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CENTRE NAME
CENTRE ADDRESS

DOCUMENT NAME	**POLICY MANUAL- ACCESS, ASSESSMENT AND CONTINUITY**
DOCUMENT NUMBER	**AAC/JSL/01**
DATE OF CREATION	**01/05/2021 – 6 MONTH AGO TODAY**
DATE OF IMPLEMENTATION	**03/05/2021 – AFTER 2 DAYS OF CREATION DATE**
DATE OF REVIEW	**30/04/2022- AFTER ONE YEAR OF CREATION DATE**
PREPARED BY	**Name & Designation: DOCTOR NAME DESIGNATION OF DOCTOR Signature:**
REVIEWED BY	**Name & Designation: DOCTOR NAME DESIGNATION OF DOCTOR Signature:**
APPROVED BY	**Name & Designation: DOCTOR NAME DESIGNATION OF DOCTOR Signature:**
ISSUED BY	**Quality Department**

AMENDMENT SHEET

Sl. No.	Section No & Page No	Details of amendment	Reasons	Signature of preparatory authority	Signature of approval authority
1.					
2.					
3.					
4.					
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Prepared by	Reviewed by	Approved by	Issued by
Dy PHYSICIAN	. **DOCTOR NAME**	CMO & SUPERINTENDENT	QUALITY DEPT

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1	CMO & Superintendent/Manager (Admin.)
2	. **DOCTOR NAME**
3	Physicians
4	Reception

1. THE ORGANISATION DEFINES AND DIPLAYS THE SERVICES THAT IT PROVIDES

1.1. PURPOSE:

To define and enlist the services provided by the hospital, keeping in mind the scope of services and the needs of the community

1.2. SCOPE – FACILITIES & SERVICES OF CENTRE

All patients availing treatment (IP/OP) at their family members and visitors

Hospital Wide:

1. Ayurvedic Consultancy (आयुर्वेदिक परामर्श)
2. Abhyangam (अभ्यंगम)
3. Diet Consultation (आहार परामर्श)
4. Ayurvedic Medicine(आयुर्वेदिक दवाई)
5. I.P.D
6. Deepan (दीपन)
7. Pachana (पाचन)
8. Snehana (स्नेहन)
9. Swedana 9.(स्वेदन)
10. Udavartan (उर्धवर्तन)
11. Panchkarma Treatment(पंचकर्मा चिकित्सा)
12. Vamanam (Emesis) (वमन)
13. Virechana (Purgation) (बिरेचन)
14. Nasyam (Nasal therapy) (नस्यम)
15. Raktamokshna (रक्तमोक्षण)
16. Matra Basti (मात्रा बस्ती)
17. Asthapana Basti अस्थापन बस्ती
18. Anuvasana Basti (Oil enema)अनुवासन बस्ती
19. Samsarjana Karma (संसर्जन कर्म)
20. Paschatkarma(पश्चात्कर्मा)
21. Shamanadi Chikitsa Special(विशेष समनादि चिकित्सा)
22. Shirodhara(शिरोधारा)
23. Shiro Pichu (शिरोपिच्चू)
24. Shirobasti,Janu Basti,Kati Basti, Greeva Basti (शिरोबस्ती, जानू बस्ती,कटी बस्ती, ग्रीवा बस्ती)
25. Rasayana Chikitsa (रसायन चिकित्सा)
26. Leech Therapy (जलौका)
27. Agni Karma (अग्नि कर्मा)
28. Alabu (cupping) अलाबु (कपिंग)
29. Vridha karma (विधा कर्मा)
30. Patra Pottali Pinda Sweda (पतरा पोटली पिंडा स्वेद)
31. Shashtika Shali Pinda Sweda (षष्टिका शाली पिंडा स्वेद)
32. Parisheka (परिषेक)
33. Panchkarma Poorvakarma (पंचकर्मा पूर्वकर्म)

1.3. RESPONSIBILITY:

CMO & Superintendent / Manager (Admn.)

1.4. POLICY

Various services provided by the hospital shall be known to the public at all levels of care

1.a. The services being provided are clearly defined and are in consonance with the needs of the community.

List of Service Provided:

Clinical Services:

i. Poorva karmas

- Snehana
- Swedana

ii. Pradhana Karmas

- Vamanam
- Virechanam
- Nasyam
- Raktamoksham
- Sneha vasthi
- Kashaya Vasthi

iii. Paschat karma

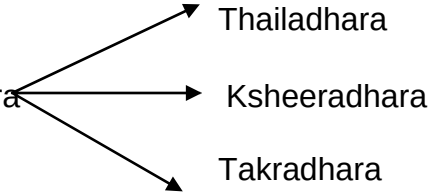
- Samsarjana karma
- Rasayana chikitsa

iv. Special procedures

- Vaman
- Virechana
- Alabu
- Vidha karma
- Agnikarma

v. Keraliya panchkarma

- Dasamula ksheeradhara
- Dhanyamladhara
- Prishta vasthi
- Njavara kizhi
- Pizhichil
- Sarvangadhara



- Siro vasthi
- Thalapothichil
- Tharpanam
- Udwartanam
- Upanaham
- Lepanam

vi. <u>Supportive services:</u>

- Hospital Kitchen
- Dispensary.
- Kashayam section
- House Keeping
- Laundry
- Maintenance

vii. <u>List of services not available</u>:

- Emergency services
- Rehabilitation
- Research services.
- Surgical procedures.
- Prasoothi tantra
- Imaging services.
- Dental services
- ICU

b. The list of services provided are prominently displayed

i. The list of services provided and provided is prominently displayed bilingually in the OP area.

c. The staff is well oriented to these services

i. All the staff is well oriented on the scope of services continuous training and discussions have been undertaken on regular basis.

ii. The staff at reception is well aware about the OPD days, availability of Physicians, room booking procedures, general information about the hospital and about the institution.

02. THE HOSPITAL HAS A WELL DEFINED REGISTRATION AND ADMISSION PROCESSES

2.1. PURPOSE:
To define the registration and admission policies and process at the hospital

2.2. SCOPE:Hospital wide
All Patients visiting the hospital, for OP consultation and IP Care.

2.3. RESPONSIBILITY:
Manager Administration.

2.4. POLICY:
The OP consultation at this hospital is free of charge as practiced in all the Branches and hospitals of CENTRE NAME.

a. Documented policies are used for registering and admitting patients

i. All patients coming for OP consultation shall register at the OP registration counter after complying with the registration process.

ii. They shall fill up the registration form/give particulars as required

iii. The Patient is then registered through software and the Unique ID is generated.

iv. The first part of OP case sheet (demographic details) is filled up at the reception and then send to the concerned Physician

v. Patient search facility using mobile number/address etc are utilized in case of missing prescription

vi. After consultation, the patient is directed to the dispensary and they can procure medicines from there

vii. Leaflets/ instructions etc as per the prescription are issued to the patient from the OP Reception counter

viii. In case of admission, advised after consultation, the patient is directed to the administrative office for room related matters meanwhile patient can wait at waiting area at ipd section building. If a room is ready, the same is shown to the patient and as per requirement the admission is processed.

ix. Otherwise an advance reservation is made in the name of the patient and they are informed as per room availability.

x. Admission to the hospital is fully based on the recommendation of the Physician and as per room booking and availability of room.

b. Documented policies and procedures address out patients, in patients and emergency patients

i. Emergency cases are not entertained as per the policy of the hospital. In case any such case reports to OP, they are advised to contact the nearest modern medicine hospital, after imparting possible first aid/ CPR etc as per the need of the case with valid reffral form.

ii. An ambulance as per the need of the case is arranged from the outsourced service provider.

iii. A doctor/ Nurse shall accompany the patient depending on the severity of the case.

iv. A referral letter would be given to the patient.

v. In case an emergency arises for an admitted patient, the following arrangements are put in practice:

- The Nursing Asst/Therapist who is attending the case shall evaluate the condition and if need
  be announces CODE BLUE. The case is then managed as mentioned in the code blue manual
- In all other cases the information with regard to the emergency is passed on to the physician in charge of the case who in turn reaches the spot and evaluates the condition and plans urgent further management
- In case the further management is beyond the scope of the available services, the case is then referred to the referral hospital.
- The procedures as required for referral case are then followed up.

c. A unique identification number is generated after registration.

i. After registration at the OP a UHID is generated from software and manually by OPD Register at reception.

ii. This number remains as UHID throughout the care/service period. And when admitted, an IP number is also generated**.**

d. Patients are accepted only if the organization can provide the required service.

i. The staff at the admission desk/ OP counter is aware of the services provided by the hospital (As defined in AAC.1.a). Continuous in-house trainings are conducted for all categories of staff. They are also advised to explain in detail about the scope of services and its limitations to the patient

e. Documented policies and procedures also address managing patients during Non-Availability of Beds:

i. The hospital accepts patients only as per the availability of beds. All admissions are pre planned, well in advance and patient comes to the admission counter with confirmed room booking information.

ii. In case a need for an emergency admission arises, after consultation in the OP, an available room is allotted to the patient, and if not available the details of the patient are

taken down and the patient is requested take up a stay nearby and is advised to

iii. continue the oral medications, as advised by the Physician. All efforts are put in, to admit the patient on the next day. Enquiries are also made to CENTRE NAME If the patient is willing to take up admissions in these hospitals they are advised accordingly. Alternatively the patient is advised to go home and to keep in touch with office.

f. The staff is aware of this process.

The staff at OP counter and at IP admission desk is well aware about the admission process. Required leaflets, brochure etc are made available in the respective counters. The patients are advised to contact Manager Admin in case their requirements are not fulfilled in an expected manner.

g. Maintenance of daily record of bed occupancy with monthly conclusion of occupancy

Software is installed in the hospital is equipped to generate bed occupancy , CENTRE NAME also having daily bed occupancy register and other connected reports in a need based manner as part of MIS

AAC 03: THERE IS AN APPROPRIATE MECHANISM FOR TRANSFER AND REFERRAL OF PATIENTS WHO DO NOT MATCH THE ORGANIZATIONAL RESOURCES

3.1. PURPOSE:
To define policies and procedures for transfer of patients or referral of patients who do not match the scope of service.

3.2. SCOPE: Hospital Wide
Stable and Unstable patients (IP & OP), who do not match the scope of services provided by the hospital.

3.3. RESPONSIBILITY:
Sr. Physician of the ward / OP/duty Physician/ Nurse/ Nursing Asst. /Care Taker

3.4. POLICY:
the patient's need, he/she shall be referred /transferred, after stabilizing reasonably, depending on the severity of the situation, to the referral hospital (with which Hospital has signed an MOU)

a. Documented policies and procedures guide the transfer of patients to another facility in an appropriate manner.

Admitted patient may need transfer to referral hospital on the following grounds:

i) The condition of the patient is beyond the scope of Ayurvedic Management.
ii) The treating Physician may opt for an opinion from a modern medicine doctor.
iii) For diagnostic purposes
iv) The patient may request for a referral
v) LAMA cases which may require referral, based on conditions of the patient.

b. Documented policies and procedures guide the transfer of stable/unstable patients
Unstable patient:

i) CPR/ such other emergency managements are carried out as per the need of the patient and as per the established policies
ii) The Sr. Physician/duty Physician contacts Casualty doctor or the concerned doctor of the referral hospital, and explains about the conditions of the patient. A channel of communication is established and a request is made to position an ambulance at the earliest.
iii) The referral hospital is requested to keep the unit/personnel/resources mobilized to stabilize the case on arrival, as per the need.
iv) The procedure remains same for OP department patients. In case of an emergency occurs to any patient/visitor he/she is immediately shifted to the referral hospital.
v) A referral letter is issued as per the standard format
vi) Nursing Asst shall accompany the patient. They shall ensure that all the clinical reports and referral letter are collected and carried along before the patient is shifted.
vii) A Physician shall accompany the patient as per the merit of the case. The physician shall continue the resuscitation (as per the need of the case) till the patient is handed over to

the referral hospital.

viii) The caretaker on duty shall coordinate the movement of ambulance managing of relatives and shifting of patient to the ambulance.

Stable Patients:

i. When a patient needs any specialty treatment which is not commensurate to the scope of the hospital, the concerned Physician opts to shift the patient to the referral facility for opinion/admission, with the consent of the patient.

ii. A referral letter is issued as per the standard format. Nursing Asst shall accompany the case depending up on the need.

iii. They shall ensure that all the clinical reports and referral letter are collected and carried along before the patient is shifted. Service of ambulance is arranged.

iv. The duty caretaker shall coordinate the movement of ambulance as well as the shifting of patient.

c. Procedures identify staff responsible during transfer/referral.

i) In the case of an emergency transfer a doctor/ a nurse shall accompany the case

ii) In the case of routine transfer/ referral a Nursing Asst/therapist shall accompany the case.

iii) In the case of diagnostic purposes Nursing Asst. /Therapist shall accompany the case, depending on the need as decided by the Physician.

iv) Transfer owing to LAMA also shall be accompanied by Nurse/ Nursing Asst as decided by the Physician

v) Caretaker shall coordinate and control the movement at all occasions of transfer

f. The organization gives a summary of patient's condition and the treatment given

i. The treating Physician shall issue a summary of the case detailing about the management being carried out in the hospital and the probable result expected out of it, indicating specific clinical conditions of the patient wherever indicated.

ii. The referral letter shall contain all the required information in this regard.

Guidelines for transfer

- The patient will be identified as medically stable for transfer by the physician responsible for arranging the transfer. This decision must be clearly documented within the health case records and this principle applies to planned and emergency transfers.
- A risk assessment must be carried out before arrangements for transfer are made.
- A decision should be made regarding the number of escorts (if required) for the patient.
- Patients and their relatives must be kept informed of the transfer arrangements before the transfer takes place.

- A photocopy of the healthcare record pertaining to the patient's current care plan (if need arises) and the results of any diagnostic tests, along with a completed, comprehensive and legible transfer letter will accompany the patient

- Detailed records of medicines prescribed, along with patient's own medications, must be sent with the patient to the receiving organization. This record should also include any allergies or adverse reactions known.
- When arranging a transfer, the person responsible for the transfer must speak to a member of the team at the receiving unit who will be receiving the patient and give details of the patient's diagnosis, condition and treatment given. This should also be recorded in the patient's health care record, along with the name of the person who has accepted the patient for transfer.
- The staff member will arrange transport and ensure that the ambulance driver or other escorts are aware of the patient's condition and about any special requirements that the patient may have.
- Before the patient leaves the premises, the bed availability should be checked again with the receiving unit.
- Any discussions about the patient's transfer must be recorded in their healthcare records. It is vital that the patient's identity is established beyond question before any transfer arrangements are made.
- When admitted patient wants to get shifted to another hospital against the advice of the treating physician a LAMA consent shall be got signed from the patient/ responsible person after educating them about the consequences, by the Sr. Physician/ duty Physician

AAC 4. PATIENTS CARED BY THE HOSPITAL UNDERGO AN ESTABLISHED INITIAL ASSESSMENT

4.1. PURPOSE:
To plan and execute proper patient care through an established initial assessment and documented care plan

4.2. SCOPE: Hospital Wide

All patients who visit the hospital, IP/ Op

4.3 RESPONSIBILITY:
Physician/Nursing Assistants

4.4. POLICY: For every patient who visits the hospital for OP/IP, their disease and connected details are assessed by a Physician, and these assessments are carried out in terms and as stipulated in the standard IP/OP Case records

a. The organization defines and documents the content of the initial assessment for the out–patients, in-patients and emergency patients.

i. Two kinds of patient case records are practiced in the hospital, IP and OP

iii. In the case of Out Patient Department a simple format, incorporating demographic details and basic needs of Rogi and Roga Pareeksha, are in use.

iv. In the case of In Patients, a detailed case record incorporating all relevant columns that are elaborately required to derive at a diagnosis and that are more specifically required as part of the general case sheet writing and as stipulated by routine medical practices, is followed

b. The organization determines who can perform the initial assessment.

i. The demographic and other basic columns of the case sheet are completed by the reception staff/nurse.

iii. Rest of the required information is noted down by the Physician after having detailed examination and discussion with the patient.

c. The organization defines the time frame within which the initial assessment is Completed based on patient needs.

i) In the case of OP, generally within 30 minutes to one hour of registration the consultation takes place. However, if the patient arrives very early and prefers to wait, the timing may change.
ii) In the case of special OPs the initial assessment may take place within the stipulated time, but the consultation with the concerned Physician may take a longer time.
iii) Patients with specific appointment shall be consulted as per the preferred timing, as far as possible.

d. The initial assessment for in-patients is documented within 24 hours or earlier as per the patient's condition or hospital policy. Initial assessment includes Identification of medication that the in-patient is using of the relevant AYUSH System, of any other AYUSH system and of modern medicine.

In the case of IP, as soon as the admission related documentation and formalities are over the patient is taken to the respective room from the Administrative Office by the Care Taker. He informs the Ward Physician about the admission to a particular room. The following procedures are then followed:

i. Every patient shall be initially assessed by the physician upon receiving as an IP in the hospital.

ii. The initial assessment for patients shall be completed within one hour of admission in general case, and depending up on the need of the case the assessment shall take place soon after admission.

iii. In the case of admissions after 5 PM, the duty doctor makes the initial assessment.

iv. In case of any urgent need of a medication he shall consult the senior physician (if need arises) and make arrangements to issues the required medicine from the dispensary. The same is noted in the case records and in other relevant registers.

v. Initial assessment shall be done systematically considering the following aspects:

- Family history
- The physical, psychological and social status of each inpatient.
- Medical and surgical history
- screening for nutritional needs
- Observing the details explained by patients.
- Preventive aspects like advice regarding diet, exercise, avoiding tobacco alcohol etc.
- Ambulatory conditions
- Astavidha pariksha
- Dash vidha pariksha
- Nadi pariksha

vi. During the initial assessment requirement of investigations (Imaging/ Lab tests etc) are taken into account in a need based manner as per the prerogative of the treating Physician. Nutritional requirements are also analysed and diet is planned accordingly.

vii. The Investigations are under taken from the empanelled hospitals or outsourced lab or diagnostic center.

viii. Based on the assessments, the Sr. physician shall draw a care plan and document it in the patient file. The care plan shall cover the following:

- Therapeutic needs of the patient
- Preventive needs for the patients
- Repetitive diagnostic needs.
- Medication advice
- Reassessment requirements/ intervals.
- Dieting requirements
- Provisional diagnosis

ix. Patient shall be educated on the care plan arrived at, by the treating physician covering the following aspects:

- Expected results as an outcome of the patient care plan execution
- Possible complications that can result consequent to the treatment and medication.
- Deciding factors between the complications, consequent to the treatment and avoiding to undertake the treatment.
- Alternate possibilities of care if it can be considered.
- The required duration and longevity of treatment process.

e. Initial assessment includes screening for nutritional needs.

i. During the initial assessment itself the concerned physician enquires about the present diet plan and analyses the nutritional status based on BMI.

ii. This is taken in to account while deciding the care plan and dietary needs of the patient.

iv. A detailed nutritional assessment is also undertaken as required and if need arises (based disease specific nature of the case) and the same is taken in to account while furthering the course of management of the case.

F, Care plan has to be documented and is monitored after the initial assessment.

i. The care plan is derived after analyzing the conditions of the patient in terms of the case records and after detailed discussion with patient and relatives.

ii. The care plan so derived is recorded in the relevant format of the case sheet.

iii. The care plan is monitored and reviewed on daily basis after the daily rounds and based on the feed backs of all stake holders involved in the process of care delivery. (Nurses. Nursing Assistants & Therapists)

iv. The relatives and the patient are taken in to confidence before planning any change in the proposed care plan.

g. The care plan also includes preventive aspects of the care where appropriate.

i. The concerned Physician shall give due importance to the preventive aspects of the disease conditions, while deciding the care plan.

ii. Medications, dietary supplements, code of conduct etc shall be designed accordingly and explained to the patients as well as to the relatives.

iii. The principle," prevention is better than cure" is adhered to at all level of patient care

h. The care plan is countersigned by the doctor in-charge of the patient within 24 hours.

i. The initial IP case sheet preparation shall be undertaken by the ward duty doctor and the case is then seen by the CMO & Supdt. / Sr. Physician who finalises the care plan.

ii. He/She shall endorse his/her signature in the relevant column.

iii. All entries shall be dated timed and signed.

I. The care plan includes desired results of the treatment, care or service.

i. The Care Plan shall be finalized by the CMO & Supdt. /Sr. Physician, after taking in to account all aspects of the disease conditions and with consultation of all those concerned and relevant in deciding the care plan.
ii. He shall also arrive at a possible outcome of the care plan and take patient in confidence on this.
iii. He shall explain the patient in detail about the progress of the treatment process and its effect on alleviating the disease conditions.

AAC 5. ALL PATIENTS CARED FOR BY THE ORGANISATION UNDERGO A REGULAR REASSESSMENT

5.1. PURPOSE:
To plan and execute patient care through an established regular re assessment and documented care plan

5.2. SCOPE: Hospital Wide
All patients who visit the hospital for IP/ OP care

5.3. RESPONSIBILITY:
Physician/Nurse/Nursing Assistants

5.4. POLICY
All patients (IP/OP) shall undergo regular reassessment as per established process in a systematic manner

a. All Patients are reassessed at appropriate intervals.

i. In the case of In Patients, re assessments are done on daily basis during the morning rounds and later during one to one meeting as required. Reports from Nurses/ Nursing Assts. and therapists are also taken in to account while undertaking the reassessment and connected follow up actions.

ii. The reassessment shall be done and documented as appropriate for the patient's age and needs as outlined in the Medical Records Content/Documentation policy

a. Out-patients are informed of their next follow-up, where appropriate.

i. Re assessments in the case of OP are planned by the concerned Physician.

ii. As a matter of routine, medicine for two weeks are issued.

iii. This is purely the prerogative of the Physician in charge of the case.

iv. Investigations referrals etc as desired may be undertaken.

c. For in-patients during reassessment the care plan is monitored and modified, where found necessary.

Re assessment shall meet the following objectives;

i. The progress made in the manifestation of disease conditions

ii. Adverse effects of medicines, if any

iii. Medication effects and its progress in alleviation of the presenting complaints

iv. Additional considerations desired

v. Nutritional requirements, effects and changes needed

vi. Need of Progressive investigations

vii. Modifications needed in the care plan, in terms of therapy. medications, procedures etc.

viii. Discharge plan

Staff involved in direct clinical care document reassessments.

i. Continued assessments shall be documented in the patient file by the concerned physician.

ii. The nurses shall maintain nurse's records

iii. The therapists shall maintain therapist's records.

iv. All the patient records shall be under the direct control of Physician

e Patients are reassessed to determine their response to treatment and to plan further treatment or discharge.

i) The Importance of Continuous assessment relies on the fact that the response to the treatment or the effect of the treatment on the disease conditions needs to be analysed for planning further actions.

ii) The physical, psychological and social status of each inpatient shall be assessed.

iii) Inpatients are screened for nutritional/functional needs all throughout the hospitalization period.

iv) Patients shall be assessed continuously throughout their hospital stay on a daily basis.

v) Discharge date shall be intimated to the patient and the doctor will also inform the patient in case of the requirement of a longer period of stay as per the progress of the treatment.

AAC.6. **Laboratory services, if applicable are provided as per the scope of Services of the organization.**

NOT APPLICABLE, LAB SERVICES ARE OUTSOURCED

AAC 07: **THERE IS AN ESTABLISHED LABORATORY QUALITY ASSURANCE PROGRAMME**

NOT APPLICABLE

AAC08. **THERE IS AN ESTABLISHED LABORATORY QUALITY ASSURANCE PROGRAMME**

NOT APPLICABLE

AAC 09: **IMAGING SERVICES IF APPLICABLE ARE PROVIDED AS PER THE SCOPE SERVICES OF THE ORGANISATION :**

NOT APPLICABLE

AAC.10. **THERE IS AN ESTABLISHED QUALITY ASSURANCE PROGRAMME FOR IMAGING:**

NOT APPLICABLE

AAC. 11 **THERE IS AN ESTABLISHED RADIATION SAFETY PROGRAMME**

NOT APPLICAB

AAC 12: PATIENT CARE IS CONTINUOUS AND MULTIDISCIPLINARY IN NATURE

12.1 PURPOSE:

To plan and execute programmes and activities to improve the health of the patient through consultative and collaborative approach.

12.2 SCOPE: Hospital Wide

All Inpatients and Outpatients

12.3 RESPONSIBILITY:

All Physicians, Nursing Assts., Therapists, and Care Takers

12.4 POLICY:

All stake holders in the case delivery shall be actively involved in providing medical care and associated auxiliary services to the patients as team and in a team

a. During all phases of care, there is a qualified individual designated as responsible for the patient's care.

i. During all phases of care it shall be ensured that Physician/ Nursing Assistant /Therapy staff so designated are only providing clinical care to the patient.

ii. The overall responsibility of case delivery rests with the Physician in charge

b) Care of patients is coordinated in all care settings within the organization.

i) Care of patients shall be coordinated effectively through the documented patient file system.

ii) The patient file system shall ensure and conveys all informations that are needed for the Physicians, Nurses, and therapists.

iii) Communication system shall be effective through a formal process during staff changes, shift changes etc.

iv) All orders should be written in relevant formats/ registers/ forms as has been establishe

v) In case of verbal orders given by the physician, the recipient shall write it in the register provided and endorse signature. Later the same shall be incorporated in the case records or in other locations as per the order and should be endorsed in the case sheet, signed timed and dated, by the concerned Physician.

c) Information about the patient's care and response to treatment is shared among medical, nursing and other care-providers.

i. Information is exchanged and documented during each staffing shift, between shifts, and during transfers.

ii The patient's record(s) is/are available only to the authorized care-providers to facilitate the exchange of information.

iii Documented policies and procedures guide the referral of patients to other departments/ specialties.

iv The process of care providing is a collaborative and consultative process and all those who are directly and indirectly connected with it are informed/taken into confidence on the condition of the patient

THE FOLLOWING POINTS SHALL BE ENSURED FOR CONTINUOUS AND MULTI DISCIPLINARY PATIENT CARE.

i. The patients must be directed to the concerned doctor for consultation, soon after the check in

ii. Non ambulatory patients are assisted by the Care Taker or attendant. Wheel chair is provided as per the requirement.

iii. Once a patient is admitted, the entire staff on duty in the ward should know the details of the patient's condition, including vulnerability, if any

iv. The staff should address the patient by his or her name, with respect and love and show concern by enquiring about their well being and wishing them a quick recovery.

v. Information about the patient, his treatment, response to treatment etc. must be shared among all the care providers. All such information must be exchanged whenever possible and properly documented in the patient's case sheet. Changes in present treatment or treatment strategies must be documented during staff/doctor changeover.

vi. All documentations should be signed with date, time.

vii. Documentation in the therapist's records shall also be accurate..

viii. The patient's case records should be updated promptly as and when any activity takes place.

ix. In the case of referral, all the service points should be informed so that timings are arranged accordingly and patient receives all the treatments/procedures etc if indicated, before departure to the referral centre, as the case may be and if indicated.

x. In the case of discharge all those involved in direct patient care should be in picture so that the patient bids adieu warmly and affectionately

AAC 13: THE ORGANISATION HAS DOCUMENTED DISCHARGE PROCESSES

13.1 PURPOSE:
To define and establish guidelines for the Discharge of Patients

13.2 SCOPE: Hospital Wide
All in-patients

13.3 RESPONSIBILITY:
Physician/ Nursing Assts.

13.4 POLICY:

The discharge process should facilitate easy release of patient with proper advice, follow up treatment information, medication and advises regarding further hospitalization.

a. The patient's discharge process is planned in consultation with the patient and/or family

i. Laid down discharge procedures must be followed to ensure that the patients are discharged effectively and efficiently, allowing for optimal utilization of available resources.

ii. Discharge shall be planned in consultation with the patient.

iii. Discharge shall be planned by the concerned physician in consultation with all those concerned with the direct patient care.

b. Documented policies and procedures exist for coordination of various departments and agencies involved in the discharge process (including medico-legal and absconded cases)

i. The follow up prescription is prepared, at least one day in advance, by the Physician as per the need of the case and after consulting the patient.

ii. Nursing Asst / Paricharak takes care of delivery and dispatch of medicines

iv. A discharge summary shall be prepared as per the software which has all relevant columns.

v. A patient may get discharged by himself/herself against medical advice (LAMA).

c. Documented policies and procedures are in place for patients leaving against medical advice (LAMA) and patients being discharged on request

i. If a patient desires to leave against medical advice, the physician shall be notified, and the patient shall sign a LAMA consent form in the presence of witness. The medical record shall be sent for processing per usual route.

ii. The concerned physician shall explain in detail about the possible complication of LAMA and its impact on the health conditions to the patient

d. A discharge summary is given to all patients leaving the organization (including patients leaving against advice and on request

i. A Discharge Summary shall be provided at the time of discharge including to the patients Leaving Against Medical Advice.
ii. Discharge Summary Content shall be as per requirement of Medical Records Policy.
iii. The discharge summary as per the HCIMs shall be delivered to the patient.
iv. Discharge is normally made when the period of stay of the patient is complete and the patient is stable.
v. The decision for discharge is to be reminded to the patient so that they can plan their return after settling of the outstanding bills.
vi. Once the Physician finds that the patient's stay at the hospital is nearing completion he will initiate the discharge process
vii. The printed form of summary will be initialed by the preparing Physician and countersigned by the Sr. Physician.
viii. After getting the discharge summary signed by the doctor, the discharge summary will be handed over to the patient and signature of the patient is obtained from the patient as a token of receipt.
ix. One copy of the discharge summary is attached in the patient file
x. The case sheet is then taken to Medical Records Department.
xi. The patient shall be allowed to leave their room after handing over the room, without any deficiency, to the house keeping department.
xii. The patient is then transported to the departure area with Caretaker accompanying them.
xiii. Discharge is also allowed if the patient is asking for discharge voluntarily.
xiv. In such situations the treating Physician should inform the patient about the possible consequences arising from such a decision. This shall be recorded and the patient's signature shall be obtained stating that they are fully aware of the consequences of leaving against medical advice.
xv. A copy of discharge summary is also given to such patients indicating that the patient is leaving against medical advice

AAC. 14. ORGANISATION DEFINES THE CONTENT OF DISCHARGE SUMMERY

14.1 PURPOSE:

To define the policy and procedure regarding the content of discharge summery so as to ensure that all the relevant data pertaining to the admission, treatment and follow up management information are available in a descriptive manner

14.2 SCOPE: Hospital wide

All admitted patients

14.3 RESPONSIBILITY:

Sr. Physician /Duty Physician

14.4 POLICY:

A Discharge summary as per standard format from software is issued to all admitted patients once they are leaving the hospital. This include around normal discharge and request discharge.

a. Discharge summary is provided to the patients at the time of discharge

i. The Sr. Physician/Physician in charge of the ward shall ensure that a discharge is summary as per the defined format is issued to all patients at the time of discharge.

ii. This shall be prepared by Sr. Physician/Physician on the previous day itself and the print out shall be taken out on the day of discharge after modifications if any

iii. This shall be delivered to the patient's room from office or through Nurse/Nursing Assistant

b. Discharge summary contains the patient's name, unique identification number, date of admission and date of discharge.

i. The demographic particulars may be rechecked before preparing the discharge summary. The patient may find it difficult for reimbursement/insurance claims etc.

c. Discharge summary contains the reasons for admission, significant findings and diagnosis and the patient's condition at the time of discharge

i. All the columns of the discharge summary shall be filled up as per standard instructions

ii. Abbreviations may not be used as far as possible except for universally accepted ones

d. Discharge summary contains information regarding investigation results, the procedure performed, medication administered and other treatment given

i. Reason for admission, significant findings, diagnosis, and condition at the time of discharge shall be mentioned in the discharge summary.

ii. Information regarding investigation results, any procedures performed, medication and other treatment given are incorporated.

iii. Follow up advice, medications, and any other instructions in an understandable manner should be indicated.

iv. Instructions about when (in case of severe pain or discomfort depending upon the disease condition) and how to obtain urgent care are to be incorporated (physician's contact number or hospital's emergency number)

v. In death cases the summary is to include cause of death.

vi. Discharge summary shall also be given to patient who wishes to leave against medical advice

vii. or seek treatment elsewhere.