operations.

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Disaster Management Plan – Internal & External Disasters

Key Roles of the HDICC

To ensure that the hospital must be prepared to:

- Receive and classify patients
- Provide emergency casualty care
- Provide continuing care for the hospital's pre-disaster critically ill patients
- Evaluate non-critical pre-disaster patients for possible transfer home or another designated location
- Maintain adequate records on casualty patients
- Provide information and facilities for federal agencies, members of the press, city, state, the clergy, patient families, employees, and the general public
- It is the crucial point for onsite and off –site communication during disaster/emergency**

Structure and Function

The Hospital plan will contain the following structure and personal incident command centre of the hospital.

➤ Command Centre

- To lead and direct the overall facility mobilization and response to an emergency.
- A vest labelled with job title will identify each staff in the Command Centre.
- Command Centre will be located near the emergency entrance of the hospital.

➤ Incident Commander

- The Incident Commander position shall be filled in normal working hours by one of the following – Medical Director(s), Chief Medical Administrator, Medical Superintendent, and Nursing Superintendent. In the night hours the Manager on Duty will automatically assume the position till relieved by one of the above mentioned
- Bears the responsibility for ensuring that the entire response is carried out in an effective, efficient and, coordinated manner.
- Gives overall direction for hospital operations and if needed, authorize evacuation.
- Incident Commander will appoint the following:
 - Command Centre Recorder
 - Medical Section Chief
 - Logistics Section Chief
 - Nursing Section Chief
 - Medical Director
 - Security Section Chief

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- g. Hospital support and Operations Section Chief
- h. Finance Coordinator

Each of these section chiefs shall wear a vest with their title labelled boldly.

Each Section Chief's function may vary according to the type of emergency. However, their overall responsibilities will include the following:

➤ **Documentation**

- Record incident-related problems
- Record any other documentation necessary as directed by the Incident Commander.

➤ **Logistics Section**

- Organize and direct operations to maintain the physical environment
- Maintain adequate levels of food, shelter and supplies supporting the medical objective.

➤ **Nursing Section**

- Organize and coordinate nursing activities.
- Direct patient care services.

➤ **Medical Section**

- Contact and coordinate physicians.
- Credential volunteer medical staff as necessary.
- Assist in assigning available medical staff.

➤ **Security Section**

- Coordinate all security operations in support of the disaster situation.
- Serve as liaison to Fire Department.
- Secure all hospital entrances/exits.
- Control traffic flow in and adjacent to Emergency Department/Disaster location.

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➤ Hospital support and Operations Section

- Protect, evaluate, control, repair and maintain plant and utility systems necessary for patient care in support of the disaster condition.
- Implement back-up measures in the event of utility failures.
- Assign Unit Leaders for power, water, HVAC, electric and medical gases.

➤ Finance Coordinator

- Monitor the utilization of financial assets in support of the emergency operation.
- He/she will maintain all related documentation necessary for managing facility record keeping and reimbursement.

➤ Public Relation Officer

- PRO shall ensure clear, accurate and timely communication and information is passed on to management (both internal and external) to ensure informed decision- making, effective collaboration and cooperation, and public awareness through the use of common terminologies, integrated communication and an efficient system of alert.
- PRO shall communicate with the District Disaster Management System & other key stake holders like Police, Fire Services, NDRF as well as other healthcare facilities managing patients in the same catchment area by establishing a regular channel of communication with them to manage the disaster more efficiently.
- In case of a biological / epidemic emergency, the PRO shall inform to the highest health authorities at the earliest.
- PRO shall also be responsible for providing information to the relatives of admitted or shifted patients, on being approached, regarding the whereabouts and conditions of the patient.
- To displayed list of casualties along with their status shall be displayed at a prominent place outside the casualty / emergency ward, in both English and the local language, which shall be periodically updated.
- PRO is responsible for the press releases after consultation with the Incident Commander.
- They shall at all moments keep the Incident Commander updated of all happenings at site.
- They shall ensure that all communications modes/lines are kept available to the maximum extent as possible.
- availability of reliable and suitable primary and back-up communication system
- Establish an Information desk to provide the requisite information at regular intervals and to serve as a hub for volunteer mobilization and management.

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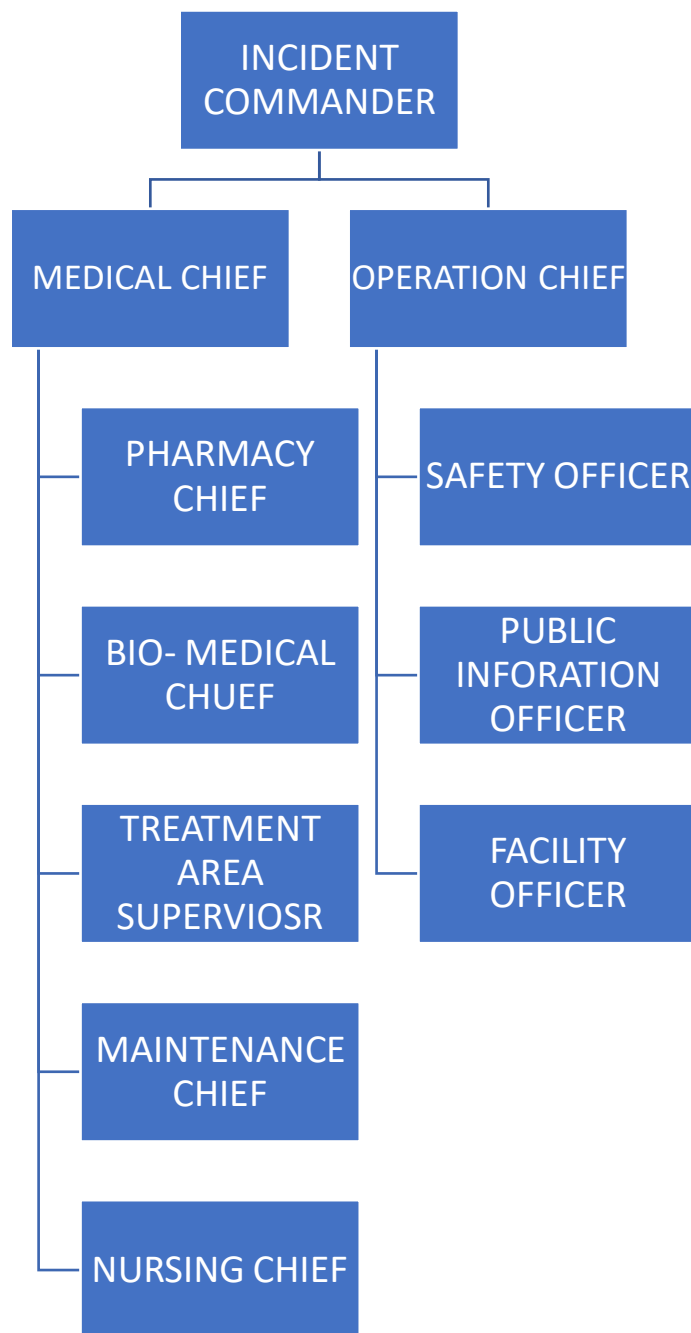
III. HOSPITAL DISASTER INCIDENT RESPONSE SYSTEM (HIRS)

These focus on provisions required to be put in place to ensure functional safety of hospital in disaster situations. The prime objective of disaster preparedness and response for hospital is to ensure that they can remain functional and continue providing the necessary health care services during and immediately after an emergency.

To enable effective preparedness for and response during disasters, an efficiently functioning HDIRS is established in hospital. The overall organisation and command structure for the HDIRS is provided below

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ORGANOGRAM



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A. Key Actions to be Ensured Under Hospital Disaster Incident Response System (HDIRS)

➤ Incident Commander Key Decisions

- Take charge of the disastrous scenario as soon as the first information arrives.
- Assess the situation and decide whether any external help would be required or not.
- Take a decision on which hospitals to be called for mutual aid.
- Review the press releases and information which is to be passed on to the statutory bodies and stakeholders
- Approve the financial budgets required for dealing with the emergency

➤ Planning

- Identify minimum needs in terms of health-care workers and other hospital staff to ensure the operational sufficiency of the hospital/department in emergencies
- Establish a contingency plan for provision of food, water and living space for hospital personnel during disasters
- Prioritize staffing requirements and resultant deployment
- Recruit and train additional staff according to the anticipated need
- Establish a clear policy to address the needs of ill or injured family members or dependants of staff
- Ensure adequate staff capacity and competency in providing high demand clinical response services during emergencies by providing training and exercises
- Ensure adequate shifts and rotation and self-care of clinical staff as well as domestic support measures to support staff to work for long hours
- Ensure adequate capacity of the local community to facilitate hospital services during emergencies
- Ensure adequate measures to deal with psychosocial and mental health issues of hospital staff and their families
- Ensure that the personnel dealing with contagious diseases are provided with appropriate Personal Protective Equipment (PPE) and interventions (eg. Vaccination)

➤ Communication

- The team shall ensure clear, accurate and timely communication and information is passed on to management (both internal and external) to ensure informed decision-making, effective collaboration and cooperation, and public awareness through the use of common terminologies, integrated communication and an efficient system of alert.
- They shall communicate with the District Disaster Management System & other key stake holders like Police, Fire Services, NDRF as well as other healthcare facilities

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managing patients in the same catchment area by establishing a regular channel of communication with them to manage the disaster more efficiently.

- In case of a biological / epidemic emergency, the team shall inform to the highest health authorities at the earliest.
- They shall also be responsible for providing information to the relatives of admitted or shifted patients, on being approached, regarding the whereabouts and conditions of the patient.
- The list of casualties along with their status shall be displayed at a prominent place outside the casualty / emergency ward, in both English and the local language, which shall be periodically updated.
- They shall be responsible for the press releases after consultation with the Incident Commander.
- They shall at all moments keep the Incident Commander updated of all happenings at site.
- They shall ensure that all communications modes/lines are kept available to the maximum extent as possible.
- Ensure availability of reliable and suitable primary and back-up communication system
- Establish an Information desk to provide the requisite information at regular intervals and to serve as a hub for volunteer mobilization and management.

➤ Safety & Security

- The hospital security team shall be responsible for all hospital safety and security activities
- Prioritize security needs of the hospital and identify areas where increased vulnerability is anticipated
- Ensure early control of facility access points, triage, and other areas of patient flow
- Establish reliable modes of identifying authorized hospital personnel, patients, patient's attendants and visitors
- Establish mechanisms to escort medical personnel related to disaster relief to the patient care areas when needed
- Deploy security measures required for safe and efficient hospital evacuation
- If any external rescue, fire fighting etc. services are engaged then the security team shall ensure efficient guidance to the external services regarding the access and routes.
- Solicit inputs from the hospital incident committee regarding challenges and constraints in prevention and control of hospital infection
- Aid the local police in implementing law enforcement
- Establish an area for radioactive, biological and chemical decontamination and isolation

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➤ Logistics Supply & Finance

- The store and finance team shall ensure logistics, supply and finance during disaster
- Develop and maintain an updated inventory of all equipment, supplies and pharmaceuticals and establishment of a shortage-alert mechanism
- Estimate consumption of essential supplies and pharmaceuticals in a disaster scenario and arrange for additional supplies from store
- Consult with authorities to ensure the continuous provision of essential medicines and supplies
- Assess the quality of the contingency items prior to purchase
- Establish contingency agreements with vendors to ensure the procurement & prompt delivery of equipment and supplies in a disaster situation
- Develop mechanisms for storage and stockpiling of additional supplies including pharmaceuticals
- Establish mechanisms for quick assessment of the functional status of different equipment and prompt maintenance and repair of those equipment required for essential services
- Define the hospital pharmacy's role in providing pharmaceuticals to patients being treated at home or at alternate treatment sites
- Establish coordination for a contingency transport strategy for patient transfer
- Establish a simple disaster budget protocol for quick mobilization of funds for disaster response
- Ensure availability of petty cash/dedicated contingency fund which could be used for disaster response
- Introduce special accounting policies and procedures for efficient financial management during emergencies
- Ensure sufficient food and shelter amenities for the affected, visitors and staff.

➤ Responsibilities of Hospital Operations team

- The housekeeping, medical support, nurse & doctors staff shall make the operations team
- They shall prepare a human and material resource plan and coordinate with the planning team for the deployment of personnel
- They shall intimate the stores regarding the stock of pharmaceuticals materials that would be expected to be consumed
- They shall coordinate with the logistics team and understand as well as update themselves with the flow of patients
- They shall be responsible for triage

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- Coordinate with the housekeeping team for the supply of fresh beddings and disposal of wastes
- Coordinate with the security team for the identification and entry of authorised personnel on the floor
- Prioritise the patients and arrange the evacuation accordingly whenever the need is required
- Coordinate with rescue team to guide the rescue of stranded or dependent patients
- Keep the logistics department apprised of the admitted patient's conditions for them to coordinate with the visitors and relatives of the patients.

➤ Documentation

- All Medico-Legal Cases shall be recorded properly. However, the treatment of patients will get priority over paperwork.
- To meet the surge of cases, additional medical records assistant/ technician shall be posted from the Medical records section.
- Computerised documentation (or manual) will be beneficial for the staff, police, next of kin and the press. Details of the casualties received and being admitted, their clinical condition, along with colour coordinated classification status by Triage shall be documented, for a credible database, for efficient retrieval of information to cater to any post-incident treatment/medico-legal/financial issues arising at a later date.

Triage

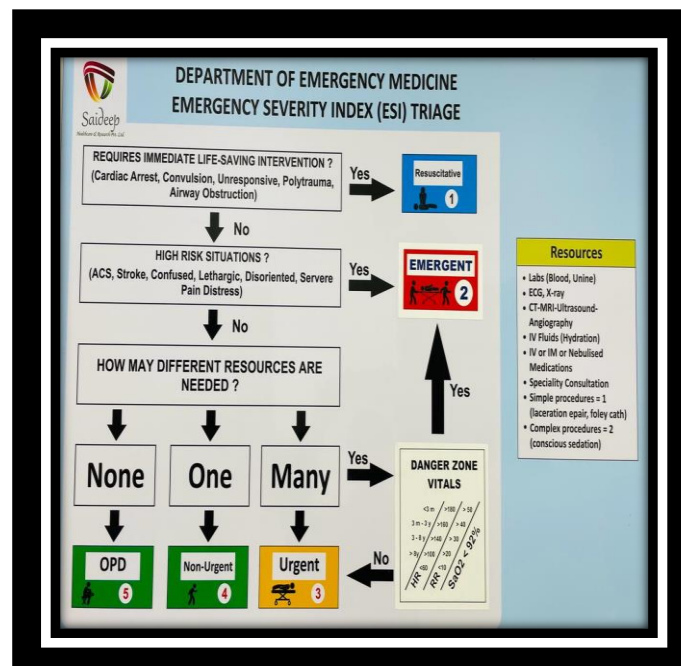
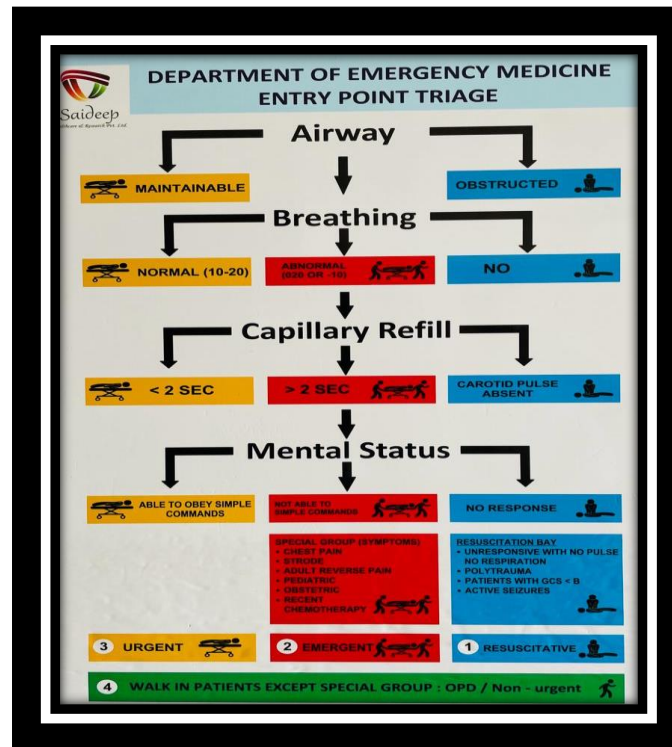
- Triage is the process of sorting injured people into groups based on the severity of their conditions, so that the most serious cases can be treated first. The hospital shall ration patient treatment efficiently when resources are insufficient, by undertaking triage based on the philosophy that '**the sickest is seen first**'.

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➤ Triage:-

Priorities of Care and Triage Categories:

- Standardized triage categories are usually developed within each ED.

- Most common triage systems consist of five levels of acuity:

1. Triage Level I - Resuscitation

2. Triage Level II - Emergent.

3. Triage Level III- Urgent.

4. Triage Level IV -Less Urgent.

5. Triage Level V –Non-urgent.

Level-1	Resuscitation	See the patient Immediately
Level-2	Emergency	15 Minutes
Level-3	Urgency	30 Minutes
Level-4	Non Urgency	60 Minutes
Level-5	OPD level	120 Minutes

TRAINING FOR DIASTER MANAGEMENT

Staff Training

- All hospital staff shall be regularly oriented to the Hospital Disaster Management Plan annually and especially each time the plan is updated or modified.
- Regular Training and capacity building will focus to enhance the staff capacity and competency in providing high demand clinical services during emergencies.
- **Drills**

The hospital conducts periodic drills and rehearsals to test the response capabilities to emergencies in real time and serve as opportunities for practical learning for the hospital staff.

SDH conducts the following types of drills alternatively every six monthly

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Table Top Exercises

An exercise is intended primarily for the administrators, managers and personnel who could conceivably be placed into an HDICC's roles upon activation of the disaster management plan.

The themes of the table top exercises are varied to develop and sharpen responses to various disaster scenarios.

The table top exercise is videographer for further analysis of the adequacy of the exercise and an assessment report is prepared and submitted to the review of hospital patient safety committee and CMD

Partial evacuation/Non-evacuation Drills & Mass Casualty Incident (MCI) Response Drills

Partial evacuation / Non-evacuation Drills will focus on handling internal disasters requiring evacuating of the patients including critical patients. This exercise may be combined with Fire Drills / Code Red Mock Drills of the hospital. Hospital will do an ICU evacuation drill & award evacuation drill once a year as a part of Disaster Drill or Fire Fighting Drill.

The MCI drill will check the resilience of the Emergency Care Unit systems in terms of capacity & capability when faced with an extraordinary surge of patient's external disaster. It is recommended to Hospital shall carry out a MCI drill once a year.

SDH will conduct one of the above exercises alternatively to build and test evolving capabilities of the hospital disaster management system

V. POST-DISASTER RECOVERY

Post-disaster recovery planning shall be part of the Hospital Disaster Management Planning process and it shall be performed at the onset of response activities.

To ensure speedy and effective post-disaster recovery the hospital will

1. Designate an official/member of the staff to oversee the hospital recovery operations
2. Undertake a Post Disaster Damage Assessment if there is structural damage to the hospital in case of internal disasters like fire and external like earth quake or flooding
3. Estimate the time and resources that shall be required to undertake complete repair/replacement/retrofitting before a facility that is severely damaged (and requires complete evacuation) can be re-opened

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- Undertake a post-response hospital inventory assessment and consider repair or replacement of equipment as required (equipment vendors could be involved in assessing the functional status of the sophisticated equipment)
- Prepare and submit a post-response report to the CMD hospital and Board of Directors
- Debrief staff meticulously immediately after the disaster response phase to enable them to cope and recovery from any post-traumatic stress disorder.
- Appropriately recognize the services provided by staff, volunteers, external personnel and donors during disaster response and recovery
- Monitor post disaster health situation in the local community in coordination with District administration / NDRF where required
- Systematically and comprehensively document lessons learnt and structural modification/adaptation of the hospital contingency plan as required

Annexure: 1

- List of Item Disaster Management Initial Supplies Kit
- Key Response Points for Probable Types of Disasters in SDH

Annexure 2 – Key Response Sequences for Various Types of Disasters

A. Mass Casualty Incidents

- Verification of Mass Casualty Incidents – The CMO will coordinate with Chief Medical Administrator (alternatively MS / Manager on Duty during night hours) to contact Police, Civil Administration, Civil Hospital, Other hospitals to verify the nature and extent of the incident. Efforts to be made to estimate possible no of casualties
- ECU Preparedness Huddle / Briefing – Quick stand-up huddle by CMO and ECU team to prepare for the MCI surge and verifying current patient in unit, staff availability
- Support System Alert – CMA / MS will alert the following departments for activating them on a standby mode – ICU, Diagnostics, Security, Central Pharmacy, Materials Management, Facility Management and Housekeeping
- CMA to Alert top Management – CMD, Medical Directors etc
- Initiate Code Yellow Announcements
- Operations Team to contact off duty staff / On-Call Staff / On Leave Staff to alert
- ECU and ICUs to start quick discharge and transfer protocols for stable patients to free beds to handle MCI

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8. Initiate and establish Incident Command Center on confirmation of MCI
9. Establish Entry Triage
10. Establish security parameters and restricted entry to campus

B. Fire Incidents

1. Announce and initiate Code Red
2. Contact Fire Force and initiate fire fighting
3. Initiate and establish Incident Command Center and coordinate fire fighting
4. Incident Commander to inform top management – CMD, Medical Directors etc.
5. Establish separate “safe zones” for staff and patients evacuated manned by security staff
6. Initiate patient and staff evacuation – Affected zones first.
7. ICC to establish contact to external resources – ambulance services, hospital to care for evacuated patients
8. Evaluate for complete building evacuation

C. Mob Violence

1. Announce and initiate Code Violet
2. Initiate and establish Incident Command Center
3. Incident Commander to inform Police / Law Enforcement
4. Security Officer to contact security service agencies for additional security personnel where needed. Recall off duty security staff
5. Incident Commander to inform top management – CMD, Medical Directors etc.
6. Try and contain impact by evacuation affected zone staff and patients to other areas and creating a security barrier
7. Coordinate with law enforcement of their arrival.
8. Create emergency care in for first aid and resuscitation of inured persons at a selected inpatient area like Day Care ward. Mobilize Disaster Management initial supply kit for medical supplies and medicines
9. ECU and ICUs to start quick discharge and transfer protocols for stable patients to free beds to handle injured people
10. ICC to establish contact to external resources – ambulance services, hospital to care for inured persons spill over
11. Security and IT to secure all CCTV footage of incident for hand over to law enforcement
12. Secure hospital assets like equipment and furniture.
13. Security to secure and take control of premises with help of police and conduct facility round to identify and evacuate any unauthorized person

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14. Cordon off affected / damaged areas with security personnel placed with access to only police, law enforcement officials and select hospital staff
15. On permission from law enforcement Facility Management and housekeeping team to initiate removal of debris, cleaning and repair works

Reference:

https://mahadish.in/media/front/images/disaster-management/ahamadnagar_offsite_dm.pdf

AMENDMENT HISTORY

Sl. No	Current Revision			Nature of Change
	Edition No	Revision No.	Date	
1	01	00	1 Oct 2019	First issue as per NABH Hospital Accreditation Standards – 4 th Edition
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Chapter: COP 6 A
 Nursing care is provided to patient in accordance with written
 guidance
 Refer Nursing department Manual

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PURPOSE

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

RESPONSIBILITY PERSON

Head-Department of various Clinical Departments

SCOPE

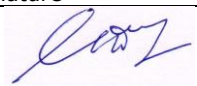
This policy is applicable in all clinical departments with diagnostic and therapeutic procedures not amounting surgery like;

- Cardiac Catheterisation Laboratory
- Endoscopy, Bronchoscopy etc.
- Dental Procedures
- Gynaecology / Labour Room – MTP etc.

POLICY

1. Qualification of staff:

All clinical procedures will be performed by clinicians qualified and privileged to perform the same. Each department will maintain a list of clinical procedures performed by department / unit and the clinicians who are privileges / authorised to

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perform the same. A copy of the list will be sent to the Medical Executive Committee and the list shall be updated by the Head of the Department of each clinical department at least once a year.

2. Pre-procedure Assessment:

Each clinical unit will maintain a list of pre-procedure evaluations / tests to be undertaken for each clinical procedure under their department. The respective nurses in the in-patient areas / ambulatory care areas will be responsible to ensure that the pre-procedure check –ups are done.

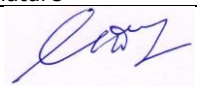
2. Pre anaesthesia Check up:

Pre-anaesthesia evaluation will be done for the patients where the procedure is conducted under anaesthesia or mild sedation. The same is not applicable where cases are done under local anaesthesia.

3. Pre-procedure Preparations and Medications

Each clinical unit will maintain written instruction for pre-preparation of patients required for each type of procedure. These may include site preparations or enemas etc.

Wherever possible the nursing units will use checklist based on the instructions to check and record whether the required preparatory activities for the clinical procedure has been performed. The nurse responsible for pre-paring patient will sign the checklist and in the absence on one will record the status of preparation with time in the nursing note section of the clinical case record.

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4. Informed Consent for Procedures:

Consent for the patients and or relatives for the clinical procedure should be obtained by the clinician performing the procedure or a clinician who member of the team / unit in the specified format after explaining the following details:

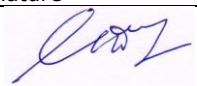
1. Nature of Procedure
2. Reason for the procedure.
3. Expected Outcome.
4. Risk Involved.
5. Expected duration of recovery
6. Other treatment options etc.

The consent is obtained from the patient and or the surrogate (Refer Informed consent Policy) as per the hospital's policy a day prior to the scheduled date for the surgery.

6. Prevention of Wrong Procedure/Side/Site and Wrong Patient:

The prevention of wrong site/side/procedure and patient begins with the preoperative evaluation of the patient.

This involves the following activities such as marking of the procedure site, verification of patient prior to the shifting of the patient from the ward to the OT, at the time of patient's entrance to procedures and prior to the initiation of the procedure etc

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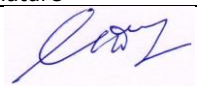
The policy for prevention of wrong procedure/side/site and patient could be referred for the hospital's detailed policy.

7. Transfer of Patient to Procedure Area:

- Prior to the transfer of the patient the ward nurse informs the nursing/ technician in-charge of the procedure area about the patient details and confirms the scheduled time for procedure forty five minutes prior to the scheduled time of procedure.
- The ward nurse prior to the transfer of the patient ensures that the nurse's pre-procedure checklist is dully filled and all the patient details as required by the clinicians are arranged in the proper order.
- The patient is transferred to the procedure area as per the hospital's intramural transfer policy.
- In case of day care procedures the above activities of pre-procedure preparation will be done by the nursing staff of the procedure area itself.

8. Receiving of patient and immediate pre-procedure assessment:

- The patient is received in the procedure room / is by the nursing staff attached to the unit.
- The nurse in-charge of the procedure area evaluates the patient's details and checks the pre-procedure nursing checklist filled by the ward nurse to ensure the patients preparedness and confirms the patient's identity as per the bed head ticket.

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- c) The patient is transferred to the procedure area where the concerned clinician and anaesthetist (for procedures requiring anaesthesia) undertake immediate preoperative evaluation.

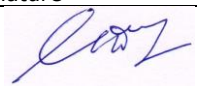
9. Post Surgery process:

- Post procedure patient is shifted to appropriate care areas (to the CCU for example for post Cath lab procedures) to their rooms / wards as required. For procedures done on ambulatory / day care basis the patient may be discharged based on observations..
- Copies of procedure note v/ procedure reports shall be prepared by the procedure team and signed by the clinician performing the procedure and attached to the clinical case records..
- The clinician performing the procedure documents the post procedure condition of the patient, post procedure treatment plan etc.
- Post-operative treatment plan includes informs regarding the need for keeping the patient under intensive care, post procedure medications , examinations required if any etc.

10. Quality Assurance Programme for Procedure Units:

All procedure areas will keep the following QI data and analyse the same periodically

- Cancellation of scheduled procedure with reasons
- Adverse Reactions / Incidents concerning patient safety
- Infection / complications in procedure sites where applicable

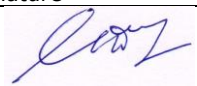
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- Unplanned conversion / usage of anaesthesia
- Malfunctioning of equipment used for performing the procedure or monitoring / diagnostic evaluation of the patient.

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	POLICY ON PREVENTION OF ADVERSE SURGICAL EVENTS		

POLICY ON PREVENTION OF ADVERSE SURGICAL EVENTS

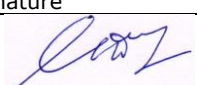
1.0 Purpose

Care is taken to prevent adverse events like the wrong site, wrong patient and wrong surgery. Written guidance shall be available for preventing adverse events like the wrong site, wrong patient, and wrong surgery by a suitable mechanism. The organisation shall be able to demonstrate methods to prevent these events, for example identification tags, badges, cross-checks, time-outs etc. Marking the surgical/invasive site involves the patient and is done with an instantly recognisable and unambiguous mark.

2.0 Scope

This policy applies to:

- All surgical and invasive procedures – elective, emergency, obstetric, laparoscopic, endoscopic, day-care, minor and complex – performed at this hospital
- All Operation Theatres (Major OT, Minor OT, Emergency OT, Obstetric OT), Procedure Rooms, Endoscopy Suites, Cardiac Catheterization Laboratories, Radiology Intervention Suites, and any setting where a surgical or invasive procedure is performed
- All personnel involved in surgical and perioperative care: Surgeons, Surgical Assistants, Anaesthesiologists, OT Nurses, Scrub Technicians, Circulating Nurses, OT Orderlies, Pre-Operative Nurses, Recovery Room Nurses
- Junior residents, senior residents, interns, and visiting surgeons

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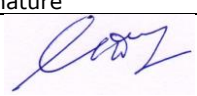
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	POLICY ON PREVENTION OF ADVERSE SURGICAL EVENTS		

3.0 Responsibility

Operating Surgeon	Accountable for correct patient, correct site and correct procedure; performs or supervises site marking; co-leads time-out; countersigns operative note if prepared by another team member
Anaesthesiologist	Leads Sign-In phase of WHO SSC; verifies patient identity, site and procedure before induction; co-leads time-out; co-leads Sign-Out
OT Nurse / Circulating Nurse	Initiates and leads time-out; completes WHO SSC documentation; verifies counts at Sign-Out; ensures checklist is archived with case record
OT In-Charge / Supervisor	Monitors daily compliance with SSC and Universal Protocol; escalates non-compliance; submits monthly compliance data to QM
Quality Manager	Maintains policy; monitors quality indicators; coordinates NABH assessor-facing evidence; processes incident reports;
Medical Superintendent / Medical Director	Overall accountability: reviews sentinel event reports; approves corrective actions; chairs RCA for any wrong site/patient/surgery event

4.0 Policy Statement

This hospital is committed to the absolute prevention of wrong site, wrong patient and wrong surgery adverse events. Written guidance shall be available, implemented, and demonstrable at all times
(Ref: WHO Surgical Safety Checklist)

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	POLICY ON PREVENTION OF ADVERSE SURGICAL EVENTS		

5.0 Procedure

The following table summarizes the NABH COP 14.d-mandated prevention mechanisms for each category of adverse event:

Wrong Patient & Wrong Surgery	• Use identification tags and wristbands • Perform cross-checks at every handover • Perform mandatory time-outs	WHO SSC Sign-In Phase Patient ID Wristband Policy
Wrong Site	• Be consistent in marking surgical sites with an instantly recognizable and unambiguous mark • Mark shall be visible in procedural field when draping is complete • Mark at minimum all procedures involving laterality, multiple structures (fingers, toes, lesions), or multiple levels (spine)	WHO SSC Sign-In: 'Is the site marked?' Written alternative process for exceptions (Note: There shall be a justifiable reason for any exception to site marking)

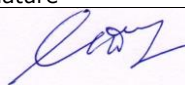
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5.1 WHO Surgical Safety Checklist – Three-Phase Implementation

The WHO Surgical Safety Checklist and JCI Universal Protocol are implemented together across three phases. Compliance with all three phases is mandatory for every surgical case:

Patient confirms: • Identity • Site • Procedure • Consent Site marked / Not applicable Anaesthesia machine & medication check complete Pulse oximeter on patient & functioning Known allergy? No / Yes Difficult airway / aspiration risk? No / Yes + equipment available Risk of >500 ml blood loss? No / Yes + 2 IVs + fluids planned	MANDATORY: Held immediately before first incision. All activity ceases. All team members participate. Team introduces by name & role Verbal agreement by ALL members on: • Correct patient identity • Correct surgical site • Correct procedure to be performed Anticipated Critical Events: • Surgeon: Critical steps? Duration? Blood loss? • Anaesthesiologist: Patient-specific concerns? • Nursing: Sterility confirmed? Equipment concerns? Imaging displayed? • Antibiotic prophylaxis within 60 min? NOTE: Procedure NOT started until ALL concerns resolved. Fresh Time-Out required if	Nurse verbally confirms: • Name of procedure recorded • Instrument, sponge and needle counts correct (or N/A) • Specimen labelling verified – read aloud, including patient name • Equipment problems to be addressed Surgeon, Anaesthesiologist & Nurse review: • Key concerns for recovery and management
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	surgeon changes for a subsequent procedure.	
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5.2 Time-Out Rules – Non-Negotiable Requirements

- The time-out is conducted immediately before the first surgical incision – not before anaesthesia, not before draping, but immediately before the incision.
- A designated team member (typically the circulating nurse) initiates the time-out.
- ALL active members of the operative team must cease their current activity, participate, and give verbal confirmation.
- The time-out is standardized and uses the approved WHO SSC form for this hospital.
- If any team member raises a concern or there is any disagreement during the time-out, the procedure shall not proceed until the issue is resolved.
- When the same patient has two or more sequential procedures and the performing surgeon changes between procedures, a fresh time-out shall be conducted before each procedure.
- The completion of the time-out shall be documented in the OT nursing record and the completed WHO SSC form shall be filed in the patient's case record.

5.3 Patient Identification Mechanisms

- All patients entering the OT complex shall wear an identification wristband containing: Patient Name, MRD/Hospital Number, Date of Birth/Age, Ward/Bed Number.
- Patient identity shall be verified using two identifiers at each of the following points: (a) admission to the pre-operative holding area, (b) on transfer to the OT table, (c) during the WHO SSC Sign-In phase, and (d) during the time-out.
- The identity verification shall be cross-checked against the patient wristband, OT list, consent form, case sheet, and radiological imaging (where applicable).
- If an identity discrepancy is found at any point, the procedure shall be halted and the discrepancy resolved before proceeding.
- Unconscious or sedated patients who cannot self-identify shall be identified by the accompanying ward nurse from the case sheet and wristband.

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5.4 Documentation Requirements

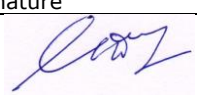
The following documents shall be maintained as evidence of compliance with this policy:

- Completed WHO Surgical Safety Checklist (original filed with each patient's case record)
- Pre-operative checklist / patient identification verification form
- OT nursing record confirming time-out completion with date, time, and team member names
- Incident reports for any near-miss, wrong site, wrong patient, or wrong surgery event with RCA reports and corrective action plans for all Moderate/ serious deviations
- Monthly SSC compliance audit reports
- Staff training records

Reference:

NABH Accreditation Standards for Hospitals, 6th Edition – COP 07 d

Sl. No	Current Revision			Nature of Change
	Edition No	Revision No.	Date	
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 the 6 th Edition
5	01	02	1 Jan 2026	No changes.

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PURPOSE:

To guide staff on appropriate handling of blood and blood components.

SCOPE:

Hospital wide.

INDICATION:

Pre-OP

Emergency

Maintenance

Ordering a Transfusion

Blood and blood components can only be prescribed by a qualified medical practitioner. All blood products must be prescribed and ordered by a doctor for a named patient. It shall be the doctor's discretion to decide whether to prescribe whole blood or blood components for the patient.

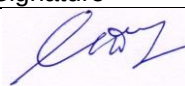
Blood Transfusion Request Form

Once prescription for blood/blood component is made by the doctor for an identified patient, a request form for cross matching and necessary lab investigations shall be made in the patient's name.

Request forms shall contain the following details and scanned copy of form can be attached.

- Patient name
- Age
- MRN number
- The date and time required
- Blood component required
- No of units
- Special instructions
- Previous reactions

Prescriptions for blood products must be clean and unambiguous

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Sample Collection, Timing and Testing

Sample collection is fundamental to the safety of blood transfusion. Sample shall be collected from all patients undergoing surgical and obstetrical procedures. The sample shall be taken by appropriately trained clinical lab personnel.

2 ml EDTA and 2 ml plain sample is collected. Those who collect blood sample shall use Vacutainer system to reduce the risk of sample haemolysis and sample leakage.

It is important that the tube is correctly filled and that the blood is not haemolysed or clotted. If in doubt, it is better to take the sample again rather than delay the transfusion or further inconvenience the patient later.

Regular TAT is one hour.

Emergency TAT is 30 Minutes

Sample shall be labeled at bedside or immediately after collecting from the patient.

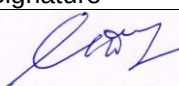
The sample tube must be labeled with:

- Hospital number
- Name of patient
- Collection Date and time

Inadequately labeled, mislabeled, discrepantly labeled samples and forms, or under-filled samples will be rejected by the Blood Bank, and will have to be repeated, so the concerned personnel have to be careful while furnishing these details.

The blood transfusion request form and sample(s) should be sent to the Blood Bank. Urgent requests, in addition, should be phoned to Blood Bank to help prioritize the work on receipt of the sample.

All activities related to the transfusion of blood should be in accordance with the Drugs and Cosmetics Act, 1945 issued by the Government of India., and NACO guide lines.

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Life threatening/emergency situations

The doctor must contact the BSU/ Clinical Laboratory to inform them of the clinical situation. A sample for urgent blood grouping and cross matching should be sent. It is essential that these be fully and accurately completed as errors will delay provision of compatible blood.

The emergency situation blood orders are determined by the consultants based on the patient conditions and threat to life.

The hospital BSU maintains a basic buffer stock to provide for such urgent situations and in cases where more volume transfusions are required. The same is coordinated with mother blood bank. Advance intimation is provided through telephone.

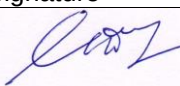
Safe Storage and transfusion

The blood issued from in-house BSU is stored and maintained as per licensing standards. The issued blood is sent to the respective IP area through hospital staff without any delay

In case of blood obtained from outsourced blood bank the patient family obtaining blood is counseled about safe transport of blood and importance of avoiding delays.

BLOOD COMPONENTS AND THEIR INDICATIONS

Appropriate and rational blood use - World Health Organization (WHO)	The appropriate use of blood and blood products means the transfusion of safe blood products only to treat a condition leading to significant morbidity or mortality that cannot be prevented or managed effectively by other means. Rational use of blood and blood products is to reduce unnecessary transfusions and minimize the risks associated with transfusion, the use of alternatives to transfusion where possible, and safe and good clinical transfusion practices, including patient blood management.
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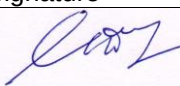
Various blood components – contents, storage and indication

A blood component is a constituent of blood which is separated from whole blood for e.g. red cell concentrate, platelet concentrate, fresh frozen plasma, etc. Table given below gives a snapshot of most commonly used blood components:

Name of the component	Approximate volume (ml)	Shelf life	Storage temperature
PRBC	150 – 250 (+10%)	35 – 42 days	2 – 6°C
FFP	180 – 300	1 year	Below minus 30°C
RDP	50 - 70	5 days	20 - 24 °C
SDP (single donor platelet)	200	5 days	20 - 24 °C
Cryoprecipitate	10 - 20	1 year	Below minus 30 °C
Whole Blood	365 to 560	21 - 35 days	2 – 6°C

a. Whole Blood

Approximate Volume:	365 to 560 ml (including the anticoagulant-preservative and acceptable variation of + 10% during collection of 350 – 450 ml whole blood from the donors)
Hematocrit:	30 – 40%
Storage Conditions:	2-6°C in a monitored blood refrigerator
Special Treatment:	Leukocyte reduction, washing, irradiation,
Crossmatch:	REQUIRED.

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Compatible alternate blood groups	NIL. Only patient's blood group can be used for whole blood. O negative whole blood CANNOT be used as a universal donor.
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Indications:

- Exchange transfusion in neonates.
- When packed red blood cells are not available, whole blood can be used in acute bleeding conditions when there is also a need to correct hypovolemia, e.g. battle field injuries, road traffic injuries, etc.

Rationality of use

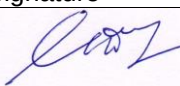
The appropriate use of blood and blood products means the transfusion of safe blood products, only to treat a condition leading to significant morbidity or mortality that cannot be prevented or managed effectively by other means¹⁰. With red cell concentrate replacing the whole blood in most of the situations, there are very few clinical and practice circumstances where whole blood use can be justified as mentioned in the table above. Platelet function is rapidly lost during the whole blood storage and there is no useful platelet function left after 24 hours of cold storage. Routine use of whole blood should thus be discouraged, as better and more specific therapy in the form of component transfusion is available.

Whole blood- The current update

Since late 1960s component therapy has increasing been used in the developed world, rapidly replacing the whole blood usage. However, in developing countries like India, whole blood is still used in many centres, mostly due to the lack of availability of blood components. Barring few studies (primarily in combat settings) done on small number of patients, there are still no randomized clinical trials or studies on large patient groups to validate the usefulness and safety of whole blood use. Hence, blood component therapy with a proven track record in terms of safety, efficacy, efficiency and usefulness is still the benchmark and whole blood use has to be discouraged in routine clinical practice.

b. Packed Red Blood Cells

Annually more than 80 million units of red cells are transfused globally and a wide variation in transfusion threshold and practices is seen for this particular blood component.

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Approximate Volume:	Minimum 250 ml $\pm$ 10% from 450 ml bag Minimum 150 ml $\pm$ 10% from 350 ml bag. (This volume is exclusive of any additive solution added to the PRBC)
Hematocrit:	65-70% when stored in CPDA1 solution 50-60% when stored in additive (SAGM/Adsol/etc) solution.
Storage Conditions:	2-6°C in a monitored blood refrigerator
Special Treatment:	Leukocyte depletion: Leucocytes in the final PRBC should be less than 5×10^8 when intended to prevent febrile reactions and less than 5×10^6 when required to prevent alloimmunization or cytomegalovirus infection. For achieving a level of less than 5×10^6, use of leucocyte filters is usually necessary. Saline washing: Red cells are washed with sterile Normal Saline by centrifugation at 2 to 8 degrees centigrade to remove residual plasma and other additives/ preservatives suspected of causing allergic/ anaphylactic reaction in select patients. Irradiation: Done using gamma rays or x-ray irradiation at 25 Gray to prevent graft versus host disease due to proliferation of lymphocytes. Freezing: Cryoprotective substance is added to the PRBCs for extended storage between minus 80 to minus 196 degrees centigrade.
Crossmatch:	Required.
Compatible alternate blood groups	See table in below.
Indications and dosage: References: Clinical Practice Guidelines From the AABB (2016) & National institute for health and care excellence (NICE 2015) guidelines on blood transfusion] a. PRBC transfusion is not indicated until the Hb level is 7 g/dL(restrictive transfusion threshold)and is recommended for hospitalized adult patients who are hemodynamically stable, including critically ill patients(strong recommendation, moderate quality evidence).	

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- b.** A restrictive RBC transfusion threshold of 8 g/dL is recommended for patients undergoing orthopedic surgery, cardiac surgery and those with preexisting cardiovascular disease (strong recommendation, moderate quality evidence).
- c.** Above recommendations do not apply to the patients with acute coronary syndrome, severe thrombocytopenia and chronic transfusion-dependent anemia.
- d.** Patients, including neonates, should receive PRBC units, irrespective of duration of storage in blood centre, rather than limiting patients to transfusion of only fresh PRBC units (strong recommendation, moderate quality evidence).
- e.** Adults without any active bleeding should be transfused single-unit red blood cell transfusions (or equivalent volumes calculated on the body weight basis for children or low body weight adults). In these patients, clinical reassessment and Hb levels should be done before further transfusions are given.

Compatible blood groups for PRBC transfusion

The below grid is for the **PACKED RED BLOOD CELLS** transfusion ONLY as there is no alternate choice of blood groups for the whole blood transfusion.

Patient's Blood Group	1 st choice for PRBC	2 nd choice for PRBC	3 rd choice for PRBC	4 th choice for PRBC
"A pos"	"A pos/ neg"	"O pos/ neg"		
"B pos"	"B pos/ neg"			
"O pos"	"O pos/ neg"			
"AB pos"	"AB pos/ neg"	"B pos/ neg"	"A pos/ neg"	"O pos/ neg"
"A neg"*	"A neg"	"O neg"		
"B neg" *	"B neg"			
"O neg" *	"O neg"			
"AB neg" *	"AB neg"	"B neg"	"A neg"	"O neg"

[pos = Rh(D) positive; neg = Rh(D) negative]

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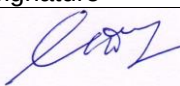
* Rh positive Packed RBCs can be transfused to Rh negative patients (post menopausal females, elderly men) when antibody screen is negative and only as a life saving measure. Informed consent from the patients/ relatives should be taken by the treating doctor/ transfusion medicine physician.

There are many existing international guidelines recommending RBC transfusions for various category of patients. Although decision to transfuse should be individualized according to the patient's condition, below mentioned indications are based on the latest scientific evidence and shall help in standardizing the blood transfusion practices in patients. Hemoglobin level is one of the critical factor used daily by the doctors to make a decision to transfuse and thus below mentioned guidelines incorporate Hb as one of the triggers wherever feasible.

1. Rationale PRBC use in Obstetrics and Gynecology

The WHO guidelines for blood transfusion in Obstetric patients published more than 15 years back recommended that blood transfusion should not be based on the HB levels alone. There were no specific recommendation regarding the trigger for blood transfusion in these patients. In view of absence of any specific recommendations/ guidelines from the Indian obstetrics and gynecology bodies/ societies (e.g. FOGSI, ICOG) till December 2019, the below mentioned practice points have been taken from the RCOG,UK guidelines (2018)¹³

- For normocytic or microcytic anemia, a trial of oral iron should be considered as the first step and further tests should be undertaken if there is no demonstrable rise in Hb at 2 weeks and compliance has been checked.
- Pregnant women should be offered screening for anemia at booking and at 28 weeks. Women with multiple pregnancies should have an additional full blood count done at 20–24 weeks.
- Parenteral iron is indicated when oral iron is not tolerated or absorbed or patient compliance is in doubt or if the woman is approaching term and there is insufficient time for oral supplementation to be effective.
- All women should have their blood group and antibody status checked at booking and at 28 weeks of gestation.
- Pre-delivery autologous blood deposit is not recommended.
- There should be a clear local protocol on how to manage major obstetric hemorrhage.

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- There are no firm criteria for initiating red cell transfusion. The decision to provide blood transfusion should be made on clinical and hematological grounds. FFP at a dose of 12–15 ml/kg should be administered for every 6 units of red cells during major obstetric hemorrhage. Subsequent FFP transfusion should be guided by the results of clotting tests. Aim to maintain the platelet count above 50,000/ microliter in the acutely bleeding patient. A platelet transfusion trigger of 75,000/ microliter is recommended to provide a margin of safety.
- Anemic women who are not actively bleeding intrapartum or immediate post-partum, an HB less than 7gm/dl is an indication for PRBC transfusion. For actively bleeding patients, follow with major obstetric protocols or massive transfusion protocol developed locally by the Hospital Transfusion Committee.
- The use of rFVIIa may be considered as a treatment for life-threatening postpartum hemorrhage (PPH), but should not delay or be considered a substitute for a life-saving procedure such as embolisation or surgery, or transfer to a referral centre.
- During major obstetric hemorrhage or with clinically diagnosed PPH, in addition to the standard care, early (within 3 hours of birth) use of intravenous Tranexamic acid is recommended (WHO 2017).

2. Rationale PRBC use in intensive care units[source: Red Blood Cell Transfusion: 2016 clinical practice guideline from AABB. Transfusion.

Sr. No	Clinical condition	Transfusion trigger	Strength of recommendation	Quality of evidence
1	Hemodynamically stable adult or pediatric patient	Hb < 7gm/ dl	Strong	High
2	Post-operative surgical patients	Hb < 8 gm/ dl Or symptoms like chest pain, orthostatic	Strong	High
3	Hemodynamically stable patients with pre-existing	hypotension, tachycardia unresponsive to fluid resuscitation or congestive	Weak	Moderate

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	cardiovascular disease	heart failure		
4	Hemodynamically stable patients with acute coronary syndrome	No recommendation for or against a liberal or restrictive RBC transfusion threshold	Uncertain	Very low

3. Rationale PRBC use in Surgery & orthopedics

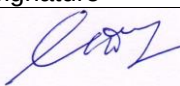
Effective and rationale BT involves pre-operative optimization of the patient, minimizing blood loss during surgery and avoiding unnecessary transfusions after the surgery. Clinical practice guidelines by AABB are relevant for BT in surgical and orthopedic patients (refer to the Rationale use in intensive care units section above). Additionally, the outcomes from the landmark FOCUS trial 14 which included only the hip fracture patients with co-existing cardiovascular (CVS) disease or CVS disease risk factors, groups previously thought to require aggressive anemia management, made it amply clear that restrictive transfusion strategy is safe. Briefly:

There was no difference in rates of mortality or mobility limitation at 60 days when patients with CV disease/ risk received BT at Hb of < 8 g/dl versus those who received BT at Hb of < 10 g/dl.

- Transfuse if symptomatic anemia, e.g. chest pain, tachycardia unresponsive to fluid resuscitation, orthostatic hypotension or congestive heart failure is present.
- The same thresholds can be safely applied to the patients with stable cardiovascular disease.
- Patients who are not actively bleeding should be transfused with a single unit of red cells and then reassessed before further blood is given.

It is commonly believed, that the surgeons and orthopedics prefer liberal blood transfusion strategy over a restricted one. However, there is now ample evidence that adhering to restrictive transfusion strategies and lower Hb thresholds (7-8 g/dl) is safe, effective as well as cheaper.

4. Rationale PRBC use in Cardiac surgery

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Cardiac surgeries have traditionally been considered as big consumers of blood and blood components with incidence of peri-operative blood transfusion ranging from 40-90%¹⁵. However, with increased awareness of adverse outcomes associated with BT and additional cost, it is now realized that transfusions should be done optimally. Indian professional bodies like ICCA and IACTA have not yet officially endorsed (till Jan 2020) any guidelines for blood use in cardiac surgery in India.

Pre-operative transfusion (EACTS & EACTA 2017 guidelines) -Preoperative erythrocyte transfusion is not routinely recommended in preoperative anemic patients to prevent postoperative AKI¹⁶. However, in the case of emergency surgery and life-threatening anemia, it is legitimate to use preoperative blood transfusions to increase the Hb levels.

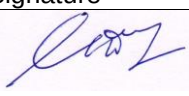
Oral or intravenous iron alone may be considered in mildly anemic patients (women, Hb 10–12 g/dl; men, Hb 10–13 g/dl) or in severely anemic patients (both genders, Hb < 10 g/dl) to improve erythropoiesis prior to cardiac surgery. Erythropoietin with iron supplementation should be considered to reduce postoperative transfusions in patients with noniron deficiency (e.g. EPO, vitamin D or folate acid deficiency) anemia, undergoing elective surgery.

Pre-operative autologous blood donation – In patients posted for elective surgery with Hb > 11 gm/dl and without severe aortic stenosis or an acute coronary syndrome within 4 weeks, PABD may decrease the number of postoperative BT. Acute normovolemic hemodilution (ANH) has not shown much advantage in cardiac surgery patients.

Quality of blood - The use of PRBCs of all ages is recommended, because the storage time of the PRBCs does not affect the outcomes (Class I, level A evidence). The use of leucocyte-depleted PRBCs is recommended to reduce infectious complications (Class I, level B evidence).

Hemoglobin trigger – The Society of Thoracic Surgeons and Society of Cardiovascular Anesthesiologists 2011 guidelines recommended RBC transfusion for Hb <6 g/dL during cardiopulmonary bypass and <7 g/dL post-operatively, except in patients at risk for decreased cerebral oxygen delivery, for whom a higher Hb level was recommended¹⁷. However, 2017 EACTS & EACTA guidelines recommend that instead of a fixed Hb threshold, BT should be based on the clinical condition of the patient (Class I, level B evidence). A restrictive Hb of 7-8 gm/dl (Hct 21-24%) with patient maintaining adequate DO₂ (> 273 ml O₂/min/m²) level can be considered during cardiopulmonary bypass (Class IIb, level B evidence).

Most cardiac anesthesiologists now agree that it is reasonable to transfuse blood with Hb <7 g/dl and transfusion is unnecessary when Hb is >10 g/dl¹⁸. The individualized approach used in

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between these two triggers (Hb between 7-10 g/dl) should be based on a restrictive strategy, with a focus on the improved clinical outcome along with the additional cost and risk of a BT.

5. Rationale PRBC use in neonates and pediatric patients [Source: Technical Manual. 19th ed. Bethesda, Maryland: AABB; 2017. p. 505 – 26]¹⁹

Age appropriate hemoglobin levels, the ability to tolerate blood volume loss and total blood volume differs in pediatric patients as compared to adults. Following are the indications of RBC transfusion in pediatric patients:

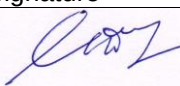
Infants less than 4 months of age:

Category	Recommendation for RBC transfusion @10-15ml/ kg
Symptomatic anemia (tachycardia, tachypnea, poor feeding)	Maintain Hb above 7 gm/dl
On oxygen (cannula/ hood) or mechanical ventilation, significant tachycardia (>180 beats/ min) or tachypnea (>80 breaths/ min) or apnea or bradycardia.	Keep Hb > 10 gm/dl
On >35% oxygen by hood or on CPAP/ IMV* with mean airway pressure > 6-8cm of water.	Keep Hb > 12gm/ dl
Congenital cyanotic heart disease or on ECMO	Keep Hb > 15 gm/ dl

*CPAP continuous positive airway pressure IMV intermittent mandatory ventilation

Infants older than 4 months and children

Category	Recommendation for RBC transfusion
Intraoperative blood loss > 15% of blood volume, Perioperative anemia, chemotherapy, radiotherapy, chronic congenital or acquired symptomatic anemia	Maintain Hb above 8gm/ dl

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Severe pulmonary disease, ECMO	Keep Hb > 13 gm/ dl
Sickle cell disease for surgery under general anesthesia.	Keep Hb > 10gm/ dl
Acute blood loss with unresponsive hypovolemia.	Any Hb level

6. Rationale PRBC use in common Hemoglobinopathies in India :

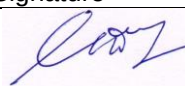
Thalassemia and Sickle cell diseases are two common Hemoglobinopathies in India that require long and specialized treatment. Despite many advancements in the diagnosis and management of these diseases, it is unfortunate that still most of the patients in India are dependent mainly upon repeated blood transfusions.

Blood transfusion in Thalassemia

In thalassemia, excess iron due to these repeated blood transfusions, needs to be removed by the use of the expensive chelation treatment. Thalassemia intermedia and Hb E thalassemia patients may not need regular red cell transfusions. Even in thalassemia major patients, regular transfusions are not justified only on the basis of Hb levels. Clinical parameters should be assessed before advising a chronic transfusion therapy because of grave risks with chronic BT therapy²¹. Following parameters suggest that the patient will need chronic red cell transfusions.

- Hb level <7 g/dl on two successive occasions separated by at least 2 weeks (the patient should be on folic acid replacement and there should be no other aggravating cause, i.e. infection, bleeding, etc.)
- Patient's growth, activity, academic performance, zeal, etc., are hampered
- Unnatural bony growth due to marrow expansion
- Development of organ failure such as cardiac failure, edema.
- Even if Hb level is >7 g/dl and <10 g/dl, and above clinical features are present, the patient may need chronic transfusion therapy.

Objectives of chronic red cell transfusions is to ensure adequate Hb level so that O₂ delivery to the tissue is not hampered. This will be indicated by:

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- Normal growth spurt.
- Increased zeal, energy, enthusiasm, and improved academic performance.
- Improved appetite.
- Suppressed over active erythropoiesis leading to bone deformities.

Red cell transfusions should be given at an interval of 2-5 weeks. This interval is optimized based on:

- The amount of red cells transfused so that pre-transfusion Hb remains >9 g/dl but post-transfusion Hb does not go above 12 g/dl
- There is no fluid overload.
- Transfusion process is over within a reasonable time (within 4 hours).
- Frequency of transfusions is not such that it interferes with patient's normal activities.
- Reducing the number of venipuncture (as lifelong transfusion is needed, peripheral veins need to be preserved well).

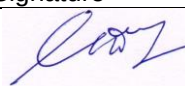
Suitable blood components for transfusion:

- Red cell concentrates (hematocrit around 0.65) is suitable
- Leucodepleted (prestorage) blood is desirable.

Amount of PRBC to be transfused:

- Pretransfusion Hb is to be estimated along with the weight of the patient and recorded.
- If the hematocrit of the red cell concentrate used is 0.65, then 3-4 ml/kg will raise the Hb by 1 g/dl in the absence of hypersplenism.
- Generally in a single transfusion an attempt is made to raise the Hb by 4 g/dl if transfusions are scheduled at 3- to 5 weekly intervals.
- Below mentioned grid can be used to guide the volume of transfusion based on the desired Hb increase in the patient and the hematocrit of the blood bag.

Target increase in Hb level	Hematocrit of the blood bag			
	50%	60%	75%	80%
1 g/dl	4.2 ml/kg	3.5 ml/kg	2.8 ml/kg	2.6 ml/kg

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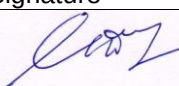
2 g/dl	8.4 ml/kg	7.0 ml/kg	5.6 ml/kg	5.2 ml/kg
3 g/dl	12.6 ml/kg	10.5 ml/kg	8.4 ml/kg	7.8 ml/kg
4 g/dl	16.8 ml/kg	14.0 ml/kg	11.2 ml/kg	10.4 ml/kg

Pre-transfusion testing should be done before starting chronic transfusion therapy as follows:

- Irregular antibody screening at regular intervals in necessary and should be done during pre-transfusion testing. Once an alloantibody is detected, it should be identified and antibody negative blood should be crossmatched.
- Extended phenotyping of patient's red cells is desirable. If possible, an extended phenotype of the patient should be done and record kept for any future need.
- If the family is interested in stem cell transplantation, then counseling and early referral to such a centre should be done.
- Serum ferritin level is not needed if the child is <2 years
- Serum ferritin levels should be recorded at regular intervals (3 months) after first 10 units of red cells have been transfused and iron chelation should be started and the dose should be adjusted so as to maintain serum ferritin between 500 and 1000 ng/ml.
- Before starting chronic red cell transfusions, hepatitis B vaccination should be completed.
- Every 3 months, virus serology should be done to detect viral infection at the earliest.
- Patient should receive NAT tested blood components as far as possible.
- Detailed record of red cell transfusions, complication, management, etc should be kept.
- Close relative's blood should not be transfused.

Blood transfusion in Sickle cell disease

- PRBC transfusions play an important role in the treatment of some acute illnesses in patients with sickle cell disease. Timely BT may be lifesaving in severe complications.
- PRBC should be transfused if the Hb is >1-2 g/dl, below baseline and the patient shows any signs of cardiovascular compromise.
- Indications for red cell transfusions include acute exacerbation of the patient's baseline anemia (e.g. hyperhemolysis, hepatic sequestration, splenic sequestration, aplastic crisis) that requires increased oxygen carrying capacity, acute life or organ-threatening vaso-occlusive episodes (e.g. stroke, acute chest syndrome, severe infection, multiorgan failure, etc.) and preparation for surgical or radiographic procedures.

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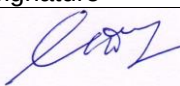
- Leukocyte-depleted, packed RBCs are recommended and where available Rh, Kell antigen matched, sickle-negative cells are preferred.
- Slow correction of the anemia, for example, 4-5 ml/kg PRBC over 4 h often with furosemide or isovolemic partial exchange transfusion may be needed to prevent precipitation of heart failure.
- Simple transfusion with 10 ml/kg of PRBC typically raises the Hb by about 2 g/dl.
- PRBC transfusion in a dose of 10 ml/kg for Hb <4-5 g/dl and signs of cardio vascular compromise should be done. Transfusion may be needed for Hb <7-8 g/dl for patients with relatively high baseline Hb Sickle levels. In severe cases, urgent initiation of transfusion prior to inpatient admission may be life-saving. A post-transfusion Hb level <8-9 g/dl is generally recommended to avoid the risk of hyperviscosity that may occur several days later when RBCs sequestered in the spleen may return to the circulation and increase the Hb 1-2 g/dl above the post-transfusion levels.
- Since sickle red cells are poorly deformable, simple red cell transfusions that increase the Hb levels to >10-11 g/dl may cause hyperviscosity in patients not receiving chronic transfusions and should be avoided.
- Partial exchange transfusion, generally by erythrocytapheresis (using apheresis technology), may be needed for severe life-threatening illness or in situations where a relatively high baseline Hb precludes a simple transfusion that would lead to the risk of hyperviscosity.
- Partial exchange transfusion or erythrocytapheresis to achieve Hb 10 g/dl and keep Hb Sickle (patient's RBC) <30%. Remove femoral or central venous catheter as soon as possible after exchange transfusion to reduce risk of thrombosis.
- Simple transfusion with PRBCs to achieve post-transfusion Hb approximately 10 g/dl may be considered as an alternative to partial exchange transfusion for stable patients with Hb 6-7 g/dl (do not transfuse acutely to Hb >10 g/dl, Hct >30%)

NICE guidelines published in 2015 recommend that individual thresholds and Hb targets should be set for each patient who needs regular blood transfusions for chronic anemia as seen in Hemoglobinopathies 12

Modification of PRBC – leukodepletion, irradiation, volume reduction.

Leukodepletion, irradiation and volume reduction are one of the most common blood unit manipulations done in a blood centre to enhance blood safety for select category of patients.

Leukocyte depletion or leukodepletion (LD) is the process of removing leukocytes (mostly before storage of blood) from whole blood or platelets to prevent:

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- Transfusion transmitted cytomegalovirus transmission
- HLA immunization
- Febrile non-hemolytic transfusion reactions
- Platelet refractoriness (failure to increase platelet count in a patient after repeated platelet transfusions)

Blood centre supplying the blood units can be asked about the availability of LD blood units.

Irradiation is done on the cellular blood components like RBC, platelets and granulocytes to prevent a fatal blood transfusion reaction called TA-GVHD (transfusion associated graft versus host disease) in at risk patients. When the blood donor/ unit is a blood relative of the transfusion recipient or the product is HLA matched, the recipient is at high risk for TA-GVHD. Acellular blood components like plasma and cryoprecipitate do not require irradiation treatment.

Volume reduction is preparing smaller aliquots for blood transfusion. This is most commonly done for the neonates and infants and may be required in the patients at risk of transfusion associated circulatory overload.

All the blood components can be volume reduced to suit the patient requirement. If done in a sterile manner (e.g. using sterile connecting device), there is no change in the original expiry and remaining aliquots can be used till the expiry of the original blood component. This is particularly useful in decreasing donor exposure in neonates and infants.

C. Fresh Frozen plasma (FFP)

FFP is conventionally transfused to patient with active bleeding or prophylactically to patients with modest to severe abnormality in the various coagulations tests like Prothrombin time, International normalized ratio (INR) and activated partial thromboplastin time (aPTT).

Indications of FFP transfusion (British Journal of Haematology guidelines 2018)²²

- **Therapeutic Indications with Active bleeding :**
- Patient with massive bleed like trauma or obstetric cases may develop multiple coagulation factor deficiency require FFP transfusion along with other blood components for maintaining the hemostatic and hemodynamic stability. details regarding massive transfusion are covered in chapter on massive transfusion
- Disseminated Intravascular Coagulation or consumptive coagulopathy with active bleeding.
- Immediate correction of Vitamin K deficiency and warfarin reversal

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- Thrombotic thrombocytopenic Purpura
- Patient with congenital factor deficiency like factor V deficiency when no alternative therapies are available.

1. Prophylactic Indications abnormal coagulation tests (INR >1.5) in the absence of bleeding:

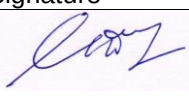
- FFP transfusion before an invasive procedure : Abnormal coagulation test are poor predictors of bleeding risks in non-bleeding patients prior to an invasive procedure (2C). Various studies have shown that mild to moderate abnormalities in the coagulations tests is not associated with bleeding and prophylactic plasma transfusion in these patients does not affect bleeding outcomes (AABB). BCSH recommends that coagulations tests should be considered in patients undergoing procedures with a moderate or high bleeding risk, any patient on anticoagulant , or those who have a personal/family bleeding history (1B).
- Patients on anticoagulants like warfarin to correct the INR prior to an invasive procedure.

2. Other Indications:

- As replacement fluid during therapeutic plasma exchange procedures for TTP and HUS
- In patients with liver disease, abnormal coagulation tests should be interpreted with caution as some of the patient may have prothrombotic tendency with elevated prothrombin time. Fresh frozen plasma transfusion is recommended only if active bleeding is present or prophylactically for high bleeding risk invasive procedures.
- Cardiopulmonary bypass surgery – use in the presence of bleeding but where abnormal coagulation is not due to heparin. Routine perioperative use is not indicated
- Severe sepsis, particularly in neonates (independent of DIC).

Dosage of FFP

1. FFP are transfused using weight based dosing of 10-15 ml/kg of recipient weight.
2. During massive transfusion, FFP transfusion may be given in a fixed ratio with red cell transfusion as per the massive transfusion protocol
3. As per BCSH, Patients with high bleeding risk during a procedure, starting dose of 15ml/kg body weight can be considered, although this is not evidence based.

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Inappropriate use of FFP

Plasma products are associated with the highest rate of inappropriate utilization (upto 50%) with evidence of inappropriate practice based on local audits. The main reason for this inappropriate use of FFP is non availability of national/local guidelines in various countries like India. Even in countries with national guidelines, the compliance is really poor as per the published studies or audits.

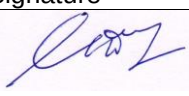
FFP transfusion is not indicated in the following conditions:

1. Use of FFP for volume replacement in patients who are not bleeding.
2. Use of FFP for nutritional purposes like hypoproteinemia.
3. Lack of evidence based local guidelines for FFP transfusion
4. Prophylactic FFP transfusion for invasive procedures with normal or mildly (INR <1.5) deranged coagulation tests.
5. FFP transfusion in patient with bleed with normal coagulation tests.

d. Platelet components

Platelet components are required for patients with bleeding due to thrombocytopenia. However, they are also given prophylactically in conditions with low platelet count with the potential to cause bleeding.

- **Dosage:**
1 unit of platelet concentrate/10 kg; for an adult of 60-70 kg, 4-6 single donor units containing at least 240×10^9 platelets should raise the platelet count by $20-40 \times 10^9/L$. Increment will be less if there is splenomegaly, disseminated intravascular coagulation (DIC) or septicemia.
- **Indications:**
Treatment of bleeding due to:
Thrombocytopenia.
Platelet function defects.

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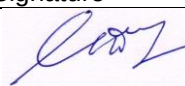
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Prevention of bleeding due to thrombocytopenia as in bone marrow failure.

- **Contraindications:**
- Absolute : Thrombotic thrombocytopenic purpura (TTP). British Journal of Haematology recommends platelet transfusion in cases of TTP only during life threatening bleeds.
- Relative :
 - Idiopathic autoimmune thrombocytopenic purpura (ITP).
 - Untreated DIC.
 - Thrombocytopenia associated with septicaemia, or in cases of hypersplenism.

Transfusion triggers (Platelet count below which platelet transfusion is indicated) for prophylactic platelet transfusion.

Clinical condition	Platelet transfusion triggers for prophylactic transfusion.
Reversible bone marrow failure where recovery is anticipated	• 10,000/μl in non-bleeding, non-infected patient • Threshold for patient with increased risk of bleeding can be increased to 10-20,000/μl
Chronic bone marrow failure where recovery is not anticipated	• No prophylactic platelet is recommended • Manage patient according to severity of their sign and symptoms.
Critical illness with no bleeding	10,000/ μ l in non-bleeding, non-infected patient.
venous central lines	10,000/ μ l
Lumbar Puncture	40,000/ μ l
Insertion removal of epidural catheter	40,000/ μ l

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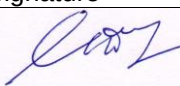
Major surgery	40,000/ μ l
Neurosurgery/ophthalmic surgeries	1 lac/ μ l
Percutaneous liver biopsy	50,000/ μ l
Renal Biopsy	- Avoid platelet transfusion because infused platelet will acquire a dysfunction similar to patient own platelet. - consider desmopressin.
Bone marrow aspirate, trephine biopsy, peripheral catheter insertion and cataract surgery.	No prophylactic platelet required

Transfusion triggers for Therapeutic platelet transfusion

Clinical condition	Platelet transfusion trigger for therapeutic transfusion.
Severe bleeding (Massive transfusion)	50,000/ μ l
Multiple trauma, traumatic brain injury or spontaneous intracerebral haemorrhage	1 lac/ μ l
Non severe bleeding	30,000/ μ l
DIC in presence of bleeding	30,000/ μ l

Use in cardiopulmonary bypass surgery:

Platelet function defects and thrombocytopenia often occur after cardiac bypass surgery. Platelet transfusion is recommended for patients with bleeding not due to surgically correctable causes (closure time done by Platelet Function Analyzer – PFA-100/Innovance PFA-200/ Sonoclot-provides global indication of platelet function). Prophylactic platelet transfusions are not required for all bypass procedures.

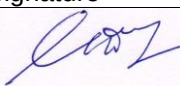
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e. Cryoprecipitate

Cryoprecipitate is a blood component which is derived from FFP. It has relatively higher concentration per milliliter for fibrinogen, factor VIII, Von Willebrand factor (vWF), factor XIII and fibronectin.

Approximate Volume:	10 – 20 ml
Storage Conditions:	Below minus 30°C in a blood centre freezer. It should be immediately transfused after thawing however, it can be stored at 2 - 6°C for a maximum duration of 6 hours post thawing, if not immediately transfused.
Special Treatment:	nil
Compatible alternate blood groups	Although blood group specificity is preferred it is not mandatory especially in adults. However in neonates or small children it is desirable to give blood group specific or neutral (AB) group cryoprecipitate. The Rh type can be ignored if there is no red cell contamination of the product.
Indications: a. Hemophilia A (when pathogen inactivated antihemophilic concentrate factors are not available) b. Von Willebrand's disease c. Congenital or acquired fibrinogen deficiency (when pathogen inactivated fibrinogen is not available or cannot be used) d. Acquired factor VIII deficiency (when pathogen inactivated antihemophilic concentrate factors are not available) e. Factor XIII deficiency f. As a source of fibrin glue for preparing topic hemostatic agent in surgical procedures when pathogen inactivated fibrinogen is not available or cannot be used.	

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Administration Commencement of Transfusion

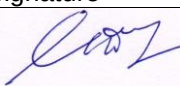
The transfusion of blood products should begin as soon as possible after delivery to the clinical area.

Check the patient information against the blood bag label and compatibility sheet UID/Name/Blood group Rh factor.

Checking the wristband is especially important when the patient is unconscious.

Check the patient's prescription & wristband information against the compatibility sheet and the free hanging label attached to the blood product. Check:

- Full name
- Age
- Sex
- Hospital MRN
- Collection Date

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- Expiry date
- Blood bag unit number
- Blood group & Rh

Check the blood group

The blood group and unit number of the unit of blood product must be identical to that on the blood transfusion compatibility report form.

The blood group on the unit must be compatible with the blood group of the patient, as indicated on the compatibility form and label attached to the blood pack.

If the blood group of the unit and the patient are not identical the blood bank should have made a specific comment on the blood bag label to indicate the blood is suitable for transfusion.

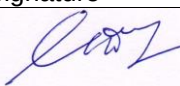
If there are any discrepancies, contact the blood bank.

Transfusion Reaction:

If transfusion reaction takes place, inform the doctors then stop the transfusion, administer the medicine ordered by doctor.

If transfusion reaction occurs then along with a transfusion reaction form, first urine sample and patient's blood sample is sent to the blood bank along with the blood bag and the BT set.

The sticker on the blood bag is removed and pasted in the patient's chart for a valid documentation.

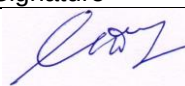
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NABH Standards: COP 8b, COP 8d, COP 8e, COP 8f

AMENDMENT HISTORY

Sl. No	Current Revision			Nature of Change
	Edition No	Revision No.	Date	
1	01	00	1 Oct 2019	First issue as per NABH Hospital Accreditation Standards – 4 th Edition
2	01	01	1 Nov 2020	Minor Revisions, updating Doc No. 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	Amended as per the 6 th Edition.
5	01	02	1 Jan 2026	No changes.

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Dr. Hrishikesh Kalgaonkar		Dr. S.S. Deepak	
Quality Head		Chairman & Managing Director	



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Document Title : QAP BSU

Doc No	SDH/COP/08
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SHRPL QAP Policy:

Quality Assurance Program in Blood Storages Unit (BSU):

S. No.	Quality Objective	Performance Indicator	Responsibility	Measurement criteria	
				Criteria	Frequency
1	Service Quality	Blood Transfusion Reaction	All Nursing In-charge	No of transfusion Reaction In a month *100 / Total no of units Transfusion	Monthly
2		Wastage OF Blood & Blood Components		No of blood & blood components waste in a month *100 / Total no of units Transfusion	
3		Blood Components Use		Percentage of blood & blood Components use in a month*100 / Total no of units Transfusion	
4		TAT time For Prescription		Sum of time taken in month / Total no of Prescription in a month	
5		TAT Time		Sum of time taken in a month / Total no of Blood Bag Received In A month	

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NABH Standards: COP 8g

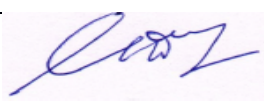
AMENDMENT HISTORY

Sl. No	Current Revision			Nature of Change
	Edition No	Revision No.	Date	
1	01	00	1 Oct 2019	First issue as per NABH Hospital Accreditation Standards – 4 th Edition
2	01	01	1 Nov 2020	Minor Revisions, updating Doc No. 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	Amended as per the 6 th Edition.
5	01	02	1 Jan 2026	No changes.

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Chapter: COP 9 A
Care of patients in intensive care and high dependency units is
provided based on written guidance
Refer ICU Manual

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Document Title : Admission and Discharge Criteria			

Intensive Care Unit Admission Criteria: The provision of intensive care services will be offered in the following circumstances

Life Support:

- Complex interventions requiring frequent and sophisticated adjustments [titration of vasopressor dose and volume infusions, advanced mechanical ventilation using high level of PEEP or alterations in I:E ratio, frequent vital sign checks (one hour or less) during times of instability or post-procedure or high risk interventions.

Transitioning to:

- Basic, more stable (Fixed dose vasopressor infusions, stable patients requiring prolonged mechanical ventilation as patient is assessed to be stable for transfer to subspecialty units)

Monitoring:

High level (use of specialty equipment including intracranial, intra-cardiac monitoring systems)

Transitioning to:

- Basic or more stable (frequent vital sign checks and neurological exams, hourly intake and output measurements, central venous pressure monitoring for fluid management, continuous pulse oximetry, cardiac and continuous rhythm monitoring)

Focused Nursing Care:

- When the ratio of nursing service to patient care require 1:1 or 1:3 to assure safety, security, and monitoring to assure stability of physiological and psychological measures. This could include drug and alcohol use patients or metabolically unstable patients like diabetic ketoacidotic admissions.

Intensive Care Unit Discharge Criteria: ICU discharge is indicated when physiologic status has stabilized such that ICU care is no longer needed and ALL the following are present:

- No ICU specific intervention or monitoring currently needed or anticipated
- Discontinuation of parenteral vasopressor and inotropic medication
- Stabilized on anti-hypertensive, anti-anginal, and anti-arrhythmic agents for more than 4 hours with stable haemodynamic condition i.e.

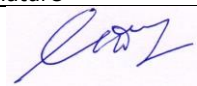
HR ≥ 50 and ≤ 120 /min with no conduction defects needing interventions

BP ≥ 90 mmhg systolic and ≤ 180 mmhg systolic and 120 mmhg diastolic

RR ≤ 20 /min and ≥ 12 /min with no supplementary oxygen

Temperature $\geq 96^{\circ}\text{F}$ and $\leq 102^{\circ}\text{F}$ (but at the discretion of the attending doctor)

Pain score $< 8/10$

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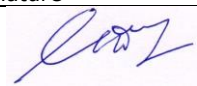
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Document Title : Admission and Discharge Criteria			

GCS >9

- Discontinuation of ICU assisted ventilation needs as indicated by ANY ONE of the following:
- Stable chronic ventilator or long term weaning needs
- Extubation and discontinuation of assisted ventilation with stable respiratory status for at least 4 hours
- Requirements for care with a staffing ratio of 1 nurse to 3 patients or more.

AMENDMENT HISTORY

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3	01	01	1 Jan 2022	No changes.
4	01	02	1 Jan 2025	No changes review completed.
5	01	02	1 Jan 2026	No changes.

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	Policy on Triage and handling patients during non - availability of beds		

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.

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	Policy on Triage and handling patients during non - availability of beds		

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

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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 of patient beds in case of non-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.

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	Policy on Triage and handling patients during non - availability of beds		

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 available in the ICU within 4 hours, 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.

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	Policy on Triage and handling patients during non - availability of beds		

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 cases are directed to the relevant consultant of their choice and after regular 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:

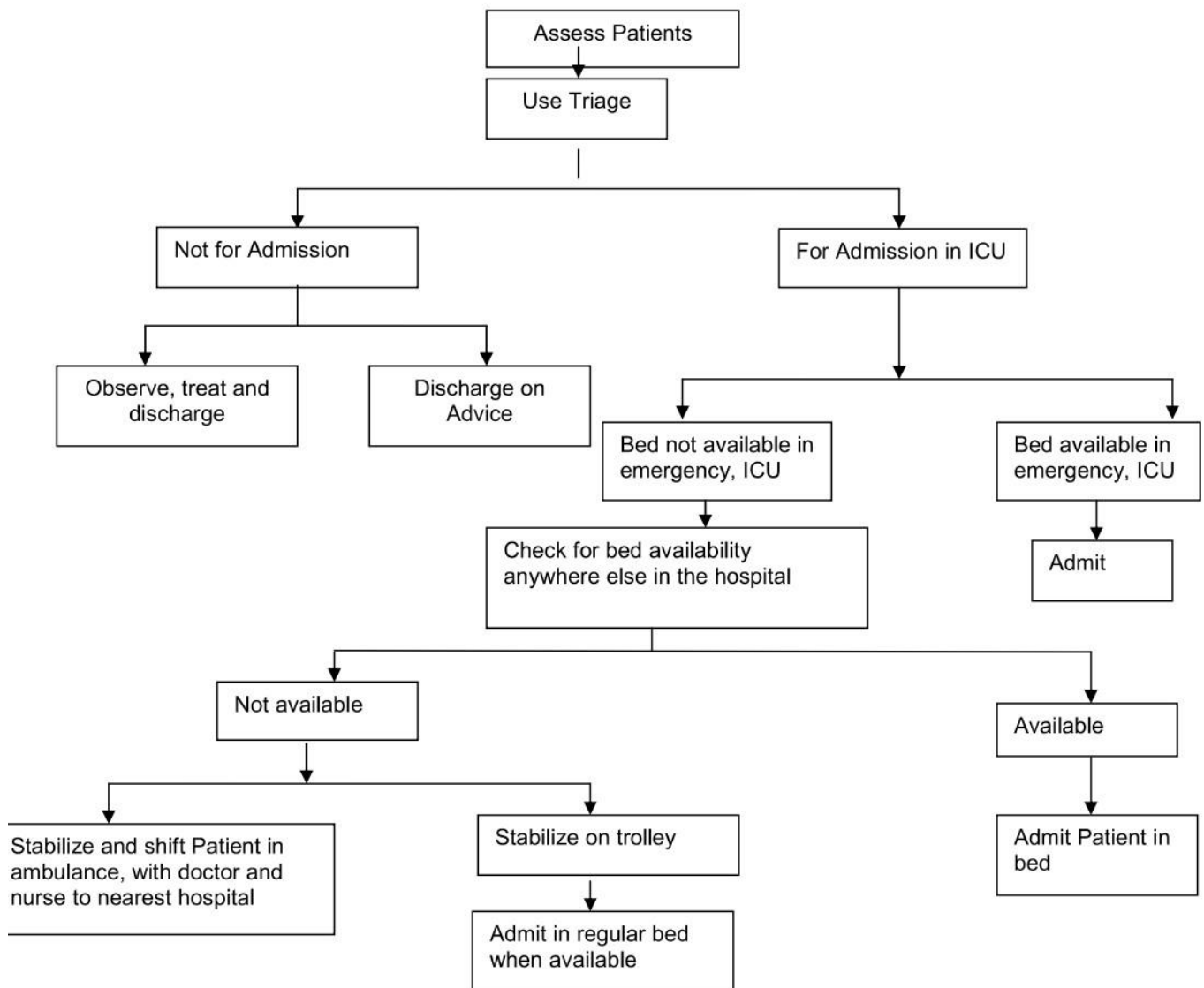
- Transfer/referral
- Admission in alternate category

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	Policy on Triage and handling patients during non - availability of beds		

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



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6.0 Procedure addressing shortage of beds in Intensive care

1. A call is made to ICU to check the availability of bed and if available the patient is shifted there.
2. The condition of all the patients in the ICU 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:

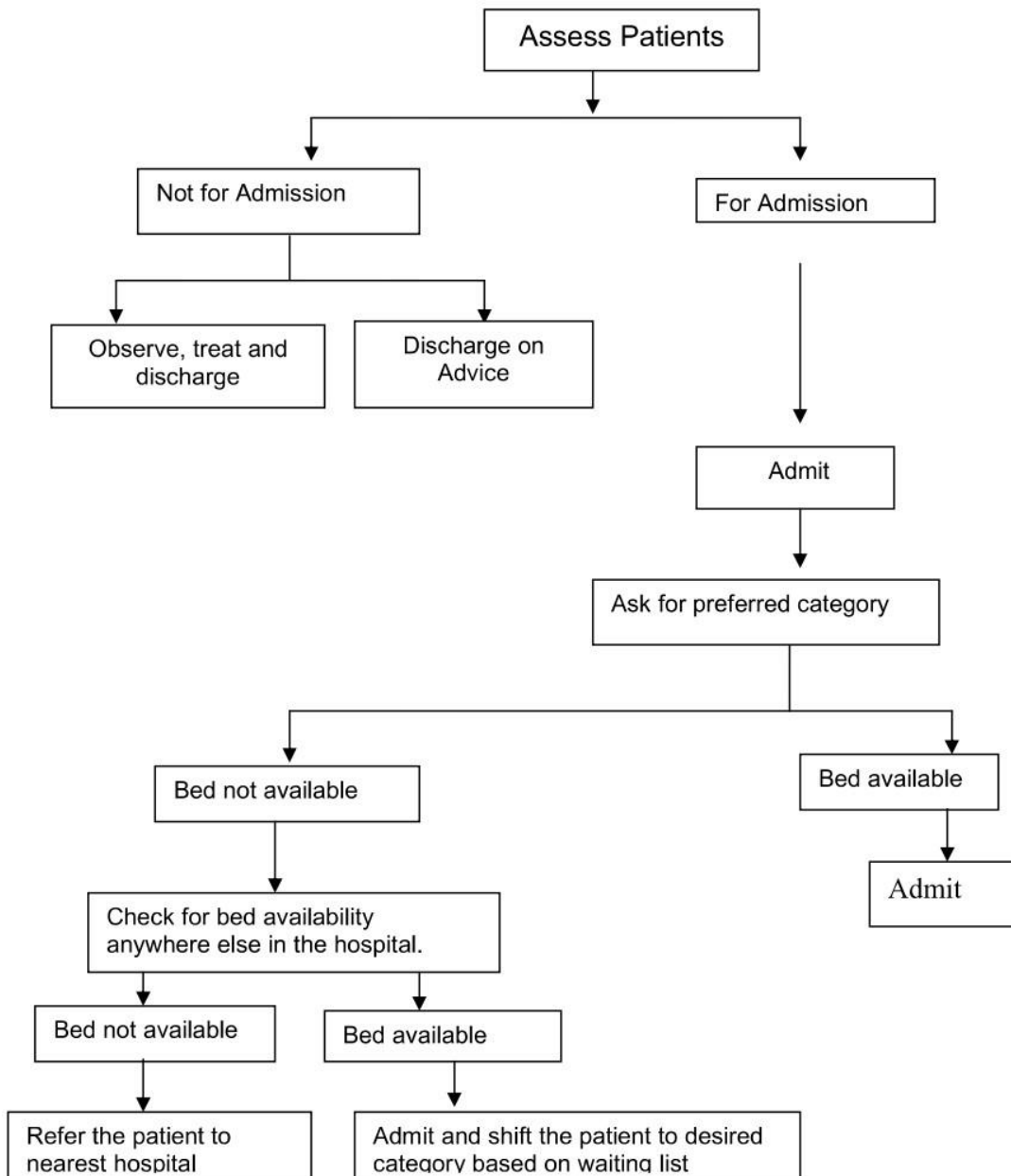
- Receiving hospital shall be informed and acceptance confirmed
- Clinical status shall be documented
- Handover communication shall be recorded

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	Policy on Triage and handling patients during non - availability of beds		

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



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	Policy on Triage and handling patients during non - availability of beds		

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

Amendment History

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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

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Chapter: COP 9 E

Infection prevention and control practices are followed.
Refer Infection prevention control Manual

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Chapter: COP 10 A
 Obstetric services are organised and provided safely.
 Refer Labour Manual

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	Guidelines for ANTENATAL CARE GUIDELINES		

ANTENATAL CARE GUIDELINES (COP 10 – NABH 6th Edition Compliant)

(Aligned with FOGSI GCPR and NABH COP 10)

1.0 PURPOSE

To ensure **safe, standardized, evidence-based antenatal care** for all pregnant women, including **high-risk and ART pregnancies**, in compliance with **NABH COP 10 standards**.

2.0 SCOPE

Applicable to:

- All pregnant women registered in the hospital
- OPD, IPD, Emergency, ART-linked pregnancies
- Includes:
 - Low-risk pregnancies
 - High-risk pregnancies
 - IVF / ART pregnancies
 - Multiple gestation pregnancies

3.0 POLICY STATEMENT

The hospital shall provide **structured antenatal services** including:

- Comprehensive assessment
- Risk stratification
- Immunization
- Nutritional counselling
- Defined frequency of visits
- Documentation via antenatal card

Assessment + Immunization + Diet counselling + Frequency of visits **must be documented**

4.0 ORGANISATION OF ANTENATAL SERVICES

4.1 Registration

- First visit preferably **<12 weeks**
- Unique MRN generated

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- Antenatal card issued (mandatory)

4.2 Care Model

- Shared care:
 - Obstetrician
 - Medical officer
 - Nurse/midwife

4.3 Risk Stratification

At every visit:

Low Risk

- No medical/obstetric complications

High Risk

Includes:

- Hypertension / Diabetes
- Previous LSCS
- Anaemia
- Thyroid disorder
- Multiple pregnancy
- IVF/ART pregnancy

High-risk cases require:

- More frequent visits
- Specialist care
- Referral if needed (COP 10.b)

5.0 SCHEDULE OF ANTENATAL VISITS

Minimum (NABH + FOGSI)

- 12 weeks
- 20 weeks
- 26 weeks
- 30 weeks
- 34 weeks

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	Guidelines for ANTENATAL CARE GUIDELINES		

- 36 weeks
- 38 weeks
- 40 weeks

Minimum **8 contacts** mandatory

Preferred

- Monthly till 28 weeks
- Fortnightly till 36 weeks
- Weekly thereafter

6.0 CLINICAL ASSESSMENT

At every visit:

General

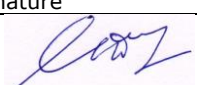
- Weight
- BP
- Pulse
- Pallor, edema

Obstetric

- Fundal height
- Fetal heart rate
- Presentation

Investigations

- Hb (every visit)
- Urine (protein, infection)
- Blood group & Rh
- HIV, HBsAg, VDRL
- TSH
- GDM screening (DIPSI)

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7.0 ULTRASOUND SCHEDULE

- <12 weeks → Dating + viability
- 11–14 weeks → NT scan
- 18–24 weeks → Anomaly scan
- 3rd trimester → Growth scan

Multiple pregnancy detection early is critical

8.0 IMMUNIZATION (MANDATORY)

- Td / Tdap
- Influenza
- COVID (as applicable)

9.0 NUTRITIONAL MANAGEMENT

Supplements:

- Iron: 100 mg daily
- Folic acid: 400 mcg
- Calcium: 1.5 g/day

Counselling:

- Diet
- Weight gain targets
- Lifestyle

10.0 SCREENING PROGRAMMES

Mandatory:

- Anaemia
- GDM
- Thyroid

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- Infections

Optional (if available):

- Down syndrome
- Thalassemia
- Pre-eclampsia screening

11.0 EDUCATION & COUNSELLING

- Danger signs
- Birth preparedness
- Breastfeeding
- Family planning

12.0 DOCUMENTATION

Each patient shall have:

- Antenatal card
- Visit-wise entries
- Risk status
- Investigations
- Treatment

13.0 SPECIAL PROTOCOL – ART / IVF PREGNANCIES

13.1 Classification

All IVF pregnancies = **HIGH RISK**

13.2 Risks

- Multiple gestation
- Preterm birth
- Placenta previa
- Preeclampsia

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Guidelines for ANTENATAL CARE GUIDELINES			

- FGR

13.3 Additional Care Monitoring

- Early viability scan
- Frequent ultrasounds
- Cervical length monitoring

Hormonal Support

- Progesterone support (as per ART protocol)

Thromboembolism Risk

- Assess and manage (LMWH if indicated)

13.4 MULTIPLE PREGNANCY MANAGEMENT

Additional risks:

- Twin-to-twin transfusion
- Growth discordance
- Preterm labour

Monitoring Protocol

- Scan every 2–4 weeks
- Doppler studies
- Cervical length

13.5 FETAL REDUCTION (CRITICAL SECTION)

Indications:

- High-order multiples

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- Maternal risk
- Fetal anomalies

Policy Requirements

- Multidisciplinary decision
- Ethical committee consideration (if required)
- Informed consent (high-risk consent)
- Documentation

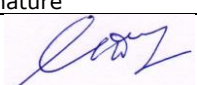
Procedure Governance

- Performed by qualified specialist
- Ultrasound-guided
- Post-procedure monitoring

Compliance point:

Must align with:

- PCPNDT Act
- ART Act
- Consent + documentation critical

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Guidelines for ANTENATAL CARE GUIDELINES			

14.0 HIGH-RISK PREGNANCY MANAGEMENT

- Defined criteria
- Flagging system
- Escalation protocol
- Referral linkage

15.0 LABOUR PREPAREDNESS

- Birth plan
- Blood availability
- NICU readiness

16.0 QUALITY & SAFETY

- Maternal audits
- High-risk tracking
- Emergency drills

17.0 RESPONSIBILITIES

Role	Responsibility
Obstetrician	Clinical management
Nurse	Monitoring & documentation
Dietician	Nutrition
Quality team	Audit

18.0 RECORDS & FORMS

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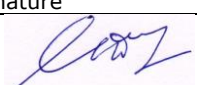
 SAIDEEP HEALTHCARE & RESEARCH PVT. LTD.	SAIDEEP HOSPITAL HOSPITAL POLICIES	Doc No	SDHCOP/10
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	Guidelines for ANTENATAL CARE GUIDELINES		

- Antenatal card
- High-risk register
- ART pregnancy register
- Consent forms

Reference:

1. NABH Accreditation Standards for Hospitals, 6th Edition – COP10 d

Sl. No	Current Revision			Nature of Change
	Edition No	Revision No.	Date	
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 the 6 th Edition
5	01	02	1 Jan 2026	No changes

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Department of Paediatrics			

Scope of Services: Department of Paediatrics

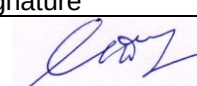
Introduction: The Department of Paediatrics is dedicated to providing selective healthcare services to infants, children, and adolescents. Our mission is to deliver high-quality, compassionate care through a multidisciplinary approach, focusing on prevention, diagnosis, treatment, and ongoing management of paediatric health conditions.

General Paediatric Care:

- Routine health check-ups and physical examinations
- Immunizations and vaccination programs
- Growth and developmental assessments
- Anticipatory counselling and guidance
- Management of common childhood illnesses and injuries
- Health education and preventive care

Emergency and Acute Care:

- Paediatric emergency services
- Acute illness and injury management
- Trauma care and stabilization

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Department of Paediatrics			

* The hospital has MOU with Star Kids Hospital for PICU services.

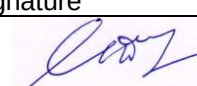
Supportive and Allied Services:

- Paediatric nursing care
- Child psychology and psychiatry

Reference:

NABH Accreditation Standards for Hospitals, 6th Edition – COP 11 a

Sl. No	Current Revision			Nature of Change
	Edition No	Revision No.	Date	
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	No changes review completed.
5	01	02	1 Jan 2026	No changes.

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Chapter: COP 11 B

Neonatal care is consonance with the national/international guidelines.

Refer NICU Manual

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	Prevention of Neonatal Abduction (CODE PINK) Plan		

1.0 Purpose

- To prevent the neonates (vulnerable group) from any abduction and abuse.
- To protect infants/children from removal by unauthorized persons.
- To identify the typical physical description and actions demonstrated by someone attempting to kidnap an infant/child from the hospital
- To define the individual and institutional response to an infant/child abduction.
- To sensitize the health care professionals to the risks and patterns of abduction

2.0 Scope

Hospital wide

3.0 Policy

3.1 Mother or in her absence a guardian is allowed to remain with the patient 24 hours.

3.2 All the neonates have a wrist band tagged with their name, hospital no, weight, birth time for their unique identification.

3.3 The Birth registration form contains information pertaining to newborn like its parent's names and address, date and time of birth.

3.4 The infants are kept in direct, line-of-site supervision at all times by a authorized staff member & the mother.

3.5 A full physical assessment of the infant is done after birth or admission and documented in the case file.

3.6 Patient movement outside the wards should be along with an identified responsible person.

3.7 The unit does not allow persons without authorization to leave or enter the unit.

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3.8 Hospital employees are to immediately report any unusual or suspicious behavior or individuals to the security officer.

3.9 Inform the security immediately in the event an infant or child cannot be located.

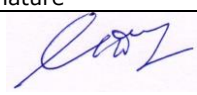
3.10 All concerned staff is made aware of the safety precautions to prevent abduction and abuse.

1. Responsibility

All hospital employees have a responsibility in protecting infants and children from being abducted from our hospital.

Employees involved in care of children in the following areas are required to be more vigilant

1. Patient waiting area in the front of hospital
2. Pediatric and neonatal areas
3. Labour room
4. Neonatal ICU

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The following health care professionals in the above areas need to be vigilant to the possibility of child abduction

1. Doctors
2. Nursing staff
3. Technicians
4. Security staff
5. Attenders
6. Staff in reception
7. Hospital cleaning staff

2. Policies and Procedure

PREVENTION OF ABDUCTIONS

Abductor Profile

The typical abductor based on various profiling studies world over:

- Is usually an overweight female, aged 20 – 60 years.
- Usually has no criminal record but may have committed mild offenses such as shop lifting or been involved in domestic or local fights.
- Has planned the abduction, but selection of the target is typically random and opportunistic.
- Usually is married or co-habituating, with troubled family relationships.

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- Usually targets a male infant/child.
- Usually acts alone, but may have a "partner" who will create a distraction to lure staff away from the target.

Frequently impersonates a nurse or other allied healthcare personnel. Often becomes familiar with healthcare personnel and even with the victim's parents

Suspicious Behavior

The following types of behaviors are considered to be unusual:

- Repeated visits to the hospital areas where children are around without any specific purpose, but "just to see" an infant or child.
- Questions about hospital procedures and floor layout, such as "When is feeding time?", "When are babies taken to the mothers?", or "Where are the stairs?"
- Comes forward to help mothers without ever having met them before
- Persons who are carrying large packages or bags off patient care areas.
- Persons unnecessarily hanging around rooms that are out of view of the nurses' station and close to staircases or emergency exits.

High Risk Situations

- Visitor's time in the hospital is always an easy time for abduction. This is because parents and care givers are busy handling guests or visitors and there is large movement of people.

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- Abductors have also been known to create a diversion in another area of the hospital to facilitate infant/child abduction.
- When there are times of high activity or confusion that is the time to become observant in the monitoring of infants/children.

Actions in case of suspected abduction (Code Pink Actions)

In the event of suspected infant/child abduction, the following steps should be taken.

- Notify the ward nurse immediately
- The in-charge nurse will call the security in charge and Security inform to the reception to initiate Code Pink (Code Pink Announcement – No 1199) and also inform the nursing supdt / floor supervisor immediately.
- The security in-charge on initiation of Code Pink assign personnel to the nearest public exits of the hospital building. All exits will be monitored. The adjacent rooms & wards checked by the nurses and closes all the exits. Safety Officer will check the recording of CCTV to locate the baby.
- Nursing staff will then notify the patient counselors to provide available support services as desired
- Security in charge will take additional follow-up steps such as monitoring hospital exits and/or informing the local police station.
- The Nursing supdt/ supervisor will inform the CMD, Medical Director(s) and Chief Medical Administrator. In case of newborns, the head of Neonatology will also be informed.

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- The Medical Director will call an emergency meeting of the above mentioned persons and the security in charge to coordinate activities and take actions to inform police in case the missing child / infant cannot be located.
- The abductor if and when identified will be secured by the security staff / lady staff (in case of female abductors) and handed over to the police. They shall be secured in a place inaccessible to relatives and general public to avoid incidences of violence against them.

Identifying hospital Babies

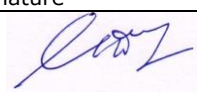
At the time of birth, all infants are assigned wristbands with name of mother, time, sex etc. Wristbands may be placed on either the arm or the leg of the baby. Wristbands are worn throughout the entire hospital stay. After an infant is discharged, the mother may remove the ID bands once she has left the hospital with her infant.

When Babies and Children are transported

There are times when babies and children must be transported to different parts of the hospital. The only ones who are allowed to transport babies and children are nursing staff, physicians, hospital attenders and the mother/ father/ grandmother.

Pediatric patients are not to leave the patient care area without the consent of the physician or nurse. Any child who is crying when transported must be viewed with suspicion.

Anyone who is transporting an infant or child is required to be wearing proper identification. Anyone who is transporting an infant or child without proper identification is considered suspicious.

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Patient/Family Teaching

Because family involvement is essential in preventing infant abduction, patient/family teaching is an essential element. Family members are taught the following:

- How they can be active participants in safeguarding their infant/child.
- To keep a deliberate, watchful eye on the infant/child at all times.
- Hospital protocols concerning routine hospital procedures such as feeding time, visitation hours, and security measures.
- Not to give the infant/child to anyone without properly verifying hospital identification.
- To become familiar with the hospital staff of the unit and to know which nurses are assigned to them.
- To question unfamiliar persons entering their room or inquiring about their infant/child, even if the person is in hospital attire
- Alert the nurses immediately if a person seems questionable.
- To determine where the infant/child will be taken for tests and how long the tests will take. Find out who authorized the tests. Alert the nurses for verification if information seems questionable.

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CODE PINK

Procedure to be Followed In Case of Suspected Infant / Child Abductions (Code Pink)

At the Location / Nursing Unit Suspecting Infant Abduction

1. Check all possible areas including bath rooms, feeding areas etc to locate the baby.
2. Ensure a senior member of the nursing team remains with the mother and family to re-assure them.
3. Inform the administrator and initiate Code Pink.
4. Prevent all people in the area from moving out till a thorough search is organized in the vicinity of the area and hospital security / police have cleared all the individuals..
5. For a newborn, notify the lab and place a hold on any blood specimens so that future identifications in case of mix ups are possible.
6. In the unit:
 - i. Perform a head count of all infants and compare to unit census.
 - ii. Leave all Childs in their existing locations (e.g. newborn nursery / NICU or mother's room) until the area is secured.
 - iii. If the mother is an in-patient, she should be transferred to a private room off the ward . Leave her belongings in the room. This is to ensure privacy, reduce stress and avoid public

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display of emotional outbursts creating a panic environment. Nursing staff from the original units should care for her on the new room

Actions By Security and Staff on Code Pink Alert

1. Security Officer deploys security at all entrances to the hospital.
2. A vehicle is dispatched immediately to scout nearby locations like bus stop etc to locate potential abductors.
3. All staff goes to an alert mode to identify any suspicious persons or activities. It is to be noted that infants may be carried in tote bags, luggage, large containers etc. Hence all such items may be requested for checking. Administrative Officer, Nursing Superintendent etc will ensure the process is under taken without inconvenience to the patients and guests involved.
4. In case any staff members observe a suspicious person, attempt to engage in conversation to slow her/him down while having a co-worker call the security and inform the AO to call the police. Staff should not get into a physical confrontation as it may cause harm to the infant. If it is possible and safe to do so, follow the person and note her direction of travel.
5. If the suspect has already left the building get a good physical description, direction of flight and other information such as vehicle make and registration and contact AO and Security immediately.
6. In case of not able to locate the infant with in premises and receiving information of the infant having been taken out of premises the AO immediately informs the MD and in turn local police station. The same is followed in case of any suspicious person being detained with in the premises by staff and security for attempted abduction.

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7. In case the suspected abduction is a case of genuine misplacement of the abduction or a event caused by panicking mother / relatives while the infant was in safe custody of a care giver / responsible relative a root cause analysis will be done to identify the reason and cause of raising a false alarm so that such incidents may be reduced. No staff will be reprimanded or punished in case of a false or avoidable Pink Code Alarm.

4. Monitoring

All infant abductions and alerts are reported in detail through an incident report form and reviewed personally by the CMD / Medical Director(s)

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NABH Standards: COP 11f

AMENDMENT HISTORY

Sl. No	Current Revision			Nature of Change
	Edition No	Revision No.	Date	
1	01	00	1 Oct 2019	First issue as per NABH Hospital Accreditation Standards – 4 th Edition
2	01	01	1 Nov 2020	Minor Revisions, updating Doc No. and updating for compliance as per NABH Hospital Standards 5 th Edition
3	01	01	1 Jan 2022	No changes.
4	01	02	1 Jan 2025	No changes review completed.
5	01	02	1 Jan 2026	No changes.

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	Guidelines for Procedural sedation		

1.0 INTRODUCTION

Moderate or deep sedation/analgesia may be used to reduce the distress and pain associated with diagnostic and therapeutic procedures. Sedation is also potentially hazardous and it is important that it is performed as safely as possible.

2.0 PURPOSE:

To define the methodology of providing and monitoring patients receiving moderate sedation at Saideep Hospital. This policy addresses moderate/procedural sedation for both adult and pediatric populations.

3.0 ABBREVIATIONS:

ASA: American Society of Anesthesiology

4.0 DEFINITIONS: (As per ASA)

- **Minimal Sedation (Anxiolysis)** is a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and physical coordination may be impaired, airway reflexes, and ventilatory and cardiovascular functions are unaffected:
- **Moderate Sedation/Analgesia (Conscious Sedation)** is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.
- **Deep Sedation/Analgesia** is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.
- **General Anesthesia** is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous

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ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

5.0 SCOPE:

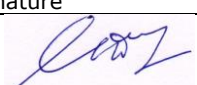
- Moderate/procedural sedation utilized for patients undergoing therapeutic, diagnostic and/or surgical procedures.
- This policy does not apply to patients being intubated for the purpose of placement on a ventilator, or to maintain sedation of patients on ventilators.
- The administration of moderate/procedural sedation can be done in the following areas of the hospital:
 - a. Critical Care Units
 - b. Emergency Departments
 - c. Imaging Departments
 - d. Cardiac Cath Lab
 - e. Operating Rooms and Post Anesthesia Care Units
 - f. NICU
 - g. Identification of some established procedures where sedation is required to be listed by each of the above departments

6.0 RESPONSIBILITY:

- Licensed medical practitioner administering moderate/procedural sedation qualified to rescue patients from deep sedation, and competent to manage a compromised airway and to provide adequate oxygenation and ventilation.
- Qualified Nurse under the supervision of a doctor
- Deep sedation is restricted to use by anesthesiologists.

7.0 PROCEDURE

- Pre-procedural checklist Patient assessment - patient is screened for potential risk factors for any pharmacological agents selected. Pre-procedure airway assessment is also performed.

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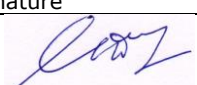
- Patients are classified as per the ASA Physical Status Classification (Annexure C); patients considered appropriate for moderate sedation are ASA Class I and Class II. Patients who meet ASA Class III or Class IV criteria need consultation with Anesthesia Department.
- Patient should be fasting to reduce risk of aspiration

Ingested Material	Minimum Fasting Period
Clear liquids	Peds-3 hours/Adults-2 hours
Breast Milk	4 hours
Infant formula/ Non-human milk	6 hours
Light meal	6 hours
Regular meal	8 hours

- A separate informed consent is obtained for the administration of moderate/procedural sedation. The consent shall be taken by the person administering sedation or doctor member of the team administering sedation. This sedation consent should be different from informed consent for the therapeutic/diagnostic procedure itself.
- Emergency drug tray and resuscitation equipment must be available; the latter is checked to ensure it is functioning (Annexure D).
- Patient is cannulated.
- Baseline pulse rate, blood pressure, respiratory rate, oxygen saturation, end tidal CO₂, and level of consciousness are recorded.
- Weight is also recorded for paediatric patients.

7.2 Intra-procedure

- Vital signs (respiratory rate, heart rate, and blood pressure), oxygen saturation, and level of consciousness will be recorded every 5 minutes unless such monitoring interferes with the procedure (e.g., magnetic resonance imaging where stimulation from the blood pressure cuff could arouse an appropriately sedated patient).
- Continuous ECG monitoring is required for deep sedation.
- Qualified personnel must be present throughout the procedure.
- **Person giving sedation and monitoring the patient should be different from the one performing the procedure**

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7.3 Post procedure

- Observe and monitor patients in an appropriately staffed and equipped area until they are near their baseline level of consciousness and are no longer at increased risk for cardiorespiratory depression.
- Monitor oxygenation continuously until patients are no longer at risk for hypoxemia.
- Monitor ventilation and circulation at regular intervals (e.g., every 5 to 15 min) until patients are suitable for discharge.
-

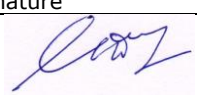
7.4 Transportation of sedated patient: Whenever the patient must be transported to another area or back to the unit, the following is to be ensured:

- Patient is transported with a portable oxygen saturation monitor on.
- Qualified personnel and appropriate equipment (oxygen, resuscitation bag, mask, oxygen tubing, oral airway, E.T. tubes, laryngoscope blades and handles, portable suction and suction catheters) accompany the patient.

7.5 Discharge Criteria: The patient may be discharged when:

- Patient is conscious, at their baseline level of verbal ability, and able to follow age-appropriate commands
- Vital signs including respiratory rate and oxygen saturation are within normal limits for this patient for a minimum of 30 minutes
- Respiratory status is not compromised
- Motor function has returned to pre-procedural levels, or patient is able to sit or ambulate unassisted (if appropriate for age) without dizziness
- Pain and/or nausea are controlled or are consistent with procedure
- Patient has voided (Not mandatory especially if the patient is to be transferred intra-hospital)
- Dressing/procedure site are dry/clean

Written discharge instructions are given to patient/parent/guardian; these instructions are also verbally reviewed with patient/parent/caregiver prior to discharge.

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7.6 Documentation - Proper documentation of

Pre procedure -

- status
- Fasting
- Consent

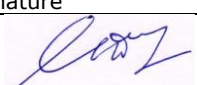
Intra procedure - Besides the procedure done, sedation notes with drugs used, their route, monitoring of vital parameters to be documented

Post procedure - Monitoring, duration of stay and shifting orders need to be documented

8.0 APPENDICES AND FORMS

Annexure A: Equipment required for the procedure

Annexure B: List of drugs for moderate/procedural sedation and their safe dosages for both adult and paediatric patients.

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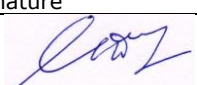
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Annexure A:
Equipment required for the procedure

- i. Pulse Oximetry
- ii. ETCO2 Monitor
- iii. Blood Pressure Monitoring Equipment
- iv. Cardiac Monitor
- v. Oxygen Source and Equipment
- vi. Oral Pharyngeal Airways
- vii. Ambu Bag and Facemask
- viii. Suction

Assure immediate accessibility of the following emergency equipment and personnel on the unit or in the area:

- i. Defibrillator with recorder capability
- ii. Adult or Pediatric Code Cart
- iii. Emergency Drug Box iv. ACLS Provider

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Annexure B

Medications to be used for Sedation

For areas other than Emergency Department, moderate sedation may be achieved using the following medications:

- Diazepam
- Ketamine
- Lorazepam
- Midazolam
- Morphine sulfate
- Fentanyl

In the Emergency Department, moderate/procedural sedation may be achieved using the medications listed above AND Etomidate and Propofol.

(Etomidate and Propofol will ONLY be administered by an anesthetist).

Reference:

1. NABH Accreditation Standards for Hospitals, 6th Edition – COP 12a

AMENDMENT SHEET

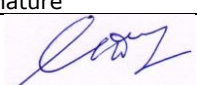
Sl. No	Current Revision			Nature of Change
	Edition No	Revision No.	Date	
2	01	01	1 Nov 2020	For compliance as per NABH Hospital Standards 5th Edition
3	01	01	1 Jan 2022	No changes.

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4	01	02	1 Jan 2025	Amended as per the 6 th Edition
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	Policy for discharge/transfer of patients from Postoperative recovery and discharge from PACU		

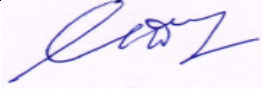
Policy for discharge/transfer of patients from Postoperative recovery and discharge from PACU

Introduction:

- Recovery is a continual and ongoing process that has been traditionally divided into three distinct yet overlapping phases: early recovery, as the patient emerges from anesthesia; intermediate recovery, when the patient achieves criteria for discharge; and late recovery, when the patient returns to their preoperative physiological state.
- Early recovery (phase I) commences on discontinuation of the anesthetic agent, which allows the patient to awaken, recover protective airway reflexes, and resume motor activity. This phase traditionally occurs in the post anesthesia care unit (PACU) in the presence of close monitoring and supervision by the nursing staff.
- Frequency of assessing and documenting vital signs is at least every 15 minutes during the first hour and then every 30 minutes until discharge from Phase I PACU care. The patient is then transitioned to Phase II, the inpatient setting, or the intensive care unit (ICU) for continued care.

Discharge of patients after General Anesthesia

- Modified Aldrete scoring system is used for determining when patients are fit for discharge from the PACU.

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Item	Answer choices (points)
Consciousness	Fully awake (2) Arousable (1) Not responding (0)
Mobility	Able to move four extremities on command (2) Able to move two extremities on command (1) Able to move 0 extremities on command (0)
Breathing	Able to breathe deeply (2) Dyspnea (1) Apnea (0)
Circulation	Systemic BP $\neq$ 20% of the preanesthetic level (2) Systemic BP between 20% and 49% of the preanesthetic level (1) Systemic BP $\neq$ 50% of the preanesthetic level (0)
Color	Normal (2) Pale, jaundiced, blotchy (1) Cyanotic (0)
O ₂ saturation	Maintaining O ₂ saturation >90% on room air (2) Needs inhalation to maintain O ₂ saturation >90% (1) O ₂ saturation <90% despite O ₂ supplementation (0)

- When a patient has achieved a score of 9, they are fit to be discharged to a step down unit where phase II recovery occurs until they reach the criteria for discharge.
- Phase II care focuses on continued recovery and is based on facility policy and the needs of the patient. The goal of this phase is to prepare the patient to be transferred home or to an extended care facility.
- The frequency of evaluating vital signs is every hour for the first 4 hours and then every 4 hours for the next 24 hours, it begins on arrival and ends at discharge or transfer to another unit.
- During this phase the patient is able to ambulate, take nutrition, and receive education and instructions necessary for self-management of care at home.

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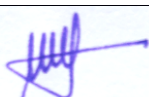
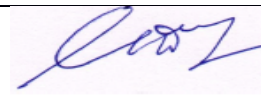
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- The drinking of fluids should not be part of a discharge/transfer protocol and may only be necessary for selected patients on a case-by-case basis
- The routine requirement for urination before discharge should not be part of a discharge protocol and may only be necessary for selected patients. When voiding is judged to be an integral part of recovery, patients can be discharged with clear instructions to seek medical help if unable to void within 6 to 8 hours of discharge.

Role of the Anesthesia Professional in Phase I and Phase II Levels of Care

Level of Care	Priorities	Possible Complications	Discharge from Phase Considerations
Phase I	• Stable airway with adequate ventilation and oxygenation • Hemodynamic stability • Manage analgesia and PONV • Oral intake	• Airway compromise • Cardiovascular depression • Pain • Side effects: - o Nausea - o Vomiting • Delirium	• Adequate airway and ventilator status • Cardiac and hemodynamic stability • Ability to move extremities on command • Fully awake • Adequate oxygen saturation on room air

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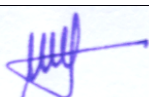
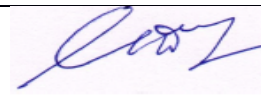
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	Discontinue or adapt IV (enhanced recovery protocol)	Procedure-specific considerations	
Phase II	- Mobility - Oral intake - Adequate analgesia - Education for discharge - Prescriptions	- Pain - Nausea - Vomiting	- Adequate pain relief and comfort - Hemodynamic stability - Nausea addressed - Takes fluids - Ambulates - Understands discharge instructions, medications and management of any issues - Safe transportation from the facility

- Phase III recovery occurs after discharge/transfer in ward (for extended stay cases) or at home and continues until the patient has resumed usual everyday activities

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After regional anesthesia

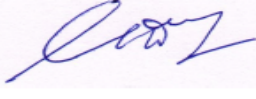
- Patients who have received a regional anesthetic need to meet the same discharge criteria as patients who have undergone general anesthesia (GA).

Spinal anesthesia

- Before patients are allowed to walk, it is important to assess whether the motor block has regressed. If there is normal perianal (S4 – 5) sensation, plantar flexion of the foot and proprioception in the great toe, the patient can safely begin to ambulate.

Major limb nerve blocks

- These are mainly used in ambulatory procedures (An ambulatory procedure is a nonemergency procedure, performed on carefully selected patients, which is undertaken with all its constituent elements (admission, operation, and discharge home) on the same day, procedures requiring extended stay (i.e. 23-hour stay) cannot be considered true ambulatory surgery). But if the patient is intended to stay in the hospital for > 24 hours then immediate transfer to the recovery / ward is initiated post operatively bypassing PACU.
- Long-acting peripheral nerve blockade results in loss of proprioception and the protective reflex of pain and an insensate extremity has the risk of injury. Also the patients who have received lower extremity nerve block have the risk of fall.

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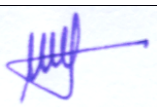
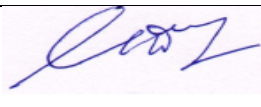
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- Such patients are transferred from PACU with clear instructions to monitor pain and protect them from a fall.
- Postoperative pain and postoperative nausea and vomiting may prolong stay after ambulatory surgery hence appropriate drugs/measures are taken to hasten the discharge by overcoming these factors.

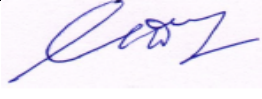
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Reference: COP -12 g, COP 13 g

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1	01	00	1 Oct 2019	First issue as per NABH Hospital Accreditation Standards – 4 th Edition
2	01	01	1 Nov 2020	Minor Revisions, updating Doc No. 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	No changes review completed.
5	01	02	1 Jan 2026	No changes

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POLICIES & PROCEDURES ON CARE OF PATIENTS REQUIRING ANESTHESIA

1.0 PURPOSE:

To provide guidelines on administration of anesthesia.

2.0 SCOPE:

All patients undergoing administration of anaesthesia at this hospital.

3.0 RESPONSIBILITY:

Anesthesiologist,

Medical Staff

Nursing staff and

Para-medical staff

4.0 ABBREVIATION:

NABH : National Accreditation Board For Hospitals and Healthcare providers

COP : Care Of Patients

6.0 POLICY:

6.1 Administration of Anesthesia: In order to achieve patient safety, the Anesthesia Care Team is responsible for the following:

1) **Pre-anesthetic evaluation of the patient:** A pre-anesthesia evaluation allows for the development of an anesthesia plan that considers all conditions and diseases of the patient that may influence the safe outcome of the anesthesia. Although non-physicians may contribute to the preoperative collection and documentation of patient data, the anesthesiologist is responsible for the overall evaluation of each patient, and needs to documentation if in written.

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2) **Prescribing of anesthesia plan:** The anesthesiologist is responsible for prescribing an anesthesia plan aimed at safety of each patient. The anesthesiologist discusses with the patient (when appropriate), the anesthesia risks, benefits and alternatives, and obtains informed consent.

3) **Management of the anesthesia:** The management of an anesthesia is dependent on many factors including the unique medical conditions of individual patients and the procedures being performed. The anesthesiologist will delegate specific tasks to qualified anesthesiologist to provide quality of care and patient safety. In critical parts of the anesthesia the Head of the Department anesthesia immediately informed for management of emergencies regardless of the type of anesthesia.

4) **Post-anesthesia care:** Routine post-anesthesia care is delegated to nurses. The evaluation and treatment of post-anesthesia complications are the responsibility of the anesthesiologist. Whether the need is preoperative medical clearance or intra-operative resuscitation from an unexpected complication, the surgeon, both ethically and according to training and ability, should be expected to provide medical oversight or supervision of all peri-operative healthcare provided.

6.2 Check list for Administration of Anesthesia: All patients for anesthesia have a pre-anesthesia assessment by a qualified anesthesiologist. There is a pre anesthesia assessment which results in formulation of an anesthesia plan which is documented. There is an immediate pre-operative reevaluation and it is documented. Informed consent for administration of anesthesia is obtained by the Anesthetist. During anesthesia there is regular and periodic monitoring and recording (documentation) of heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation, airway security and patency and level of anesthesia. Each patient's post anesthesia status is monitored and documented. The anesthesiologist applies defined criteria to transfer the patient from the recovery area. All adverse anesthesia events are recorded and monitored.

6.3 Pre Anesthesia evaluation: An Anesthesiologist shall be responsible for determining the medical status of the patient and developing a plan of anesthesia care. The Anesthesiologist is responsible for: Reviewing the available medical record; Interviewing and performing a focused examination of the patient to: Discuss the medical history, including previous anesthetic experiences and medical therapy; Assess those aspects of the patient's physical condition that might affect decisions regarding pre-operative risk and management; Prescribing and reviewing of available tests and consultations as necessary for administration of anesthesia care;

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Prescribing appropriate preoperative medications; Ensuring that consent has been obtained for the anesthesia care; Documenting in the patient case sheet that the above has been performed.

6.4 Routine Pre-operative Laboratory and Diagnostic Screening: Discovery or identification of a disease or disorder which may affect pre-operative anesthetic care; Verification or assessment of an already known disease, disorder, medical or alternative therapy which may affect pre-operative anesthetic care, and; Formulation of specific plans and alternatives for pre-operative anesthetic care; Routinely Hb%, TLC, DLC, ESR, Blood Sugar, Blood Urea, Urine analysis, CXR, ECG before any anesthesia exposure. Appropriate indications for ordering tests include the identification of specific clinical indicators or risk factors (e.g., age, pre-existing disease, magnitude of the surgical procedure).

6.5 Intra Procedural Monitoring: Immediate review prior to initiation of anesthetic procedures: Patient re-evaluation; Check of equipment, drugs and gas supply; Monitoring of the patient (e.g., recording of vital signs); Amounts of drugs and agents used, and times of administration; The type and amounts of intravenous fluids used, including blood and blood products, and times of administration; The technique(s) used; Unusual events during the administration of anesthesia; The status of the patient at the conclusion of anesthesia.

6.6 Post Anesthesia Care: Patient evaluation on admission and discharge from the recovery area. A time-based record of vital signs and level of consciousness. A time-based record of drugs administered their dosage and route of administration. Type and amounts of intravenous fluids administered, including blood and blood products. Any unusual events including post-anesthesia or post-procedural complications. Post-anesthesia visits.

6.7 Regional Anesthesia:

1) Phase I Recovery to Phase II Recovery Discharge Criteria following

Regional/ Neuraxial Anesthesia: The patient is suitable for transfer from Phase I Recovery when your institution's discharge criteria following General Anesthesia are met (see Tables one and two below) and the Motor and Sensory Assessments as outlined below in Table

Three have been met:

2) Modified Aldrete Scoring System:

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6.8 General Anesthesia : Modified Aldrete Scoring System: A minimum score of 9/10 (and/or return to similar pre-op status) is achieved prior to transferring the patient to a Phase II recovery area.

Category	Score = 2	Score = 1	Score = 0
Respirations	Breathes, coughs freely	Dyspnea	Apnea
O2 Saturation	SpO2 > 92% on R/A	Supplemental O2	SpO2 < 92% on O2
Circulation	BP +/- 20 mmHg pre-op value	BP +/- 20-50 mmHg pre-op value	BP +/- 50 mmHg pre-op value
LOC	Awake and oriented	Wakens with stimulation	Non-responsive
Movement	Moves 4 limbs spontaneously	Moves 2 limbs spontaneously	Moves 2 limbs spontaneously

6.9 Infection Control Protocols:

- 1) A specified consultant in each department of anaesthesia should liaise with the Hospital Infection Control Teams to ensure that relevant specialist standards are established and monitored in all areas of anaesthetic practice.
- 2) Precautions against the transmission of infection between patient and anaesthetist or between patients should be a routine part of anaesthetic practice.
- 3) In particular, anaesthetists must ensure that hand hygiene becomes an indispensable part of their clinical culture.
- 4) Anaesthetists must comply with local theatre infection control policies including the safe use and disposal of sharps.
- 5) Anaesthetic equipment is a potential vector for transmission of disease.
- 6) Policies should be documented to ensure that nationally recommended decontamination practices are followed and audited for all reusable anaesthetic equipment.
- 7) Single use equipment should be utilised where appropriate but a central sterile supplies department (CSSD) should process reusable items.

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8) It is recommended that anaesthetic departments should consider changing anaesthetic circuits on a daily basis in line with daily cleaning protocols.

9) Appropriate infection control precautions should be established for each anaesthetic procedure, to include maximal barrier precautions for the insertion of central venous catheters, spinal and epidural procedures and any invasive procedures in high risk patients.

6.10 Adverse Anaesthesia Events:

1) All post-operative patients shall be monitored for any adverse anaesthesia event.

2) The patients shall be shifted from the recovery area as per the Scoring by the Aneesthesiologist.

7.0 PROCEDURE:

7.1 Preliminary preparation should be made before conscious sedation. Services are provided in a particular clinic:

1) **Administrative:** If the provision of conscious sedation services is being considered in a clinic, the department Chair should review the policy for Conscious Sedation and make a decision regarding the clinic's ability to meet staffing, educational and equipment requirements.

2) **Medical Staff:** The physician supervising the administration of conscious sedation should be qualified to rescue patients from deep sedation and must obtain specific privileges from the Core Committee through the Medical Staff Office credentialing procedure. As per Department of Anesthesia recommendations, the following general anesthetic agents are not considered appropriate for IV conscious sedation. These agents include, but are not limited to : Thiopental (Pentothal); Methohexital (Brevital); Ketamine; Propofol (Diprivan); and anesthetic gases (Isoflurane, Halothane, Nitrous Oxide). The physician will direct the administration of conscious sedation to achieve the desired level of sedation and have available the necessary equipment and trained staff required in the event of an adverse reaction to the medication or procedure.

3) **Assisting Staff:** Health care providers assisting and monitoring the patient before, during, and after a procedure should have specific training in conscious sedation and have no other

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duties assigned until the patient is ready for discharge (usually a minimum of one hour post-procedure monitoring).

7.2 Planning for Care:

1) Pre –anaesthesia assessment: All the anaesthesia has a pre –anaesthesia assessment by the qualified individual. The pre anaesthesia assessment results in formulation of an anaesthesia plan which is documented.

2) **Pre-operative re-evaluation:** An immediate pre-operative re-evaluation is documented. The physician will determine the appropriateness of performing the procedure(s) requiring conscious sedation based upon:

7.2.2.1 The patient's medical, anaesthetic, and medication history.

7.2.2.2 The patient's current medical condition.

7.2.2.3 Available diagnostic data.

7.2.2.4 Risks, benefits and alternatives of the procedure

7.3 Consent: The physician will discuss the purpose, options, and risks for conscious sedation with the patient and family prior to the procedure; and will obtain and document informed consent. The informed consent for the administration of anaesthesia is obtained by the anaesthetist.

7.4 Pre-anesthesia assessment: All patients posted for elective surgery should be admitted one day prior to surgery so that the anesthesiologist can do pre-anesthesia assessment and plan anesthesia procedures accordingly. During the anesthesia monitoring includes regular and periodic recording of the heart rate, cardiac rhythm, respiratory rate, blood pressure ,oxygen saturation, airway security and the patency and the level of anesthesia.

1) History:

7.4.1.1 History of previous illness (Diabetes, HT, renal or liver disease, bronchial asthma, epilepsy etc) and history of drug intake for the same should be taken. History of allergy to any drug should be elicited. History must be taken of any previous surgery and any adverse effect after anesthesia such as delayed recovery from anesthesia or severe bronchospasm after anaesthesia. A family history of somebody having problems with anaesthesia should be taken.

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History of blood disorders, prolonged bleeding and clotting time should be taken. History should be taken of cardiac disease, chest infection, jaundice, alcoholism, smoking and urinary problem. History of having any pacemakers implanted inside the body should be elicited. History should be taken on the hours of starvation

2) Examinations:

7.4.2.1 Detailed examinations of all systems are necessary to assess the pre-operative physical status of the patient. Pulse, BP, RR and temperature must be taken. Cardiovascular and respiratory system must be extensively examined. Airway examination includes mouth, protruding tooth, and shaky tooth, uvula and opening of mouth. History of the use of artificial dentures should be elicited and it has to be removed before the anaesthesia procedure. Along with the assessment of the physical status of the patient, the anesthesiologist has to assess the mental status of the patient. The anesthesiologist has to explain in a reassuring manner how the anaesthesia procedure is planned, the approximate duration of surgery, how long the patient will be inside the post op ICU, when he can take food or water. When a patient is thus educated he can be mentally and psychologically prepared to tolerate better the stress and strain of an anaesthesia and surgery.

3) **Investigations:** Routine blood investigations such as Hb, TC, DC, ESR, Blood sugar, blood urea, S. Creatinine, CT, BT, PCV, HIV, HBS Ag, Urine routine are done. In indicated patients, LFT, PT, PTT, and S. electrolytes are also done. Pulmonary function tests are done preoperatively in COPD patients to assess respiratory status and improve functional vital capacity before being taken up for surgery. ABG analysis in indicated patients, chest X-ray and ECG are also done. If ECG changes are seen, detailed cardiac evaluation by a cardiologist including echocardiography, TMT etc. Patients are routinely examined by physicians to assess all systems. The concerned super-specialists such neurologists, nephrologists, cardiologists etc. are consulted as the case may arise. All the relevant details of the patient are documented in the case sheet during this pre anesthesia visit.

7.5 Premedication: Reasons for premedication: Patient's comfort for analgesia, sedation Drugs used are Diazepam, Alprazolam, Midazolam, etc. Decrease in gastric volume and increase in PH. Drugs used are antacids, Ranitidine, Omeprazole, Pantoprazole, Rabeprazole etc. Decrease in airway secretion, e.g. Glycopyrolate, Atropine. Decrease in autonomic response

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e.g. Atropine. Prophylaxis against allergic reactions e.g. Dexona, Betnesol etc. Continue therapy for concurrent disease. Decrease in incidence of nausea and vomiting e.g. Ondansetron, metocloperamide, Phenergan etc.

7.6 Restriction of Oral Intake before Surgery: Vomiting and aspiration of gastric contents during induction of anaesthesia can cause pulmonary damage, if volume of aspirate reaches 25ml/Kg and smaller volume can also produce damage. Patients who are pregnant, obese, smokers and Patients who have hiatus hernia are at a greater risk of aspiration. Usually the patients are instructed to take nothing orally for 6 to 8 hours before surgery to reduce the risk of aspiration of gastric contents. Children and new born are advised only 4 hours of starvation.

7.7 Documentation: All the relevant history, investigation reports and examination findings are documented by the anesthesiologist which including an immediate pre operative re-evaluation, In addition to this, the pre anesthesia assessment results in formulation of an anesthesia plan , Pre-medication and pre-op. orders should also be documented.

7.8 Informed Consent: Written informed consent should be obtained from the patient before any surgery and anaesthesia. In the case of a child aged less than 16 years or unconscious/ mentally retarded patient, the parent's guardian signs the form. Explanation of the hazards of surgery and anaesthesia should be given to the patients and bystanders.

7.9 Anaesthesia Procedure: During anaesthesia induction and maintenance, regular and periodic recordings of heart rate, temperature, Respiratory rate, and Oxygen saturation should be done. Urine output and CVP should be recorded for prolonged cases.

7.10 Post Anaesthesia Care: Patient is shifted to the recovery room and the patient's vitals should be monitored. ECG monitor, Pulse oxymeter, central oxygen supply, intubation equipment, airway maintenance equipments, and emergency drugs should be always kept ready in the recovery room. After the patient has sufficiently recovered from anaesthesia, the patient is shown to the bystanders and shifted to the post OP / ICU, where the patient is usually kept for 24 hours. In the post OP/ICU the patient's vitals are regularly monitored and recorded.

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The patient is shifted to the ward according to the surgeon's discretion. All the drug anesthesia events are recorded and monitored.

7.11 Post-Operative Pain Management : Post-operative pain is mainly managed by epidural analgesia, NSAIDS. Epidural analgesia for labour pain is also done. Opioids commonly used are Fortwin, Pethidine, Morphine. and fentanyl. For epidural analgesia drugs used are Sensorcaine (0.25%), Fentanyl, and Tramadol. All adverse anaesthesia events are recorded and analysed by the Pharmacy and therapeutic committee for taking preventive actions in the future.

Reference – COP 13 A

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	Policy for discharge/transfer of patients from Postoperative recovery and discharge from PACU		

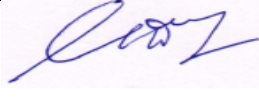
Policy for discharge/transfer of patients from Postoperative recovery and discharge from PACU

Introduction:

- Recovery is a continual and ongoing process that has been traditionally divided into three distinct yet overlapping phases: early recovery, as the patient emerges from anesthesia; intermediate recovery, when the patient achieves criteria for discharge; and late recovery, when the patient returns to their preoperative physiological state.
- Early recovery (phase I) commences on discontinuation of the anesthetic agent, which allows the patient to awaken, recover protective airway reflexes, and resume motor activity. This phase traditionally occurs in the post anesthesia care unit (PACU) in the presence of close monitoring and supervision by the nursing staff.
- Frequency of assessing and documenting vital signs is at least every 15 minutes during the first hour and then every 30 minutes until discharge from Phase I PACU care. The patient is then transitioned to Phase II, the inpatient setting, or the intensive care unit (ICU) for continued care.

Discharge of patients after General Anesthesia

- Modified Aldrete scoring system is used for determining when patients are fit for discharge from the PACU.

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Item	Answer choices (points)
Consciousness	Fully awake (2) Arousable (1) Not responding (0)
Mobility	Able to move four extremities on command (2) Able to move two extremities on command (1) Able to move 0 extremities on command (0)
Breathing	Able to breathe deeply (2) Dyspnea (1) Apnea (0)
Circulation	Systemic BP $\neq$ 20% of the preanesthetic level (2) Systemic BP between 20% and 49% of the preanesthetic level (1) Systemic BP $\neq$ 50% of the preanesthetic level (0)
Color	Normal (2) Pale, jaundiced, blotchy (1) Cyanotic (0)
O2 saturation	Maintaining O ₂ saturation >90% on room air (2) Needs inhalation to maintain O ₂ saturation >90% (1) O ₂ saturation <90% despite O ₂ supplementation (0)

- When a patient has achieved a score of 9, they are fit to be discharged to a step down unit where phase II recovery occurs until they reach the criteria for discharge.
- Phase II care focuses on continued recovery and is based on facility policy and the needs of the patient. The goal of this phase is to prepare the patient to be transferred home or to an extended care facility.
- The frequency of evaluating vital signs is every hour for the first 4 hours and then every 4 hours for the next 24 hours, it begins on arrival and ends at discharge or transfer to another unit.
- During this phase the patient is able to ambulate, take nutrition, and receive education and instructions necessary for self-management of care at home.

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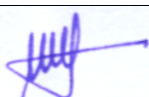
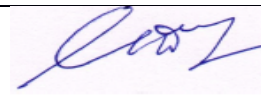
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- The drinking of fluids should not be part of a discharge/transfer protocol and may only be necessary for selected patients on a case-by-case basis
- The routine requirement for urination before discharge should not be part of a discharge protocol and may only be necessary for selected patients. When voiding is judged to be an integral part of recovery, patients can be discharged with clear instructions to seek medical help if unable to void within 6 to 8 hours of discharge.

Role of the Anesthesia Professional in Phase I and Phase II Levels of Care

Level of Care	Priorities	Possible Complications	Discharge from Phase Considerations
Phase I	• Stable airway with adequate ventilation and oxygenation • Hemodynamic stability • Manage analgesia and PONV • Oral intake	• Airway compromise • Cardiovascular depression • Pain • Side effects: - o Nausea - o Vomiting • Delirium	• Adequate airway and ventilator status • Cardiac and hemodynamic stability • Ability to move extremities on command • Fully awake • Adequate oxygen saturation on room air

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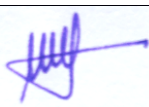
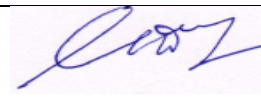
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	Discontinue or adapt IV (enhanced recovery protocol)	Procedure-specific considerations	
Phase II	- Mobility - Oral intake - Adequate analgesia - Education for discharge - Prescriptions	- Pain - Nausea - Vomiting	- Adequate pain relief and comfort - Hemodynamic stability - Nausea addressed - Takes fluids - Ambulates - Understands discharge instructions, medications and management of any issues - Safe transportation from the facility

- Phase III recovery occurs after discharge/transfer in ward (for extended stay cases) or at home and continues until the patient has resumed usual everyday activities

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After regional anesthesia

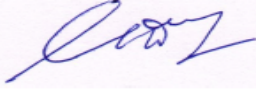
- Patients who have received a regional anesthetic need to meet the same discharge criteria as patients who have undergone general anesthesia (GA).

Spinal anesthesia

- Before patients are allowed to walk, it is important to assess whether the motor block has regressed. If there is normal perianal (S4 – 5) sensation, plantar flexion of the foot and proprioception in the great toe, the patient can safely begin to ambulate.

Major limb nerve blocks

- These are mainly used in ambulatory procedures (An ambulatory procedure is a nonemergency procedure, performed on carefully selected patients, which is undertaken with all its constituent elements (admission, operation, and discharge home) on the same day, procedures requiring extended stay (i.e. 23-hour stay) cannot be considered true ambulatory surgery). But if the patient is intended to stay in the hospital for > 24 hours then immediate transfer to the recovery / ward is initiated post operatively bypassing PACU.
- Long-acting peripheral nerve blockade results in loss of proprioception and the protective reflex of pain and an insensate extremity has the risk of injury. Also the patients who have received lower extremity nerve block have the risk of fall.

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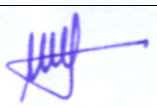
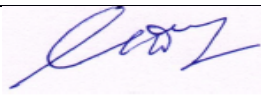
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- Such patients are transferred from PACU with clear instructions to monitor pain and protect them from a fall.
- Postoperative pain and postoperative nausea and vomiting may prolong stay after ambulatory surgery hence appropriate drugs/measures are taken to hasten the discharge by overcoming these factors.

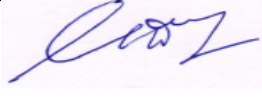
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AMENDMENT HISTORY

Sl. No	Current Revision			Nature of Change
	Edition No	Revision No.	Date	
1	01	00	1 Oct 2019	First issue as per NABH Hospital Accreditation Standards – 4 th Edition
2	01	01	1 Nov 2020	Minor Revisions, updating Doc No. 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	No changes review completed,
5	01	02	1 Jan 2026	No changes

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List of Surgeries and Approved Competencies

Sr.	SPECIALITY	SURGERY NAME	SURGERY TYPE	Required Competanacy Level	
			Category		
				Qualification	Experience
1	CARDIOVASULAR THORACIC	Pericardiocentesis	Minor	MCH - Cardiothoracic Surgery or Equivalent	3 Years
2	CARDIOVASULAR THORACIC	Pleural Tapping	Minor		
3	CARDIOVASULAR THORACIC	Tube Thoracotomy	Minor		
4	CARDIOVASULAR THORACIC	Pericardial Biopsy/Pericardiocentesis	Minor		
5	CARDIOVASULAR THORACIC	Wire Removal/Secondary Suturing	Minor		
6	CARDIOVASULAR THORACIC	Removal Of Sternal Wires	Intermediate		
7	CARDIOVASULAR THORACIC	Patent Ductus Arteriosus (Pda) Closure/Open	Intermediate		
8	CARDIOVASULAR THORACIC	Pacemaker implantation	Intermediate		
9	CARDIOVASULAR THORACIC	Embolectomy	Major		
10	CARDIOVASULAR	Ligation And Stripping Of Various Veins	Major		

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	THORACIC		
11	CARDIOVASULAR THORACIC	Ligation Or Plication Of Vena Cava	Major
12	CARDIOVASULAR THORACIC	Tracheal Dilatation And Foreign Body Removal	Major
13	CARDIOVASULAR THORACIC	Venous Thrombectomy	Major
14	CARDIOVASULAR THORACIC	Unifocalization Of Mapcas With Bt/Central Shunt	Major
15	CARDIOVASULAR THORACIC	Pda Vat	Major
16	CARDIOVASULAR THORACIC	Bt Shunt	Major
17	CARDIOVASULAR THORACIC	Pa Banding	Major
18	CARDIOVASULAR THORACIC	Coarctation Repair/Aortic Arch Open	Major
19	CARDIOVASULAR THORACIC	Pericardectomy	Major
20	CARDIOVASULAR THORACIC	Vats Bullectomy	Major
21	CARDIOVASULAR	Atrial Septal Defect (Asd)	Major Plus

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22	CARDIOVASULAR THORACIC	Ventricular Septal Defect (Vsd)	Major Plus
23	CARDIOVASULAR THORACIC	Simple Open Heart Surgery Above 3 Years Of Age	Major Plus
24	CARDIOVASULAR THORACIC	Glenn Shunt	Major Plus
25	CARDIOVASULAR THORACIC	Pulmonary Valvotomy	Major Plus
26	CARDIOVASULAR THORACIC	Sub Aortic Membrane Resection	Major Plus
27	CARDIOVASULAR THORACIC	All Open Heart Surg.For Congen.Heart Diseases	Major Plus
28	CARDIOVASULAR THORACIC	B.T.Shunt	Major Plus
29	CARDIOVASULAR THORACIC	Femoropopliteal Bypass	Major Plus
30	CARDIOVASULAR THORACIC	Pleurectomy	Major Plus
31	CARDIOVASULAR THORACIC	Removal Of Mediastinal Mass	Major Plus
32	CARDIOVASULAR	Repair Of Diaphragmatic Hernia	Major Plus

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33	CARDIOVASULAR THORACIC	Segmental Resection Of The Lung	Major Plus
34	CARDIOVASULAR THORACIC	Aorto-Femoral Bypass	Supra Major
35	CARDIOVASULAR THORACIC	Closed Heart Valvotomy	Supra Major
36	CARDIOVASULAR THORACIC	Lt Thoracotomy+Pleurectomy+Bullectomy	Supra Major
37	CARDIOVASULAR THORACIC	Operations For Oesophageal Varices	Supra Major
38	CARDIOVASULAR THORACIC	Repair Of Patent Ductus	Supra Major
39	CARDIOVASULAR THORACIC	Tetralogy Of Fallot Correction (Tof)	Supra Major
40	CARDIOVASULAR THORACIC	Health Valve Repair/Replacement	Supra Major
41	CARDIOVASULAR THORACIC	Open Heart Surgery Below 3 Years	Supra Major
42	CARDIOVASULAR THORACIC	Congenital Surgeries With More Than 1 Defect	Supra Major
43	CARDIOVASULAR	Ventricular Septal Defect With Pulmonary Hypertension (Vsd W	Supra Major

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44	CARDIOVASULAR THORACIC	Atrial Septal Defect + Partial Anomalous Pulmonary Venous Re	Supra Major
45	CARDIOVASULAR THORACIC	C.A.B.G.	Supramajor Plus
46	CARDIOVASULAR THORACIC	Coarctation Of Aorta	Supramajor Plus
47	CARDIOVASULAR THORACIC	Double Valve Repair And Replacement Surger	Supramajor Plus
48	CARDIOVASULAR THORACIC	Reconstruction Of Trachea	Supramajor Plus
49	CARDIOVASULAR THORACIC	Resection Of Aneurysm Of Abdominal Aorta	Supramajor Plus
50	CARDIOVASULAR THORACIC	Surg.For Aneurysm Of Aortic Arch And Thoracic/Aorta.	Supramajor Plus
51	CARDIOVASULAR THORACIC	Arterial Switch For Transposition Of Great Vessels(Arterial	Supramajor Plus
52	CARDIOVASULAR THORACIC	Total Anomalous Pulmonary Venous Correction (Tapvc) Repair	Supramajor Plus
53	CARDIOVASULAR THORACIC	Fontan/Tcpc Surgery	Supramajor Plus
54	CARDIOVASULAR	Rastelli Repair	Supramajor Plus

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	THORACIC				
55	CARDIOVASULAR THORACIC	Atrioventricular Canal Defect/Repair	Supramajor Plus		
56	CARDIOVASULAR THORACIC	Truncus Arteriosus Repair (Tar)	Supramajor Plus		
57	CARDIOVASULAR THORACIC	Open Heart Surgery Below 6 Months	Supramajor Plus		
58	CARDIOVASULAR THORACIC	Ross Procedure	Supramajor Plus		
59	CARDIOVASULAR THORACIC	Complex Birth Defects In Adults	Supramajor Plus		
60	CARDIOVASULAR THORACIC	Single Valve Replacement And Repair	Supramajor Plus		
61	CARDIOVASULAR THORACIC	CABG + AVR	Supramajor Plus		
62	CARDIOVASULAR THORACIC	MVR	Supramajor Plus		
63	CARDIOVASULAR THORACIC	ASD Closure Adult CVTS	Supramajor Plus		
Sr.	Speciality	Surgery	Category	BDS / MDS	3
64	DENTAL	Single Impacted Molar Surgery	Minor		
65	DENTAL	Biopsy Of Oral Mucosa, Tongue And Jaw Bones.	Intermediate		

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66	DENTAL	Cauterization Of Intra Oral Soft Tissue Lesions	Intermediate	MDS	3
67	DENTAL	Clw Suturing	Intermediate		
68	DENTAL	Dilatation Of Salivary Ducts	Intermediate		
69	DENTAL	Excision Of Sinus Or Scar Tissue	Intermediate		
70	DENTAL	Frenectomy	Intermediate		
71	DENTAL	Multiple Molar (Impacted) Surgery	Intermediate		
72	DENTAL	Apicectomy And Periapical Curcettage	Major		
73	DENTAL	Management Of Dento-Alveolar Fractures	Major		
74	DENTAL	Multiple Molar Deeply Impacted	Major		
75	DENTAL	Removal Of Fixations	Major		
76	DENTAL	Removal Of Teeth In A Single Quardrant With Alveoloplasty	Major		
77	DENTAL	Sialolithotomy-Parotid And Submandibular Glands	Major		
78	DENTAL	Single Tooth Apicectomy And Periapical Curettage	Major		
79	DENTAL	Subgingival Curettage Per Quadrant	Major		
80	DENTAL	Total Arch Alveoloplasty	Major		
81	DENTAL	Clos.Of Oro-Antral Fistula With Or Without Caldwell	Major Plus		
82	DENTAL	Closed Reduction And Fixation Of Fractures Of The Facial Ske	Major Plus		
83	DENTAL	Conservative/Endodontic Treatment Of Multiple Teeth Under La/	Major Plus		
84	DENTAL	Excision Of MAJO Salivary Gland	Major Plus		
85	DENTAL	Full Mouth Extractions Of Teeth With Alveoloplasty	Major Plus		

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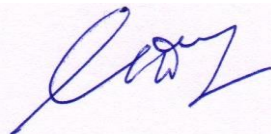


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86	DENTAL	Full Mouth Periodontal Flap Surgery	Major Plus	
87	DENTAL	Incision And Drainage Of Oro Facial Infections	Major Plus	
88	DENTAL	Management Of Unilocular Cystic Lesion Of The Jaw	Major Plus	
89	DENTAL	Mandible - Plating With Arch Fixation	Major Plus	
90	DENTAL	Multiple Apicectomy	Major Plus	
91	DENTAL	Neurorrhaphy-Inferior Alveolar Nerve	Major Plus	
92	DENTAL	Oral Implant Surgery-Single Unit	Major Plus	
93	DENTAL	Removal Of Multiple Impacted Teeth Through Transalveolar App	Major Plus	
94	DENTAL	Sequestration And/Or Saucerization For Chronic Osteotomy Of	Major Plus	
95	DENTAL	Surgical Removal Of Single Third Molar Exhibit.Bony Implant	Major Plus	
96	DENTAL	Surgical Removal Of Multiple Third Molars Exhi.Soft Tissue	Major Plus	
97	DENTAL	Oral Implant Surgery-Single Quadrant Multiple Unit	Supra Major	
98	DENTAL	Peripheral Osteotomy For Tumours Of The Jaws	Supra Major	
99	DENTAL	Replantation Of Autotransplantation Of Teeth(Multiple)	Supra Major	
100	DENTAL	Subtotal/Partial Mandibuotomy/Maxillectomy	Supra Major	
101	DENTAL	Excision Of Fibrous Bands And Skin Grafting For Oral Submuco	Supra Major	
102	DENTAL	Excision Of Mucocele,Mucosal Cyst,Eruption Cyst	Supra Major	
103	DENTAL	Fractures Of The Facial Skeleton	Supra Major	
104	DENTAL	Management Of Multilocular Cystic Lesions Of The Jaw	Supra Major	
105	DENTAL	Onlay Bone Grafting Or Silastic Prosthesis	Supra Major	
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106	DENTAL	Bilateral Release Of Fibrous Band -Excision Of Coronoid	Supramajor Plus		5 Years
107	DENTAL	Open Reduction And Fixation Of Fractures Of The Facial Skele	Supramajor Plus		
108	DENTAL	Oral Implant Surgery-Full Mouth Multiple Units	Supramajor Plus		
109	DENTAL	Orthognathic Surgery For Facial Deformities	Supramajor Plus		
110	DENTAL	Tmj Surgery-Bilateral Condylectomy	Supramajor Plus		
111	DENTAL	Total Mandibulectomy/Maxillectomy	Supramajor Plus		
Sr.	Speciality	Surgery	Category		
112	ENT	Steroid Injection For Tm Joint	Minor	MS ENT	
113	ENT	Anterior Nasal Packing	Minor		
114	ENT	Aural Polypectomy	Minor		
115	ENT	Examination Under Microscope	Minor		
116	ENT	Excision Preauricular Sinus	Minor		
117	ENT	Exploratory Tympanotomy	Minor		
118	ENT	F.B. Nose Removal	Minor		
119	ENT	F.B.Removal From Ear	Minor		
120	ENT	I And D Peritonsillar Abscess	Minor		
121	ENT	I And D Mastoid Abscess	Minor		
122	ENT	Lobuloplasty (Unilateral)	Minor		
123	ENT	Polypi Nasal Along With The Pack Removal	Minor		
124	ENT	Injection Intratympanic	Minor		
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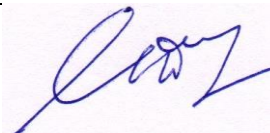


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125	ENT	Grommet Insertion	Intermediate	
126	ENT	Unilateral Endoscopic Dcr	Intermediate	
127	ENT	Mini Incision Myringoplasty	Intermediate	
128	ENT	Trans Tympanic Myringoplasty	Intermediate	
129	ENT	Canalplasty	Intermediate	
130	ENT	Atticotomy	Intermediate	
131	ENT	Maxillary Ostiumplasty	Intermediate	
132	ENT	Sleeve Resection Of External Auditory Canal (Partial)	Intermediate	
133	ENT	Post Canal Wall Reconstruction	Intermediate	
134	ENT	Adenoidectomy With Bilateral Grommet Insertion	Intermediate	
135	ENT	Adenotonsillectomy	Intermediate	
136	ENT	Antrostomy	Intermediate	
137	ENT	Bilateral Grommet Insertion	Intermediate	
138	ENT	Bronchoscopy	Intermediate	
139	ENT	Caldwell Luc S Operation	Intermediate	
140	ENT	Cryo Vidian Neurectomy	Intermediate	
141	ENT	Diagnostic MIs	Intermediate	
142	ENT	Nasal Cauterization/Submucosal Diathermy	Intermediate	
143	ENT	Nasal Endoscopy-Diagnostic	Intermediate	
144	ENT	Oesophagoscopy	Intermediate	
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145	ENT	Oro Antral Fistula	Intermediate
146	ENT	Post Nasal Mass Removal Endoscopic Trans Oral	Intermediate
147	ENT	Ranula Lip Laser Excision	Intermediate
148	ENT	Posterior Nasal Packing	Intermediate
149	ENT	S M R Of Nasal Septum	Intermediate
150	ENT	Sedto Plasty	Intermediate
151	ENT	Submucous Diathermy/Cryo Nose	Intermediate
152	ENT	Tracheostomy	Intermediate
153	ENT	Turbinestomy	Intermediate
154	ENT	Tongue Tie Release	Intermediate
155	ENT	Sleep Endoscopy	Intermediate
156	ENT	INTRATYMAPANIC INJECTION	Intermediate
157	ENT	MYRINGOPLASTY	Intermediate
158	ENT	TEAR EAR LOBE REPAIR UNILAT	Intermediate
159	ENT	NASAL PACK REMOVAL	Intermediate
160	ENT	NASAL PACKING	Intermediate
161	ENT	Myringoplasty	Major
162	ENT	Osteoma Excision	Major
163	ENT	Thyroplasty Type I	Major
164	ENT	Choanal Atresia	Major

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165	ENT	Direct Laryngoscopy And Removal Of Bilat. Vocal Nodes	Major
166	ENT	F.E.S.S.	Major
167	ENT	Fracture Maxilla	Major
168	ENT	Laryngo-Fissure	Major
169	ENT	Lateral Pharyngotomy	Major
170	ENT	Lateral Rhinotomy	Major
171	ENT	Micro Laryngeal Surgery	Major
172	ENT	Cwd Mastoidectomy	Major
173	ENT	Mastoid Exploration	Major
174	ENT	Stapedotomy	Major
175	ENT	Atticoantrostomy	Major
176	ENT	Frontal Sinusotomy	Major
177	ENT	Sleeve Resection Of Auditory Canal (Total)	Major
178	ENT	Microflap Surgery In Larynx	Major
179	ENT	Parapharyngeal Tumour Exicisio	Major
180	ENT	Revision Septoplasty	Major
181	ENT	Septoplasty With Turbinate Cauterisatiopn	Major
182	ENT	Tar With Bilateral Myringotomy Grommet	Major
183	ENT	Transantral Ethmoidectomy	Major
184	ENT	Fess Unilateral	Major

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185	ENT	Adenotonsillectomy With Bilat Grommet Insertion	Major
186	ENT	Fracture Nasal Bone	Major
187	ENT	Endoscopic Septoplasty	Major
188	ENT	MYRINGOTOMY WITH GROMMET INSERTION UNILAT	Major
189	ENT	MYRINGOTOMY	Major
190	ENT	TEAR EAR LOBE REPAIR BILAT	Major
191	ENT	DNE NASAL PACKING/REMOVAL	Major
192	ENT	I & D PERITONSILLAR ABSECSS	Major
193	ENT	I & D of ABSCESS(EAR/NOSE/THROAT)	Major
194	ENT	TONGUE TIE RELEASE	Major
195	ENT	ENDOSCOPIC SEPTOPLASTY	Major
196	ENT	CHOANAL ATRESIA	Major
197	ENT	DIAGNOSTIC BRONCHOSCOPY	Major
198	ENT	Laryngectomy	Major Plus
199	ENT	Fess Bilateral	Major Plus
200	ENT	Laser Arytenoidectomy	Major Plus
201	ENT	Mastoidectomy	Major Plus
202	ENT	Rhinoplasty	Major Plus
203	ENT	Stapedectomy	Major Plus
204	ENT	Thyroplasty	Major Plus

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205	ENT	Unilateral Nasal Polypectomy	Major Plus
206	ENT	Septoplasty With Vp 3	Major Plus
207	ENT	Near Total Thyroidectomy	Major Plus
208	ENT	T Tube Insertion	Major Plus
209	ENT	Uvulopalatopharyngoplasty (Upp/Up3)	Major Plus
210	ENT	Coblation Assisted Uvulopalatopharyngoplasty (Caup)	Major Plus
211	ENT	Tympanoplasty With Reconstruction	Major Plus
212	ENT	Tympanomastoidectomy	Major Plus
213	ENT	Septoplasty with Balloon Sinuplasty	Major Plus
214	ENT	Balloon Sinoplasty extended	Major Plus
215	ENT	Tympanoplasty	Major Plus
216	ENT	Endoscopic Septoplasty + Grommet Insertion	Major Plus
217	ENT	Microchoectomy	Major Plus
218	ENT	Tonsillectomy [Coblation Assisted]	Major Plus
219	ENT	TYMPANOPLASTY WITH MASTOIDECTOMY	Major Plus
220	ENT	STAPEDECTOMY	Major Plus
221	ENT	OSSICULOPLASTY	Major Plus
222	ENT	MYRINGOTOMY WITH GROMMET INSERTION BILT	Major Plus
223	ENT	PREAURICULAR SINUS UNILAT	Major Plus
224	ENT	BALLOON SINUPLASTY	Major Plus

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225	ENT	SEPTOPLASTY	Major Plus
226	ENT	SEPTOPLASTY WITH TURBINATE REDUCTION	Major Plus
227	ENT	ENDOSCOPIC SINUS SURGERY	Major Plus
228	ENT	ENDOSCOPIC POLYPECTOMY	Major Plus
229	ENT	SEPTOPLASTY WITH MINIMAL FESS	Major Plus
230	ENT	ENDOSCOPIC DCR	Major Plus
231	ENT	FRACTURE NASAL BONE REDUCTION	Major Plus
232	ENT	CALD WELL LUCS OPERATION	Major Plus
233	ENT	ADENOIDECTOMY	Major Plus
234	ENT	TONSILLECTOMY	Major Plus
235	ENT	ADENO-TONSILLECTOMY	Major Plus
236	ENT	COBLATION ASSISTED UVULO-PALATOPLASTY(CAUVPP	Major Plus
237	ENT	MICROLARYNGOSCOPY	Major Plus
238	ENT	MICROLARYNGOSCOPY WITH LASER	Major Plus
239	ENT	INJECTION LARYNGOPLASTY	Major Plus
240	ENT	THYROIDECTOMY HEMI	Major Plus
241	ENT	PAROTECTOMY SUPERFICIAL	Major Plus
242	ENT	THYROGLOSSAL CYST EXCISION SISTRUNKS OPERATION	Major Plus
243	ENT	BRANCHIAL CYST EXCISION	Major Plus
244	ENT	EXCISION OF LYMPH NODE	Major Plus

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245	ENT	PAN ENDOSCOPY	Major Plus
246	ENT	FOREIGN BODY REMOVAL ESOPHAGUS	Major Plus
247	ENT	I & D SEPTAL ABSCESS	Major Plus
248	ENT	STYLOIDECTOMY	Major Plus
249	ENT	Fess With Orbital Decompression	Supra Major
250	ENT	Radio Guided Parathyroidectomy	Supra Major
251	ENT	Fess With Septoplasty With Myringoplasty	Supra Major
252	ENT	Osteoplastic Flap & Exposure Of Frontal Sinus	Supra Major
253	ENT	Trans Maxillary Endoscopic Excision Of Trigeminal Schwannoma	Supra Major
254	ENT	Bilateral Fess With Septoplasty	Supra Major
255	ENT	Bilateral Superficial Parotidectomy	Supra Major
256	ENT	Endolymphatic Sac Decompression	Supra Major
257	ENT	Septoplasty + Bilateral Fess	Supra Major
258	ENT	FESS with Tonsillectomy	Supra Major
259	ENT	Septoplasty + CAUVPP (Coblation Assisted Uvuloplasty)	Supra Major
260	ENT	TYROIDECTOMY SUBTOTAL	Supra Major
261	ENT	MASTOID CAVITY OBLITERATION	Supra Major
262	ENT	MASTOIDECTOMY WITH RECONSTRUCTION	Supra Major
263	ENT	PREAURICULAR SINUS BILAT	Supra Major
264	ENT	SEPTOPLASTY WITH FESS	Supra Major

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265	ENT	FESS WITH BALLOON SINUPLASTY	Supra Major
266	ENT	CSF RHINORROEA REPAIR	Supra Major
267	ENT	SEPTORHINOPLASTY	Supra Major
268	ENT	EXCISION OF VASCULAR NASAL MASS	Supra Major
269	ENT	FACIAL/OPTIC NERVE DECOMPRESSION	Supra Major
270	ENT	TYROIDECTOMY NEAR TOTAL	Supra Major
271	ENT	PAROTIDECTOMY TOTAL	Supra Major
272	ENT	PARATHYROIDECTOMY	Supra Major
273	ENT	THYROPLASTY TYPE-I WITH ARYTENOIDECTOMY	Supra Major
274	ENT	PHARYNGO CUTANEOUS FISTULA REPAIR	Supra Major
275	ENT	RADIOGUIDED PARATHYROIDECTOMY	Supra Major
276	ENT	Infra-Temporal Fossa Approach Type A And B	Supramajor Plus
277	ENT	Laryngectomy With Neck Dissection	Supramajor Plus
278	ENT	Maxillectomy With Radical Neck Dissection	Supramajor Plus
279	ENT	Bithermal Caloric Test	Supramajor Plus
280	ENT	Cautery+Patch	Supramajor Plus
281	ENT	Cold Caloric Test	Supramajor Plus
282	ENT	Facial Nerve/Sac Decompression	Supramajor Plus
283	ENT	Furuncle Packing	Supramajor Plus
284	ENT	BAHA (BONE ANCHORED HEARING AID IMPLANT)	Supramajor Plus

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285	ENT	COCHLEAR IMPLANT	Supramajor Plus		
286	ENT	BONE BRIDGE IMPLANT	Supramajor Plus		
287	ENT	INFRATEMPORAL APPROACH	Supramajor Plus		
288	ENT	GLOMUS JUGULARE	Supramajor Plus		
289	ENT	Nasopharyngeal Angiofibroma	Supramajor Plus		
290	ENT	LARYNGEAL STENOSIS	Supramajor Plus		
291	ENT	CAROTID BODY TUMOR	Supramajor Plus		
292	ENT	CSF OTORRHOEA	Supramajor Plus		
293	ENT	EXTENDED ENDOSCOPIC NASAL APPROACH	Supramajor Plus		
294	ENT	MEDIAL MAXILLECTOMY ENDOSCOPIC	Supramajor Plus		
295	ENT	TORS	Supramajor Plus		
296	ENT	ROBOTIC HEMITHYROIDECTOMY	Supramajor Plus		
297	ENT	ROBOTIC PARATHYROIDECTOMY	Supramajor Plus		
Sr.	Speciality	Surgery	Category	MS Surgery and Above	3
298	GENERAL SURGERY	Banding Piles	Minor		
299	GENERAL SURGERY	Biopsy Of Skin,Mucosa,Muscle,Gland	Minor		
300	GENERAL SURGERY	C.L.W.Suturing	Minor		
301	GENERAL SURGERY	Desloughing Of Infected Wound	Minor		
302	GENERAL SURGERY	Dilatation Salivary Duct	Minor		
303	GENERAL SURGERY	Multiple Avulsions Of Varicosities	Minor		

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304	GENERAL SURGERY	Evacuation/Excision Superficial Haematoma	Minor
305	GENERAL SURGERY	Excision Renula	Minor
306	GENERAL SURGERY	Excision Carbuncle	Minor
307	GENERAL SURGERY	Excision Of Superficial Tumour/Cyst	Minor
308	GENERAL SURGERY	Excision Of Warts/Keloids	Minor
309	GENERAL SURGERY	Excision Sinus/Bursa/Ganglion/Scar	Minor
310	GENERAL SURGERY	F.B/Skin/Subcutaneous	Minor
311	GENERAL SURGERY	I/D Abscess	Minor
312	GENERAL SURGERY	Maximal Anal Stretching	Minor
313	GENERAL SURGERY	Release Tongue Tie	Minor
314	GENERAL SURGERY	Scraping Of Ulcer	Minor
315	GENERAL SURGERY	Sphincterotomy	Minor
316	GENERAL SURGERY	Thierschs Operation	Minor
317	GENERAL SURGERY	Defunctioning Stoma Open	Minor
318	GENERAL SURGERY	Internal Sphincterotomy	Minor
319	GENERAL SURGERY	Eua And Injection Of Botox	Minor
320	GENERAL SURGERY	Kidney Biopsy	Minor
321	GENERAL SURGERY	Minor Ear Lobe repair	Minor
322	GENERAL SURGERY	DJ Stenting	Minor
323	GENERAL SURGERY	Oral Biospy	Minor

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324	GENERAL SURGERY	Exploration	Minor	
325	GENERAL SURGERY	DJ Stent Removal	Minor	
326	GENERAL SURGERY	Circumcision	Minor	
327	GENERAL SURGERY	Interventional Pain Management	Minor	
328	GENERAL SURGERY	Fasciotomy	Intermediate	
329	GENERAL SURGERY	Temporal Artery Biopsy	Intermediate	
330	GENERAL SURGERY	Debridement/Drainage Of Infected Foot	Intermediate	
331	GENERAL SURGERY	Debridement Of Leg Ulcers	Intermediate	
332	GENERAL SURGERY	Botox Injection To Axilla For Hyperhydrosis	Intermediate	
333	GENERAL SURGERY	Botox Injection To Palm For Hyperhydrosis	Intermediate	
334	GENERAL SURGERY	High Saphenous Ligation, Stripping And Avulsions-Unilateral	Intermediate	
335	GENERAL SURGERY	Sapheno-Popliteal Ligation And Avulsions-Unilateral	Intermediate	
336	GENERAL SURGERY	Abdominal Wall Abscess Multiple	Intermediate	
337	GENERAL SURGERY	Co2 Laser (Surgery For Superficial Lesions)	Intermediate	
338	GENERAL SURGERY	Evacuation Parotid Cyst	Intermediate	
339	GENERAL SURGERY	Excision Multiple Lymph Glands Neck/Axilla/Inguina	Intermediate	
340	GENERAL SURGERY	Excision Pilonidal Sinus	Intermediate	
341	GENERAL SURGERY	Excision With Scooping Of Hydradenitis Suprafacial	Intermediate	
342	GENERAL SURGERY	F.B.From Muscles/Tendons	Intermediate	
343	GENERAL SURGERY	Fissurectomy	Intermediate	
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344	GENERAL SURGERY	Herniotomy	Intermediate
345	GENERAL SURGERY	Hydrocele	Intermediate
346	GENERAL SURGERY	Lipectomy	Intermediate
347	GENERAL SURGERY	Maximal Anal Stretching+Banding Of Pile+Inj.Of Pil	Intermediate
348	GENERAL SURGERY	Multiple C.L.W.	Intermediate
349	GENERAL SURGERY	Multiple Tumors/Cysts	Intermediate
350	GENERAL SURGERY	Naso - Jejunal Tube Insertion Under C - Arm	Intermediate
351	GENERAL SURGERY	Open Operation For Piles	Intermediate
352	GENERAL SURGERY	Suturing Of "Burst Abdomen"	Intermediate
353	GENERAL SURGERY	Tumors From Muscles/Tendons	Intermediate
354	GENERAL SURGERY	Wide Excision Malignant Tumors Skin	Intermediate
355	GENERAL SURGERY	Stapled Haemorrhoidectomy	Intermediate
356	GENERAL SURGERY	Lap Defunctioning Stoma	Intermediate
357	GENERAL SURGERY	Exploration Simple	Intermediate
358	GENERAL SURGERY	Eua With Fistula Plug	Intermediate
359	GENERAL SURGERY	Peg Removal	Intermediate
360	GENERAL SURGERY	Av Fistula Wrist	Intermediate
361	GENERAL SURGERY	Diagnostic Gastroscopy	Intermediate
362	GENERAL SURGERY	Diagnostic Colonoscopy	Intermediate
363	GENERAL SURGERY	Diagnostic Sigmoidoscopy	Intermediate

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364	GENERAL SURGERY	Diagnostic Arteriogram	Intermediate
365	GENERAL SURGERY	Diagnostic Venogram	Intermediate
366	GENERAL SURGERY	Rectal Stricturoplasty	Intermediate
367	GENERAL SURGERY	Paraumbilical Hernia	Intermediate
368	GENERAL SURGERY	Enoscopic Njt Insertion	Intermediate
369	GENERAL SURGERY	Bone Marrow biopsy	Intermediate
370	GENERAL SURGERY	Stent Removal	Intermediate
371	GENERAL SURGERY	Incision and Drainage [I and D]	Intermediate
372	GENERAL SURGERY	Reversal of Stoma	Intermediate
373	GENERAL SURGERY	EUA + Fistulectomy	Intermediate
374	GENERAL SURGERY	EUA + Internal Sphincterotomy	Intermediate
375	GENERAL SURGERY	Fistulectomy	Intermediate
376	GENERAL SURGERY	Large Lymph Node Biopsy	Intermediate
377	GENERAL SURGERY	Cystoscopy - Urethral Dilatation	Intermediate
378	GENERAL SURGERY	Mini Exploratory Laparotomy	Intermediate
379	GENERAL SURGERY	Venous Thrombo-Embolectomy	Major
380	GENERAL SURGERY	Thrombo-Embolectomy Of Blocked Bypass Graft	Major
381	GENERAL SURGERY	Bilateral Hydrocele	Major
382	GENERAL SURGERY	Cervical Oesophagostomy	Major
383	GENERAL SURGERY	Cholecystectomy Open	Major

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384	GENERAL SURGERY	Cholecystectomy/Cholecystotomy	Major
385	GENERAL SURGERY	Cholecystojejunostomy	Major
386	GENERAL SURGERY	Drainage Of Subphrenic Abscess	Major
387	GENERAL SURGERY	Entero-Enterostomy	Major
388	GENERAL SURGERY	Excision Of Submandibular Salivary Gland	Major
389	GENERAL SURGERY	Excision Tumour+Skin Grafting	Major
390	GENERAL SURGERY	Fistulectomy extended	Major
391	GENERAL SURGERY	Sapheno-Popliteal Ligation And Avulsions-Bilateral	Major
392	GENERAL SURGERY	Sapheno-Femoral And Sapheno-Popliteal Ligation, Stripping An	Major
393	GENERAL SURGERY	Radio-Frequency Ablation Of Long Saphenous Vein And Ablation	Major
394	GENERAL SURGERY	Radio-Frequency Ablation Of Short Saphenous Vein And Ablatio	Major
395	GENERAL SURGERY	Radio-Frequency Ablation Of Perforators	Major
396	GENERAL SURGERY	Surgery For Recurrent Varicose Veins	Major
397	GENERAL SURGERY	Trans-Brachial Embolectomy	Major
398	GENERAL SURGERY	Trans Femoral Embolectomy +/- Fasciotomy	Major
399	GENERAL SURGERY	Trans Luminal Procedures Via The Femoral Artery	Major
400	GENERAL SURGERY	Revision Of Amputation To A Higher Level	Major
401	GENERAL SURGERY	High Saphenous Ligation, Stripping And Avulsions-Bilateral	Major
402	GENERAL SURGERY	Gastrostomy/Colostomy/Ileostomy	Major
403	GENERAL SURGERY	Hernia Mesh Repair	Major

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404	GENERAL SURGERY	Hernia/Hernioplasty/Herniotomy	Major
405	GENERAL SURGERY	Incisional Hernia Repair	Major
406	GENERAL SURGERY	Inguinal/Femoral Hernia	Major
407	GENERAL SURGERY	Lap Varicocoele	Major
408	GENERAL SURGERY	Laparo.+Ostomy/Adhesi./Exc.Meckel"S/Suturi.Pept.Pe	Major
409	GENERAL SURGERY	Laparoscopic Thoracoscopy	Major
410	GENERAL SURGERY	Laparotomy For Liver Abscess/Liver Biopsy	Major
411	GENERAL SURGERY	Laparotomy For Traumatic Abdomen-Single Organ Injury	Major
412	GENERAL SURGERY	Mecreis Diverticulectomy	Major
413	GENERAL SURGERY	Peptic Ulcer Perforation	Major
414	GENERAL SURGERY	Radical Excision T.B.Glands-Neck/Axilla/Groin	Major
415	GENERAL SURGERY	Repair Fecal Fistula	Major
416	GENERAL SURGERY	Sistrunk"S Operation	Major
417	GENERAL SURGERY	Small Intestinal Resection - Single Anastomosis	Major
418	GENERAL SURGERY	Stricuroplasty	Major
419	GENERAL SURGERY	Lap Rectopexy	Major
420	GENERAL SURGERY	Interstim Placement	Major
421	GENERAL SURGERY	Varicose Veins	Major
422	GENERAL SURGERY	Exploration Complex	Major
423	GENERAL SURGERY	Ventral Scar Hernia	Major

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Dr. Hrishikesh Kalgao1kar		Dr. S.S. Deepak	
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424	GENERAL SURGERY	Anal Sphincter Repair	Major
425	GENERAL SURGERY	Rectovaginal Fistula Repair	Major
426	GENERAL SURGERY	Laparoscopic Lymph Node Biopsy	Major
427	GENERAL SURGERY	Peg Insertion	Major
428	GENERAL SURGERY	Endoscopic Foreign Body Removal	Major
429	GENERAL SURGERY	Av Fistula Revision With Embolectomy &/Or Re Siting	Major
430	GENERAL SURGERY	Av Fistula With Native Veins At Elbow	Major
431	GENERAL SURGERY	Basilic Vein Transposition	Major
432	GENERAL SURGERY	Endovenous Laser Ablation Of Varicose Veins Unilateral	Major
433	GENERAL SURGERY	Catheter Directed Thrombolysis Of Artery/Graft	Major
434	GENERAL SURGERY	Major Incision and Drainage [I and D]	Major
435	GENERAL SURGERY	Debridement	Major
436	GENERAL SURGERY	Diagnostic Laparoscopy	Major
437	GENERAL SURGERY	AV Fistula	Major
438	GENERAL SURGERY	Endovascular Repair Of Abdominal Aortic Aneurysm - Elective	Major Plus
439	GENERAL SURGERY	Endovascular Repair Of Thoracic Aortic Aneurysm-Elective	Major Plus
440	GENERAL SURGERY	Aorto-Bifemoral/Bi-Iliac Bypass For Aortic Occlusive Diseas	Major Plus
441	GENERAL SURGERY	Bypass Of The Iliac Artery For Occlusive Or Aneurismal Disea	Major Plus
442	GENERAL SURGERY	Axillo-Femoral Bypass	Major Plus
443	GENERAL SURGERY	Femero-Femoral Cross Over Bypass	Major Plus

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444	GENERAL SURGERY	Femoral Artery Endarterectomy	Major Plus
445	GENERAL SURGERY	Femoral Artery Endarterectomy And Patch Angioplasty	Major Plus
446	GENERAL SURGERY	Femoral To Above Knee Popliteal Artery Bypass	Major Plus
447	GENERAL SURGERY	Femoral To Below Knee Popliteal Artery Bypass	Major Plus
448	GENERAL SURGERY	Bypass Reconstruction For Popliteal Artery Aneurysm	Major Plus
449	GENERAL SURGERY	Aorto/Illio Renal Artery Bypass	Major Plus
450	GENERAL SURGERY	Excision Of Cervical/First Rib	Major Plus
451	GENERAL SURGERY	Radio-Frequency Ablation Of Long And Short Saphenous Veins A	Major Plus
452	GENERAL SURGERY	Vascular Trauma-Repair Of MAJO Peripheral Artery	Major Plus
453	GENERAL SURGERY	Vascular Trauma-Repair Of Venous Injury	Major Plus
454	GENERAL SURGERY	Thrombo-Embolectomy Of Blocked Bypass Graft And Further Reco	Major Plus
455	GENERAL SURGERY	Lap Cholecystectomy	Major Plus
456	GENERAL SURGERY	Lap Resection Rectopexy	Major Plus
457	GENERAL SURGERY	Carotid Endarterectomy	Major Plus
458	GENERAL SURGERY	Carotid Artery Ligation(External/Internal)	Major Plus
459	GENERAL SURGERY	Carotid-Subclavian Bypass	Major Plus
460	GENERAL SURGERY	Carotid-Carotid Bypass	Major Plus
461	GENERAL SURGERY	Open Repair Of Abdominal Aortic Aneurysm-Elective	Major Plus
462	GENERAL SURGERY	Laparoscopic Small Bowel Resection	Major Plus

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463	GENERAL SURGERY	Splenectomy (No Portal Hypertension)	Major Plus
464	GENERAL SURGERY	Abdominal Repair Of Rectal Prolapse	Major Plus
465	GENERAL SURGERY	Bilateral Inguinal Hernia	Major Plus
466	GENERAL SURGERY	Bilateral Partial/Subtotal Thyroidectomy	Major Plus
467	GENERAL SURGERY	Block Dissection Lymph Glands, Neck, Axilla, Groin.	Major Plus
468	GENERAL SURGERY	Choledochoduodenostomy	Major Plus
469	GENERAL SURGERY	Diagnostic Thoracoscopy	Major Plus
470	GENERAL SURGERY	Extended Right Colectomy	Major Plus
471	GENERAL SURGERY	Hemi/Partial Colectomy	Major Plus
472	GENERAL SURGERY	Closure Of Defunctioning Colostomy	Major Plus
473	GENERAL SURGERY	Hemi/Partial Gastrectomy	Major Plus
474	GENERAL SURGERY	Lap Adhesiolysis	Major Plus
475	GENERAL SURGERY	Pej With Introducer	Major Plus
476	GENERAL SURGERY	Lap Appendectomy	Major Plus
477	GENERAL SURGERY	Revision Of Av Fistula At Elbow	Major Plus
478	GENERAL SURGERY	Lap Biopsy (Ln, Liver)	Major Plus
479	GENERAL SURGERY	Endovenous Lase Ablation Of Varicose Veins Bilateral	Major Plus
480	GENERAL SURGERY	Lap Drainage Of Abscesses(Ala/ Psoas)	Major Plus
481	GENERAL SURGERY	Lap Unilateral Hernia	Major Plus
482	GENERAL SURGERY	Therapeutic Ercp	Major Plus

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483	GENERAL SURGERY	Angioplasty+/- Stenting Of Iliac Artery Unilateral	Major Plus
484	GENERAL SURGERY	Lap. Incisional Hernia Repair	Major Plus
485	GENERAL SURGERY	Angioplasty +/- Stenting Of Sfa	Major Plus
486	GENERAL SURGERY	Ivc Filter Insertion Without Thrombolysis	Major Plus
487	GENERAL SURGERY	Tibial To Popliteal Bypass	Major Plus
488	GENERAL SURGERY	Laparoscopic Cholecystectomy	Major Plus
489	GENERAL SURGERY	Laparoscopic Of Removal Of Gastric Band	Major Plus
490	GENERAL SURGERY	Modified Radical Mastectomy	Major Plus
491	GENERAL SURGERY	Open Achalesia Cardia	Major Plus
492	GENERAL SURGERY	Operation For Hydatid Cyst Liver	Major Plus
493	GENERAL SURGERY	Pancreatic Cyst/Abscess	Major Plus
494	GENERAL SURGERY	Partial Parotidectomy	Major Plus
495	GENERAL SURGERY	Proximal Gastric Vagotomy	Major Plus
496	GENERAL SURGERY	Small Intestinal Resection - Multiple Anastomosis	Major Plus
497	GENERAL SURGERY	Sphincteroplasty	Major Plus
498	GENERAL SURGERY	Subhepatic Suprarenal Abscess	Major Plus
499	GENERAL SURGERY	Vagotomy+Bypass	Major Plus
500	GENERAL SURGERY	Varicose Veins - Saphenous Ligation With Stripping	Major Plus
501	GENERAL SURGERY	Lap Gastric Banding	Major Plus
502	GENERAL SURGERY	RF ablation of varicose veins one leg	Major Plus

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503	GENERAL SURGERY	RFA + USG Guided Sclerotherapy [Left/Right]	Major Plus	5
504	GENERAL SURGERY	Extensive Incision and Drainage [I and D]	Major Plus	
505	GENERAL SURGERY	Reversal of Hartmanns	Major Plus	
506	GENERAL SURGERY	Extended Anal Sphincter Repair	Major Plus	
507	GENERAL SURGERY	Post Delivery Sphincter Repair	Major Plus	
508	GENERAL SURGERY	Anal Transposition	Major Plus	
509	GENERAL SURGERY	Exploratory Laparotomy Extensive	Major Plus	
510	GENERAL SURGERY	Peg Introducer	Major Plus	
511	GENERAL SURGERY	Exploratory Laparotomy extensive	Major Plus	
512	GENERAL SURGERY	Hernioplasty	Major Plus	
513	GENERAL SURGERY	Laparoscopic Subtotal Cholecystectomy	Major Plus	
514	GENERAL SURGERY	Oesophageal Stenting	Major Plus	
515	GENERAL SURGERY	Endovascular Repair Of Thoracic Aortic Aneurysm-Emergency	Supra Major	
516	GENERAL SURGERY	Lap Sleeve Gastrectomy	Supra Major	
517	GENERAL SURGERY	Anal Reconstruction With Craciloplasty	Supra Major	
518	GENERAL SURGERY	Subtotal Colectomy	Supra Major	
519	GENERAL SURGERY	Open Radical Cholecystectomy	Supra Major	
520	GENERAL SURGERY	Laparoscopic Radical Cholecystectomy	Supra Major	
521	GENERAL SURGERY	Laparoscopic Liver Cyst Excision	Supra Major	
522	GENERAL SURGERY	Angioplasty+/- Stenting Of Iliac Arteries Bilateral	Supra Major	
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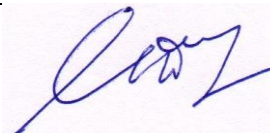


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523	GENERAL SURGERY	Below Knee Arterial Angioplasty	Supra Major	
524	GENERAL SURGERY	Ivc Filter With Catheter Directed Thrombolysis	Supra Major	
525	GENERAL SURGERY	Abdmno Plasty	Supra Major	
526	GENERAL SURGERY	Bilateral Block Dissection Of Lymph,Glands,Neck,Axila,Groin	Supra Major	
527	GENERAL SURGERY	Choledochojejunostomy	Supra Major	
528	GENERAL SURGERY	Distal Pancreatectomy	Supra Major	
529	GENERAL SURGERY	Excision Retroperitoneal Tumours	Supra Major	
530	GENERAL SURGERY	Excn Of Large Soft Tissue Sarcoma And Skin Grafting	Supra Major	
531	GENERAL SURGERY	Hepatocojejunostomy	Supra Major	
532	GENERAL SURGERY	Lap Achalasia Cardia	Supra Major	
533	GENERAL SURGERY	Lap Adrenalectomy	Supra Major	
534	GENERAL SURGERY	Lap Bilateral Hernia	Supra Major	
535	GENERAL SURGERY	Lap Chole + Cbd Exploration	Supra Major	
536	GENERAL SURGERY	Lap Hemicolectomy	Supra Major	
537	GENERAL SURGERY	Lap Pancreatic Cyst Excision	Supra Major	
538	GENERAL SURGERY	Lap Pancreatic Necrosectomy	Supra Major	
539	GENERAL SURGERY	Lap Renal Cyst	Supra Major	
540	GENERAL SURGERY	Lap Resection Anastomosis	Supra Major	
541	GENERAL SURGERY	Lap Splenectomy	Supra Major	
542	GENERAL SURGERY	Lap Vagotomy + Gastro-Jejunostomy	Supra Major	
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543	GENERAL SURGERY	Lap. Lavage With Ileal Perforation Suturing	Supra Major
544	GENERAL SURGERY	Lap. Nephrectomy	Supra Major
545	GENERAL SURGERY	Lap Fundoplication	Supra Major
546	GENERAL SURGERY	Pancreatico-Jejunostomy	Supra Major
547	GENERAL SURGERY	Parathyroid Surgery	Supra Major
548	GENERAL SURGERY	Surgery For Achalasia Cardia	Supra Major
549	GENERAL SURGERY	Surgery For Hiatus Hernia	Supra Major
550	GENERAL SURGERY	RF ablation of varicose veins two legs	Supra Major
551	GENERAL SURGERY	Donor Nephrectomy	Supra Major
552	GENERAL SURGERY	Robotic â Pyeloplasty	Supra Major
553	GENERAL SURGERY	Skin Grafting	Supra Major
554	GENERAL SURGERY	RFA + USG Guided Sclerotherapy [Bilateral]	Supra Major
555	GENERAL SURGERY	Excision of carotid body tumour	Supra Major
556	GENERAL SURGERY	Sigmoidoscopy	Supra Major
557	GENERAL SURGERY	Exploratory Laparotomy extended	Supra Major
558	GENERAL SURGERY	CLW Suturing	Supra Major
559	GENERAL SURGERY	Lap Appendectomy + Cholecystectomy	Supra Major
560	GENERAL SURGERY	Vertebroplasty	Supra Major
561	GENERAL SURGERY	SILS Cholecystectomy	Supra Major
562	GENERAL SURGERY	Hernia Repair	Supra Major

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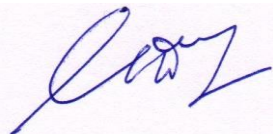


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563	GENERAL SURGERY	Hepatectomy SM	Supra Major	
564	GENERAL SURGERY	Laparoscopic Nissen Fundoplication	Supra Major	
565	GENERAL SURGERY	Thoracoscopic Decortication	Supramajor Plus	
566	GENERAL SURGERY	Total Colectomy	Supramajor Plus	
567	GENERAL SURGERY	Total Pancreatectomy	Supramajor Plus	
568	GENERAL SURGERY	Total Radical Gastrectomy	Supramajor Plus	
569	GENERAL SURGERY	Total Thyroide.With Radical Neck(Block)Dissection.	Supramajor Plus	
570	GENERAL SURGERY	Whipples Pancreaticoduodenectomy	Supramajor Plus	
571	GENERAL SURGERY	Open Repair Of Abdominal Aortic Aneurysm-Emergency	Supramajor Plus	
572	GENERAL SURGERY	Endovascular Repair Of Abdominal Aortic Aneurysm-Emergency	Supramajor Plus	
573	GENERAL SURGERY	Femoral To Distal Vessel Bypass	Supramajor Plus	
574	GENERAL SURGERY	Revision Of Lower Limb Bypass Graft	Supramajor Plus	
575	GENERAL SURGERY	Removal Of Infected Aortic Prosthesis And Bypass	Supramajor Plus	
576	GENERAL SURGERY	Aorto/Illio Mesenteric Bypass	Supramajor Plus	
577	GENERAL SURGERY	Vascular Trauma-Repair Of Aorta And Its Branches	Supramajor Plus	
578	GENERAL SURGERY	Vascular Trauma-Repair Of The Vena Cava And Its Tributaries	Supramajor Plus	
579	GENERAL SURGERY	Laparoscopic Parproctocolectomy	Supramajor Plus	
580	GENERAL SURGERY	Extended Open Radical Cholecystectomy	Supramajor Plus	
581	GENERAL SURGERY	Cystectomy+Abd Hysterectomy+Ureteric Transplant Of Colon	Supramajor Plus	
582	GENERAL SURGERY	Exci-Ectopic Kidney/Tuboovarianmass/Appendicectomy	Supramajor Plus	
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583	GENERAL SURGERY	Hemiman.With Reconstruction By Microvascular Flaps	Supramajor Plus
584	GENERAL SURGERY	Hepatic Lobectomy	Supramajor Plus
585	GENERAL SURGERY	Lap Procto-Colectomy With Eleoanal Anastomosis	Supramajor Plus
586	GENERAL SURGERY	Laproscopy Sos Laprotomy For C. A. Gall Bladder	Supramajor Plus
587	GENERAL SURGERY	Removal Of Infected Peripheral Graft And Reconstruction	Supramajor Plus
588	GENERAL SURGERY	Laparoscopic Pan Procto Colectomy	Supramajor Plus
589	GENERAL SURGERY	Abdominoperineal Resection	Supramajor Plus
590	GENERAL SURGERY	Anterior Resection Of Lt. Colon	Supramajor Plus
591	GENERAL SURGERY	Lap Anterior Resection	Supramajor Plus
592	GENERAL SURGERY	Lap Antrectomy	Supramajor Plus
593	GENERAL SURGERY	Lap Foundoplication	Supramajor Plus
594	GENERAL SURGERY	Oesophageal Resection	Supramajor Plus
595	GENERAL SURGERY	Surgery For Portal Hypertension	Supramajor Plus
596	GENERAL SURGERY	Robotic â Mini Gastric Bypass	Supramajor Plus
597	GENERAL SURGERY	Robotic - Pyeloplasty	Supramajor Plus
598	GENERAL SURGERY	Spine Surgery	Supramajor Plus
599	GENERAL SURGERY	Robotic â Thyroidectomy	Supramajor Plus
600	GENERAL SURGERY	Robotic Achalasia Cardia with Fundoplication	Supramajor Plus
601	GENERAL SURGERY	Robotic Fundoplication	Supramajor Plus
602	GENERAL SURGERY	Lap Distal Pancreatectomy+Splenectomy	Supramajor Plus

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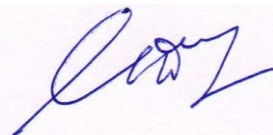


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603	GENERAL SURGERY	Laparoscopic Sleeve Gastrectomy	Supramajor Plus		
604	GENERAL SURGERY	Hemicolectomy	Supramajor Plus		
605	GENERAL SURGERY	Extended CLW Suturing	Supramajor Plus		
606	GENERAL SURGERY	Hemiglossectomy	Supramajor Plus		
607	GENERAL SURGERY	Abdominoplasty	Supramajor Plus		
608	GENERAL SURGERY	Robotic Sleeve Gastrectomy SM Plus	Supramajor Plus		
609	GENERAL SURGERY	Hepatectomy SMB plus	Supramajor Plus		
610	GENERAL SURGERY	Robotic Sleeve Gastrectomy SMB plus	Supramajor Plus		
611	GENERAL SURGERY	Craniotomy Extensive	Supramajor Plus		
Sr.	Speciality	Surgery	Category		
612	GYNAC AND OBS	Cervical Cauterisation	Minor		
613	GYNAC AND OBS	Cone Biopsy	Minor	MS - Obsterics & Gynaecology	3
614	GYNAC AND OBS	Copper T Insertion/Removal	Minor		
615	GYNAC AND OBS	Incision Of Bartholins Abscess	Minor		
616	GYNAC AND OBS	Salpingostomy	Minor		
617	GYNAC AND OBS	Vulva Biopsy	Minor		
618	GYNAC AND OBS	D And C Hysteroscopy With Mirena Insertion	Minor		
619	GYNAC AND OBS	Hysteroscopy Myomectomy	Minor		
620	GYNAC AND OBS	Post Episiotomy Perineal Tear Suturing	Minor		
621	GYNAC AND OBS	Endometrial Biopsy	Minor		
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622	GYNAC AND OBS	Embryo Transfer	Minor
623	GYNAC AND OBS	Bil.Lap.Ovariopexy	Intermediate
624	GYNAC AND OBS	Dilatation And Curettage	Intermediate
625	GYNAC AND OBS	Hysterotomy	Intermediate
626	GYNAC AND OBS	Microwave Ablation	Intermediate
627	GYNAC AND OBS	Mrop (Manual Removal Of Placenta)	Intermediate
628	GYNAC AND OBS	Posterior Repair	Intermediate
629	GYNAC AND OBS	Thermal Balloon Ablation	Intermediate
630	GYNAC AND OBS	D And C / Diag.	Intermediate
631	GYNAC AND OBS	Diagnostic Laparoscopy And Hysteroscopy	Intermediate
632	GYNAC AND OBS	Diagnostic: Laparoscopy With Diagnostic D And C	Intermediate
633	GYNAC AND OBS	Ap Repair	Intermediate
634	GYNAC AND OBS	Hysteroscopy With D & C	Intermediate
635	GYNAC AND OBS	Suction Mtp	Intermediate
636	GYNAC AND OBS	Mirena Ius Insertion	Intermediate
637	GYNAC AND OBS	Suction Mtp With Mirena	Intermediate
638	GYNAC AND OBS	Caesarean section	Intermediate
639	GYNAC AND OBS	B Lunch suture for atonic PPH	Intermediate
640	GYNAC AND OBS	Balloon tamponade for PPH	Intermediate
641	GYNAC AND OBS	Removal of cervical suture	Intermediate

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642	GYNAC AND OBS	Cervical Cerclage	Major
643	GYNAC AND OBS	Culdoscopy Colpotomy	Major
644	GYNAC AND OBS	D And C Cx.Biopsy-Electroconisa.Or Electro.Of The Cervix	Major
645	GYNAC AND OBS	Ectopic Pregnancy - Open	Major
646	GYNAC AND OBS	Excision Of Bartholin Cyst	Major
647	GYNAC AND OBS	Fenton"S Operation	Major
648	GYNAC AND OBS	Fothergills Operation	Major
649	GYNAC AND OBS	Hysteroscopy Missed Cu-T Removal	Major
650	GYNAC AND OBS	Hysteroscopy Polypectomy	Major
651	GYNAC AND OBS	Laparoscopic Bilateral Salphingo Oopherectomy	Major
652	GYNAC AND OBS	Laparoscopic Pcod Drilling	Major
653	GYNAC AND OBS	Laparoscopic Vault Suspension Sacral Fixation	Major
654	GYNAC AND OBS	Laparoscopy Adhesiolysis	Major
655	GYNAC AND OBS	Laparoscopy Salpingo-Ovariolyis	Major
656	GYNAC AND OBS	Simple Vulvectomy	Major
657	GYNAC AND OBS	Trachelorrhaphy	Major
658	GYNAC AND OBS	Tubal Ligation	Major
659	GYNAC AND OBS	Tubal Ligation - Laparoscopic	Major
660	GYNAC AND OBS	Oocyte Retrieval	Major
661	GYNAC AND OBS	Second Trimester Mtp	Major

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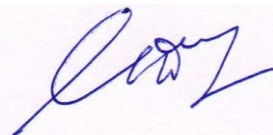


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662	GYNAC AND OBS	Abdominal Hysterectomy	Major	
663	GYNAC AND OBS	Laparoscopic Myomectomy Less Than Two Myoma	Major Plus	
664	GYNAC AND OBS	Laparoscopic Surgery For Endometriosis	Major Plus	
665	GYNAC AND OBS	Myomectomy Abdominal	Major Plus	
666	GYNAC AND OBS	Obstetric Hystrectomy	Major Plus	
667	GYNAC AND OBS	Oper.Lapar.For Mild To Moderate Endomctriosis	Major Plus	
668	GYNAC AND OBS	Oper.Laparo.For Small(Upto5Cms)Sized Myoma	Major Plus	
669	GYNAC AND OBS	Opera.Hysterosco.For Mild To Moder.Intra Uterine Adhesions	Major Plus	
670	GYNAC AND OBS	Opera.Laparos.For Small To Moderate Ovarian Cyst	Major Plus	
671	GYNAC AND OBS	Operative Laparoscopy For Dermoid Large	Major Plus	
672	GYNAC AND OBS	Operative Laparoscopy For Ovarian Cyst Large	Major Plus	
673	GYNAC AND OBS	Ovarian Cystectomy (Including Laparoscopic)	Major Plus	
674	GYNAC AND OBS	Ovarian Wedge Resection	Major Plus	
675	GYNAC AND OBS	Pre Sacral Neurectomy	Major Plus	
676	GYNAC AND OBS	Repair Of Complete Perineal Tear	Major Plus	
677	GYNAC AND OBS	T.C.R.E.	Major Plus	
678	GYNAC AND OBS	Tension Free Vaginal Tape For Sui	Major Plus	
679	GYNAC AND OBS	Tot Abd Hysterectomy With Lt Salpingo Oopherectomy	Major Plus	
680	GYNAC AND OBS	Total Abd. Hysterctomy+Bilat. Salphingo Oopherectomy	Major Plus	
681	GYNAC AND OBS	Tuboplasty	Major Plus	
Recommended By		Signature	Approved By	Signature
Dr. Hrishikesh Kalgao1kar			Dr. S.S. Deepak	
Quality Head			Chairman & Managing Director	



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682	GYNAC AND OBS	Vaginal Hysterectomy	Major Plus
683	GYNAC AND OBS	Vaginal Hysterectomy With Bso	Major Plus
684	GYNAC AND OBS	Venteosuspension	Major Plus
685	GYNAC AND OBS	Werine Operation For Inversion Of Uterus	Major Plus
686	GYNAC AND OBS	Tvt Tape Insertion	Major Plus
687	GYNAC AND OBS	Vaginal Tape Procedures For Prolapse	Major Plus
688	GYNAC AND OBS	Laparoscopic Myomectomy	Major Plus
689	GYNAC AND OBS	Abdominal Hysterectomy	Major Plus
690	GYNAC AND OBS	Anterior Colporrhaphy And Posterior Colpoperineorrhapia	Major Plus
691	GYNAC AND OBS	Hysterectomy: Abdomen	Major Plus
692	GYNAC AND OBS	Hysterectomy: Vaginal	Major Plus
693	GYNAC AND OBS	Hysteroscopic Cannulation	Major Plus
694	GYNAC AND OBS	Hysteroscopic Septal Incision	Major Plus
695	GYNAC AND OBS	Int Iliac Ligation	Major Plus
696	GYNAC AND OBS	Lap Ectopic Pregnancy	Major Plus
697	GYNAC AND OBS	Laparoscopic Hysterectomy	Major Plus
698	GYNAC AND OBS	Total Laparoscopic Hysterectomy	Major Plus
699	GYNAC AND OBS	Dilatation and Evacuation	Major Plus
700	GYNAC AND OBS	Abdominal Hyst + Uretric Dissection	Supra Major
701	GYNAC AND OBS	Hysteroplasty	Supra Major

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgao1kar		Dr. S.S. Deepak	
Quality Head		Chairman & Managing Director	

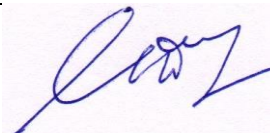


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702	GYNAC AND OBS	Hysteroscopic Myomectomy With Tcre	Supra Major	
703	GYNAC AND OBS	Operative Laparoscopy For Vault Prolapse	Supra Major	
704	GYNAC AND OBS	Lap Myomectomy > Or =5Cm	Supra Major	
705	GYNAC AND OBS	Lap Myomectomy- Multiple Fibroids	Supra Major	
706	GYNAC AND OBS	Laparoscopic Hysterect. With Laparosco. Burch Calpo	Supra Major	
707	GYNAC AND OBS	Laparoscopic Tubal Recanalization	Supra Major	
708	GYNAC AND OBS	Laprotomy For Adhesiolysis With Abd Hysterectomy With Bso	Supra Major	
709	GYNAC AND OBS	Mayo Wards Hysterectomy	Supra Major	
710	GYNAC AND OBS	Operations For Stress Incontmence Shing Procedures	Supra Major	
711	GYNAC AND OBS	Operative Laparoscopy For Moderate To Severe Endom	Supra Major	
712	GYNAC AND OBS	Pan Hysterectomy With Omentectomy+Lymph. Rem Ca	Supra Major	
713	GYNAC AND OBS	V.V.F. And R.V.F	Supra Major	
714	GYNAC AND OBS	Vaginal Hystrectomy With Ap Repair	Supra Major	
715	GYNAC AND OBS	Vaginoplasty	Supra Major	
716	GYNAC AND OBS	Vault Prolapse	Supra Major	
717	GYNAC AND OBS	Lap Myomectomy & Lap Cholecystectomy	Supra Major	
718	GYNAC AND OBS	Lap Total Hysterectomy And Lap Cholecystectomy	Supra Major	
719	GYNAC AND OBS	Robotic Total Laparoscopic Hysterectomy	Supra Major	
720	GYNAC AND OBS	Robotic Myomectomy	Supra Major	
721	GYNAC AND OBS	Robotic Endometriosis	Supra Major	
Recommended By		Signature	Approved By	Signature
Dr. Hrishikesh Kalgao1kar			Dr. S.S. Deepak	
Quality Head			Chairman & Managing Director	

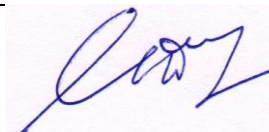


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722	GYNAC AND OBS	Laparoscopic Vault Sacrocolpopexy	Supra Major		
723	GYNAC AND OBS	Extensive Endomctrosis Grade Iv With Presacral Ncu	Supramajor Plus		
724	GYNAC AND OBS	Lap Wertheim`S	Supramajor Plus		
725	GYNAC AND OBS	Robotic Myomectomy Extended	Supramajor Plus		
726	GYNAC AND OBS	Robotic Endometriosis Extended	Supramajor Plus		
727	GYNAC AND OBS	Robotic Laparoscopic Sacrocolpopexy	Supramajor Plus		
Sr.	Speciality	Surgery	Category	Mch - Neurosurgery or equavaent	5
729	NEUROSURGERY	Shunt Tap	Minor		
730	NEUROSURGERY	Excision Of Scalp Lesions	Minor		
731	NEUROSURGERY	Muscle/Sural Nerve Biopsy	Minor		
732	NEUROSURGERY	Twist Drill For Icp Monitor Insertion	Minor		
733	NEUROSURGERY	EVD (external ventricular drain)	Minor		
734	NEUROSURGERY	Burr Hole And Implantation Of Strip Electrodes	Intermediate		
735	NEUROSURGERY	Burr Hole For Cerebral Abscess Drainage	Intermediate		
736	NEUROSURGERY	Burr Hole For External Ventricular Drain Insertion	Intermediate		
737	NEUROSURGERY	Carpal Tunnel Decompression	Intermediate		
738	NEUROSURGERY	Externalization Of Ventriculo-Peritoneal Shunt	Intermediate		
739	NEUROSURGERY	Lumbar Drain Insertion(Spinal Drain)	Intermediate		
740	NEUROSURGERY	Twist Drill For Ventricular Drain Insertion	Intermediate		
Recommended By		Signature	Approved By	Signature	
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741	NEUROSURGERY	Lumbar Puncture	Intermediate
742	NEUROSURGERY	Open Lumbar Sympathectomy	Major
743	NEUROSURGERY	Burr Hole Drainage Of Subdural Empyema	Major
744	NEUROSURGERY	Burr Hole For Chronic Subdural Hematoma Drainage	Major
745	NEUROSURGERY	Cranioplasty-Acrylic/Titanium	Major
746	NEUROSURGERY	Glycerol Trigeminal Rhizotomy	Major
747	NEUROSURGERY	Lumbar Interspinous Distraction Device Insertion	Major
748	NEUROSURGERY	Lumbo-Peritoneal Shunt	Major
749	NEUROSURGERY	Radiofrequency Trigeminal Rhizotomy	Major
750	NEUROSURGERY	Revision Of Lumbo-Peritoneal Shunt	Major
751	NEUROSURGERY	Ulnar Nerve Decompression	Major
752	NEUROSURGERY	Lateral Cutaneous Nerve Decompression	Major
753	NEUROSURGERY	Neurosurgery - Vertebroplasty	Major
754	NEUROSURGERY	Craniotomy for excision	Major
755	NEUROSURGERY	Extended Carpal Tunnel Decompression	Major
756	NEUROSURGERY	Neurosurgery - Vertebroplasty	Major
757	NEUROSURGERY	Cervical Laminectomy	Major Plus
758	NEUROSURGERY	Cysto Peritoneal Shunt	Major Plus
759	NEUROSURGERY	Elevation/Debridement Of Depressed Fracture	Major Plus
760	NEUROSURGERY	Open Repair Of Csf Rhinorrhoea	Major Plus

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761	NEUROSURGERY	Intrathecal Baclofen/Morphine Pump Insertion	Major Plus
762	NEUROSURGERY	Laminectomy For Spinal Epidural Abscess	Major Plus
763	NEUROSURGERY	Lumbar Laminectomy	Major Plus
764	NEUROSURGERY	Lumbar Microdecompression	Major Plus
765	NEUROSURGERY	Lumbar Microdiscectomy	Major Plus
766	NEUROSURGERY	Posterior Foraminotomy	Major Plus
767	NEUROSURGERY	Revision Of Venriculo-Peritoneal Shunt	Major Plus
768	NEUROSURGERY	Stereotactic Biopsy Of Brain Tumour	Major Plus
769	NEUROSURGERY	Steretactic Aspiration Of Brain Cyst/Abscess/Hematoma	Major Plus
770	NEUROSURGERY	Syringo-Pleural Shunt	Major Plus
771	NEUROSURGERY	Syringo-Subarachnoid Shunt	Major Plus
772	NEUROSURGERY	Ventriculo-Peritoneal Shunt	Major Plus
773	NEUROSURGERY	Ventriculo-Pleural Shunt	Major Plus
774	NEUROSURGERY	Craniotomy And Implantation Of Grid Electrodes	Major Plus
775	NEUROSURGERY	Balloon Compression Of Trigeminal Nerve	Major Plus
776	NEUROSURGERY	Lumbar Laminectomy	Major Plus
777	NEUROSURGERY	Cranioplasty	Major Plus
778	NEUROSURGERY	Lumbar Microdecompression	Major Plus
779	NEUROSURGERY	Lumbar Microdiscectomy	Major Plus
780	NEUROSURGERY	Ventriculo-Peritoneal Shunt	Major Plus

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Quality Head		Chairman & Managing Director	



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781	NEUROSURGERY	Evacuation of Haematoma	Major Plus
782	NEUROSURGERY	Bifrontal Craniotomy And Intradural Carpeting For Traumatic/	Supra Major
783	NEUROSURGERY	Craniotomy And Excision Of Neurocysticercal Lesion/Tuberculoma	Supra Major
784	NEUROSURGERY	Craniotomy For Acute Extradural Hematoma	Supra Major
785	NEUROSURGERY	Craniotomy For Acute Intracerebral Hematoma	Supra Major
786	NEUROSURGERY	Craniotomy For Acute Subdural Hematoma	Supra Major
787	NEUROSURGERY	Craniotomy For Cerebral Contusions/Contusectomy	Supra Major
788	NEUROSURGERY	Craniotomy For Convexity/Parasagittal Meningiomas	Supra Major
789	NEUROSURGERY	Craniotomy For Frontal /Temporal Lobectomy For Trauma/Tumour	Supra Major
790	NEUROSURGERY	Craniotomy For Low Grade Glioma	Supra Major
791	NEUROSURGERY	Craniotomy For Malignant Glioma	Supra Major
792	NEUROSURGERY	Craniotomy For Metastatic Tumour	Supra Major
793	NEUROSURGERY	Craniotomy For Subdural Emphysema	Supra Major
794	NEUROSURGERY	Endoscopic Biopsy Of Pineal Region Tumours	Supra Major
795	NEUROSURGERY	Endoscopic Biopsy Of Ventricular Tumours	Supra Major
796	NEUROSURGERY	Endoscopic Third Ventriculostomy	Supra Major
797	NEUROSURGERY	Excision Of Spinal Extradural Tumours	Supra Major
798	NEUROSURGERY	Foramen Magnum Decompression With Duraplasty For Chiari Malformation	Supra Major

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgao1kar		Dr. S.S. Deepak	
Quality Head		Chairman & Managing Director	



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799	NEUROSURGERY	Multiple Subpial Transections	Supra Major
800	NEUROSURGERY	Posterior Fossa Craniectomy For Cerebellar Hematoma	Supra Major
801	NEUROSURGERY	Release Of Tethered Cord	Supra Major
802	NEUROSURGERY	Removal Of Infected Bone Flap	Supra Major
803	NEUROSURGERY	Sagittal Suturectomy For Sagittal Synostosis	Supra Major
804	NEUROSURGERY	Stereotactic Placement Of Depth Electrodes	Supra Major
805	NEUROSURGERY	Stereotactic Aspiration Of Suprasellar Cyst	Supra Major
806	NEUROSURGERY	Thoracic Laminectomy	Supra Major
807	NEUROSURGERY	Vagal Nerve Stimulator Insertion	Supra Major
808	NEUROSURGERY	Decompressive Craniectomy For Trauma/Stroke Cases	Supra Major
809	NEUROSURGERY	Anterior Temporal Lobectomy	Supra Major
810	NEUROSURGERY	Lesionectomy	Supra Major
811	NEUROSURGERY	Vagal Nerve Stimulator Implantation	Supra Major
812	NEUROSURGERY	Stereotactic Depth Electrode Implantation	Supra Major
813	NEUROSURGERY	Minimally Invasive Lumbar Microdiscectomy	Supra Major
814	NEUROSURGERY	Minimally Invasive Lumbar Microdecompression	Supra Major
815	NEUROSURGERY	Major Cranioplasty	Supra Major
816	NEUROSURGERY	Extended Cerebral Laminectomy	Supra Major
817	NEUROSURGERY	Posterior Foraminotomy Extended	Supra Major
818	NEUROSURGERY	Endoscopic repair of CSF Rhinorrhoea	Supra Major

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgao1kar		Dr. S.S. Deepak	
Quality Head		Chairman & Managing Director	



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819	NEUROSURGERY	V. P. Shunt	Supra Major
820	NEUROSURGERY	Stereotactic Biopsy	Supra Major
821	NEUROSURGERY	Craniotomy	Supra Major
822	NEUROSURGERY	Decompressive Craniectomy SM	Supra Major
823	NEUROSURGERY	Artificial Cervical Disc Replacement	Supramajor Plus
824	NEUROSURGERY	Awake Craniotomy With Neocortical Mapping	Supramajor Plus
825	NEUROSURGERY	C1/C2 Fusion	Supramajor Plus
826	NEUROSURGERY	Anterior Temporal Lobectomy With Intraoperative Ecog	Supramajor Plus
827	NEUROSURGERY	Selective Amygdalo Hippocampectomy	Supramajor Plus
828	NEUROSURGERY	Tailored Cortical Resection	Supramajor Plus
829	NEUROSURGERY	Resection Of Hypothalamic Hamartoma	Supramajor Plus
830	NEUROSURGERY	Multi Lobar Resection	Supramajor Plus
831	NEUROSURGERY	Hemispherectomy/Hemispherotomy	Supramajor Plus
832	NEUROSURGERY	Cervical Corpectomy And Fusions	Supramajor Plus
833	NEUROSURGERY	Corpus Callosotomy	Supramajor Plus
834	NEUROSURGERY	Costotransversectomy For Thoracic Disc Prolapse	Supramajor Plus
835	NEUROSURGERY	Craniotomy For All Other Meningiomas Including Skull Base Me	Supramajor Plus
836	NEUROSURGERY	Craniotomy For Colloid Cyst	Supramajor Plus
837	NEUROSURGERY	Craniotomy For Excision Of Avm	Supramajor Plus
838	NEUROSURGERY	Craniotomy For Excision Of Cavernoma	Supramajor Plus

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Dr. Hrishikesh Kalgao1kar		Dr. S.S. Deepak	
Quality Head		Chairman & Managing Director	



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839	NEUROSURGERY	Craniotomy For Intraventricular Lesions	Supramajor Plus
840	NEUROSURGERY	Craniotomy For Pineal Region Tumours	Supramajor Plus
841	NEUROSURGERY	Craniotomy For Sellar/Suprasellar Tumours	Supramajor Plus
842	NEUROSURGERY	Deep Brain Stimulation For Dystonia	Supramajor Plus
843	NEUROSURGERY	Deep Brain Stimulation For Parkinsons Disease	Supramajor Plus
844	NEUROSURGERY	Endoscopic Excision Of Colloid Cyst	Supramajor Plus
845	NEUROSURGERY	Endoscopic Transphenoidal Hypophysectomy	Supramajor Plus
846	NEUROSURGERY	Excision Of Spinal Intramedullary Tumours	Supramajor Plus
847	NEUROSURGERY	Excision Of Spinal Schwannomas/Meningiomas	Supramajor Plus
848	NEUROSURGERY	Frontal Advance For Metopic/Coronal Synostosis	Supramajor Plus
849	NEUROSURGERY	Laminectomy For Spinal Avms	Supramajor Plus
850	NEUROSURGERY	Lateral Lumbar Interbody Fusion	Supramajor Plus
851	NEUROSURGERY	Occipitocervical Fusion	Supramajor Plus
852	NEUROSURGERY	Odontoid Screw Placement	Supramajor Plus
853	NEUROSURGERY	Posterior Fossa Craniectomy For Cerebellar/Brainstem Tumours	Supramajor Plus
854	NEUROSURGERY	Posterior Lumbar Interbody Fusion	Supramajor Plus
855	NEUROSURGERY	Posterior Thoracic Fusions	Supramajor Plus
856	NEUROSURGERY	Retromastoid Craniectomy For C.P.Angle Tumours	Supramajor Plus
857	NEUROSURGERY	Sta-Mca Bypass	Supramajor Plus
858	NEUROSURGERY	Stereotactic Thalamotomy For Essential Tremor.	Supramajor Plus

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgao1kar		Dr. S.S. Deepak	
Quality Head		Chairman & Managing Director	



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859	NEUROSURGERY	Temporal Lobectomy For Mesial Temporal Sclerosis	Supramajor Plus
860	NEUROSURGERY	Thoracotomy For Anterolateral Thoracic Fusions	Supramajor Plus
861	NEUROSURGERY	Transforaminal Lumbar Interbody Fusion	Supramajor Plus
862	NEUROSURGERY	Transnasal Transphenoidal Hypophysectomy(Nonendoscopic)	Supramajor Plus
863	NEUROSURGERY	Transoral Decompression Of Basilar Invagination	Supramajor Plus
864	NEUROSURGERY	Minimally Invasive Lumbar Fusion	Supramajor Plus
865	NEUROSURGERY	Post-Lumbar Interbody Fusion	Supramajor Plus
866	NEUROSURGERY	Amygdalohippocampectomy	Supramajor Plus
867	NEUROSURGERY	Anterior Cervical Discectomy And Fusion	Supramajor Plus
868	NEUROSURGERY	Anterior Lumbar Interbody Fusion	Supramajor Plus
869	NEUROSURGERY	Craniotomy For Treatment Of Cerebral Aneurysms	Supramajor Plus
870	NEUROSURGERY	Repair Of Encephalocele	Supramajor Plus
871	NEUROSURGERY	Repair Of Myelomeningocele Repair	Supramajor Plus
872	NEUROSURGERY	Craniotomy-Large Acute Intracereb Haematoma	Supramajor Plus
873	NEUROSURGERY	Craniotomy-Large Convex/Parasag Meningioma	Supramajor Plus
874	NEUROSURGERY	Craniotomy-Frontal/Temporal Lobectomy-Large Tum/Trau	Supramajor Plus
875	NEUROSURGERY	Craniotomy For Large Low Grade Glioma	Supramajor Plus
876	NEUROSURGERY	Craniotomy For Large Malignant Glioma	Supramajor Plus
877	NEUROSURGERY	Craniotomy For Large Metastatic Tumour	Supramajor Plus
878	NEUROSURGERY	Endoscopic Biopsy Of Pineal Region Tumours	Supramajor Plus

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgao1kar		Dr. S.S. Deepak	
Quality Head		Chairman & Managing Director	

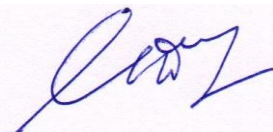


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879	NEUROSURGERY	Endoscopic Biopsy Of Ventricular Tumours	Supramajor Plus		
880	NEUROSURGERY	Microvascular Decompression Of Fifth/Seventh Cranial Nerve	Supramajor Plus		
881	NEUROSURGERY	TLIF	Supramajor Plus		
882	NEUROSURGERY	Decompression + Stabilisation	Supramajor Plus		
883	NEUROSURGERY	Decompressive Craniectomy SMB Plus	Supramajor Plus		
Sr.	Speciality	Surgery	Category	MS Ophthalmology with appropriate anterior segment / posterior segment fellowships and training	3
884	OPHTHALMOLOGY	Intravitreal Injections	Minor		
885	OPHTHALMOLOGY	Examination Under Anaesthesia	Minor		
886	OPHTHALMOLOGY	Corneal Foreign Body Deep	Minor		
887	OPHTHALMOLOGY	Examination Under Ga	Minor		
888	OPHTHALMOLOGY	Probing Syringing Under Ga	Minor		
889	OPHTHALMOLOGY	Lid Tumours Excision And Repair Minor	Minor		
890	OPHTHALMOLOGY	Scleral Buckle Removal	Intermediate		
891	OPHTHALMOLOGY	Silicone Oil Removal	Intermediate		
892	OPHTHALMOLOGY	Cyclorcryopexy	Intermediate		
893	OPHTHALMOLOGY	Dermoid Removal	Intermediate		
894	OPHTHALMOLOGY	Drainage Of Lacrimal Abscess	Intermediate		
895	OPHTHALMOLOGY	Drainage Of Lid Abscess	Intermediate		
896	OPHTHALMOLOGY	Ectropion Bilateral	Intermediate		
897	OPHTHALMOLOGY	Entropion Bilateral	Intermediate		
Recommended By		Signature	Approved By	Signature	
Dr. Hrishikesh Kalgao1kar			Dr. S.S. Deepak		
Quality Head			Chairman & Managing Director		



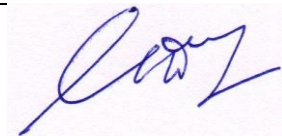
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898	OPHTHALMOLOGY	Enucleation	Intermediate
899	OPHTHALMOLOGY	Evisceration	Intermediate
900	OPHTHALMOLOGY	Pterygium	Intermediate
901	OPHTHALMOLOGY	Resuturing / A.C.Wash	Intermediate
902	OPHTHALMOLOGY	Tarsorrhaphy	Intermediate
903	OPHTHALMOLOGY	Cataract Economy	Intermediate
904	OPHTHALMOLOGY	Lid Tumours Excision And Repair Intermediate	Intermediate
905	OPHTHALMOLOGY	Cataract Standard	Intermediate
906	OPHTHALMOLOGY	Cataract Golden	Intermediate
907	OPHTHALMOLOGY	Cataract Premium	Intermediate
908	OPHTHALMOLOGY	Cataract Extra Premium	Intermediate
909	OPHTHALMOLOGY	Cataract Toric	Intermediate
910	OPHTHALMOLOGY	Cataract Multifocal 2	Intermediate
911	OPHTHALMOLOGY	Cataract Multifocal 1	Intermediate
912	OPHTHALMOLOGY	Cataract ICL/Prelex	Intermediate
913	OPHTHALMOLOGY	Cataract Crystalens	Intermediate
914	OPHTHALMOLOGY	Pars Plana Vitrectomy + Endolaser + (Gas / Silicone Oil)	Major
915	OPHTHALMOLOGY	Scleral Buckling + Cryo +/- Gas	Major
916	OPHTHALMOLOGY	Dct (Dacryocystomy/Cyst)	Major
917	OPHTHALMOLOGY	Epicanthus	Major

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Quality Head		Chairman & Managing Director	

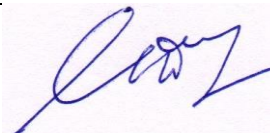


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918	OPHTHALMOLOGY	Lid Tumours Excision And Repair	Major	
919	OPHTHALMOLOGY	Peripheral Iridectomy Iris Cyst	Major	
920	OPHTHALMOLOGY	Ptosis - MINO	Major	
921	OPHTHALMOLOGY	Repair (Lid Canaliculi Injury)	Major	
922	OPHTHALMOLOGY	Repair Of Lid Coloboma	Major	
923	OPHTHALMOLOGY	Squint (Up To 2 Muscles)	Major	
924	OPHTHALMOLOGY	Trabeculectomy	Major	
925	OPHTHALMOLOGY	Pars Plana Vitrectomy	Major	
926	OPHTHALMOLOGY	Scleral Buckling	Major	
927	OPHTHALMOLOGY	Perforating Injuries Of Cornea	Major	
928	OPHTHALMOLOGY	Lid Tumours Excision And Repair Extended	Major	
929	OPHTHALMOLOGY	Pars Plana Vitrectomy +Scleral Buckle (Sb) + Pfcl + Endolase	Major Plus	
930	OPHTHALMOLOGY	Ptosis	Major Plus	
931	OPHTHALMOLOGY	Squint (More Than 2 Muscles)	Major Plus	
932	OPHTHALMOLOGY	Pars Plana Vitrectomy With Endolaser	Major Plus	
933	OPHTHALMOLOGY	Pars Plana Vitrectomy +Scleral Buckle (Bb) + Endolaser + (Ga	Major Plus	
934	OPHTHALMOLOGY	Pars Plana Vitrectomy With Gas Or Silicone Oil Insertion	Supra Major	
935	OPHTHALMOLOGY	Corneal Grafting (Keratoplasty	Supra Major	
936	OPHTHALMOLOGY	Dcr	Supra Major	
937	OPHTHALMOLOGY	Intraocular Foreign Body Removal	Supra Major	
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938	OPHTHALMOLOGY	Lensectomy	Supra Major	MS Orthopaedics	5
939	OPHTHALMOLOGY	Perforating Injuries Of Cornea Multiple	Supra Major		
940	OPHTHALMOLOGY	Symblepheron With Graft	Supra Major		
941	OPHTHALMOLOGY	Major Lid Reconstructive Surgery	Supramajor Plus		
942	OPHTHALMOLOGY	Orbitotomy	Supramajor Plus		
943	OPHTHALMOLOGY	Retinal Surgery	Supramajor Plus		
944	OPHTHALMOLOGY	Vitrectomy	Supramajor Plus		
945	OPHTHALMOLOGY	Exenteration	Supramajor Plus		
Sr.	Speciality	Surgical	Category		
946	ORTHOPEDICS	Ddh Arthrogram	Minor		
947	ORTHOPEDICS	Botox LI/UI	Minor		
948	ORTHOPEDICS	Tenotomy + Pop	Minor		
949	ORTHOPEDICS	K-Wire Removal	Minor		
950	ORTHOPEDICS	Examination Under Anesthesia Eua	Minor		
951	ORTHOPEDICS	Manipulation Under Anesthesia Mua	Minor		
952	ORTHOPEDICS	Intra Articular Injections	Minor		
953	ORTHOPEDICS	Bone / Cartilage Biopsy	Minor		
954	ORTHOPEDICS	Joint Aspiration	Minor		
955	ORTHOPEDICS	Closed Reduction Under Ga	Minor		

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956	ORTHOPEDICS	Ganglion Excision Open	Minor
957	ORTHOPEDICS	Plaster Under Ga	Minor
958	ORTHOPEDICS	MINO Implant Removal	Minor
959	ORTHOPEDICS	MINO Secondary Wound Closure	Minor
960	ORTHOPEDICS	Diagnostic Knee Arthroscopy	Minor
961	ORTHOPEDICS	Second Look Diagnostic Knee Arthroscopy.	Minor
962	ORTHOPEDICS	Arthroscopic Biopsy Of Synovium / Cartilage.	Minor
963	ORTHOPEDICS	Prp Injection	Minor
964	ORTHOPEDICS	Aspiration Of Cold Abscess	Minor
965	ORTHOPEDICS	Biopsy - Needle / Truecut (Spine/Pe)	Minor
966	ORTHOPEDICS	Biopsy Small Bone	Minor
967	ORTHOPEDICS	Bone Grafting - MINO	Minor
968	ORTHOPEDICS	Closed Reduction Of Fracture - Small Joint	Minor
969	ORTHOPEDICS	Closed Reduction Of Joint Dislocation-Small Joints	Minor
970	ORTHOPEDICS	Disl.MINO-Wrist/Fingers/Digit	Minor
971	ORTHOPEDICS	Epidural Steroid	Minor
972	ORTHOPEDICS	Euga	Minor
973	ORTHOPEDICS	Ganglion Excision	Minor
974	ORTHOPEDICS	Implant Removal-MINO	Minor
975	ORTHOPEDICS	Incision And Drainage	Minor

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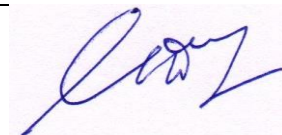


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976	ORTHOPEDICS	Muga	Minor	
977	ORTHOPEDICS	Needle Biopsy	Minor	
978	ORTHOPEDICS	Removal of Screw For interlockin	Minor	
979	ORTHOPEDICS	Secondary Closure Of Wounds-MINO	Minor	
980	ORTHOPEDICS	Sinogram	Minor	
981	ORTHOPEDICS	Ske. Trac.Steinamann Pin/Crutch	Minor	
982	ORTHOPEDICS	Skeletal Traction Femur Tibia	Minor	
983	ORTHOPEDICS	Spinal Surgery - Epidural Steroid	Minor	
984	ORTHOPEDICS	Tumour Surgery - Excision Of Small Tumour	Minor	
985	ORTHOPEDICS	Abscess Drainage - Small (Collection > 100 ML)	Minor	
986	ORTHOPEDICS	Arthrotomy - MINOR Joint	Minor	
987	ORTHOPEDICS	Skull Traction - Per Day	Minor	
988	ORTHOPEDICS	Injection Synvisc	Minor	
989	ORTHOPEDICS	Abscess Drainage - Large (Collection > 200 ML)	Intermediate	
990	ORTHOPEDICS	Amputation Digits	Intermediate	
991	ORTHOPEDICS	Cl. Redc.Of Frac/Dis. Loc-Sabilization-Small Joint	Intermediate	
992	ORTHOPEDICS	Closed Reduction Of Fracture - Large Joint	Intermediate	
993	ORTHOPEDICS	Closed Reduction Of Joint Dislocation-MAJO Joints	Intermediate	
994	ORTHOPEDICS	Compo Fracture Small Bone Debridment+Cl. Reduction	Intermediate	
995	ORTHOPEDICS	Compo Fracture Small Bone Debridment+Stabilization	Intermediate	
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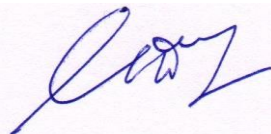


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996	ORTHOPEDICS	Contracture Release - MINO	Intermediate	
997	ORTHOPEDICS	Decompression (Tendon Or Nerve) For Teno-Sinovitis	Intermediate	
998	ORTHOPEDICS	Dislocation Elbow Shoulder Hip	Intermediate	
999	ORTHOPEDICS	Dislocation Wrist Fingers	Intermediate	
1000	ORTHOPEDICS	Epiphyseal Procedures - Epiphysiodesis	Intermediate	
1001	ORTHOPEDICS	Epiphyseal Procedures - Reduction	Intermediate	
1002	ORTHOPEDICS	Excision Arthroplasty Of Small	Intermediate	
1003	ORTHOPEDICS	Fixa./Excision Radial Head Fra	Intermediate	
1004	ORTHOPEDICS	For (Forearm/Wrist/Hand/Ankle	Intermediate	
1005	ORTHOPEDICS	Forearm / Legarm Thigh	Intermediate	
1006	ORTHOPEDICS	Frac. Forearm-Orif Single Bone	Intermediate	
1007	ORTHOPEDICS	Ii And Foot	Intermediate	
1008	ORTHOPEDICS	Ilizarov Fixation - MINO	Intermediate	
1009	ORTHOPEDICS	Jess Fixation - MINO	Intermediate	
1010	ORTHOPEDICS	Joint Replacement Hemi-Arthroplasty - Small Bones	Intermediate	
1011	ORTHOPEDICS	Knee Aspiration Haematoma And Knee Wash	Intermediate	
1012	ORTHOPEDICS	Knee Synovectomy	Intermediate	
1013	ORTHOPEDICS	Manipulation Under Anaesthesia	Intermediate	
1014	ORTHOPEDICS	Mp And Ip Joints	Intermediate	
1015	ORTHOPEDICS	Open Reduction Of Joint Dislocation- Small Joints	Intermediate	
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1016	ORTHOPEDICS	Osteotomies - Small Bones	Intermediate
1017	ORTHOPEDICS	Percutaneous Screw Fixation	Intermediate
1018	ORTHOPEDICS	Primary Suturing Of Lacerated	Intermediate
1019	ORTHOPEDICS	Reconst. For Recurrent Dislocation-Small Joints	Intermediate
1020	ORTHOPEDICS	Removal Loose Body Knee	Intermediate
1021	ORTHOPEDICS	Removal Of Plate In Femur	Intermediate
1022	ORTHOPEDICS	Skin Grafting - MINO	Intermediate
1023	ORTHOPEDICS	Small Bone Debridement	Intermediate
1024	ORTHOPEDICS	Arthroscopic Loose Body Removal (Knee)	Intermediate
1025	ORTHOPEDICS	Arthroscopic Partial Meniscectomy	Intermediate
1026	ORTHOPEDICS	Arthroscopic Lateral Release (Knee)	Intermediate
1027	ORTHOPEDICS	Arthroscopic Chondral Sharing/Chondroplasty	Intermediate
1028	ORTHOPEDICS	Spinal Surgery - Vertebroplasty	Intermediate
1029	ORTHOPEDICS	Surgery For Dequervains Disease	Intermediate
1030	ORTHOPEDICS	Synovectomy - MINO Joint	Intermediate
1031	ORTHOPEDICS	Tarsal/ Metatars./Metacarpal Fixation	Intermediate
1032	ORTHOPEDICS	Tumour Surgery - Curratage Of Small Tumour	Intermediate
1033	ORTHOPEDICS	Tumour Surgery - Excision Of Large Tumour	Intermediate
1034	ORTHOPEDICS	Vertibral Biopsy With Needle	Intermediate
1035	ORTHOPEDICS	Wire Fixation Of Extension Mech. Of Patella	Intermediate

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1036	ORTHOPEDICS	Wound Debridement - MINO	Intermediate
1037	ORTHOPEDICS	Wrist Hand Ankle Foot Bone	Intermediate
1038	ORTHOPEDICS	Arthrolysis - Small Joints	Intermediate
1039	ORTHOPEDICS	Botox Multiple LI/UI	Intermediate
1040	ORTHOPEDICS	Plate Removal	Intermediate
1041	ORTHOPEDICS	Arthrotomy - Intermediate	Intermediate
1042	ORTHOPEDICS	Ddh Closed Reduction & Spica	Intermediate
1043	ORTHOPEDICS	Ctev Limited Soft Tissue Release	Intermediate
1044	ORTHOPEDICS	Ankle Frac - Unimalleolar	Intermediate
1045	ORTHOPEDICS	Arthrogram	Intermediate
1046	ORTHOPEDICS	Biopsy - Open Of Bones (Foot/Hand)	Intermediate
1047	ORTHOPEDICS	Biopsy-Open Of Ilium / Long Bone	Intermediate
1048	ORTHOPEDICS	Bone Grafting Of Small Bones	Intermediate
1049	ORTHOPEDICS	Car.Tunnel Release/Tenosynovectomy	Intermediate
1050	ORTHOPEDICS	Arthroscopic Loose Body Removal	Intermediate
1051	ORTHOPEDICS	Arthroscopic Lateral Retinacular Release	Intermediate
1052	ORTHOPEDICS	Arthroscopic Chondral Shaving/Chondroplasty	Intermediate
1053	ORTHOPEDICS	8 Plate One Bone	Intermediate
1054	ORTHOPEDICS	Adductor Release	Intermediate
1055	ORTHOPEDICS	Joint Contracture Release	Intermediate

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1056	ORTHOPEDICS	Titanium Elastic Nails MINO	Intermediate
1057	ORTHOPEDICS	Torticollis Release MINO	Intermediate
1058	ORTHOPEDICS	Cerebral Palsy Limited Soft Tissue Release	Intermediate
1059	ORTHOPEDICS	Ilizarov/Orthofix MINO	Intermediate
1060	ORTHOPEDICS	Diagnostic Arthroscopy Of Shoulder	Intermediate
1061	ORTHOPEDICS	Diagnostic Arthroscopy Of Elbow	Intermediate
1062	ORTHOPEDICS	Diagnostic Arthroscopy Of Wrist	Intermediate
1063	ORTHOPEDICS	Diagnostic Arthroscopy Of Hip	Intermediate
1064	ORTHOPEDICS	Diagnostic Arthroscopy Of Ankle	Intermediate
1065	ORTHOPEDICS	Excision Arthroplasty - Large Joints	Major
1066	ORTHOPEDICS	External Fixation - MINO	Major
1067	ORTHOPEDICS	Fibula Radius Ulna Calvicle	Major
1068	ORTHOPEDICS	Fixation Humerus Epicondyle	Major
1069	ORTHOPEDICS	Fixation Matarsal/ Metacarpal	Major
1070	ORTHOPEDICS	Foot Or Hand	Major
1071	ORTHOPEDICS	Forearm Nailing	Major
1072	ORTHOPEDICS	Forearm Plating-One Bone	Major
1073	ORTHOPEDICS	Frac. Forearm-Orif Both Bones	Major
1074	ORTHOPEDICS	Ibone Grafting Of Long Bones	Major
1075	ORTHOPEDICS	Ilizarov Fixation (Small)	Major

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1076	ORTHOPEDICS	Implant Removal-MAJO	Major
1077	ORTHOPEDICS	Internal Fixation - Small Bones	Major
1078	ORTHOPEDICS	Below Knee Amputation	Major
1079	ORTHOPEDICS	Above Knee Amputation	Major
1080	ORTHOPEDICS	Joint Replacement Hemi-Arthroplasty - Large Bones	Major
1081	ORTHOPEDICS	Large Bone Debridement	Major
1082	ORTHOPEDICS	Lateral Cutaneous Nerve Of The Thigh Release	Major
1083	ORTHOPEDICS	Lengthning	Major
1084	ORTHOPEDICS	Open Reduction Of Joint Dislocation- MAJO Joints	Major
1085	ORTHOPEDICS	Open Reduction-Complex Frac And Dis Loc Of Finger Jt	Major
1086	ORTHOPEDICS	Osteoperiosteal Gap Bone Graft	Major
1087	ORTHOPEDICS	Osteotomies - Large Bones	Major
1088	ORTHOPEDICS	Percutaneous K-Wire Fix.Shoulder	Major
1089	ORTHOPEDICS	Pop -Spinal Jacket/Hip/Shoulder	Major
1090	ORTHOPEDICS	Primary Replac Finger Joint(Each)	Major
1091	ORTHOPEDICS	Arthroscopic Meniscus Repair (Upto 2 Cm)	Major
1092	ORTHOPEDICS	Reconst. For Recurrent Dislocation-Large Joints	Major
1093	ORTHOPEDICS	Release Of Sternomastoid	Major
1094	ORTHOPEDICS	Removal K.Nail A.O.Plates Fore	Major
1095	ORTHOPEDICS	Removal Of Spur And Osteophyte And Tendon Suture	Major

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1096	ORTHOPEDICS	Secondary Closure Of Wounds-MAJO	Major
1097	ORTHOPEDICS	Short Bones	Major
1098	ORTHOPEDICS	Skin Grafting - MAJO	Major
1099	ORTHOPEDICS	Souter Yountss Release And Contr	Major
1100	ORTHOPEDICS	Surgery For Chr Osteomyelitis	Major
1101	ORTHOPEDICS	Surgery Tumours Of Small Bones	Major
1102	ORTHOPEDICS	Synovectomy - MAJO Joint	Major
1103	ORTHOPEDICS	Arthroscopic Cartilage Surgery (Upto 2 Cm)	Major
1104	ORTHOPEDICS	Isolated Corrective Osteotomy	Major
1105	ORTHOPEDICS	Subacromial Decompression Shoulder	Major
1106	ORTHOPEDICS	Open Mcl Repair	Major
1107	ORTHOPEDICS	Arthroscopic Synovectomy	Major
1108	ORTHOPEDICS	Arthroscopic Debridement	Major
1109	ORTHOPEDICS	Autologous Chondrocyte Transplantation	Major
1110	ORTHOPEDICS	Ddh Open Reduction	Major
1111	ORTHOPEDICS	Ctev Soft Tissue Release MAJO	Major
1112	ORTHOPEDICS	Long Bone Osteotomy	Major
1113	ORTHOPEDICS	Joint Contracture Release With Fixation	Major
1114	ORTHOPEDICS	Ctev Jess	Major
1115	ORTHOPEDICS	Ctev Tendon Transfer	Major

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1116	ORTHOPEDICS	8 Plate 2 Bones	Major
1117	ORTHOPEDICS	Cerebral Palsy Soft Tissue Release MAJO	Major
1118	ORTHOPEDICS	Titanium Elastic Nails MAJO	Major
1119	ORTHOPEDICS	Torticollis Release	Major
1120	ORTHOPEDICS	Ilizarov/Orthofix MAJO	Major
1121	ORTHOPEDICS	Mpfl Reconstruction	Major
1122	ORTHOPEDICS	Tbw-Olecranon / Patella	Major
1123	ORTHOPEDICS	Tendon Repair - MINO	Major
1124	ORTHOPEDICS	Tendon Transfer - MINO	Major
1125	ORTHOPEDICS	Total Joint Replacement - Small Bone	Major
1126	ORTHOPEDICS	Transpositions	Major
1127	ORTHOPEDICS	Tumour Surgery - Curratage Of Large Tumour	Major
1128	ORTHOPEDICS	Tumour Surgery - Excision + Recon. Of Small Tumour	Major
1129	ORTHOPEDICS	Tumours - MINO	Major
1130	ORTHOPEDICS	Wound Debridement - MAJO	Major
1131	ORTHOPEDICS	Wrist Ankle Hand Foot	Major
1132	ORTHOPEDICS	Wrist Dislocation Inter Carpal	Major
1133	ORTHOPEDICS	Arthrotomy - MAJOR Joint	Major
1134	ORTHOPEDICS	Vertebroplasty Multiple Level	Major
1135	ORTHOPEDICS	Arthroscopic Arthrolisis	Major

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1136	ORTHOPEDICS	Operative Arthroscopy Of Shoulder (MINO Reconstruction)	Major
1137	ORTHOPEDICS	Acromioclavicular Or Sternoclavicular	Major
1138	ORTHOPEDICS	Amputation Of Digits - Extended	Major
1139	ORTHOPEDICS	Arthrodesis Mp And Ip Joints	Major
1140	ORTHOPEDICS	Arthrolysis - Large Joints	Major
1141	ORTHOPEDICS	Arthrolysis - Open	Major
1142	ORTHOPEDICS	Bone Grafting - MAJO	Major
1143	ORTHOPEDICS	Cdh Open Reduction	Major
1144	ORTHOPEDICS	Cl. Redc.Of Frac/Disloc-Stabilization-Large Joint	Major
1145	ORTHOPEDICS	Compound Fracture Large Bone Debridment + Cl. Red	Major
1146	ORTHOPEDICS	Contracture Release-MAJO	Major
1147	ORTHOPEDICS	Core Decompression And Strut Grafting	Major
1148	ORTHOPEDICS	Cr. Osteomyelitis Sequestrectomy	Major
1149	ORTHOPEDICS	Ctev (congenital talipes equinovarus)	Major
1150	ORTHOPEDICS	Curetage Bone Grafting Of Bone	Major
1151	ORTHOPEDICS	Debridement Primary Closure	Major
1152	ORTHOPEDICS	Diagnostic Shoulder A"Scopy	Major
1153	ORTHOPEDICS	Digits	Major
1154	ORTHOPEDICS	Disl. MAJO (Hip/Knee/Shoulder/Elb)	Major
1155	ORTHOPEDICS	Drainage Of Psoas Abscess-Par	Major

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1156	ORTHOPEDICS	Epiphyseal Procedures - Reduction With Fixation	Major
1157	ORTHOPEDICS	Excision Exostosis Long Bones	Major
1158	ORTHOPEDICS	Operative Arthroscopy Of Hip [MINO Reconstruction]	Major
1159	ORTHOPEDICS	Operative Arthroscopy Of Wrist [MINO Reconstruction]	Major
1160	ORTHOPEDICS	Operative Arthroscopy Of Ankle [MINO Reconstruction]	Major
1161	ORTHOPEDICS	Operative Arthroscopy Of Elbow [MINO Reconstruction]	Major
1162	ORTHOPEDICS	Osteotomy â Isolated / MINO	Major
1163	ORTHOPEDICS	Bone Marrow harvesting	Major
1164	ORTHOPEDICS	Injection Botox	Major
1165	ORTHOPEDICS	Closed Reduction	Major
1166	ORTHOPEDICS	Vertebroplasty	Major
1167	ORTHOPEDICS	Cerebral Palsy Multilevel Soft Tissue Release	Major Plus
1168	ORTHOPEDICS	Ctev Extended Soft Tissue Release	Major Plus
1169	ORTHOPEDICS	Ilizarov/Orthofix Extended Frame	Major Plus
1170	ORTHOPEDICS	8 Plate 4 Bones	Major Plus
1171	ORTHOPEDICS	Mcl Repair / Reconstruction	Major Plus
1172	ORTHOPEDICS	Arthroscopic Meniscus Surgery âComplex Tear	Major Plus
1173	ORTHOPEDICS	Arthroscopic Mpfl Reconstruction	Major Plus
1174	ORTHOPEDICS	Plc Repair / Reconstruction	Major Plus
1175	ORTHOPEDICS	Arthroscopic Supraspinatus Repair	Major Plus

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1176	ORTHOPEDICS	Arthroscopic Rotator Cuff Repair	Major Plus
1177	ORTHOPEDICS	Hip Arthroscopy [MAJO Reconstruction]	Major Plus
1178	ORTHOPEDICS	Ankle Arthroscopy [MAJO Reconstruction].	Major Plus
1179	ORTHOPEDICS	Elbow Arthroscopy [MAJO Reconstruction].	Major Plus
1180	ORTHOPEDICS	Wrist Arthroscopy [MAJO Reconstruction].	Major Plus
1181	ORTHOPEDICS	Hindfoot Endoscopy	Major Plus
1182	ORTHOPEDICS	Bone Endoscopy	Major Plus
1183	ORTHOPEDICS	Soft Tissue Endoscopy	Major Plus
1184	ORTHOPEDICS	Total Knee Replacement Scopy	Major Plus
1185	ORTHOPEDICS	Muscle / Tendon Repair Or Reconstructive Surgery	Major Plus
1186	ORTHOPEDICS	Aci Stage 1	Major Plus
1187	ORTHOPEDICS	Aci Stage 2	Major Plus
1188	ORTHOPEDICS	Additional Soft Tissue Surgery	Major Plus
1189	ORTHOPEDICS	Amputation Ak/Bk/Ae/Be	Major Plus
1190	ORTHOPEDICS	Angular Plate - Condylar Plating	Major Plus
1191	ORTHOPEDICS	Arthrolysis, Synovectomy, Meniscus Surger	Major Plus
1192	ORTHOPEDICS	Arthroscopic Surgery	Major Plus
1193	ORTHOPEDICS	Bachelors/Grice Greenarthodes	Major Plus
1194	ORTHOPEDICS	Cemented Bipolar Large Bone	Major Plus
1195	ORTHOPEDICS	Comp. Fracture Large Bone Debridment+Stabilization	Major Plus

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1196	ORTHOPEDICS	Complex Fracture Fixation	Major Plus
1197	ORTHOPEDICS	Arthroscopic Pcl Reconstruction	Major Plus
1198	ORTHOPEDICS	Open Plc Repair/Reconstruction	Major Plus
1199	ORTHOPEDICS	Arthroscopic Meniscus Repair (More Than 2 Cm)	Major Plus
1200	ORTHOPEDICS	Arthroscopic Cartilage Surgery (More Than 2 Cm)	Major Plus
1201	ORTHOPEDICS	Complex Corrective Osteotomy	Major Plus
1202	ORTHOPEDICS	Arthroscopic Slap Repair	Major Plus
1203	ORTHOPEDICS	Arthroscopic Capsular Release For Stiff Shoulder	Major Plus
1204	ORTHOPEDICS	Arthroscopic Synovectomy Shoulder	Major Plus
1205	ORTHOPEDICS	Operative Arthroscopy Of Hip (MAJO Reconstructions)	Major Plus
1206	ORTHOPEDICS	Operative Arthroscopy Of Ankle (MAJO Reconstructions)	Major Plus
1207	ORTHOPEDICS	Operative Arthroscopy Of Elbow (MAJO Reconstructions)	Major Plus
1208	ORTHOPEDICS	Operative Arthroscopy Of Wrist (MAJO Reconstructions)	Major Plus
1209	ORTHOPEDICS	MINO Arthrodesis	Major Plus
1210	ORTHOPEDICS	Arthroscopic Bankart Repair	Major Plus
1211	ORTHOPEDICS	Ddh Open Reduction+Osteotomy	Major Plus
1212	ORTHOPEDICS	Cord Decompression - Both Side	Major Plus
1213	ORTHOPEDICS	Drain. Of Psoas/Paravertebral A	Major Plus
1214	ORTHOPEDICS	Epiphyseal Stimulation Epiphyse	Major Plus
1215	ORTHOPEDICS	External Fixation -MAJO	Major Plus

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1216	ORTHOPEDICS	Fixation Olecranon	Major Plus
1217	ORTHOPEDICS	Fixation Tarsal Bone	Major Plus
1218	ORTHOPEDICS	Fixation/Excision Redial Head	Major Plus
1219	ORTHOPEDICS	For (Arm/Leg/Thigh)	Major Plus
1220	ORTHOPEDICS	Fore Quarter Or Hind Quarter	Major Plus
1221	ORTHOPEDICS	Forearm Plating-Both Bones	Major Plus
1222	ORTHOPEDICS	Frac. Humerus/Tibia/Femur-Orif	Major Plus
1223	ORTHOPEDICS	Frac. Neck Femur-Cancellous Screw Fixation	Major Plus
1224	ORTHOPEDICS	French Osteotomy	Major Plus
1225	ORTHOPEDICS	Girdlestone Arthroplasty	Major Plus
1226	ORTHOPEDICS	Hemi-Arthroplasty Hip Uncemented	Major Plus
1227	ORTHOPEDICS	Humerus Of Replatting And Bone Grfting	Major Plus
1228	ORTHOPEDICS	Internal Fixation - Large Bones	Major Plus
1229	ORTHOPEDICS	Internal Fixation - Pelvic Fracture	Major Plus
1230	ORTHOPEDICS	Leg Or Forearm	Major Plus
1231	ORTHOPEDICS	Open Rotator Cuff Repair	Major Plus
1232	ORTHOPEDICS	Operations Of Hallus Valgus Va.	Major Plus
1233	ORTHOPEDICS	Osteotomies - If Associated With Internal Fixation	Major Plus
1234	ORTHOPEDICS	Revision Joint Replacement - Small Bone	Major Plus
1235	ORTHOPEDICS	Small Joint Replacement	Major Plus

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1236	ORTHOPEDICS	Tendon Repair - MAJO	Major Plus
1237	ORTHOPEDICS	Tendon Repair-Tendon With Nerve And Vascular Repair	Major Plus
1238	ORTHOPEDICS	Thigh Or Arm	Major Plus
1239	ORTHOPEDICS	Tumour Surgery - Excision + Recon. Of Large Tumour	Major Plus
1240	ORTHOPEDICS	Unicondylar Fracture Femur	Major Plus
1241	ORTHOPEDICS	Vertebro Plasty	Major Plus
1242	ORTHOPEDICS	Lumbar Microdecompression	Major Plus
1243	ORTHOPEDICS	Arthroscopic Surgery â Knee	Major Plus
1244	ORTHOPEDICS	Arthroscopic Surgery â shoulder	Major Plus
1245	ORTHOPEDICS	Injection Botox Multiple	Major Plus
1246	ORTHOPEDICS	Ddh developmental dysplasia of the hip Open Reduction+Osteotomy+Reconstruction	Supra Major
1247	ORTHOPEDICS	Ctev Extensive Footreconstruction	Supra Major
1248	ORTHOPEDICS	Cerebral Palsy Extensive Soft Tissue Release	Supra Major
1249	ORTHOPEDICS	First Stage Revision Joint Replacement	Supra Major
1250	ORTHOPEDICS	Second Stage Revision Joint Replacement	Supra Major
1251	ORTHOPEDICS	Arthroscopic Acl/Pcl Reconstruction + Meniscus Surgery + Car	Supra Major
1252	ORTHOPEDICS	Arthroscopic Subacromial Decompression + Rotator Cuff Repai	Supra Major
1253	ORTHOPEDICS	Bone Endoscopic Tumour/Cyst Excision	Supra Major

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1254	ORTHOPEDICS	Arthroscopic Synovectomy With Biopsy, Chondroplasty	Supra Major
1255	ORTHOPEDICS	Posterior Instrumentative Scoliosis Correction	Supra Major
1256	ORTHOPEDICS	Spinal Surgery - Lumbar Decompression	Supra Major
1257	ORTHOPEDICS	Close Interlock Nailing Femur	Supra Major
1258	ORTHOPEDICS	Acetabular And Pelvic Frac -1Col	Supra Major
1259	ORTHOPEDICS	Acl Package (Minus Implants)	Supra Major
1260	ORTHOPEDICS	Ankle Frac. Bimalleolar/Trimall	Supra Major
1261	ORTHOPEDICS	Anterior Cervical Discectomy	Supra Major
1262	ORTHOPEDICS	Antero - Lateral Decompression - A	Supra Major
1263	ORTHOPEDICS	Shoulder Arthroplasty	Supra Major
1264	ORTHOPEDICS	Combination Surgery For Knee (Ligaments, Menisci, Cartilage,	Supra Major
1265	ORTHOPEDICS	Fai Surgery Hip	Supra Major
1266	ORTHOPEDICS	Dislocated Knee Multiple Ligament Reconstruction	Supra Major
1267	ORTHOPEDICS	Major Arthrodesis	Supra Major
1268	ORTHOPEDICS	Major Open Shoulder Reconstructive Surgery	Supra Major
1269	ORTHOPEDICS	Arthroscopic Subacromial Decompression With Rotator Cuff Rep	Supra Major
1270	ORTHOPEDICS	Complex Cartilage Reconstructive Procedure Including Implant	Supra Major
1271	ORTHOPEDICS	Cervical Spine Stabilization	Supra Major
1272	ORTHOPEDICS	Arthrodesis Shoulder/Knee/Ankle	Supra Major
1273	ORTHOPEDICS	Arthroscopic Surgery Extensive Shoulder	Supra Major

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1274	ORTHOPEDICS	Bone Grafting In Assoc.With O	Supra Major
1275	ORTHOPEDICS	Close Interlock Nailing Humeru	Supra Major
1276	ORTHOPEDICS	Corrective Osteotomy Of Long B	Supra Major
1277	ORTHOPEDICS	Disarticul. Hind/Fore-Quarter Am	Supra Major
1278	ORTHOPEDICS	Disarticul. Of Knee/Elbow/Wris	Supra Major
1279	ORTHOPEDICS	Disarticulation Of Hip Or Shoulder	Supra Major
1280	ORTHOPEDICS	Disarticulation Of Knee/Elbow	Supra Major
1281	ORTHOPEDICS	Disc Excision/Lamninectomy	Supra Major
1282	ORTHOPEDICS	Excision Arthroplasty Of Elbow	Supra Major
1283	ORTHOPEDICS	Excision Mycotic Mass Both Hips	Supra Major
1284	ORTHOPEDICS	Excision Tumour Long Bones Axi	Supra Major
1285	ORTHOPEDICS	Fixation Fracture Humerus With	Supra Major
1286	ORTHOPEDICS	Fixation Humerus/Tibia Condyle	Supra Major
1287	ORTHOPEDICS	Fixation Inter-Trochanteric Fracture	Supra Major
1288	ORTHOPEDICS	Forearm Plating-Both With Bone	Supra Major
1289	ORTHOPEDICS	Frac.Inter-Trochanteric / Dhs	Supra Major
1290	ORTHOPEDICS	Frac.Orif-009 With Bone Graftin	Supra Major
1291	ORTHOPEDICS	Hemi Shoulder Replacement	Supra Major
1292	ORTHOPEDICS	Hemi-Arthroplasty Hip	Supra Major
1293	ORTHOPEDICS	Hemi-Arthroplasty Shoulder	Supra Major

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1294	ORTHOPEDICS	High Tibial Osteotomy	Supra Major
1295	ORTHOPEDICS	Ilizarov Fixation - MAJO	Supra Major
1296	ORTHOPEDICS	Ilizarov Fixation (Large)	Supra Major
1297	ORTHOPEDICS	Intercondylar Fracture Femur	Supra Major
1298	ORTHOPEDICS	Intercondylar Fracture Humerus	Supra Major
1299	ORTHOPEDICS	Intercondylar Fracture Tibia	Supra Major
1300	ORTHOPEDICS	Interlo. Nailing-Femur/Tibia/Huerus	Supra Major
1301	ORTHOPEDICS	Interlo.After Orif Removal.Bon	Supra Major
1302	ORTHOPEDICS	Invominate Osteotomy	Supra Major
1303	ORTHOPEDICS	Jess Fixation - MAJO	Supra Major
1304	ORTHOPEDICS	Leglengthning Shortening	Supra Major
1305	ORTHOPEDICS	Micro -Lumbar Discectomy / Lamine	Supra Major
1306	ORTHOPEDICS	Multiple Nerve/ Tendon / Repair / Transfer	Supra Major
1307	ORTHOPEDICS	Nerve Repair	Supra Major
1308	ORTHOPEDICS	Open Ilium And Long Bones	Supra Major
1309	ORTHOPEDICS	Osteosynthesis Pelvic And Acetab	Supra Major
1310	ORTHOPEDICS	Osteotomy Around Knee	Supra Major
1311	ORTHOPEDICS	Pauwell"S Osteotomy	Supra Major
1312	ORTHOPEDICS	Primary Replacement Finger Joi	Supra Major
1313	ORTHOPEDICS	Primary Total Hip Replacement	Supra Major

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1314	ORTHOPEDICS	Primary Total Knee Replacement	Supra Major
1315	ORTHOPEDICS	Primary Total Shoulder Replacement	Supra Major
1316	ORTHOPEDICS	Recurrent Dislocation Patella	Supra Major
1317	ORTHOPEDICS	Recurrent Dislocation Shoulder	Supra Major
1318	ORTHOPEDICS	Repair	Supra Major
1319	ORTHOPEDICS	Rotator Cuff And Bankart Repair	Supra Major
1320	ORTHOPEDICS	Shoulder Dislocation/Knee Dislocation	Supra Major
1321	ORTHOPEDICS	Spinal Fracture Fixation	Supra Major
1322	ORTHOPEDICS	Spinal Fusion - Posterrior	Supra Major
1323	ORTHOPEDICS	Spinal Tumours-Open Biopsy	Supra Major
1324	ORTHOPEDICS	Spodylolisthesis - Gill'S Proce	Supra Major
1325	ORTHOPEDICS	Steffi / Harrington/Luque / Hartsh	Supra Major
1326	ORTHOPEDICS	Tendon Transfer - MAJO	Supra Major
1327	ORTHOPEDICS	Tendon Transfers	Supra Major
1328	ORTHOPEDICS	Total Joint Replacement - Large Bone	Supra Major
1329	ORTHOPEDICS	Total Knee Elbow Shoulder And	Supra Major
1330	ORTHOPEDICS	Trans / Retro - Peritoneal Decompr	Supra Major
1331	ORTHOPEDICS	Trans-Abdominal Decompression	Supra Major
1332	ORTHOPEDICS	Trans-Thoracic Decompression	Supra Major
1333	ORTHOPEDICS	Upper Femoral Osteotomy	Supra Major

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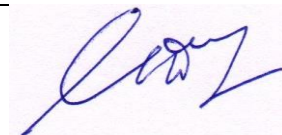


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1334	ORTHOPEDICS	Upper Femoral Ost-Varus/Valgus	Supra Major	
1335	ORTHOPEDICS	TLIF	Supra Major	
1336	ORTHOPEDICS	Arthroscopic Surgery Extensive Knee	Supra Major	
1337	ORTHOPEDICS	ORIF Surgery SM	Supra Major	
1338	ORTHOPEDICS	Bilateral Knee Replacement	Supramajor Plus	
1339	ORTHOPEDICS	Acetabular And Pelvic Frac - 2 Col	Supramajor Plus	
1340	ORTHOPEDICS	Anter.Spinal Fusion + Post Fix	Supramajor Plus	
1341	ORTHOPEDICS	Cdh Open Reduc. And Salter"S Osteo	Supramajor Plus	
1342	ORTHOPEDICS	Open Red.Elbow,Arthrolysis Elbow,Radial Head Repmt	Supramajor Plus	
1343	ORTHOPEDICS	Revision Arthroplasty Hip	Supramajor Plus	
1344	ORTHOPEDICS	Revision Arthroplasty Knee	Supramajor Plus	
1345	ORTHOPEDICS	Revision Arthroplasty Shoulder	Supramajor Plus	
1346	ORTHOPEDICS	Revision Joint Replacement - Large Bone	Supramajor Plus	
1347	ORTHOPEDICS	Scoliois Correction And Spinal F	Supramajor Plus	
1348	ORTHOPEDICS	Scoliosis Instrumentation And Fu	Supramajor Plus	
1349	ORTHOPEDICS	Scoliosis Instrumentation And Sp	Supramajor Plus	
1350	ORTHOPEDICS	Spinal Surgery - Scoliosis	Supramajor Plus	
1351	ORTHOPEDICS	Revision Shoulder Arthroplasty	Supramajor Plus	
1352	ORTHOPEDICS	Combined Arthroscopic Reconstructions Of Knee Involving Over	Supramajor Plus	
1353	ORTHOPEDICS	Meniscus Transplantation	Supramajor Plus	
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1354	ORTHOPEDICS	Spine Surgery - Cervical And Lumbar Decompression	Supramajor Plus
1355	ORTHOPEDICS	Spinal Surgery - Decompression With Stabilisation	Supramajor Plus
1356	ORTHOPEDICS	Bilat T / Kr	Supramajor Plus
1357	ORTHOPEDICS	Fixation Femoral Neck Fracture	Supramajor Plus
1358	ORTHOPEDICS	Interlo.Nailing-Revision + Bon Grafting	Supramajor Plus
1359	ORTHOPEDICS	Nerve Surgery	Supramajor Plus
1360	ORTHOPEDICS	Orthopaedic Surgery	Supramajor Plus
1361	ORTHOPEDICS	Osteosynthesis Pel And Acet-Larg	Supramajor Plus
1362	ORTHOPEDICS	Tendon Surgery	Supramajor Plus
1363	ORTHOPEDICS	Tendon Surgery Nerve Soft Tiss	Supramajor Plus
1364	ORTHOPEDICS	Tumours - MAJO	Supramajor Plus
1365	ORTHOPEDICS	PLIF (posterior lumbar interbody fusion)	Supramajor Plus
1366	ORTHOPEDICS	Major Scoliosis/Kyphosis	Supramajor Plus
1367	ORTHOPEDICS	Major Anterior Transthoracic / Cervical Abdominal Surgery	Supramajor Plus
1368	ORTHOPEDICS	Major Revision Surgery	Supramajor Plus
1369	ORTHOPEDICS	Major Tumour Excision	Supramajor Plus
1370	ORTHOPEDICS	Minimally Invasive Lumbar Surgery	Supramajor Plus
1371	ORTHOPEDICS	ORIF Surgery SMB plus	Supramajor Plus
1372	ORTHOPEDICS	Lumbar Microdissectomy	Supramajor Plus
1373	ORTHOPEDICS	Lumbar Microdissectomy Redo	Supramajor Plus

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1374	ORTHOPEDICS	Revision PLIF	Supramajor Plus	MS Surgery / MCH Pediatric Surgery	3
Sr.	Speciality	Surgical	Category		
1375	PEDIATRIC SURGERY	Minor Dressing	Minor		
1376	PEDIATRIC SURGERY	E.U.A.	Minor		
1377	PEDIATRIC SURGERY	Incision And Drainage Abscess	Minor		
1378	PEDIATRIC SURGERY	Suture Removal	Minor		
1379	PEDIATRIC SURGERY	Umbilical Polyp	Minor		
1380	PEDIATRIC SURGERY	Urethral Dilatation	Minor		
1381	PEDIATRIC SURGERY	Anal Stretching	Minor		
1382	PEDIATRIC SURGERY	Intracath Insertion	Minor		
1383	PEDIATRIC SURGERY	Venesection	Minor		
1384	PEDIATRIC SURGERY	Neonatal Circumcision Under L.A.	Minor		
1385	PEDIATRIC SURGERY	Aspiration Of Intraabdominal Abscess Under Ga	Minor		
1386	PEDIATRIC SURGERY	Incision And Drainage For Single Abscess	Minor		
1387	PEDIATRIC SURGERY	Incision And Drainage For Multiple Abscesses	Minor		
1388	PEDIATRIC SURGERY	Small Lymphnode Biopsy	Minor		
1389	PEDIATRIC SURGERY	Submucus Cyst	Minor		
1390	PEDIATRIC SURGERY	Desloughing And Debridement	Minor		
1391	PEDIATRIC SURGERY	Excision:Dermoid Cyst / Small Superficial Tumor	Minor		

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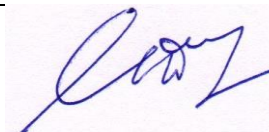


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1392	PEDIATRIC SURGERY	Excision:Hemangioma Small	Minor		
1393	PEDIATRIC SURGERY	Burns Dressing Under Ga	Minor		
1394	PEDIATRIC SURGERY	Any Opd Procedure Under Ga	Minor		
1395	PEDIATRIC SURGERY	Anal Dilatation Under Ga	Minor		
1396	PEDIATRIC SURGERY	Injection Of Hemangiomas	Minor		
1397	PEDIATRIC SURGERY	Skin Biopsy	Minor		
1398	PEDIATRIC SURGERY	Fraenuloplasty / Tongue Tie Release	Minor		
1399	PEDIATRIC SURGERY	Esophageal Dilatation	Minor		
1400	PEDIATRIC SURGERY	MINO Skin Graft / Thiersch	Minor		
1401	PEDIATRIC SURGERY	Testicular Implant Insertion	Intermediate		
1402	PEDIATRIC SURGERY	Polydytly	Intermediate		
1403	PEDIATRIC SURGERY	Medium Clw / Suturing	Intermediate		
1404	PEDIATRIC SURGERY	Staged Laparoscopic Orchiopexy	Intermediate		
1405	PEDIATRIC SURGERY	Circumcission	Intermediate		
1406	PEDIATRIC SURGERY	Diagnostic Scopies	Intermediate		
1407	PEDIATRIC SURGERY	Exchange Transfusion Blood	Intermediate		
1408	PEDIATRIC SURGERY	Excision Of Moderate Size Swelling	Intermediate		
1409	PEDIATRIC SURGERY	Rectal Polypectomy	Intermediate		
1410	PEDIATRIC SURGERY	Full Thickness Rectal Biopsy	Intermediate		
1411	PEDIATRIC SURGERY	B.C.G. Adenitis- Excision/ Scooping	Intermediate		
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1412	PEDIATRIC SURGERY	Medium Lymphnode Biopsy / Excision	Intermediate
1413	PEDIATRIC SURGERY	Umbilical Cutdown	Intermediate
1414	PEDIATRIC SURGERY	Paediatric Sigmoidoscopy	Intermediate
1415	PEDIATRIC SURGERY	Diagnostic Bronchoscopy	Intermediate
1416	PEDIATRIC SURGERY	Foreign Body Removal Under litv	Intermediate
1417	PEDIATRIC SURGERY	Nerve Or Muscle Biopsy	Intermediate
1418	PEDIATRIC SURGERY	Preputioplasty	Intermediate
1419	PEDIATRIC SURGERY	Hypospadias-MINO Corrections	Intermediate
1420	PEDIATRIC SURGERY	Thiersch Stitch	Intermediate
1421	PEDIATRIC SURGERY	Reduction Of Intussusception	Intermediate
1422	PEDIATRIC SURGERY	Intercostal Drainage	Intermediate
1423	PEDIATRIC SURGERY	Liver/Kidney Biopsy	Intermediate
1424	PEDIATRIC SURGERY	Pararectal Injections	Intermediate
1425	PEDIATRIC SURGERY	Hypospadias Fistula Closure	Intermediate
1426	PEDIATRIC SURGERY	Small Clw Under Ga/Suturing	Intermediate
1427	PEDIATRIC SURGERY	Long / Central Line	Intermediate
1428	PEDIATRIC SURGERY	Fissurectomy / Anal Fistula	Intermediate
1429	PEDIATRIC SURGERY	Submucosal-Rectal Injections	Intermediate
1430	PEDIATRIC SURGERY	Suprapubic Cystostomy Open	Intermediate
1431	PEDIATRIC SURGERY	Suprapubic Cystostomy With Trocar	Intermediate

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1432	PEDIATRIC SURGERY	Hypospadias - MAJO Secondary Corrections	Major
1433	PEDIATRIC SURGERY	Distal Hypospadias Corrections	Major
1434	PEDIATRIC SURGERY	All Therapeutic Endoscopies	Major
1435	PEDIATRIC SURGERY	Gastrostomy / Jejunostomy	Major
1436	PEDIATRIC SURGERY	Lap Fowler Stephen	Major
1437	PEDIATRIC SURGERY	Excision : Thyroglossal Fistula	Major
1438	PEDIATRIC SURGERY	Cutaneous Ureterostomy Unilateral	Major
1439	PEDIATRIC SURGERY	Urethroplasty (Small Seg) 1St Stage	Major
1440	PEDIATRIC SURGERY	Torsion Testis-Bilateral Testicular Fixation	Major
1441	PEDIATRIC SURGERY	Post /Ant Urethral Valve Fulguration	Major
1442	PEDIATRIC SURGERY	Deflux Injection	Major
1443	PEDIATRIC SURGERY	Bladder Botox Injection	Major
1444	PEDIATRIC SURGERY	Ace Procedure	Major
1445	PEDIATRIC SURGERY	Major Clw / Complex Repair	Major
1446	PEDIATRIC SURGERY	Branchial And Thyroglossal Cysts	Major
1447	PEDIATRIC SURGERY	Umbilical Hernia	Major
1448	PEDIATRIC SURGERY	All Scopies With Procedures	Major
1449	PEDIATRIC SURGERY	Closure Of Colostomy/Vesicostomy/Ureterostomy/Enterostomy	Major
1450	PEDIATRIC SURGERY	Intussusception Without Resection	Major
1451	PEDIATRIC SURGERY	Umbilical Hernia Repair	Major

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1452	PEDIATRIC SURGERY	Inguinal Herniotomy- Unilateral	Major
1453	PEDIATRIC SURGERY	Orchidectomy-Unilateral	Major
1454	PEDIATRIC SURGERY	Anorectal Myectomy	Major
1455	PEDIATRIC SURGERY	Larger Lymphadenectomy / Mass Of Lymph Nodes	Major
1456	PEDIATRIC SURGERY	Anoplasty For Low Imp.Anus	Major
1457	PEDIATRIC SURGERY	Surgery For Torticollis	Major
1458	PEDIATRIC SURGERY	Ranula Excision	Major
1459	PEDIATRIC SURGERY	Preauricular Sinus Excision	Major
1460	PEDIATRIC SURGERY	Sistrunks Operation: Thyroglossal Cyst / Fistula	Major
1461	PEDIATRIC SURGERY	Colostomy	Major
1462	PEDIATRIC SURGERY	Evaluation Under Anaesthesia + Anoplasty + Mcu	Major
1463	PEDIATRIC SURGERY	Hernia/Hydrocele	Major
1464	PEDIATRIC SURGERY	Hypospadias	Major
1465	PEDIATRIC SURGERY	Intussusception	Major
1466	PEDIATRIC SURGERY	Oesophageal Rail Road Dilatation	Major
1467	PEDIATRIC SURGERY	Orchidopexy	Major
1468	PEDIATRIC SURGERY	Pyloromyotomy (Ramstedt'S Operation)	Major
1469	PEDIATRIC SURGERY	Suprapubic Cystolithotomy	Major
1470	PEDIATRIC SURGERY	Abdominal Tumours	Major Plus
1471	PEDIATRIC SURGERY	Achalasia Cardia	Major Plus

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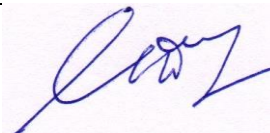


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1472	PEDIATRIC SURGERY	Biliary Surgery	Major Plus	
1473	PEDIATRIC SURGERY	Hiatus Hernia	Major Plus	
1474	PEDIATRIC SURGERY	Hydatid Cysts	Major Plus	
1475	PEDIATRIC SURGERY	Intestinal Resections	Major Plus	
1476	PEDIATRIC SURGERY	Myelomeningocele	Major Plus	
1477	PEDIATRIC SURGERY	Ventriculo Atrial Peritoneal Shunts	Major Plus	
1478	PEDIATRIC SURGERY	Herniotomies-Bilateral-Open	Major Plus	
1479	PEDIATRIC SURGERY	Bronchoscopy With Foreign Body Removal	Major Plus	
1480	PEDIATRIC SURGERY	Colostomy With Multiple Biopsies	Major Plus	
1481	PEDIATRIC SURGERY	Intestinal Obstruction / Intussuscetion With Resection And A	Major Plus	
1482	PEDIATRIC SURGERY	Lap Herniotomies-Bilateral	Major Plus	
1483	PEDIATRIC SURGERY	Lap Herniotomy	Major Plus	
1484	PEDIATRIC SURGERY	Lap Orchiopexy Unilateral	Major Plus	
1485	PEDIATRIC SURGERY	Lap Pyloromyotomy	Major Plus	
1486	PEDIATRIC SURGERY	Laparoscopic Appendicectomy	Major Plus	
1487	PEDIATRIC SURGERY	Psarp For Intermediate Anomalies	Major Plus	
1488	PEDIATRIC SURGERY	Staged Hypospadias Repair-Each Stage	Major Plus	
1489	PEDIATRIC SURGERY	Large Ventral Hernia	Major Plus	
1490	PEDIATRIC SURGERY	Nephrectomy-Easy	Major Plus	
1491	PEDIATRIC SURGERY	Obstructed Hernia-Inguinal	Major Plus	
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Dr. Hrishikesh Kalgao1kar			Dr. S.S. Deepak	
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1492	PEDIATRIC SURGERY	Pyelotithotomy-Simple	Major Plus
1493	PEDIATRIC SURGERY	Ramstedts Pyloromyotomy	Major Plus
1494	PEDIATRIC SURGERY	Repair Recurrent Inguinal Hernia	Major Plus
1495	PEDIATRIC SURGERY	Neonatal Herniotomy	Major Plus
1496	PEDIATRIC SURGERY	Vesicostomy	Major Plus
1497	PEDIATRIC SURGERY	V-P Shunt	Major Plus
1498	PEDIATRIC SURGERY	Intra-Op Cholangiogram With Liver Biopsy	Major Plus
1499	PEDIATRIC SURGERY	Meningomyelocele /Encephalocele	Major Plus
1500	PEDIATRIC SURGERY	Penoscrotal Transposition	Major Plus
1501	PEDIATRIC SURGERY	Esophagostomy	Major Plus
1502	PEDIATRIC SURGERY	Cholecystectomy - Laparoscopic	Major Plus
1503	PEDIATRIC SURGERY	Xiao'S Procedure	Major Plus
1504	PEDIATRIC SURGERY	Mekelâ s Diverticulum	Major Plus
1505	PEDIATRIC SURGERY	Completed Meckel's Diverticulum	Major Plus
1506	PEDIATRIC SURGERY	Unilateral orchidopexy	Major Plus
1507	PEDIATRIC SURGERY	Abdomino Perineal Pull Through	Supra Major
1508	PEDIATRIC SURGERY	Biliary Atresia	Supra Major
1509	PEDIATRIC SURGERY	Choledochal Cyst	Supra Major
1510	PEDIATRIC SURGERY	Cystic Hygroma Fistula	Supra Major
1511	PEDIATRIC SURGERY	Ectopia Vcsicac	Supra Major

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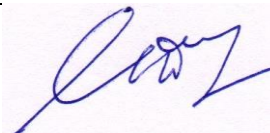


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1512	PEDIATRIC SURGERY	Exomphalos MAJO	Supra Major	
1513	PEDIATRIC SURGERY	Intestinal Atresia	Supra Major	
1514	PEDIATRIC SURGERY	One Stage Hypospadias Correction	Supra Major	
1515	PEDIATRIC SURGERY	Pectus Excavatum	Supra Major	
1516	PEDIATRIC SURGERY	Portal Hypertension	Supra Major	
1517	PEDIATRIC SURGERY	Pyeloplasty And Renal Procedure	Supra Major	
1518	PEDIATRIC SURGERY	Thoracotomy	Supra Major	
1519	PEDIATRIC SURGERY	Tracheo Oesophageal Fistula	Supra Major	
1520	PEDIATRIC SURGERY	Ureteric Re-Implantation	Supra Major	
1521	PEDIATRIC SURGERY	Cutaneous Ureterostomy -Bilateral	Supra Major	
1522	PEDIATRIC SURGERY	Diaphragmatic Hernia Repair	Supra Major	
1523	PEDIATRIC SURGERY	Epispadias Repair	Supra Major	
1524	PEDIATRIC SURGERY	Excision: Retroperitoneal Mass	Supra Major	
1525	PEDIATRIC SURGERY	Extended Pyclothotomy / Nephrolithotomy	Supra Major	
1526	PEDIATRIC SURGERY	Hellers Operation	Supra Major	
1527	PEDIATRIC SURGERY	Hiatus Hernia Repair	Supra Major	
1528	PEDIATRIC SURGERY	Laparoscopic Fundoplication	Supra Major	
1529	PEDIATRIC SURGERY	Laparoscopic Release Of Adhesions	Supra Major	
1530	PEDIATRIC SURGERY	Laparoscopic Splenectomy / Open Splenectomy	Supra Major	
1531	PEDIATRIC SURGERY	Large Cystic Hygroma Excision	Supra Major	
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1532	PEDIATRIC SURGERY	Lobectomy / Pneumonectomy	Supra Major
1533	PEDIATRIC SURGERY	Psarp For High Anomalies	Supra Major
1534	PEDIATRIC SURGERY	Neonatal Obstruction / Perforation	Supra Major
1535	PEDIATRIC SURGERY	Pyeloplasty	Supra Major
1536	PEDIATRIC SURGERY	Reimplantation Of Ureter -Bilateral	Supra Major
1537	PEDIATRIC SURGERY	Reimplantation Of Ureter -Unilateral	Supra Major
1538	PEDIATRIC SURGERY	Repair Of Omphalocele / Gastroschisis	Supra Major
1539	PEDIATRIC SURGERY	Sacroccygeal Teratoma	Supra Major
1540	PEDIATRIC SURGERY	Bladder Reconstructions	Supra Major
1541	PEDIATRIC SURGERY	Penile Reconstructions	Supra Major
1542	PEDIATRIC SURGERY	Surgery For Hirschsprungs	Supra Major
1543	PEDIATRIC SURGERY	Hypospadias - Proximal / Cripple	Supra Major
1544	PEDIATRIC SURGERY	Chestwall Deformity Correction	Supra Major
1545	PEDIATRIC SURGERY	Bilateral Hernia Repair In Newborn	Supra Major
1546	PEDIATRIC SURGERY	Decortication	Supra Major
1547	PEDIATRIC SURGERY	Bilateral orchidopexy	Supra Major
1548	PEDIATRIC SURGERY	Portoenterostomy For Biliary Atresia	Supramajor Plus
1549	PEDIATRIC SURGERY	Exstrophy Of Bladder	Supramajor Plus
1550	PEDIATRIC SURGERY	Redo-Psarp	Supramajor Plus
1551	PEDIATRIC SURGERY	Psarvup	Supramajor Plus

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1552	PEDIATRIC SURGERY	Aortopexy	Supramajor Plus	Mch - Plastic and Reconstructive Surgery	5
1553	PEDIATRIC SURGERY	Eso Replacement	Supramajor Plus		
1554	PEDIATRIC SURGERY	Tracheo-Esophageal Fistula -Complete Repair	Supramajor Plus		
1555	PEDIATRIC SURGERY	Reconstructive Surgery For Intersex	Supramajor Plus		
1556	PEDIATRIC SURGERY	Mediastinal Mass Excision	Supramajor Plus		
1557	PEDIATRIC SURGERY	Surgeries For Portal Hypertension	Supramajor Plus		
Sr.	Speciality	Surgical	Category		
1558	PLASTIC SURGERY	Gr 1	Minor	Mch - Plastic and Reconstructive Surgery	5
1559	PLASTIC SURGERY	Biopsy Of Muscle	Minor		
1560	PLASTIC SURGERY	Biopsy Of Nerve	Minor		
1561	PLASTIC SURGERY	Biopsy Of Skin Lesion	Minor		
1562	PLASTIC SURGERY	Cauterisation Of Skin Lesions	Minor		
1563	PLASTIC SURGERY	Corn Paring Or Cutting	Minor		
1564	PLASTIC SURGERY	Cryotherapy	Minor		
1565	PLASTIC SURGERY	Debridement Small	Minor		
1566	PLASTIC SURGERY	Drain Removal	Minor		
1567	PLASTIC SURGERY	Dressing - Small	Minor		
1568	PLASTIC SURGERY	Inflation Of Tissue Expander	Minor		
1569	PLASTIC SURGERY	Intralesional Injections	Minor		

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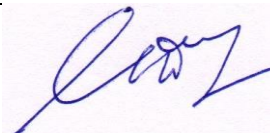


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1570	PLASTIC SURGERY	Naso-Endoscopy	Minor	
1571	PLASTIC SURGERY	Removal Of Arch Bars	Minor	
1572	PLASTIC SURGERY	Removal Of Skin Tag	Minor	
1573	PLASTIC SURGERY	Trimming Of Dystrophic Nails	Minor	
1574	PLASTIC SURGERY	Gr 2	Intermediate	
1575	PLASTIC SURGERY	Clw Suturing - Small	Intermediate	
1576	PLASTIC SURGERY	Debridement - Medium	Intermediate	
1577	PLASTIC SURGERY	Dermabrasion Local	Intermediate	
1578	PLASTIC SURGERY	Dressing - Large	Intermediate	
1579	PLASTIC SURGERY	Ear Lobe Repair	Intermediate	
1580	PLASTIC SURGERY	Excision Of Small Lesion	Intermediate	
1581	PLASTIC SURGERY	Foreign Body Removal - Area Other Than Face Or Hand	Intermediate	
1582	PLASTIC SURGERY	Removal Of Multiple Skin Tags	Intermediate	
1583	PLASTIC SURGERY	Scar Revision - Small	Intermediate	
1584	PLASTIC SURGERY	Skin Grafting - Small	Intermediate	
1585	PLASTIC SURGERY	K-Wire Fixation	Intermediate	
1586	PLASTIC SURGERY	Gr 3	Major	
1587	PLASTIC SURGERY	Application Of Arch Bars	Major	
1588	PLASTIC SURGERY	Buried Penis	Major	
1589	PLASTIC SURGERY	Clw Suturing - Medium	Major	
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1590	PLASTIC SURGERY	Correction Of Inverted Nipple	Major
1591	PLASTIC SURGERY	Debridement - Extensive	Major
1592	PLASTIC SURGERY	Dermabrasion - Multiple Areas	Major
1593	PLASTIC SURGERY	Dressing - Extensive	Major
1594	PLASTIC SURGERY	Excision Of Medium Sized Skin Lesion	Major
1595	PLASTIC SURGERY	Excision Of Pressure Ulcer - Small	Major
1596	PLASTIC SURGERY	Finger Tip Repair	Major
1597	PLASTIC SURGERY	Foreign Body Removal - Hand Or Face	Major
1598	PLASTIC SURGERY	Full Thickness Graft - Small	Major
1599	PLASTIC SURGERY	Gynaecomastia - Small	Major
1600	PLASTIC SURGERY	Hypospadias Chordee Correction	Major
1601	PLASTIC SURGERY	Insertion Of Tissue Expander - Small	Major
1602	PLASTIC SURGERY	Liposuction Localised	Major
1603	PLASTIC SURGERY	Local Flap - Small	Major
1604	PLASTIC SURGERY	Otoplasty - Simple	Major
1605	PLASTIC SURGERY	Removal Of Implants	Major
1606	PLASTIC SURGERY	Scar Revision - Medium	Major
1607	PLASTIC SURGERY	Skin Grafting - Medium	Major
1608	PLASTIC SURGERY	V-Y Plasty	Major
1609	PLASTIC SURGERY	Lipoma Excision	Major

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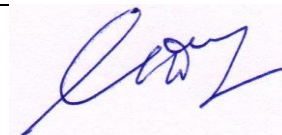


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1610	PLASTIC SURGERY	Faciotomy	Major	
1611	PLASTIC SURGERY	Hypospadias Staged Repair	Major Plus	
1612	PLASTIC SURGERY	Insertion Of Tissue Expander - Large	Major Plus	
1613	PLASTIC SURGERY	Large Lipectomy	Major Plus	
1614	PLASTIC SURGERY	Lid Reconstruction	Major Plus	
1615	PLASTIC SURGERY	Lid Repair	Major Plus	
1616	PLASTIC SURGERY	Lip Reconstruction	Major Plus	
1617	PLASTIC SURGERY	Lipectomy - Small	Major Plus	
1618	PLASTIC SURGERY	Liposuction- Medium	Major Plus	
1619	PLASTIC SURGERY	Malar Augmentation	Major Plus	
1620	PLASTIC SURGERY	Mastopexy	Major Plus	
1621	PLASTIC SURGERY	Mini - Abdominoplasty	Major Plus	
1622	PLASTIC SURGERY	Mini Facelift	Major Plus	
1623	PLASTIC SURGERY	Nasal Dorsum Augmentation	Major Plus	
1624	PLASTIC SURGERY	Otoplasty - Complex	Major Plus	
1625	PLASTIC SURGERY	Pollicisation	Major Plus	
1626	PLASTIC SURGERY	Radial Club Hand	Major Plus	
1627	PLASTIC SURGERY	Removal Of Ruptured Implant	Major Plus	
1628	PLASTIC SURGERY	Revision Of Microvascular Anstomosis	Major Plus	
1629	PLASTIC SURGERY	Revision Of Reconstructed Breast	Major Plus	
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1630	PLASTIC SURGERY	Scar Revision - Large	Major Plus	
1631	PLASTIC SURGERY	Skin Grafting - Large	Major Plus	
1632	PLASTIC SURGERY	Tendon Repair	Major Plus	
1633	PLASTIC SURGERY	Tendon Transfer	Major Plus	
1634	PLASTIC SURGERY	Tip Rhinoplasty	Major Plus	
1635	PLASTIC SURGERY	Ventral Hernia Repair	Major Plus	
1636	PLASTIC SURGERY	Paed Resection Of Posterior Urethral Valves	Major Plus	
1637	PLASTIC SURGERY	Syndactyly Release	Major Plus	
1638	PLASTIC SURGERY	Gr 4	Major Plus	
1639	PLASTIC SURGERY	Amputaion Below Elbow/Knee	Major Plus	
1640	PLASTIC SURGERY	Blepharoplasty - 2 Eyelid	Major Plus	
1641	PLASTIC SURGERY	Breast Reconstruction - Lat. Dorsi	Major Plus	
1642	PLASTIC SURGERY	Breast Augmentation	Major Plus	
1643	PLASTIC SURGERY	Breast Reconstruction - Implant	Major Plus	
1644	PLASTIC SURGERY	Cartilage Grafting	Major Plus	
1645	PLASTIC SURGERY	Change Of Implant	Major Plus	
1646	PLASTIC SURGERY	Chin Augmentation	Major Plus	
1647	PLASTIC SURGERY	Cleft Lip Repair	Major Plus	
1648	PLASTIC SURGERY	Cleft Palate Repair	Major Plus	
1649	PLASTIC SURGERY	Cleft Rhinoplasty	Major Plus	
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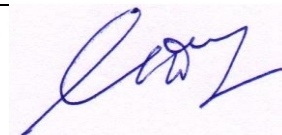


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1650	PLASTIC SURGERY	Clw Suturing - Multiple	Major Plus	
1651	PLASTIC SURGERY	Composite Tissue Graft	Major Plus	
1652	PLASTIC SURGERY	Contracture Release	Major Plus	
1653	PLASTIC SURGERY	Contracture Release - Simple	Major Plus	
1654	PLASTIC SURGERY	Dermabrasion Full Face	Major Plus	
1655	PLASTIC SURGERY	Duputryns Contracture	Major Plus	
1656	PLASTIC SURGERY	Ectropion Correction	Major Plus	
1657	PLASTIC SURGERY	Entropion Correction	Major Plus	
1658	PLASTIC SURGERY	Faciomaxillary Injury - Single #	Major Plus	
1659	PLASTIC SURGERY	Fat Injection - Small	Major Plus	
1660	PLASTIC SURGERY	Flap - Local - Large	Major Plus	
1661	PLASTIC SURGERY	Flap - Regional	Major Plus	
1662	PLASTIC SURGERY	Flap Pedicled	Major Plus	
1663	PLASTIC SURGERY	Forehead Lift - Open	Major Plus	
1664	PLASTIC SURGERY	Full Thickness Graft - Medium	Major Plus	
1665	PLASTIC SURGERY	Gynaecomastia - Medium	Major Plus	
1666	PLASTIC SURGERY	Reduction Mammoplasty	Major Plus	
1667	PLASTIC SURGERY	Debridement large	Major Plus	
1668	PLASTIC SURGERY	Dressing	Major Plus	
1669	PLASTIC SURGERY	Full Thickness Graft - Large	Supra Major	
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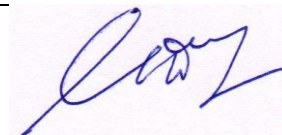


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1670	PLASTIC SURGERY	Gynaecomastia - Large	Supra Major	
1671	PLASTIC SURGERY	Hair Transplant Small Patch	Supra Major	
1672	PLASTIC SURGERY	Hypospadias - Single Staged Repair	Supra Major	
1673	PLASTIC SURGERY	Liposuction Large	Supra Major	
1674	PLASTIC SURGERY	Major Face Lift	Supra Major	
1675	PLASTIC SURGERY	Microneural Repair	Supra Major	
1676	PLASTIC SURGERY	Microvascular Flap Transfer	Supra Major	
1677	PLASTIC SURGERY	Myocutaneous Flap	Supra Major	
1678	PLASTIC SURGERY	Neurovascular Flap	Supra Major	
1679	PLASTIC SURGERY	Perforator Flap	Supra Major	
1680	PLASTIC SURGERY	Reconstruction For Microtia /Anotia	Supra Major	
1681	PLASTIC SURGERY	Septorhinoplasty	Supra Major	
1682	PLASTIC SURGERY	Single Digit Replant	Supra Major	
1683	PLASTIC SURGERY	Skin Graft Extensive	Supra Major	
1684	PLASTIC SURGERY	T-M Jt Ankylosis Surgery	Supra Major	
1685	PLASTIC SURGERY	Transfer Of 2 Regional Flaps	Supra Major	
1686	PLASTIC SURGERY	Gr 5	Supra Major	
1687	PLASTIC SURGERY	Abdominal Wall Reconstruction	Supra Major	
1688	PLASTIC SURGERY	Abdominoplasty - MAJO	Supra Major	
1689	PLASTIC SURGERY	Braest Augmentation With Mastopexy	Supra Major	
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1690	PLASTIC SURGERY	Breast Reconstruction - Flap With/Without Implant	Supra Major
1691	PLASTIC SURGERY	Breast Reduction	Supra Major
1692	PLASTIC SURGERY	Chest Wall Reconstruction	Supra Major
1693	PLASTIC SURGERY	Cleft Nlip And Palate Repair - One Stage	Supra Major
1694	PLASTIC SURGERY	Congenital Hand Deformity	Supra Major
1695	PLASTIC SURGERY	Contracture Release Difficult	Supra Major
1696	PLASTIC SURGERY	Endoscopic Forehead Lift	Supra Major
1697	PLASTIC SURGERY	Facial Nerve Repair And Grafting	Supra Major
1698	PLASTIC SURGERY	Faciomaxillary Injury - Multiple #S	Supra Major
1699	PLASTIC SURGERY	Fasciocutaneous Flap	Supra Major
1700	PLASTIC SURGERY	Extensive Burn Debridement & Collagen Dressing	Supra Major
1701	PLASTIC SURGERY	Debridement extensive	Supra Major
1702	PLASTIC SURGERY	Extensive Dressing	Supra Major
1703	PLASTIC SURGERY	Gr 6	Supramajor Plus
1704	PLASTIC SURGERY	Hair Transplant - Large Patch	Supramajor Plus
1705	PLASTIC SURGERY	Major Limb Replant	Supramajor Plus
1706	PLASTIC SURGERY	Microneural Repairs - Multiple	Supramajor Plus
1707	PLASTIC SURGERY	Microvascular Osteo-Cutaneous Flap Transfer	Supramajor Plus
1708	PLASTIC SURGERY	Microvascular Bone Transfer	Supramajor Plus
1709	PLASTIC SURGERY	Muliple Finger Replant	Supramajor Plus

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1710	PLASTIC SURGERY	Toe To Thumb Transfer	Supramajor Plus		
1711	PLASTIC SURGERY	Brachial Plexus Repair/Reconstruct	Supramajor Plus		
1712	PLASTIC SURGERY	Breast Reconstruction - Microvascular Flap	Supramajor Plus		
1713	PLASTIC SURGERY	Craniofacial Surgery	Supramajor Plus		
1714	PLASTIC SURGERY	Facio-Maxillary Injury - Extensive Fractures	Supramajor Plus		
1715	PLASTIC SURGERY	Extensive Facial Fractures	Supramajor Plus		
1716	PLASTIC SURGERY	Grade 7	Supramajor Plus		
1717	PLASTIC SURGERY	Multiple Facial Fracture	Supramajor Plus		
1718	PLASTIC SURGERY	Extensive Skin Grafting	Supramajor Plus		
1719	PLASTIC SURGERY	Maxilla with mandible fracture	Supramajor Plus		
Sr.	Speciality	Surgical	Category	Mch - Surgical Oncology, ENT With Head and Neck Fellowship / MD-OBGYN with Surgical Oncology Fellowship / MS Surgery with Surgical Oncology based on procedural privileges	5
1720	SURGICAL ONCOLOGY	Vulval/Vaginal Biopsy	Minor		
1721	SURGICAL ONCOLOGY	Dilation And Curettage	Minor		
1722	SURGICAL ONCOLOGY	Micro-Laryngoscopy (MI Scopy)	Minor		
1723	SURGICAL ONCOLOGY	Axillary Ln Biopsy	Minor		
1724	SURGICAL ONCOLOGY	Supraclavicular Lymph Node Biopsy	Minor		
1725	SURGICAL ONCOLOGY	Core/ Gun Biopsy	Minor		
1726	SURGICAL ONCOLOGY	Incision Biopsy	Minor		
1727	SURGICAL ONCOLOGY	Corrugated Drain Placement	Minor		

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1728	SURGICAL ONCOLOGY	Insertion Of Tep	Minor
1729	SURGICAL ONCOLOGY	Cervix Brachytherapy	Minor
1730	SURGICAL ONCOLOGY	Biopsy Node	Minor
1731	SURGICAL ONCOLOGY	Excision Lipoma, Sabaceous Cyst	Minor
1732	SURGICAL ONCOLOGY	Removal Of Hickman S Catheter	Minor
1733	SURGICAL ONCOLOGY	Biopsy Mole,Wart Or Small Skin Lesion	Minor
1734	SURGICAL ONCOLOGY	Bilateral Scrotal Orchiectomy	Minor
1735	SURGICAL ONCOLOGY	Rigid Cystoscopy	Minor
1736	SURGICAL ONCOLOGY	Secondary Suturing Of Wound	Minor
1737	SURGICAL ONCOLOGY	Bcg Instillation	Minor
1738	SURGICAL ONCOLOGY	Urethral Meatal Dilatation/ Urethral Dilatation	Minor
1739	SURGICAL ONCOLOGY	Inguinal Lymph Node Biopsy	Minor
1740	SURGICAL ONCOLOGY	Examination Under Anaesthesia(Eua)	Minor
1741	SURGICAL ONCOLOGY	Cervical Biopsy	Minor
1742	SURGICAL ONCOLOGY	Colposcopy + Cervical Biopsy	Minor
1743	SURGICAL ONCOLOGY	Eua + Cervical Biopsy	Minor
1744	SURGICAL ONCOLOGY	Lymph Node Biopsy	Minor
1745	SURGICAL ONCOLOGY	Direct Laryngoscopy	Minor
1746	SURGICAL ONCOLOGY	Port Removal	Minor
1747	SURGICAL ONCOLOGY	Trans Oral Buccal Mucosa Wide Excision	Intermediate

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1748	SURGICAL ONCOLOGY	Rigid Cystoscopy With Biopsy And /Or Eua	Intermediate
1749	SURGICAL ONCOLOGY	Partial Penectomy	Intermediate
1750	SURGICAL ONCOLOGY	Open Unilateral/Bilateral, Superficial/Modified Inguinal Lym	Intermediate
1751	SURGICAL ONCOLOGY	High Inguinal Orchiectomy	Intermediate
1752	SURGICAL ONCOLOGY	Transurethral Resection Of Bladder Tumor (Turbt)	Intermediate
1753	SURGICAL ONCOLOGY	Cervical Conization	Intermediate
1754	SURGICAL ONCOLOGY	Colposcopy + Loop Electrosurgical Excision	Intermediate
1755	SURGICAL ONCOLOGY	Fibroadenoma Excision Biopsy	Intermediate
1756	SURGICAL ONCOLOGY	Microdochectomy (Single Duct Excision)	Intermediate
1757	SURGICAL ONCOLOGY	Hadfield S Operation	Intermediate
1758	SURGICAL ONCOLOGY	Rigid Bronchoscopy	Intermediate
1759	SURGICAL ONCOLOGY	Excision Of Spermatic Cord	Intermediate
1760	SURGICAL ONCOLOGY	Excision Of Paratesticular Mass	Intermediate
1761	SURGICAL ONCOLOGY	Hemiscroterectomy	Intermediate
1762	SURGICAL ONCOLOGY	Exloratory Thoracotomy Inop	Intermediate
1763	SURGICAL ONCOLOGY	Excision Breast Lump/Fibroaderoma	Intermediate
1764	SURGICAL ONCOLOGY	Excision Multiple Lipoma	Intermediate
1765	SURGICAL ONCOLOGY	Hickman Port Insertion/Placement	Intermediate
1766	SURGICAL ONCOLOGY	High Orchidectomy	Intermediate
1767	SURGICAL ONCOLOGY	Insertion Of Hickman S Catheter	Intermediate

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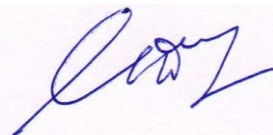


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1768	SURGICAL ONCOLOGY	M L Scopy + MINO Laser Co2	Intermediate	
1769	SURGICAL ONCOLOGY	Partial Glossectomy	Intermediate	
1770	SURGICAL ONCOLOGY	Secondary Suturing Of Multiple Wounds Of Abdomen	Intermediate	
1771	SURGICAL ONCOLOGY	Thoracoscopy With Biopsy	Intermediate	
1772	SURGICAL ONCOLOGY	Partial Vulvectomy/Hemi Vulvectomy	Intermediate	
1773	SURGICAL ONCOLOGY	Per-Oral Wide Excision W/E (Tongue / Buccal Mucosa / Palate)	Intermediate	
1774	SURGICAL ONCOLOGY	Meatoplasty	Intermediate	
1775	SURGICAL ONCOLOGY	Clot Evacuation	Intermediate	
1776	SURGICAL ONCOLOGY	Bilateral Scrotal Orchiectomy-LT	Intermediate	
1777	SURGICAL ONCOLOGY	Secondary Suturing	Intermediate	
1778	SURGICAL ONCOLOGY	Transurethral Fulguration Of Bladder Tumor (Tufbt)-ST	Intermediate	
1779	SURGICAL ONCOLOGY	Cystoscopy Extensive	Intermediate	
1780	SURGICAL ONCOLOGY	Bilateral Salpingo-Oophorectomy	Major	
1781	SURGICAL ONCOLOGY	Excision Of Parathyroid Adenoma	Major	
1782	SURGICAL ONCOLOGY	Wide Excision Abomial Wall Mas	Major	
1783	SURGICAL ONCOLOGY	Total Urethrectomy	Major	
1784	SURGICAL ONCOLOGY	Rib Excision	Major	
1785	SURGICAL ONCOLOGY	Retroperitoneal Lymph Node Biopsy	Major	
1786	SURGICAL ONCOLOGY	Single Duct Excision	Major	
1787	SURGICAL ONCOLOGY	Palliative Ileal Conduit	Major	
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1788	SURGICAL ONCOLOGY	Cystoscopy+T.U.R. Bladder Tumour	Major
1789	SURGICAL ONCOLOGY	Excision Very Large Tissue And Tumour	Major
1790	SURGICAL ONCOLOGY	Excision Of Tumor In Undescended Testis	Major
1791	SURGICAL ONCOLOGY	Channel Turp	Major
1792	SURGICAL ONCOLOGY	Exploratory Laparotomy + Unilateral Salphingoophrectomy	Major
1793	SURGICAL ONCOLOGY	Exploratory Laparotomy + Bilateral Salphingoophrectomy	Major
1794	SURGICAL ONCOLOGY	Partial Vaginectomy	Major
1795	SURGICAL ONCOLOGY	Unilateral Groin Node Dissection	Major
1796	SURGICAL ONCOLOGY	Transurethral Resection Of MAJO/Multiple Bladder Tumor (Tur	Major
1797	SURGICAL ONCOLOGY	Transurethral Fulguration Of Bladder Tumor (Tufbt)	Major
1798	SURGICAL ONCOLOGY	Upper Alveolectomy	Major
1799	SURGICAL ONCOLOGY	Partial Maxillectomy	Major
1800	SURGICAL ONCOLOGY	Neck Dissection	Major
1801	SURGICAL ONCOLOGY	Per-Oral W/E (Tongue / Buccal Mucosa / Palate) MAJO	Major
1802	SURGICAL ONCOLOGY	Axillary Clearance Only	Major
1803	SURGICAL ONCOLOGY	Wide Excision Only	Major
1804	SURGICAL ONCOLOGY	Galliard Thomas Approach For Fibroadenoma	Major
1805	SURGICAL ONCOLOGY	Sonolocalization Excision Biopsy	Major
1806	SURGICAL ONCOLOGY	Mammolocalization Excision Biopsy	Major
1807	SURGICAL ONCOLOGY	Port Insertion	Major

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1808	SURGICAL ONCOLOGY	Supraclavicular Neck Dissection	Major	
1809	SURGICAL ONCOLOGY	Gastro-Jejunostomy	Major	
1810	SURGICAL ONCOLOGY	Insertion Of Bard Porta Catheter	Major	
1811	SURGICAL ONCOLOGY	Trucut Biopsy Of Breast + With Bard Porta Catheter	Major	
1812	SURGICAL ONCOLOGY	Open Bilateral Pelvic Lymph Node Dissection	Major	
1813	SURGICAL ONCOLOGY	Partial Penectomy With Unilateral Inguinal Lymph Node Dissec	Major	
1814	SURGICAL ONCOLOGY	Open Unilateral Ilio Inguinal Lymph Node Dissection	Major	
1815	SURGICAL ONCOLOGY	Total Penectomy	Major	
1816	SURGICAL ONCOLOGY	Major Clot Evacuation	Major	
1817	SURGICAL ONCOLOGY	Open Bilateral, Superficial/Modified Inguinal Lym	Major	
1818	SURGICAL ONCOLOGY	High Inguinal Orchiectomy- LT	Major	
1819	SURGICAL ONCOLOGY	Partial Penectomy-LT	Major	
1820	SURGICAL ONCOLOGY	Total Penectomy-ST	Major	
1821	SURGICAL ONCOLOGY	Photo Dynamic Therapy	Major	
1822	SURGICAL ONCOLOGY	Fibroadenoma Excision	Major	
1823	SURGICAL ONCOLOGY	Rib Excision Extended	Major Plus	
1824	SURGICAL ONCOLOGY	Radical Vulvectomy+ Unilateral Groin Node Disection	Major Plus	
1825	SURGICAL ONCOLOGY	Bilateral Groin Node Dissection	Major Plus	
1826	SURGICAL ONCOLOGY	Tah + Bso + Pelvic Node Dissection	Major Plus	
1827	SURGICAL ONCOLOGY	Upper Alveolectomy / Partial Maxillectomy + Neck Dissection	Major Plus	
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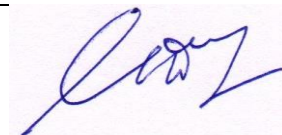


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1829	SURGICAL ONCOLOGY	Hemithyroidectomy + Neck Dissection	Major Plus	
1830	SURGICAL ONCOLOGY	Simple Mastectomy Extended	Major Plus	
1831	SURGICAL ONCOLOGY	Bsoh+Plnd	Major Plus	
1832	SURGICAL ONCOLOGY	Fibrotic Bronchoscopy+Diode Laser Fulguration Vcp	Major Plus	
1833	SURGICAL ONCOLOGY	Hemi Colectomy	Major Plus	
1834	SURGICAL ONCOLOGY	Hemi-Mandibulectomy	Major Plus	
1835	SURGICAL ONCOLOGY	Lobectomy	Major Plus	
1836	SURGICAL ONCOLOGY	M L Scopy + Co2 Laser Arythnoied	Major Plus	
1837	SURGICAL ONCOLOGY	Maxillectomy	Major Plus	
1838	SURGICAL ONCOLOGY	MI Scopy + Co2 Laser Primary Vocal Cord Papilloma	Major Plus	
1839	SURGICAL ONCOLOGY	Partial Radial Neck Dissection	Major Plus	
1840	SURGICAL ONCOLOGY	Radical Neck Dissection	Major Plus	
1841	SURGICAL ONCOLOGY	Removal Of Adrenal Tumour	Major Plus	
1842	SURGICAL ONCOLOGY	Superficial Parotidectomy	Major Plus	
1843	SURGICAL ONCOLOGY	Laparoscopic Unilateral Adrenalectomy (Non Functioning Tumor	Major Plus	
1844	SURGICAL ONCOLOGY	Open Segmental Ureterectomy With End To End Anastomosis	Major Plus	
1845	SURGICAL ONCOLOGY	Open Bilateral Ilio Inguinal Lymph Node Dissection	Major Plus	
1846	SURGICAL ONCOLOGY	Videoscopic Unilateral Ilio Inguinal Lymph Node Dissection	Major Plus	
1847	SURGICAL ONCOLOGY	Turbt + Turp	Major Plus	
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1849	SURGICAL ONCOLOGY	Open Partial Cystectomy With Bilateral Pelvic Lymph Node Dis	Major Plus
1850	SURGICAL ONCOLOGY	Exploratory Laparotomy + Tah + Bso	Major Plus
1851	SURGICAL ONCOLOGY	Per-Oral W/E + Neck Dissection	Major Plus
1852	SURGICAL ONCOLOGY	W/E (Bm / Tongue) With Cheek Flap	Major Plus
1853	SURGICAL ONCOLOGY	W/E (Bm / Tongue) With Pull Through	Major Plus
1854	SURGICAL ONCOLOGY	W/E (Bm / Tongue) With Mandibulotomy	Major Plus
1855	SURGICAL ONCOLOGY	Composite Resection	Major Plus
1856	SURGICAL ONCOLOGY	Total Parotidectomy(Facial Nerve Sacrifice)	Major Plus
1857	SURGICAL ONCOLOGY	Simple Mastectomy Axillary Clearance	Major Plus
1858	SURGICAL ONCOLOGY	Breast Conservation Surgery	Major Plus
1859	SURGICAL ONCOLOGY	Sentinel Node Biopsy/ Axillary Sampling	Major Plus
1860	SURGICAL ONCOLOGY	Latissimus Dorsi Musculocutaneous Flap	Major Plus
1861	SURGICAL ONCOLOGY	Transverse Rectus Abdominis Myocutaneous Flap	Major Plus
1862	SURGICAL ONCOLOGY	Simple Mastectomy With Axillary Clearance	Major Plus
1863	SURGICAL ONCOLOGY	Bilat Needle Localization With Excision Biopsy	Major Plus
1864	SURGICAL ONCOLOGY	Channel Turp And Bilateral Orchidectomy	Major Plus
1865	SURGICAL ONCOLOGY	Segmental Ureterectomy With Ureteric Reimplant	Major Plus
1866	SURGICAL ONCOLOGY	Extended clot evacuation	Major Plus
1867	SURGICAL ONCOLOGY	Simple Mastectomy	Major Plus

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1868	SURGICAL ONCOLOGY	Channel TURP extended	Major Plus
1869	SURGICAL ONCOLOGY	Total Penectomy-LT	Major Plus
1870	SURGICAL ONCOLOGY	Microdochoectomy	Major Plus
1871	SURGICAL ONCOLOGY	Wide Excision	Major Plus
1872	SURGICAL ONCOLOGY	Bilateral Uteroscopy With Lithotripsy & Dj Stenting	Supra Major
1873	SURGICAL ONCOLOGY	Sigmoid Colectomy	Supra Major
1874	SURGICAL ONCOLOGY	Mastectomy Bilateral	Supra Major
1875	SURGICAL ONCOLOGY	Modified Radical Mastectomy With Port Insertion	Supra Major
1876	SURGICAL ONCOLOGY	Breast Conservation Surgery With Port Insertion	Supra Major
1877	SURGICAL ONCOLOGY	Bilateral Modified Radical Mastectomy	Supra Major
1878	SURGICAL ONCOLOGY	Bilateral Breast Conservation Surgery	Supra Major
1879	SURGICAL ONCOLOGY	Excision Of Locally Recurrent Tumour After Rad Neph	Supra Major
1880	SURGICAL ONCOLOGY	Modified Radical Mastectomy - Onc	Supra Major
1881	SURGICAL ONCOLOGY	Open Bilateral Ilio Inguinal Lymph Node Dissection (Large Ln	Supra Major
1882	SURGICAL ONCOLOGY	Billroth 2	Supra Major
1883	SURGICAL ONCOLOGY	Radical Vulvectomy + Reconstruction	Supra Major
1884	SURGICAL ONCOLOGY	Composite Resection + Pedicled Flap	Supra Major
1885	SURGICAL ONCOLOGY	Subtotal / Total Maxillectomy + Neck Dissection	Supra Major
1886	SURGICAL ONCOLOGY	Parotidectomy + Pedicled Flap Reconstruction	Supra Major
1887	SURGICAL ONCOLOGY	Conservative Laryngectomy	Supra Major

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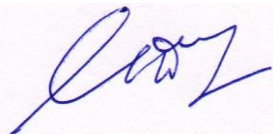


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1888	SURGICAL ONCOLOGY	Near Total Laryngectomy	Supra Major	
1889	SURGICAL ONCOLOGY	Total Laryngectomy	Supra Major	
1890	SURGICAL ONCOLOGY	W/E (Bm / Tongue) + Pedicled Flap	Supra Major	
1891	SURGICAL ONCOLOGY	Radical Mastectomy	Supra Major	
1892	SURGICAL ONCOLOGY	Oncoplastic Breast Conservation Surgery	Supra Major	
1893	SURGICAL ONCOLOGY	Exploratory Laparotomy For Ca Ovary	Supra Major	
1894	SURGICAL ONCOLOGY	N.S.Rplnd	Supra Major	
1895	SURGICAL ONCOLOGY	Ovar.Debulk.-Opera.(Bsoh+Omente.Remo.Ofmult.Intra	Supra Major	
1896	SURGICAL ONCOLOGY	Partial Hepatectomy	Supra Major	
1897	SURGICAL ONCOLOGY	Pelvic And Retrop.Node Dissect For Ca.Testis Or Ovar	Supra Major	
1898	SURGICAL ONCOLOGY	Pneumonectomy	Supra Major	
1899	SURGICAL ONCOLOGY	Transhiatal Oesophagectomy	Supra Major	
1900	SURGICAL ONCOLOGY	Abdominal Tumour Multiple/Large	Supra Major	
1901	SURGICAL ONCOLOGY	A.P.Resection	Supra Major	
1902	SURGICAL ONCOLOGY	Bilateral Ilio Inguinal Node Dissection	Supra Major	
1903	SURGICAL ONCOLOGY	Bilateral Radical Neck Dissection	Supra Major	
1904	SURGICAL ONCOLOGY	Bile Duct Tumour Excision	Supra Major	
1905	SURGICAL ONCOLOGY	Co2 Laser - Supraglottic	Supra Major	
1906	SURGICAL ONCOLOGY	Commando Operation	Supra Major	
1907	SURGICAL ONCOLOGY	Double Flap Reconstruction	Supra Major	
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1908	SURGICAL ONCOLOGY	Excision Of Neuroblastoma (Pediatric)	Supra Major	
1909	SURGICAL ONCOLOGY	Therapeutic Retroperitoneal Lymph Node Dissection (Rplnd)	Supra Major	
1910	SURGICAL ONCOLOGY	Open Radical Cystoprostatectomy With Ileal Conduit	Supra Major	
1911	SURGICAL ONCOLOGY	Tah + Bso + Pelvic And Paraaortic Dissection	Supra Major	
1912	SURGICAL ONCOLOGY	Radical Hysterectomy(Wertheims) + Bilateral Pelvic Node Dis	Supra Major	
1913	SURGICAL ONCOLOGY	Explo Laparotomy + Tah + Bso + Omentectomy + Node Sampling	Supra Major	
1914	SURGICAL ONCOLOGY	Laryngopharyngectomy	Supra Major	
1915	SURGICAL ONCOLOGY	Low Anterior Resection	Supra Major	
1916	SURGICAL ONCOLOGY	M L Scopy + Co2 Laser Extended Laryngotomy	Supra Major	
1917	SURGICAL ONCOLOGY	Radical Hysterectomy/Wertheim S	Supra Major	
1918	SURGICAL ONCOLOGY	Removal Of Adrenal Tumour (Bilateral)	Supra Major	
1919	SURGICAL ONCOLOGY	Sub Total Glossectomy With Primary Reconstruction	Supra Major	
1920	SURGICAL ONCOLOGY	Total Abdominal Hysterectomy With Bso	Supra Major	
1921	SURGICAL ONCOLOGY	Total Thyroidectomy	Supra Major	
1922	SURGICAL ONCOLOGY	Wide Field Laryngectomy	Supra Major	
1923	SURGICAL ONCOLOGY	Excision Of Retroperitoneal Mass	Supra Major	
1924	SURGICAL ONCOLOGY	Laparoscopic Radical Nephrectomy	Supra Major	
1925	SURGICAL ONCOLOGY	Open Nephro-Ureterectomy	Supra Major	
1926	SURGICAL ONCOLOGY	Laparoscopic Unilateral Adrenalectomy (Functioning Tumor)	Supra Major	
1927	SURGICAL ONCOLOGY	Open Bilateral Adrenalectomy (Non Functioning Tumor)	Supra Major	
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1928	SURGICAL ONCOLOGY	Laparoscopic Bilateral Adrenalectomy (Non Functioning Tumor)	Supra Major
1929	SURGICAL ONCOLOGY	Laparoscopic Partial Cystectomy With Bilateral Pelvic Lymph	Supra Major
1930	SURGICAL ONCOLOGY	Open Radical Prostatectomy	Supra Major
1931	SURGICAL ONCOLOGY	Total Penectomy With Bilateral Inguinal Lymph Node Dissectio	Supra Major
1932	SURGICAL ONCOLOGY	Ilio Inguinal Lymph Node Dissection With Flap Reconstructon-	Supra Major
1933	SURGICAL ONCOLOGY	Videoscopic Bilateral Ilio Inguinal Lymph Node Dissection	Supra Major
1934	SURGICAL ONCOLOGY	Prophylactic Retroperitoneal Lymph Node Dissection	Supra Major
1935	SURGICAL ONCOLOGY	Open Radical Nephrectomy	Supra Major
1936	SURGICAL ONCOLOGY	Open Radical Nephrectomy (Wilms Tumor)	Supra Major
1937	SURGICAL ONCOLOGY	Open Radical Nephrectomy With Renal Vein Thrombus	Supra Major
1938	SURGICAL ONCOLOGY	Open Unilateral Adrenalectomy (Functioning Tumor And Pheoch	Supra Major
1939	SURGICAL ONCOLOGY	Robotic Adrenal Tumour Small NF Tumour	Supra Major
1940	SURGICAL ONCOLOGY	Robotic Nephrectomy Small Tumour	Supra Major
1941	SURGICAL ONCOLOGY	Robotic Radical Hysterectomy small tumour	Supra Major
1942	SURGICAL ONCOLOGY	Robotic Hysterectomy +Pelvic Node dissection	Supra Major
1943	SURGICAL ONCOLOGY	Robotic Restaging of Ovarian Cancer	Supra Major
1944	SURGICAL ONCOLOGY	Robotic â Lobectomy	Supra Major
1945	SURGICAL ONCOLOGY	Partial Gastrectomy	Supra Major
1946	SURGICAL ONCOLOGY	Laparoscopic Unilateral Adrenalectomy -LT-NF	Supra Major

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1947	SURGICAL ONCOLOGY	Open Segmental Ureterectomy With End To End Anastomosis - LT	Supra Major
1948	SURGICAL ONCOLOGY	Open Segmental Ureterectomy With Uretero-Neocystostomy	Supra Major
1949	SURGICAL ONCOLOGY	Laparoscopic Bilateral Pelvic Lymph Node Dissection -	Supra Major
1950	SURGICAL ONCOLOGY	Partial Penectomy With Bilateral Inguinal Lymph Node Dissect	Supra Major
1951	SURGICAL ONCOLOGY	Total Penectomy With Unilateral Inguinal Lymph Node Dissecti	Supra Major
1952	SURGICAL ONCOLOGY	Videoscopic Unilateral Ilio Inguinal Lymph Node Dissection-L	Supra Major
1953	SURGICAL ONCOLOGY	Open Partial Cystectomy With BPLND -LT	Supra Major
1954	SURGICAL ONCOLOGY	Excision Of Tumor In Undescended Testis-LT	Supra Major
1955	SURGICAL ONCOLOGY	Laparoscopic Bilateral Pelvic Lymph Node Dissection- LT	Supra Major
1956	SURGICAL ONCOLOGY	Open Partial Nephrectomy-ST	Supra Major
1957	SURGICAL ONCOLOGY	Laparoscopic Partial Nephrectomy-ST	Supra Major
1958	SURGICAL ONCOLOGY	Robotic Bilateral VEIL [Unilateral]	Supra Major
1959	SURGICAL ONCOLOGY	Robotic Bilateral VEIL [Bilateral]	Supra Major
1960	SURGICAL ONCOLOGY	TORS	Supra Major
1961	SURGICAL ONCOLOGY	VATS â	Supra Major
1962	SURGICAL ONCOLOGY	Mandibulectomy	Supra Major
1963	SURGICAL ONCOLOGY	VATS	Supra Major
1964	SURGICAL ONCOLOGY	Robotic Surgery SM	Supra Major
1965	SURGICAL ONCOLOGY	Excision Of Tumor In Undescended Testis With Rpnld Extended	Supramajor Plus

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1966	SURGICAL ONCOLOGY	Commando Excision + Pmmc Reconstruction	Supramajor Plus
1967	SURGICAL ONCOLOGY	Commando With Flap Reconstruction	Supramajor Plus
1968	SURGICAL ONCOLOGY	Cranio Facial Resection With Reconstruction-Microvascular	Supramajor Plus
1969	SURGICAL ONCOLOGY	Ivor Lewis Operation	Supramajor Plus
1970	SURGICAL ONCOLOGY	Laryngopharyngectomy With Reconstruction	Supramajor Plus
1971	SURGICAL ONCOLOGY	Ovarian Tumor Debulking-Perito/Oment/Splen-Ectomy	Supramajor Plus
1972	SURGICAL ONCOLOGY	Total Gastrectomy With Node Dissection	Supramajor Plus
1973	SURGICAL ONCOLOGY	Whipples Or Total Pancreatectomy	Supramajor Plus
1974	SURGICAL ONCOLOGY	Open Radical Nephrectomy With Renal Vein Thrombus And Ivc Th	Supramajor Plus
1975	SURGICAL ONCOLOGY	Open Partial Nephrectomy	Supramajor Plus
1976	SURGICAL ONCOLOGY	Laparoscopic Partial Nephrectomy	Supramajor Plus
1977	SURGICAL ONCOLOGY	Open Bilateral Adrenelectomy (Functioning Tumor)	Supramajor Plus
1978	SURGICAL ONCOLOGY	Laparoscopic Bilateral Adrenalectomy (Functioning Tumor)	Supramajor Plus
1979	SURGICAL ONCOLOGY	Open Radical Cystoprostatectomy With Neobladder	Supramajor Plus
1980	SURGICAL ONCOLOGY	Anterior Exenteration With Neobladder	Supramajor Plus
1981	SURGICAL ONCOLOGY	Ovarian Tumor Bebulking + Omentectomy /Bowel Resection/	Supramajor Plus
1982	SURGICAL ONCOLOGY	Ovarian Tumor Bebulking +Splenectomy/Peritonectomy/Hepatic R	Supramajor Plus
1983	SURGICAL ONCOLOGY	Radical Vulvectomy + Reconstruction+ Groin Node Dissection	Supramajor Plus

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Dr. Hrishikesh Kalgao1kar		Dr. S.S. Deepak	
Quality Head		Chairman & Managing Director	



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1984	SURGICAL ONCOLOGY	Composite Resection + Free Flap	Supramajor Plus
1985	SURGICAL ONCOLOGY	Subtotal / Total Maxillectomy + Reconstruction	Supramajor Plus
1986	SURGICAL ONCOLOGY	Parotidectomy + Free Flap Reconstruction	Supramajor Plus
1987	SURGICAL ONCOLOGY	Total Laryngectomy + Reconstruction	Supramajor Plus
1988	SURGICAL ONCOLOGY	W/E (Bm / Tongue) + Free Flap	Supramajor Plus
1989	SURGICAL ONCOLOGY	Pleuro Pneumonectomy	Supramajor Plus
1990	SURGICAL ONCOLOGY	Excision Of Large Retroperitoneal Tumour	Supramajor Plus
1991	SURGICAL ONCOLOGY	Major Hepatectomy	Supramajor Plus
1992	SURGICAL ONCOLOGY	Rad Mastectomy, Abd Rot Flap, Bard Porta Catheter	Supramajor Plus
1993	SURGICAL ONCOLOGY	Supra Clavicular Neck Dissection	Supramajor Plus
1994	SURGICAL ONCOLOGY	Total Or Subtotal Oesophagectomy	Supramajor Plus
1995	SURGICAL ONCOLOGY	Laparoscopic Nephro-Ureterectomy	Supramajor Plus
1996	SURGICAL ONCOLOGY	Anterior Exenteration With Ileal Conduit	Supramajor Plus
1997	SURGICAL ONCOLOGY	Laparoscopic Radical Prostatectomy	Supramajor Plus
1998	SURGICAL ONCOLOGY	Anterior Exenteration	Supramajor Plus
1999	SURGICAL ONCOLOGY	Posterior Exenteration	Supramajor Plus
2000	SURGICAL ONCOLOGY	Total Exenteration	Supramajor Plus
2001	SURGICAL ONCOLOGY	Free Flap Reconstruction	Supramajor Plus
2002	SURGICAL ONCOLOGY	Any Flap With Silicone Implant Reconstruction	Supramajor Plus
2003	SURGICAL ONCOLOGY	Therapeutic Retroperitoneal Lymph Node Dissection (Rplnd) Ex	Supramajor Plus

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2004	SURGICAL ONCOLOGY	Pancreas Sparing Duodenectomy	Supramajor Plus
2005	SURGICAL ONCOLOGY	Open Radical Cystectomy With Ileal Conduit Large Tumour	Supramajor Plus
2006	SURGICAL ONCOLOGY	Bilateral Breast Cancer Surgery	Supramajor Plus
2007	SURGICAL ONCOLOGY	Total Abd Hysterectomy+Bilat Salpingo Ooph+Bilat Pelvic Node	Supramajor Plus
2008	SURGICAL ONCOLOGY	Robotic Radical Cystectomy IC/NB	Supramajor Plus
2009	SURGICAL ONCOLOGY	Robotic Nephrectomy Large Tumour	Supramajor Plus
2010	SURGICAL ONCOLOGY	Robotic Partial Nephrectomy	Supramajor Plus
2011	SURGICAL ONCOLOGY	Robotic Radical Nephroureterectomy	Supramajor Plus
2012	SURGICAL ONCOLOGY	Robotic Adrenal Large F Tumour	Supramajor Plus
2013	SURGICAL ONCOLOGY	Robotic Radical Prostatectomy	Supramajor Plus
2014	SURGICAL ONCOLOGY	Robotic Radical Hysterectomy large tumour	Supramajor Plus
2015	SURGICAL ONCOLOGY	Robotic Hysterectomy +Pelvic+ParaAortic Node dissection	Supramajor Plus
2016	SURGICAL ONCOLOGY	Robotic VEIL & Total Penectomy	Supramajor Plus
2017	SURGICAL ONCOLOGY	Robotic â Esophagectomy	Supramajor Plus
2018	SURGICAL ONCOLOGY	Robotic - Excision Of Renal Cyst	Supramajor Plus
2019	SURGICAL ONCOLOGY	Open Radical Cystectomy	Supramajor Plus
2020	SURGICAL ONCOLOGY	Ilio Ing LN Dissec with Flap Recon-Extensive	Supramajor Plus
2021	SURGICAL ONCOLOGY	Robotic Radical Cystectomy	Supramajor Plus
2022	SURGICAL ONCOLOGY	Laparoscopic Radical Nephrectomy- LT	Supramajor Plus
2023	SURGICAL ONCOLOGY	Open Nephro-Ureterectomy-LT	Supramajor Plus

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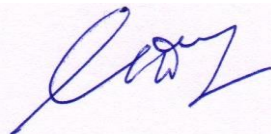


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2024	SURGICAL ONCOLOGY	Laparoscopic Unilateral Adrenalectomy -LT-F	Supramajor Plus	
2025	SURGICAL ONCOLOGY	Partial Penectomy/TP With Bilateral Inguinal Lymph Node Diss	Supramajor Plus	
2026	SURGICAL ONCOLOGY	Open Radical Nephrectomy - LT	Supramajor Plus	
2027	SURGICAL ONCOLOGY	Open radical prostatectomy-LT	Supramajor Plus	
2028	SURGICAL ONCOLOGY	Laparoscopic Partial Cystectomy With BPLND-LT	Supramajor Plus	
2029	SURGICAL ONCOLOGY	N.S.Rplnd-LT	Supramajor Plus	
2030	SURGICAL ONCOLOGY	PP/TP With Bilateral GND with Flap -LT	Supramajor Plus	
2031	SURGICAL ONCOLOGY	Open Unilateral Adrenalectomy FT/LT	Supramajor Plus	
2032	SURGICAL ONCOLOGY	Pneumonectomy+Lobectomy+LN dissection	Supramajor Plus	
2033	SURGICAL ONCOLOGY	Wide Excision Breast+SN Biopsy+Axillary Dissection	Supramajor Plus	
2034	SURGICAL ONCOLOGY	BCT+Axillary Clearance	Supramajor Plus	
2035	SURGICAL ONCOLOGY	Pneumonectomy + Lobectomy + Lymph Node Dissection	Supramajor Plus	
2036	SURGICAL ONCOLOGY	MRM + Port Insertion	Supramajor Plus	
2037	SURGICAL ONCOLOGY	VATS â Bullectomy	Supramajor Plus	
2038	SURGICAL ONCOLOGY	MRM	Supramajor Plus	
2039	SURGICAL ONCOLOGY	Wide Excision âBreast Lump â SNB + Axillary Dissection	Supramajor Plus	
2040	SURGICAL ONCOLOGY	Upper and Middle Lobectomy [Thoracic]	Supramajor Plus	
2041	SURGICAL ONCOLOGY	Robotic RPLND	Supramajor Plus	
2042	SURGICAL ONCOLOGY	Pulmonary metastatectomy	Supramajor Plus	
2043	SURGICAL ONCOLOGY	Billrooth II	Supramajor Plus	
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2044	SURGICAL ONCOLOGY	BCT + SNB	Supramajor Plus		
2045	SURGICAL ONCOLOGY	MRM + Axillary Clearance	Supramajor Plus		
2046	SURGICAL ONCOLOGY	Upper / Middle / Lower Lobectomy	Supramajor Plus		
2047	SURGICAL ONCOLOGY	BCT with Port Insertion	Supramajor Plus		
2048	SURGICAL ONCOLOGY	BCT	Supramajor Plus		
2049	SURGICAL ONCOLOGY	Composite Resection SM Plus	Supramajor Plus		
2050	SURGICAL ONCOLOGY	Robotic Surgery SM plus	Supramajor Plus		
2051	SURGICAL ONCOLOGY	Composite Resection SMB plus	Supramajor Plus		
2052	SURGICAL ONCOLOGY	Robotic Surgery SMB plus	Supramajor Plus		
2053	SURGICAL ONCOLOGY	Robotic TORS	Supramajor Plus		
2054	SURGICAL ONCOLOGY	VATS âDecortication	Supramajor Plus		
Sr.	Speciality	Surgical	Category		
2055	UROLOGY	A.V.Shunt	Minor	Mch - Urology	5 Years
2056	UROLOGY	Cystoscopic Stent Removal	Minor		
2057	UROLOGY	Cystoscopy	Minor		
2058	UROLOGY	Meatotomy	Minor		
2059	UROLOGY	Prostatic Biopsy	Minor		
2060	UROLOGY	S.P.Cystostomy	Minor		
2061	UROLOGY	Urethral Catheterization	Minor		

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2062	UROLOGY	ICD Insertion	Minor
2063	UROLOGY	Unilateral Varicocelectomy	Intermediate
2064	UROLOGY	Varicocele Surgery	Intermediate
2065	UROLOGY	Vasectomy	Intermediate
2066	UROLOGY	A.V.Fistula	Intermediate
2067	UROLOGY	Bilateral Orchidectomy	Intermediate
2068	UROLOGY	Bladder Neck Incision	Intermediate
2069	UROLOGY	Capd Catheter Insertion/Removal	Intermediate
2070	UROLOGY	Cystolitholapexy - Medium Sized Stone	Intermediate
2071	UROLOGY	Cystolithotomy	Intermediate
2072	UROLOGY	Cystoscopy + Bladder Lavage	Intermediate
2073	UROLOGY	Cystoscopy + Micturating Cysto-Urethrogram	Intermediate
2074	UROLOGY	Cystoscopy Retrograde Pyelography	Intermediate
2075	UROLOGY	Cystoscopy+Biopsy	Intermediate
2076	UROLOGY	D.J.Stenting	Intermediate
2077	UROLOGY	Drainage Of Abscess-Scrotal,Prostatic	Intermediate
2078	UROLOGY	Drainage Of Perinephric Abscess	Intermediate
2079	UROLOGY	Epididymectomy	Intermediate
2080	UROLOGY	Extraction Of Urethral Calculi	Intermediate
2081	UROLOGY	Open Orchidopexy: Unilateral	Intermediate

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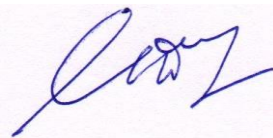


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2082	UROLOGY	Optical Urethrotomy	Intermediate	
2083	UROLOGY	P.C.N.	Intermediate	
2084	UROLOGY	Surgery For Hydrocele	Intermediate	
2085	UROLOGY	Testicular Biopsy	Intermediate	
2086	UROLOGY	Trus Guided Prostatic Biopsy	Intermediate	
2087	UROLOGY	Orchidectomy	Intermediate	
2088	UROLOGY	Relook URS+Stent removal	Intermediate	
2089	UROLOGY	Ureteroscopy With Lithotripsy Dj Stenting	Major	
2090	UROLOGY	Urs Lower Ureteric Stone	Major	
2091	UROLOGY	Tvto	Major	
2092	UROLOGY	Bilateral Ureteric Reimplantation	Major	
2093	UROLOGY	Bilateral Varicocelectomy	Major	
2094	UROLOGY	Cutaneous Ureterostomy	Major	
2095	UROLOGY	Cystolitholapexy - Large Sized Stone	Major	
2096	UROLOGY	Cystoscopic Teflon Injection For Reflux	Major	
2097	UROLOGY	Excision Bladder Diverticulum	Major	
2098	UROLOGY	Excision Of Peyronies Plaque	Major	
2099	UROLOGY	Open Orchidopexy: Bilateral	Major	
2100	UROLOGY	Operations For Renal Cysts	Major	
2101	UROLOGY	Orchiopexy	Major	
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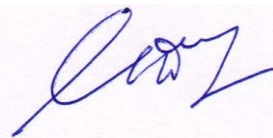


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2102	UROLOGY	Partial Amputation Of Penis	Major	
2103	UROLOGY	Penile Implant-Semi Rigid Or Malleable	Major	
2104	UROLOGY	Release Of Chordee	Major	
2105	UROLOGY	Repair Of Hypospadias - Staged	Major	
2106	UROLOGY	Staged Urethroplasty	Major	
2107	UROLOGY	Stone Basketing	Major	
2108	UROLOGY	T.U.R.-Prostate	Major	
2109	UROLOGY	Ureterectomy	Major	
2110	UROLOGY	Ureterectomy For Ureterocele	Major	
2111	UROLOGY	Ureteric Reimplantation- Unilateral	Major	
2112	UROLOGY	Uretero Neocystostomy Bilateral	Major	
2113	UROLOGY	Uretero Renoscopic Surgery/Urs	Major	
2114	UROLOGY	Vasovasotomy	Major	
2115	UROLOGY	Open Prostatectomy	Major	
2116	UROLOGY	URS + DJ Stenting/Removal	Major	
2117	UROLOGY	Stent Removal + Relook URS	Major	
2118	UROLOGY	Bladder Neck Incision extended	Major	
2119	UROLOGY	TURP + Bilateral Orchidectomy	Major	
2120	UROLOGY	TURP Major	Major	
2121	UROLOGY	Urs Upper Ureteric Stone	Major Plus	
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2122	UROLOGY	Tur Prostate Grade 3	Major Plus
2123	UROLOGY	Endopyelotomy	Major Plus
2124	UROLOGY	Extended Pyelolithotomy	Major Plus
2125	UROLOGY	Laparoscopic Marsupialisation Of Retention Cyst	Major Plus
2126	UROLOGY	Laparoscopic Orchidectomy	Major Plus
2127	UROLOGY	Laparoscopic Orchidopexy Stage 1	Major Plus
2128	UROLOGY	Laparoscopic Orchidopexy Stage 2	Major Plus
2129	UROLOGY	Laparoscopic Orchidopexy: Unilateral	Major Plus
2130	UROLOGY	Laparoscopic Pyelolithotomy	Major Plus
2131	UROLOGY	Laparoscopic Renal Cyst Marsupialisation	Major Plus
2132	UROLOGY	Laparoscopic Seminal Vesiculectomy	Major Plus
2133	UROLOGY	Laparoscopic Simple Nephrectomy	Major Plus
2134	UROLOGY	Laparoscopic Ureterolithotomy	Major Plus
2135	UROLOGY	Malignant Urethral Mass Excision Tot Urethrectomy	Major Plus
2136	UROLOGY	Nephrolithotomy	Major Plus
2137	UROLOGY	P.C.N.L.	Major Plus
2138	UROLOGY	Partial Cystectomy	Major Plus
2139	UROLOGY	Penile Prosthesis	Major Plus
2140	UROLOGY	Repair Of Epispadias	Major Plus
2141	UROLOGY	Simple Nephrectomy	Major Plus

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2142	UROLOGY	Simple Pyelolithotomy	Major Plus
2143	UROLOGY	Surgery For Post Prostatectomy Incontinence	Major Plus
2144	UROLOGY	Surgery For R.P.F Bilateral	Major Plus
2145	UROLOGY	Surgery For R.P.F. -Unilateral	Major Plus
2146	UROLOGY	Surgery For Stress Incontinence	Major Plus
2147	UROLOGY	Uretero Colic Anastomosis	Major Plus
2148	UROLOGY	Uretero Ureterostomy	Major Plus
2149	UROLOGY	Urethrectomy	Major Plus
2150	UROLOGY	Urinary Unidiversion	Major Plus
2151	UROLOGY	Ureterolithotomy	Major Plus
2152	UROLOGY	Scrotal Exploration	Major Plus
2153	UROLOGY	TURP Major plus	Major Plus
2154	UROLOGY	Lap Pyeloplasty And Lap Uretrolysis	Supra Major
2155	UROLOGY	Laparoscopic Adrenalectomy : Unilateral	Supra Major
2156	UROLOGY	Laparoscopic Bladder Diverticulectomy	Supra Major
2157	UROLOGY	Laparoscopic Donor Nephrectomy	Supra Major
2158	UROLOGY	Laparoscopic Heminephrectomy	Supra Major
2159	UROLOGY	Laparoscopic Orchidopexy: Bilateral	Supra Major
2160	UROLOGY	Laparoscopic Partial Cystectomy	Supra Major
2161	UROLOGY	Laparoscopic Pelvic Lymphadenectomy	Supra Major

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2162	UROLOGY	Laparoscopic Radical Nephroureterectomy	Supra Major
2163	UROLOGY	Laparoscopic Ureteric Reimplantation	Supra Major
2164	UROLOGY	Laparoscopic Uretero-Ureterostomy	Supra Major
2165	UROLOGY	Laparoscopic Uvf Repair	Supra Major
2166	UROLOGY	Laparoscopic Vvf Repair	Supra Major
2167	UROLOGY	Nephrourecerectomy	Supra Major
2168	UROLOGY	Partial Nephrectomy	Supra Major
2169	UROLOGY	Radi.Inguin.Lymphadene.Unilateral	Supra Major
2170	UROLOGY	Radical Inguinal Lymphadenectomy-Bilateral	Supra Major
2171	UROLOGY	Repair Of Hypospadias One Stage Repair	Supra Major
2172	UROLOGY	Unilateral Adrenal Surgery	Supra Major
2173	UROLOGY	V.V.F.Repair	Supra Major
2174	UROLOGY	Bilateral Urs	Supra Major
2175	UROLOGY	Urethroplasty Adult	Supra Major
2176	UROLOGY	Anatropic Nephrolithotomy	Supra Major
2177	UROLOGY	Bench Surgery For Kidney	Supra Major
2178	UROLOGY	Bowel Replacement Of Ureter	Supra Major
2179	UROLOGY	Iical Conduit	Supra Major
2180	UROLOGY	Ileo Ureterostomy	Supra Major
2181	UROLOGY	RIRS	Supra Major

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2182	UROLOGY	PCNL + DJ Stenting	Supra Major	
2183	UROLOGY	TURP + Meatoplasty	Supra Major	
2184	UROLOGY	Augmentation Cystoplasty	Supramajor Plus	
2185	UROLOGY	B/L Radical Ing,Ili,Obtu Node Dissection	Supramajor Plus	
2186	UROLOGY	Laparoscopic Total Cystectomy	Supramajor Plus	
2187	UROLOGY	Laparoscopic Ureterolysis	Supramajor Plus	
2188	UROLOGY	Reno Vascular Surgery	Supramajor Plus	
2189	UROLOGY	Bilateral Adrenal Surgery	Supramajor Plus	
2190	UROLOGY	Laparoscopic Adrenalectomy: Bilateral Single Stage	Supramajor Plus	
2191	UROLOGY	Laparoscopic Rplnd	Supramajor Plus	
2192	UROLOGY	Radical Nephrectomy	Supramajor Plus	
2193	UROLOGY	Radical Prostatectomy	Supramajor Plus	
2194	UROLOGY	Gender Reassignment	Supramajor Plus	
2195	UROLOGY	Total penectomy with robotic inguinal node dissection	Supramajor Plus	
2196	UROLOGY	Bilateral Vasectomy reversal	Supramajor Plus	
2197	UROLOGY	Urethroplasty	Supramajor Plus	
2198	UROLOGY	Uretheroplasty	Supramajor Plus	
2199	UROLOGY	Robotic â Augmentation Cystoplasty	Supramajor Plus	
2200	UROLOGY	Kidney Transplant	Supramajor Plus	Mch - Urology with Trnasplant Fellowships
2201	UROLOGY	Donor Nephrectomy	Supramajor Plus	5

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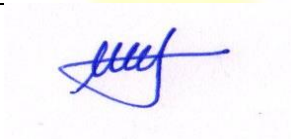
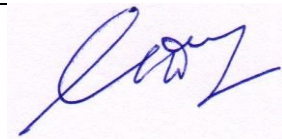


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Quality Head		Chairman & Managing Director	

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	POLICY ON PREVENTION OF ADVERSE SURGICAL EVENTS		

POLICY ON PREVENTION OF ADVERSE SURGICAL EVENTS

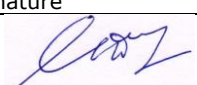
1.0 Purpose

Care is taken to prevent adverse events like the wrong site, wrong patient and wrong surgery. Written guidance shall be available for preventing adverse events like the wrong site, wrong patient, and wrong surgery by a suitable mechanism. The organisation shall be able to demonstrate methods to prevent these events, for example identification tags, badges, cross-checks, time-outs etc. Marking the surgical/invasive site involves the patient and is done with an instantly recognisable and unambiguous mark.

2.0 Scope

This policy applies to:

- All surgical and invasive procedures – elective, emergency, obstetric, laparoscopic, endoscopic, day-care, minor and complex – performed at this hospital
- All Operation Theatres (Major OT, Minor OT, Emergency OT, Obstetric OT), Procedure Rooms, Endoscopy Suites, Cardiac Catheterization Laboratories, Radiology Intervention Suites, and any setting where a surgical or invasive procedure is performed
- All personnel involved in surgical and perioperative care: Surgeons, Surgical Assistants, Anaesthesiologists, OT Nurses, Scrub Technicians, Circulating Nurses, OT Orderlies, Pre-Operative Nurses, Recovery Room Nurses
- Junior residents, senior residents, interns, and visiting surgeons

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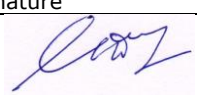
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	POLICY ON PREVENTION OF ADVERSE SURGICAL EVENTS		

3.0 Responsibility

Operating Surgeon	Accountable for correct patient, correct site and correct procedure; performs or supervises site marking; co-leads time-out; countersigns operative note if prepared by another team member
Anaesthesiologist	Leads Sign-In phase of WHO SSC; verifies patient identity, site and procedure before induction; co-leads time-out; co-leads Sign-Out
OT Nurse / Circulating Nurse	Initiates and leads time-out; completes WHO SSC documentation; verifies counts at Sign-Out; ensures checklist is archived with case record
OT In-Charge / Supervisor	Monitors daily compliance with SSC and Universal Protocol; escalates non-compliance; submits monthly compliance data to QM
Quality Manager	Maintains policy; monitors quality indicators; coordinates NABH assessor-facing evidence; processes incident reports;
Medical Superintendent / Medical Director	Overall accountability: reviews sentinel event reports; approves corrective actions; chairs RCA for any wrong site/patient/surgery event

4.0 Policy Statement

This hospital is committed to the absolute prevention of wrong site, wrong patient and wrong surgery adverse events. Written guidance shall be available, implemented, and demonstrable at all times
(Ref: WHO Surgical Safety Checklist)

Recommended By	Signature	Approved By	Signature
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Quality Head		Chairman & Managing Director	

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5.0 Procedure

The following table summarizes the NABH COP 14.d-mandated prevention mechanisms for each category of adverse event:

Wrong Patient & Wrong Surgery	• Use identification tags and wristbands • Perform cross-checks at every handover • Perform mandatory time-outs	WHO SSC Sign-In Phase Patient ID Wristband Policy
Wrong Site	• Be consistent in marking surgical sites with an instantly recognizable and unambiguous mark • Mark shall be visible in procedural field when draping is complete • Mark at minimum all procedures involving laterality, multiple structures (fingers, toes, lesions), or multiple levels (spine)	WHO SSC Sign-In: 'Is the site marked?' Written alternative process for exceptions (Note: There shall be a justifiable reason for any exception to site marking)

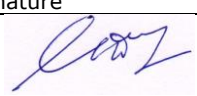
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5.1 WHO Surgical Safety Checklist – Three-Phase Implementation

The WHO Surgical Safety Checklist and JCI Universal Protocol are implemented together across three phases. Compliance with all three phases is mandatory for every surgical case:

Patient confirms: • Identity • Site • Procedure • Consent Site marked / Not applicable Anaesthesia machine & medication check complete Pulse oximeter on patient & functioning Known allergy? No / Yes Difficult airway / aspiration risk? No / Yes + equipment available Risk of >500 ml blood loss? No / Yes + 2 IVs + fluids planned	MANDATORY: Held immediately before first incision. All activity ceases. All team members participate. Team introduces by name & role Verbal agreement by ALL members on: • Correct patient identity • Correct surgical site • Correct procedure to be performed Anticipated Critical Events: • Surgeon: Critical steps? Duration? Blood loss? • Anaesthesiologist: Patient-specific concerns? • Nursing: Sterility confirmed? Equipment concerns? Imaging displayed? • Antibiotic prophylaxis within 60 min? NOTE: Procedure NOT started until ALL concerns resolved. Fresh Time-Out required if	Nurse verbally confirms: • Name of procedure recorded • Instrument, sponge and needle counts correct (or N/A) • Specimen labelling verified – read aloud, including patient name • Equipment problems to be addressed Surgeon, Anaesthesiologist & Nurse review: • Key concerns for recovery and management
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	surgeon changes for a subsequent procedure.	
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5.2 Time-Out Rules – Non-Negotiable Requirements

- The time-out is conducted immediately before the first surgical incision – not before anaesthesia, not before draping, but immediately before the incision.
- A designated team member (typically the circulating nurse) initiates the time-out.
- ALL active members of the operative team must cease their current activity, participate, and give verbal confirmation.
- The time-out is standardized and uses the approved WHO SSC form for this hospital.
- If any team member raises a concern or there is any disagreement during the time-out, the procedure shall not proceed until the issue is resolved.
- When the same patient has two or more sequential procedures and the performing surgeon changes between procedures, a fresh time-out shall be conducted before each procedure.
- The completion of the time-out shall be documented in the OT nursing record and the completed WHO SSC form shall be filed in the patient's case record.

5.3 Patient Identification Mechanisms

- All patients entering the OT complex shall wear an identification wristband containing: Patient Name, MRD/Hospital Number, Date of Birth/Age, Ward/Bed Number.
- Patient identity shall be verified using two identifiers at each of the following points: (a) admission to the pre-operative holding area, (b) on transfer to the OT table, (c) during the WHO SSC Sign-In phase, and (d) during the time-out.
- The identity verification shall be cross-checked against the patient wristband, OT list, consent form, case sheet, and radiological imaging (where applicable).
- If an identity discrepancy is found at any point, the procedure shall be halted and the discrepancy resolved before proceeding.
- Unconscious or sedated patients who cannot self-identify shall be identified by the accompanying ward nurse from the case sheet and wristband.

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5.4 Documentation Requirements

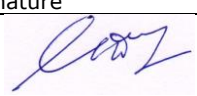
The following documents shall be maintained as evidence of compliance with this policy:

- Completed WHO Surgical Safety Checklist (original filed with each patient's case record)
- Pre-operative checklist / patient identification verification form
- OT nursing record confirming time-out completion with date, time, and team member names
- Incident reports for any near-miss, wrong site, wrong patient, or wrong surgery event with RCA reports and corrective action plans for all Moderate/ serious deviations
- Monthly SSC compliance audit reports
- Staff training records

Reference:

NABH Accreditation Standards for Hospitals, 6th Edition – COP 14d

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2	01	01	1 Nov 2020	For compliance as per NABH Hospital Standards 5th Edition
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5	01	02	1 Jan 2026	No changes.

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Document Title : QAP OT

SHRPL QAP policy:

Quality Assurance Programme in OT:

Sr. No.	Quality Objective	Performance Indicator	Responsibility	Measurement criteria	
				Criteria	Frequency
1	Service Quality	% of Unplanned Return to OT (Re exploration rate)	CVTS OT In charge / 6 Th floor OT In charge	Number of unplanned return to OT / Number of patients who underwent surgeries in the OT *100	Monthly
		% of cases who received Appropriate (drug, dose as per policy) prophylactic antibiotics within specified timeframe. (60mins)	CVTS OT In charge / 6 Th floor OT In charge	No. of patients who received Appropriate Prophylactic antibiotic/ Total no. surgeries *100	Monthly

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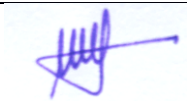
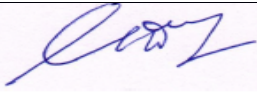
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		% of cases where the organisations's procedure to prevent adverse events like wrong site, wrong patient, and wrong surgery have been adhered to.	CVTS OT In charge / 6 Th floor OT In charge	No. of surgeries where - WHO Safe Surgery checklist was followed / No of surgeries that were audited *100	Monthly
		Re-scheduling of surgeries (>4hrs) including cancellation	CVTS OT In charge / 6 Th floor OT In charge	No. of cancellation and postponed surgeries (beyond 4hrs)/ Total no. surgeries planned *100	Monthly

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REFERENCES : NABH 6TH EDITION COP 14 I

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	Policy Of operation theatre environment		

Air Conditioning in OT

A. The air conditioning requirements for operation theatre in HCO have been revisited in the context of points raised by various HCOs during surveys. These standards were examined by Technical committee and various latest international and national standards on air conditioning were reviewed. Retrofitting in the HCOs constructed before these guidelines came in to being was also considered.

B. Though these guidelines are desirable under all programs, they are NOT MANDATORY for the HCOs implementing pre-entry certification standards.

C. Modular Operation Theatre is NOT A MANDATORY REQUIREMENT under any program. It is totally left to HCO whether they want to install it.

D. For this purpose operation theatres have been divided into two groups:

1. Type A (Erstwhile Super specialty OT): Type A OT means operation theatres for Neurosciences, Orthopaedics (Joint Replacement), Cardiothoracic and Transplant Surgery (Renal, Liver, heart etc.).
2. Type B (Erstwhile General OT): This includes operation theatres for Ophthalmology, day-care surgeries and all other basic surgical disciplines.

REQUIREMENTS – Type A (Erstwhile Super Specialty OT)

1. Air Changes Per Hour:

- Minimum total air changes should be 20 based on biological load and the location.
- The fresh air component of the air change is required to be minimum 4 air changes out
- Minimum total air changes should be 20 based on biological load and the location.
- If Healthcare Organization (HCO) chooses to have 100% fresh air system then of total minimum 20 air changes. appropriate energy saving devices like heat recovery wheel, run around pipes etc. should be installed.

2. Air Velocity:

The airflow needs to be unidirectional and downwards on the OT table. The air face velocity of 25-35 FPM (feet per minute) from non-aspirating unidirectional laminar flow diffuser/ceiling array is recommended

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3.Positive Pressure:

The minimum positive pressure recommended is 2.5 Pascal (0.01 inches of water). There is a requirement to maintain positive pressure differential between OT and adjoining areas to prevent outside air entry into OT. Positive pressure will be maintained in OT at all times (operational & non-operational hours)

4.Air handling in the OT including air Quality:

Air is supplied through Terminal HEPA (High-Efficiency Particulate Air) filters in the ceiling. The HEPA can be at AHU level if it not feasible at terminal level inside OT. The minimum size of the filtration area should extend one foot on all sides of the OT table

5.Air Filtration:

The AHU (i.e. air handling unit) must be an air purification unit and air filtration unit. There must be two sets of washable flange type filters of efficiency 90%down to 10 microns and 99% down to 5 microns with aluminium / SS 304 frame within the AHU. The necessary service panels to be provided for servicing the filters, motors & blowers. HEPA filters of efficiency 99.97% down to 0.3 microns or higher efficiency are to be provided. Air quality at the supply i.e. at grille level should be Class 100/ISO Class 5 (at rest condition). Note : class 100 means a cubic foot of air should not have more than 0.5 microns or larger.

6. Temperature & Relative Humidity: I

Temperature should be maintained $21\text{ C} \pm 3\text{ C}$ (except for Joints replacement where it should be $18\text{ C} \pm 2\text{ C}$) with corresponding relative humidity between 20 to 60%, though the ideal RH is considered to be 55%. Appropriate devices to monitor and display these conditions inside the OT may be installed.

REQUIREMENTS – Type B (Erstwhile General OT)

1. Air Changes Per Hour: Same as Type A OT requirements above.

2. Air Velocity: Same as Type A OT requirements above

3.Positive Pressure: Same as Type A OT requirements above

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4. Air Filtration: The AHU (i.e. air handling unit) must be an air purification unit and air filtration unit. There must be two sets of washable flange type filters of efficiency 90% down to 10 microns and 99% down to 5 microns with aluminium/ SS 304 frame within the AHU. The necessary service panels to be provided for servicing the filters, motors & blowers. HEPA filters of efficiency 99.97% down to 0.3 microns or higher efficiency may be provided. The Air quality at the supply i.e. at grille level should be class 1000/ISO Class 6 (at rest condition). Note: Class 1000 means a cubic foot of air must have no more than 1000 particles measuring 0.5 microns or larger.

5. Temperature and Humidity: The temperature should be maintained at $21\text{ C} \pm 3\text{ C}$ inside the OT at all times with corresponding relative humidity between 20 to 60%. Appropriate devices to monitor and display these conditions inside the OT may be installed.

Design considerations for Operation Theatres

- A. The AHU of each OT should be dedicated one and should not be linked to air conditioning of any other area in the OT and surroundings.

One AHU for multiple OTs is permitted provided there is a back-up/contingency plan to accommodate surgeries in other OTs in the eventuality of failure of infection control in these OTs. Redundancy in terms of multiple fans for return and input air with UPS and DG set supply is provided to such type of common AHU. Direct drive fans will be required in such common AHU. The specific evidence of validation for the above will have to be provided either by the vendor/third party.

B. Outdoor Air intakes: The location of outdoor air intake for an AHU must not be located near potential contaminated sources like DG exhaust hoods, lab exhaust vents, and vehicle parking area

C. Window & split A/c should not be used in any type of OT because they are pure re-circulating units and have pockets for microbial growth which cannot be sealed.

D. For old constructions and for retrofitting (constructed/renovated prior to 2015)

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1. Where space is a constraint, ceiling suspended AHU is permitted provided there is accessibility for maintenance of filters and other parts of AHU.
2. Dx unit with AHU is recommended for OTs where retrofitting solution is possible.
3. All requirements spelt out for new constructions and Type A and Type B OTs above in terms of air changes, particle count, positive pressure, temperature, humidity and air velocity will have to be met by such OTs in old constructions/HCOs

E. During the non-functional hours AHU blower will be operational round the clock (may be without temperature control). Variable frequency devices (VFD) may be used to conserve energy. Air changes can be reduced to 25% during non-operating hours thru VFD provided positive pressure relationship is not disturbed during such period.

Maintenance of the system

Validation of system should be done every 6 months and as per ISO 14644 standards.

This should include:

- Temperature and Humidity check
- Air particulate count
- Air Change Rate Calculation
- Air velocity at outlet of terminal filtration unit /filters
- Pressure Differential levels of the OT with respect to ambient / adjoining areas
- Validation of HEPA Filters by appropriate tests.

Preventive Maintenance of the system:

It is recommended that periodic preventive maintenance be carried out in terms of cleaning of pre filters, micro vee filters at the interval of 30 days. Preventive maintenance of all the parts of AHU is carried out as per manufacturer recommendations.

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References : NABH Guideline 6 th COP 14 J

- 1.ANSI/ASHRAE (American Society of Heating, Refrigerating and Air Conditioning Engineers) /ASHE standards 170-2017.
2. Previous NABH guidelines for air conditioning in operation theatre
3. Memarazadeh I, and A. Manning 2002. Comparison of operating room ventilation systems in the protection of surgical site.
4. HVAC Design Manual for hospitals and clinics 2 nd edition, ASHRAE 2016. 5. CPWD design guidelines HVAC guide 2017 Ministry of Public works New Delhi 2017.

AMENDMENT HISTORY

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2	01	01	1 Nov 2020	For compliance as per NABH Hospital Standards 5th Edition
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	Policies & Procedures for Handling of Vulnerable Patients		

PURPOSE

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

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

SCOPE

In patient Services

DEFINITION

‘Vulnerability’ is operationally defined as the potential risks associated with the physical and mental status of an individual, which might reasonably be anticipated irrespective of the context in which care is provided.

Vulnerability is being described in terms of potential for exposure to deliberate maltreatment (active) and unintentional or thoughtless acts (passive). There are many risks involved, which mean that the potential for a breach of care is always present and is not restricted to specific care contexts.

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PROCEDURE

1. Identification of Vulnerable patient group: All patients will be assessed for falls within 24 hours of admission as a part of the Nursing Assessment Process. All the ICU patients, all women of labor room will automatically be considered vulnerable.
2. In our cultural scenario the family plays an important role in taking care of the patients and the attendants (close relatives and friends) do accompany the patients.
3. The hospital shall encourage family members to be present for admission of patients falling in the above categories.
4. The hospital shall provide special attention and care to the physically challenged patients visiting the hospital. Any physically challenged patient shall be assisted by the security staff, specially trained by the hospital. Inside the hospital, the nursing staff / attendants shall assist the patients.
5. In case of the patients who come in their own cars and have physical disability shall be assisted by the security staff at the emergency reception. The hospital shall arrange of valet parking for such patients.
6. Identification of vulnerable patients by:

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- Senior Consultants/ Junior consultants/PG's (Based on medical condition)
- Nursing (Based on Nursing Admission Assessment Tool)
- Interdisciplinary Team (Based on Multi-disciplinary Assessment)

7. Identifier- A "Safety First" sign shall be placed on the head end of the bed (except for Children on Pediatric Units, HDU and ICU patients, as all these are vulnerable).

8. Nursing staff will institute falls risk strategies as per the risk status of the patients. This will be documented in the care plan. These may include railings, assisted mobility, frequent monitoring, family involvement etc.

9. All falls shall be documented in each nursing unit records

10. All falls shall be reported using the incident report forms.

11. Ward Supervisors shall conduct audits to check for compliance with falls prevention program.

12. Women in labor room and pediatric patients will have different assessments by both doctors and nurses. The same shall be documented in Doctors / Nurses notes in the clinical case sheets.

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13. Nursing staff shall have competency testing if they are required to take care of these groups of patients as a part of the induction and training program in these units.

14. A competency testing will also be done for nursing staff, taking care of geriatric patients by the respective ward supervisors before assigning them to the patient / beds.

STANDARD REFERENCE

COP- 16 a

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1	01	00	1 Oct 2019	First issue as per NABH Hospital Accreditation Standards – 4 th Edition
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	PATIENT FALL POLICY		

INTRODUCTION:

Falls are the most reported type of patient safety incident in healthcare. The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Up to 90% of older patients who fracture their neck of femur may fail to recover their previous level of mobility or independence. Falling also affects the family members and care of people who fall. Fall is a major cause of injury and death among psychiatric clients and elderly people. It is the most common safety incident in the hospital. In a health care facility, an accidental fall can change a short stay for a minor problem into a prolonged stay for serious and possibly life threatening problems. Management of fall requires an approach that increases patient safety in hospital by identifying patients at risk and implementing interventions that reduce patient falls, including consideration and assessment of environmental risk factors. It is, however, recognized that patient safety should be balanced with the promotion of patient recovery and independence, with the aim of discharging patients home safely

Higher falls risk groups include:

- Older people, those suffering from dementia are particularly vulnerable to falling because of cognitive impairment and associated difficulties such as loss of spatial awareness, side effects from medication, or problems with their balance, strength, or mobility.
- People with cardiac, neurological, muscular-skeletal conditions, continence problems, and sensory losses and difficulties.
- People with learning disabilities, who may have a combination of physical, sensory and cognitive problems.

PURPOSE:

The purpose of this policy is to ensure that consistent standards are adhered to in order to reduce the likelihood of an inpatient falling. This will be achieved by ensuring that:

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- All patients have a falls risk assessment completed within 1 hours of admission, then daily, if patient condition changes or after a patient fall.
- Preventative measures and actions are put in place for those patients identified at moderate/ significant risk of falling.
- Appropriate care is given to any patient who has fallen.

DEFINITIONS

Fall: loss of upright position that results in landing on the floor, ground, or an object or furniture, or a sudden, uncontrolled, unintentional, non-purposeful, downward displacement of the body to the floor/ground or hitting another object like a chair or stair; excluding falls resulting from violent blows or other purposeful actions.

SCOPE

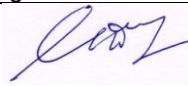
This document applies to all healthcare professionals in Saideep Hospital who work directly or has an impact to the welfare of patients at risk of fall. This covers all clients at risk of fall who attend to Hospital.

POLICY

Saideep Hospital is committed in providing an efficient process of initial and ongoing assessment of patients at risk of falling, identifying them, and establishing proactive risk management to reduce risk of falls, thus, all healthcare professionals with direct contact to patient care must adhere to this policy and procedure at all times.

UNIVERSAL FALL PRECAUTIONS

Universal fall precautions are called "universal" because they apply to all patients regardless of fall risk. Universal fall precautions revolve around keeping the patient's environment safe and

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comfortable. Although the choice of which precautions to emphasize may vary by hospital, a good starting list adapted from the Institute for Clinical Systems Improvement guideline is provided here:

- Familiarize the patient with the environment.
- Have the patient demonstrate call light use.
- Maintain call light within reach.
- Keep the patient's personal possessions within patient safe reach.
- Have sturdy handrails in patient bathrooms, room, and hallway.
- Place the hospital bed in low position when a patient is resting in bed; raise bed to a comfortable height when the patient is transferring out of bed.
- Keep hospital bed brakes locked.
- Keep wheelchair wheel locks in "locked" position when stationary.
- Keep nonslip, comfortable, well-fitting footwear on the patient.
- Use night lights or supplemental lighting.
- Keep floor surfaces clean and dry. Clean up all spills promptly.
- Keep patient care areas uncluttered.
- Follow safe patient handling practices.

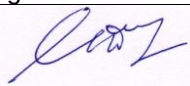
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2	01	01	1 Nov 2020	For compliance as per NABH Hospital Standards 5th Edition
3	01	01	1 Jan 2022	No changes.
4	01	02	1 Jan 2025	Amended as per the 6 th Edition
5	01	02	1 Jan 2026	No changes.

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	Pressure Ulcer		

INTRODUCTION

This policy provides a framework for the prevention and treatment of pressure ulcers for inpatients of Saideep Hospital. This is in light of the national focus on improving patient safety and patient experience, and reducing avoidable harm to clients.

SCOPE

This document covers all clients who are admitted in Saideep Hospital and to all employees who work directly with inpatients and who has an impact upon welfare of patients at risk of pressure ulcers.

PURPOSE

- To guide nurses in the prevention and management of pressure ulcers for all client who are at risk of pressure ulcers.
- To maintain skin integrity and prevent the formation of bed sores.
- To promote/facilitate healing process by minimizing the pressure on the affected area.

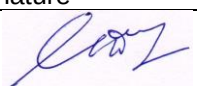
DEFINITIONS

Braden Assessment: a scale used to help health professionals, especially the nurse to assess a patient risk of developing pressure ulcer and categories the pressure based on stages. Pressure Ulcer Assessment Scale (Braden scale))

Decubitus Ulcer: The terms "Decubitus ulcer" or "Pressure sore" or "pressure ulcer" are used to describe any area of damage to the skin or underlying tissues caused by direct pressure or shearing forces. The extent of this damage can range from persistent erythematic to necrotic ulceration involving muscle, tendon and bone.

Norton Assessment: a scale used to predict the likelihood a client will develop pressure ulcers. The client is rated from 1 (low risk) to 4 (high risk) using the following five criteria: physical condition, mental condition, activity, mobility, and incontinence. (See Appendix 2. Norton Pressure Sore Risk-Assessment Scale Scoring System)

Skin Inspection: from head to toe evaluation of bony prominences and skin folds/creases when prolonged pressure may result in skin breakdown.

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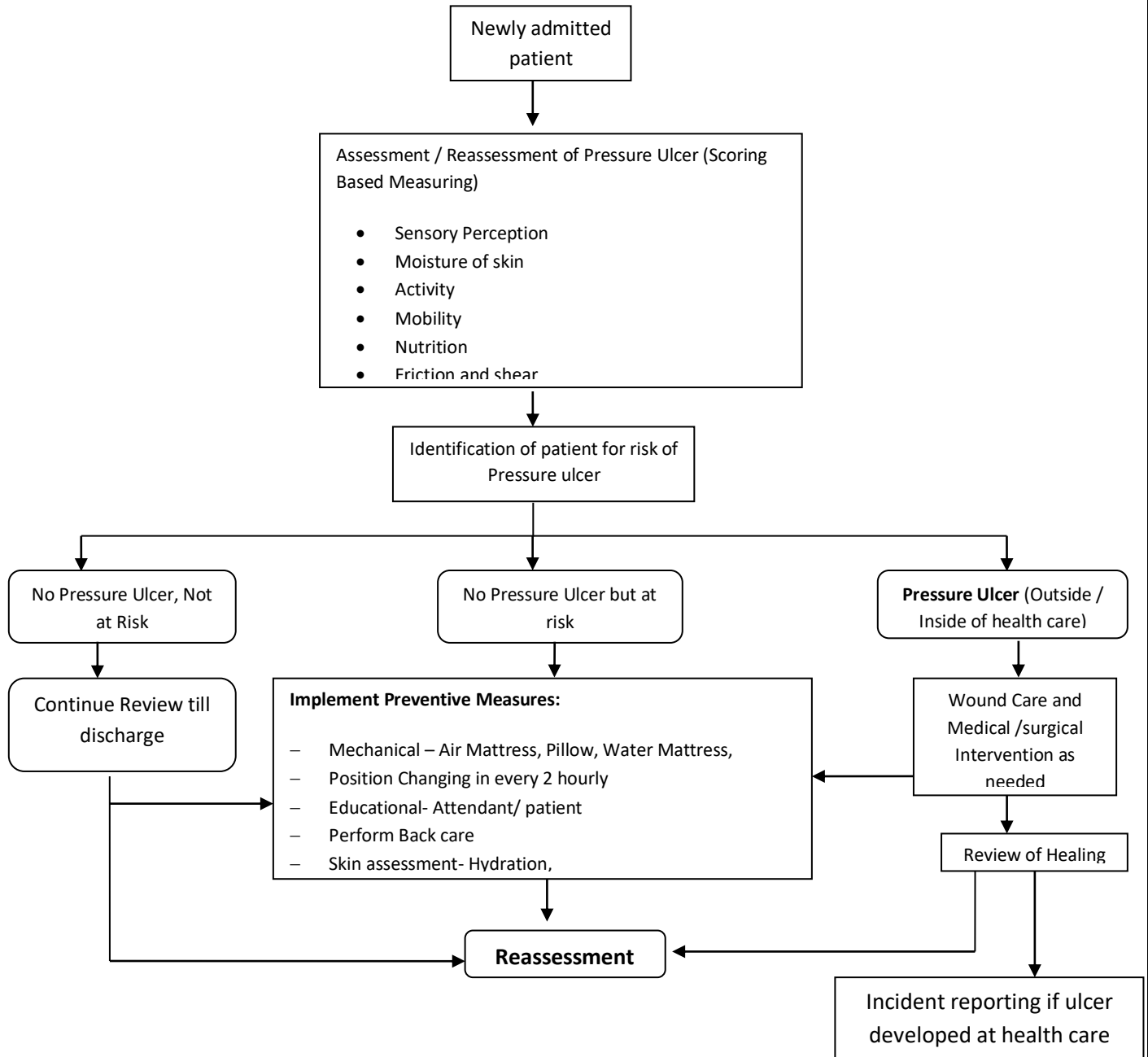
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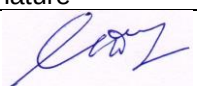
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Pressure ulcer prevention



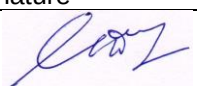
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	Venous Thromboembolism Prevention Policy		

1.0 Introduction

The House of Commons Health Committee reported in 2005 that an estimated 25,000 people a year in the UK die from preventable hospital-acquired venous thromboembolism (VTE). This includes patients admitted to hospital for medical care and surgery. The inconsistent use of prophylactic measures for VTE in hospital patients has been widely reported. A UK survey suggested that 71% of patients assessed to be at medium or high risk of developing deep vein thrombosis (DVT) did not receive any form of mechanical or pharmacological VTE prophylaxis.

VTE encompasses a range of clinical presentations. Venous thrombosis is often asymptomatic; less frequently it causes pain and swelling in the leg. Part or all of the thrombus can come free and travel to the lung as a potentially fatal pulmonary embolism. The patient typically suffers chest pain, breathlessness and collapse. Deep vein thrombosis carries a considerable burden of morbidity, including long-term morbidity because of chronic venous insufficiency. This in turn can cause venous ulceration and development of a post-thrombotic limb (characterised by chronic pain, swelling and skin changes). Pulmonary embolism can leave a legacy of pulmonary hypertension.

VTE is an important cause of death in hospital patients, and treatment of non-fatal symptomatic VTE and related long-term morbidities is associated with considerable cost to the health service.

The purpose of this policy is to enable healthcare practitioners at MTW to identify patients at risk of developing VTE and select the appropriate therapy to reduce the associated mortality and morbidity risks associated with this disease.

The diagnosis and treatment of VTE (DVT and PE) is covered in the *MTW Policy and Procedure for the Diagnosis and Management of VTE* and the *MTW Policy and Procedure for the Safe Management of Anticoagulation Therapy*.

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1.1 Scope

The policy applies to:

All those 18 years and older admitted to hospital as inpatients or formally admitted to a hospital for day-case procedures, including:

surgical and medical inpatients

orthopaedic and trauma inpatients

patients admitted to Intensive Care Units

cancer inpatients

people undergoing long-term rehabilitation in hospital

patients admitted to a hospital bed for day-case medical or surgical procedures.

Please note: Appendix 8 - this applies to patients 16 and over and is relevant to both outpatients and inpatients with lower limb casts.

The policy does not apply to:

- People younger than 18 years (but please use clinical judgement for teenage inpatients) (exception please see Appendix 8 for lower limb casts)
- People attending hospital as outpatients (exception - please see Appendix 8 for lower limb casts)
- People presenting to emergency departments without admission.
- Elderly or immobile people cared for at home, or in external residential accommodation, unless admitted to hospital.
- Women in pregnancy; a separate policy exists relating to women in pregnancy (*Venous Thromboembolism (VTE) in Pregnancy and Puerperium*)

Patients admitted to hospital with a diagnosis of, or suspected diagnosis of, deep vein thrombosis or pulmonary embolism should follow a treatment plan and not the prophylactic plan. Please refer to the Trust Policy and Procedure for the Diagnosis and Management of VTE and the Trust Policy and Procedure for the Safe Management of Anticoagulation Therapy and this policy.

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2.0 Definitions

Venous Venous thrombosis is a condition in which a blood clot **Thromboembolism** (thrombosis) forms in a deep vein. Blood flow along the

(VTE) affected vein can be limited by the clot, causing swelling and pain. Venous thrombosis most commonly occurs in the 'deep veins' in the leg or pelvis. This is known as a deep vein thrombosis (DVT). An embolism is created if a part or all of the thrombosis in the deep vein breaks off from the site where it is created and travels along the venous system. A leg DVT can travel to the lungs, known as pulmonary embolism (PE). DVT and PE are the most common manifestations of venous thrombosis. Both conditions can be asymptomatic. DVT and PE are known collectively as venous thromboembolism (VTE).

Deep Vein A thrombosis occurring in a deep vein, most commonly

Thrombosis (DVT) a deep vein of the leg or pelvis but can affect any deep vein.

Pulmonary If the clot lodges in the lung a very serious condition,

Embolism (PE) pulmonary embolism (PE) arises.

Thromboprophylaxis Thromboprophylaxis is the treatment to prevent blood clots forming in veins – this may be chemical or mechanical.

Chemical Pharmaceutical agents (oral or parenteral) used to decrease

thromboprophylaxis the clotting ability of the blood.

Mechanical Devices including anti-embolism stockings (AES) and

thromboprophylaxis intermittent pneumatic compression devices (IPCD) can be used to increase venous blood flow and reduce stasis within the leg veins.

Significantly reduced Used to denote patients who are bedbound, unable to walk

mobility unaided or likely to spend a substantial proportion of the day in bed or in a chair

Major bleeding Refers to bleeding events that result in one or more of the following:

- death

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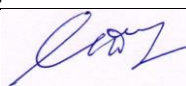
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- a decrease in haemoglobin concentration of 2g/dl or more
- transfusion of two or more units of blood
- bleeding into a retroperitoneal, intracranial or intraocular site
- a serious or life-threatening clinical event
- a surgical or medical intervention.

Thrombosis The Thrombosis Committee was established under the committee auspices of the Medical Director to lead on the prevention, reduction and treatment of VTE. It ensures best practice for the prevention and management of VTE, based on national guidance and other examples of best practice.

3.0 Duties (roles and responsibilities)

- **Chief Executive** has overall responsibility and accountability for the implementation of this policy.
- **Medical Director** has delegated responsibility for the implementation of this policy.
- **Clinical Directors** will be responsible for ensuring that the clinical staff within their area follow this policy. They will also review any audits undertaken to ensure highlighted actions are completed and implemented in a timely manner.
- **VTE Lead Nurse** will be responsible for providing the education and training to assist in the implementation of this policy, ensuring audits are undertaken to monitor the effectiveness of the policy and ensure the policy is revised when necessary.
- **Clinical staff** (Medical/Nursing/Midwifery) will be responsible for undertaking appropriate and timely risk assessments on patients (as detailed in this policy) and entering these onto Patient Centre, as well as ensuring that necessary prophylactic treatment is prescribed as necessary. This applies to all patients admitted whether emergency or planned.
- **Theatre staff** should ensure that the nursing pre-operative checklist i is performed ensuring that appropriate VTE risk assessments have been undertaken as necessary. If no appropriate risk assessment has been undertaken the surgical procedure should not proceed unless a life-threatening situation.
- **Pharmacists:** Pharmacists are responsible for checking chemical prophylaxis is appropriately prescribed and administered. Any discrepancies should be recorded in the patient's healthcare record and discussed with the prescriber and / or the patient's medical team.

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4.0 Training / competency requirements

All medical, nursing and midwifery staff are made aware of the VTE risk assessment tool, thromboprophylaxis and patient information documents in conjunction with this policy at local induction.

Doctors, nurses and midwives will undertake VTE training either through e-learning or the mandatory update study day VTE session and this will be monitored as part of their annual appraisal.

Pharmacists will undertake VTE training either through e-learning or the mandatory update study day VTE session and this will be monitored as part of their annual appraisal.

The above training will be monitored via the AT-Learning training database. The training should take place every two years.

All clinical staff (Medical/Nursing/Midwifery) will be made aware of the AES care pathway, AES patient information and the AES manufacturer's guidelines.

They should receive training in AES and a declaration of their competency should be documented.

All clinical staff (medical / nursing / midwifery) will be made aware of the IPCD care pathway and IPCD manufacturer's guidelines. They must receive training in IPCD and a declaration of their competency should be documented.

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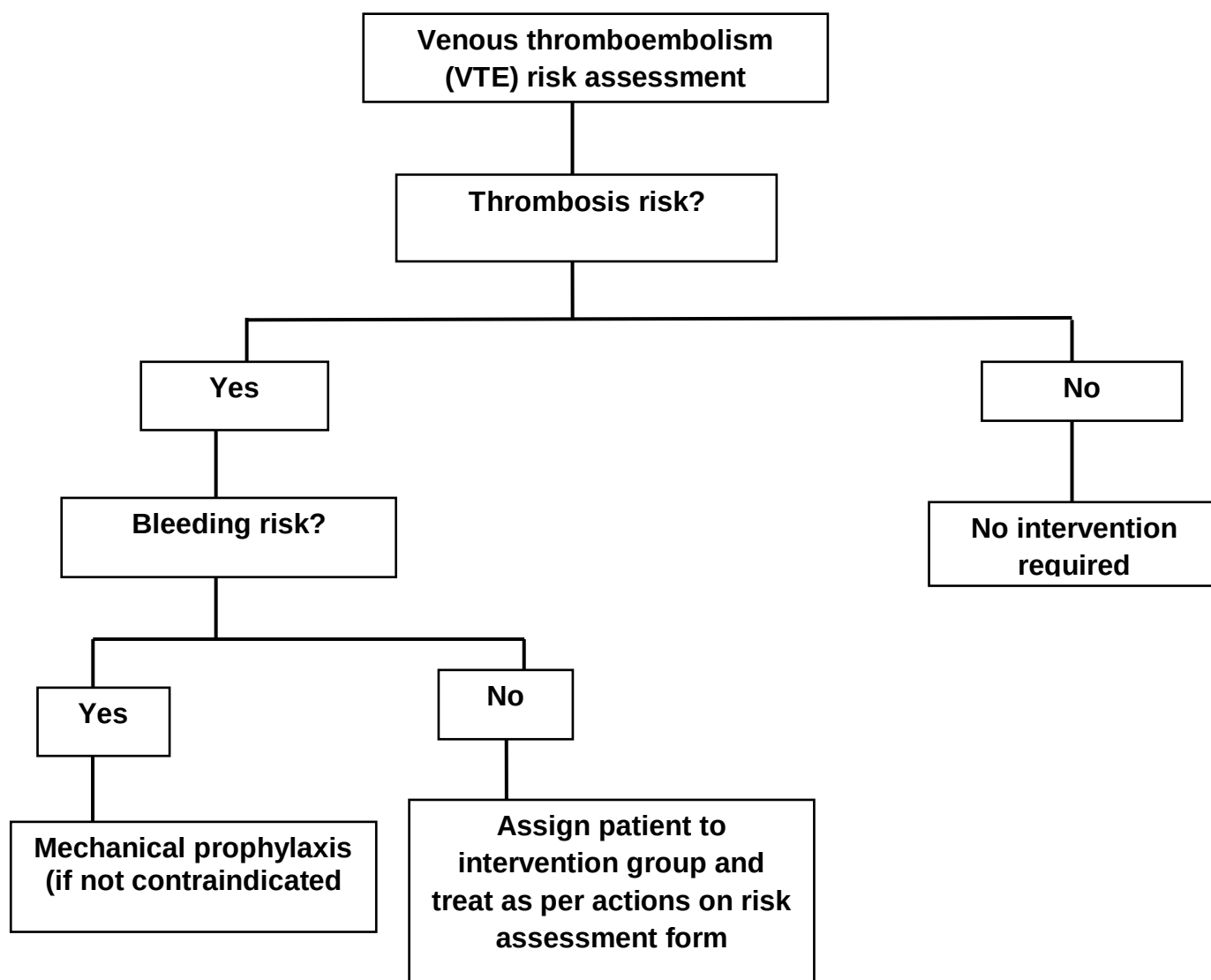
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5.0

Care pathway



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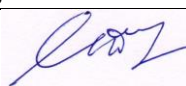
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6.0 Patient risk assessment

- All patients admitted to Maidstone and Tunbridge Wells Trust must be screened within two hours of admission for risk of VTE and considered for thromboprophylaxis using the screening tool. Please refer to the VTE Risk Assessment form.
- All patients must be assessed for risk of bleeding before being offered chemical VTE prophylaxis. Patients with any of the risk factors for bleeding will not be offered chemical prophylaxis unless the risk of VTE outweighs the risk of bleeding.
- The patient's VTE risk will be recorded on the risk assessment form and if appropriate, thromboprophylaxis (chemical, mechanical or a combination of both) will be commenced. for 'Thromboprophylaxis summary'.
- The risk of VTE and bleeding must be reassessed within 24 hours of admission and whenever the clinical situation changes and treatment adjusted accordingly, taking into account the need for extended thromboprophylaxis in certain cases.
- Treatment must take into account any contraindications to chemical or mechanical therapies. Contraindications must be recorded in the patient's healthcare record.

7.0 Thromboprophylaxis

- Treatment should continue until the patient is fully mobile. Extended thromboprophylaxis should be considered in high risk patients
- All patients who have risk factors for VTE will be prescribed low molecular weight heparin (LMWH) from admission at 22.00 hours unless this is contraindicated.
- Patients who are at risk of VTE but who have an absolute contraindication to LMWH must be prescribed anti-embolism stockings unless contraindicated.
- Pre-operative LMWH should not be given to elective surgical patients unless this has been specifically requested and prescribed by the admitting consultant.
- Trauma list and non-elective surgical patients should where possible be delayed until at least 12 hours after the last dose of LMWH has been administered.
- All patients should be adequately hydrated.
- Patients should be mobilised as early as possible. Patients should be shown how to exercise their legs if they are on bed rest.
- Consider offering temporary inferior vena cava filters to patients who are at very high risk of VTE (such as patients with a previous VTE event or an active malignancy) and for whom mechanical and pharmacological VTE prophylaxis are contraindicated.
- Invasive procedures with a risk of bleeding (e.g. liver biopsy, endoscopy with biopsy) should where possible be delayed until at least 12 hours after the last dose of LMWH has been administered.

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7.1 VTE prophylaxis in surgical patients

Surgical patients are at high risk if their combined surgical and anaesthetic time is 60 minutes or longer **or** they have any additional risk factor as identified on the MTW VTE risk assessment form. High risk surgical patients should be prescribed LMWH daily as per actions on MTW VTE risk assessment form plus AES (unless contraindicated) and/or intermittent pneumatic compression device.

Patients undergoing major cancer surgery in the abdomen or pelvis should continue chemical and mechanical thromboprophylaxis for 28 days post-surgery. Surgical patients with a body mass index of 30 or greater should have extended chemical and mechanical thromboprophylaxis for 7 days post-surgery. Other high risk surgical patients (including day surgery patients) should continue thromboprophylaxis until their mobility is no longer significantly reduced, including after discharge if necessary.

Surgical patients are at low risk if their combined surgical and anaesthetic time is less than 60 minutes **and** they have no additional risk factor. Low risk surgical patients should mobilise early and AES should be considered (unless contraindicated).

If a spinal or epidural anaesthesia is used, additional care must be exercised when placing or removing the catheters. Placement should be delayed until at least 12 hours after the last LMWH dose to avoid bleeding complications at the catheter site. Presence of a spinal or epidural catheter is not a contraindication to LMWH use. At the discretion of the anaesthetist, LMWH may be started immediately after the catheter is removed, or immediately after a regional block.

For patients booked on the emergency theatre list, there needs to be a 12 hour gap between chemical thromboprophylaxis and spinal anaesthetic. Therefore consideration must be given to the timing of the pre-operative dose, i.e. this should be prescribed at 20.00 hours on the evening pre-surgery as a stat dose with the 22.00 dose cancelled.

Thromboprophylaxis must not simply be omitted.

7.2 Thromboprophylaxis for orthopaedic patients

Unless contraindicated, patients admitted for elective hip or knee replacement should have mechanical VTE prophylaxis which should continue until the patient's mobility is no longer significantly reduced. The patient should be commenced on chemical thromboprophylaxis 6-10 hours post operatively. This should continue for 35 days for hip replacements and 14 days for knee replacements. Each patient should be reviewed on a case by case basis. Hip fracture patients should be prescribed LMWH daily as per actions on MTW VTE risk assessment form plus AES (unless contraindicated) and/or intermittent pneumatic compression device. Thromboprophylaxis should be continued for 28 days. Please for summary of extended thromboprophylaxis for specific orthopaedic surgery.

It is acceptable to reduce thromboprophylaxis to 2,500 units subcutaneous daily for trauma patients with a weight of 49kg or under.

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For patients booked on the orthopaedic trauma list, there needs to be a 12 hour gap between chemical thromboprophylaxis and spinal anaesthetic. Therefore consideration must be given to the timing of the pre-operative dose, i.e. this should be prescribed at 20.00 hours on the evening pre surgery as a stat dose with the 22.00 dose cancelled. Thromboprophylaxis must not simply be omitted.

7.3 VTE prophylaxis in medical patients

Patients expected to have ongoing reduced mobility plus one or more risk factors and no contraindications identified should be prescribed LMWH daily as per actions on the MTW VTE risk assessment form.

Patients who have a bleeding risk or an absolute contraindication to LMWH must be prescribed AES instead unless contraindicated. If AES also contraindicated (e.g. acute stroke patients) then an intermittent compression device should be considered.

7.4 VTE prophylaxis in acute stroke patients

Patients admitted with an acute stroke should have a VTE risk assessment on admission. LMWH should be withheld until CT imaging has excluded a haemorrhage and the size of any infarct has been able to be assessed. Once haemorrhage has been excluded and the patient has been reviewed by the stroke/medical consultant to assess the size of the infarct, the VTE risk assessment should be repeated within 24 hours. Unless there are further contraindications, prophylactic LMWH should be prescribed within the first 72 hours of admission. Care should be taken if there are large territorial infarcts, if there is a risk of haemorrhagic transformation or if there is a high risk of intra or extra cranial haemorrhage (this decision will be made the Stroke Consultant). Patients who have received thrombolysis should not be prescribed LMWH until they have undergone a follow up CT brain imaging after 24 hours. A second VTE risk assessment should take place following the repeat CT head scan. It is expected that the majority of patients will be able to commence VTE chemical prophylaxis following this assessment but there will be some patients where this will not be appropriate due to possible post thrombolysis complications such as haemorrhagic conversion or due to the size or location of the established infarct. These patients should be reviewed by the responsible stroke consultant for a decision and future management in relation to VTE prevention including consideration of using IPCD after the

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initial 12 hours if not already commenced. This decision will be documented in the patient's record.

All patients with a bleeding risk e.g. haemorrhagic stroke or other contraindication to LMWH and who have reduced mobility **must** be assessed for the use of an intermittent pneumatic compression device (IPCD) using the IPCD proforma. All patients commenced on the IPCD's must have the care plan completed within the stroke integrated care pathway document. Any removal of the IPCDs for anything other than physical therapy or brief inspection and care of the legs for longer than 2 hours must be documented on the IPCD monitoring sheet within the stroke integrated care pathway. If the IPCD have been left off for more than 2 hours the patient's legs must be checked carefully for any signs of DVT before reapplying IPCD.

If the use of an IPCD is indicated the IPCD will be prescribed on the patient's prescription chart by the doctor or appropriate non-medical prescriber. Do NOT offer AES for VTE prophylaxis to patients who are admitted for stroke.

7.5 VTE prophylaxis in cancer patients

Definition: active cancer should be considered to be:

1. A diagnosis of cancer (other than basal cell or squamous cell carcinoma of the skin) within the previous six-month period
2. Any treatment for cancer within the previous six-month period
3. Recurrent or metastatic cancer

7.5.1 Patients with active cancer should receive thromboprophylaxis throughout their hospital admission unless contraindicated.

7.5.2 Extended surgical thromboprophylaxis should be offered to those requiring surgery for the management of abdominal and pelvic cancer (NICE 2010).

7.5.3 Thromboprophylaxis is not routinely recommended to prevent catheter-related thrombosis.

7.6 VTE prophylaxis in end of life patients

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Patients in palliative care, who have potentially acute reversible pathology, should be considered for LMWH. However, if the patient is in terminal care or on an end-of-life care pathway, pharmacological or mechanical VTE prophylaxis should not routinely be offered. In both cases, decisions about VTE prophylaxis should be reviewed daily, taking into account potential risks and benefits and views of the patient, family and/or carers and multidisciplinary team.

7.7 Patients already on anti-platelet or anticoagulant therapy

Consider offering additional mechanical or pharmacological VTE prophylaxis if the patient is at risk of VTE. Take into account the risk of bleeding and of co-morbidities such as arterial thrombosis.

If the risk of VTE outweighs the risk of bleeding, consider offering pharmacological VTE prophylaxis according to the reason for admission.

If the risk of bleeding outweighs the risk of VTE, offer mechanical VTE prophylaxis.

Do not offer additional pharmacological or mechanical VTE prophylaxis to patients who are taking vitamin K antagonists (warfarin) and who are within their therapeutic range, or direct oral anticoagulants (rivaroxaban, apixaban, dabigatran, edoxaban), providing anticoagulant therapy is continued.

Do not offer additional pharmacological or mechanical VTE prophylaxis to patients who are having full anticoagulant therapy (for example, Fondaparinux sodium, LMWH or UFH).

7.8 VTE prophylaxis in pregnancy and up to six weeks post-partum

Please refer to separate policy for Obstetrics: Maidstone and Tunbridge Wells NHS Trust. *Venous Thromboembolism (VTE) in Pregnancy and Puerperium*

7.9 Lower limb immobilisation and LMWH

Immobilisation is defined as rigid immobilisation in plaster or fibre-glass. This specifically excludes removable devices such as walking boots or cricket-pad splints as there is no evidence for VTE prophylaxis in these patients. There is no evidence for VTE prophylaxis in upper limb injuries.

The use of prophylactic LMWH is effective at reducing incidence of VTE in ambulatory patients with lower limb immobilisations. If commenced, prophylactic LMWH should be

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given for the duration of immobilisation. The use of LMWH is associated with low rates of heparin induced thrombocytopenia (HIT) and major bleeding when used for thromboprophylaxis in ambulatory patients with cast immobilisation.

8.0 Patient information and consent

Treatment and care should take into account patients' needs and preferences. People admitted to hospital should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. If patients do not have the capacity to make decisions, healthcare professionals should follow the Policy and Procedure for Consent to Examination or Treatment written with regard to the Department of Health's advice on consent and the Mental Capacity Act.

Good communication between healthcare professionals and patients is essential. It should be supported by evidence-based written information tailored to the patient's needs. Treatment and care, and the information patients are given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English.

All patients admitted to hospital will receive a patient information document, produced by the Trust, relating to the prevention of thromboembolism, i.e. one of the following:

- Blood clots (thrombosis), Preventing hospital acquired
- Blood clots (thrombosis), Preventing hospital acquired
- Blood clots (thrombosis), Preventing hospital acquired; information for maternity patients.
- Blood clots (thrombosis), Preventing hospital acquired; information for maternity patients.

This information will be used to obtain verbal consent from the patient allowing healthcare staff to assess and where necessary provide prophylactic treatment to the patient to reduce the risk of VTE.

Ward medical and nursing staff must be completely familiar with the patient information provided, enabling them to answer general questions that may arise while obtaining verbal consent.

9.0 Discharge

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On discharge, all patients and/or their families / carers will be informed of the signs and symptoms of DVT and PE and the importance of seeking medical help if this is suspected.

If discharged with VTE prophylaxis (pharmacological and/or mechanical), patients and/or their families or carers will be given verbal and written information on the correct use and duration of VTE prophylaxis at home and who to contact if problems occur.

If VTE prophylaxis is either pharmacological or mechanical, the patient and/or their family should be shown how to use it. The patient's GP must be notified that the patient is being discharged with VTE prophylaxis.

Patients should be advised to wear their anti-embolism stockings until they regain their usual mobility or longer if advised. When patients are discharged with anti-embolism stockings, it should be ensured that they are able to remove and replace the stockings for daily hygiene needs or that they have someone who can do this for them. Patients should also be informed to check for skin marking, blistering or discolouration, particularly over heels and bony prominences.

10.0 Anti-embolism stockings (AES)

Anti-embolism stockings (AES) exert graduated circumferential pressure from distal (below knee) to proximal (above knee) regions of the leg. They work to help prevent the formation of thrombosis (blood clot) by promoting increased blood flow velocity in the leg veins by compression of the deep venous system, and by reducing venous dilatation.

One of the purposes of this Policy is to ensure that anti-embolism stockings are correctly supplied, applied and utilised, and that their use is not contraindicated.

Correctly applied, in the absence of contra-indications, anti-embolism stockings are a safe and non-invasive therapy for reducing the incidence of venous thromboembolism by the promotion of venous blood flow.

Anti-embolism stockings can be used as a therapy on their own or as an adjunct to low molecular weight heparin in patients who have been clinically assessed as having a risk of venous thromboembolism. AES can be used in conjunction with IPCD.

It is important to ensure safe application through assessment, measurement and application to ensure patients receive the correct management.

Patients should be informed of decisions about their care and treatment.

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10.1 Indications for AES

Indication for use of AES - All patients admitted to hospital are eligible for anti-embolism stockings as part of their thromboprophylaxis based on an up to date VTE risk assessment.

Surgical patients: All surgical patients with a risk of VTE (unless anti-embolism stockings contraindicated).

Medical patients: Medical patients with a risk of VTE and for whom anticoagulation therapy (chemical thromboprophylaxis) is contraindicated (unless anti-embolism stockings are also contraindicated).

Obstetric patients: All obstetric patients with a risk of VTE (unless anti-embolism stockings are contraindicated).

Patients admitted to hospital with a diagnosis of, or suspected diagnosis of, deep vein thrombosis or pulmonary embolism should follow the Policy and Procedure for Diagnosis and Management of VTE and not this prophylactic plan.

10.2 Contraindications for AES

- Acute stroke patients
- Patients with suspected or confirmed peripheral arterial disease
- Patients who are receiving high dose vasopressor inotropes
- Patients with severe dermatitis
- Patients with very fragile 'tissue paper' skin
- Patients who have recently undergone skin grafting
- Patients with an allergy to the stocking fabric
- Patients with peripheral neuropathy
- Patients with cardiac failure
- Patients with massive leg oedema
- Patients who have an unusual leg size or shape or deformity preventing correct fit
- Venous ulcers or wounds

10.3 Caution for use of AES

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Use caution in patients with sensory impairment e.g. patients undergoing mechanical ventilation, sedated patients or those with an epidural – check skin integrity twice daily.

Use caution in patients with diabetes mellitus and assess for sensory impairment.

10.4 Pre requisites for practitioners Registered Nurse / Midwife / Doctor with appropriate training and experience.

Clinical Support Workers (CSW) with appropriate training and experience.

Student nurse / midwife under the supervision of a registered nurse / midwife.

Use in accordance with manufacturer's guidelines.

11.0 Intermittent pneumatic compression devices (IPCD)

Intermittent pneumatic compression devices (IPCD) work by augmenting venous blood flow velocity, thus reducing venous stasis and by enhancing early fibrinolytic activity to reduce the risk of clot formation.

The garments, which can be either leg sleeves or foot cuffs, compress the limbs to enhance venous blood movement. After the compression and then release, the controller waits for a period of time before the next compression is initiated.

Correctly applied, in the absence of contra-indications, intermittent pneumatic compression devices are a safe and non-invasive therapy for reducing the incidence of venous thromboembolism by the promotion of venous blood flow.

Intermittent pneumatic compression devices are useful as a therapy on their own in VTE prevention for both medical and surgical patients where there is an identified risk of VTE together with a risk of bleeding. They can be also used as an adjunct to low molecular weight heparin in patients who have been clinically assessed as having a risk of venous thromboembolism. IPCD can be used in conjunction with AES.

It is important to ensure safe application through assessment, measurement and application to ensure patients receive the correct management.

Patients should be informed of decisions about their care and treatment and their consent obtained prior to use wherever possible. This should be documented in the healthcare record

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11.1 Indications for use of IPCD

Indication for use of IPCD - All patients admitted to hospital are indicated for (and eligible for) intermittent pneumatic compression devices as part of their thromboprophylaxis based on an up to date VTE risk assessment.

11.1.1 Surgical patients

IPCD are used widely within the operating department for surgical patients with a risk of VTE who will be on the operating table for 30 minutes or more (unless IPCD contraindicated), either alone or in conjunction with chemical thromboprophylaxis and/or another form of mechanical thromboprophylaxis, for example anti-embolism stockings.

IPCD are also used in the immediate post-operative period (unless IPCD contraindicated), particularly in orthopaedic hip and knee joint replacements, gynaecology surgery and obstetric caesarean section surgery, either alone or in conjunction with chemical thromboprophylaxis and/or another form of mechanical thromboprophylaxis, for example anti-embolism stockings.

11.1.2 General medical patients

IPCD are indicated for medical patients with a risk of VTE, where both anticoagulation and anti-embolism stockings are contraindicated (unless IPCD are also contraindicated).

11.1.3 Acute stroke medical patients

Patients admitted to hospital with a diagnosis of, or suspected diagnosis of, deep vein thrombosis or pulmonary embolism should follow the Policy and Procedure for the Diagnosis and Management of

VTE. IPCD should not be applied until resolution of the clot has been confirmed with diagnostic testing. The time frame for this is individual to each patient.

11.2 Contraindications for use of IPCD

- Patients with an acute or suspected DVT or PE
- Patients with suspected or confirmed peripheral arterial disease
- Patients with severe dermatitis
- Patients with a leg wound
- Patients with very fragile 'tissue paper' skin

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- Patients who have recently undergone skin grafting
- Patients with an allergy to the fabric of the sleeve
- Patients with peripheral neuropathy
- Patients with massive oedema of the legs or pulmonary oedema from congestive heart failure
- Patients who have an unusual leg size or shape or deformity preventing correct fit

This is not an exhaustive list.

11.3 Cautions for the use of IPCD

Use caution in patients with sensory impairment e.g. patients undergoing mechanical ventilation, sedated patients or those with an epidural – check skin integrity twice daily.

Use caution in patients with diabetes mellitus and assess for sensory impairment.

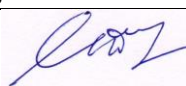
Use caution in patients who are receiving high dose vasopressor inotropes.

11.4 Pre-requisites for practitioners

- Registered nurse / midwife / doctor with appropriate training and experienced Clinical Support Workers (CSW) with appropriate training and experience.
- Student nurse / midwife under the supervision of a registered nurse / midwife.
- Use in accordance with manufacturer's guidelines

12.0 Monitoring and audit

- Completion of VTE risk assessments will be entered onto the Patient Administration System and data is extracted and available daily. Retrospective periods can also be viewed. Data is submitted via Unify as required by the Department of Health.
- Audits of VTE risk assessment and thromboprophylaxis will be undertaken and data submitted to local commissioners if requested. Frequency of audits will be determined by the Thrombosis Committee. Auditors will vary, audits may be delegated to directorates to complete or completed centrally by the VTE Lead Nurse.
- Other formal audits of VTE risk assessment and thromboprophylaxis may be undertaken with support from the audit department.

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- Random spot check audits will be carried out ad hoc to ensure that VTE risk assessment, prescription of chemical thromboprophylaxis and data capture processes are being followed. The results of which will be shared appropriately.
- Information from formal audits and the data capture will be reported at ward level and to the Directorates, Thrombosis committee and trust executives.
- The VTE Prevention policy and procedure document will be reviewed every three years.

All hospital acquired VTE incidents should be reported either verbally to the VTE Lead Nurse or by using the e-reporting system. Investigation and root cause analysis (RCA) will be undertaken on all hospital acquired VTE incidents. Actions arising from VTE RCA and / or VTE serious incident investigations will be added to the VTE trust wide action plan.

12.1 APPENDIX ONE

Process requirements

1.0 Implementation and awareness

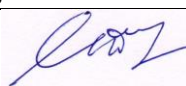
- Once ratified the document lead or author will submit this policy/procedural document to the Clinical Governance Assistant who will activate it on the Trust approved document management database on the intranet, under 'Trust policies, procedures and leaflets'.
- A monthly publications table is produced by the Clinical Governance Assistant which is published on the Trust intranet under "Policies"; notification of the posting is included on the intranet "News Feed" and in the Chief Executive's newsletter.
- On reading of the news feed notification all managers should ensure that their staff members are aware of the new publications.
- The policy will be disseminated to all clinical staff and ward areas.
- The policy/procedure will be launched via cascade through directorate nurse managers.

2.0 Review

This policy/procedure will be reviewed once every three years, as a minimum; however, if changes in legislation or Trust practice require, amendments will be made following Trust consultation and approval procedures.

3.0 Archiving

The Trust approved document management database on the intranet retains all superseded files in an archive directory (obsolete register) in order to maintain document history.

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AMENDMENT SHEET

Sl. No	Current Revision			Nature of Change
	Edition No	Revision No.	Date	
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 the 6 th Edition
5	01	02	1 Jan 2026	No changes.

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POLICY ON USE OF RESTRAINTS (PHYSICAL & CHEMICAL)

POLICY ON USE OF RESTRAINTS (PHYSICAL & CHEMICAL)

1. Purpose

To ensure that restraints are used **only when absolutely necessary**, in a **safe, ethical, and legally compliant manner**, with protection of patient dignity, rights, and safety.

2. Scope

Applicable to:

- All inpatients (IPD)
- Emergency & ICU patients

3. Definitions

As per your consent form :

- **Restraint:** Any method (manual, physical, mechanical, chemical, or psychological) that restricts a patient's voluntary movement.

Types:

- **Physical restraint** – Manual or mechanical restriction
- **Mechanical restraint** – Devices (belt, mittens, wrist restraints)
- **Chemical restraint** – Sedative medications
- **Psychological restraint** – Verbal restriction (discouraged)

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POLICY ON USE OF RESTRAINTS (PHYSICAL & CHEMICAL)

4. Policy Statement

4.1 Restraints shall be used **only as a last resort** when:

- Patient poses risk to **self or others**
- Essential treatment is at risk (e.g., pulling tubes)

4.2 Restraints shall:

- Be **least restrictive**
- Be used for **minimum duration**
- Be **regularly reviewed**

4.3 **Patient dignity, privacy, and rights** shall be maintained at all times.

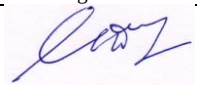
5. Identification of Vulnerable Patients

As per MRD form:

- Patients marked as **“Vulnerable”**
- Identified using **Yellow Wrist Band**

Includes:

- Elderly
- Confused/disoriented patients
- ICU/sedated patients
- Paediatric patients
- Psychiatric or cognitively impaired patients

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6. Indications for Restraint

Based on your Section I:

- Pulling IV/arterial lines
- Pulling endotracheal tube / Ryle's tube
- Removing monitoring devices
- Severe agitation / fall risk
- Risk to self or others

7. Alternatives (MANDATORY before restraint)

As per your Section II:

- Reorientation and reassurance
- Environmental safety optimization
- Access to call bell, water, assistance
- Pain/medical cause evaluation (e.g., hypoxia)
- Engagement/redirection

Restraint only if these fails

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POLICY ON USE OF RESTRAINTS (PHYSICAL & CHEMICAL)

8. Authorization Process

8.1 Physician Order (Mandatory)

- Type of restraint specified
- Duration clearly defined
- Signed by treating physician

(Ref: Section IV)

8.2 Consent

- **Informed consent mandatory** from patient/representative
- Must include:
 - Reason
 - Type
 - Risks/discomfort

(Ref: Consent form)

8.3 Emergency Use

- Can be initiated by nurse in emergency
- Must be:
 - Documented
 - Physician informed immediately
 - Order obtained retrospectively

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9. Application of Restraint

- Use **approved restraint devices only**
- Ensure:
 - Proper positioning
 - No circulatory compromise
 - Padding applied where required
- Never:
 - Tie to movable side rails
 - Apply excessively tight restraints

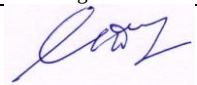
10. Monitoring & Care

Continuous monitoring required:

- Circulation (color, pulse, temperature)
- Skin integrity
- Level of consciousness
- Comfort and distress

Frequency:

- As per clinical condition (typically every 2 hours in ICU /4 hours in ward) but more frequently if the patient is agitated and pulling at the physical restraints or if multiple drugs which may cause sedation are administered.

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POLICY ON USE OF RESTRAINTS (PHYSICAL & CHEMICAL)

Care during restraint

- Release periodically (if safe)
- Provide:
 - Hydration
 - Nutrition
 - Toileting
 - Position change

11. Documentation (CRITICAL)

Must be recorded in MRD Form 78:

- Indication
- Alternatives attempted
- Patient response
- Type of restraint
- Time of initiation & removal
- Monitoring entries
- Education given

12. Education

As per Section V:

- Patient/family shall be informed about:
 - Need for restraint
 - Temporary nature

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POLICY ON USE OF RESTRAINTS (PHYSICAL & CHEMICAL)

- Safety precautions

13. Discontinuation

Restraints shall be removed:

- As soon as risk reduces
- On physician review

Daily reassessment mandatory

14. Special Considerations

14.1 Vulnerable Patients

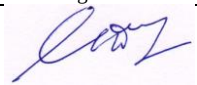
- Extra caution required
- Frequent monitoring
- Avoid prolonged restraint

14.2 Paediatric Patients

- Parent involvement preferred
- Use minimal restraint

14.3 Elderly

- High risk of injury
- Avoid unless essential

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POLICY ON USE OF RESTRAINTS (PHYSICAL & CHEMICAL)

14.4 Chemical Restraint

- Only by physician order
- Monitor for:
 - Respiratory depression
 - Over-sedation

15. Prohibited Practices

- Use for:
 - Convenience
 - Staff shortage
 - Punishment

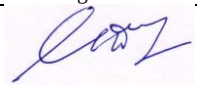
16. Incident Reporting

- Any injury due to restraint:
 - Must be reported
 - Root cause analysis done

17. Audit & Quality Monitoring

- Restraint usage reviewed by:
 - Nursing team
 - Quality team

Indicators:

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POLICY ON USE OF RESTRAINTS (PHYSICAL & CHEMICAL)

- % patients restrained
- Duration of restraint
- Adverse events

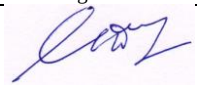
18. Governance

- Approved by **Patient Safety & Quality Committee**
- Periodic review and training conducted

Annexure

Restraint Form

Informed consent for restraint

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POLICY ON USE OF RESTRAINTS (PHYSICAL & CHEMICAL)

REFERENCES : NABH 6TH EDITION 16 e

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1	01	00	1 Oct 2019	First issue as per NABH Hospital Accreditation Standards – 4 th Edition
2	01	01	1 Nov 2020	Minor Revisions, updating Doc No. 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	Amended as per the 6 th Edition.
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	Policies & Procedures for Pain Management		

1.0. Purpose

To provide guidelines for a comprehensive approach to the needs of patients who experience both acute and/or chronic pain.

2.0. Policy

It is the policy of Saideep Hospital to utilize an interdisciplinary approach to the management of pain in order to eliminate or minimize pain. The patient's report of pain shall be accepted as the key indicator of the amount of pain experienced. While acknowledging all forms of pain cannot be controlled in all patients all the time, every effort shall be made by the medical team to:

- i) Recognize the right of individuals to appropriate assessment and management of pain
- ii) Plan, support, and coordinate activities and resources to ensure that the pain of all individuals is recognized and addressed appropriately
- iii) Provide individualized care in settings responsive to specific needs
- iv) Provide education on pain management as part of the patient's treatment
- v) Work with the patient to set, develop and implement a plan to reach a goal for pain relief
- vi) Develop plan in conjunction with the patient, if on discharge the patient has pain, to address management at home

Monitor the performance of the pain management program

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4.0 Definitions

Acute Pain: Short term, self-limited pain with a probable duration of less than 6 months; expected to resolve when the tissue heals.

Chronic Pain: Pain that persists or progresses over a long period of time. In contrast to acute pain that arises suddenly in response to a specific injury and is usually treatable, chronic pain persists over time and is often resistant to medical treatments.

5.0 Assessment

5.1 A patient's report of pain will be accepted and respected as they key indicator of the amount of pain he/she is experiencing. Medical/nursing staff will assign the rating only if the patient is unable to report their pain.

5.2 The presence of pain is assessed on admission to the hospital, at the initial OPD/ Emergency visits, post invasive procedure and when the patient complains of pain. The assessment is performed by: a physician and assigned staff nurse. The assessment should be documented in the medical record.

5.3 The frequency of pain reassessment shall be documented during each shift by the nursing staff. However, when pain is present, a pain reassessment is generally performed hourly and more often as needed. The physician is notified of the patient's pain when treatment fails to reduce the pain to a level acceptable to the patient, as ordered by the physician, or pain score > 4 using the approved Pain Scales. If no pain is present, the licensed healthcare provider will reassess

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for pain as warranted by patient condition, when the patient complains of pain and post invasive procedure.

5.4 Pain Rating and Pain Assessment

- i. **The Numeric Pain Intensity Scale** will be used universally to assess pain for patients 12 years or older. Patients will be asked to rate their pain a scale of 0-10. Zero represents no pain; a rating of 5 would indicate that the patient is experiencing moderate pain, and a rating of 10 would indicate the worst imaginable pain.
- ii. **The Wong-Baker Faces Pain Scale**, consisting of graduated facial expressions of pain, will be used for patients, age 7years – 12 years, and those unable to comprehend the numerical scale. Zero will represent no hurt and a rating of 10 would indicate the patient is experiencing the worst possible hurt. This scale will also be used for adults with cognitive impairment.

5.5 If pain is present, a more comprehensive assessment is performed,

Which may include?

- i) Onset
- ii) Intensity (Numerical 0 -10, Wong-Baker Face Scale,)
- iii) Location(s) (All pain locations are assessed)
- iv) Other symptoms
- v) Variation

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- vi) Alleviating and aggravating factors
- vii) Present pain management regimen and effectiveness
- viii) Medication history

5.6 Physical examination:

- i) Mental status examination
- ii) Motor and sensory examination
- iii) Reflexes
- iv) Gait
- v) Maneuvers targeted to pain diagnoses

5.7 Documentation of pain, for all patients, should include the following:

- i) Type of pain and/or location
- ii) Intensity scale
- iii) Level of consciousness
- iv) Respiratory rate
- v) Activity
- vi) Medication
- vii) Patient and family education
- viii) Treatment goal

6.0 Treatment

Pain is managed by pharmacological treatment, non pharmacological treatment, and interventional procedures.

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6.1 Pharmacological treatment may include non-opioids, opioids, and adjuvants.

6.2 Perioperative Techniques for Pain Management

For perioperative pain control, the commonly employed techniques include but are not limited to

- i) Oral non-steroidal analgesic anti-inflammatory drugs
- ii) Systemic (intramuscular or intravenous) opioids,
- iii) Regional analgesic techniques (e.g. epidural or intrathecal opioids / local anesthetic agents, intercostal blocks, interpleural blocks, plexus blocks, and local anesthetic infiltration of incisions).

These techniques will be used, either alone or in combination, by the attending clinician when considered appropriate and feasible.

6.3 Non pharmacological treatment may include physical interventions and cognitive behavioral strategies.

- i) Physical interventions may include:
 - a. Heat
 - b. Cold
 - c. Exercise
 - d. Physical/Occupational therapy
 - e. Immobilization
 - f. Massage

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ii) Cognitive behavioral strategies may include:

- a. Distraction
- b. Relaxation
- c. Guided imagery
- d. Other coping strategies

7.0 Documentation

7.1 Nursing Admission Assessment

8.0 Patient / Family Education

8.1 Patient education may focus on fears commonly held by patients in pain, including:

- i) Fear of drug addiction,
- ii) Fear of drug dependence,
- iii) Fear of drug tolerance,
- iv) Fear of appearing uninformed or unable to understand

8.2 Educational content may include:

- i) Definitions of physical dependence, drug tolerance, and addiction
- ii) Explanation of pain intensity scales
- iii) Explanation of various modes of treatment

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Policies & Procedures for Nutritional Therapy			

PURPOSE

- 1.1 To ensure diet provided to each patient is based on their diagnosis, physiological and metabolic requirements and social needs of the patients.
- 1.2 To educate the patients and their attendants for their nutritional requirements as a part of their treatment and continuity of Nutritional care at home.

SCOPE

Hospital wide

PROCEDURE

- 3.1 The nurses inform the dieticians about the new patient's arrival, their Height & weight, and any metabolic derangement, whether Veg, Diabetic / Non Diabetic.
- 3.2 The nutritional assessment is done with the basic criteria's of height, weight, sex and metabolic criteria of the patient.
- 3.3 Doctors explain the dietician the amount of calories, proteins, fats and carbohydrates to be taken by the patient on the basis of patients' clinical condition.
- 3.4 Communication
- 3.4.1 Nurse in charges pass the information of prescribed diet to the dietician regularly through the requisitions at the scheduled time.

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3.4.2 Communication for diet regarding new admissions changes in diet plan and shifting will be communicated to the Dieticians' help desk through phone calls.

3.5 A diet schedule is prepared by the dietician as per the clinical needs of the patient and on the advice of the doctor. A Diet Card is maintained for the patient's on oral feed.

3.5 Nutritional therapy is planned and provided in a collaborative manner by the doctors and the dieticians.

- In critical areas where the patient is not able to tolerate normal calories for the day, a diet chart is maintained, where daily calorie intake of the patient is calculated.
- The patient's who are on the Ryle's Tube feed (enteral fed); the nurse maintains a Critical Care Nutrition chart in which the dietician calculates the energy, protein, carbohydrates and fats on the doctor's advice.
- The critically ill patients who cannot be fed by enteral route are kept on parenteral nutrition feed.
- The composition of parenteral nutrition is decided by doctors on individual patient's condition and requirement.

3.6 The doctors and the dieticians do the reassessment collaboratively based on the reports of relevant investigations.

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	Policies & Procedures for End of Life Care		

INTRODUCTION

The care of a patient and family prior to, during and following death is one of the most significant and sensitive aspects of care in which a member of staff can be involved.

Consideration must be given to the wishes of the patient if known regarding cultural and religious preferences, the family circumstances and the legal situation in relation to death.

PURPOSE AND SCOPE

The purpose of this policy is to;

- Addressing legal aspects involved in end of life care situations including medico-legal cases.
- Addressing unique needs of patients and family.
- Sensitive handling of situations involving autopsy and organ donations.

RESPONSIBILITIES

Clinical Staff

The attending doctors / clinical unit is responsible for ensuring provision of end of life care as per hospital policies.

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Nursing Staff

Ward / Unit Nurses are responsible for ensuring that patients and family wishes are addressed in a sensitive manner in accordance with the hospital policy.

POLICIES

End of Life care.

- Medical decision like Do not Resuscitate (DNR), pain management is discussed by the treating M.O professor in detail with the patient's next of kin.
- Currently no organ donation is followed at our hospital & so, no such policy regarding this has been framed.
- As per our hospital norms, relatives are not allowed to enter the ICU/ SICU; except during strict visiting hours.
 - Considering the condition of the patient respecting the religious & cultural belief, relatives are allowed to enter one by one, after they have been briefed about the patient's condition by Doctor.
- Declaration of death is done by duty M.O
- Death of patient will be informed to the night supervisor on immediately duty & M.S the next Day.
- Death is recorded & signed by the duty M.O in the Death Register.
- Birth & Death registration department is functioning during day time. This department informs all birth & death to the local authorities by online with in 48 hrs.
- Saideep Hospital is committed to delivering high quality sensitive care to individuals identified as in the end of life stage.

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- Due to the specialist and sensitive nature of neonatal and pediatric deaths separate policies and procedures have been prepared and implemented as per the Pediatrics department policies and procedures.
- In some situations death is anticipated and this gives both the patient and their family time to express their wishes regarding a plan of care and for the actions that will take place once death has occurred.
- Request for pain relief from patients identified as end of life and their relatives will be accorded high priority. The treating unit will prescribe medication to ensure that the patient do not suffer avoidable pain in the last days of his life. Palliative care physicians / anesthetists may be called in to ensure that suitable medications are used as per circumstances.
- Family visits will be arranged if required in relaxation of the normal visiting policies to ensure appropriate sensitivity to the wishes of the patient and family.
- Nurses and PG's will only verify death, only registered medical practitioner will certify death.
- Following the event death it is very important that the families are supported and all the necessary administration is appropriately completed to avoid further distress to the family.

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- In case of delay in releasing the body the same is shifted to the mortuary and facility for mourning / bereavement provided at the location.
- In case of death in Medico Legal Cases the police is informed immediately; and body is handed over to the police.
- All death cases requiring autopsy by law are also handed over to the police.
- In case of relatives requesting for an autopsy in cases where it is not required as per law the police is informed and arrangement for the shift to government hospital with autopsy facility is done as per family request in writing.
- In cases where the patient has expressed a desire for organ donation or is an organ donor card holder; the relatives consent for organ harvest will be sought in sensitive manner. The consent for organ harvesting from the legal heirs is a must to proceed even if the patient has expressed his desire for the same prior to his death.
- In cases where the patient is requesting for arrangements for donation prior to death; his family may be involved at that stage and consent obtained. However such consents have to be revalidated by the legal heirs again post death.
- In case any patients want to make a dying declaration the R.M.O will be contacted to arrange for a judicial official to record the same. In case such

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arrangements cannot be made in a short notice RMO or attending doctor can record the same with in the presence of witnesses.

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