HOSPITAL WIDE
POLICY & PROCEDURES

SUB-DIVISIONAL HOSPITAL, ANANDAPUR,
KEONJHAR, ODISHA
Web- sdhanandapur.in

CONTENT

CONDEMNATION POLICY GOVT.

Government of Odisha
Health & Family Welfare Department
***
No 5038 /H., Dated 12.2.13
Sch-I-Med-344/12

From

Sri Sibabrata Dash, IAS,
Additional Secretary to Government.

To

The Director, Health Services, Odisha
The Director, Medical Education & Training, Odisha
The Director, Family Welfare, Odisha
The Director, State Institute Health & Family Welfare, Odisha
The Director, AYUSH, Odisha
The Drugs Controller, Odisha

Sub: Condemnation of old, unused and unserviceable instrument & equipments lying idle in different Health Institutions in the State.

Ref: This Department letter No.14445/H., dt.19.04.1999.

Madam/Sir,

With reference to the above cited subject and letter under reference, I am directed to say that Government have been pleased to revise the guidelines and financial limits of different controlling officers in condemning old, unused and unserviceable instrument & equipments lying idle in different Health Institutions in the State.

You are, therefore, requested, please adhere to the procedure laid down in the proceeding of meeting held on 26.11.2012 (copy enclosed) while condemning the unused items narrated above observing due financial propriety as enumerated in rule 95 to rule 125 of OGFR-Vol-I.

Yours faithfully,
Additional Secretary to Govt.
11/2/2013

Memo No 5039 /H., Dt. 12.2.13

Copy along with proceeding of the meeting held on 26.11.2012 is forwarded to Joint Director, State Drug Management Unit, Odisha, Bhubaneswar for information and necessary action.

Additional Secretary to Govt.
11/2/2013

PROCEEDING OF THE MEETING REGARDING FORMULATION OF GUIDELINES FOR CONDEMNATION OF OLD, UNUSED AND UNSERVICEABLE INSTRUMENT & EQUIPMENTS IN DIFFERENT HEALTH INSTITUTIONS HELD ON 26.11.2012.

Addl. Secretary to Govt. in Health & F.W. Deptt. Chaired the meeting. Proceeding of the meeting last held on 26.07.2012 to formulate a revised guideline for condemnation of old, unused and un-serviceable equipment and instrument formed the basis of discussion. The members present in the meeting are at Annexure-I.

The committee reviewed in detail the guidelines communicated vide Govt. Letter No. 1445/H, dated 19.4.1999 for condemnation of unused and unserviceable equipment/instruments lying in different DHHs/SDHs/CHCs/PHCs and other hospitals. Recently, the financial competency of different controlling officers under Rule-10, Rule-12, Rule-13 has been enhanced by Finance Deptt. vide FDOM. No.4939/F dt.13.02.2012, No.22393/F , dt.08.06.2012, No.25893/F , dt.12.07.2012, No.28648/F , dt.06.08.2012 respectively.

The committee after careful consideration unanimously agreed to recommend following changes in the existing govt. guideline to make it operational in the present context.

1. **District Committee**
   - The CDMO of the Dist. : Chairman.
   - The ADMO (Medical) of the Dist. : for DHH : Member Convener
   - The ADMO (PH) of the Dist.: for peripheral Institutions : Member Convener
   - Representative of the Dist. Collector : Member
   - Senior most Specialists of the concerned Disciplines (in case of DHH) : Member
   - Concerned Medical Officer I/c Of CHCs/PHCs/SDH/Area Hospitals : Member
   - Internal audit officer(IAO) of Health & Family Welfare Deptt. working in the district. : Member
   - Bio-medical Engineer under SEMU : Member

2. **Committee for Govt. Medical Colleges**
   - The Principal of concerned Medical College : Chairman.
   - The Suptd. Of concerned MCH : Member Convener
   - HOD of the concerned Department : Member
   - The Accounts Officer of concerned MCH : Member
   - Representative of the Dist. Collector : Member
   - Internal audit officer(IAO) of Health & Family Welfare Deptt. working in the district. : Member
   - Bio-medical Engineer under SEMU : Member

(contd.)

3. Unserviceable equipment, where the **purchase price** is Rs.5.00 lakh or less per unit may be condemned by the concerned CDMO of the District on recommendation of the committee.
4. Unserviceable equipment, where the **purchase price** is Rs.5.00 lakh to Rs.5.00 crore per unit may be condemned by the DHS (O) the Dist. Committee for peripheral health institutions. Similarly, by DMET (O) on the recommendation of Committee for Govt. Medical Colleges.
5. Unserviceable equipment, where the **purchase price** is more than Rs.5.00 crore per unit may be condemned with approval of Govt. in H & FW Deptt. Necessary proposal with recommendation of the Dist. Committee for peripheral health institutions is to be forwarded by D.H.S (O). Similarly, for Medical Colleges, proposal with recommendation is to be moved by DMET (O).

   Equipment which are considered to be condemned, a certificate shall be obtained by the Head of institution from the supplying firm / Authorized service engineer of the firm to the effect that, the equipment is out of order and not repairable or the cost of repair would be uneconomical (Repair cost will be more than 50% of purchase price). In case the farm does not respond such certificate may be obtained from the Biomedical Engineer. The list of equipment to be condemned along with the above certificate will be presented before the committee by the member convener.
6. Equipment lying unserviceable for a long period, particularly purchases before the year of 2000 shall be considered for condemnation in the first instance.

   (Note: Unused should not be mis-conceived as unserviceable.)
7. Materials other than instruments and equipment such as furniture's, fixtures etc. shall be condemned only after recording a certificate by the heads of the institution that the items are not reparable and if repair is undertaken, the cost of the repair shall be more that 50% of the purchase price of the materials.
8. The committee shall recommend condemnation of the instruments, equipment, furniture's and fixtures etc. and refer the case in the following manner:
   a) Periphery health institutions to DHS(O)
   b) Medical Colleges to DMET(O) and

c) Purchase amount exceeding Rs.5.00 crore, DHS (O)/DMET(O) to Govt.

The committee shall also decide the **offset price** of each item before going for condemnation auction observing all financial propriety under Rule-103, 106, 108, 111, 112, 113 & Rule-117 of OGFR, Vol.-I.

9) The sale proceeds is to be deposited in the appropriate receipt Head of account of Govt.

The meeting ended with vote of thanks to the chair.

(N.K. Das)
DHS, Odisha

(S.B. Dash)
Addl. Secretary,
H&FW Deptt.

(B.B. Dash)
FA-cum-Joint Secy.,
H&FW Deptt.

(Dr. B. Panigrahi)
Addl. DHS (P&D),
Odisha

(Dr. D.K. Prusty)
Addl. DHS (PM&AR),
Odisha

(Dr. N.K. Kar)
Jt. Director, SDMU

(S.P. Nayak)
Asst. Manager

(P. Dash)
Sr. Consultant(P&IM)
NRHM

(S.K. Suar)
AFA-cum-Under Secy.
H&FW Deptt.

7 copies

ANNEXURE-I

MEMBERS PRESENT IN THE MEETING HELD ON 26.11.2012

1. Sri S.B. Dash, Addl. Secy. to Govt., H&FW Deptt.
2. Sri B.B. Dash, FA-cum-Joint Secy. to Govt., H&FW Deptt.
3. Dr. N.K. Das, Director of Health Services, Odisha
4. Dr. B. Panigrahi, Addl. Director of Health Services, Odisha.
5. Dr. D.K.Prusty, Addl. Director of Health Services (PM&AR), Odisha.
6. Dr. Nishikanta Kar, Jt. Director of Health Services (SDMU), Odisha.
7. Sri S.K. Suar, AFA-cum-Under Secy., H&FW Deptt.
8. Sri P. Dash, Sr. Consultant (P&IM), NRHM.
9. Sri S.P. Nayak, Asst. Manager (P&IM), NRHM

END OF LIFE CARE

Purpose: To identify the emotional, psychological and spiritual / religious needs of such dying patients and their families.

Scope: Family members of patients who are at the end stage of life and unlikely to recover, e.g. brain dead patients.

Responsibility: Nurses, Doctors, Counselors

POLICY

PATIENT CENTERED GOALS

- Identify patients who require end of life care.
- Document all criteria and check lists for end of life care

FAMILY CENTERED GOALS

The clinical team (Doctors, Nursing personnel, Counsellors) must strengthen the own relationship with the patient's loved ones by:

- Facilitating ongoing communication among family members, and members of the care team.
- Shared decision making between health team and patient/family have to be made and family's consent documented in patient case sheet.
- Supporting families, and caregivers including grief, and follow-up services.

SPECIAL ISSUES IN COMMUNICATING WITH FAMILIES NEAR THE TIME OF DEATH

- Arrangements for the last wishes of patients or request of family members
- Notification of Death.
- Organ Donation
- Paperwork & discharge formalities

CHECKLIST

S. No	PSYCHOLOGICAL INSIGHT	Yes	No
1.	Patients family aware of diagnosis		
2.	Psychological support required		
S. No	**RELIGIOUS SUPPORT**		
1.	Religious / spiritual needs assessed		
2.	Special needs at time of death and after identified		

Nurse's Name……..Signature……..Date……Time……..

CARE AFTER DEATH

S. No.	Goal	Yes	No	N/A
1.	Death Forms filled as per norms			
2.	Procedures following death discussed or carried out: Patient had infectious disease Patient has religious needs Post mortem discussed Preservation of body / mortuary / hearse requirements checked			
3.	Family/ Others given information on hospital procedures Informed to collect death certificate Death summary			
4.	Hospital policy followed for patient's valuable and belongings			
5.	Family request for Organ donation			
	If yes: Information for Organ bank provided Eye / Ear Kidney Heart Pancreas/Liver Other			

Nurse's Name…….. Signature…… .Date…… Time……

USE OF ANTIBIOTICS

Purpose:

- To improve patient care by promoting the best practice in antibiotic prophylaxis and therapy.
- To ensure better use of resources by using cheaper drugs where possible.
- To retard the emergence and spread of multiple antibiotic – resistant bacteria.
- To improve education of junior doctors by providing guidelines for appropriate therapy.
- To eliminate the use of unnecessary or ineffective antibiotics and restrict the use of expensive or unnecessarily powerful ones.
- To combat emergence of antibiotic resistance

Scope: Hospital Wide

Our policy is to rationally and judiciously use the antibiotics for patient treatment.
Antibiotics are categorized under following categories and authorization to prescribe those antibiotics is given according to the qualification and designation of doctor.

Categories of antibiotics:

- First Level Antibiotics – can be prescribed by Junior GDMO
- Second Level Antibiotics - can be prescribed by Senior GDMO
- Third Level Antibiotics- can be prescribed by Junior Consultants
- Fourth Level Antibiotics- can be prescribed only by Senior Consultants

(These categories can be further modified by the hospital as per their needs Hospital is supposed to differentiate the antibiotics under above mentioned categories used in the hospital.)

- Assessment is done to know whether the patient actually requires an antibiotic or not.
- In general antibiotic therapy is not changed if the clinical condition is improving.
- If there is no clinical response within 72 hours, the clinical diagnosis, the choice of antibiotic and/or the possibility of a secondary infection should be reconsidered.
- Antibiotic are prescribed for the minimum length of time that is effective.

- Review the duration of antibiotic therapy is done after 5 days.
- For surgical prophylaxis antibiotics are started one day before induction of anaesthesia and continue for a maximum of five days as per prescribed by treating surgeon.
- Pathogen is targeted first –cultures are obtained from the patient;
- Empiric therapy is targeted for likely pathogens;
- Definitive therapy is given for known pathogens.
- Standard infection control practices and isolation precautions are adopted to avoid hospital acquired infection.
- Medical audit is done to know who prescribed what.
- Training and education is provided to the antibiotic prescribers to keep them updated about judicious usage of antibiotics.

C. General Guideline for Antibiotic Treatment and Prophylaxis:

Common Pathogen	1st Line	2nd Line	Comment
Acute viral inf	No Antibiotic	Antiviral	Symptomatic
Viral with secondary inf	Penicillin deriviates -Macrolidus	Quinolone Cefalosporin	-
Acute Bacterial	-Colrimexole -Penicillin derivatives -1st generation quinolones -1st and 2nd gen cephalosporin	2nd and 3rd Generation quinolones 3rd generation Cefalosporin	-
Mix Bacteria inf Gram+ve, Gram-ve	Broad spectrum antibiotic of any generation Aminoglycocytes	As per culture sensitivity result	-
Mix Anaerobic inf	Broadspectrum antibiotic Aminoglycocytes Tinidazole Metronidazole Ormidazole Secinidazole	As per culture sensitivity result	-
Worms infestation	Antihelminthics Specific or Broad specific		-

Fungal	Kelacenazole, Macunzole, Fluconazole	With suitable Antibiotics	-
Tuberculosis	As policy of DOT's clinic		-
Amoebic inf	Anti amoebics		-
Malarial Parasite	Chloroquines and Primaquines	Artisunate Artimether	Resistant cases Quinine Derivatives

Visitors Policy-

- ***Objective-*** *To make sure that our patients gets the rest they need and other patients are not* disturbed .

2. *To help and protect our patients, visitors and employees from exposures to respiratory , viral illness including seasonal influenza.*

Policy

1. Visitors must be age of 12 years.
2. Siblings will be allowed to visit the maternity units as long as they do not exhibit symptoms of cold or other respiratory infection .
3. Request to visit in compassionate care, situation may be approved by the nursing sister. While we are fully appreciate the impact of this policy on our patients and visitors, we believe these action are necessary to help, prevent the spread of illness with in the hospital

Visiting Hours

Daily visiting hours an rules are established for the comfort and safety of your loved one as well as for other patients in the hospital, we welcomes visitors and realize that you are integral to our patients recovery.

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General Visiting Hours

- *Before and after the round of doctor.*
- *Please limit your stay to 15-20 minutes*
- *Maximum no. of visitors in the rooms are 02 at a time*
- *Children under the age of 12 are not permitted in wards nor may they Waite in the waiting area*
- *A care giver may interrupt your visit during patients care routine.*
- *If you are unfit please postpone your visit.*

Maternity Visiting Hours.

1. Father May Visit 24 hours with an identification band or pass provided by the PHC staff
2. Siblings of all age may visit
3. all visitors including children must be healthy with no rashes , infection , cold , run-noses, diarrhea , recent exposure to infectious diseases .

PATIENT CONFIDENTIALITY PRIVACY & DIGNITY

Purpose: The policy outlines the requirements relating to the way information is collected, accessed, used, stored or disclosed.

Responsibility: All staff members of the SDH, Anandapur in every department.

Standards:

Patients, SDH, Anandapur staff and Hospital Management Committee have the right to complete confidentiality. Medical / departmental records and information regarding patients/ company matters are legally protected for protection of privacy.

- In the course of performing work responsibilities, information is considered confidential with regard to patients, their families, their physicians, SDH, ANANDPAUR staff details, and/or SDH, ANANDPAUR matters. As a condition of employment, personnel are cautioned not to discuss any such information with others.
- SDH, ANANDPAUR staff will extend their ethical responsibility of patient confidentiality, to hospital /organizational confidentiality by not disclosing any hospital related matters where patients can hear, other than as a professional response to general inquiries. SDH, ANANDPAUR personnel should avoid making any public statements related to hospital /organizational confidential matters, leaving the responsibility for such statements to the manager who will coordinate with the public relations department.

SDH, ANANDPAUR staff shall NOT release any general information such as verification that a patient has visited the hospital, the general nature of the injuries, and the degree of seriousness of His/hercondition, such as "critical" "satisfactory" or "not serious'; NOR disclose detailed information to the press without the signed authorization of the patient or Register next of kin. Any such enquiries shall be directed to Administrator.

- SDH, ANANDPAUR staff will prevent the disclosure of any personal or medical information obtained during the course of their professional duties, with anyone except other health professionals directly involved in the care. The patient right to privacy extends beyond their discharge from hospital, and beyond their death.
- Personnel shall not discuss patients in common areas or outside of the facility.
- Medical records are accessed only by staffs who are involved with the patient's care.

Medical records are protected from unauthorized access by storing in protected areas when outside of the Medical Records Department.

- The computer system requires access codes to obtain information from sensitive areas, i.e., business office, medical records, and laboratory results.
- Patient physical assessments are conducted in a location that affords visual and auditory privacy.

MAINTENANCE OF PATIENT RECORD:-

Medical records are maintained in a manner that is current, detailed, organized, and easily accessible to authorized person. All patient data is filed in the medical record, (i.e., lab, x-ray, consultation notes, etc.). Radiology investigations are also attached and are part of the medical records.

General:

- At the time of registration a unique identifier of patient is given on every file
- All orders are written in indelible ink for handwritten documentation. No pencil entries are made
- All notes and orders are dated, named dated, timed and signed (include day, month, and year).
- Timing of entries is mentioned, especially on Medication orders and administration, Pre-Operative, and Nursing documentation.
- For records on electronic media it is preferable that the date and time is automatically generated.
- All notes are legible and include clear, concise patient information.

Orders are authenticated and signatures mentioning professional title of the author are there.
Orders are written in the designated place marked for the purpose in the medical
Record/ case sheet/ OPD Card taking care, not disturbing the Chronological order.

Making Entries in the Medical Record:

1. All disciplines document according to discipline specific documentation standards.
2. Entries written in error have a single line drawn through and "ERROR" written above. Never erase, obliterate or use liquid paper correction fluid on a patient's record.
3. All forms in the record must have been previously approved.
4. No part of the medical record is ever to be removed after entry.
5. The patient's name and medical record number must appear on every record page/document in case of electronic medical record.
6. Rubber stamps are not allowed for physician signatures.
7. Inpatient Care is documented in the Medical Record and includes:

- Reason for admission, diagnosis, and plan of care is included in the documents.
- Evidence of the initial patient assessment and all subsequent reassessments.
- Documentation of interventions based on physician orders and/or on unit standards of care or approved protocols.
- Documentation of nursing care provided.

- Any Procedure performed in detail, Name, signature, and date, time on every entry made in the record.
- The record is legible.
- The records are in a chronological order demonstrating the continuity of care.
- Transfer notes is in accordance to the policy of transfer and should includes- Date, reason for discharge and name of the receiving hospital.
- Medication administration is recorded on the Medical Administration Record or area specific forms
- Specific care provided is evidenced on the patient care flow sheet.
- Patient discharge instructions

Content of Medical Records (Minimum Requirements) List:

1. Patient Identification Details on each page (e.g.: Name, Age, Sex, Ward/Bed)
2. Date and Time of examination
3. Presenting Complaints
4. Complete History
5. Assessment Findings
6. Provisional / Admitting Diagnosis
7. Reason For Admission in case of IPD Case files
8. Investigation chart and Reports
9. Treatment Plan
10. Medication Orders
11. Progress notes and orders
12. Critical Care Notes as applicable
14. Handover Notes.
16. Referral Notes where ever applicable
17. Fitness for Discharge
18. Condition on discharge.
19. Discharge summary with all instructions:

- Final diagnosis
- Reason for admission, including a brief clinical statement of the chief complaint and history of the present illness
- physical, laboratory, x-ray and other diagnostic procedures and studies
- Medical and/or surgical treatment, including the patient's response, and complications
- Condition on discharge, including, for example ability to ambulate, degree of self-care, and ability to work
- Instructions for continuing care, including information on diet, medications, activities, and follow-up.
- Prescribed medications (to clearly mention drug, dose, route and duration)
- Follow up date, time and place
- Emergency Contact information after discharge

In all IPD cases duplicated copies of discharge summary are prepared. While one copy is issued to the patient at discharge, the other one is filed in the patient's case file and is retained by the medical records dept. (Please refer to the document-"Discharge of patients"). Discharge summary is prepared and signed or countersigned by the clinician in-charge.Recording times and signatures

- Notes should be written during the patient encounter or immediately afterwards. Notes should be in a straightforward, purposeful and factual style. If on paper, write such that it cannot be erased. Use clear handwriting that is large enough to be readable on photocopying and ensure that you can be identified as the author.
- All notes MUST have a date, time, signature and name/stamp of Physician.

Note that the stamp shall not replace the manual signatures.

GENERAL CONSENT

Purpose: The purpose of obtaining a patient's general consent is to ensure that patient is informed about the routine medical and nursing care that will be provided to the patient based on which he takes decision of getting registered and admitted in this hospital.
General consent is not an alternative to Informed Consent. Informed consent shall be taken in all situations

Scope: Scope of general consent includes consent for clinical consultation, admission, disclosure of information required for clinical management (under confidence), routine medical examination (physical examination, palpation, percussion, auscultation), routine lab and imaging investigations, general nursing care, diet and physiotherapy assessment and counselling

POLICY:

- General consent shall be taken from all patients being registered and admitted in the hospital & at the time when patient enters the hospital. General consent must be obtained from an adult patient with decision-making capacity, or person legally authorized to consent on behalf of the patient.
- In case of the patients from whom consent can not be taken, (for e.g. in case of unattended, unconscious patient, Minor patients) consent shall be taken from next kin/legal guardian/relative.
- If consent is not obtained (for e.g. in case of unattended, unconscious patient, Minor patients), the reason must be documented in the patient medical record.
- General consent shall be taken in written with patients / relative's signature at the time of admission and as implied consent at the time of registration.

INFORMED CONSENT

Purpose: To define the obligations in obtaining and documenting informed consent by SDH, ANANDPAUR Consultants and staff.

Policy: SDH, ANANDPAUR Consent Policy will include all guidelines laid down by the Medical Council of India's Code of Medical Ethics. Doctors should familiarize themselves with guidance relevant to their area of practice.

THE PATIENT'S RIGHTS

- Patients must be given information, in a way that they can understand, to enable them to exercise their right to make informed decisions about their care.
- A patient has the right to give or withhold consent prior to examination or treatment.
- Patients must be allowed to decide whether they will agree to the treatment and they may refuse treatment or withdraw consent at any time.
- Minors and incompetent adult's rights regarding informed consent will be exercised through their parents or legal representative.
- The physician performing a medical or surgical procedure on a patient is responsible for obtaining the patient's informed consent prior to the treatment or procedure.

Special Instructions:

A. Elements of Informed Consent

Informed consent is a process in which the physician provides adequate information for the patient or patient's legal representative to make an informed decision on the proposed treatment, including medications or procedure.

B. Specifically, the physician must disclose in a reasonable manner all significant medical information that the physician believes is relevant and material to making an informed decision by the patient in deciding whether or not to undergo the procedure or treatment. This information should include all of the following:

- The nature of the patient's condition;
- The proposed treatment, possible treatment alternatives, including no treatment;

- The benefits of the proposed procedure, as well as frequently occurring and significant risks of the proposed treatment and alternatives;
- The consequences of no treatment;
- If applicable, the possible use in education and/or research of blood or tissue removed from the patient not needed for further medical care.
- The patient or patient's authorized representative should be given the opportunity to ask question and receive additional as required.
- The patient should also be advised that it is not possible to predict or guarantee results.

C. Documentation

1. If preoperative medication (sedation or pain medication) is to be administered, informed consent or verification of informed consent must be obtained prior to the administration of such medication.

2. The physician must document in the medical record, on an approved hospital form when available, consent for all therapeutic and diagnostic procedures where disclosure of significant medical information, including significant and frequently occurring risks involved, would assist a patient in making an informed decision whether to undergo the proposed treatment or procedure. Such procedures include surgical and other invasive procedures, other treatments with significant risks, and transfusion of blood and/or blood products.

3. The approved hospital forms must always be completed on all cases involving a procedure for which documented consent is required.

D. Exceptions: Certain recognized exceptions to informed consent include:

1. Medical Emergency: A procedure which may otherwise require informed consent may be performed without obtaining prior informed consent in an emergency when the patient is incapacitated and cannot make an informed decision, and the patient has a life or health-threatening situation requiring immediate treatment such that any delay in treatment would likely result in death, deterioration, or serious permanent impairment.

2. Patient's Lack of Capacity to Consent: Patient is incapable or lacks the capacity to give consent. In these cases, suitable alternative procedures, including use of legal guardian where appropriate, should be initiated if no emergency exists.

3. Minor: If the patient is under eighteen years of age, consent should be obtained and documented in the otherwise usual manner from the minor's parent or the minor's legal guardian. The specific facts and reasons the exception applies must be thoroughly documented in the medical record. These exceptions should not be made in lieu of appropriate consent process except under extraordinary circumstances.

E. Duration of Informed Consent

1. Informed consent may be considered to have continuing force and effect until the patient revokes the consent, or until circumstances change so as to materially affect the nature of, or the risks or benefits of, the procedure and/or the alternatives to the procedure to which the patient consented. For example, if a patient has been admitted for a specific treatment or procedure, the consent should be valid through the course of the admission unless the patient's condition or treatment changes significantly. In that event, the physician should obtain a new informed consent. Generally, informed consent should be obtained and documented no longer than 60 days prior to a procedure, surgery, or treatment. After this time period, the informed consent should be re-obtained and re-documented by the physician.

2. Revocation - A patient may revoke consent verbally or in writing. This should be communicated to the patient's physician and documented in the medical record.

F. Informed Consent for Continuing Therapy

Informed consent shall generally be obtained before each new procedure. However, patients in certain therapeutic programs involving a course of multiple treatments may consent to an entire course of routine therapy prior to the first treatment, and a single consent form may be signed for the entire course of treatment (not to exceed one year), if:

1. The entire course of treatment is disclosed, consented to, and documented in accordance with this policy, and

2. No material change occurs in:

- the risks, benefits of and alternatives to the treatment;
- the mode of treatment;
- the patient's medical condition; or
- the patient's capacity to consent; and

3. Patient does not revoke consent; and

4. Consent is re-obtained and re-documented at least annually. Examples of therapeutic programs covered by this exception include, but are not limited to the following: chemotherapy,

repetitive blood or blood products transfusions; peritoneal dialysis, and hemodialysis; and plasmapheresis procedures.

G. Role of Registered Nursing Staff in the Informed Consent Process

1. The treating physician has the duty to disclose all information relevant to the patient's decision and to obtain the patient's informed consent. The registered nurse should verify with the patient and/or by specific documentation of informed consent in the medical record that consent has been obtained by the physician prior to the procedure or treatment.

2. In the event the nurse determines that informed consent has not been obtained or documented, the nurse will contact the physician who will complete the consent process, speak with the patient, and/or provide specific documentation of the informed process which has previously taken place.

Treatments and Procedures where *written* consent is necessary:

The patient's signature consent must be obtained for treatments and procedures that:

1. Involve the use of sedation
2. Involve the use of anesthesia or narcotic analgesia
3. Can be reasonably expected to produce significant discomfort to the Patient
4. Can be reasonably considered to have a significant risk of complication or morbidity
5. Require injections of any substance into a joint space or body cavity, including any nonvascular space.
6. Involve testing for human immunodeficiency virus (HIV)
7. Surgical or invasive procedures, including but not limited to:
    - Acupuncture
    - Anesthesia (except for low-risk local anesthesia);
    - Aspiration of body fluids through the skin (e.g., arthrocentesis, bone marrow aspiration, lumbar puncture, paracentesis, thoracentesis);
    - Biopsy (e.g., breast, liver, muscle, kidney, genitourinary, prostate, bladder, skin);
    - Cardiac procedures (e.g., cardiac catheterization, cardiac pacemaker electrode insertion, electrical cardioversion);
    - Central vascular access device insertion (e.g., arterial line, Swan-Ganz catheter, percutaneous intravascular catheter (PIC) line, Hickman catheter);
    - Electrocautery;

- Endoscopy (e.g., bronchoscopy, colonoscopy, cystoscopy, laparoscopy);
- Laser therapy;
- Oral surgical procedures (including gingival biopsy);
- Sterilization of reproductive capacity;
- Thoracotomy;
- Tracheostomy; and
- Transjugular intrahepatic portal stent (TIPS).

1. Blood product transfusion.
2. Dialysis (hemodialysis or peritoneal).
3. Electroconvulsive therapy.
4. Genetic testing.
5. Hazardous drugs (e.g., cancer chemotherapy, disulfiram, methadone for narcotic dependence, naltrexone).
6. Photochemotherapy in combination with psoralens or other topical agents.
7. Ultrasound therapy (e.g., lithotripsy).

8. OTHER PROCEDURES
   1. Amniocentesis
   2. Aspiration of Cysts
   3. Biopsies
   4. Bone Marrow Biopsies
   5. Colposcopy-With or Without Cervical and/or Endocervical Curettage
   6. Incision or Drainage of Cysts
   7. IUD
   8. Lumbar Procedure
   9. Polyp Removal
   10. Proctoscopy
   11. Sigmoidoscopy

9. High Risk Procedures in OPD
   1. Minor Surgeries
   2. Stress Tests
10. All procedures in Operating Theatres
11. Admission

12. Research
13. Statutory Requirements
14. **With reference to specific practice (Statutory Requirements)**

- The Physician may undertake in vitro fertilization and / artificial insemination with the informed consent of the patient and her spouse in writing. They should be explained, at their level of comprehension, about the purpose, method inconveniences, rate of success as well as probable and possible risks.
- The Physician must follow Guidelines laid down by the Indian Council of Medical Research for research and therapeutics trials.
- Special Consent provisions under PNDT Act (Form G)
- Consent Requirements under MTP Act (Form C)

The **Written Consent** Form **Must** include as a minimum:

1. The name(s) of all the practitioner(s) immediately responsible for the performance, and if applicable, the supervision of the treatment or procedure, such as the resident physician and the attending.
2. A brief description of the recommended treatment or procedure.
3. A statement that relevant aspects of the treatment, or procedure, including indications, benefits, risks, and alternatives including no treatment have been discussed with the patient in language that the patient could understand; and that the patient indicated comprehension of the discussion.
4. A statement that the patient had an opportunity to ask questions.
5. The date and time the discussion took place and whether the patient consented to the treatment or procedure.
6. The written signature of the practitioner writing the note (including the Practitioner's legibly written name).
7. Signature/Thumb impression of Patient/Next of Kin/Guardian as applicable and legible written name.
8. Date of Consent

Treatments and Procedures that do not require Written Consent.

- Treatments and procedures that are low risk and are within broadly accepted standards of medical practice (e.g. administration of most drugs or for the performance of minor procedures such as routine X-rays) do not require signature consent.

Withdrawal of consent by Patient

Patients can change their minds about a decision at any time, as long as they have the capacity to do so.

Refusal of Treatment by Patient

Patients are entitled to refuse consent to treatment even when doing so may result in permanent physical injury or death. When the consequences of refusal are grave, it is important that patients understand this, and also that, for clinical reasons, refusal may limit future treatment.

Consent for blood transfusion

The nursing staff will assess the pre-operative anesthetists assessment and orders in which it is expected that she/he will indicate on the form if a blood transfusion has been indicated, the patient's blood type and where the blood transfusion is to be collected from. The nurse will check with the patient that they were aware that this was included in the patients consent and that they agree to the blood transfusion.

All procedures will be delayed if these criteria have not been met and there is no evidence of informed patient consent for the procedure and/or blood transfusion and the patient is likely to require a blood transfusion.

Appendix 1

Statutory Requirements of Consent: Medical Council of India's Code of Medical Ethics:

2. **Before performing an operation** the physician should obtain in writing the consent from the husband or wife, parent or guardian in the case of minor, or the patient himself as the case may be.
3. In an operation, which may result in sterility, the consent of both husband and wife is needed.
4. A registered medical practitioner shall not publish photographs or case reports of his / her patients without their permission, in any medical or other journal in a manner by which their identity could be made out. If the identity is not to be disclosed, the consent is not needed.

5. No act of invitro fertilization or artificial insemination shall be undertaken without the informed consent of the female patient and her spouse as well as the donor. Such consent shall be obtained in writing only after the patient is provided, at her own level of comprehension, with sufficient information about the purpose, methods, risks, inconveniences, disappointments of the procedure and possible risks and hazards.
6. **Research**: Clinical drug trials or other research involving patients or volunteers as per the guidelines of ICMR can be undertaken, provided ethical considerations are borne in mind. Violation of existing ICMR guidelines in this regard shall constitute misconduct. Consent taken from the patient for trial of drug or therapy which is not as per the guidelines shall also be construed as misconduct.
7. A Physician must attend to her/his pregnant patient in her confinement on terms agreed upon. If exceptional circumstances prevent the Physician from providing services, another physician may be sent for. When the delivery is accomplished, the visiting physician is entitled to his/her professional fees, but he/she must obtain consent from the patient to leave, when the primary Physician arrives.

8. **Obtaining Consent**

Successful relationship between doctors and patient depends on trust.

- The Physician must respect the patients autonomy, their right to decide whether or not to undergo any medical intervention.
- Patients must be given sufficient information in a way they can understand to enable them to exercise their right to make informed decision about their treatment.
- The Physician must give patients details before he/she decides to consent to an investigation or a treatment.
- The Physician must give details of the diagnosis and prognosis of the disease, if left untreated.
- The Physician must inform the common and serious side effect for each option available to the patient. And also of any lifestyle changes which may be caused by or necessitated by the treatment.
- The Physician must respond honestly to any question the patient raises. She/He must answer such question as fully, accurately and objectively as possible.
- The Physician must not exceed the scope of authority given to you by your patients, except in an emergency.

- The Physician must obtain consent from patients before testing for a serious communicable disease. The information provided, when seeking consent, should be appropriate to the circumstances and the nature of the conditions being tested for. Some conditions such as HIV have serious social and financial as well as medical implications.
- When investigating / treating a child who cannot give or withhold consent, seek consent from a person with parental responsibility for the child.

LINEN CHANGE POLICY

1. SDH staff will provide patient care linen appropriate to the specific requirements of each patient's care needs.
2. There will be procedures used universally that are intended to meet the general requirement. This establishes cost control and allows variance to meet specific patient care needs above the general requirement.
3. Clean linens are to be stored on the clean linen carts or in the clean linen closets.

STANDARD PATIENT ROOM PREPARATION

1. Each hospital bed, prior to patient occupancy, is made up according to the following standard use of linen:

Medical beds/labour room beds
(1) Fitted Sheet
(1) Flat Sheet
(1) Draw Sheet
(1) Pillow
(1) Pillowcase
(1) Thermal spread

2. Additional bed linen should not be necessary for routine patient care. Exceptions must be justified by need. Note the additional guidelines.

- Additional pillows if requested by the patient for comfort.
- Additional pillows required for patient positioning.
- For additional warmth a bath blanket or additional sheet may be placed over the thermal blanket/spread. Thermal blankets should not be layered.

STANDARD LINEN CHANGE FREQUENCY

1. Bed linen will be changed as follows:
    - Patient/family will be asked daily if they would like their linen changed.
    - Linens will be changed at the request of the patient/family.
    - Linens are to be checked and straightened as needed.
    - Linens will be changed as needed due to soiling.

- The thermal spread will remain on the bed throughout the patient stay unless it becomes soiled or wet.
- All torn or stained linen is to be place in the mesh bag located near the dirty linen carts or chutes. Do not throw linen into trash or red bags.
- Upon discharge, any linen left in a patient room should be placed in the dirty laundry for reprocessing.

EXCESS LINEN IN PATIENT ROOMS

1. Only linen additionally necessary for immediate use should be placed in the room.

2 If a patient is going to be discharged, no clean linen should be placed in the room if it does not compromise patient care or comfort.

ADDITIONAL LINEN GUIDELINES

1. No soiled linen is to be rinsed.
2. All linen is to go into the laundry bags.
3. Hospital linen should not be worn or used by SDH, Anandpaur staff (unless assigned).
4. Linens and scrubs are the property of the SDH, Anandpaur and are not authorized for patients, employees or students to take home. Employees found to be non-compliant, will be subject to disciplinary action.
5. Paramedics and ambulance staff are not to remove linens and pillows from the nursing units or other patient care areas.
6. Linens for ambulances are stocked outside of the ambulance office. These are linens that are slightly stained or do not belong to SDH, ANANDPAUR.

Color Coding of Laundry Bags:

Yellow Bag: Infected linen soiled with patient blood, excreta or body fluids.
Green Bag: Clean contaminated linen.

Categories of Linen

Clean Contaminate Linen

Used linen that is apparently not stained with blood, excreta, body fluids etc
All the linen that is not contaminated is send for washing directly after packing in the laundry bags.

Known, or potentially, infected/ infested linen

All linen that is:

- Grossly contaminated with excreta, blood or body fluids.
- Contaminated linen from a patient who is known, or clinically suspected, to be infectious. For example salmonella, hepatitis A, B or C, open pulmonary tuberculosis, HIV.

All the contaminated linen is dipped in 5% sodium hypochlorite for 1-2 hrs and first disinfected and then sent for washing

Items Specified:

Pillows

These must be protected by heat-sealed, waterproof covers, which are cleaned with detergent and water between patients. Alcohol wipes must not be used to clean these items as alcohol damages the cover which may allow fluid to pass through the mattress foam. If cover is damaged or punctured, and article itself is contaminated it must be condemned and disposed of as a waste. Pillows are regularly changed with fresh pillow case and beds are disinfected with 1% sodium hypo chloride after death and discharge of a patient.

- Linen must be handled with care to prevent environmental contamination with excretion or secretions, skin scales or bacteria. Linen must be bagged at the bedside, never shaken or allowed to touch the floor.
- All the items send to the laundry are appropriately marked including mattress- overlays, clothing.
- Gloves may be also required if linen is wet. Hands must be washed after handling soiled or infected linen.
- Linen should be held away from the body to prevent contamination of clothing.
- All the used linen is stored in a laundry bag .

Records Generated

Linen stock registers

Condemnation Process

- The Condemnation committee is to be formed by the SDH, ANANDPAUR Ghatagaon
- The committee will inspect each and every item of linen meant for discard and recommend for their condemnation and replacement.
- List of items approved for condemnation has to be filled up.
- Replenishment of linen items condemned by the committee is done by the general store in order to maintain adequate inventory level to ensure smooth functioning of the facility services.

USE OF PERSONAL PROTECTIVE EQUIPMENT:-

Gloves

A. Disposable (single use) gloves shall be readily available in patient care and specimen handling areas.

- Gloves must be worn for:

  i) Anticipated contact with moist body substances, mucous membranes, tissue, and non-intact skin of all patients;

  ii) Contact with surfaces and articles visibly soiled/contaminated by body substances;

iii) Performing venipuncture or other vascular access procedures (IV starts, phlebotomy and in-line blood draws);

iv) Handling specimens when contamination of hands is anticipated

A. Remove and discard gloves after each individual task involving body substance contact, before leaving the bedside.

- Gloves should not be worn:

i) Away from the bedside or lab bench

ii) At the nursing station

iii) To handle charts, clean linen, clean equipment or patient care supplies

iv) In hallways or elevators.

B. Wash hands as soon as possible after glove removal or removal of other protective equipment. Gloves are not to be washed or decontaminated for reuse (exception: heavy duty gloves)

C. Caution: Gloves do not provide protection from needle sticks or other puncture wounds caused by sharp objects. Use extreme caution when handling needles, scalpels, etc.

Masks, eye protection and face shields

1. Wear masks in combination with eye protection devices (goggles or glasses provide with side shields) or chin-length face shields during procedures that are likely to generate droplets, spray, or splash of body substances to prevent exposure to mucous membranes of the mouth, nose and eyes. Masks are also worn to protect personnel from transmission of infectious droplets during close contact with the symptomatic patient.
2. Situations, which may increase risk of splash/splatter, include the following

a) Trauma care
b) Surgery
c) Emptying bedpans/ suction canisters into hopper/toilet
d) Code blue
e) Patient care of coughing patient with suspected infectious etiology

Aprons, gowns, and other protective body clothing

The appropriate type of garment shall be based on the task and the degree of exposure anticipated. Gowns are worn to prevent contamination of clothing and protect the skin of personnel from blood/body fluid exposure.

a) Wear plastic aprons or gowns during patient care procedures that are likely to soil clothing with body substances.

b) Wear lab coats in laboratory settings.

c) Remove protective body clothing before leaving the immediate work area.

d) In surgical or autopsy areas, additional protective attire may include surgical caps or hoods and shoes

PRESCRIPTION BY GENERIC NAME POLICY

Purpose: The Purpose of this policy is to set standards for

- Physician orders (Inpatient as well as Outpatient orders),
- Verbal/Telephone orders

Scope: The policy applies to all the clinical specialties, including ICU's, Inpatient area and Out-patient Department.

Responsibility: Physicians

Physician Orders:

- Only Physicians authorized by SDH, ANANDPAUR can prescribe medications.
- All drugs must be prescribed in Generic Name.
- Physicians are authorized to use only those drugs listed in the Formulary except in specific instances.
- All medication orders to be written on HIS/SDH, ANANDPAUR GHATAGAON Prescription Form/Letterhead or the Case Sheets labeled/verified with Patient's name and Registration number.
- **Use of Hospital Information System:** Use of Hospital Information System for reducing prescribing errors is desirable to reduce prescription errors.
- Orders are to be written in a uniform location in the medical records.
- History for drug allergies to be documented in red ink.
- Abbreviations for drug names are not be written.
- All medication orders to specify the drug name, dosage or dosage range, the route of administration, the frequency and duration of administration.
- High Risk medications need to be verified by treating Consultant prior to administration.
- Medication orders are to be clear, legible, dated, named and signed.
- Doses:

a. For paediatric age group patient shall be based on age, weight etc.
b. All orders for a drug dose less than one shall have a zero preceding the decimal amount. E.g. write 0.25mg instead of 0.25 mg.
c. Do not use decimal points or trailing zeros. e.g. Write 2 mg instead of 2.0 mg.
d. Microgram amounts shall be clearly written as “microgram” to clearly distinguish form milligrams (mg).
e. All orders for units shall be clearly written in “units”.
f. Orders calculated in either milligrams or micrograms doses shall be left in the units in which the calculation was made.

- If more than one physician is prescribing medications for one patient, each individual medication order must be written separately and each medication order must be signed.
- To change any of the medication orders, physician must cease the original order and write a new order.
- To cease a medication order physician must draw a line across the area of the chart where administration is recorded (after the last entry) and sign and date adjacent to this line.
- The original order must not be obliterated.
- If a drug is not to be given on certain days, cross out those days on the medication chart, in order to prevent the drug being administered in error on those days.
- There shall be an automatic cancellation of drug orders when a patient changes service, when a patient is moved into or out of an intensive care unit, or when a patient is sent to the operating room or delivery room.
- All the medications prescribed at the time of discharge should be included in the discharge summary, whether or not it is to be supplied by the hospital pharmacy.
- Orders for research drugs can only be written by the physician involved in that research protocol.

Patient and Family Education

- Patient and family are to be educated about safe and effective use of medication.
- Patient and family are to be educated about food-drug interactions.

SPECIFIC SITUATIONS:

1. **Drops:** specify which orifice (ear, eye, oral) and the number of drops to be given. **Do not** use Latin abbreviations such as AU for both ears, AS for left ear, AD for right ear.
2. **Skin creams:** specify the area of skin on which application is required and the amount to be applied on a given occasion.
3. **Infusions:** specify as subcutaneous, intravenous, epidural or intrathecal. For intravenous infusions----specify via regular drip set, microdrip set or syringe pump; peripheral vs central access, mode of preparation of infusion , rate, duration, titrating orders for nursing staff (eg—as per BP level, as per HR, as per glucometer reading, etc)
4. **Insulins and insulin syringes :** specify 40 Unit/ml or 100 Units/ml
5. **Oxygen:** specify as --- litre/min via nasal cannula/venturi mask/ventilator
6. **Vaccines:** patient leaflet to accompany each vaccine. Batch number to be indicated on patent's immunization card.
7. **Paediatrics:** dose --- mg/kg/day in 3 divided doses is better written as --- mg thrice-a-day factoring in the patient's weight. Avoid leaving that responsibility on the nurse/pharmacist.
8. **Narcotics:** Requires narcotic prescribing license number
9. **Emergencies:** write " STAT" next to the prescribed item
10. **IUCD/pessary:** specify when next to be changed
11. **Surgical / miscellaneous items:** specify number of items needed and their size (eg: 16 gauge or small/medium/large/X large)
12. The Physician is to notify the nursing staff when "Stat" orders are written. "Stat" orders must be transcribed immediately and followed.
13. "Hold" means discontinue the medication.

Telephone or Verbal Orders:

Safety is the overriding principle in accepting verbal or telephone orders. Verbal and telephone orders have a higher potential for errors as these orders can be misheard, misinterpreted and/or mistranscribed.

1. Verbal or telephone orders are to be accepted only by GDMO when it is impossible or impractical for the physician to write them.
2. Verbal or telephone orders for chemotherapy are not acceptable.

3. Abbreviations should not be used when an order is given or received.

Process for giving verbal or telephonic orders:

1. The Physician will call up the concerned GDMO at the hospital.
2. The physician identifies self, specifies the patient's name and communicates the order.
3. The Receiver will document the order immediately on the physician's order form/case sheet including the date, time, physician's name and pager number/service. Receiver's name, status and signature.
4. The Receiver should **read back** the order to the physician including the patient's name, drug name and spelling of the drug to avoid an error due to sound alike drugs, Dosage, pronouncing it in single digits (e.g. 15 mg should be read as one five), route, frequency (e.g. three times daily, not TID)
5. The Receiver should also Request the indication for the medication to assist in avoiding errors.
6. The Receiver should question the Physician if there is any uncertainty regarding the order.
7. The Physician must counter sign the order as soon as possible or within 24 hour after communicating the order.

Rules to be followed while writing Patient prescriptions:

1. CHECK BEFORE YOU WRITE!
Allergies & Sensitivities
Cautions & Contraindications
Drug Interactions
Pre-Existing Conditions
Renal & Hepatic Function
Patient's Age
Patient's Weight
2. DRUG NAMES:
Always write Legibly
Prefer CAPITAL LETTERS
Use Black or Blue Ink
3.APPROVED NAMES OF DRUGS

Prescribe those Drugs listed in SDH, ANANDPAUR Drug Formulary
4. DOSE
Always Prescribe Dosage units in full i.e UNITS MICROGRAMS, NANOGRAMS.
Accepted Abbreviations
mg =milligrams
ml =milliliter
g = gram
Always specify Strength of Preparation
When using decimals, write a zero in front of the decimal point. e.g. 0.5ml.
5.ROUTES OF ADMINISTRATION
IV for Intravenous, IM for Intramuscular
SC for Subcutaneous
SL for Sublingual
PV for per vagina
Neb. for via Nebulisers
Inhal. for by inhalation
Other routes write in full eg Oral, rectal, topical, intrathecal, epidural.
IV Infusions On IV Charts
1. Dose of drug
2. Diluent & volume of infusion
3. Rate of Infusion
Infuse over 8 hours
X ml per hour
X mm/hour etc
6. TIMES OF ADMINISTRATION
Always state dose and frequency and maximum daily dose.
On inpatient prescriptions always write times of administration.
OM – Once daily in morning
ON – Once daily in Night
BD – Twice a Day
TDS – three times a day
Four times a day – four times a day

7.DATE STARTED/DATE CANCELLED
Always state stop and start dates
Cancellations must always be signed and dated
8. REWRITING OF PRESCRIPTIONS
Don't Rewrite on Prescriptions
Alterations must not be made to prescriptions
Each change of dose, route etc must be written as a new prescription in order to avoid ambiguity and errors.
9. PATIENT DEMOGRAPHICS
In OPD Prescriptions always note down
NAME
AGE
SEX
WEIGHT
ADDRESS
Other relevant information according to the Specialty.
10. IDENTIFICATION OF PRESCRIBER
Name of Doctor
Signature of Doctor
Registration number with concerned Medical Council

ADVERSE EVENT REPORTING POLICY

Purpose: To provide a mechanism for identifying, reporting, and monitoring adverse drug events (ADES).

Scope: This policy applies to medication therapy for all patients cared for in the hospital.
Anyone who provides patient care at the hospital can report an Adverse Drug Event

Definitions

What is a reportable Adverse Drug Event (ADE)?

1. Adverse Drug Event includes all medication errors and adverse drug reactions.

2. A Medication Error is any preventable event that may cause or lead to inappropriate medication use or patient harm.
3. A Reportable Adverse Drug Reaction (ADR) is an unintended drug reaction that:
   - Prolongs hospital stay
   - Results in admission or an Emergency Department visit
   - Causes the postponement or cancellation of surgery
   - Is unlabeled or rarely seen
   - Results in death or permanent disability
   - Is potentially life-threatening.
   - Also reportable:
     - Known reactions that present in unexpected or unusual ways also are reportable.
     - Potential Adverse Drug Event (PADE) or Near miss - a hazardous situation that could lead to an error.

Procedures & Responsibilities

1. **Identifying an ADE**
   - Staffs who suspect an ADE notify prescriber and GDMOimmediately if the event is significant or may alter the patient's plan of care.
   - Assess the patient.
   - Implement adjustments in patient's treatment as ordered.
   - Document the description of the ADE in incident form, categorize subsequently monitor in the progress record.

2. **Reporting an ADE**
   - Staff completes the Incident reporting form immediately or not later than 24 hours of the ADE identification.
   - Forms are sent, confidentially to the Manager Quality, either as hard copy or via`email.
   - Security of Information: No copies are made of the incident forms.
   - Reports to include:
     - Describe the error or preventable adverse drug reaction. What went wrong?
     - Was this an actual medication accident (reached the patient) or are you expressing concern about a potential error or writing about an error that was discovered before it reached the patient?

- Patient outcome.
- Where in hospital did this occur.
- Generic name of all products involved.
- Brand name of all products involved.
- Dosage form, concentration or strength, etc.
- Where error was based on communication problem, is a sample of the order available? Are samples or pictures available if requested?
- Please state your recommendations for error prevention.
- Please include the name and contact info of reportee.

3. Reviewing ADEs

- Supervisor/manager completes timely evaluation of the circumstances surrounding the event.
- Root cause analysis
- In the case of significant ADE's or medication-related sentinel events, reviewers inform department director or manager, as well as compliance with sentinel event policy.
- ADE reports are categorized by: location, severity, product information and therapeutic classification, type, causes and contributing factors.
- ADR's are further evaluated to determine:
    - Appropriateness of medication for patient's condition
    - Any contraindications to medication
    - Appropriate documentation of Allergies
    - Appropriate management and monitoring of ADR

The P & T Committee reviews the monthly report, significant events, and results of root cause analysis and makes recommendations for improvements to the medication use process.

EXCEPTIONS

Adverse reactions that occur following the administration of investigational drugs are reported according to the specific protocol for that drug by contacting the principle investigator.

References: National Coordinating Council for Medication Error Reporting and Prevention

CATEGORIES OF ADVERSE DRUG EVENTS:

Category	Description	Effect
Category A	An error occurred that **may have the capacity** to cause error	**No Error**
Category B	An Error occurred but the error did not reach the patient	**Error, but No Harm**
Category C	An Error occurred that reached the patient but **did not cause patient harm**	**Error, but No Harm**
Category D	An error occurred that reached the patient and **required monitoring** to confirm that it resulted in no harm to the patient and / or required intervention to preclude harm	**Error, but No Harm**
Category E	An Error occurred that may have contributed to or resulted in **temporary harm** to the patient and required intervention	**Error + Harm**
Category F	An error occurred that may have contributed to or resulted in **temporary harm** to the patient and required **initial or prolonged hospitalization**	**Error + Harm**
Category G	An error occurred that may have contributed to or resulted in **permanent patient harm**	**Error + Harm**
Category H	An error occurred that required **intervention necessary to sustain life**	**Error + Harm**
Category I	An error occurred that may have contributed to or resulted in the patient's death	**Error + Death**

CONSULTATION AND BED ALLOCATION POLICY

Purpose: To provide a mechanism to facilitate admission of patients.

Scope: Covers OPD, IPD, and Emergency patients

Responsibility: Help Desk Staff, Consultants and Nurses

Policy: The hospital will register and admit a patient according to the process laid down and according to the scope of the services provided by the hospital.

- No patient is to be denied admission due to race, color, religion, ancestry, or nationality origin.
- Patients will be admitted under doctors with admitting privileges only.
- All patients requiring admission will be screened by the admitting doctor to decide the urgency, the bed category (Ward), and necessary examination to establish a provisional diagnosis or valid need for admission based on the scope of services.
- In emergency, a screening for triage of patients will be carried out.
- Admissions are accepted 24 hours a day, 7 days a week, irrespective of any holidays.

Prioritization of Admissions

1. Patients shall be admitted to the Hospital on the basis of the following order of priorities when there is a shortage of available beds:

- Emergency: Needs immediate care
- Routine: For surgical or other treatment and waiting will not affect the patient's medical condition.

2. Admissions to special care units shall be in accordance with established criteria.

3. Exceptions shall be approved by the Head of Department/Medical Officer.

Patient & Family Education on Admission

1. During admission the patient and /or the family members are educated to make informed decisions, by all members of the team, as appropriate.

2. This shall include but not be limited to:

- An explanation about the medical condition

- Proposed care, including procedures to be carried out, expected length of stay, where it can be anticipated, expected results and risks of complication.
- An estimate of the costs will be provided in package or planned procedures where expected length of stay / treatment is known.

3. The following will be ensured/ provided on admission:

- Admission orders by Physician
- Completed admission request form either prior to admission or to be provided by the Resident/treating Doctor immediately on admission.
- Allocation of IPD Number
- Allocation of Bed
- Inpatient information sheet
- Admission face sheet which includes Authorization signed by Patient / family for admission and treatment.
- IPD guide, with stated visiting hours, attendant pass etc.
- Patient &/or Family Rights and Responsibilities brochure
- In case of Medico legal admissions, a medico legal report will be generated as per policy.
- Disclosure of information form to be signed by the patient.

Admission Procedure

1. Pre admission investigations process

- Patient approaches IPD with admission request form issued by the doctor
- Patient details entered in register.
- Pre admission tracking sheet generated.
- Patient is told about the reporting time and entry is made in Expected Admission register

2. Patient Admission Process

- Pre-admission investigation reports collected from the report desk on the day of admission.
- Patient informed about the charges and other essential details like Estimated Expense, inpatient Information, Mentor etc required during the stay.
- Availability of room is checked from the record and clearance is taken from SN I/C
- Patient details entered in register and face sheet generated
- Advance amount taken from the patient by cash / credit card / as per the estimated cost

- For TPA patient pre-authorization form is given to be filled up by the patient and the doctor (see insurance process)and signature is taken on TPA - Hospital Policy Form
- Passes are issued to the patient as per visitor policy and entry made in Admission & Discharge Register
- Patient folder is created & sent to the wards
- If patient came in Triage and needs to be admitted then the Admission request is filled by Emergency Medical Officer.

BED MANGEMENT

Purpose: To establish an overall management plan to provide appropriate and consistent inpatient access during periods of high volume.

Scope: All Inpatient areas.

Responsibility: The Hospital Manager /BPM, Emergency in-charge, collaborates with Asst. Matron/ NS to uphold the policy and procedure.

Policy: The management of patient volume is essential in order to minimize delay and/or diversion of patients to other facilities. The Help Desk notifies all services of census levels in order to initiate the appropriate census management activity.

Specific Information:

1. Beds are assigned according to the following guidelines:

- When beds are available, these are routinely allocated on first cum first serve basis, keeping the patient request as well as medical condition in view.
- Standby beds are kept to receive surgical patients undergoing surgery.

2. The priority for bed allocation includes the following:

- Patients who are already admitted in SDH, ANANDPAUR are given first priority for bed assignment based on the patients' medical needs and request.
- Patients external are placed in queue to receive a bed, with medical condition being the factor for priority consideration.
- Emergency and critical patients will be given first priority in allocation of beds.
- Routine admissions will be allocated a fresh date for admission, and the rescheduled patients will get priority bed allocation over fresh admission requests.
- For patients being transferred from another hospital, the external facility may be asked to hold the transfer until the room is available.

3. Inpatient Overflow Plan in case of overflow of patients.

4. Emergency room:

- In case of non disaster episodes the most stable patients are transferred either towards /discharged as per the condition may be. The decision on labeling patient stable and

transferring patients is decided by the Emergency in-charge in routine hours (9:00 am - 5:30 pm) and doctor on duty in consultation with emergency in-charge during off hours.

- In case none of the patients is stable and inflow of the patients is still there then shift/refer the patients to the hospital.
- In case the emergency of the hospital is also running full then it is the duty of the doctor on duty to arrange for emergency bed in other hospital nearby.

5. Wards

In case there is no room available in the desired category and the desired department then the patient will be transferred in the following order:

- First category wise available room.
- First department wise available room.
- First category and department wise available room in SDH, ANANDPAUR.
- Emergency room
- Isolation room if available
- Nearby hospital

TRANSFER OR REFERRAL

Purpose: To establish an appropriate mechanism for transfer or referral of patients who do not match the organizational resources.

Scope: Patients who do not match organizational resources, both in emergency as well as non emergency situations.

Responsibility: Treating Consultant & Emergency Doctor

Policy: While majority of patients accessing care directly or through referrals, match the scope of available facilities, there may be instances where patients who seek treatment do not match the available resources. Such cases will need to be referred or transferred to another facility both for emergency as well as non emergency conditions.

Emergency Medical Conditions:

The Emergency Department will ensure:

- Prompt initial assessment and management of all emergency conditions by qualified staff within their capabilities and resources available
- Provide stabilization and prompt and safe transfer to another facility if a decision to transfer has been established.
- The decision for transfer will be taken by the treating Physician, depending on the medical condition of the patient.
- In selecting the appropriate centre for transfer, the patient's preference, vicinity, and availability of care and available bed is taken into consideration.
- A transfer of a critical patient between facilities, in which the benefit does not outweigh the risk, is not an appropriate transfer. The decision to transfer should be taken by the transferring Physician and made on proper assessment of the condition of the patient and deciding that the benefits of transfer outweigh the risks. Generally speaking, if the patient is likely to deteriorate or Register condition is unstable, it is better to withhold transfer, as it is better to avoid death en route unless conditions are forcing the decision. In such cases, the consent, risks of transfer etc should be fully explained and documented.

- The hospital provides the receiving hospital with all appropriate medical records, or copies thereof, related to the emergency medical condition, including without limitation available History, observations of signs or symptoms, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies, treatment provided, and results of any tests. Other appropriate medical records not available at the time of transfer must be sent as soon as possible thereafter. Additionally, documentation must include the patient's written informed consent to the transfer or the written certification that the benefits of transfer outweigh the risks.
- The transfer is affected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.
- A proper handover of the patient takes place when handing over is carried out at the receiving facility.

To Stabilize:

With respect to an Emergency Medical Condition that the individual is provided, such medical treatment as is necessary to assure that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from the facility as determined by a physician. Such treatment may include the following, whenever indicated:

a. Establishing and assuring an adequate airway and adequate ventilation

b. Initiating control of hemorrhage.

c. Stabilizing and splinting the spine or fractures.

d. Establishing and maintaining adequate access routes for fluid administration.

e. Initiating adequate fluid and/or blood replacement.

f. Determining that the patient's vital signs (including blood pressure, pulse, respiration, and urinary output, if indicated) are sufficient to sustain adequate perfusion.

Transfer of Unstable Patients

1. If a patient has not been or cannot be stabilized, the hospital may not transfer the patient unless either (a) or (b) is met:

a. The patient, or legally responsible person acting on the patient's behalf, requests in writing that the transfer be affected, after being provided complete information pertaining to the transfer decision, including information concerning:

- The medical necessity of the transfer.

- The availability of appropriate medical services at both the hospital and the receiving hospital.
- The hospital obligation to provide screening and stabilization services without regard to the patient's ability to

b. A physician has determined and signed a certification to the effect that, based upon the reasonable risk and expected benefits to the patient and based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another hospital outweighs the increased risks to the individual.

2. The patients who are unstable and/or are on ventilator support will be transferred in an ACLS ambulance and have to be accompanied by at least the following staff.

- A qualified Physician with BCLS/ACLS training.
- A qualified Nurse/Pharmacist

Transfer of Stable Patients

If a patient has been stabilized, such that

- no material deterioration of the patient's condition is likely within reasonable medical probability, to result from or occur during the transfer of the individual,
- or if a patient has been determined not to have an emergency medical condition,

The hospital may transfer the patient, if written informed consent is obtained from the patient/attendant, after the patient has been provided complete information pertaining to the transfer decision, including the risks and benefits of the transfer.

Documentation:

- Physician documentation
- Progress note stating medical necessity, if the procedure is emergent or urgent, and if the patient is stable for transport.
- Consent form signed and on file.
- Nursing documentation
- Time patient left the unit
- Vital signs before leaving/patient stable for transport.
- Patient and/or family in agreement with plan.
- If sedation, anesthesia, or other medications will be required, a physician to physician or Nurse to Nurse phone report may be necessary to maintain continuity of care.

Non Emergency Medical Conditions

In such cases, the Consulting Physician, discusses the further treatment requirements with the patient and documents a referral to another centre.

DRESS CODE POLICY

Uniform & Dress Code Policy

All SDH, ANANDPAUR employees, volunteers and physicians will maintain a professional, well groomed appearance at work. Clothing and grooming of all personnel should contribute to a positive impression of the Hospital while maintaining safety standards and adhering to the following principles:

- Dress to prevent the spread of infection to others
- Incorporate occupational health and safety recommendations for appropriate attire while in the hospital clinic setting
- Dress in such a way that work can be completed efficiently
- Dress appropriate to the clinical work situation while recognizing cultural norms and religious requirements
- Dress to portray a competent professional image through workplace attire

General Dress Code

- SDH, ANANDPAUR name badges are to be worn by all healthcare providers.
- Personal hygiene must be maintained. Excessive use of make-up is discouraged. If an employee has or wears long hair, loose clothing or jewelry that may present a hazard, it shall be suitably confined. Jewelry such as rings and bracelets hinder the effectiveness of hand hygiene and increase the risk of glove tears and should not be worn for patient contact.
- Healthcare providers, volunteers and physicians must maintain clean, neat and tidy finger nails to facilitate effective hand hygiene in the workplace. Artificial nails or nail enhancements are not to be worn by those giving patient care as they are implicated in the transfer of microorganisms.
- All employees and volunteers must conform to the uniform regulations of their departments and wear designated uni forms and/or lab coats
- If staff require personal protective equipment to prevent soiling of their clothing from blood or body fluids their manager/ the facility must provide them with the appropriate personal protective equipment, .
- isolation gowns and other typcs of personal protective equipment (PPE) such as gloves and masks are to be worn for the purpose of adhering to Routine Practices and additional precautions and must be removed and discarded prior to exiting a procedure or patient room. Practices for Airborne, Contact and Droplet Precautions".
- Washable sweaters, vests, jackets or personal lab coats may be worn to provide additional warmth and should be laundered regularly.
- Facility provides allowance to nursing sister and fourth classs for uniform as well as doctors purchases their own. All employees must wear their respective dress code as per the rule.

USE OF NARCOTIC DRUGS & PSYCHOTROPIC SUBSTANCES

Purpose: To maintain a system for the safe use & storage of narcotic drugs.

Responsibility: Nursing Staff and Pharmacy Staff

Policy

- All narcotic drugs shall be kept in double lock & key under the supervision of a nominated person.
- All transaction records shall be maintained for two years.
- Every order for narcotic drug should contain prescriber name, date, reg. no. along with the name & doses of drug.
- Pharmacy shall issue narcotic drugs against the “narcotic issue form” duly approved by medical superintendent
- Proper documentation shall be there for all orders of narcotic drug use.
- Patient Specific drug administration / consumption record shall be maintained for two years.
- Hospital shall have a license for the procurement & uses of controlled drugs.
- Information about losses/theft shall be given to local police station and excise inspector.
- Breakage/ Expiry Should are informed to excise inspector immediately for records.
- Transportation of narcotic drug from the vendor should be done through well covered four wheeler vehicle.
- Liaison department shall be responsible for renewal of narcotic drug liaison.

Procedure

Prescription: Prescription/ Order for a narcotic drug shall have prescriber name, date & name, dose of drug.

1. **Issue**: - After receiving the approved prescription for narcotic drug, Pharmacist will issue the medicine.
2. All Records of Prescription/ Order should be documented for two years.
3. Signature of receiver of narcotic drug will be taken on the issue form/register & has to keep for two year.
4. Nursing staff involved in administration should maintain a record of doses administered in narcotic transaction record/register, as per the instructions.

Breakage/ Expiry

1. In case of expiry / breakage, excise inspector will be informed accordingly.
2. Excise inspector will observe the expiry / breakage
3. After observing the breakage/ expiry records, Excise inspector will destroyed them &enter his remark into the record with his signature & date, Qty. of destroyed item.
4. All expired/ breakage stock shall be stored separately with clean & clear label.

Theft

If there is any unjustified mismatch in the stock, Excise inspector has to inform as soon as possible.

PATIENT COMPLAINT & GRIEVANCE REDRESSAL

Purpose: To ensure patient grievances are appropriately received and effectively resolved.

Scope: Hospital Administration Department and Help Desk.

Definitions:

Grievance: A grievance is a formal statement of complaint, generally against an authority figure.

Medical grievance: Medical grievance is a grievance or complaint specific to the provision or non-provision of medical care or services. An example might be a grievance concerning medications, the need for a diagnostic procedure, or a request for an opinion from another medical practitioner.

Sentinel events: A relatively infrequent unexpected incident, related to system or process deficiencies, which leads to death or major and enduring loss of function for a recipient of health care services.

Adverse events: An adverse event is any adverse change in health or "side-effect" that occurs in a person who participates in a clinical trial while the patient is receiving the treatment (study medication, application of the study device, etc.) or within a pre-specified period of time after their treatment has been completed.

PGC: Patient Grievance Committee- Shall consists members of Hospital Administration, Clinical and support departments who are involved in grievance.

3.13 **Patient Rights:** Patient rights encompass legal and ethical issues in the provider-patient relationship, including a person's right to privacy, the right to quality medical care without prejudice, the right to make informed decisions about care and treatment options, and the right to refuse treatment.

Responsibility: Front Office, Hospital Manager & ADMO (Medical) & Patient Grievance committee.

Policy:

- Upon admission, sometimes patient is given a copy of the Patient Rights in front desk. Patients are also explained about their rights & grievance procedure.
- Patient Rights and the Patient Grievance Procedure are posted on each unit and patient grievance forms are available at all units.

STEP 1

- Grievance forms are provided to patients whenever requested. Patients may file the grievance by filling out the form and giving it to FDE or placing it in a hospital mailbox. FDE, other patients, or others may assist the patient in filling out the grievance.
- All grievances will be forwarded to the Patient Grievance Committee for recording.
- Within seven working days, any individual will be designated by the PGC will address the issue through informal means in an attempt for resolution.
- If a resolution is reached to the satisfaction level of the patient, the Hospital Administrator will sign the complainant and date the grievance form as satisfied. It will forward the grievance form to the Patient Grievance Committee.
- If a resolution cannot be reached, the HA will forward the Patient Grievance Form, the Patient Grievance Action Form, and relevant documentation as necessary, to the PGC.
- The PGC will meet and discuss the grievance within next seven working days. The PGC shall make recommendations of appropriate action within a stipulated time frame.
- The PGC will operate on a consensus basis, working to find a response to patient grievances that is agreeable with all members of the committee. If the committee is unable to reach consensus, the Chair will determine the appropriate response with input

from all members of the committee. The grievance process may be terminated at any time if:

- A resolution is reached;
- A patient objects to continuing with a grievance filed by a third party on the patient's behalf.
- The issue grieved is found by the PGC, to be without merit.
- The issue was previously grieved by the patient and a decision rendered from the PGC (This does not apply to appeals of a decision).

- The complainant and the HA will be notified in writing of the PGC decision. The committee will maintain records of its findings and actions.
- In case the complainant is not satisfied with the action, may bring Register concerns about the decision.
- PGC once again shall evaluate the complaint and process the same within next 14 days. PGC shall communicate the decision and correction action to the complainant & HA.

Step II: If the complainant is not satisfied with the response of the Step I, an appeal may be submitted to the HA within thirty days of receiving the written decision.

The HA shall make a decision based on the investigation findings. The complainant, PRE shall be notified in writing of the decision. PGC shall co-ordinate and document all the investigation findings & decisions made.

Step III: If the complainant is not satisfied with the response of the in step II, an appeal may be submitted to the CDMO within sixty days of receiving the written decision.

- The Hospital Administrator will be notified by the PGC of This appeal. A hearing will be scheduled and conducted, unless waived by the complainant, within sixty days of receipt of appeal. The complainant, associates and others involved with the issue will be notified in advance of the date, time and location of the hearing.
- CDMO will prepare a written decision within sixty days. The complainant will be notified in writing of the decision.
- In the event the hearing is waived by the complainant, PGC will review applicable statements and documentation and render a written decision within sixty days of receipt of the appeal.

Step IV: If the complainant is not satisfied with the response of the Step III, an appeal may be submitted within ninety days of receiving the written decision.

- The HA will be notified within three days of receipt of the appeal. The appeal and relevant information will be directed to the Medical Director.
- The Medical Director will render a written decision within ninety days of His/her receipt of the grievance unless he/she requests additional investigation into the issue. The complainant and PGC will be notified in writing of the decision. The Medical Director's decision is final.
- The PGC maintains files of all grievances and corresponding documentation, statements and decisions.
- A database of aggregate grievance information (number of grievances filed, types of complaints, resolutions reached, etc.) is also maintained.

No Smoking Policy

Ms. Arti Ahuja, I.A.S
MPP- Health Policy(Princeton)
MPH-[illegible](Harvard)
Secretary,
Health & Family Welfare Department
Government of Odisha
Bhubaneswar-751001

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Letter No. 29946 /SHFW,
PH-COTPA-6/2012(Pt.)
Date: 27th November, 2014
28th

To,

All Chief District Medical Officers

Sub: - Implementation of Tobacco Free Health Institutions.

Madam/ Sir,

You may be aware that Tobacco use is the foremost preventable cause of diseases both globally as well as in India. Tobacco use is one of the common risk factors for the major Non-Communicable Disease such as cancer and cardiovascular diseases, and accounts for more than two-third of all disease burden. Approximately 8-9 lakh persons die annually in India due to tobacco attributable diseases. To discourage the use and consumption of tobacco products the Cigarette and Other Tobacco Product Act (COTPA), 2003 and Food Safety Standards Act, 2006 has been enacted in our State. Section-4 of COTPA-2003 prohibits the smoking in the public places which includes premises of hospitals.

Further, for better implementation of these above two Acts the State Level Co-ordination Committee has been constituted under the chairmanship of the Chief Secretary and it was decided to declare all the health institutions as tobacco free and there will be no sale of tobacco products near hospitals.

Recently the decision taken by the Governing body of RKS of Koraput may be referred to where not only the sale of tobacco products near hospital areas was restricted but also the use of tobacco by all including the visitors and staffs inside the hospital premises was also prohibited.

In view of the above, similar steps should be taken at the district level to ensure all health institutions under your jurisdiction are made tobacco free by prohibiting tobacco use inside the campus. There should also be a strict ban on selling of tobacco products near hospital areas.

Yours faithfully,

28/11/14

(Arti Ahuja)

QUALITY POLICY

National Quality Framework for Public Health Facilities

Quality of Care has emerged as key thrust area for both Policy Makers and Public Health Practitioners as an instrument of optimal utilization of resources and improving health outcomes and client satisfaction. The National Health Policy 2016 clearly states in its objective – Improve health status through concentrated policy action in all sectors and expand preventive, promotive, curative, palliative and rehabilitative services provided through the public health sector with focus on Quality.

Ministry of Health & Family Welfare, Government of India in collaboration with state health departments has developed and implementing a comprehensive quality assurance framework for public health facilities and Programs. This Framework comprises of four interrelated approach and activities to achieve patient centric quality system

- Instituting Organizational Framework for Quality
- Defining Standards of Service Delivery and Patient Care
- Continuous Assessment of services against set standards
- Improving Quality through closing gaps and implementing opportunities for Improvement.

The framework based works on following principles –

1. Systems approach –Quality System should be integral part of Health Systems. Rather than working on isolated themes and facilities, the approach should be holistic quality improvement involving all components of health system. Quality processes should be interlaced with healthcare planning and provision processes to give optimal results. This is achieved by instituting a system of continuous assessment, handholding and participative quality improvement through coordinated efforts of all stakeholders.

2. Client Focus –The quality system should enable providers to meet and surpass the expectations of it clients. These may be patients, beneficiaries and community at large. The patient care and quality assurance processes should be designed keeping in mind the users of public health facilities, so these are accessible, affordable, dignified and user-friendly to its seekers. This achieved though taking continuos objective feedback from users and using it for improving the services.

3. Recognizing the champions- Healthcare Quality improvement on large scale thrives upon success stories, role models, inspirational leaders and champions to spread quality culture. The quality framework gives provision of promoting and recognizing champions through incentives and reward mechanism.

4. Team work– Quality can only be achieved by concentrated, coordinated and sustainable efforts of all stakeholders be it policy makers, health administrators, clinicians, patient care staff or frontline community health workers. Quality Assurance committees and units have been instituted at National, state and district level to facilitate team work. At facility level Quality Team have been constituted so all service providers can pool their efforts to for quality improvement.

5. Process Focus– Healthcare quality is comprises for three components – structure, process and outcome. The desired outcome can only be achieved when optimal infrastructure and human resources is utilized by efficient processes. Though structure is important component to ensure quality, National Quality Framework is predominately relying on improving the outcome by optimizing the processes within given structural limitations. This is achieved by through assessment, improvement and standardization healthcare processes.

6. Continual Improvement –Quality is a long journey, requires concentrated and sustained efforts. The quality framework believes in incremental improvement in healthcare process through continual quality improvement cycle. This enables serviceproviders.

7. Objective Quality Measurement – The journey towards quality improvement starts with objective and unbiased measurement of quality of existing healthcare processes and services. Under Quality Framework, National Quality Assurance Standards have been instituted of all level of public health facilities. Explicit assessment tools and scoring system has been developed for objective measurement and fact based decision making for quality improvement.

8. Concern & Context – Public Hospitals service a large section of community those don't have access to private health care because of affordability or access. Public system also has almost exclusive responsibility for implementing preventive and promotive health programs. National Quality Framework works towards develop indigenous quality system of public health facilities that meets specific requirements of its users as well global benchmarks.

HANDING OVER POLICY

All patients who clinically need handover must get it. This policy applies in all circumstances where a handover is required. It is recognised that not all patients require a formal handover between all types of clinicians at each shift change. For example, all inpatients may be handed over between nursing staff during a shift change, but only a subgroup of those patients may be handed over between medical staff during a medical staff shift change. It is recognised that there will be situations where exceptions to this policy will be necessary for best patient care. These exceptions must be justified and documented within the medical record.

Health care services must implement the principles listed in 2.1.
All principles in this policy are applicable to allied health, nursing, medical, and midwifery staff unless otherwise specified.

Additional principles specifically relevant for the organisation should also be considered, e.g. culturally and linguistically diverse, mental health, maternity, or paediatric patients.Health service organisations and departments must develop a documented process for handovers based on this policy.

Patient/carer involvement

■ Where practicable, handovers should be conducted, in part, in the presence of the
patient (e.g. at the bedside) or carer.

■ Where practicable, the patient (and/or carer) should be invited to be involved in the
handover.

■ All handovers, other than discharges, must use the iSoBAR tool (Appendix A) to guide the content and structure of the handover in a manner that suits the clinical context.

■ Use of a tool apart from iSoBAR, as detailed in Appendix A, must be approved by a Health Service.

■ Handover content should be clear, concise, and use easily understood words with minimal, accepted, abbreviations.

■ The most senior clinician available should lead the handover process and has responsibility for ensuring the handover happens in accordance with this policy.

■ It is the responsibility of the most senior clinician available to decide which patients
require handover.

■ To ensure clarity, each area/service must identify the staff, including senior (e.g. consultant) staff, who are required to be involved in handovers.

■ All identified members of the clinical team(s) should support the handover process
and be available to attend handovers where possible.

■ Handover must be understood by staff as an explicit transfer, not just of information,
but of clinical accountability and responsibility.

■ Roles, responsibilities and accountabilities must be clearly described to, and agreed
to by, all staff involved in handover.

■ regarding the patient, other staff and the organisation

■ with regard to patient risks and emergencies during handover

■ with regard to transfers and discharges.

■ All inpatient handovers, other than discharge, must include a verbal component. That is, a current clinician responsible for the patient should speak directly to a receiving clinician prior to handover of responsibility or accountability.

■ Handover should be conducted face-to-face wherever possible.

■ Handover modalities must conform to the recommended or adequate options detailed in Appendix E.

■ Voice-recorded handover is not permitted under this policy.

■ Environmental controls should be in place to limit non-critical interruptions to communication during handover.

■ Wherever possible, the clinician initiating handover should ensure access to relevant test results, risk and functional assessments, x-rays, and clinical information.

■ Where use of alternate technologies is necessary, e.g. telephone or video-conference, the individual initiating the handover should ensure the environment conforms to the requirements above.

■ All handovers must be supported by current, appropriate documentation (clinical notes, test results etc).

■ Handover tools must comply with this policy. These include:

■ mobile electronic tools

■ computer-generated patient information sheets.

■ Patients should be handed over in accordance with their severity and clinical risk,

as determined by a treating clinician.

■

Management of a deteriorating patient must be escalated as soon as deterioration in condition is detected.

■ Handover of patients of concern must be documented.

■ Documentation should include:

■ pertinent clinical information (using the iSoBAR structure)

■ time and date of handover

■ details of at least one of each of the providing and receiving clinicians.

■ All staff must receive education on the site/service handover protocol and this policy.

It is recommended that this occurs at the commencement of rotation or employment

■ All staff should understand that they are required to comply with the site/service handover protocol and this policy for all forms of handover.

FREE TREATMENT TO BPL PATIENTS POLICY

ODISHA STATE TREATMENT FUND

	It is applicable to persons below the poverty line, person with annual family income not exceeding Rs.40,000/- in rural area and Rs.60,000/- in urban areas. Either BPL card / AAY card or annual income certificate issued by concerned Tahasildar will be accepted for determining the eligibility.
	RSBY card holder is also eligible under this scheme.
	An unknown accident victim, patients duly referred from registered destitute home / orphanage / mental asylum / Child care Institutions are also eligible for assistance under the scheme subject to citing sufficient reason thereof for recommending the patient under the scheme.
	The Central Government / State Government / PSU employees are not eligible.

	Assistance will be available only to patients undergoing treatment as in-patient in any of the Govt./Empanelled private hospitals. However this will not restrict : *i. Cancer patients from getting chemo in Govt. Day Care Centre without being formally admitted.* *ii. Patients who have undergone kidney transplantation at Govt. Hospitals from getting post-operative care including supply of free medicines and investigation up to 6 months from the date discharge.*
	Assistance will not be available for reimbursing the expenditure incurred by the applicant. The date of application seeking financial assistance should be during the course of treatment.
	Re-imbursement of medical expenditure already incurred for treatment / operation shall not be permissible.
	Diseases of common nature and disease for which treatment is available free of cost under other health programmes / schemes will not be covered.
	Assistance will normally not be provided where medical coverage under ESI, CGHS or any other scheme is available or where there is a provision for reimbursement of cost of medicine.
	Any person shall be assisted once in a financial year. Repeat assistance for the same ailment shall not be allowed in any case. However, this will not be a bar for receiving the treatment assistance in phased manner for diseases like Cancer, Collagen disease, Renal failure etc.

AVAILIBILITY OF EDL AND STOCKOUT MANAGEMENT POLICY

Government of Odisha has the mandate to improve access to quality healthcare including medicine and diagnostics for the entire population of the state . The declaration of "Free Medicine Distribution Scheme"by the government is one such step taken in that direction. The Aim of the scheme is to ensure availability of essential medicines ,within the context of functioning health facilities ,at all times ,in adequate quantity,in the appropriate dosage with assured quality ,available adequate information and at free of cost.

Department of Health and Family Welfare, Government of Odisha, has taken various measures

to ensure successful implementation of the Scheme. The need for an appropriate reform strategy based on empirical evidence was felt necessary to bring about order in the system and to ensure sustainable improvement in accessibility of medicines at government health facilities. The need for an indepth assessment of the issues and challenges relating to accessibility to essential drugs was of paramount importance; more

so when almost 68% of the people in India have limited or no access to essential medicines

1.In view of above facts, Indian Institute of Public Health(IIPH) at Bhubaneswar, was commissionedthrough the Technical Management and Support Team (TMST) under DFID Supported Odisha Health Sector and Nutrition Plan (OHSNP) to carry out a rapid assessment

of availability of drugs at government health facilities. It has the following objectives:

a)Assess the extent of availability and stock out of essential medicines and other medical supplies at the health facilities;

b)Analyse consumption patterns at different levels of health facilities to facilitate rational drug budgeting and better procurement planning ; and

c)Identify the factors that drive both availability and consumption of essential drugs at health facilities.

IIPH started field assessment process during Sept'14 with concurrence of the department. The assessment tools, methodology and the approach were finalised in consultation with the government counterparts. The first draft report was submitted by IIPH in the 1stweek of Dec'14. The meeting on sharing the assessment findings with department officials was held on 22ndDec'14. The findings and recommendations were deliberated upon in detail and an action plan agreed. It was also agreed that the new procurement and inventory management system, which is under implementation

1.WHO report on the world's medicines situation through Odisha State Medical Corporation Limited

2.shall address the majority of the issues identified. The report on the rapid assessment clearly depicts the survey findings and provides appropriate analysis. The survey findings are detailed out within the report and have been summarized under separate heads. In line with the study findings the report also recommends both short term and long term measures for improving

drug availability at the facilities.

The minutes of the meeting held with the department on sharing first hand findings of the rapid assessment study,along with the recommended action plan as agreed,is enclosed herewith for reference and the records of the department.

AVAILIBILITY OF EDL AND STOCK OUT MANAGEMENT POLICY

Policy of Avoiding stock outs of drugs and consumables and ensuring drugs as per EDL

Policy Name :	**Policy of Avoiding stock outs of drugs and consumables and ensuring drugs as per EDL**

Date of implementation :

Approved By :

Superintendent SDH, Anandapur
Name : Dr Dhaneswar Sethy

Signature :

Reviewed By:

SDH, ANANDPAUR Quality Assurance Team (Incharge / Member)
Name :Dr Dhaneswar Sethy

Signature :

Responsibility of Updating :

Head Of Department
Name :Dr Krushna Ch. Dash

Signature :

Last Date of Updating

1. **Purpose:** To provide guideline instructions for effective management of pharmacy in which drugs & consumables were not get stock out as per EDL.

2. **Scope:** It covers all activities under the pharmacy services

3. **Responsibility Person:**
   Medical Officer In charge of Pharmacy, Chief Pharmacist, Pharmacist and Nursing Staff

4. **Policy:**

- **Some common systems for arranging medicines include:-**

a) Alphabetical order by generic name: When using this system, the labeling must be changed when the Essential Medicines List is revised or updated.

b) Therapeutic or pharmacologic category: Most useful in small storerooms or dispensaries where the storekeeper is very knowledgeable about pharmacology.

c) Dosage form: Medicines come in different forms, such as tablets, syrups, injectables, and external use products such as ointments and creams. In this system, medicines are categorized according to their dosage form. Within the area for each form, a fixed, fluid, or semi-fluid system is used to store items. Any of the other methods of categorizing can be used to organize the items more precisely.

d) System level: Items for different levels of the health care system are kept together. This works well in stores at a higher level when storage of kits is required.

e) Frequency of use: Frequently used products that move quickly or often through the store should be placed in the front of the room or closest to the staging area. This system should be used in combination with another system.

f) Random bin: Identifies a specific storage space or cell with a code that corresponds to its aisle, shelf, and position on the shelf. This system requires computer automation. **g) Commodity coding:** Each item has its own article and location code. This system has the greatest flexibility, but it is also the most abstract. Stores staff do not need any technical knowledge of the products to manage this system because the codes contain the information needed for storing products properly, such as temperature requirements, level of security, and flammability. This system works well in computerized inventory control systems.

h) Separate storage of items of resale potential (high value items, narcotics, psychotropic drugs) and flammable liquids (acetone, alcohol, anesthetic ether and store in security zones.

i) Stock rotation

a. Follow First to Expire First to be Out (FEFO) procedure.

b. Place products that will expire first in front.

j) Write expiry date on product card.

k) For items which do not have an expiry date, the principal to be followed is FIFO-First in First Out.

l) Put newly received items at the back of existing stock

m) Always remove expired and poor quality stock from the store

n) Identify overstocked items and items that are not in use and distribute them to other facilities

o) Keep a record of all items removed so that balances can be tallied later.

- Regular counting of drugs in register and issue the drugs according to FEFO (First Expire First Out) Procedure
- Drugs should be present in excess which drug are used in large amount or prescribed more in numbers by Doctors
- A well-managed distribution system should:

  a) Maintain a constant supply of drugs

  b) Keep drugs in good condition

  c) Minimize drug losses due to spoilage and expiry

  d) Rationalize drug storage points

  e) Use available transport as efficiency as possible

  f) Reduce theft and fraud

  g) Provide information for forecasting drug needs The distribution cycle begins when drugs are dispatched by the manufacturer or supplier. It ends when drug consumption information is reported back to the procurement unit

  Advantages:

  1. The drugs when purchased in bulk may be bought for a lower price directly from the manufacturers

  2. Transportation of these drugs is borne by the supplying firm

  3. Loss/ theft during transport is the responsibility of the firm.

- The entire drug management can be assessed based on four major indicators :

1. Total expenditure on drugs and medicines (percentage of total expenditure on health) 2. Total expenditure on drugs and medicines (per capita average)
3. Government expenditure on drugs (per capita average)
4. Private expenditure on drugs (per capita average)

- The drug supply management at a health facility has seven components for avoiding stock outs of drugs and consumables as per EDL:
  A. Preparation of drug store
  B. Supply ordering
  C. Receiving supplies
  D. Organization of drug supplies
  E. Inventory Management
  F. Record keeping
- Medical stores must have a system for classifying or organizing medicines, and must ensure that all employees know the system being used.

SOCIAL,CULTURE AND RELIGIOUS EQUALITY POLICY

Objectives

1.Describe the importance of social & cultural determinants of health.

2.Compare the Sociocultural model with the Disease model.

3.Differentiate key anthropological perspectives on culture.

4.Develop curiosity about cultural systems of communities.

5.Rate local cultural systems as important for impacting a community's health practices and outcomes.

6.Demonstrate awareness of one's own cultural assumptions about health and behavior through self -reflection exercises.

7.Apply module principles to practice through case studies.

8.Recognize cultural humility as a practice that applies the socio-cultural model.

Outline

1.Importance of social & cultural factors in health

A.Culture

B.Social Factors

2.How sociocultural factors relate to health: The Sociocultural Model

3.Theories of knowledge: context of the Sociocultural Model

A.Naturalism and the Anthropological Perspectives on Understanding Culture–Health Beliefs and Practices–Critical Medical Anthropology–Discourse Analysis

B.Positivism: the Disease Model

4.Combining Concepts: Health is determined by a convergence of factors

A.Interdisciplinary Medicine

B.Recognizing the Culture of Medicine

C.Cultural Humility

5.Summary and Bridging to next module

Community. You learn that mothers in the community eagerly participate in nutrition classes

but will not stop feeding their babies junk food.

Importance of Social & Cultural Factors in Healthcare

A.The ways people think about health and illness

B.Individual behaviors and habits that influence health

C.How you and your actions are perceived by the community where you work

D.How culture interacts with environment, economy, and politics to affect health

Religion and public health

Background: Correlations between determinants of health and religious affiliation

As briefly referred to in the previous chapter, public health is a proactive,preventative approach to healthcare as opposed to the more traditional reactive, curative practice of medicine. The UK Government has increasingly sought, particular since the 1990s, to improve the general health of the nation1 2 as much as simply providing healthcare for the sick.Central to understandings and approaches of public health are notions of health inequalities, the existence of which was made glaringly apparent by The Black Report, published in 19803. In contrast to the neo-liberal underpinnings of certain conceptualisations of public health which emphasise the responsibility of each individual for living 'well', increasing evidence points towards the stark contrasts in opportunities for healthy living based around a number of determinants – not least class.Socio-economic status and income are defining variables which explain a great deal of inequalities in morbidity and mortality – often functioning through associated variables such as education and 'health literacy',employment conditions, housing, social support networks, cultural capitaland social status. Gender is another factor associated with certain differences in health and morbidity, going beyond the biological and related to social norms and constructs and again interacting with, and working through, socio-economic and occupational life-history. Hence why life expectancy in 'Glasgow City' (one of the poorest areas in the UK) for men is 69.3 years, whereas men living in Chelsea and Kensington (one of the wealthiest) live on average for 80.8 years - whilst for women the figure is even higher in the latter location, at 85.8 years.Although the previous chapter referred to a significant portion of research pointing towards the health benefits attached to religious and spiritual beliefs, the inequalities outlined thus far in this section help explain why many people suffering from the greatest inequalities in health may also have strong religious affiliations. The key linking factor between these variables is ethnicity – where "Pakistanis, Bangladeshis and Caribbeans have the poorest health of anyone in Britain, because so many are living in poverty". Within these cleavages further

inequalities become apparent: “Pakistanis and Bangladeshis are 50 per cent more likely to suffer ill-health than whites and Caribbeans are 30 per cent more likely to be in poor health. Pakistanis, Bangladeshis and Caribbeans are the three poorest ethnic groups in Britain. Indians, African Asians and Chinese, who are closest to whites in income are as healthy as whites”.That significant portions of these poorer ethnic minorities have religious affiliations explains the correlations between religion and poor health amongst these minorities, and why Muslims have the poorest overall health

in the UK. It is important not to synonymise ethnic background and religious beliefs/affiliations9, nor to assume that those who state religious affiliations are regular attendees at churches, mosques or other such institutions, yet it would seem that the ethnic groups with the poorest health are also those most likely to be religious – where “fewer than 1 in 200 Pakistanis and Bangladeshis reported having no religion”. In spite of these strong correlations with ill health, there is a lack of initiatives and research into the health needs of specific religious minorities within the UK, not least those of Muslims11. Potential for such approaches will be set out in later sections of

this chapter.

Ethnicity, though important, is not the only connecting factor between

religious affiliation and (poor) health. Age is also an important correlated variable. Church attendance, for example, remains relatively high across the older UK population compared with younger generations12 and this group, for a range of reasons, are more likely to suffer poor health. Traditionally old age has been seen as synonymous with poor health. Yet this apparent inevitability is increasingly coming to be seen as a fallacy, with corresponding increased efforts towards health promotion amongst older adults13. Poor health and old age are again correlated with socio-economic factors as well as those associated with lifestyle, nutrition, social isolation, home safety, dignity and cognitive training. Most of these are amenable to modification through health promotion initiatives14. The combination of poor health and increased religious affiliation amongst older people highlights the possibility of using the latter as a means to combating the

former, as will be set out later in this chapter. The health determinants discussed thus far linking poor health to both ethnicity and older age suggests that it may be 'ethnic elders' who face the greatest inequalities in terms of their health. The combination of age and race-related socio-economic inequalities can render parts of these populations most vulnerable15 and yet most isolated. The other research discussed thus far linking both older age and ethnicity to increased religious affiliation suggests therefore the likelihood of ethnic elders experiencing poor health, but yet being more likely to attend church, mosque, synagogue or other religious institutions. A brief, simplistic assessment of this evidence would seem to suggest that it contradicts the findings described in the previous chapter which pointed towards positive correlations between religious or spiritual belief/affiliation and health. However, as set out earlier in this chapter, there is no direct causal linkage between religious interests and poor health, but rather that both are linked to the common independent variable of socio-economic deprivation. Therefore it would seem tenable to suggest that were it not for religious beliefs, the health inequalities resulting from ethnic- or age correlated poverty would be even more pronounced, and that it is likely that religious or spiritual beliefs are an attenuating factor in this causal relationship between the independent socio-economic variables and the dependent variable - poor health16. The following two sections will look at ways in which this mediating factor of religious affiliation may already be at work. They will also seek to address at least some of the array of possibilities for health promotion and other related policy initiatives to harness the influence of religious institutions on the lifestyle, social lives, mental health, and attitudes towards healthcare institutions of their attendees.

Religion, lifestyle and the facilitating of *healthy living*

Before setting out in a more thorough way how religious institutions may play a role in maintaining and promoting the health of vulnerable groups, it would be useful to briefly sketch some of complexities surrounding the vulnerabilities related to older age and ethnic minorities as a result of socioeconomic inequalities. The socio-economic inequalities faced by certain ethnic minorities are not merely related to income, but rather

are caused by, and result in, wider issues of access to education, health information, cultural capital and social networks. Not only are these self-perpetuating from one generation to the next but moreover a lack of access to one often also precludes the others. Problems with accessing these socio-cultural resources which can affect health are typical of those of lower socio economic status but may be especially pronounced amongst certain ethnic minorities (especially those whose composition is linked to more recent migration) due to issues of language competencies and a lack of familiarity with prevailing cultural norms. Limited opportunities to access the labor market may result in a less active lifestyle and poorer mental health, with these two outcomes potentially reinforcing one another. Similarly complex and mutually effectual co morbidities are prevalent amongst poorer older people. Where limited physical capacity may precipitate social isolation, this can result in negative effects on mental health which in turn leads to a less active lifestyle, further limiting physical capacity. Such vicious circles are the modes through which socio-economic status can have such a profound impact on health – the effects of which (as already discussed) are likely to be disproportionately experienced by certain groups which are more likely than most to participate in corporate religious activity. Hence places of prayer, worship or other spiritual involvement are potentially able to limit the negative effects of these health determinants such as social exclusion. The social support, networks and organizational structure provided by religious institutions17 may go some way to redressing the deficiency of more mainstream social networks and corresponding opportunities for social support and accessing the labor market. Attending meetings, being visited by members of the institution or the development of further social ties may therefore ward against the isolation which might ordinarily be experienced by some older people. Equally certain religious communities may provide the means for finding employment, friendship and wider forms of social support which might not be accessible for certain members of minority ethnic groups within the wider, mainstream social community. As will be explored in more detail, religious centers may also form the basis of wider voluntary and community sector

initiatives which may be able to assist members of vulnerable communities beyond those who regularly attend the religious meetings. Such fostering of social capital and in some cases social entrepreneurship may therefore have broader impacts on mental health and wellbeing across the local community. On a more individual level, and as was referred to in the previous chapter, by encouraging and educating attendees in the spiritual beliefs and moral order of the faith system, religious institutions are therefore equipping these people with the coping skills and competencies to develop a 'sense of coherence' even amongst the daily experiences of social exclusion and economic disfranchisement. These benefits of religious or spiritual belief and affiliation, though beneficial, must remain outside the direct involvement of health policy due to the need to maintain differentiation between the central concerns of the clerical and medical professions. However the educative role provided by these institutions and their credibility amongst those attending them points towards the possibility of harnessing these institutions as the basis for specific health –education and -promotion projects. Certain religious groups, by the nature of their general teaching on lifestyle and morality, may already have health promoting affects on their members, for example research into the behavioral factors associated with adolescent morbidity and mortality in the US noted that "religious youth are less likely to engage in behaviors that compromise their health (e.g., carrying weapons, getting into fights, drinking and driving) and are more likely to behave in ways that enhance their health (e.g., proper nutrition, exercise, and rest)". There exists further potential for religious groups in areas with elevated health inequalities to carry out health education programmes to improve the health awareness and 'literacy' of their members and the wider community . The development of Faith Community Nursing programmes in Australia similarly illustrates the potential for healthcare work to function amongst, and in co-operation with, specific faith communities. The Australian model is one of co-operation between healthcare chaplains, church pastors and nursing staff, though it is recognized that the viability of such a system depends very much on the organizational culture and perspectives of the professionals involved. Yet in providing and combining

"physical and spiritual care by creatively linking healthcare chaplains, parish clergy and the nursing profession with those in the community needing support", the model represents one form of solution to the problems of the inequalities and specific needs deriving from certain minority groups. For example Sheikh underlines the health inequalities and specific needs amongst British Muslims. These include preferences for seeing doctors of the same sex and the prescribing of pharmacological interventions where alternatives to alcohol and porcine based drugs are made available. Having specifically trained health professionals attached to certain religious institutions, or working amongst these communities, would provide one proactive means of meeting these needs and tackling the specific health determinants they face. This approach may also help overcome the reluctance of certain isolated or excluded minorities in seeking help from healthcare agencies. In the field of mental health, ethnic minorities may be less likely to seek interventions due to narrow stereotypes about the role of mental health services whilst religious minorities may tend towards seeking pastoral help at the religious institution for emotional problems rather than specialist mental health support. Issues linked to an individual familiarity with institutions, and correspondingly of trust, may be important to overcoming these, and partnerships between healthcare professionals and religious institutions may be one effectual means of achieving this. This co-working also would facilitate the sharing of expertise between clerical and medical professionals – improving the assistance that both are able to offer.