LOGO
CENTRE NAME
CENTRE ADDRESS

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AMENDMENT SHEET

Sl. No.	Section No & Page No	Details of amendment	Reasons	Signature of preparatory authority	Signature of approval authority
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SUMMARY	This document provides instruction and guidance to Hospital staff regarding uniform care of patients
DISTRIBUTION	To all departments, units through the Hospital Manual

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. All treatment orders would be signed, dated and timed by the concerned clinician.
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 24 hours.
5. In case required the primary treating consultant of the patient may consult other care providers available within the hospital for patients care related issues.
6. 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
7. The primary treating consultant can refer the patient to other clinical specialty either within the hospital or to the identified external healthcare institutions if the patient's medical need demand the same (Refer Policy on Referral of Patients).
8. 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.

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).
c. Critically appraise the evidence for its validity and usefulness.
d. Integrate appraisal results with clinical expertise and patient values.
e. Evaluate outcomes.

Reference

Standards

COP 01 – All elements

Mandatory Documents/Forms/Registers Maintained

- Treatment Plan

SUMMARY	This document provides instruction and guidance to all types of hospital staff on policies and procedures for the Emergency services provided in the hospital.
DISTRIBUTION	To all departments, units through the Hospital Manual.

1 Aim:

To provide guideline for management of the medical emergencies of the IP & OP patients of CENTRE NAME.

2. Process:

CENTRE NAME is not having in house emergency care unit but facilities to handle first aid basic emergency conditions. Unstable patients which require multidisciplinary care are referred to higher centers. The transportation team consists of a medical officer, nursing assistant.

Reception of patient

- Emergency staff shall ensure availability of wheelchairs and stretcher trolleys at the Emergency room (ER) main door.
- After examining the patient the medical officer (MO) shall contact the Consultant on-call in the relevant specialty by means of the telephone. MO shall apprise the Consultant of the patient's condition and take instructions regarding investigations and treatment.
- MO advises admission if required and the front office staff shall fill the Admission Request Form if the patient requires admission. A patient is to be admitted only when the Consultant advises admission.
- Patients shall be discharged or transferred at the earliest after screening or earlier if the patient condition so requires.

- If the patient requires advanced emergency care then the patient is referred to higher centre with appropriate transportation team (Refer: Emergency referral policy- CENTRE NAME.
- The CENTRE NAME has in house ambulance facility for emergency transportation. Kindly refer the Emergency department manual for the requisites and protocols of Ambulance.

- For Inpatients the MO will attend the patient on emergency basis on intimation and necessary interventions shall be done and On call consultants shall be contacted and co-ordinated. The patient shall me transferred with referral note containing treatment summary, details of investigations, status of the patient at the time of referral with transportation team.

Handling Medico legal Cases

- All cases of accidents, burns, assaults, alleged suicide or homicide, poisoning, road traffic accident, rape, drowning, etc shall be registered as medico legal cases (MLC).
- All cases registered as medico legal in hospitals where he/she reported first must also be registered as Medico legal and the outside MLC number recorded on the case file.
- Any case of a cognizable offense as mentioned above even if brought at a later date by the police must be informed and the case registered as medico legal.
- When a case identified as medico legal is brought to Emergency Dept. CMO shall provide medical care as required.
- Emergency staff shall inform the Front office staff who will intimate the police. The time of call and the police personnel spoken to shall also be documented in the front office register.
- MLC Form shall be filled by CMO in duplicate (one copy for Medical Records Dept. and one for the Police) MLC report shall be completed and signed as soon as possible after the patient arrives in Emergency and in all cases before the

CMO goes off duty. CMO shall not be relieved until MLC reports for patients managed in the tenure of duty are completed.

- An entry must be made in MLC intimation report in case the patient is already registered as Medico legal in another hospital.

Triaging

- Through regular modules, held for both Doctors and nursing staff, the staff shall be trained in the technique of Triaging.
- The policy of prioritizing patients is based on the urgency of their individual need for medical care.
- Under normal working conditions, patients shall be triaged and allotted beds in the ER as per the urgency of their medical needs.
- During external disasters (Code Red) patients shall be triaged as Red, Yellow, Green and Black. (Procedure of Triage – Refer Emergency Department manual)
- The Red category patients are referred to the Higher centre for expert management and care.

3. References

AAC 02

TITLE	Policy on Vulnerable Patients Handling
SUMMARY	This document provides instructions and guidance to Hospital staff regarding handling of vulnerable patients. The policy details the process of vulnerability assessment and identification, vulnerability handling and wherever applicable reporting of incidents.
DISTRIBUTION	To all concerned departments

1.0 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.

2.0 Scope – FACILITIES & SERVICES OF CENTRE

In patient Services

Ayurvedic Consultancy (आयुर्वेदिक परामर्श)

1. Abhyangam (अभ्यंगम)
2. Diet Consultation (आहार परामर्श)
3. Ayurvedic Medicine(आयुर्वेदिक दवाई)
4. I.P.D
5. Deepan (दीपन)
6. Pachana (पाचन)
7. Snehana (स्नेहन)
8. Swedana 9.(स्वेदन)
9. Udavartan (उर्धवर्तन)
10. Panchkarma Treatment(पंचकर्मा चिकित्सा)
11. Vamanam (Emesis) (वमन)
12. Virechana (Purgation) (बिरेचन)
13. Nasyam (Nasal therapy) (नस्यम)
14. Raktamokshna (रक्तमोक्षण)

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)

Vulnerable Patient

Those Patient who are prone to injury and disease by virtue of their age, sex, physical, mental and immunological status, eg: infants, elderly, physically- and – mentally challenged, semiconscious /unconscious, those on immunosuppressive and/or chemotherapeutic agents.

4.0 Procedure

4.1 Identification and Assessment 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 patients above the age of 70, paediatric (Patients below 12 years), patients with mental disability, preganent ladies and bed ridden are automatically treated as vulnerable.

4.2 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.

4.3 The hospital shall encourage family members to be present for admission of patients falling in the above categories and shall not admit such patients without an accompanying attendant. For patients above 70 years and below 75 years capable of taking care of themselves and in an active physical condition; exemptions may be provided on case to case basis. In case of patient directly admitted based on telephone / internet enquiry the case details have to be discussed with Senior Doctors before granting exemptions. All such patients who are not exempted have to be specifically informed by RMO to bring along an attendant.

4.4 All pediatric patients must be accompanied by a family member when treatment is provided at the Pancakarma Theatre.

4.5 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 into the hospital and provided wheel chair assistance where required nurses / housekeeping will provide assistance with stretchers in case of bed ridden patients brought to hospital for consultation, treatment and / or admission.

4.6 In case of the patients who come in their own cars and have physical disability shall be assisted by the security staff at the reception. The hospital shall arrange of valet parking for such patients.

4.7 Identification of vulnerable patients is by:

- Doctors
- Nursing (Based on Nursing Admission Assessment Tool)

4.8 Nursing staff will assess all patients for risks of fall and document / institute falls prevention 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.

4.9 For quick identification of such patients and “Safety First” sticker at the head end side of the end and orange patient tag for their identification

4.10 All falls shall be reported using the incident report forms.

4.11 Ward Supervisors shall conduct audits to check for compliance with falls prevention program. 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.

4.12 The environment safety of vulnerable patients is ensured through the process of facility inspections and safety audits conducted regularly by the hospital safety and engineering teams.

4.13 Additional consent for care of these patients are obtained from family / legal representative.

4.14 All staff members are trained on handling of vulnerable patients and the training records of same maintained

5. Monitoring

The Medical Record Audit process reviews the adherence of the vulnerability identification and care aspects of patient care

6. References

A. Standards

COP 4 – All elements

B. Mandatory Documents/Forms/Registers Maintained

- Vulnerability Assessment Sheet

General Policy for Panchkarma and Parasurgical procedures

SUMMARY	This document provides details regarding the policies for the handling of clinical procedures The policy discusses in detail regarding aspects like general protocols for any In patient for any type of clinical procedures
DISTRIBUTION	To all clinical departments, units and wards through the Hospital Manual

PURPOSE

To provide general guidelines for handling patient undergoing various clinical procedures like Panchkarma, Anusastra Karmas (agnikarma,leech therapy,alabu chikitsa)

RESPONSIBILITY PERSON

Doctors, Panchkarma In-charges, Therapy Co-ordinators, Minor Procedure room in-charges

SCOPE: Hospital Wide

This policy is applicable for Panchkarma, other Anusastra procedures in the hospital

POLICY

1. **Qualification of staff**:
   All procedures will be performed by qualified doctors and trained staff under supervision of doctors.

2. **Pre-procedure Assessment:**

All patients shall go a pre procedure examination which would include vital signs, general well being intake output etc. – by a Junior doctor and whenever required by Senior doctors.

3. Pre-procedure Preparations and Medications

Panchkarma therapy section – in charge consultant will maintain written instruction for pre-preparation of patients required for each type of procedure.

Therapy Co-ordinator in association with the Panchkarma In charge will prepare the indent of medicines which are required for the procedures for next day and the Medicine preparation Kitchen Staff will prepare as per the requirement and will keep it labelled with date & time of preparation along with patient identifiers & details of the medicines.

The medicines thus prepared will be issued to the corresponding therapy team and the same shall be documented.

Anusastra Karmas – the HOD or other members of the department will conduct the pre-procedure screening of the patient .

4. Informed Consent

Consent from the patient or his representative 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 if any
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 procedure

5. Transfer of Patient to Procedure Area:

The patient is accompanied and directed to treatment room by Therapists in case of panchakarma and nurses in case of Anusastra karmas. In case of specific mobility requirements, a wheel chair or stretcher is used.

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

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

The same is strengthened adhering to Safe Panchkarma procedure checklist for therapist and Shastra/Anushastra karma checklist by assisting nurses or assisting doctors

7. Post Procedure process:

a) Post procedure patient is observed for any adverse events/Vyapats. Eg: giddiness or weakness.
b) The Monitoring Doctors/consultants shall be informed and required medical aid shall be provided.
c) The vitals are checked and noted
d) Once the patient is found stable he/she is transferred to room.

e) In case of Shastra/Anushastra karmas patient is transferred to post operative room/Ward based on instructions of the Consultant. If Sedation of anaesthesia is given then the patient transfer and further care shall be decided by the Anaesthetist.

STANDARD REFERENCE-

COP 9 - All elements.

SUMMARY	This document provides instruction and guidance to hospital staff on handling of pediatric services
DISTRIBUTION	To all departments, units and wards through the Hospital Manual

PURPOSE

The purpose of the policy and procedure is to guide the handling of pediatric patients at CENTRE NAME

SCOPE

Hospital wide

POLICY

The hospital treats all patients up to the age of 14 as pediatric cases medically and up to 18 years legally.

All pediatric cases (both medical and legal) will be admitted to the hospital only with the presence of a legal guardian.

PROCEDURE

General Guidelines for Handling of Pediatric Cases

- Pediatric cases will be treated only by doctors who are competent to handle the particular age group – infant, child, adolescent etc.
- The nurses and therapist assigned to handle pediatric cases are ensured to be trained and experienced in handling such cases.

- All pediatric cases handled by the hospital is treated as vulnerable and are handled as per policy and procedures for handling vulnerable cases.
- Periodic drills for handling situations of child abduction are done toensure readiness for such events.
- While handling infants and small children; mothers / parents areallowed to accompany the patient for treatments / panchkarma to ensure cooperation of the child for treatments; where deemed necessary.
- Facility for breast feeding is provided on request for nursing mothers attending OPDs.
- All pediatric cases shall be assessed for nutritional, growth, psychosocial and immunization status as applicable and same recorded in initial assessment sheets.

Safety Precautions for Care of Pediatric Patients

- All pediatric cases will be automatically considered as vulnerable andprocedures for handling same shall be ensured.
- The family shall be educated to keep infants in the bed along with mothers to prevent fall. Railings may be provided for beds when small children are admitted to prevent falls.

6. References

Standards-COP 8 – All elements
Safety Manual –

Amendment Record

Pediatric Nutrition Assessment Form

Name of Child: _____ DOB :_____ Age :_____

Name of Parents :_____

Address : _____

Telephone numbers : _____ Gmail _____

Pediatrician :_____

Health Insurance :_____

Referred by :_____

Today's Date :_____

What concerns do you have about your child's diet?

How can I help you and your child? What kind of information and support are you looking for?

Describe your child's physical activity

How much time does your child spend outside per day?

How many minutes per day is your child sitting in front of a screen?

How many hours of sleep does your child get?

Does your child experience constipation, diarrhea, loose stool, heart burn, gas, or bloating? Difficulty swallowing?

List foods that your child is allergic or digestively sensitive to and their reaction:

Height_____ Current weight

List all medications, vitamin, mineral, and herbal supplements that he/she is taking:

Signatur

TITLE	Use of Restraints
SUMMARY	This document provides instruction and guidance to hospital staff on use of restraints on patients and precautions to ensure patient's rights in such cases and also patient safety
DISTRIBUTION	This policy is for distribution to all departments, units and wards of through the Hospital Manual

1. Purpose

Restraints are used to reduce the risk of patients from falling and to minimize the risk of persons injuring themselves or others. The purpose of this policy is to establish guidelines governing the use of restraint, where a patient is at risk of harming him/herself or others and no other less restrictive intervention is possible.

2. Scope

Hospital wide

3. Procedure

Patient Restraint shall be employed to ensure patient and provider safety and to facilitate the thorough examination and care of any individual exhibiting an altered level of consciousness. Only physical Restraints are used here.

Types of Physical Restraints

Only hospital approved restraint devices are to be used.

3.1 Anklets and Wristlets: These shall be used to restrict the activity of limbs in a patient who is potentially harmful to himself or others to prevent the patient from removing any appliances used in the treatment and to immobilize one or more limbs during a procedure (e.g. nasyam in children).

3.2 Elbow and Knee restraints: The purpose of elbow and knee restraints is to prevent flexion of the elbow and knee joints. These restraints shall be made by making pockets or slots on a piece of cloth into which tongue blades will fit. These restraints shall be then wrapped around the elbow or knee joints and tied at the ends.

3.3 Environmental controls:

3.3.1. Side rails:

These shall be attached to both sides of the bed to prevent the patient from getting out or falling out of the bed. Side rails shall be kept raised on beds of all patients who have an altered level of consciousness, the elderly, debilitated patients and children.

4. Responsibilities

4.1 Medical staff

4.1.1 The medical staff must conduct a clinical assessment for the use of restraint

4.1.2 The doctor shall obtain a verbal consent from the patient's relatives before any kind of restraint is used on the patient.

4.1.3 The doctor shall also explain to the patient's family and friends the need for the restraint.

4.2 Nursing Staff

4.2.1 A nurse shall try to get assistance from other hospital personnel while restraining a patient. Sufficient staff shall be able to approach the patient as a unified team.

4.2.2 The nursing staff shall assist the doctor in safely administering the restraint. In the absence of the physician, the nursing staff shall initiate restraints in the safe interest of the patient.

4.2.3 The nursing staff shall ensure that proper care, observation, documentation and reporting procedures are completed.

4.2.4 The nursing staff shall ensure the removal of potentially dangerous objects away from the patient that could be used by the patient to harm self, another person or to escape.

4.2.5 Patients under restraint shall be continuously monitored. This shall be documented at-least 2 hourly.

4.2.6 The nursing staff shall promptly inform the Senior Doctors if there is any notable change in the behavior of the patient.

4.2.7 The nursing staff shall explain all steps of the intervention to the patient's family as soon as possible after the intervention and appropriate intervals thereafter, including which of the patient's specific behaviors required restraint; the nursing care and attention that will be provided while in restraint.

6. References

A. Standards

COP 14 – All elements

B. Mandatory Documents/Forms/Registers Maintained

- Restrain Order Form

A. Purpose: To provide guideline instruction for management of pain.

B. Policy: The hospital and its staff members

- Recognizes the right of individuals to appropriate assessment and management of pain.
- Plans, supports, and coordinates activities and resources to ensure that the pain of all individuals is recognized and addressed appropriately.
- Provides individualized care in settings responsive to specific needs.
- Provides education on pain management as part of the patient's treatment considering the patient's personal, cultural, spiritual, and/or ethnic beliefs.
- Develops plan in conjunction with the patient, if on discharge the patient has pain, to address management at home.
- Monitors the performance of the pain management program

C. Assessment:

1. A patient's report of pain will be accepted and respected as the key indicator of the amount of pain he/she is experiencing. Medical staffs will assign the rating only if the patient is unable to report their pain.
2. The presence of pain is assessed on admission to the hospital, at the initial clinic visit, post procedure and when the patient complains of pain. The assessment is performed by a Doctor in the care team in the medical record.
3. The frequency of pain reassessment shall be dictated by the intensity of the patient's pain and the effectiveness of pain relief strategies. However, when pain is present, a pain reassessment is generally performed at least every day and more often as needed by a licensed health care provider. 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 > 5 using the approved Pain Scales. If no pain is present, the health care provider will reassess for pain as warranted by patient condition, when the patient complains of pain and post invasive procedure.
4. Pain Scales:
   a. The Numeric Pain Intensity Scale (NPIS) will be used universally to assess pain for patients 13 years or older. Patients will be asked to rate their pain a scale of 0-10. Zero represents no pain; a rating of 1-3 would indicate that the patient is experiencing mild pain; 4-6 would indicate that

the patient is experiencing mild pain and a rating of 7-10 would indicate the worst imaginable pain.

b. The Wong-Baker Faces Pain Scale, consisting of graduated facial expressions of pain, will be used for patients, ages < 13 and those unable to comprehend the numerical scale. Zero represents no pain; a rating of 1-3 would indicate that the patient is experiencing mild pain; 4-6 would indicate that the patient is experiencing severe pain and a rating of 7-10 would indicate the worst imaginable pain.

5. If pain is present, a more comprehensive assessment is performed, which may include:

A. Intensity (Numerical 0 -10, Wong-Baker Face Scale)
B. Quality
C. Location(s) (All pain locations are assessed)
D. Onset
E. Duration
F. Variation
G. Alleviating and aggravating factors
H. Present pain management regimen and effectiveness
I. Medication history
J. Presence of common barriers to reporting pain and using analgesics
K. Past interventions and response
L. Manner of expressing pain
M. Effect of pain on activities of daily living, sleep, appetite, relationships, emotions and concentration.
N. Pain goal, expressed as measures of intensity and function.
O. Physical examination:

i. Mental status examination
ii. Motor and sensory examination
iii. Reflexes
iv. Gait
v. Maneuvers targeted to pain diagnoses
vi. Documentation of pain, for all patients, should include the following:

a. Type of pain and/or location
b. Intensity scale
c. Level of consciousness (for score >7)
d. Respiratory rate (for score >7)
e. Activity

f. Medication
g. Patient and family education
h. Treatment goal.

vii. Staff shall be educated about pain assessment, including the availability of non pharmacological interventions.
viii. To care of unbearable pain the patient shall be referred to the Allopathic department for further management and shall be documented and reassessed.

E. Treatment

1. Pain is managed by pharmacological treatment, non pharmacological treatment, and interventional procedures.

a. Pharmacological treatment may done though Ayurvedic medicines
b. Non pharmacological treatment may include physical interventions and cognitive behavioral strategies.

Physical interventions may include:
a. Heat
b. Cold
c. Exercise
d. Physical/Occupational therapy
e. Immobilization
f. Manipulation
g. Massage

Cognitive behavioral strategies may include:
a. Distraction
b. Relaxation
c. Other coping strategies

F. Pain Reassessment:

A. Pain will be reassessed:
1. Once in 24 hours for all hospitalized patients with pain score > 7, once in 48 hours for pain ranging from 4-6.
2. For patients will high potential for pain (disease specific/post Procedural)
a. At least every 12 hours

b. Prior to pain relieving intervention.

G. Patient Education

1. Patient education may focus on fears commonly held by patients in pain on non pharmacological methods of pain management, copping mechanism, disease specific exercise etc

H. Pain Scale:

1. Numerical pain scale (0-10)
2. Wong-Baker Faces pain scale (0-10)

Explanation of treatments:

1. Pharmacological
2. Procedural
3. Non-pharmacological

I. Discharge:

Discharge notes shall include reference to physical needs, emotional needs, and symptom management.

K. Documentation:

1. Inpatient: The following information will be documented
   a. Initial pain screening
   b. Initial pain assessment
   c. Pain score
   d. Pain management procedure used
   e. Discharge instructions

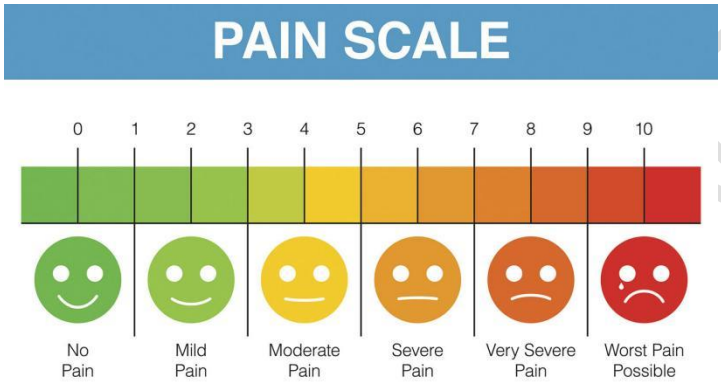
2. Outpatient: The following information will be documented

   a. Initial pain assessment.
   b. Initial pain screening
   c. Pain score.
   d. Pain management procedure
   e. Instructions for the patients.

Pain Management Form

Wong Baker Faces Pain Scale Please Put Image (Suggested Age Group <13 Years / Cognitively Impaired Adults)

Legend: 0 – No Pain 1-3 Mild Pain 4-6 Moderate Pain 7-10 Severe Pain



Reference

Standards – COP 15 – All elements

A. Mandatory Documents/Forms/Registers Maintained
Pain Management Form

SUMMARY	This document provides instruction and guidance to Hospital staff nutritional assessment and reassessment.
DISTRIBUTION	To all departments through the Hospital Manual.

PURPOSE

- To ensure diet provided to each patient is based on their diagnosis, physiological and metabolic requirements and social needs of the patients.
- To educate the patients and their attendants for their nutritional requirements as a part of their treatment and continuity of Nutritional care at home.
- To ensure diet is prepared and distributed safely, in accordance with treatment requirements and taking into consideration patients dietary choices where possible.

PROCEDURE

- The nurses inform the Dietary in Charge/Medical Officer about the new patient's arrival.
- Their nutritional assessment is done which includes Height & weight, BMI, any metabolic derangement, Habits etc and Consultant assessments and orders on diet.
- The doctors / dietary In Charge shall prepare a diet chart listing the requirements of pathyahara. In case of normal diet the same shall be denoted allowing patient choice of food as per approved menu of hospital

- CENTRE NAME does not allow outside food including food brought by family especially for Patients in Post-Operative care and in selected cases/for all procedures where Pathyahara is mandatory. With the consent of RMO the family can bring food from outside based on the dietary assessment and Diet prescribed for the patient.
- Family members and / or accompanying persons are educated about patient's food requirements and restrictions.
- The food preparation, kitchen activities and distribution is detailed and controlled through a SOP prepared for the purpose.
- A diet schedule is maintained in the kitchen based on the doctor's suggestion as per the clinical needs of the patient.
- Nutritional therapy is planned and provided in a collaborative manner by the doctors.
- The doctors do the reassessment collaboratively based on the reports of relevant investigations.

REFERENCE

Standards - COP- 18 – All Elements
Manuals

SUMMARY	This document provides instruction and guidance to Hospital staff regarding rehabilitative services
DISTRIBUTION	To all departments through the Hospital Manual

POLICY

Rehabilitative services are non scope