national health authority

Pradhan Mantri Jan Arogya Yojana
Ayushman Bharat
PM-JAY

QCI
QUALITY COUNCIL OF INDIA
Creating an Ecosystem for Quality

KASP

സ്റ്റേറ്റ് ഹെൽത്ത് ഏജൻസി
കരുതലിന്റെ കൈത്താങ്ങ്

STATE HEALTH AGENCY KERALA

TRAINING ON

QUALITY CERTIFICATE STANDARDS FOR AB PM-JAY-KASP

EXPECTATIONS !

TRAINING DELIVERABLES

- Additional Support to create quality culture
- To Exchange Indicator based quality tool
- Patient safety and Increased care for Patient
- Improve National Recognition of EHCPs

INTRODUCTION

PM-JAY established a 3 level Hospital Quality certification

BRONZE

SILVER

GOLD

BENEFITS

- **Incentivization (Silver & Gold)**
- **To provide Quality of services, Enhance patient satisfaction and improve Standard of care**

PROCESS TO OBTAIN BRONZE CERTIFICATION

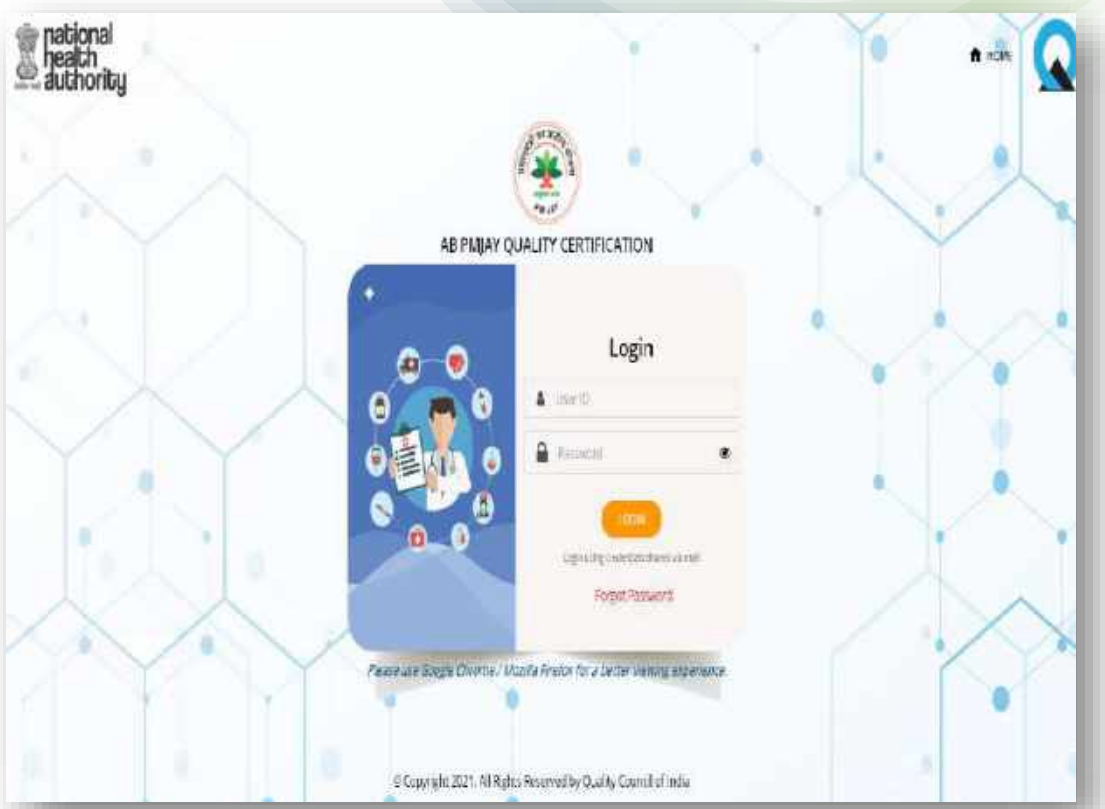
Launched in **August 2019**

Bronze quality certificate is a pre-entry level certificate

Aims to bring both private and public AB PMJAY empanelled hospitals at par in terms of quality of service

Comprehensive, User Friendly, Evidence-Based, Digital Certification, Objectivity, Balanced

Approx. 75% small healthcare organisation (SHCO) will be able to start their journey to improve quality



https://pmjay.qcin.org/pages/login

BRONZE CERTIFICATION

- Hospitals that are **empaneled** with AB PM-JAY
- **Do not possess any accreditation or certification** from any other recognized certification body (NQAS, NABH & JCI) can apply for this certificate
- **53 standards & 182 means of verification** (Inputs, Clinical and Support services, patient care and Health outcomes)

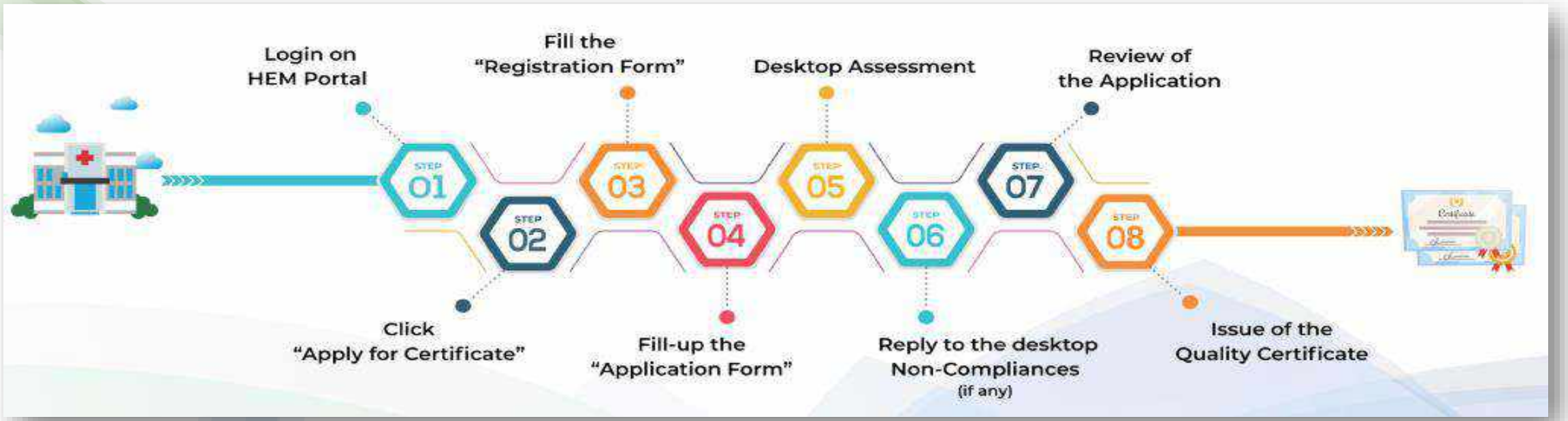
Registration on Portal → Information & Document Submission → Fees Payment & Submission of Application → Desktop Assessment → Onsite Assessment → Onsite Assessment Review → Certificate !

28 Days

SILVER & GOLD QUALITY CERTIFICATE

Silver Quality Certificate is the second level of Ayushman Bharat Quality Certification which is revised terminology for Entry level NABH/NQAS Certification.

Gold Quality Certificate is the third & the highest level of Ayushman Bharat Quality Certification which is revised terminology for NABH full /JCI Certification.



15 Days

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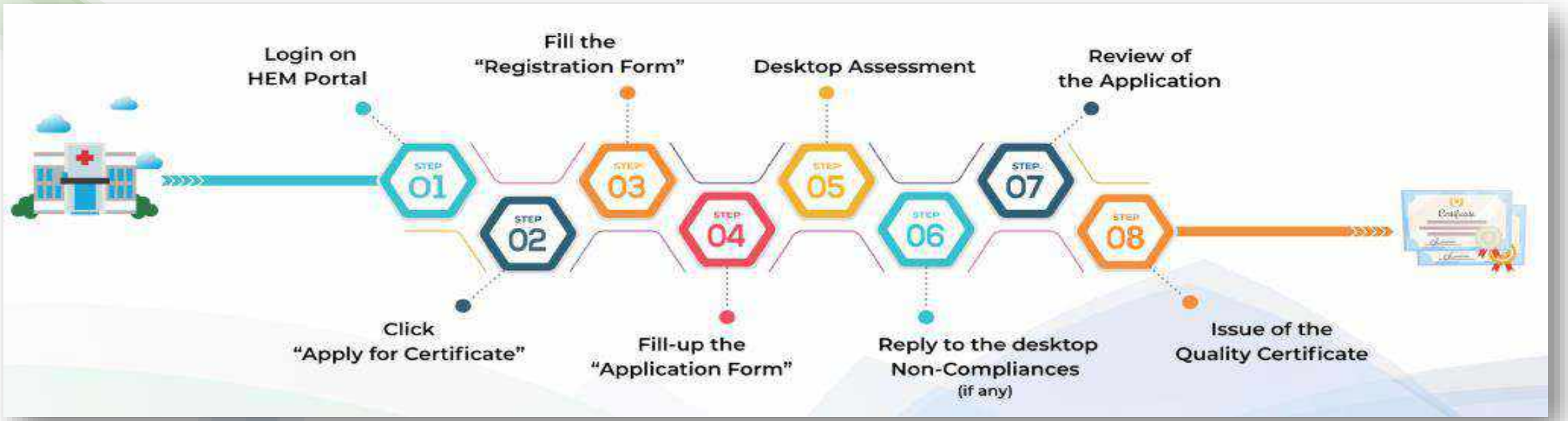


15 Days

HOW TO OBTAIN AB PM-JAY GOLD / SILVER / BRONZE QUALITY CERTIFICATE

GOLD QUALITY CERTIFICATE FOR AB PM-JAY

Gold Quality Certificate is the highest level of Ayushman Bharat Quality Certification which signifies that the certified hospital is complying with most of the healthcare protocols to ensure best quality of services and patient care. Gold Quality Certificate is revised terminology for already existing outcome -based incentivization structure i.e. NABH Full / JCI Accreditation to AB PM-JAY Gold Quality Certification. Silver Quality Certified hospital can directly apply for this certification. Gold Quality Certified hospitals will get additional and higher financial benefits over and above the 'Hospital benefit plans'.

GOLD QUALITY CERTIFICATE FOR AB PM-JAY

SILVER QUALITY CERTIFICATE FOR AB PM-JAY

Silver Quality Certificate is the second level of Ayushman Bharat Quality Certification which is revised terminology for already existing outcome -based incentivization structure i.e. Entry level NABH/NQAS Certification. It indicates that hospital has better quality of services and patient care but need to focus next on organization centered standards in terms of responsibility of management system among others. It is intended to motivate hospitals to keep increasing the level of quality in their services. Bronze Quality Certified hospital can directly apply for this certification. Silver Quality Certified hospitals will get additional financial benefits over and above the 'Hospital benefit plans'.

SILVER QUALITY CERTIFICATE FOR AB PM-JAY

QUESTIONS FOR AB PM-JAY GOLD / SILVER QUALITY CERTIFICATION:-

Questions are divided in two parts-

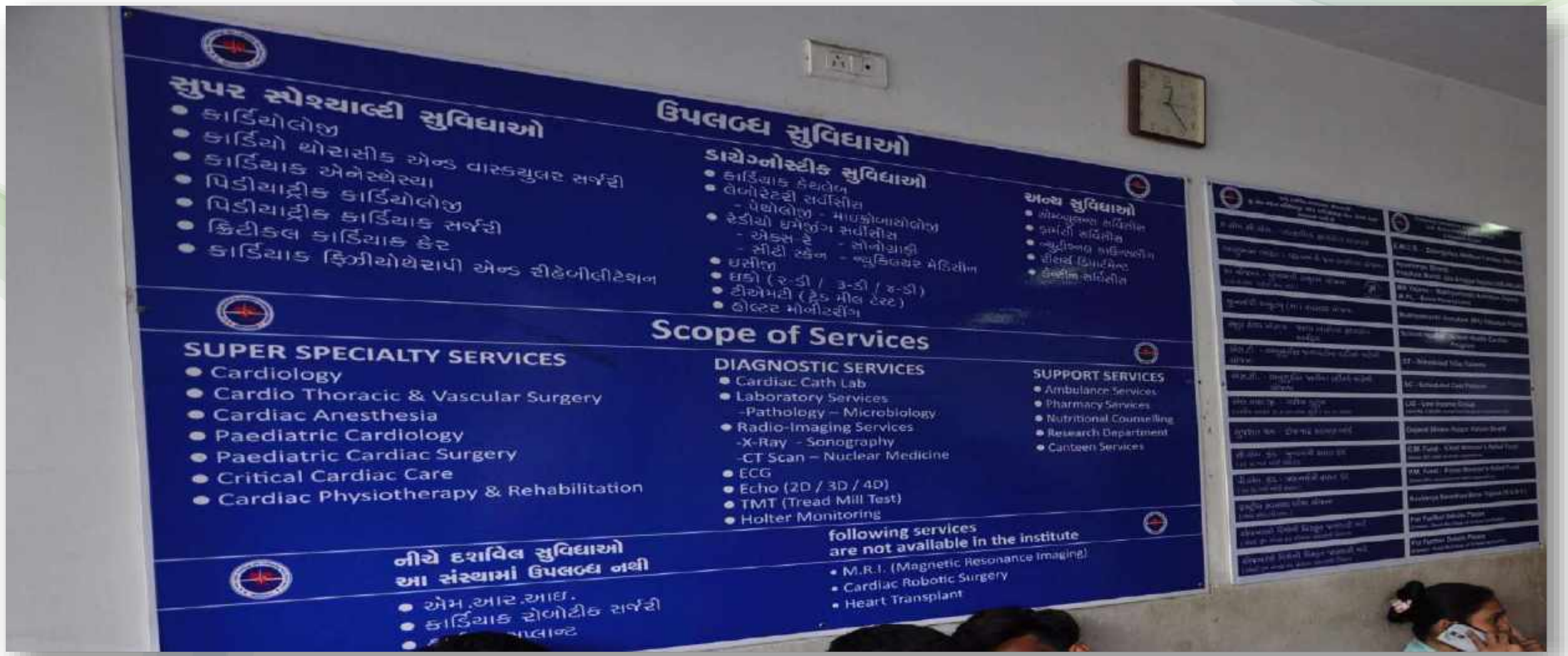
1. AB PM-JAY Specific Questions (25)

2. Quality Audit Checklist Questions (20)

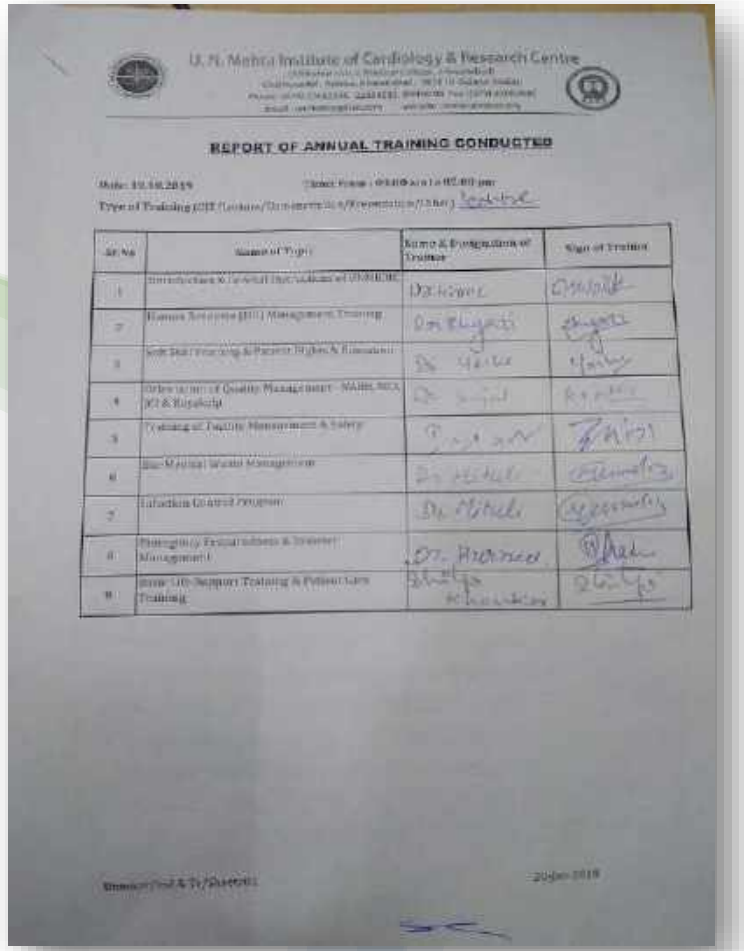
Note:- After completion of Quality Audit Checklist please submit and take Screenshot and this Screenshot should be upload as an evidence of AB PM-JAY Specific Question number – 25.

1. Are 'scope of services' registered under AB PM-JAY clearly defined and displayed at prominent place (e.g. Hospital entrance, Registration area, Waiting area, etc.) ?

2. Are 'scope of services' registered under AB PMJAY displayed bilingually (Malayalam & English)?

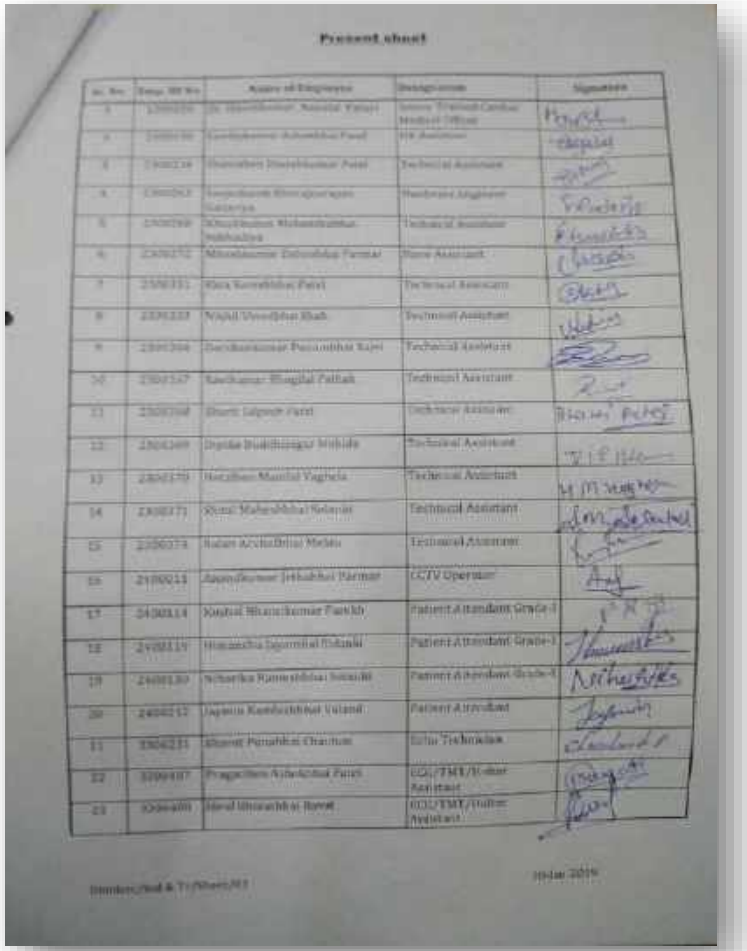


3. Is the hospital staff aware of 'scope of services' registered under AB PMJAY?

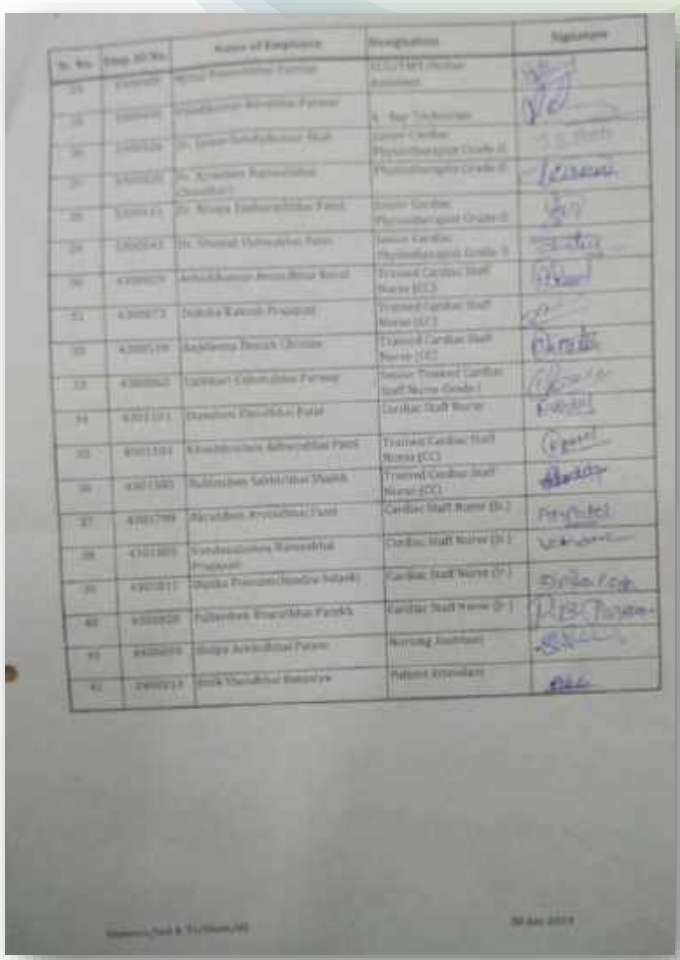


U. N. Mehta Institute of Cardiology & Research Centre

REPORT OF ANNUAL TRAINING CONDUCTED

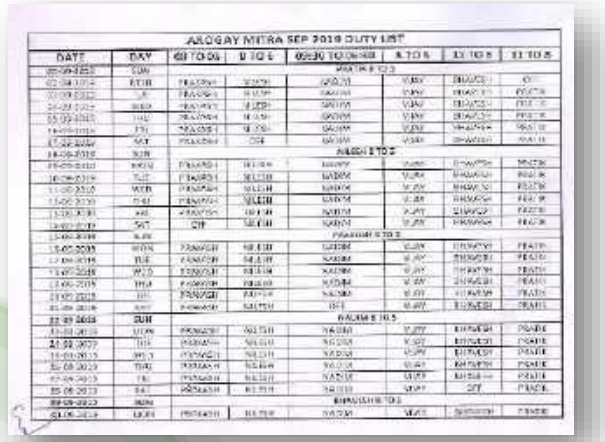


Present sheet



4. Is there a dedicated kiosk/ counter for AB PMJAY at prominent place in the hospital?

5. Is the kiosk/ counter manned by Pradhan Mantri Arogya Mitra (PMAM)/ trained staff during the operational hours (e.g. Arogya Mitra & its Duty list) ?



Duty from 30-09-2019 to 03-11-2019

Day	Date	harshad	tejalben	akshay	devendra	mukesh	Nisha	Jayesh
Monday	30-09-19	2 to 10	8 To 4	9 to 5	11 TO 7	12 to 8	9 to 5	2 to 10
Tuesday	01-10-19	2 to 10	8 To 4	9 to 5	11 TO 7	12 to 8	9 to 5	2 to 10
Wednesday	02-10-19	2 to 10	8 To 4	9 to 5	11 TO 7	12 to 8	9 to 5	2 to 10
Thursday	03-10-19	2 to 10	8 To 4	9 to 5	11 TO 7	12 to 8	9 to 5	2 to 10
Friday	04-10-19	2 to 10	8 To 4	9 to 5	11 TO 7	12 to 8	9 to 5	2 to 10
Saturday	05-10-19	2 to 10	8 To 4	9 to 5	11 TO 7	12 to 8	9 to 5	2 to 10
Sunday	06-10-19	9 to 5	week off	wk off	wk off	wk off	wk off	wk off
Monday	07-10-19	12 to 8	2 to 10	8 To 4	9 to 5	11 TO 7	9 to 5	2 to 10
Tuesday	08-10-19	12 to 8	2 to 10	8 To 4	9 to 5	11 TO 7	9 to 5	2 to 10
Wednesday	09-10-19	12 to 8	2 to 10	8 To 4	9 to 5	11 TO 7	9 to 5	2 to 10
Thursday	10-10-19	12 to 8	2 to 10	8 To 4	9 to 5	11 TO 7	9 to 5	2 to 10
Friday	11-10-19	12 to 8	2 to 10	8 To 4	9 to 5	11 TO 7	9 to 5	2 to 10
Saturday	12-10-19	12 to 8	2 to 10	8 To 4	9 to 5	11 TO 7	9 to 5	2 to 10
Sunday	13-10-19	wk off	9 to 5	wk off	wk off	wk off	wk off	wk off
Monday	14-10-19	11 TO 7	12 to 8	2 to 10	8 To 4	9 to 5	9 to 5	2 to 10
Tuesday	15-10-19	11 TO 7	12 to 8	2 to 10	8 To 4	9 to 5	9 to 5	2 to 10
Wednesday	16-10-19	11 TO 7	12 to 8	2 to 10	8 To 4	9 to 5	9 to 5	2 to 10
Thursday	17-10-19	11 TO 7	12 to 8	2 to 10	8 To 4	9 to 5	9 to 5	2 to 10
Friday	18-10-19	11 TO 7	12 to 8	2 to 10	8 To 4	9 to 5	9 to 5	2 to 10
Saturday	19-10-19	11 TO 7	12 to 8	2 to 10	8 To 4	9 to 5	9 to 5	2 to 10
Sunday	20-10-19	wk off	wk off	9 to 5	wk off	wk off	wk off	wk off
Monday	21-10-19	9 to 5	11 TO 7	12 to 8	2 to 10	8 To 4	9 to 5	2 to 10
Tuesday	22-10-19	9 to 5	11 TO 7	12 to 8	2 to 10	8 To 4	9 to 5	2 to 10
Wednesday	23-10-19	9 to 5	11 TO 7	12 to 8	2 to 10	8 To 4	9 to 5	2 to 10
Thursday	24-10-19	9 to 5	11 TO 7	12 to 8	2 to 10	8 To 4	9 to 5	2 to 10
Friday	25-10-19	9 to 5	11 TO 7	12 to 8	2 to 10	8 To 4	9 to 5	2 to 10
Saturday	26-10-19	9 to 5	11 TO 7	12 to 8	2 to 10	8 To 4	9 to 5	2 to 10
Sunday	27-10-19	wk off	wk off	wk off	9 to 5	wk off	wk off	wk off
Monday	28-10-19	8 To 4	9 to 5	11 TO 7	12 to 8	2 to 10	9 to 5	2 to 10
Tuesday	29-10-19	8 To 4	9 to 5	11 TO 7	12 to 8	2 to 10	9 to 5	2 to 10
Wednesday	30-10-19	8 To 4	9 to 5	11 TO 7	12 to 8	2 to 10	9 to 5	2 to 10
Thursday	31-10-19	8 To 4	9 to 5	11 TO 7	12 to 8	2 to 10	9 to 5	2 to 10
Friday	01-11-19	8 To 4	9 to 5	11 TO 7	12 to 8	2 to 10	9 to 5	2 to 10
Saturday	02-11-19	8 To 4	9 to 5	11 TO 7	12 to 8	2 to 10	9 to 5	2 to 10

6. Are required equipment's provided to Arogya Mitra for AB PM-JAY beneficiary identification?

Allotment Letter

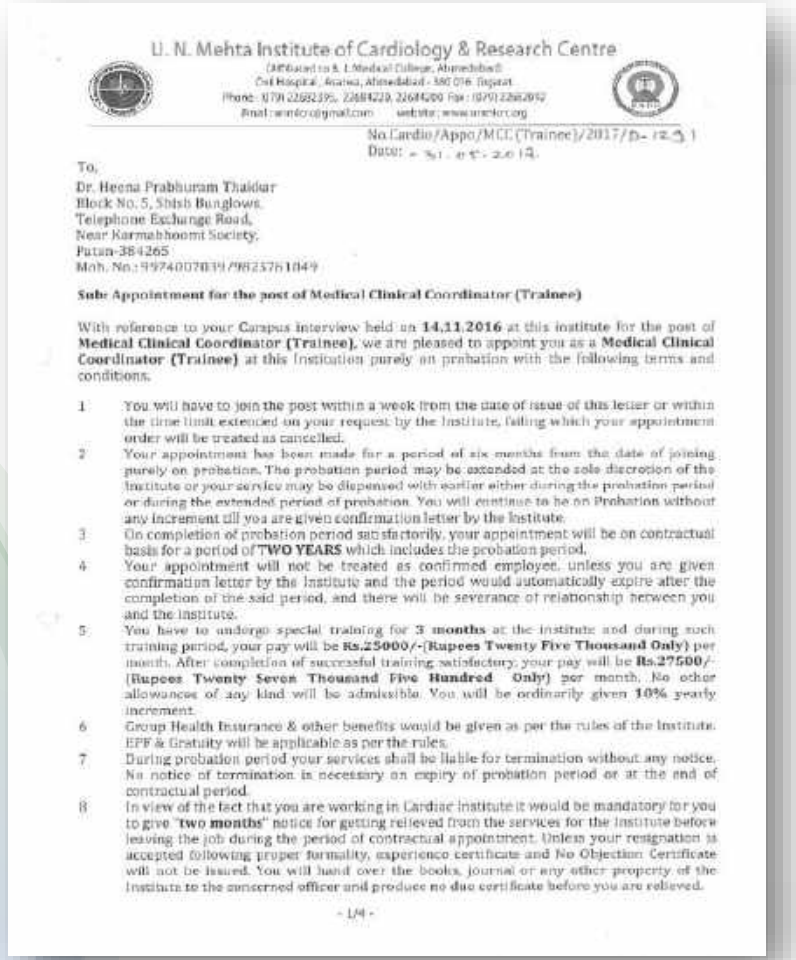
Counter

Computer

Biometric Scanner

Printer

8. Does the hospital have at least one Pradhan Mantri Arogya Mitra (PMAM)/ dedicated person per shift appointed for looking after the work of Ayushman Bharat Scheme?



U. N. Mehta Institute of Cardiology & Research Centre

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Civil Hospital, Asarwa, Ahmedabad - 380 016. Gujarat
Phone : (079) 22682395, 22684229, 22684200 Fax : (079) 22682092
Email : unmicro@gmail.com website : www.unmicro.org

No.Cardio/Appo/MCC (Trainee)/2017/D- 12.31
Date : 31-05-2017

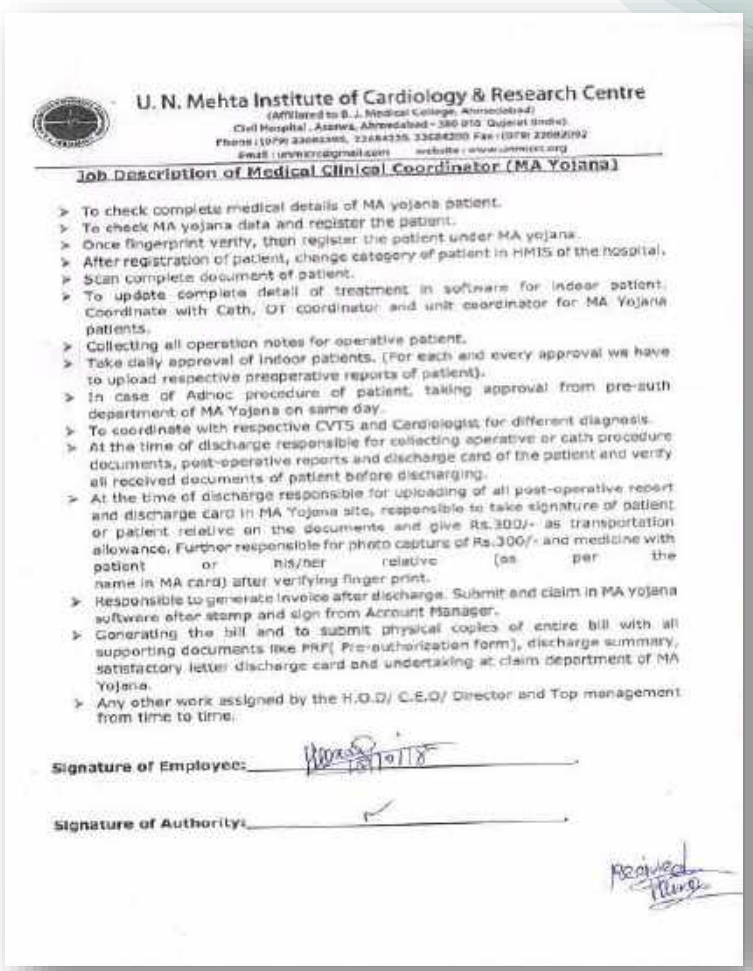
To,
Dr. Heena Prabhuram Thakkar
Block No. 5, Shish Bunglows,
Telephone Exchange Road,
Near Karmabhoomi Society,
Patan-384265
Mob. No.: 9974007839/9825761049

Sub: Appointment for the post of Medical Clinical Coordinator (Trainee)

With reference to your Campus interview held on **14.11.2016** at this institute for the post of **Medical Clinical Coordinator (Trainee)**, we are pleased to appoint you as a **Medical Clinical Coordinator (Trainee)** at this Institution purely on probation with the following terms and conditions.

1. You will have to join the post within a week from the date of issue of this letter or within the time limit extended on your request by the Institute, failing which your appointment order will be treated as cancelled.
2. Your appointment has been made for a period of six months from the date of joining purely on probation. The probation period may be extended at the sole discretion of the Institute or your service may be dispensed with earlier either during the probation period or during the extended period of probation. You will continue to be on Probation without any increment till you are given confirmation letter by the Institute.
3. On completion of probation period satisfactorily, your appointment will be on contractual basis for a period of **TWO YEARS** which includes the probation period.
4. Your appointment will not be treated as confirmed employee, unless you are given confirmation letter by the Institute and the period would automatically expire after the completion of the said period, and there will be severance of relationship between you and the Institute.
5. You have to undergo special training for **3 months** at the institute and during such training period, your pay will be **Rs.25000/-(Rupees Twenty Five Thousand Only)** per month. After completion of successful training satisfactory, your pay will be **Rs.27500/- (Rupees Twenty Seven Thousand Five Hundred Only)** per month. No other allowances of any kind will be admissible. You will be ordinarily given **10%** yearly increment.
6. Group Health Insurance & other benefits would be given as per the rules of the Institute. EPF & Gratuity will be applicable as per the rules.
7. During probation period your services shall be liable for termination without any notice. No notice of termination is necessary on expiry of probation period or at the end of contractual period.
8. In view of the fact that you are working in Cardiac Institute it would be mandatory for you to give "**two months**" notice for getting relieved from the services for the Institute before leaving the job during the period of contractual appointment. Unless your resignation is accepted following proper formality, experience certificate and No Objection Certificate will not be issued. You will hand over the books, journal or any other property of the Institute to the concerned officer and produce no due certificate before you are relieved.

- 1/4 -



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Phone : (079) 22682395, 22684229, 22684200 Fax : (079) 22682092
Email : unmicro@gmail.com website : www.unmicro.org

Job Description of Medical Clinical Coordinator (MA Yojana)

- To check complete medical details of MA yojana patient.
- To check MA yojana data and register the patient.
- Once fingerprint verify, then register the patient under MA yojana.
- After registration of patient, change category of patient in HMIS of the hospital.
- Scan complete document of patient.
- To update complete detail of treatment in software for indoor patient. Coordinate with Cath, OT coordinator and unit coordinator for MA Yojana patients.
- Collecting all operation notes for operative patient.
- Take daily approval of indoor patients. (For each and every approval we have to upload respective preoperative reports of patient).
- In case of Adhoc procedure of patient, taking approval from pre-auth department of MA Yojana on same day.
- To coordinate with respective CVTS and Cardiologist for different diagnosis.
- At the time of discharge responsible for collecting operative or cath procedure documents, post-operative reports and discharge card of the patient and verify all received documents of patient before discharging.
- At the time of discharge responsible for uploading of all post-operative report and discharge card in MA Yojana site, responsible to take signature of patient or patient relative on the documents and give Rs.300/- as transportation allowance. Further responsible for photo capture of Rs.300/- and medicine with patient or his/her relative (as per the name in MA card) after verifying finger print.
- Responsible to generate invoice after discharge. Submit and claim in MA yojana software after stamp and sign from Account Manager.
- Generating the bill and to submit physical copies of entire bill with all supporting documents like PRF(Pre-authorization form), discharge summary, satisfactory letter discharge card and undertaking at claim department of MA Yojana.
- Any other work assigned by the H.O.D/ C.E.O/ Director and Top management from time to time.

Signature of Employee: _____

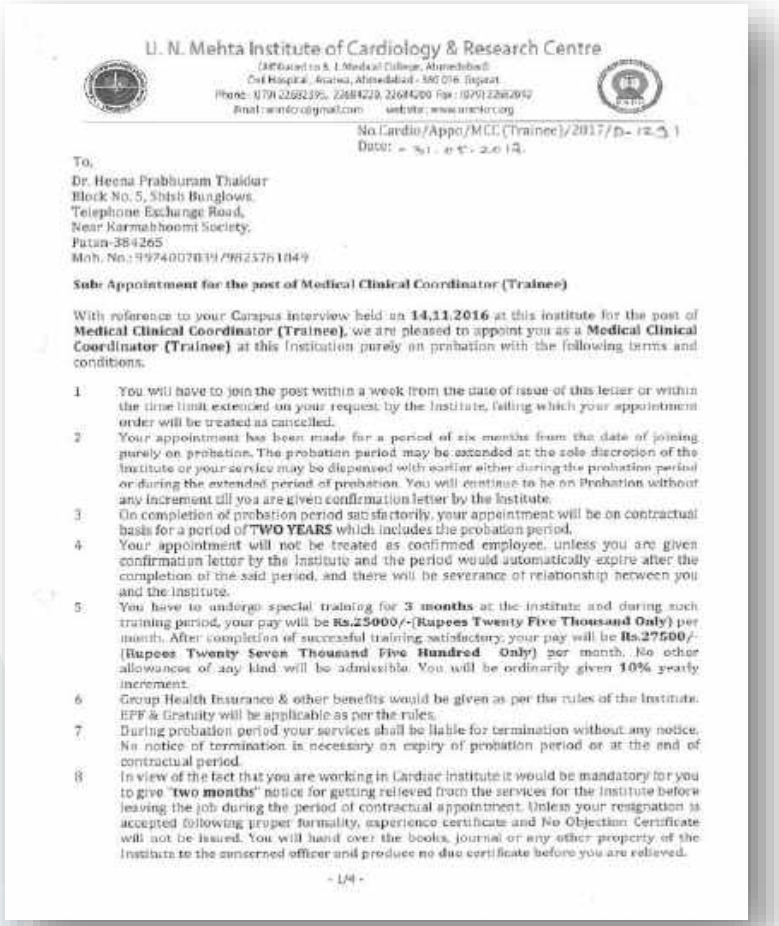
Signature of Authority: _____

Received

7. Does the hospital have a dedicated team for AB PMJAY?

Yes / No

8. Does the hospital have at least one Pradhan Mantri Arogya Mitra (PMAM)/ dedicated person per shift appointed for looking after the work of Ayushman Bharat Scheme?



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No.Cardio/Appo/MCC(Trainee)/2017/D- 12.5.1
Date: - 31.05.2017

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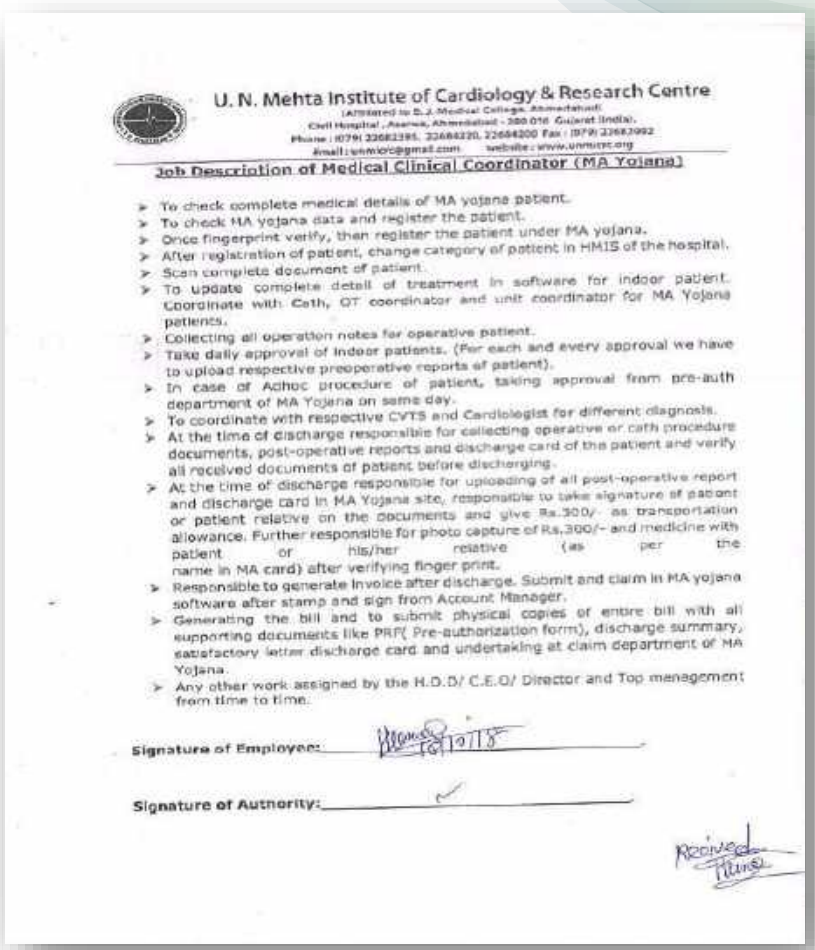

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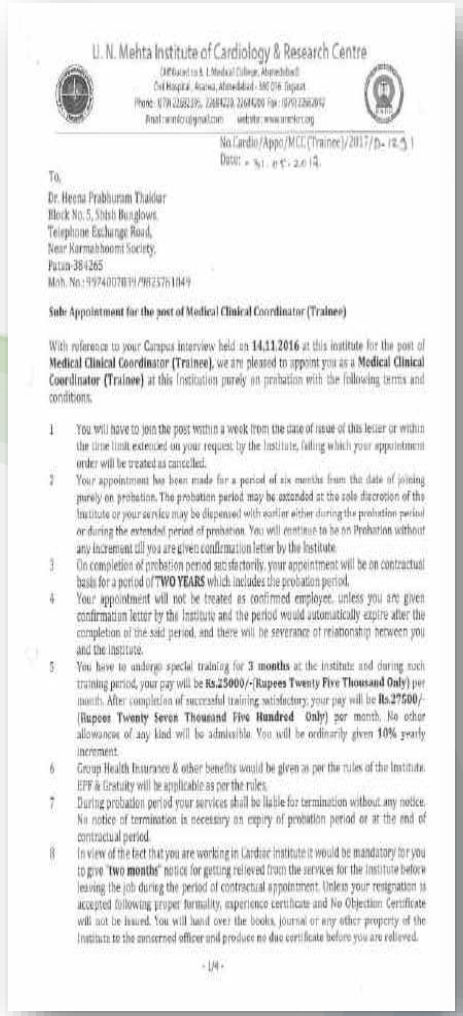
- Any other work assigned by the H.O.D/ C.E.O/ Director and Top management from time to time.

Signature of Employee: 10/7/17

Signature of Authority:

Received

9.Does the nominated AB PMJAY team have doctor(s) engaged?



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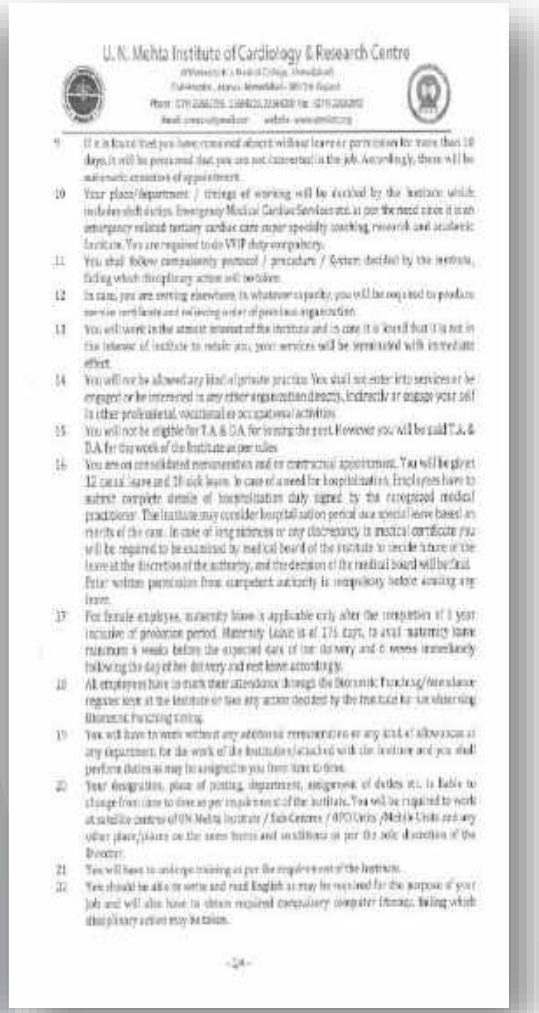
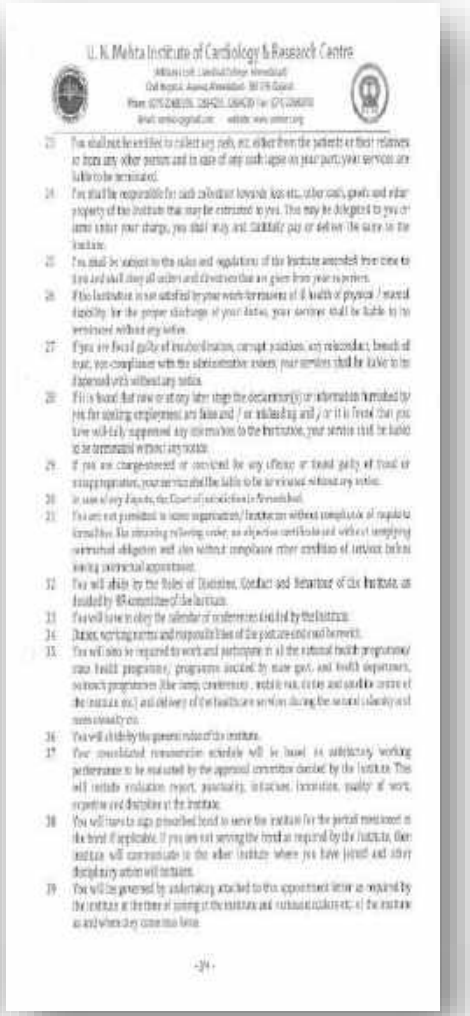
6. Group Health Insurance & other benefits would be given as per the rules of the Institute. EPF & Gratuity will be applicable as per the rules.
7. During probation period your services shall be liable for termination without any notice. No notice of termination is necessary on expiry of probation period or at the end of contractual period.
8. In view of the fact that you are working in Cardiac institute it would be mandatory for you to give **"two months"** notice for getting relieved from the services for the Institute before leaving the job during the period of contractual appointment. Unless your resignation is accepted following proper formality, experience certificate and No Objection Certificate will not be issued. You will hand over the books, journal or any other property of the Institute to the concerned officer and produce no dues certificate before you are relieved.



U. N. Mehta Institute of Cardiology & Research Centre

9. If it is found that you have remained absent without leave or permission for more than 10 days, it will be presumed that you are not interested in the job. Accordingly, there will be automatic cessation of appointment.
10. Your place/department / timings of working will be decided by the Institute which includes shift duties, Emergency Medical Cardiac Services etc. as per the need since it is an emergency related tertiary cardiac care super speciality teaching, research and academic institute. You are required to do VVIP duty compulsorily.
11. You shall follow compulsorily protocol / procedure / System decided by the institute, failing which disciplinary action will be taken.
12. In case, you are serving elsewhere, in whatever capacity, you will be required to produce service certificate and relieving order of previous organization.
13. You will work in the utmost interest of the institute and in case it is found that it is not in the interest of institute to retain you, your services will be terminated with immediate effect.
14. You will not be allowed any kind of private practice. You shall not enter into services or be engaged or be interested in any other organization directly, indirectly or engage your self in other professional, vocational or occupational activities.
15. You will not be eligible for T.A & D.A for joining the post. However you will be paid T.A & D.A for the work of the Institute as per rules.
16. You are not considered permanent on and on contractual appointment. You will be given 12 casual leave and 28 sick leave. In case of need for hospitalization, Employees have to submit complete details of hospitalization duly signed by the recognized medical practitioner. The Institute may consider hospitalization period as special leave based on merits of the case. In case of long sickness or any discrepancy in medical certificate you will be required to be examined by medical board of the institute to decide future of the leave at the discretion of the authority, and the decision of the medical board will be final. Prior written permission from competent authority is compulsory before availing any leave.
17. For female employee, maternity leave is applicable only after the completion of 1 year inclusive of probation period. Maternity Leave is of 135 days, to avail maternity leave minimum 4 weeks before the expected date of her delivery and 6 weeks immediately following the day of her delivery and rest leave accordingly.
18. All employees have to mark their attendance through the Electronic Punching/Attendance register kept at the Institute or take any action decided by the Institute for the observing Biometric Punching timing.
19. You will have to work without any additional remuneration or any kind of allowances at any department for the work of the Institution/attached with the Institute and you shall perform duties as may be assigned to you from time to time.
20. Your designation, place of posting, department, assignment of duties etc. is liable to change from time to time as per requirement of the institute. You will be required to work at satellite centres of U.N. Mehta Institute / Sub-Centres / OPD Units /Mobile Units and any other place/stations on the same terms and conditions as per the sole discretion of the Director.
21. You will have to undergo training as per the requirement of the Institute.
22. You should be able to write and read English as may be required for the purpose of your job and will also have to obtain required computer literacy, failing which disciplinary action may be taken.



U. N. Mehta Institute of Cardiology & Research Centre

23. You shall not be entitled to collect any cash, etc. either from the patients or their relatives or from any other person and in case of any such lapse on your part, your services are liable to be terminated.
24. You shall be responsible for such collection towards loss etc., other cash, goods and other property of the Institute that may be entrusted to you. This may be delegated to you or some under your charge, you shall duly and faithfully pay or deliver the same to the Institute.
25. You shall be subject to the rules and regulations of the Institute amended from time to time and shall obey all orders and directions that are given from time to time.
26. If the Institution is not satisfied by your work/performance or if health of physical / mental capability for the proper discharge of your duties, your services shall be liable to be terminated without any notice.
27. If you are found guilty of misbehaviour, corrupt practices, any misconduct, breach of trust, non-compliance with the administrative orders, your services shall be liable to be dispensed with without any notice.
28. If it is found that now or at any later stage the document(s) or information furnished by you for seeking employment are false and / or misleading and / or it is found that you have wilfully suppressed any information to the Institution, your service shall be liable to be terminated without any notice.
29. If you are charge-sheeted or convicted for any offence or found guilty of fraud or wrong registration, your services shall be liable to be terminated without any notice.
30. In case of any dispute, the Court of jurisdiction is Ahmedabad.
31. You are not permitted to leave organization/Institution without completion of requisite formalities like obtaining relieving order, no objection certificate and without completing contractual obligation and also without compliance other condition of services before leaving contractual appointment.
32. You will abide by the Rules of Discipline, Conduct and Behaviour of the Institute as decided by the committee of the Institute.
33. You will have to obey the calendar of conferences decided by the Institute.
34. Duties, working norms and responsibilities of the post are enclosed herewith.
35. You will also be required to work and participate in all the national health programme/ state health programme, programme decided by state govt. and health departments, outreach programmes like camp, conferences, mobile van, centre and satellite centre of the institute etc.) and delivery of the healthcare services during the national calamity and state calamity etc.
36. You will abide by the general rules of the institute.
37. Your consolidated remuneration schedule will be based on satisfactory working performance to be evaluated by the appraisal committee decided by the Institute. This will include evaluation report, punctuality, initiative, innovation, quality of work, expertise and discipline at the institute.
38. You will have to sign prescribed bond to serve the institute for the period mentioned in the bond if applicable. If you are not serving the bond as required by the Institute, then institute will communicate to the other institute where you have joined and other disciplinary action will be taken.
39. You will be governed by undertaking attached to this appointment letter as required by the institute at the time of joining of the institute and subsequent enlistment, if the institute so and when they come into force.

U. N. Mehta Institute of Cardiology & Research Centre

40. The Institute may at its discretion consider reorganization/ restructure and other service conditions on the basis that the earlier entitlements earned by the employee will be protected.
41. You will have to return the goods or books or any other materials or instruments, given to you during the course of service, without claiming any lien when so ever thereon at any time during the probation / appointment or upon termination.
42. Your appointment is provisional subject to your medical fitness & police verification as per Rules in force.
43. You shall have to produce the Discharge/Relieving Certificate from your present employer and submit the same to the Institute before joining the post.

You are requested to sign and return one copy of this appointment order, as a token of acceptance to the appointment on the terms and conditions here in above stated, along with your joining report at this institute.

(Dr. R. K. Patel)
Director

Copy to:
1. CEO/CFO/CTO
2. Accounts Section/Account Officer
3. Medl. Supt. / Admin.
4. PA to Director
5. Personal file
6. All the Doctors in Cardiothoracic Surgery /Cardiology/Cardiac Anesthesiology/ Anesthesiology /Medicine (Critical Care) /Surgery (Critical Care)/ Paediatrics Department and Other Departments

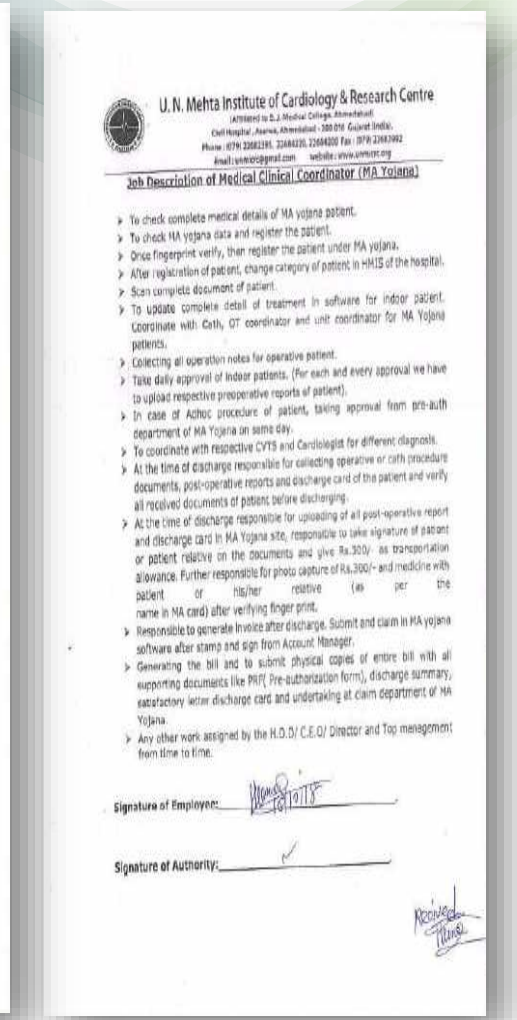
Copy submitted for:
1. Chairman of the Governing Board, U. N. Mehta Institute of Cardiology and Research Centre, Ahmedabad and Principal Secretary, Health and Family Welfare Department, Gujarat State, Gandhinagar, for information.
2. The Commissioner, Health, Medical Services, Medical Education and Research, Block No. 5, Dr. Jivraj Mehta Bhavan, Gandhinagar, for information.
3. The Additional Director, Medical Education and Research, Gandhinagar, for information.

ENDORSEMENT OF ACCEPTANCE

I, DR. HEENA P. THAKKAR, unconditionally accept the above appointment of the terms and conditions mentioned therein and I agree to be abide by that I am reporting for the duty today i.e. 31/01/2017 at 12.30 hrs.

Place: Ahmedabad
Date: 31/01/2017

Signature



U. N. Mehta Institute of Cardiology & Research Centre

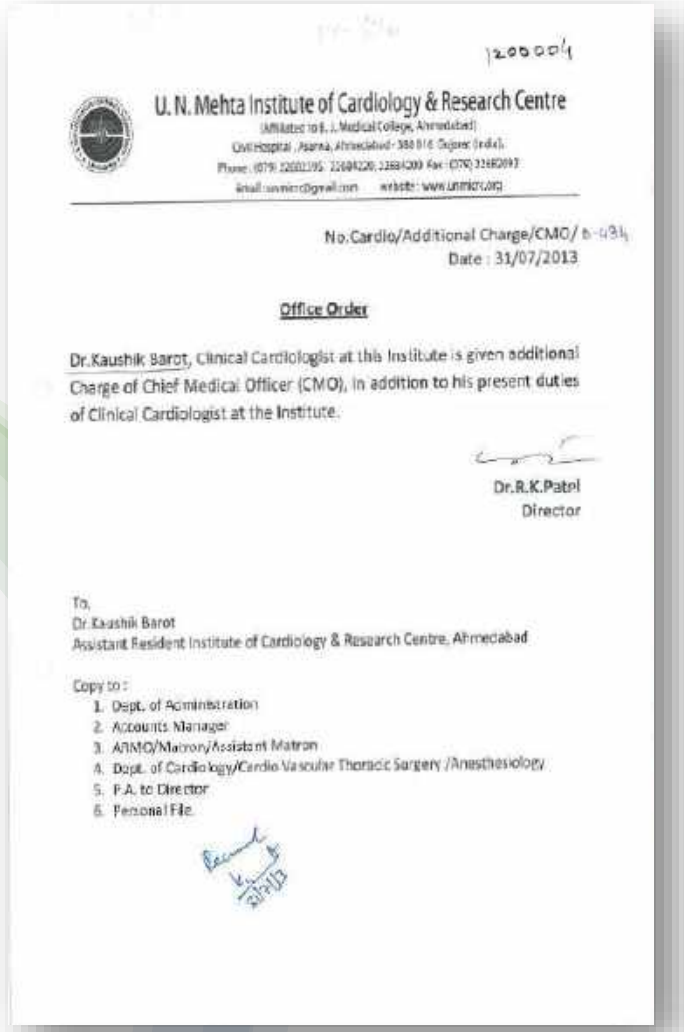
Job Description of Medical Clinical Coordinator (MA Yojana)

- To check complete medical details of MA yojana patient.
- To check MA yojana data and register the patient.
- Once fingerprint verify, then register the patient under MA yojana.
- After registration of patient, change category of patient in HMIS of the hospital.
- Scan complete document of patient.
- To update complete detail of treatment in software for indoor patient. Coordinate with Cath, OT coordinator and unit coordinator for MA Yojana patients.
- Collecting all operation notes for operative patient.
- Take daily approval of indoor patients. (For each and every approval we have to upload respective preoperative reports of patient).
- In case of Achoc procedure of patient, taking approval from pre-auth department of MA Yojana on same day.
- To coordinate with respective CVTS and Cardiologist for different diagnosis.
- At the time of discharge responsible for collecting operative or cath procedure documents, post-operative reports and discharge card of the patient and verify all received documents of patient before discharging.
- At the time of discharge responsible for uploading of all post-operative report and discharge card in MA Yojana site, responsible to take signature of patient or patient relative on the documents and give Rs.300/- as transportation allowance. Further responsible for photo capture of Rs.300/- and medicine with patient or his/her relative (as per the name in MA card) after verifying finger print.
- Responsible to generate Invoice after discharge. Submit and claim in MA yojana software after stamp and sign from Account Manager.
- Generating the bill and to submit physical copies of entire bill with all supporting documents like PRP(Pre-authorization form), discharge summary, satisfactory letter discharge card and undertaking at claim department of MA Yojana.
- Any other work assigned by the H.O.D/ C.E.O/ Director and Top management from time to time.

Signature of Employee:

Signature of Authority:

10. Does the nominated AB PMJAY team have a member from administration department?



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Civil Hospital, Asarwa, Ahmedabad-380 016. Gujarat (India).
Phone : (079) 22683195, 22684220, 22684200 Fax : (079) 22683093
email : unmicrc@gmail.com website : www.unmicrc.org

No.Cardio/Additional Charge/CMO/ 6-434
Date : 31/07/2013

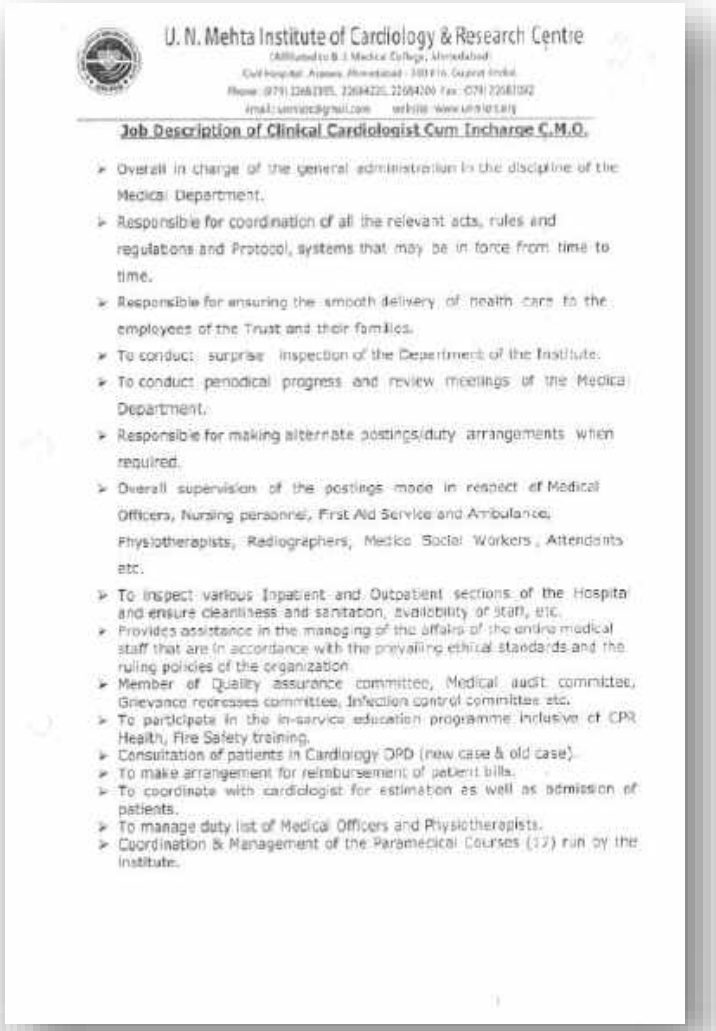
Office Order

Dr.Kaushik Barot, Clinical Cardiologist at this Institute is given additional Charge of Chief Medical Officer (CMO), in addition to his present duties of Clinical Cardiologist at the Institute.

Dr.R.K.Patel
Director

To,
Dr.Kaushik Barot
Assistant Resident Institute of Cardiology & Research Centre, Ahmedabad

Copy to :
1. Dept. of Administration
2. Accounts Manager
3. ANMO/Matron/Assistant Matron
4. Dept. of Cardiology/Cardio Vascular Thoracic Surgery /Anesthesiology
5. P.A. to Director
6. Personal File



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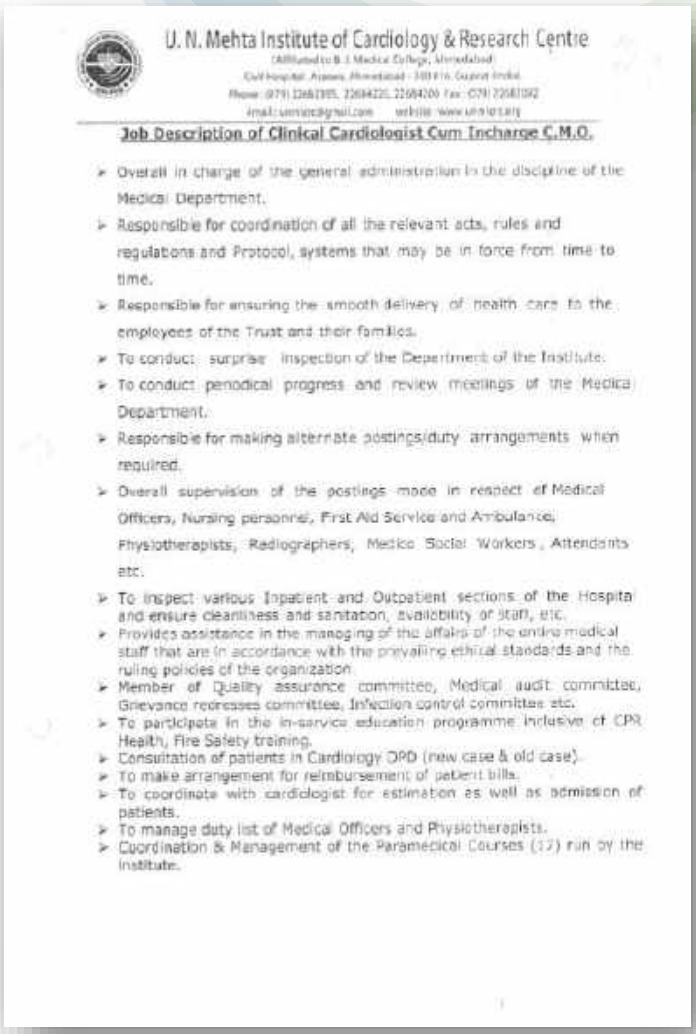
email : unmicrc@gmail.com website : www.unmicrc.org

Job Description of Clinical Cardiologist Cum Incharge C.M.O.

- Overall in charge of the general administration in the discipline of the Medical Department.
- Responsible for coordination of all the relevant acts, rules and regulations and Protocol, systems that may be in force from time to time.
- Responsible for ensuring the smooth delivery of health care to the employees of the Trust and their families.
- To conduct surprise inspection of the Department of the Institute.
- To conduct periodical progress and review meetings of the Medical Department.
- Responsible for making alternate postings/duty arrangements when required.
- Overall supervision of the postings made in respect of Medical Officers, Nursing personnel, First Aid Service and Ambulance, Physiotherapists, Radiographers, Medico Social Workers, Attendants etc.
- To inspect various Inpatient and Outpatient sections of the Hospital and ensure cleanliness and sanitation, availability of staff, etc.
- Provides assistance in the managing of the affairs of the entire medical staff that are in accordance with the prevailing ethical standards and the ruling policies of the organization
- Member of Quality assurance committee, Medical audit committee, Grievance redresses committee, Infection control committee etc.
- To participate in the in-service education programme inclusive of CPR Health, Fire Safety training.
- Consultation of patients in Cardiology OPD (new case & old case).
- To make arrangement for reimbursement of patient bills.
- To coordinate with cardiologist for estimation as well as admission of patients.
- To manage duty list of Medical Officers and Physiotherapists.
- Coordination & Management of the Paramedical Courses (17) run by the Institute.



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11. Does the hospital have AB PMJAY specific IEC materials near hospital entry and at prominent areas?

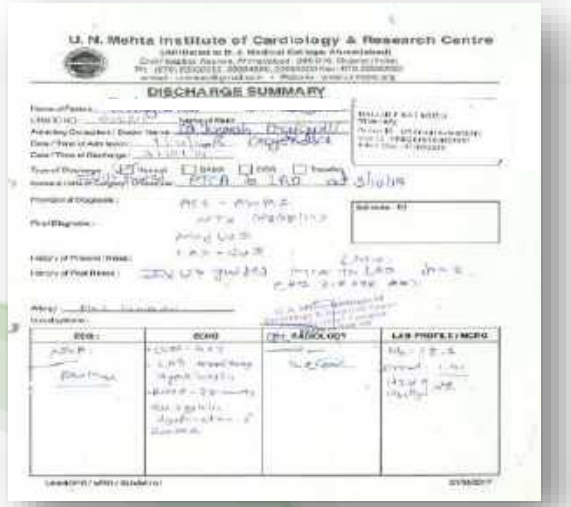
12. Does the AB PMJAY kiosk/ counter has IEC materials pertaining to AB PMJAY on or near it?

13. Has hospital conducted any promotional activity (like camping) for spreading awareness regarding the AB PM-JAY scheme?

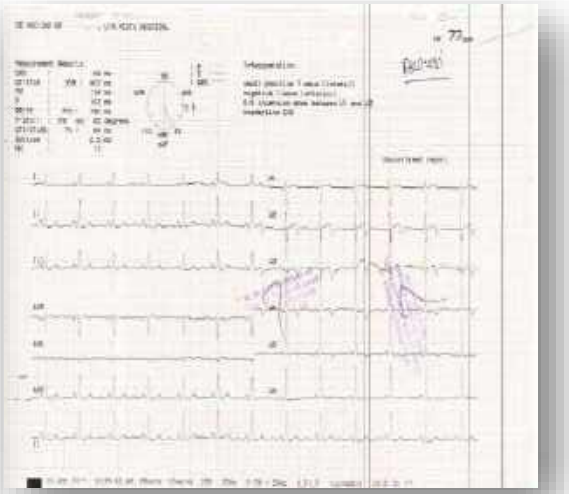
14. Is hospital's scope of services mapped with hospital's Manpower/Human Resources?

S.No	Doctor Name	Higher Qualification	Doctor Registration No	Experience (Years)
1	Dr Ramesh Dahyabhai Patel	MD (Doctor of Medicine)	11674	16
2	Dr Jigisha Chandrakant Pujara	MD (Doctor of Medicine)	14350	12
3	Dr Ritesh Babulal Shah	MD (Doctor of Medicine)	11496	16
4	Dr Hemang Kirtikumar Gandhi	MD (Doctor of Medicine)	12558	12
5	Dr Rajesh Mockhandbhai Thesani	MD (Doctor of Medicine)	7304	11
6	Dr Mrugesh Manilal Prajapati	MD (Doctor of Medicine)	13955	9
7	Dr Devvrat Kirtidhar Parmar	MD (Doctor of Medicine)	19039	8
8	Dr Jigar Jashvantbhai Patel	MD (Doctor of Medicine)	18878	8
9	Dr Jigar Hasmukhbhai Panchal	MD (Doctor of Medicine)	14271	9
10	Dr Bharat G Makwana	MD (Doctor of Medicine)	14668	7
11	Dr Sayyedahmed Y Vahra	MD (Doctor of Medicine)	21870	4
12	Dr Deepal Vitthalbhai Prajapati	MD (Doctor of Medicine)	19979	6
13	Dr Vikharad C Trivedi	MD (Doctor of Medicine)	19137	6
14	Dr Alpesh C Sarvaia	DM (Doctorate of Medicine)	24845	5
15	Dr Hasmukh N Patel	DM (Doctorate of Medicine)	24241	5
16	Dr Sunilkumar Nareshbhai Nimavat	MD (Doctor of Medicine)	18699	7
17	Dr Ruchika Vidyasthi Jain	MD (Doctor of Medicine)	8595	7
18	Dr Nimy Pathik	MD (Doctor of Medicine)	12995	5
19	Dr Jigar Surti	MD (Doctor of Medicine)	13751	5

15. Do the hospitals maintain proper medical records maintained for AB PMJAY patients?


U. N. Mehta Institute of Cardiology & Research Centre

DISCHARGE SUMMARY




TO

PATIENT NAME:

ID NO:

PATIENT POSTED FOR PTCA

BECAUSE OF

1 DIABETES MELLITUS

2 HTN

3 LESION LENGTH >15MM

4 VESSEL DIAMETER < 2.5 MM

5 BIFURCATION

KINDLY GIVE PERMISSION FOR BIS UNDER MA YOJANA

THANK YOU,


2D+ECHO (without Pilot) + 3D Echocardiography Report

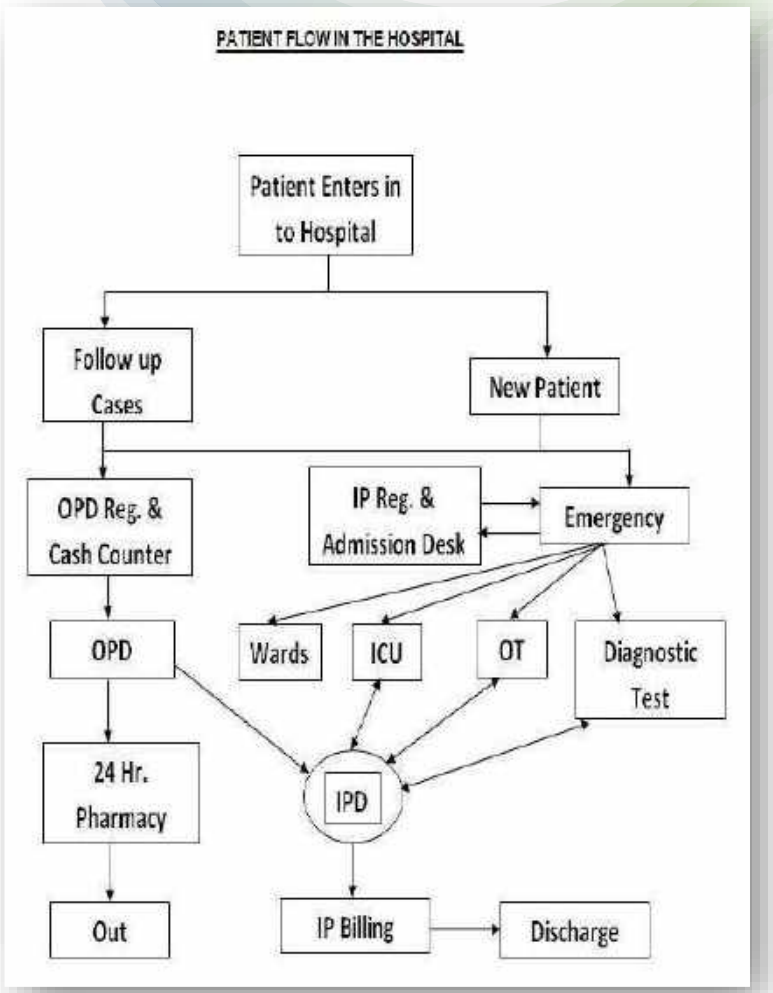

U. N. Mehta Institute of Cardiology & Research Centre

Y ANGIOGRAM

HAND WASHING PREVENTS INFECTION

16. Is AB PMJAY claim process documented in the hospital's policies?

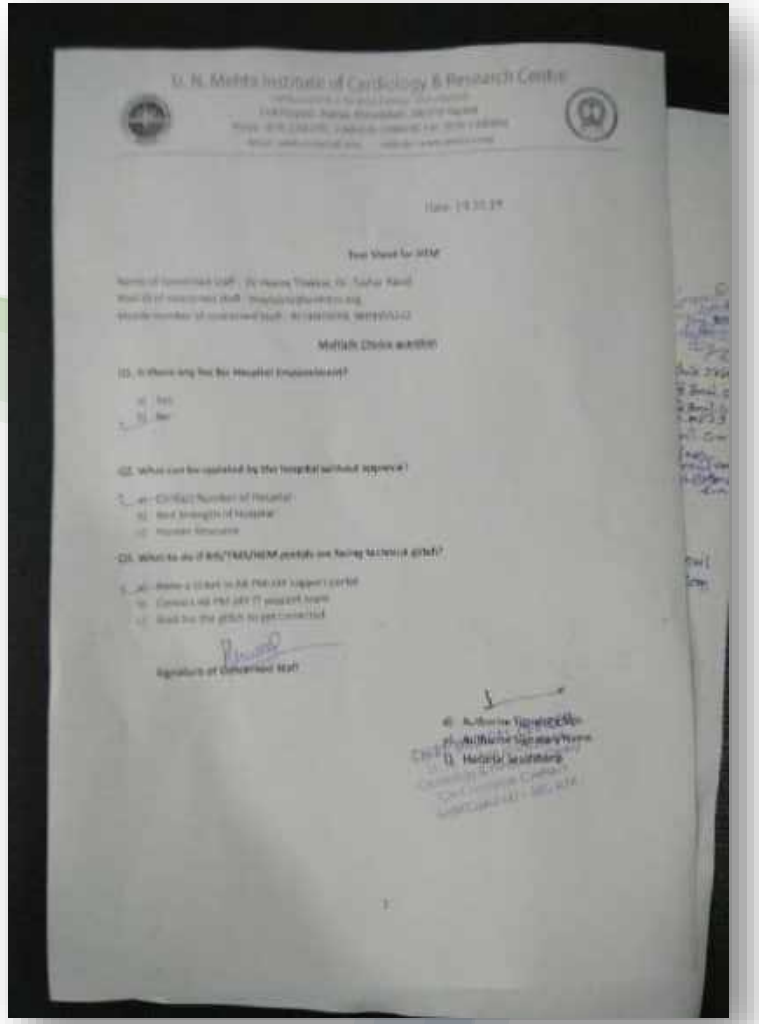
Name of Policy Policy No.	**Policy for Registration & Admission** & Admission NCHS/AAC/02/A
Purpose	& of and to the with the aims to: • needs and expectations of customers. • Customers satisfaction. • a of patients. • Feedback continuous improvements.
scope	All patients undergoing at NCHS.
Responsibility	All members of front /Case window staff, nursing staff of NCHS.

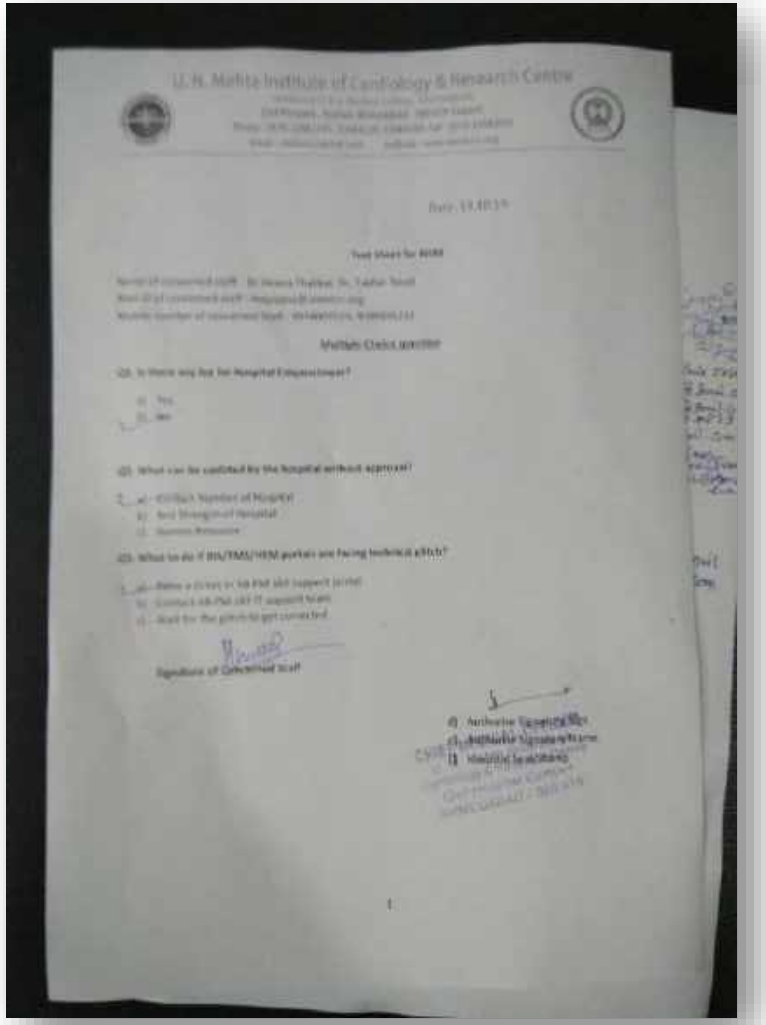


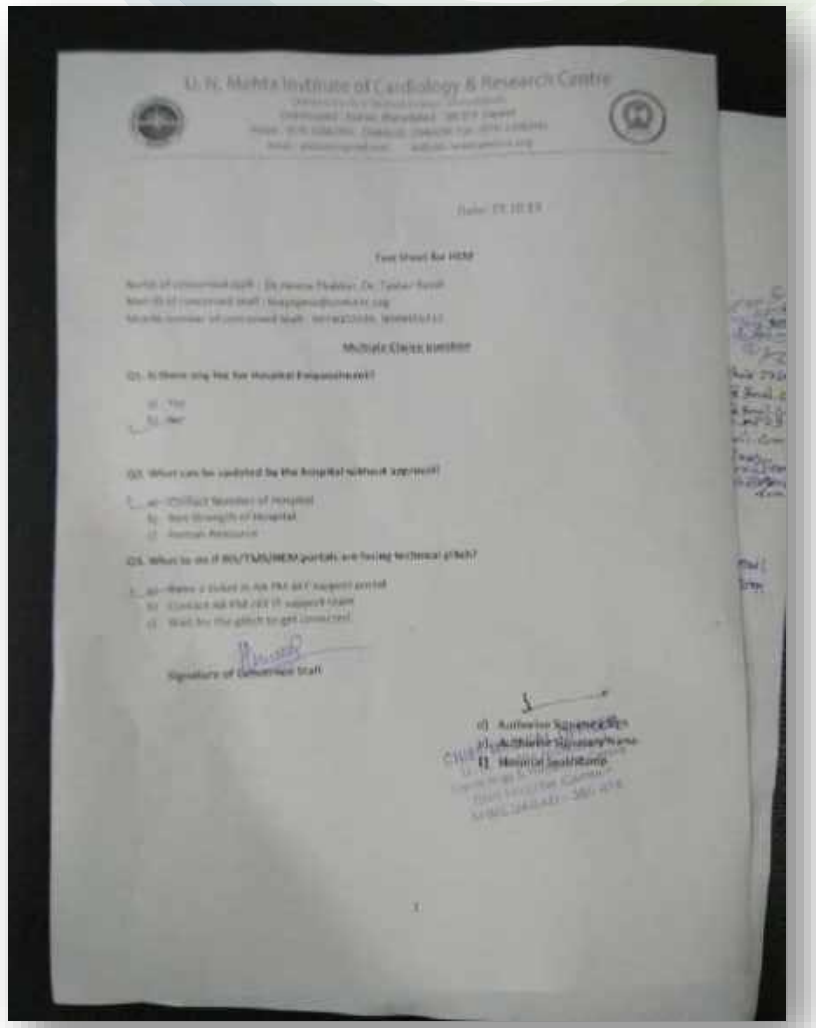
17. Does the hospital charge any extra money from AB PMJAY beneficiaries?

Yes / No

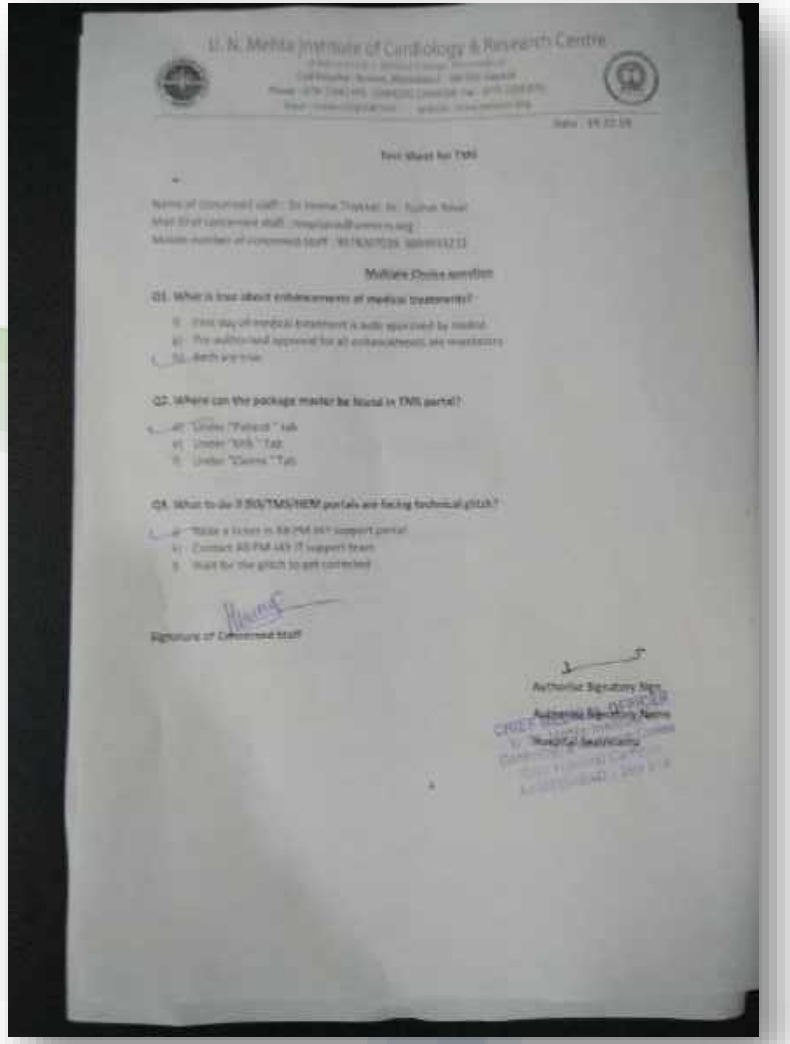
18. Are the deployed staff members trained for HEM portal?

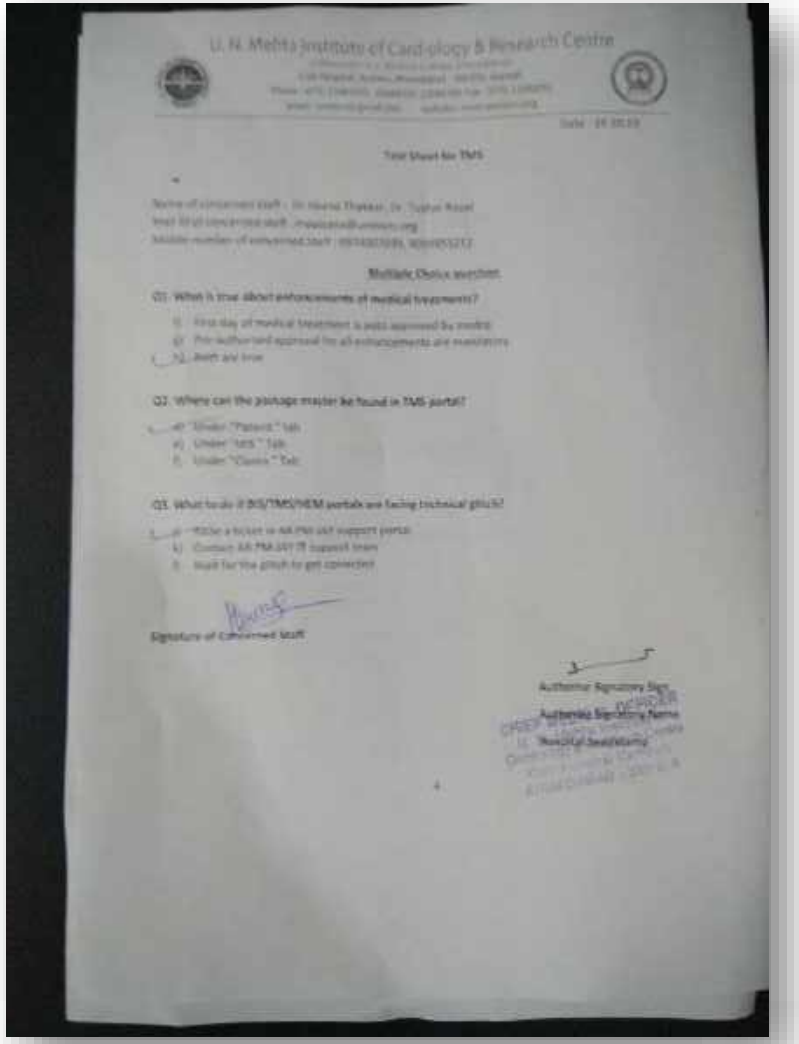


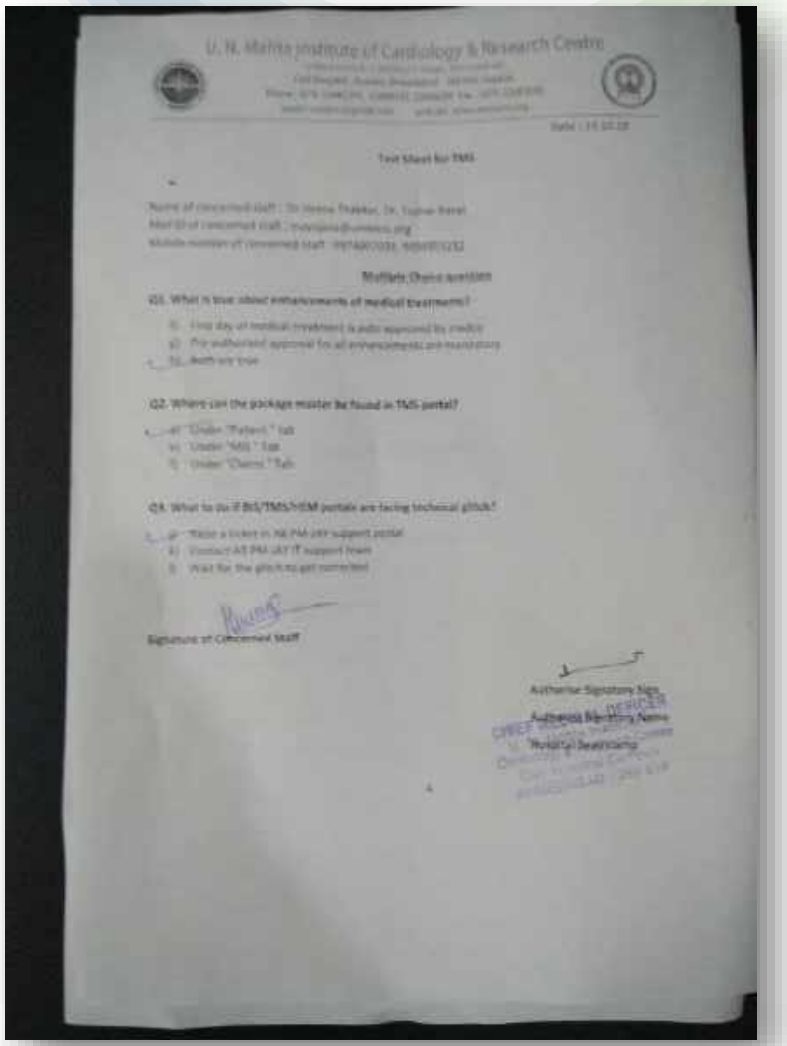




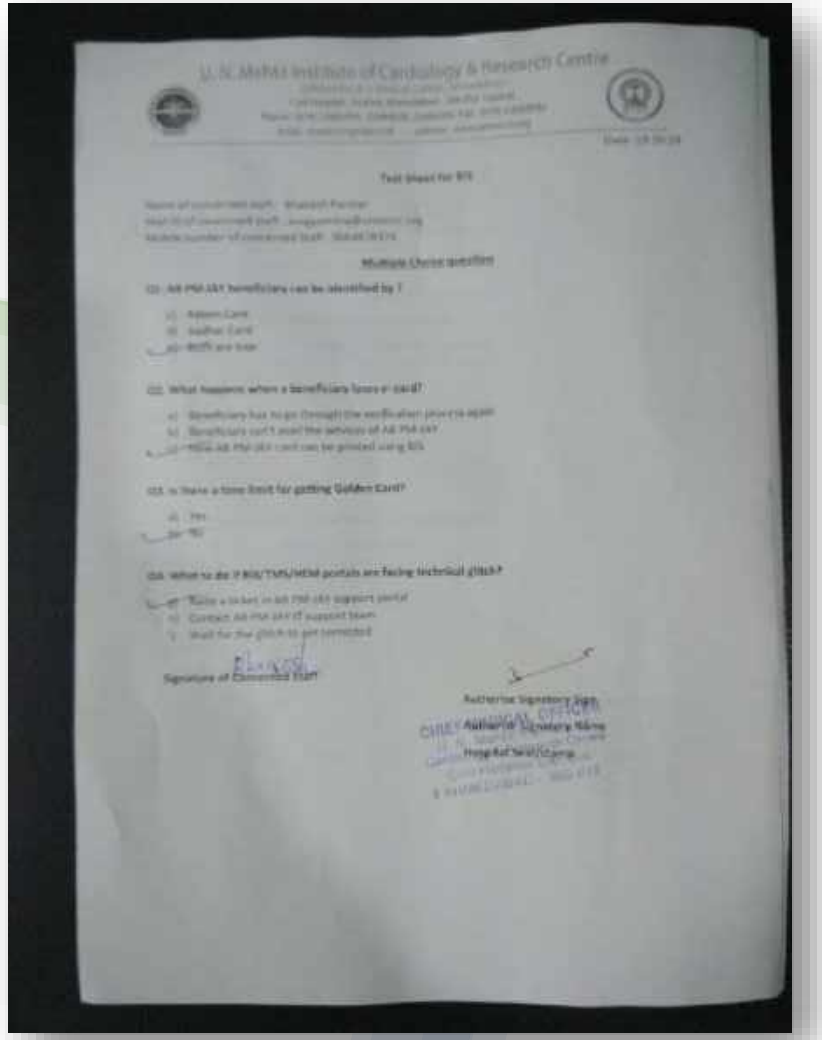
19. Are the deployed staff members trained for TMS portal?

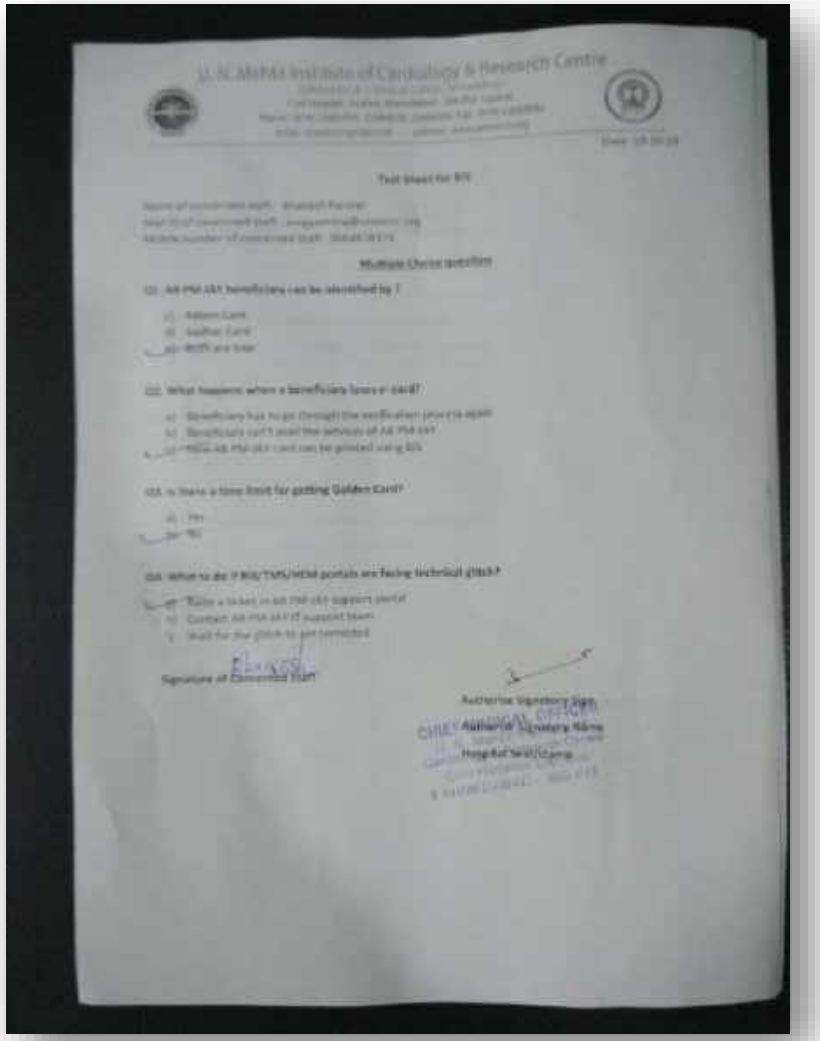


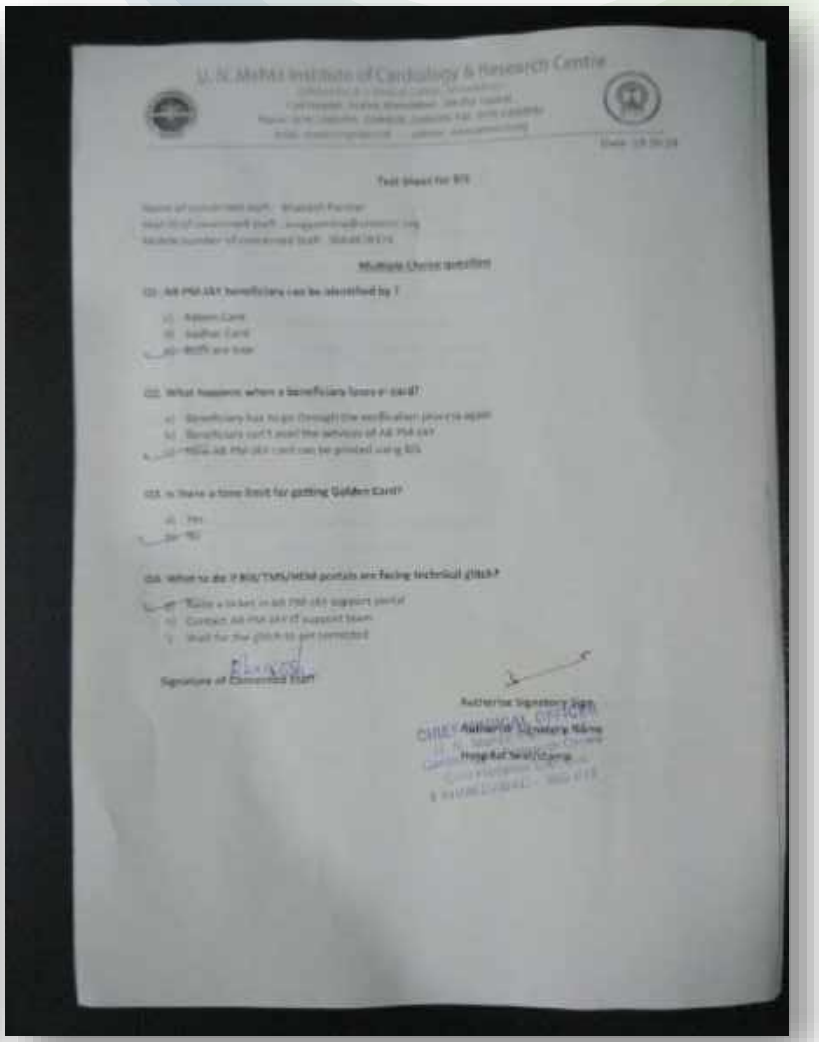




20. Are the deployed staff members trained for BIS portal?







21. Does the hospital maintain proper records for AB PMJAY referred beneficiaries?

1	APRIL	IPD/2019/04/00090 19	UNM-2019-04-025045	01-04-19	01-04-19	NEW IPD	HIRALAL MANGILAL PRAJAPATI	Male	49y	40Y - 60Y	ADULT	01/04/1970	Cardiology Unit - 2	Married	Gujarati	WARD NO-17	TARAKHEDI	Jaora	Ratlam	MADHYA PRADESH	OTHER STATE	MADHYA PRADESH	INDIA
2	APRIL	IPD/2019/04/00090 26	UNM-2018-07-058187	24-07-18	01-04-19	FOLLOW UP	VANITABEN BALKISHAN NORA	Female	40y 8m	40Y - 60Y	ADULT	24/07/1978	Cardiology Unit - 1	Married	Gujarati	585/3691, G.H.B.,BAPUNAGAR	AHMEDABAD	AHMEDABAD	AHMEDABAD	GUJARAT	GUJARAT	GUJARAT	INDIA
3	APRIL	IPD/2019/04/00090 28	UNM-2019-03-021286	18-03-19	01-04-19	FOLLOW UP	SHAKARIBEN BHULESHWARBHAI DARJI	Female	70y	>= 60Y	ADULT	18/03/1949	Cardiology Unit - 2	Widow	Gujarati	NR. BAL MANDIR	kankanol	HIMATNAGAR	SABARKANTHA	GUJARAT	GUJARAT	GUJARAT	INDIA
4	APRIL	IPD/2019/04/00090 53	UNM-2019-04-025122	01-04-19	01-04-19	NEW IPD	MANJULABEN MAHESHBHAI JADAV	Female	52y	40Y - 60Y	ADULT	01/04/1967	Cardiology Unit - 2	Married	Gujarati	B/H RAILWAY CROSSING, NEW CHAMUNDA SOC-36, NR. NAVRANG HIGH SCHOOL, JAGATPUR ROAD, CHANDKHEDA	AHMEDABAD	AHMEDABAD	AHMEDABAD	GUJARAT	GUJARAT	GUJARAT	INDIA
5	APRIL	IPD/2019/04/00090 63	UNM-2019-03-021083	16-03-19	01-04-19	FOLLOW UP	MANGILAL RAMLALJI DHANGAR	Male	56y	40Y - 60Y	ADULT	16/03/1963	CVTS Unit - 1	Married	Hindi	-	SARSOD	Daloda	Mandsaur	MADHYA PRADESH	OTHER STATE	MADHYA PRADESH	INDIA
6	APRIL	IPD/2019/04/00090 68	UNM-2019-04-025070	01-04-19	01-04-19	NEW IPD	GOPAL RODUJI SURYAVANSHI	Male	36y 9m	18Y - 40Y	ADULT	05/06/1982	Cardiology Unit - 2	Married	Gujarati	-	RAHIMGARH	Sitamau	Mandsaur	MADHYA PRADESH	OTHER STATE	MADHYA PRADESH	INDIA
7	APRIL	IPD/2019/04/00090 78	UNM-2019-04-025095	01-04-19	01-04-19	NEW IPD	PUSHPABEN PRAKASHBHAI DHOBI	Female	42y 3m	40Y - 60Y	ADULT	01/01/1977	CVTS Unit - 1	Married	Gujarati	BIHAND SANSAD BHAVAN	MANDSAUR	Mandsaur	Mandsaur	MADHYA PRADESH	OTHER STATE	MADHYA PRADESH	INDIA
8	APRIL	IPD/2019/04/00090 85	UNM-2019-03-016731	01-03-19	01-04-19	FOLLOW UP	NATVARLAL MOHANLAL SOLANKI	Male	69y 8m	>= 60Y	ADULT	07/07/1949	CVTS Unit - 2	Married	Gujarati	OD VAS,BUKDI ROAD	PATAN	PATAN	PATAN	GUJARAT	GUJARAT	GUJARAT	INDIA
9	APRIL	IPD/2019/04/00091 07	UNM-2019-04-025431	01-04-19	01-04-19	NEW IPD	RASIKBHAI MOHANBHAI MAKWANA	Male	55y	40Y - 60Y	ADULT	01/04/1964	Cardiology Unit - 2	Married	Gujarati	-	BAHADURPUR	PALITANA	BHAVNAGAR	GUJARAT	GUJARAT	GUJARAT	INDIA

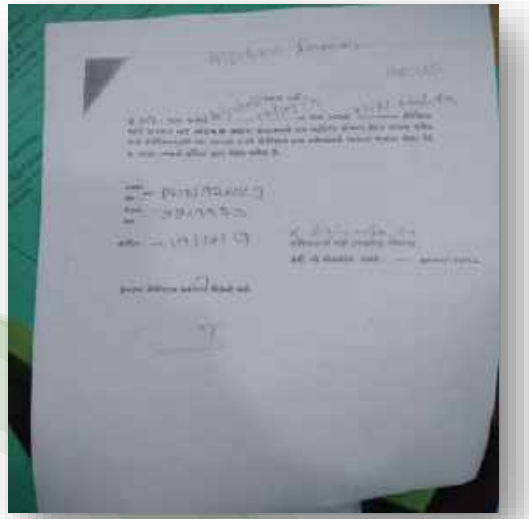
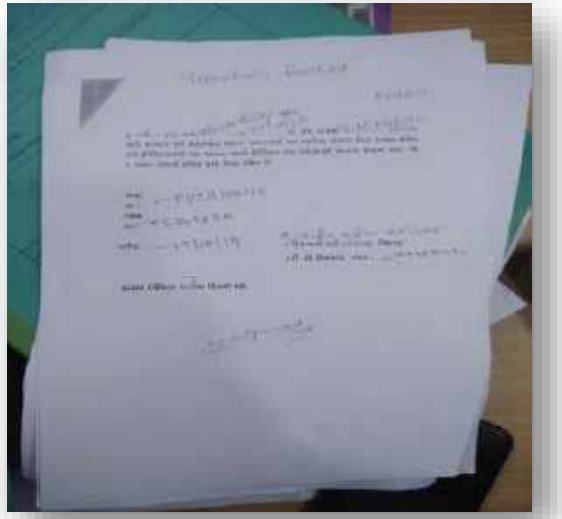
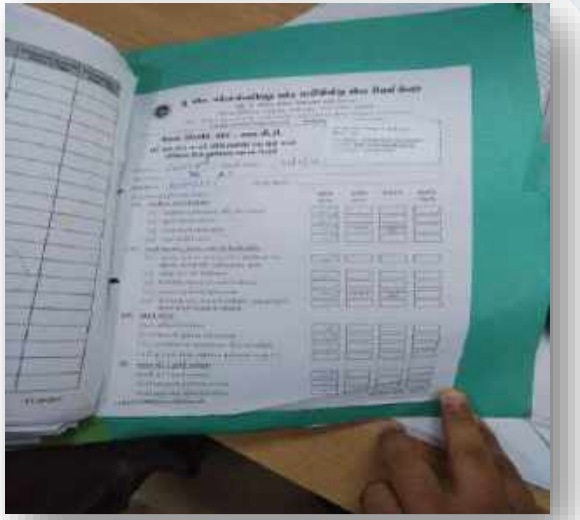
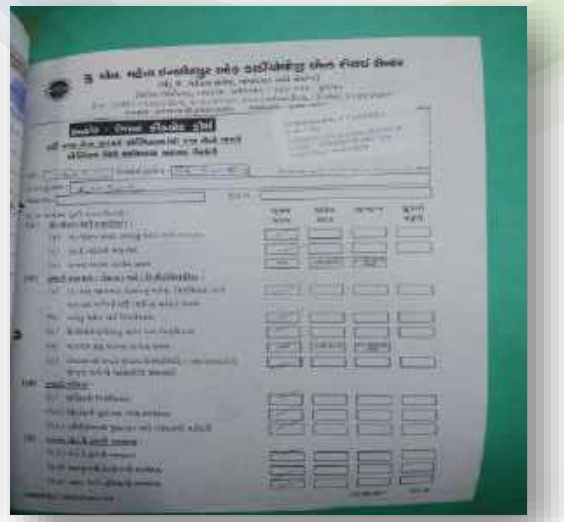
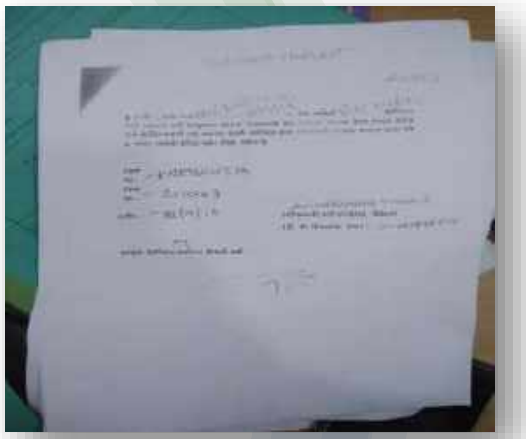
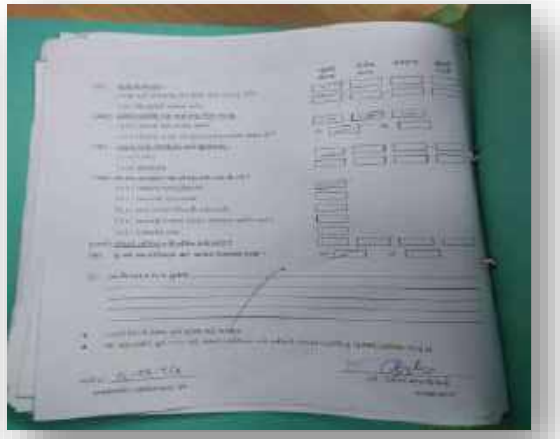
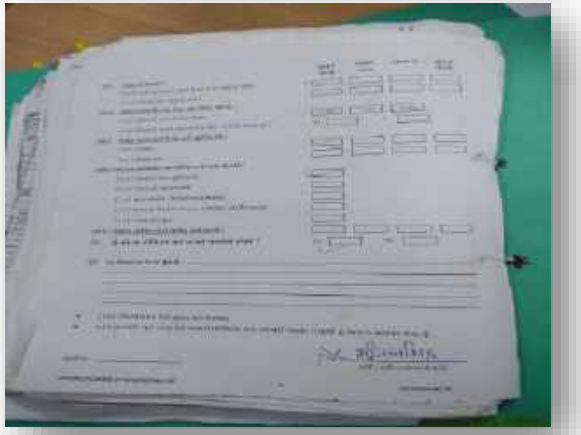
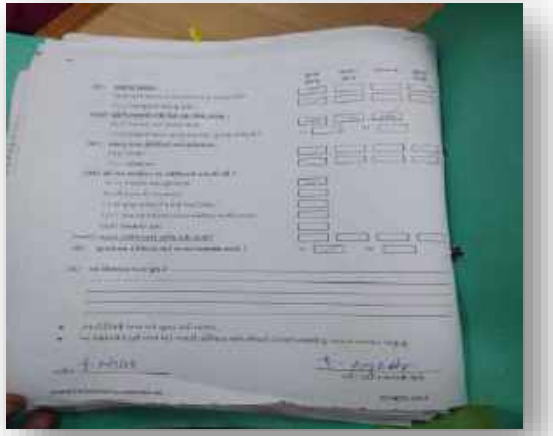
22. Number of AB PMJAY beneficiaries referred to AB PMJAY hospitals in last 6 month

Only Number..

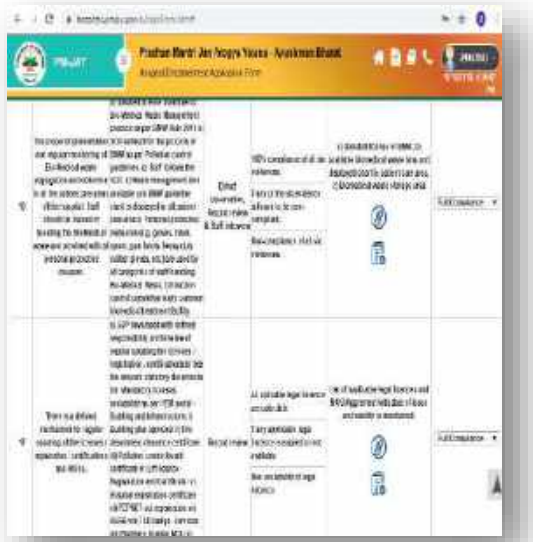
23. Number of AB PMJAY In-Patient Department (IPD) census for last 6 months

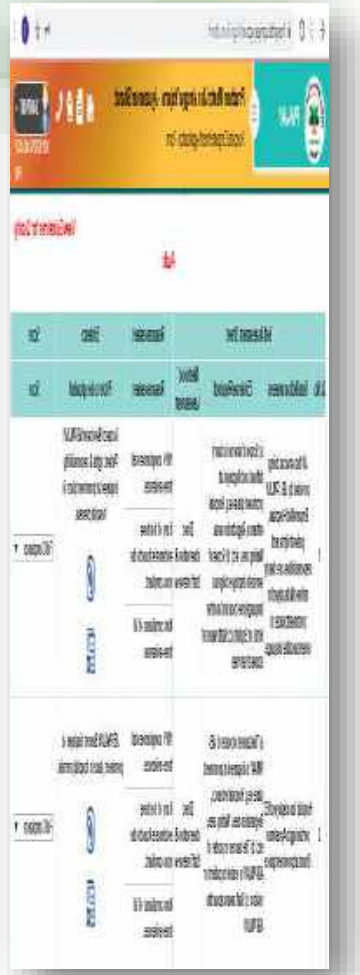
Only Number..

24. Does the hospital collect feedback during discharge from AB PMJAY beneficiaries?

25. AB PM-JAY quality audit checklist filled regularly in HEM portal?



Guidelines for Quality Audit Checklist

Link:- https://hospitals.pmjay.gov.in

- **Quality Audit Checklist to be filled for all 20 parameters.**
- **Each parameter to be assessed based on compliance to required evidences.**
- **Method of Assessment includes - Direct observation, Patient Interview, Staff Interview and Record Review required as per parameter.**
- **Scoring is 0 (Non Compliance), 5 (Partial Compliance) and 10 (Full Compliance) based on the evidences**
- **Empaneled hospitals have to perform an online self assessment every month and average score will be considered as yearly assessment score.**

1. All the services being provided by AB – PMJAY Empanelled Hospitals, patient rights and responsibilities are clearly defined & display at prominent place in understandable language.

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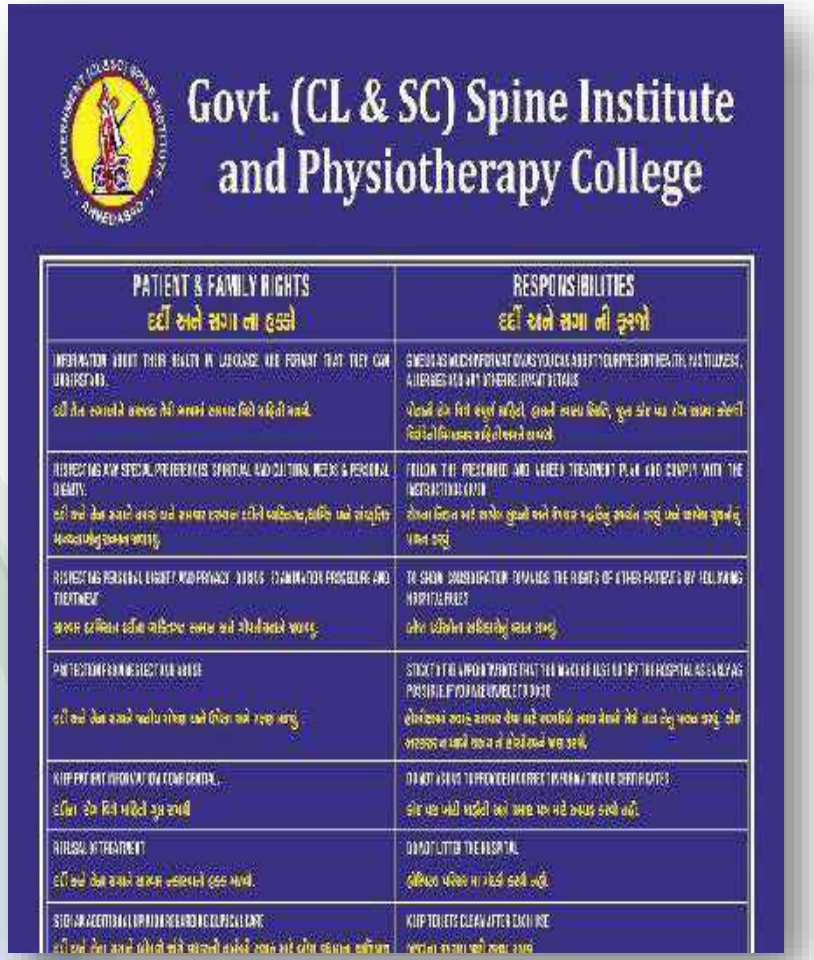

Govt. (CL & SC) Spine Institute and Physiotherapy College

PATIENT & FAMILY RIGHTS	RESPONSIBILITIES
INFORMATION ABOUT THEIR HEALTH IN LANGUAGE AND FORMAT THAT THEY CAN UNDERSTAND.	GIVE US AS MUCH INFORMATION AS YOU CAN ABOUT YOUR PRESENT HEALTH, PAST ILLNESS, ALLERGIES AND ANY OTHER RELEVANT DETAILS
RESPECTING ANY SPECIAL PREFERENCES, SPIRITUAL AND CULTURE NEEDS & PERSONAL DIGNITY.	FOLLOW THE PRESCRIBED AND AGREED TREATMENT PLAN AND COMPLY WITH THE INSTRUCTIONS GIVEN
RESPECTING PERSONAL DIGNITY AND PRIVACY DURING EXAMINATION PROCEDURE AND TREATMENT	TO SHOW CONSIDERATION TOWARDS THE RIGHTS OF OTHER PATIENTS BY FOLLOWING HOSPITAL RULES
PROTECTION FROM NEGLECT AND ABUSE	STICK TO THE APPOINTMENTS THAT YOU MAKE OR ELSE NOTIFY THE HOSPITAL AS EARLY AS POSSIBLE, IF YOU ARE UNABLE TO DO SO
KEEP PATIENT INFORMATION CONFIDENTIAL.	DO NOT ASK US TO PROVIDE INCORRECT INFORMATION OR CERTIFICATES
REFUSAL OF TREATMENT	DO NOT LITTER THE HOSPITAL
SEEK AN ADDITIONAL OPINION REGARDING CLINICAL CARE	KEEP TOILETS CLEAN AFTER EACH USE

Sr. No	Patient & Family Rights	Responsibilities
1	Information about their health in language and format that they can understand.	Give us as much information as you can about your present health, past illness, allergies and any other relevant details
2	Respecting any special preferences, spiritual and culture needs & personal dignity.	Follow the prescribed and agreed treatment plan and comply with the instructions given
3	Respecting personal dignity and privacy during examination procedure and treatment	To show consideration towards the rights of other patients by following hospital rules
4	Protection from neglect and abuse	Stick to the appointments that you make or else notify the hospital as early as possible, if you are unable to do so
5	Keep patient information confidential.	Do not ask us to provide incorrect information or certificates
6	Refusal of treatment	Do not litter the hospital
7	Seek an additional opinion regarding clinical care	Keep toilets clean after each use
8	Informed consent before transfusion of blood and blood products, anesthesia, surgery, initiation of any research protocol and any other invasive/high risk procedure/treatment.	Do not smoke or spit inside the hospital premises
9	Patient and family are made aware to lodge complaint and give feedback. The complaint is addressed to grievance redressal committee	Wait patiently for your turn
10	Information on the expected cost of the treatment and about financial implications when there is a change in the patient condition or treatment setting	Maintain silence

2. Hospital has displayed the IEC pertaining to Ayushman Bharat at prominent place

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
a) The banner or poster of AB-PMJAY is displayed at prominent place (e.g. Hospital entrance, Registration area, Waiting area, etc.) b) The banner or poster of AB-PMJAY is visible to patient or visitors c) Staff aware about the AB-PMJAY	Direct observation & Staff interview	100% compliance of all three evidences.	10	AB PM-JAY Banner displayed at prominent place in hospital premsis.
		if any of the three evidence is found to be non-compliant.	5	
		Non-compliance of all three evidences.	0	

2. Hospital have displayed the IEC pertaining to Ayushman Bharat at prominent place

3. The initial assessment by doctors for in-patients is documented within 24 hours or earlier and the Patient record file have care and treatment orders which is signed, named, timed and dated by the concerned doctor.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
See minimum 5 in-patients files of existing (admitted) patient record and check for: a) Availability of Initail assesment form b) Initial assemnent form filled by concerned personal c) Time of admission ,Time of initial assessment , Initial assesment start and completion time. d) Treatment orders are signed, named, timed and dated by the concerned doctor	Record review & Staff interview	100% compliance of all four evidences.	10	Doctor's initial assessment form and Nursing initial assessment form.
		if any of the four evidence is found to be non-compliant.	5	
		Non-compliance of all four evidences.	0	

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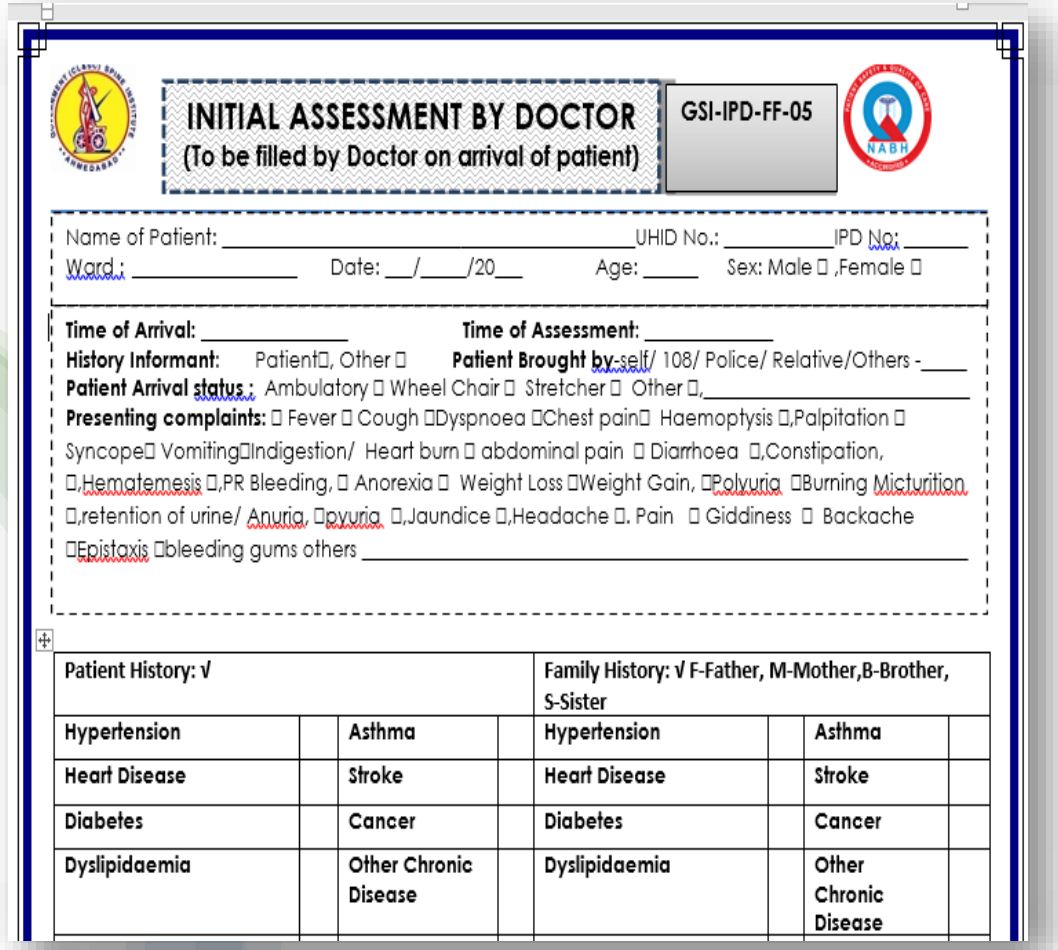


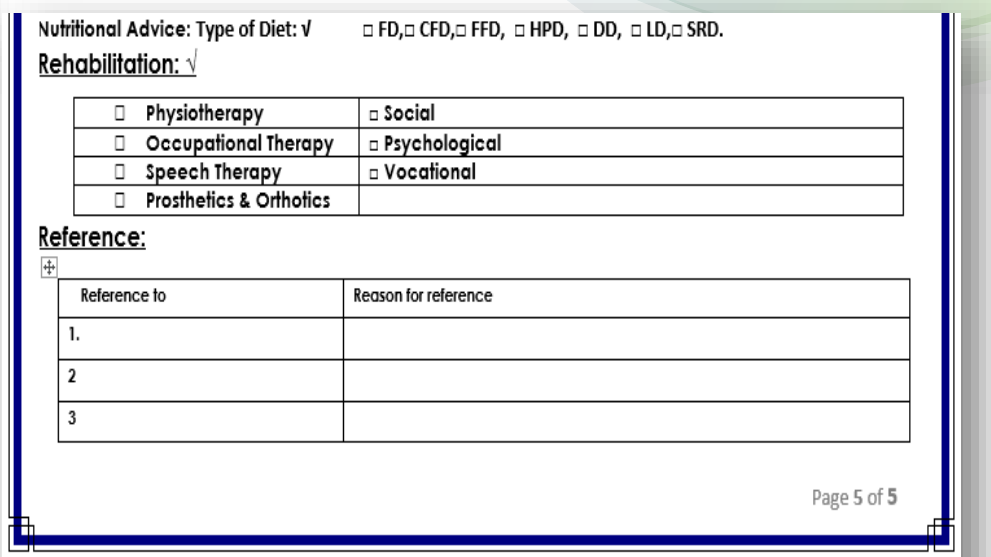
INITIAL ASSESSMENT BY DOCTOR
(To be filled by Doctor on arrival of patient)

GSI-IPD-FF-05

Name of Patient: _____ UHID No.: _____ IPD No: _____
Ward : _____ Date: __/____/20__ Age: _____ Sex: Male □ ,Female □

Time of Arrival: _____ **Time of Assessment:** _____
History Informant: Patient□, Other □ **Patient Brought by**-self/ 108/ Police/ Relative/Others -____
Patient Arrival status : Ambulatory □ Wheel Chair □ Stretcher □ Other □,_____
Presenting complaints: □ Fever □ Cough □Dyspnoea □Chest pain□ Haemoptysis □,Palpitation □ Syncope□ Vomiting□Indigestion/ Heart burn □ abdominal pain □ Diarrhoea □,Constipation, □,Hematemesis □,PR Bleeding, □ Anorexia □ Weight Loss □Weight Gain, □Polyuria □Burning Micturition □,retention of urine/ Anuria, □pyuria □,Jaundice □,Headache □. Pain □ Giddiness □ Backache □Epistaxis □bleeding gums others _____

Patient History: √				Family History: √ F-Father, M-Mother,B-Brother, S-Sister			
Hypertension		Asthma		Hypertension		Asthma	
Heart Disease		Stroke		Heart Disease		Stroke	
Diabetes		Cancer		Diabetes		Cancer	
Dyslipidaemia		Other Chronic Disease		Dyslipidaemia		Other Chronic Disease	



Nutritional Advice: Type of Diet: √ □ FD,□ CFD,□ FFD, □ HPD, □ DD, □ LD,□ SRD.

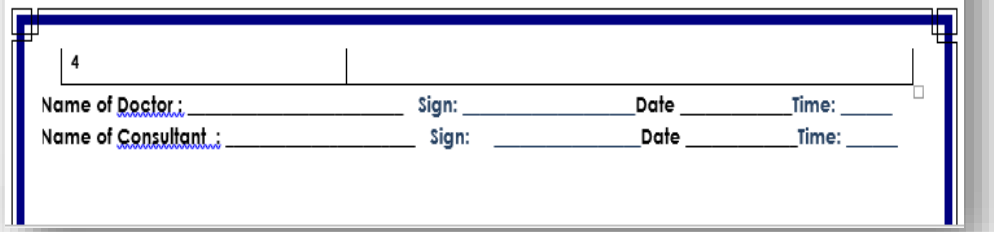
Rehabilitation: √

□ Physiotherapy	□ Social
□ Occupational Therapy	□ Psychological
□ Speech Therapy	□ Vocational
□ Prosthetics & Orthotics	

Reference:

Reference to	Reason for reference
1.	
2	
3	

Page 5 of 5



4	

Name of Doctor : _____ Sign: _____ Date _____ Time: _____
Name of Consultant : _____ Sign: _____ Date _____ Time: _____

4 . The results of the diagnostic (Laboratory, Radiology, etc.) tests should be made available in defined time frame and intimated about the critical results to the concerned personnel immediately.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
a) Time frame of diagonostic results are displayed in diagnostic department and followed. b) See minimum five cases of Critical value and check for: i) Critical result value identification time and informed time to concerned personnel. ii) Appropriate action taken by the concerned person for the critical result.	Direct observation, Record review, Patient interview & Staff interview	100% compliance of all three evidences.	10	Turn around Time, Critical value Chart are displayed in Diagnostic area. Registry maintained for TAT and Critical value
		if any of the three evidence is found to be non-compliant.	5	
		Non-compliance of all three evidences.	0	

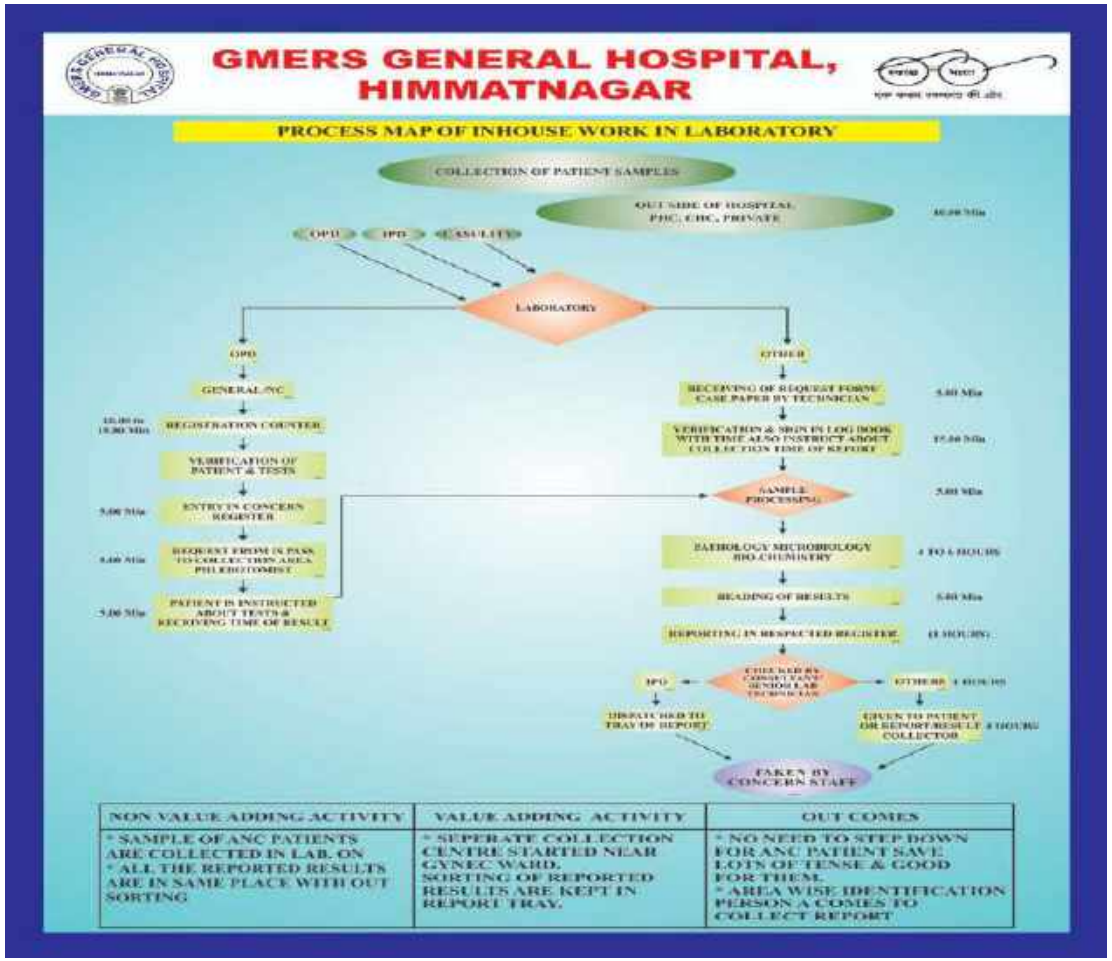
4. The results of the diagnostic (Laboratory, Radiology, etc.) tests should be made available in defined time frame and intimated about the critical results to the concerned personnel immediately.

CRITICAL ALERT INTERVANTION MONITORING FORM

GOVERNMENT (CL&SC) SPINE INSTITUTE AND PHYSIOTHERAPY COLLEGE, AHMEDABAD.
(To be filled by Laboratory/Radiology Department)

Date	Patient's Name	Age/ Sex	UHID	Critical Alert Result Report (1)	Critical Alert Result Receiving Time (2)	Critical Alert Result Response Time (3)	Clinical Intervention (4)	Remarks

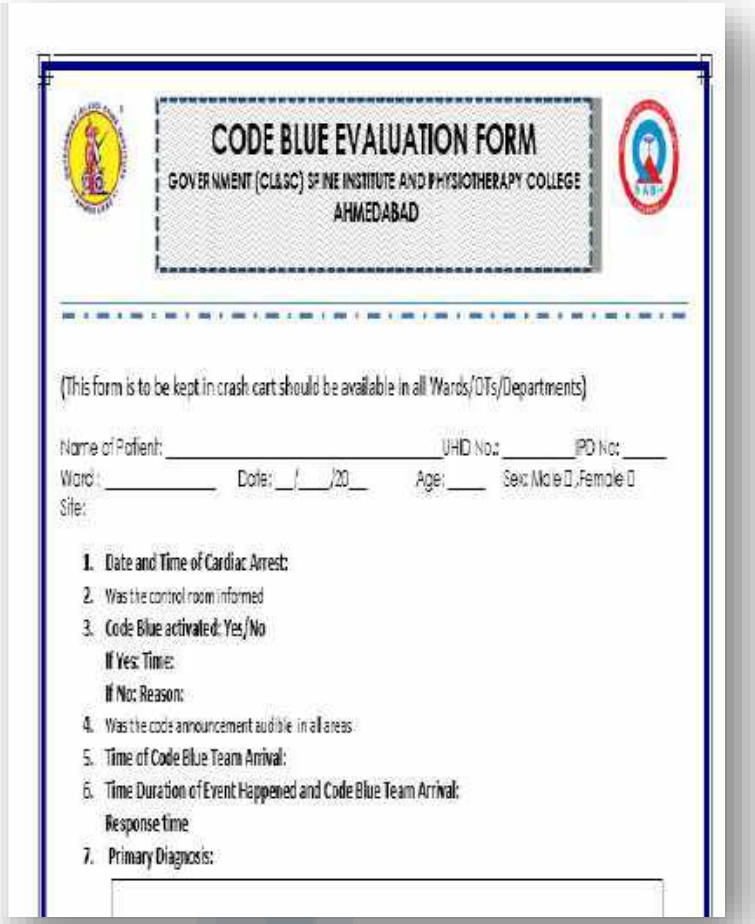
4. The results of the diagnostic (Laboratory, Radiology, etc.) tests should be made available in defined time frame and intimated about the critical results to the concerned personnel immediately.



5. Events during cardio-pulmonary resuscitation are recorded and mock drills conducted at regular interval; sequence of CPR in pictorial manner should be displayed.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
a) Policy for cardio-pulmonary resuscitation b) CPR process flow chart displayed in patient care area c) Staff aware of steps in cardio-pulmonary resuscitation d) Documentation of Regular mock drill conducted, variations observed in each drill and CAPA taken by respective personnel's.	Direct observation, record review & Staff interview	100% compliance of all four evidences.	10	Documents of CPR mock drills conducted at regular intervals and CPR chart display in patient care area.
		if any of the four evidence is found to be non-compliant.	5	
		Non-compliance of all four evidences.	0	

5. Events during cardio-pulmonary resuscitation are recorded and mock drills conducted at regular interval; sequence of CPR in pictorial manner should be displayed.



CODE BLUE EVALUATION FORM

GOVERNMENT (CL&SC) SPINE INSTITUTE AND PHYSIOTHERAPY COLLEGE AHMEDABAD

(This form is to be kept in crash cart should be available in all Wards/OTs/Departments)

Name of Patient: _____ UHID No.: _____ IPD No: _____

Ward: _____ Date: __/___/20__ Age: ____ Sex: Male ☐, Female ☐

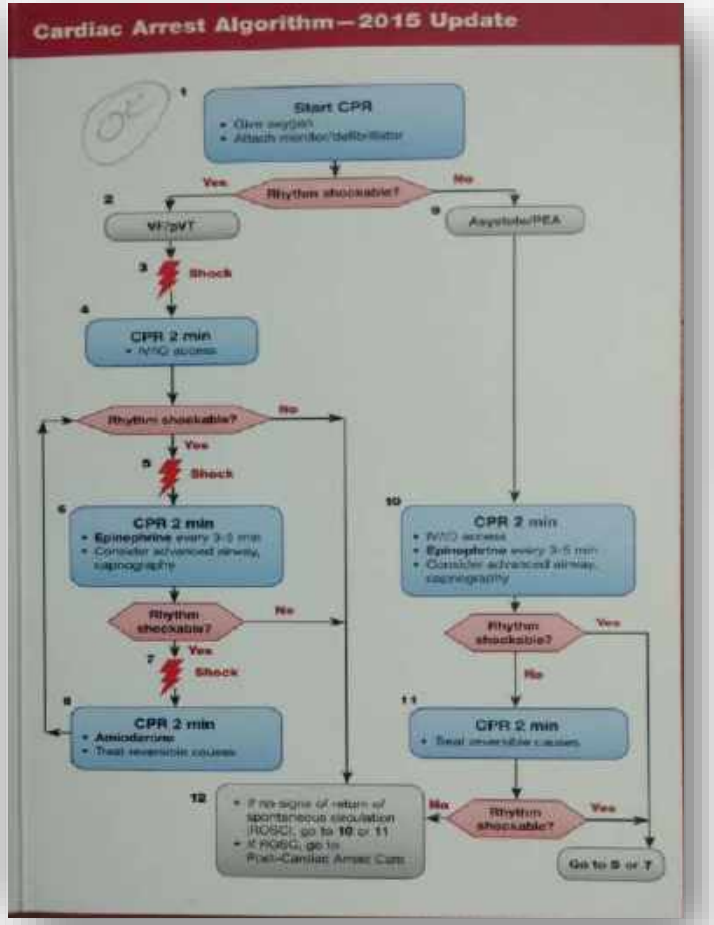
Site:

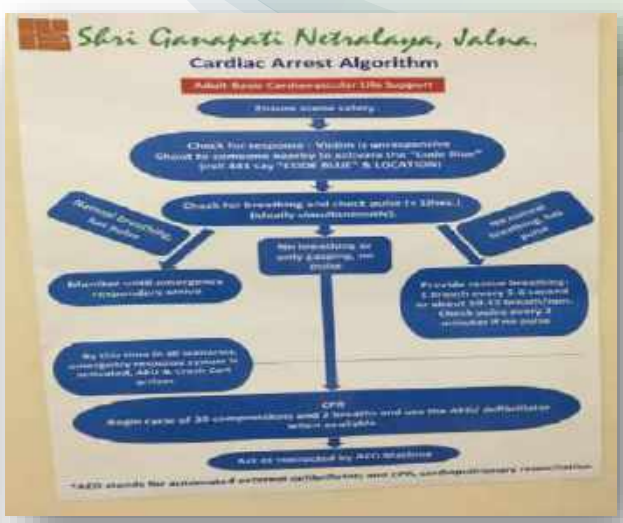
1. Date and Time of Cardiac Arrest:
2. Was the control room informed
3. Code Blue activated: Yes/No

   If Yes: Time:

   If No: Reason:
4. Was the code announcement audible in all areas
5. Time of Code Blue Team Arrival:
6. Time Duration of Event Happened and Code Blue Team Arrival:

   Response time
7. Primary Diagnosis:





6. Informed consent about the information on risks involved, benefits, alternatives for the procedures, surgeon who will perform the requisite procedure in an understandable language

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
a) SOP developed for taking the informed consent from patient or patient relative. b) See minimum 5 in-patients files of previous month and check availability of: i) Clearly defined information on risks involved, benefits, alternatives for the procedures by surgeon who will perform the requisite procedure in an understandable language. ii) Informed consent is duly signed by patient or patient relative and countersigned by concerned surgeon. iii) Post operative notes by concerned surgeon.	Direct observation, Record review, Patient interview & Staff interview	100% compliance of all four evidences.	10	Informed consent form and Post operative notes in patient files.
		if any of the four evidence is found to be non-compliant.	5	
		Non-compliance of all four evidences.	0	

7. The regular and periodic monitoring of anaesthesia components like recording of heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation, airway security and patency and level of anaesthesia should be done.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
See minimum 5 post-operative files of previous month and check for: a) Availability of completely filled Pre-anaesthesia, during anaesthesia and post- anaesthesia form in each patient file. b) Pre-anaesthesia consent is duly signed by patient or patient relatives and countersigned by anaesthetists in each patient file.. c) Complete documentation (e.g. Recording of heart rate, cardiac rhythm, respiratory rate, BP, oxygen saturation, airway security recorded) in each patient file.	Record review & Staff interview	100% compliance of all three evidences.	10	a) Complete documentation: Recording of heart rate, cardiac rhythm, respiratory rate, BP, oxygen saturation, airway security b) Pre-anaesthesia consent duly signed by pt. or pt. relatives and countersigned by anaesthetists
		if any of the three evidence is found to be non-compliant.	5	
		Non-compliance of all three evidences.	0	

7. The regular and periodic monitoring of anaesthesia components like recording of heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation, airway security and patency and level of anaesthesia should be done.

MONITORING OF PATIENTS DURING ANAESTHESIA (To be filled in by Anesthesiologist)

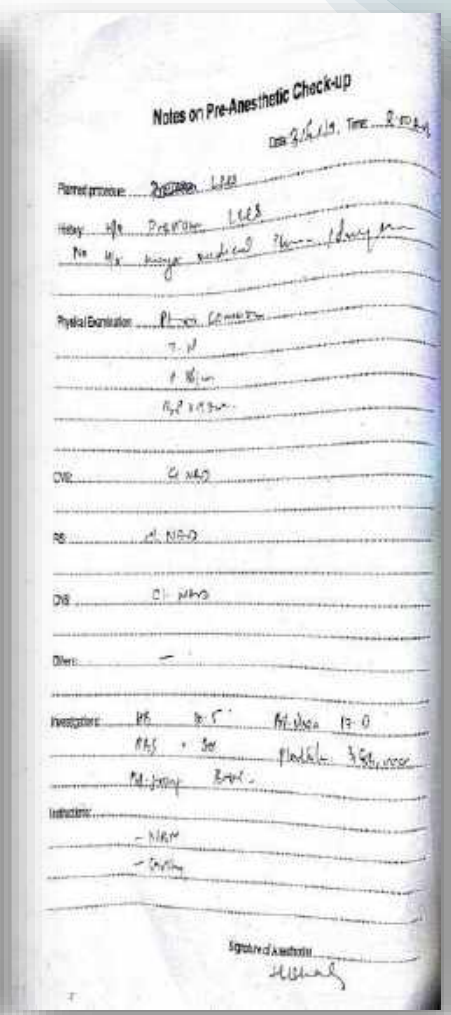
GSI - IPD-FF-20

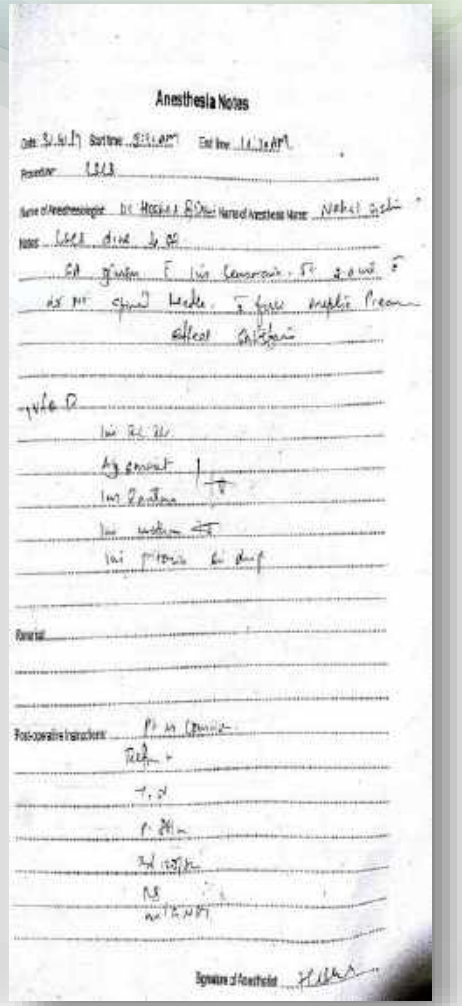
Name of Patient: _____ Date: __/__/20__ UHID No.: _____ I.P.D. No.: _____

Unit/ Ward: _____ Diagnosis: _____

Procedure/ Operation: _____

Crystalloids	250
Colloids	240
Blood	230
Reg Anaesthesia- Drug Catheter	220
KEY	210
Pulse / min °	200
Systolic BP v	190
Diastolic BP ^	180
Respiratory rate r	170
SpO2 % •	160
EtCO2 ⊖	150
Temp. □	
CVP ✱	

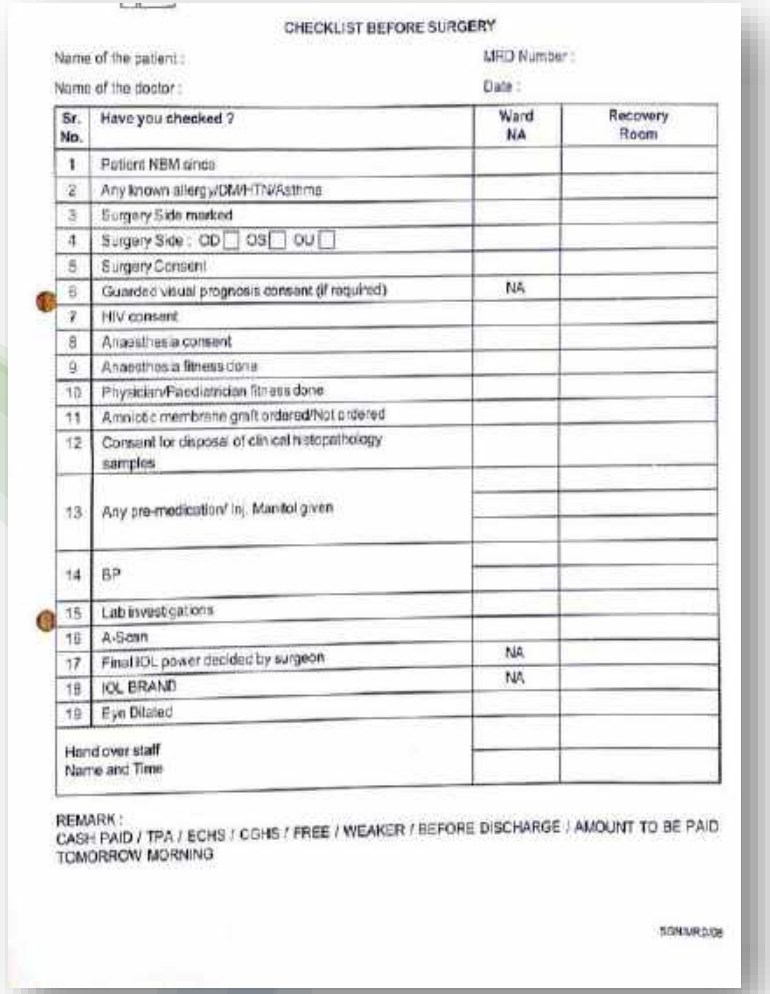




8. The documented procedure is defined and adhered to, for the prevention of adverse events like wrong site, wrong patient and wrong surgery.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
See minimum 5 post-operative files of previous month and check : a) Availability of WHO safety checklist. b) WHO safety checklist is filled and signed by anaesthetist(before induction of anaesthesia), surgeon(before skin incision) and OT incharge(before patient leaves OT)	Record review & Staff interview	100% compliance of all two evidences.	10	WHO safety checklist signed by OT Incharge, anaesthetist and surgeon
		if any of the two evidence is found to be non-compliant.	5	
		Non-compliance of all two evidences.	0	

8. The documented procedure is defined and adhered to, for the prevention of adverse events like wrong site, wrong patient and wrong surgery.



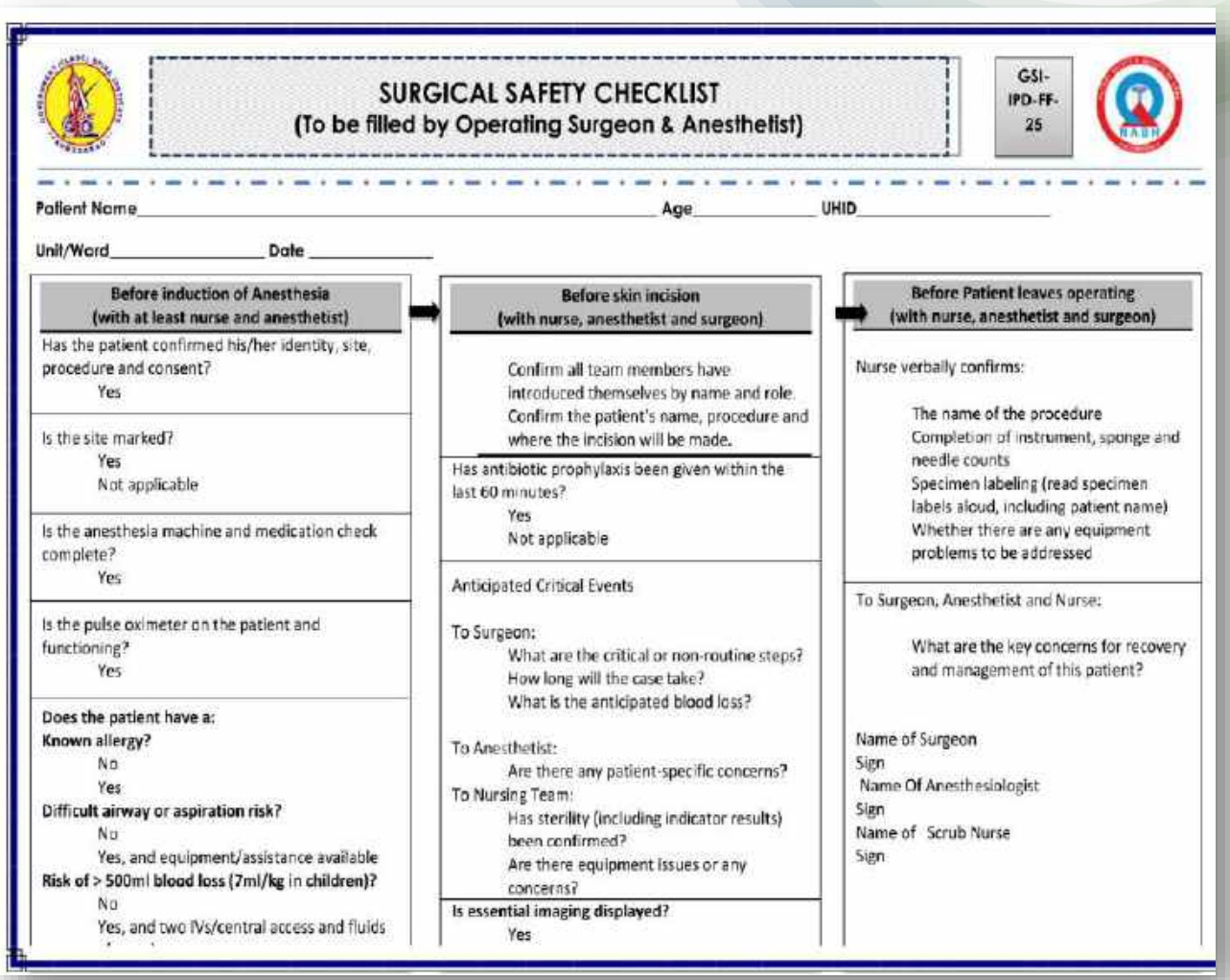
CHECKLIST BEFORE SURGERY

Name of the patient : MRD Number :

Name of the doctor : Date :

Sr. No.	Have you checked ?	Ward NA	Recovery Room
1	Patient NBM since		
2	Any known allergy/DM/HTN/Asthma		
3	Surgery Side marked		
4	Surgery Side : OD ☐ OS ☐ OU ☐		
5	Surgery Consent		
6	Guarded visual prognosis consent (if required)	NA	
7	HIV consent		
8	Anaesthesia consent		
9	Anaesthesia fitness done		
10	Physician/Paediatrician fitness done		
11	Amniotic membrane graft ordered/Not ordered		
12	Consent for disposal of clinical histopathology samples		
13	Any pre-medication/ Inj. Mannitol given		
14	BP		
15	Lab investigations		
16	A-Scan		
17	Final IOL power decided by surgeon	NA	
18	IOL BRAND	NA	
19	Eye Dilated		
	Hand over staff Name and Time		

REMARK :
CASH PAID / TPA / ECHS / CGHS / FREE / WEAKER / BEFORE DISCHARGE / AMOUNT TO BE PAID TOMORROW MORNING



SURGICAL SAFETY CHECKLIST
(To be filled by Operating Surgeon & Anesthetist)

GSI-IPD-FF-25

Patient Name _____ Age _____ UHID _____

Unit/Ward _____ Date _____

Before induction of Anesthesia (with at least nurse and anesthetist)

Has the patient confirmed his/her identity, site, procedure and consent?
Yes

Is the site marked?
Yes
Not applicable

Is the anesthesia machine and medication check complete?
Yes

Is the pulse oximeter on the patient and functioning?
Yes

Does the patient have a:
Known allergy?
No
Yes
Difficult airway or aspiration risk?
No
Yes, and equipment/assistance available
Risk of > 500ml blood loss (7ml/kg in children)?
No
Yes, and two IVs/central access and fluids

Before skin incision (with nurse, anesthetist and surgeon)

Confirm all team members have introduced themselves by name and role.
Confirm the patient's name, procedure and where the incision will be made.

Has antibiotic prophylaxis been given within the last 60 minutes?
Yes
Not applicable

Anticipated Critical Events

To Surgeon:
What are the critical or non-routine steps?
How long will the case take?
What is the anticipated blood loss?

To Anesthetist:
Are there any patient-specific concerns?
To Nursing Team:
Has sterility (including indicator results) been confirmed?
Are there equipment issues or any concerns?

Is essential imaging displayed?
Yes

Before Patient leaves operating (with nurse, anesthetist and surgeon)

Nurse verbally confirms:

The name of the procedure
Completion of instrument, sponge and needle counts
Specimen labeling (read specimen labels aloud, including patient name)
Whether there are any equipment problems to be addressed

To Surgeon, Anesthetist and Nurse:

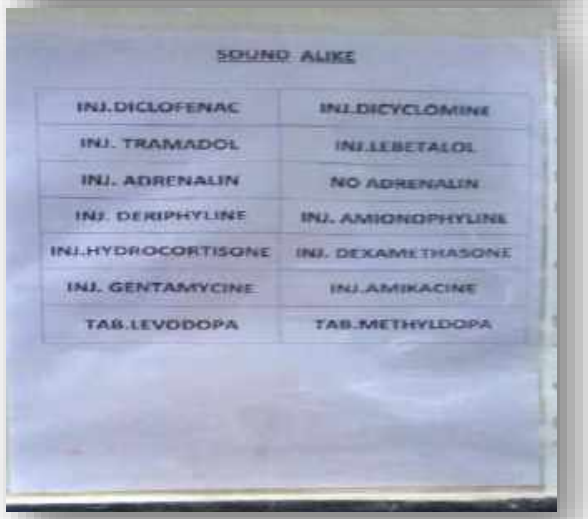
What are the key concerns for recovery and management of this patient?

Name of Surgeon
Sign
Name Of Anesthesiologist
Sign
Name of Scrub Nurse
Sign

9. Documented procedure for management of medication are defined and implemented e.g. Sound alike and look alike medications are stored separately.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
a) Defined list of sound alike and look alike medications b) Display of the sound alike and look alike medications list in all patient-care area c) Sound alike and look alike medications are stored separately in pharmacy and all patient-care area	Direct observation, Record review & Staff interview	100% compliance of all three evidences.	10	a) List of sound alike and look alike defined and displayed in all patient-care area b) Sound alike and look alike medications are stored separately in pharmacy and all patient-care area
		if any of the three evidence is found to be non-compliant.	5	
		Non-compliance of all three evidences.	0	

9. Documented procedure for management of medication are defined and implemented e.g. Sound alike and look alike medications are stored separately.



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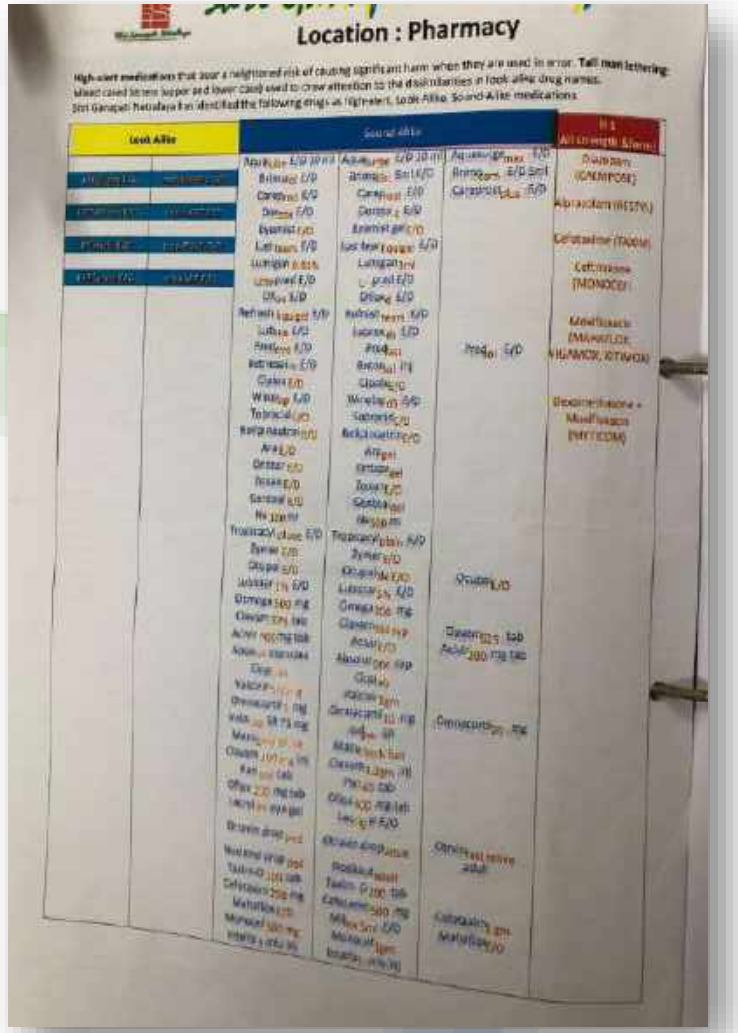
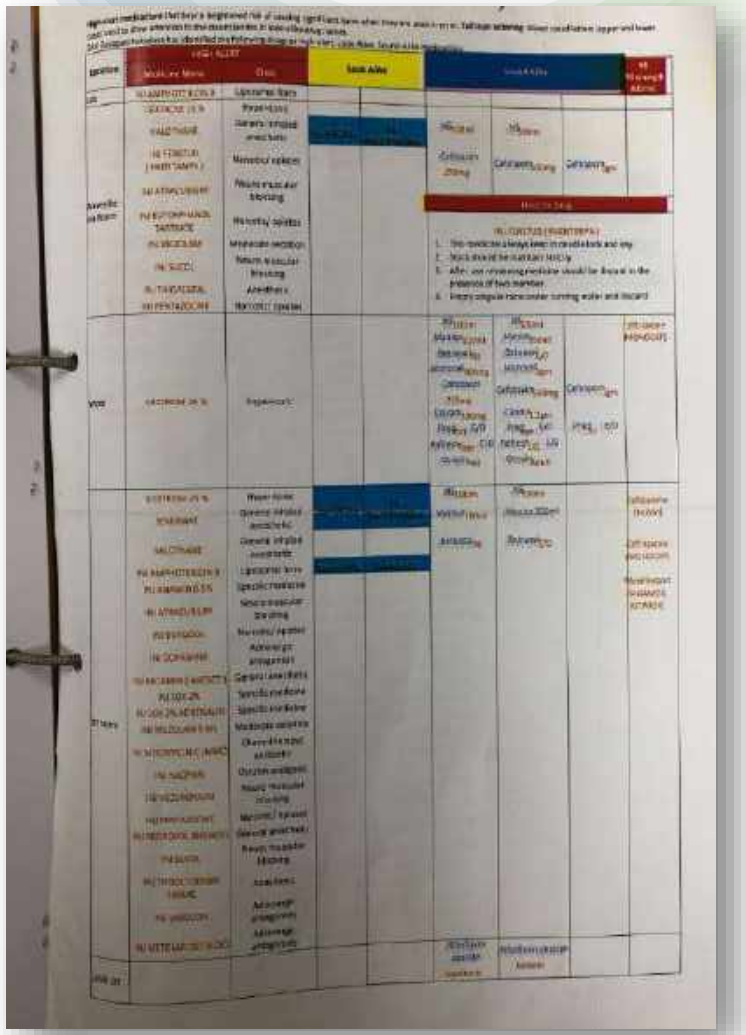
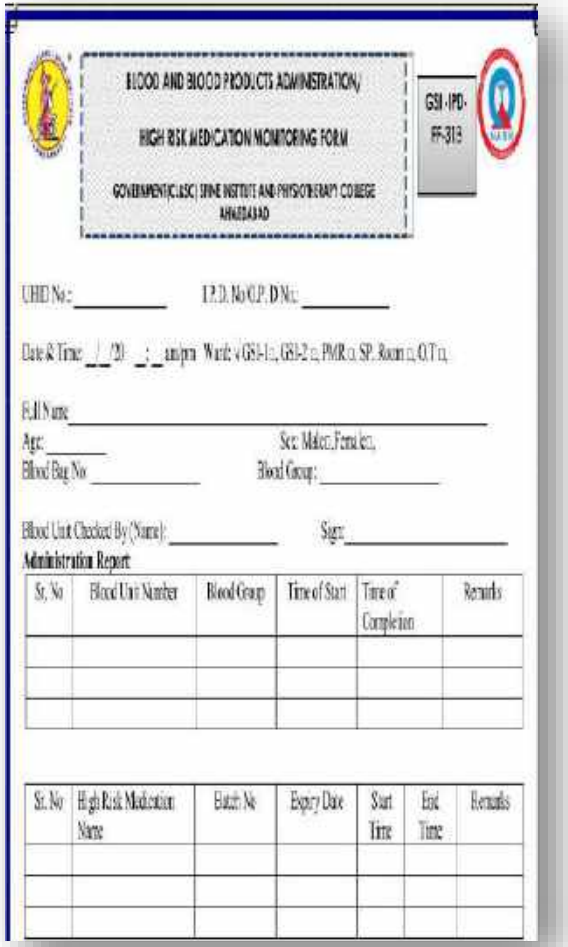


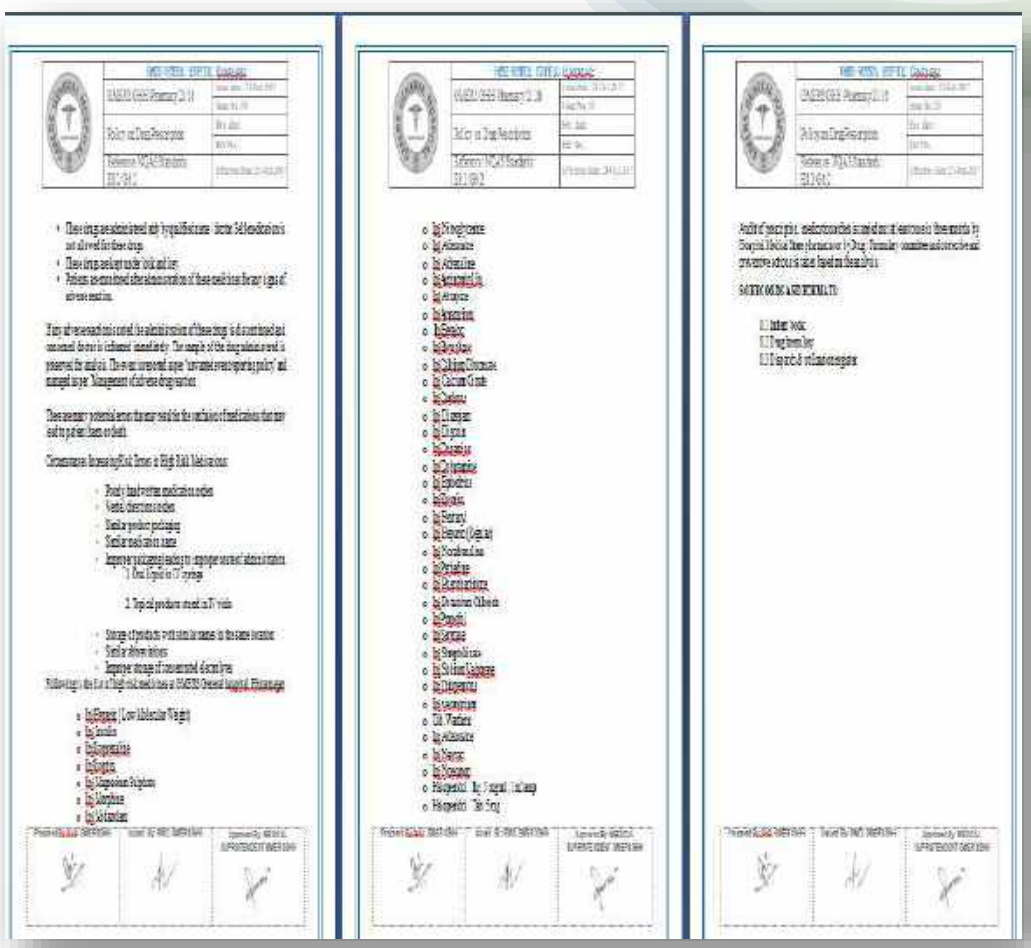


10. Listing and storage of High risk medications to be done & orders should be verified before their dispensing.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
a) The list of High risk medications are available b) Updated legal licence available if narcotics are stored and used. c) The high risk medications are stored separately in secure enviorment (double lock). d) Check patient file for documentation verification.	Direct observation, Record review & Staff interview	100% compliance of all four evidences.	10	a) List of High risk medication b) High Risk Medications are kept under lock and key in separate drawer c) Legal liscence for narcotics if narcotics are stored and used.
		if any of the four evidence is found to be non-compliant.	5	
		Non-compliance of all four evidences.	0	

10. Listing and storage of High risk medications to be done & orders should be verified before their dispensing.





10. Listing and storage of High risk medications to be done & orders should be verified before their dispensing.

11. Verification of dosage, route, timing and expiry date before administering the medication should be done.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
a) Defined SOP for process of administration of medication b) Check minimum 5 in-patients files of previous month and look for implemented process as defined in SOPs (dosage, route, timing and expiry date before administering the medication) c) Medication orders are clear, legible, dated, named and signed by the concerned doctor.	Direct observation, Record review & Staff interview	100% compliance of all three evidences.	10	a) Policy of Management of Medications b) Patient files with Medication orders that are clear, legible, dated, named and signed by the concerned doctor.
		if any of the three evidence is found to be non-compliant.	5	
		Non-compliance of all three evidences.	0	

11. Verification of dosage, route, timing and expiry date before administering the medication should be done.

MEDICATION ERROR MONITORING

GOVERNMENT(C.&S.C) SPINE INSTITUTE AND PHYSIOTHERAPY COLLEGE
AHMEDABAD

NAME OF DEPARTMENT: _____ NAME OF AUDITOR: _____ Month: _____

Right Patient	Right Drug	Right Dose	Right Route	Right Frequency	Right Time	Right Documentation	Correct Cut Tablet Strip Labelling	Correct Preparation of Drug (Correct IV Fluid Rate)	Medication Reconciliation	Adverse Drug Reaction	Doctor's Registration Number	Remarks

5. PROCESS DETAILS:

Sr. NO.	STEPS	RESPONSIBILITY
1	Writing of medication orders	Consultant/ Resident Doctor
2	In case of verbal order, signature shall be taken within **24 hours** of order. Refer document 'verbal orders for medications'	Attending Consultant
3	Inform the patient about the prescription	Staff Nurse
4	Medicine is provided as per doctor's orders. Medications from Hospital/ brought from outside Provided by staff nurse/ Self administration	Staff Nurse
5	Checking of UHID number, Name of Patient, expiry date, dosage (mg, gm), frequency of medicines while receiving.	Staff Nurse
6	Keep these Seven 'R' in mind before giving medicine. 1) Right Patient 2) Right dose 3) Right Route 4) Right time 5) Right drugs 6)Right frequency 7)Right documentation & Right Disposal	Staff Nurse

PREPARED BY	REVIEWED BY	APPROVED BY	ISSUED BY
QUALITY TEAM GOVT SPINE INSTITUTE	RMO GOVT SPINE INSTITUTE	DIRECTOR GOVT SPINE INSTITUTE AHMEDABAD	ACCREDITATION CO-ORDINATOR

PAGE 1 OF 2

12. Adverse drug events are collected, analysed by the treating doctor and practices are modified (if necessary) to reduce the same.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
a) Clearly defined policy for the adverse drug events. b) Adverse drug events are reported to concerned authority and record is available b) Corrective and preventive action taken for Adverse drug events.	Record review & Staff interview	100% compliance of all three evidences.	10	Records of adverse drug events kept with CAPA.
		if any of the three evidence is found to be non-compliant.	5	
		Non-compliance of all three evidences.	0	

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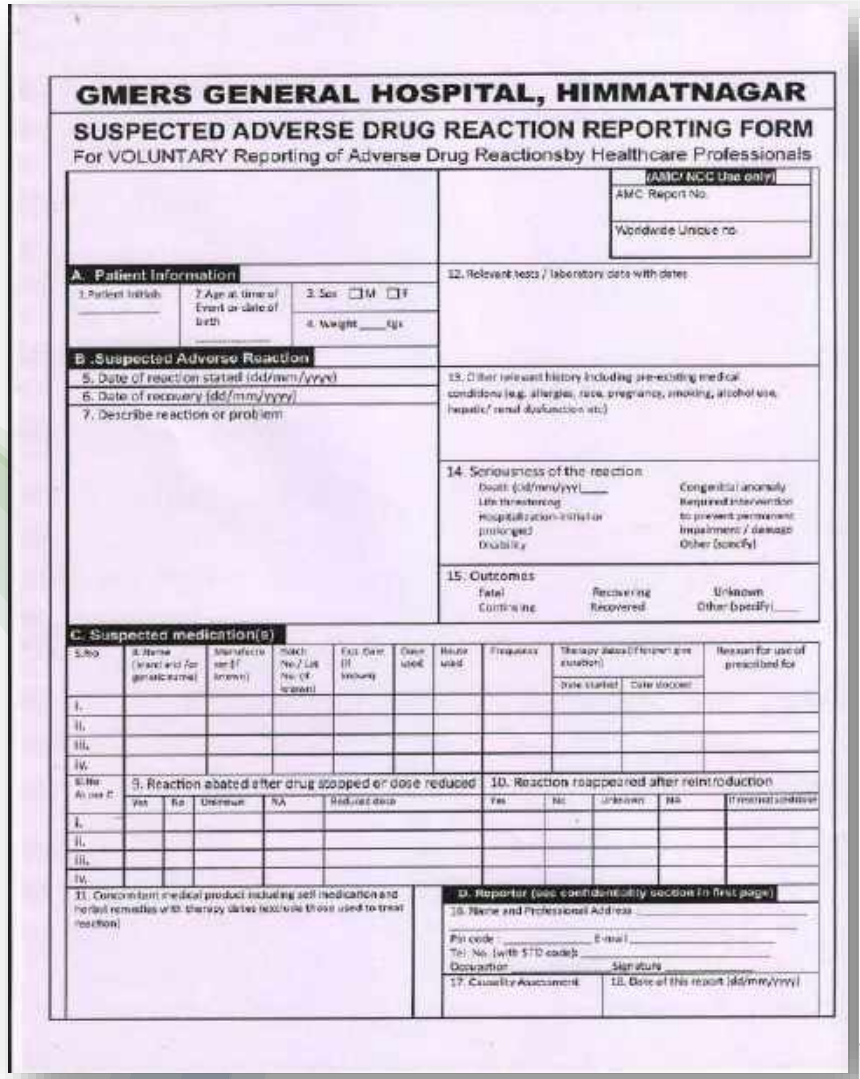


GMERS GENERAL HOSPITAL, HIMMATNAGAR

SUSPECTED ADVERSE DRUG REACTION REPORTING FORM

For VOLUNTARY Reporting of Adverse Drug Reactionsby Healthcare Professionals

(AMC/ NCC Use only)

AMC Report No.

Worldwide Unique no.

A. Patient Information

1. Patient Initials

2. Age at time of Event or date of birth

3. Sex ☐M ☐F

4. Weight ____Kgs

12. Relevant tests / laboratory data with dates

B .Suspected Adverse Reaction

5. Date of reaction started (dd/mm/yyyy)

6. Date of recovery (dd/mm/yyyy)

7. Describe reaction or problem

13. Other relevant history including pre-existing medical conditions (eg. allergies, race, pregnancy, smoking, alcohol use, hepatic/ renal dysfunction etc)

14. Seriousness of the reaction

Death (dd/mm/yyyy)____

Life threatening

Hospitalization -initial or prolonged

Disability

Congenital anomaly

Required intervention to prevent permanent impairment / damage

Other (specify)

15. Outcomes

Fatal

Not recovering

Recovering

Recovered

Unknown

Other (specify)____

C. Suspected medication(s)

S.No	B. Name (brand and /or generic name)	Manufacturer (if known)	Batch No./ Lot No. (if known)	Exp. Date (if known)	Dose used	Route used	Frequency	Therapy dates (if known give duration)		Reason for use of prescribed for
								Date started	Date stopped	
i.										
ii.										
iii.										
iv.										

Sl.No As per C	9. Reaction abated after drug stopped or dose reduced					10. Reaction reappeared after reintroduction				
	Yes	No	Unknown	NA	Reduced dose	Yes	No	Unknown	NA	If restarted continued
i.										
ii.										
iii.										
iv.										

11. Concomitant medical product including self medication and herbal remedies with therapy dates (exclude those used to treat reaction)

D. Reporter (see confidentiality section in first page)

16. Name and Professional Address

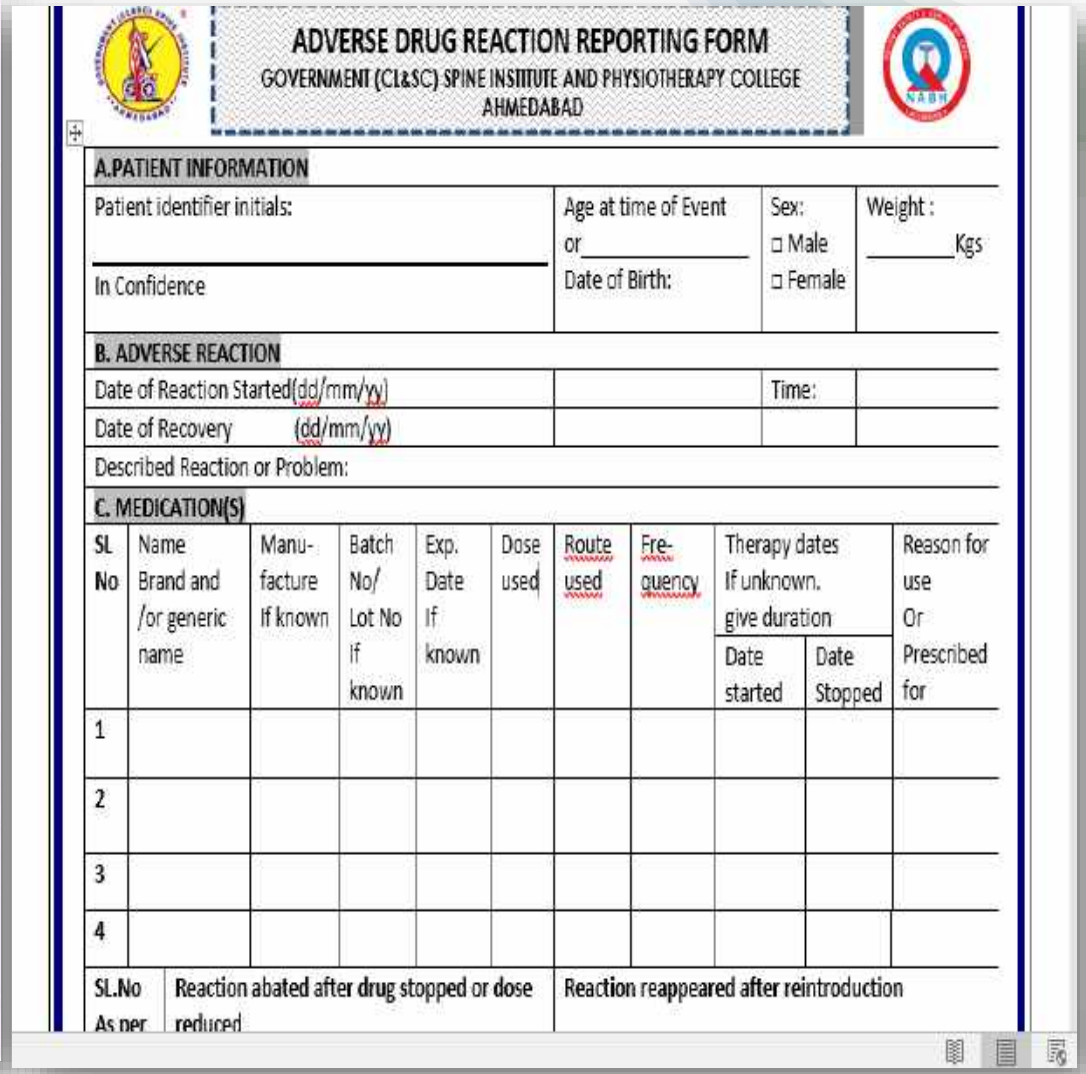
Pin code ____ E-mail

Tel: No. (with STD code)

Occupation ____ Signature

17. Causality Assessment

18. Date of this report (dd/mm/yyyy)



ADVERSE DRUG REACTION REPORTING FORM

GOVERNMENT (CL&SC) SPINE INSTITUTE AND PHYSIOTHERAPY COLLEGE AHMEDABAD

A.PATIENT INFORMATION

Patient identifier initials: ____ In Confidence

Age at time of Event or ____ Date of Birth:

Sex: ☐ Male ☐ Female

Weight : ____Kgs

B. ADVERSE REACTION

Date of Reaction Started(dd/mm/yy) ____ Time: ____

Date of Recovery (dd/mm/yy) ____

Described Reaction or Problem:

C. MEDICATION(S)

SL No	Name Brand and /or generic name	Manu-facture If known	Batch No/ Lot No If known	Exp. Date If known	Dose used	Route used	Fre-quency	Therapy dates If unknown. give duration		Reason for use Or Prescribed for
								Date started	Date Stopped	
1										
2										
3										
4										

SL.No As per	Reaction abated after drug stopped or dose reduced	Reaction reappeared after reintroduction

13. The hospital infection control committee is constituted and functional with defined surveillance method for tracking and analysing appropriate infection rates.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
a) Availability of infection control committee formation letter with list of members's. b) List of identified high risk areas. c) Defined SOP for tracking and analysing infection rates. d) Minutes of the meeting of infection control committee. e) Corrective and preventive action taken to prevent infection.	Record review & Staff interview	100% compliance of all five evidences.	10	a) SOPs are defined for Infection control b) Minutes of the meeting of infection control committee with corrective and preventive action
		if any of the five evidence is found to be non-compliant.	5	
		Non-compliance of all five evidences.	0	

13. The hospital infection control committee is constituted and functional with defined surveillance method for tracking and analysing appropriate infection rates.

2.INFECTION CONTROL COMMITTEE

COMPOSITION OF COMMITTEE

Sr. No.	Designation Organization	Designation Committee
1	Director	Chairman
2	Microbiologist	Infection Control Officer &Member Secretary
3	Assistant Professor (Ortho)	Member
4	Assistant Professor (Anaesthesia)	Member
5	Resident Medical Officer – (RMO)– Accreditation Coordinator	Member
6	PIU Engineer- Civil	Member
7	PIU Engineer – Electrical	Member
8	Assistant Nursing Superintendent	Member
9	Infection Control Nurse	Member
10	Linen keeper	Member
11	Sanitary Inspector	Member
12	CSSD Technician	Member

HAI -FORM

GOVERNMENT(CL&SC) SPINE INSTITUTE AND PHYSIOTHERAPY COLLEGE AHMEDABAD

HEALTH CARE ASSOCIATED INFECTION SURVEILLANCE FORM

Patient UHID :	Gender : F / M	Age:
Patient Name :		
Date Of Admission : Tra In Date:		Ward/Unit :
Birth Weight (grams) : (if applicable)		
Admission Diagnosis:		Final Diagnosis :
Surgery performed: Yes / No If Yes Type of operation :		Date & Duration of Surgery :
Elective/Emergency :		Major/Minor:
OT:		Anaesthesia Type: General/Spinal/Local
Shifted from other Hospital : Yes / No		Date Of Discharge :

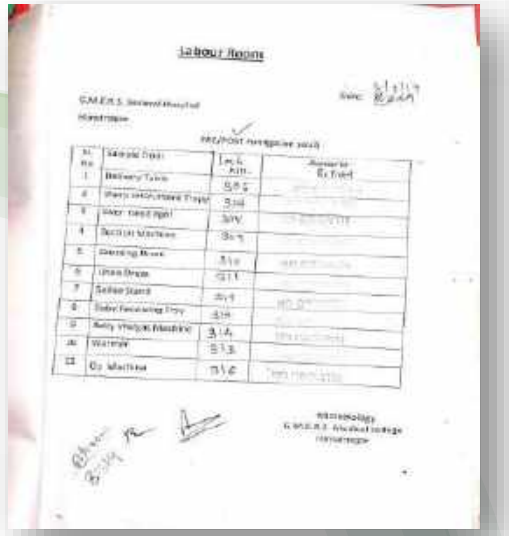
INDWELLING DEVICES

DATE	URINARY CATHETER PUT ON	CENTRAL LINE PUT ON

HEALTH CARE ASSOCIATED INFECTION MONITORING

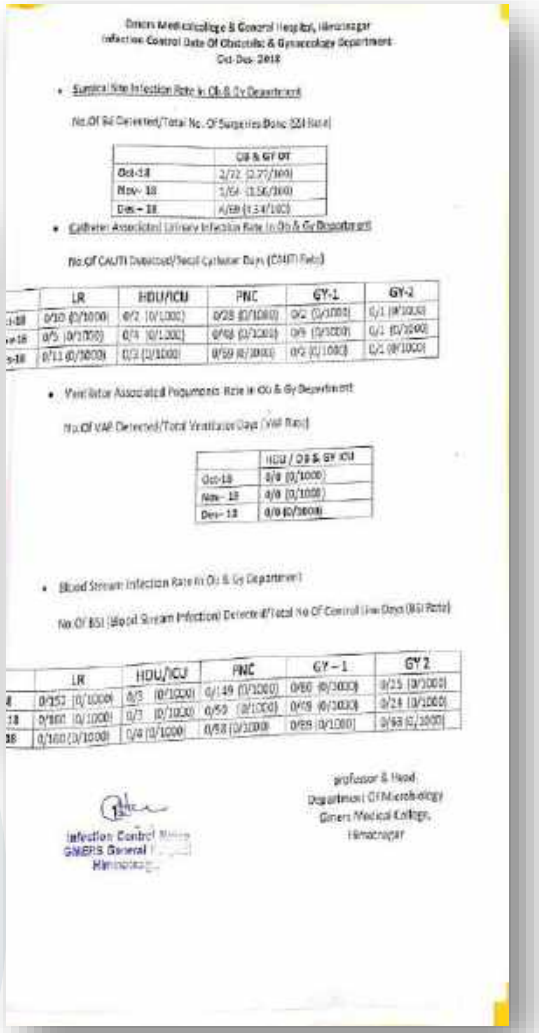
	CAUTI					CRBSI		SSI						LAB REPORTS					
DATE	Fever/ Hypothermia	Burning urine	Urgency/ Frequency	pain at renal angle or suprapubic	Turbid Urine	Tachy-cardia	Hypo-tension	BT: Yes/ No	ICU Stay (Post op day)	**Wound Type:-** clean/ contaminated /Dirty	**Wound Dressing** Pus/ Discharge (Post Operative Day): Yes/No	**Type of SSI:** Superficial SSI/Deep/ Organ/Space Involvement	Other Symptoms	Urine CS	Blood CS	Swab/ Pus CS	Radiology Reports	Anti-biotics taken	Remarks

13. The hospital infection control committee is constituted and functional with defined surveillance method for tracking and analysing appropriate infection rates.



Labour Room

Sr. No.	Material Desc.	Tag & Attr.	Remarks for Rejected
1	Delivery Table	01	
2	Sheets (MOT, Towel, Drape)	01nos	
3	Baby Cloth Rack	04Nos	
4	Suction Machine	01 No	
5	Dressing Trolley	01 No	
6	Utility Drum	01	
7	Soiled Stand	01	
8	Baby Resuscitating Tray	01	
9	Baby Weighing Machine	01	
10	Warmer	01	
11	O2 Machine	01	



Gmers Medical College & General Hospital, Himatnagar
Infection Control Data Of Obstetric & Gynaecology Department
Oct-Dec-2018

- Surgical Site Infection Rate in Ob & Gy Department

No.Of Ssi Detected/Total No. Of Surgeries Done(SSI Rate)

	Ob & GY OT
Oct-18	2/22 (0.27/100)
Nov- 18	1/64 (1.56/100)
Dec – 18	4/69 (5.14/100)

- Catheter Associated Urinary Infection Rate in Ob & Gy Department

No.Of CAUTI Detected/Total Catheter Days (CAUTI Rate)

	LR	HDU/ICU	PNC	GY-1	GY-2
Oct-18	0/310 (0/1000)	0/2 (0/1000)	0/28 (0/1000)	0/2 (0/1000)	0/1 (0/1000)
Nov- 18	0/5 (0/1000)	0/1 (0/1000)	0/69 (0/1000)	0/6 (0/1000)	0/1 (0/1000)
Dec- 18	0/11 (0/1000)	0/3 (0/1000)	0/59 (0/1000)	0/2 (0/1000)	0/1 (0/1000)

- Ventilator Associated Pneumonia Rate in ICU & Gy Department

No.Of VAP Detected/Total Ventilator Days (Vap Rate)

	HDU / OB & GY ICU
Oct-18	0/0 (0/1000)
Nov- 18	0/0 (0/1000)
Dec- 18	0/0 (0/1000)

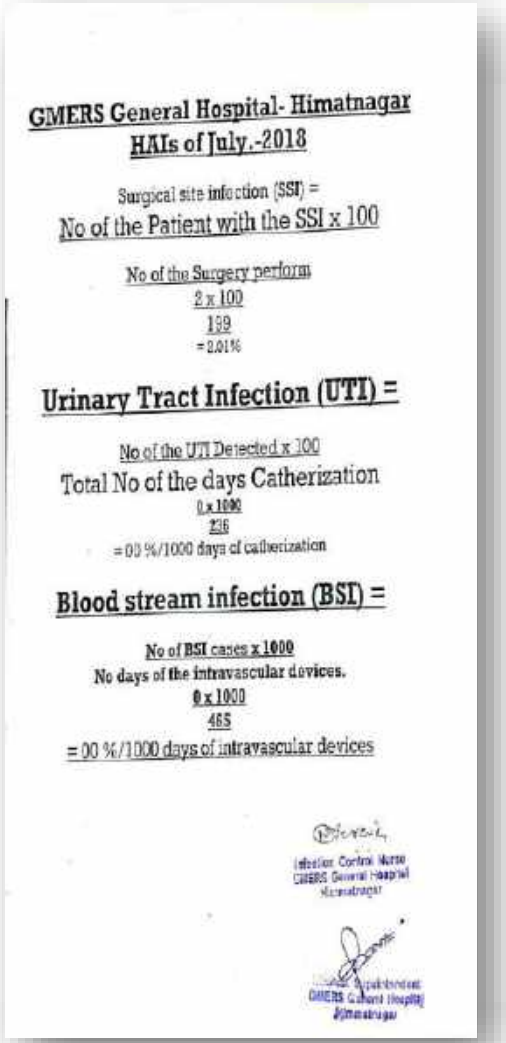
- Blood Stream Infection Rate in Ob & Gy Department

No.Of BSI (Blood Stream Infection) Detected/Total No.Of Central Line Days (BSI Rate)

	LR	HDU/ICU	PNC	GY – 1	GY 2
Oct-18	0/252 (0/1000)	0/3 (0/1000)	0/149 (0/1000)	0/60 (0/1000)	0/25 (0/1000)
Nov- 18	0/160 (0/1000)	0/3 (0/1000)	0/59 (0/1000)	0/19 (0/1000)	0/24 (0/1000)
Dec- 18	0/160 (0/1000)	0/4 (0/1000)	0/58 (0/1000)	0/29 (0/1000)	0/68 (0/1000)

Infection Control Nurse
GMERS General Hospital
Himatnagar

professor & Head
Department Of Microbiology
Gmers Medical College,
Himatnagar



GMERS General Hospital- Himatnagar
HAIs of July.-2018

Surgical site infection (SSI) =
No of the Patient with the SSI x 100
No of the Surgery perform
2 x 100
139
= 2.01%

Urinary Tract Infection (UTI) =

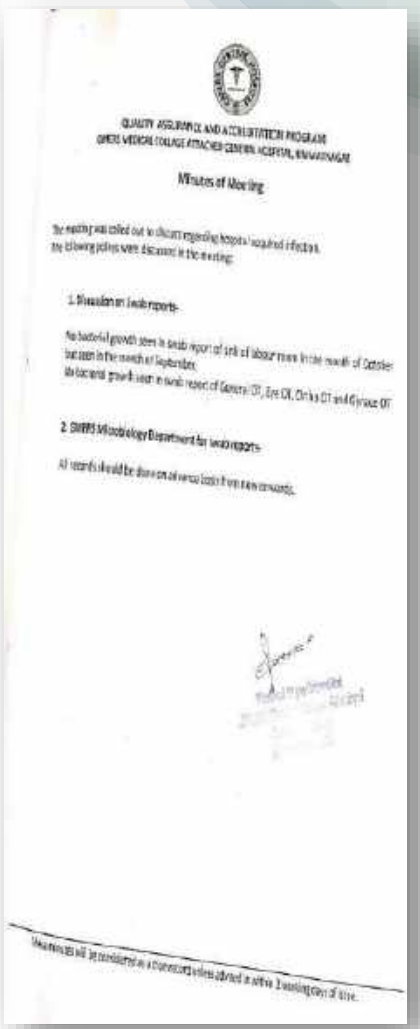
No of the UTI Detected x 100
Total No of the days Catherization
0 x 1000
236
= 00 %/1000 days of catherization

Blood stream infection (BSI) =

No of BSI cases x 1000
No days of the intravascular devices.
0 x 1000
465
= 00 %/1000 days of intravascular devices

Infection Control Nurse
GMERS General Hospital
Himatnagar

Superintendent
GMERS General Hospital
Himmatnagar



QUALITY ASSURANCE AND ACCREDITATION PROGRAM
GMERS MEDICAL COLLEGE ATTACHED CENTERS, HOSPITAL, HIMMATNAGAR

Minutes of Meeting

The meeting was called out to discuss regarding hospital acquired infection.
The following points were discussed in the meeting:

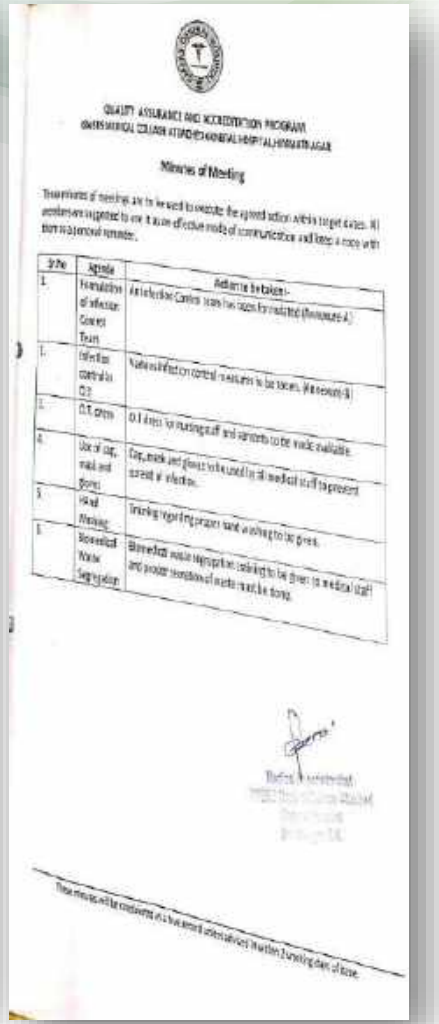
1. Discussion on Swab reports-

No bacterial growth seen in swab report of sink of labour room in the month of October but seen in the month of September.
No bacterial growth seen in swab report of Gynae OT, Eye OT, Ortho OT and Labour OT

2. GMERS Microbiology Department for swab reports-

All records should be done on all nurses basis from now onwards.

Meeting was will be conducted on a bi-annual basis (third in active 2 working days of June.



QUALITY ASSURANCE AND ACCREDITATION PROGRAM
GMERS MEDICAL COLLEGE ATTACHED HOSPITAL HIMMATNAGAR

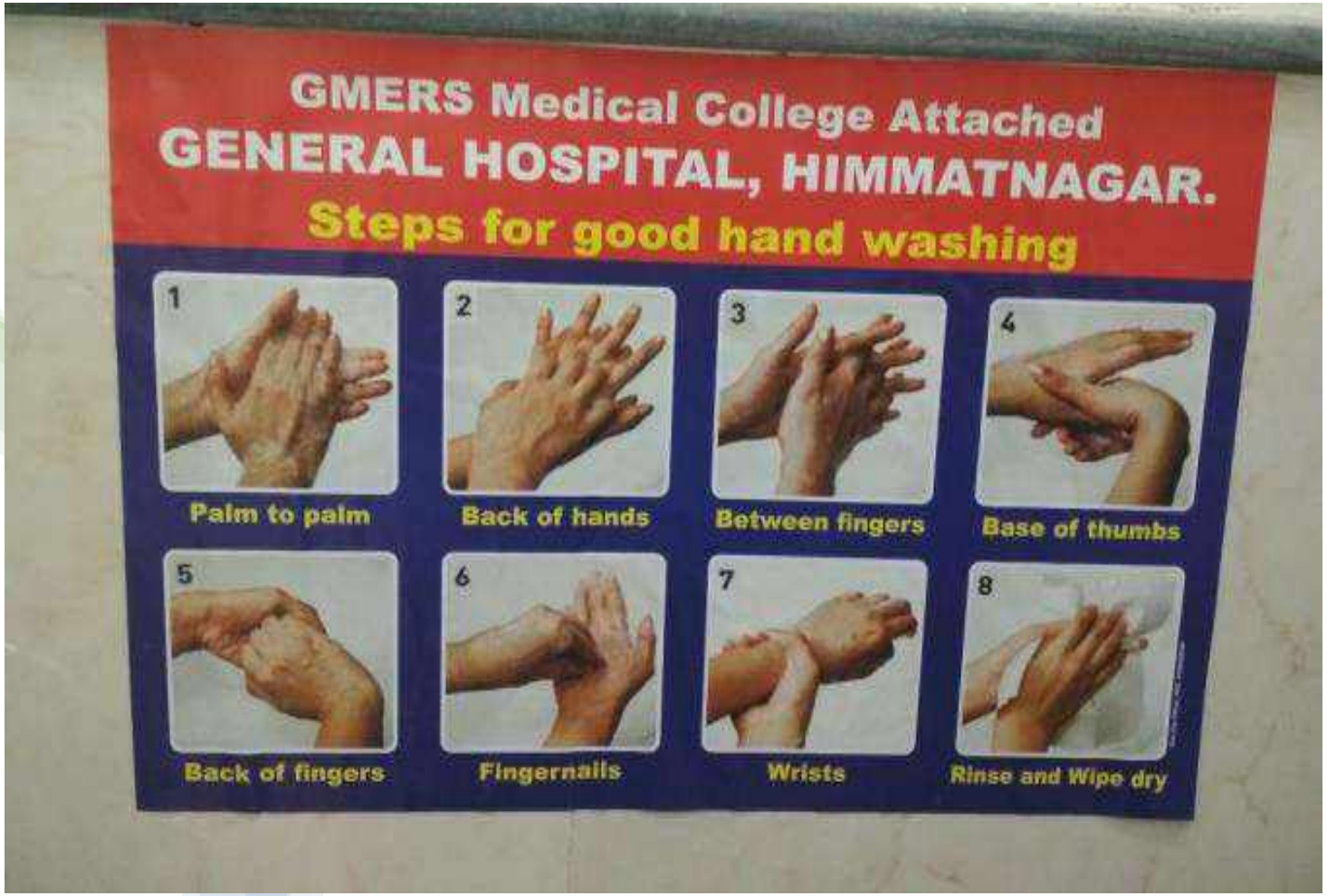
Minutes of Meeting

Minutes of meetings are to be used to evaluate the agreed action within target dates. It accelerates response to one's issue effective mode of communication and keeps a note with them as personal reminder.

S.No	Agenda	Action to be taken:-
1.	Formation of Infection Control Team	Infection Control team has been formulated (Annexure-A)
2.	Infection control measures	Various infection control measures to be taken. (Annexure-B)
3.	O.T. gowns	0.1 gowns for nursing staff and attendants to be made available.
4.	Use of cap, mask and gloves	Cap, mask and gloves to be used by all medical staff to prevent spread of infection.
5.	Hand Washing	Washing/ rubbing of hands with soap and water to be given.
6.	Biomedical Waste Segregation	Biomedical waste segregation guidelines to be given to medical staff and proper segregation of waste must be done.

Meeting was will be conducted on a bi-annual basis (third in active 2 working days of June.

14. All the healthcare providers should have easy accessibility to the hand washing facility in all patient care areas. Hand hygiene steps to be displayed at each hand washing facilities.



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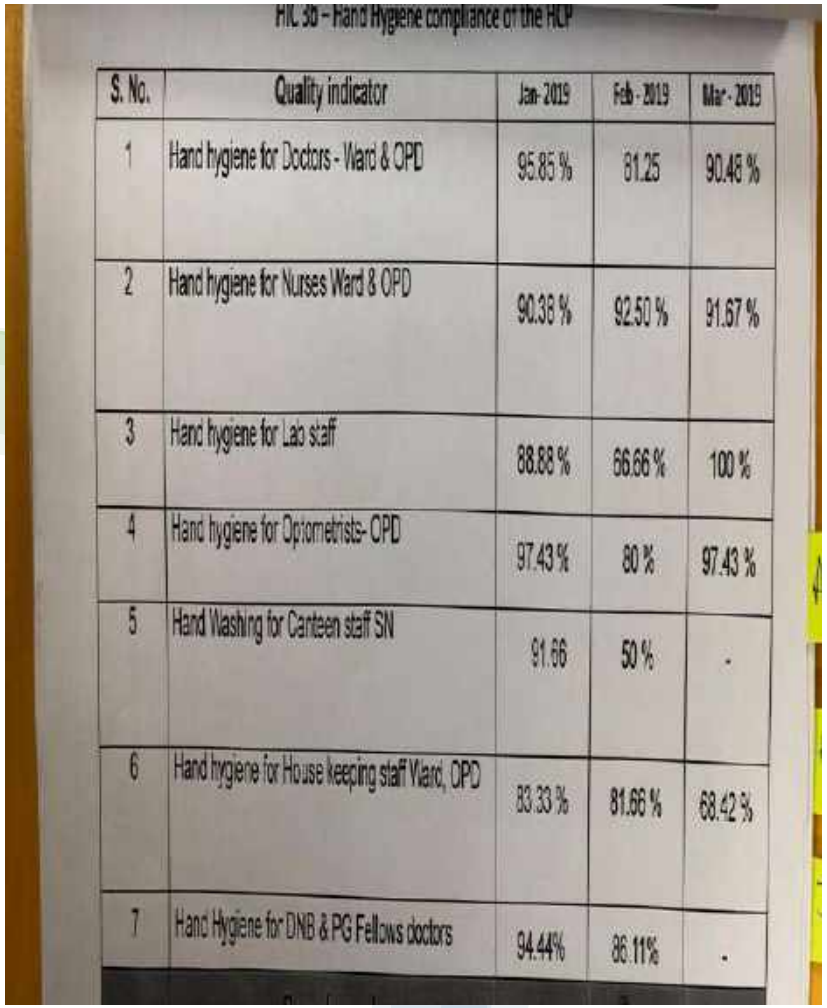
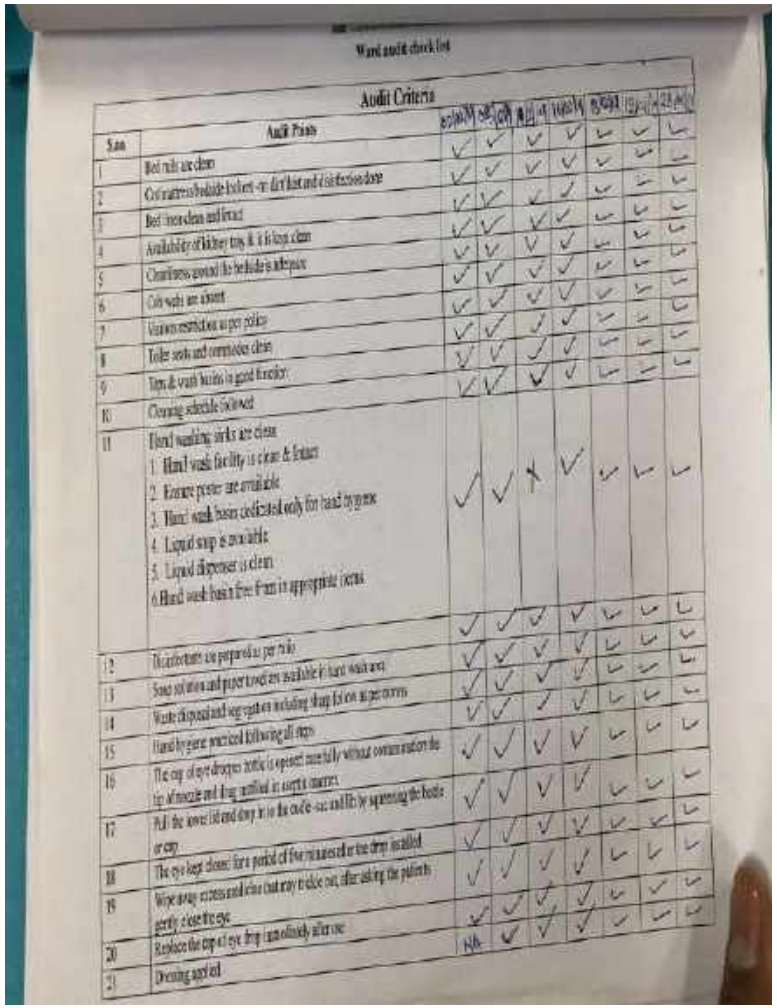


HIC 35 – Hand Hygiene compliance of the HCP

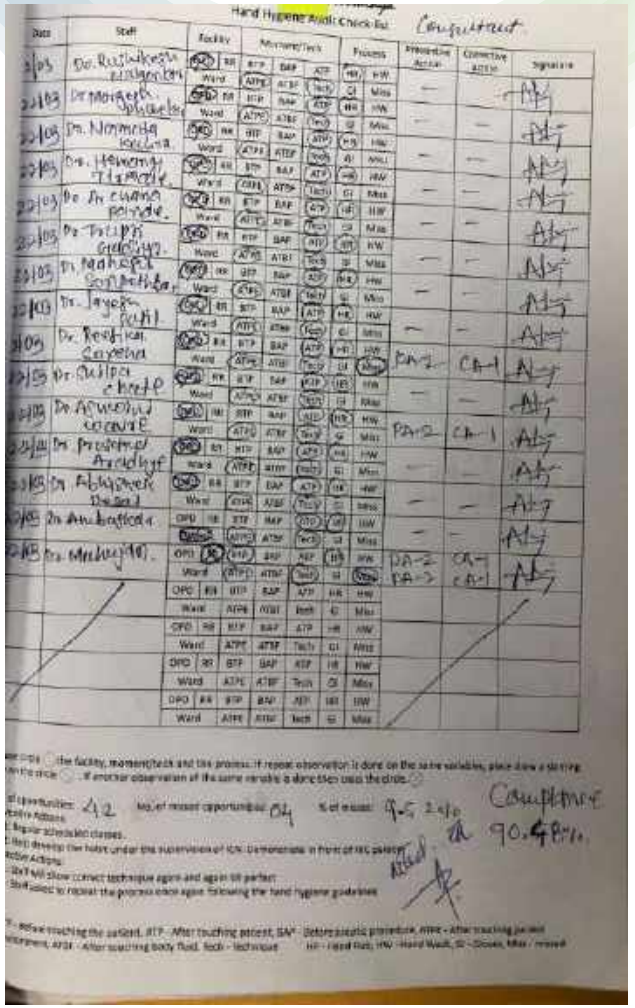
S. No.	Quality indicator	Jan-2019	Feb - 2019	Mar - 2019
1	Hand hygiene for Doctors - Ward & OPD	95.85 %	81.25	90.48 %
2	Hand hygiene for Nurses Ward & OPD	90.38 %	92.50 %	91.57 %
3	Hand hygiene for Lab staff	88.88 %	66.66 %	100 %
4	Hand hygiene for Optometrists- OPD	97.43 %	80 %	97.43 %
5	Hand Washing for Canteen staff SN	91.66	50 %	-
6	Hand hygiene for House keeping staff Ward, OPD	83.33 %	81.66 %	68.42 %
7	Hand Hygiene for DNB & PG Fellows doctors	94.44%	86.11%	-



Ward audit check list

Audit Criteria

S.no	Audit Points
1	Bed rails are clean
2	Over mattress bedside lockers -re- disinfected and disinfection done
3	Bed linen clean and intact
4	Availability of kidney tray, if it is less clean
5	Cleanliness around the bed side is adequate
6	Curtains are present
7	Visitors restriction as per rules
8	Toilet seats and commodes clean
9	Taps & wash basins in good condition
10	Cleaning schedule followed
11	Hand washing sinks are clean 1. Hand wash facility is clean & intact 2. Hand rub posters are available 3. Hand wash basin dedicated only for hand hygiene 4. Liquid soap is available 5. Liquid dispenser is clean 6. Hand wash basin free from inappropriate items
12	Disinfectants are prepared as per rules
13	Soap solution and paper towels are available in hand wash area
14	Waste disposal and segregation including sharp bin are as per norms
15	Hand hygiene practiced following all steps
16	The cap of eye dropper bottle is opened carefully without contamination the tip of nozzle and drug instilled in correct manner.
17	Pull the lower lid and drop is in the cul-de-sac and then by squeezing the bottle or cap
18	The eye kept closed for a period of few minutes after the drop instilled
19	Wipe away excess and wise cautiously tickle out, after asking the patients gently close the eye
20	Replace the cap of eye drop immediately after use
21	Dressing applied



Hand Hygiene Audit Check list

Consultant

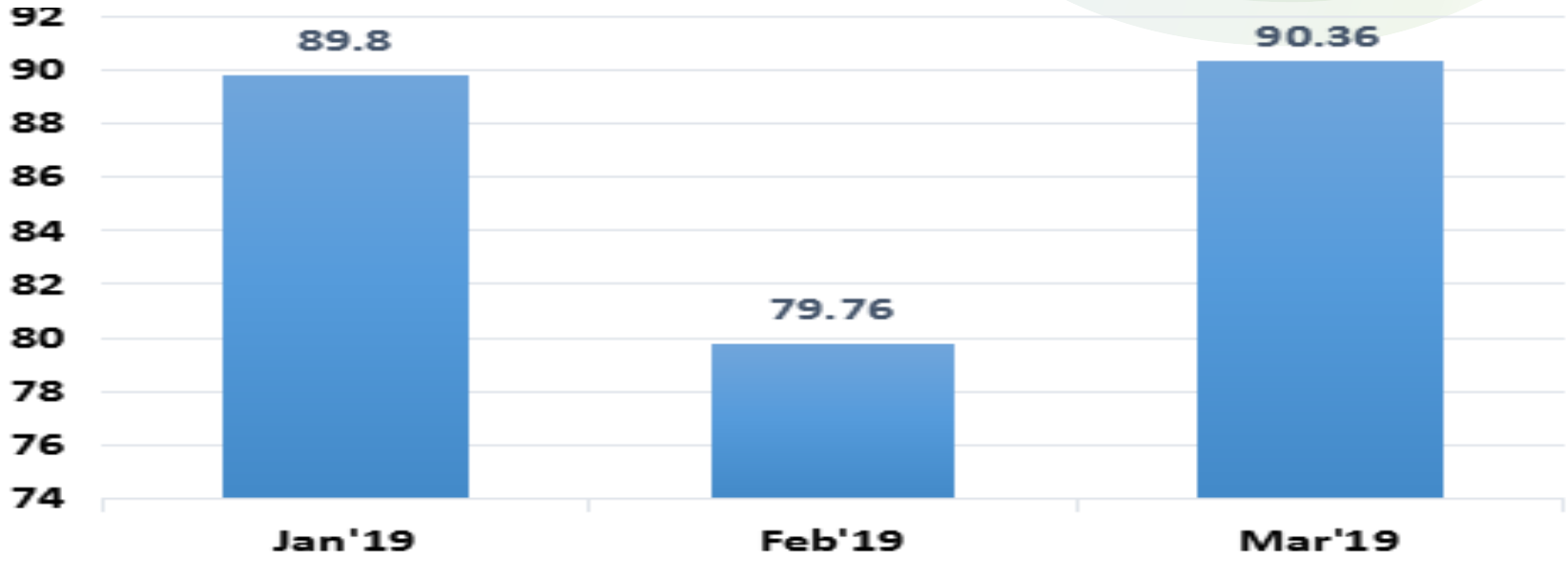
Compliance 90.48%

14. All the healthcare providers should have easy accessibility to the hand washing facility in all patient care areas. Hand hygiene steps to be displayed at each hand washing facilities.

Bench mark		
1	Criteria	Target
2	% of Compliance	100 %

Jan'19	89.80	141/157
Feb'19	79.76	138/173
Mar'19	90.36	225/249

Total no. of hand hygiene opportunity - missed opportunities X100
Total no. of hand hygiene opportunities



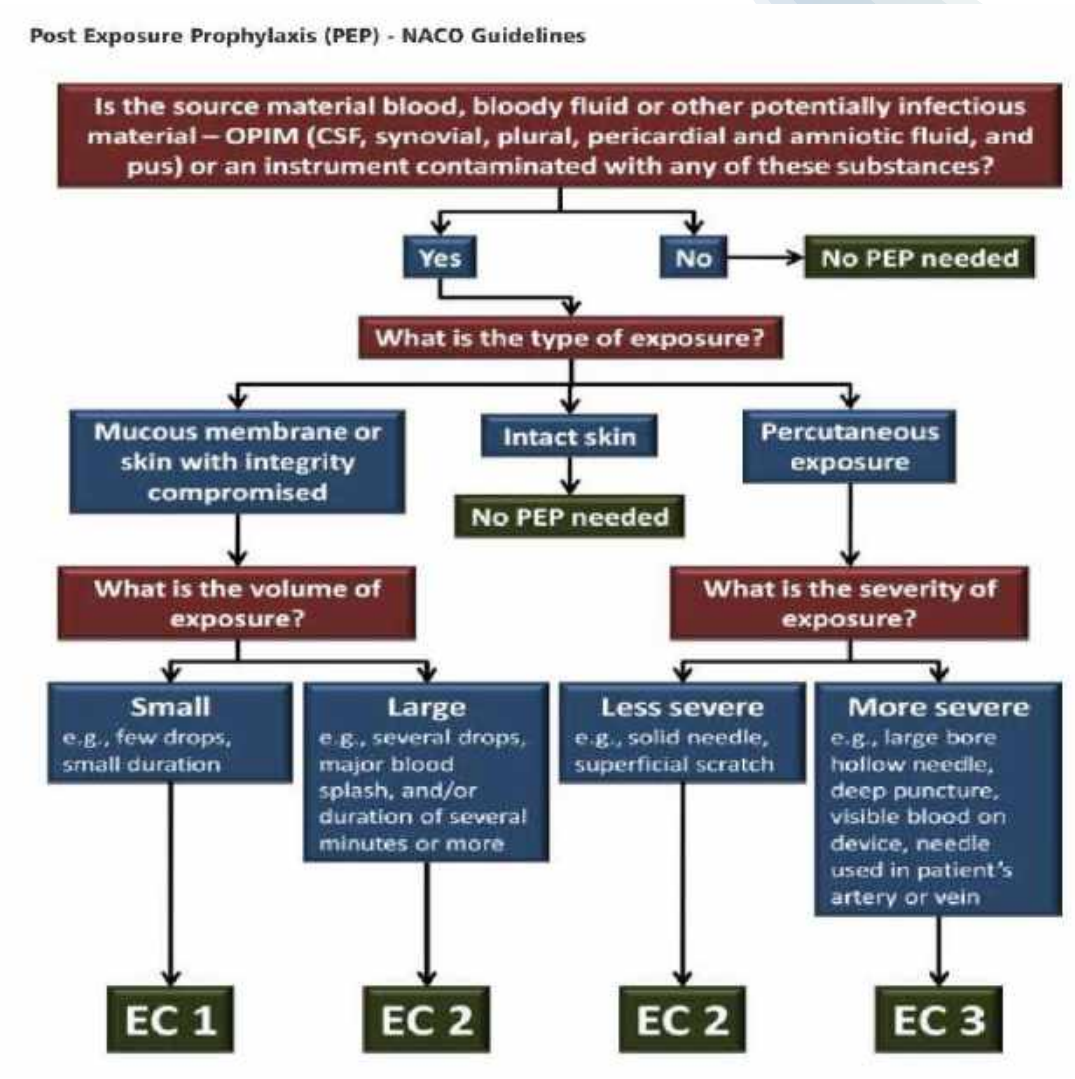
RCA – Deviation from 100 % Compliance was observed due to –
1.Heavy workload
2.Emergency situation
3.Hand hygiene done but steps not followed properly.

CAPA –
1. Regular training & education.

15. Staff members should be provided with the adequate and appropriate pre and post exposure prophylaxis

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
a) The Vaccination (Inj. TT, Hepatitis – B, Typhoid)and medical checkup record available of all concerned staff members b) Hospital provided Personal protective equipment to concerned staff. c) Staff uses Personal protective equipment while conducting any procedure/activity. d) Display of Post exposure prophylaxis chart in all patient care areas	Direct observation, Record review & Staff interview	100% compliance of all four evidences.	10	a) Staff vaccination record. b) PPE Equipments used by staff while conducting any procedure/activity. c) Post exposure prophylaxis chart in patient care area.
		if any of the four evidence is found to be non-compliant.	5	
		Non-compliance of all four evidences.	0	

15. Staff members should be provided with the adequate and appropriate pre and post exposure prophylaxis



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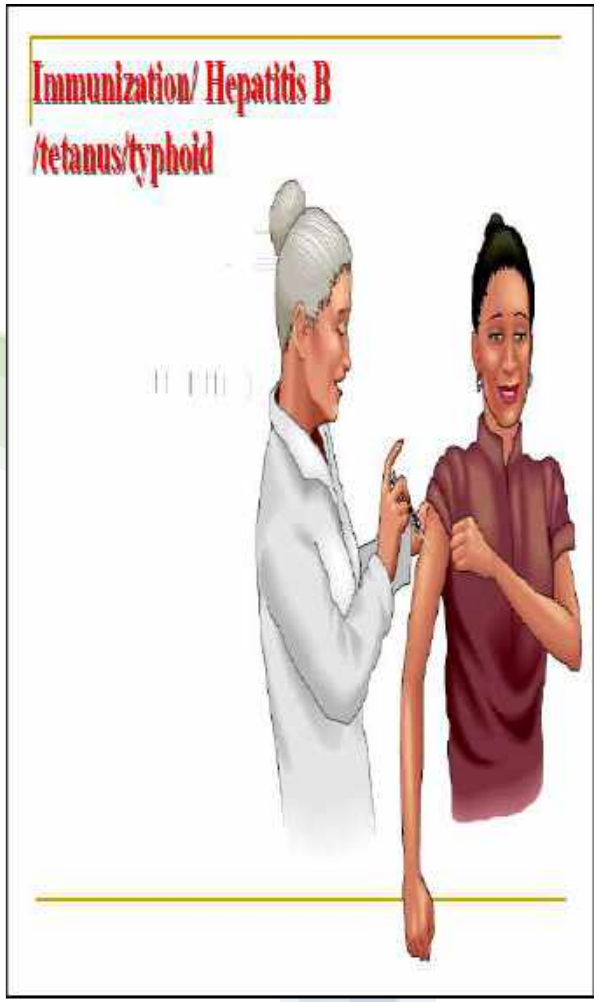

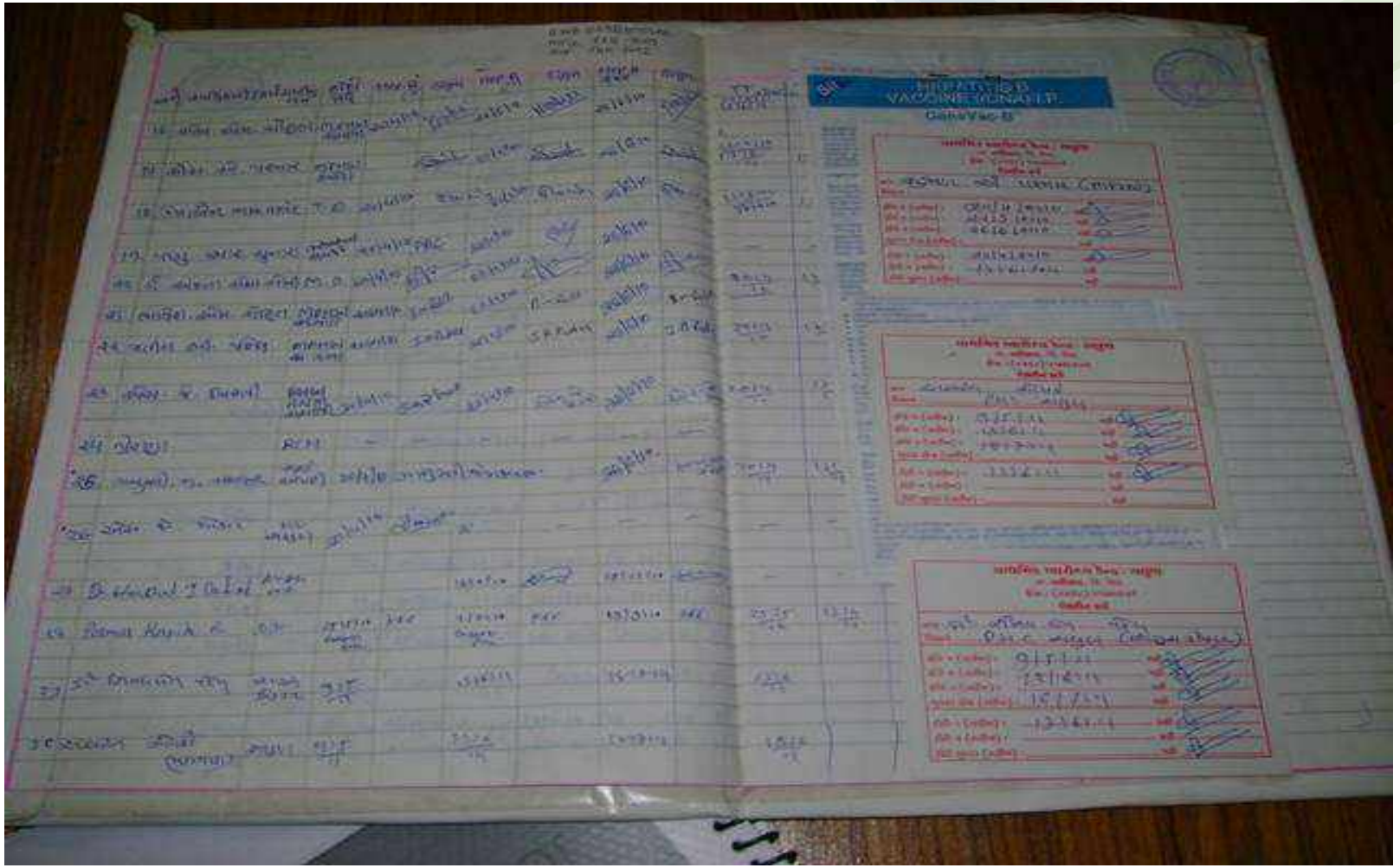

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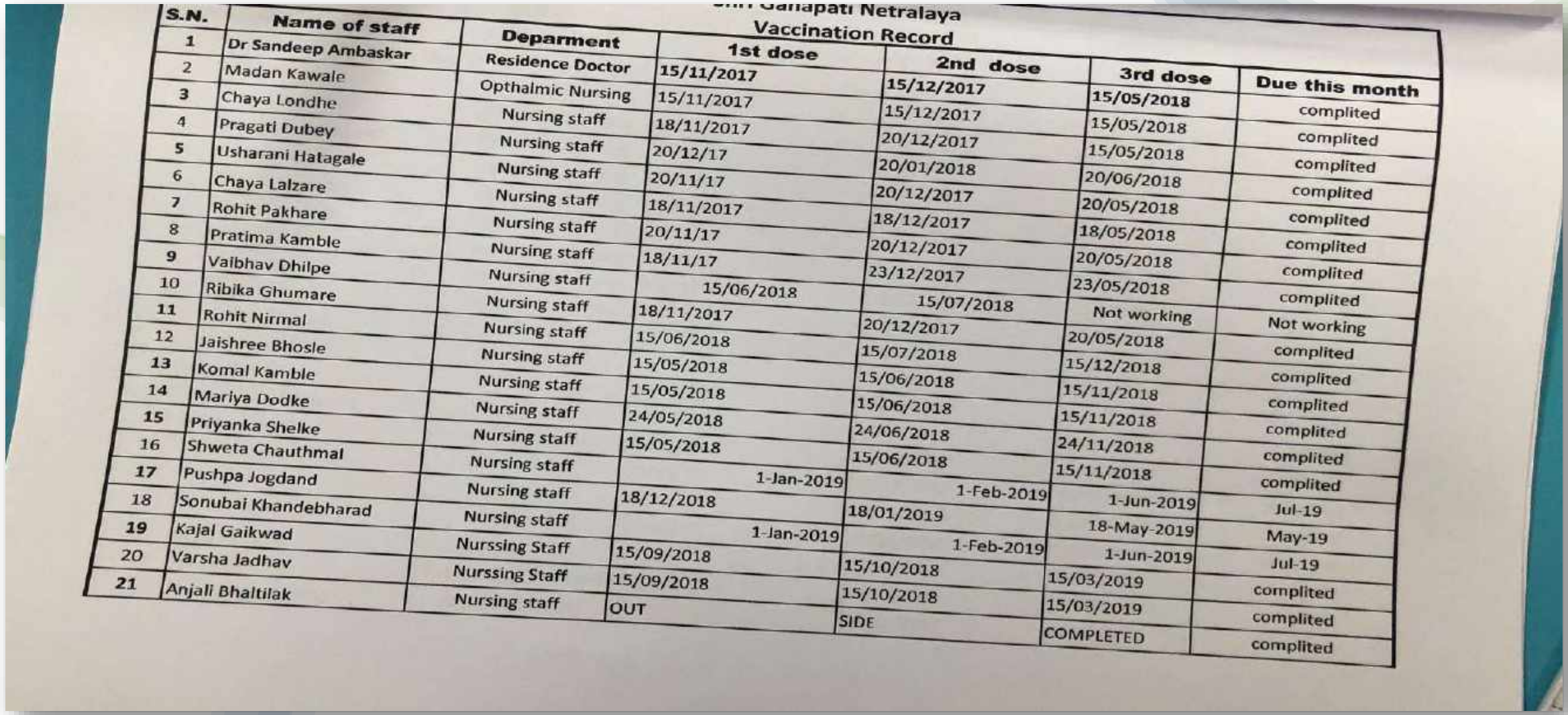

...Ganapati Netralaya

Vaccination Record

S.N.	Name of staff	Deparment	1st dose	2nd dose	3rd dose	Due this month
1	Dr Sandeep Ambaskar	Residence Doctor	15/11/2017	15/12/2017	15/05/2018	complited
2	Madan Kawale	Opthalmic Nursing	15/11/2017	15/12/2017	15/05/2018	complited
3	Chaya Londhe	Nursing staff	18/11/2017	20/12/2017	15/05/2018	complited
4	Pragati Dubey	Nursing staff	20/12/17	20/01/2018	20/06/2018	complited
5	Usharani Hatagale	Nursing staff	20/11/17	20/12/2017	20/05/2018	complited
6	Chaya Lalzare	Nursing staff	18/11/2017	18/12/2017	18/05/2018	complited
7	Rohit Pakhare	Nursing staff	20/11/17	20/12/2017	20/05/2018	complited
8	Pratima Kamble	Nursing staff	18/11/17	23/12/2017	23/05/2018	complited
9	Vaibhav Dhilpe	Nursing staff	15/06/2018	15/07/2018	Not working	Not working
10	Ribika Ghumare	Nursing staff	18/11/2017	20/12/2017	20/05/2018	complited
11	Rohit Nirmal	Nursing staff	15/06/2018	15/07/2018	15/12/2018	complited
12	Jaishree Bhosle	Nursing staff	15/05/2018	15/06/2018	15/11/2018	complited
13	Komal Kamble	Nursing staff	15/05/2018	15/06/2018	15/11/2018	complited
14	Mariya Dodke	Nursing staff	24/05/2018	24/06/2018	24/11/2018	complited
15	Priyanka Shelke	Nursing staff	15/05/2018	15/06/2018	15/11/2018	complited
16	Shweta Chauthmal	Nursing staff	1-Jan-2019	1-Feb-2019	1-Jun-2019	Jul-19
17	Pushpa Jogdand	Nursing staff	18/12/2018	18/01/2019	18-May-2019	May-19
18	Sonubai Khandebharad	Nursing staff	1-Jan-2019	1-Feb-2019	1-Jun-2019	Jul-19
19	Kajal Gaikwad	Nurssing Staff	15/09/2018	15/10/2018	15/03/2019	complited
20	Varsha Jadhav	Nurssing Staff	15/09/2018	15/10/2018	15/03/2019	complited
21	Anjali Bhaltilak	Nursing staff	OUT	SIDE	COMPLETED	complited

15. Staff members should be provided with the adequate and appropriate pre and post exposure prophylaxis

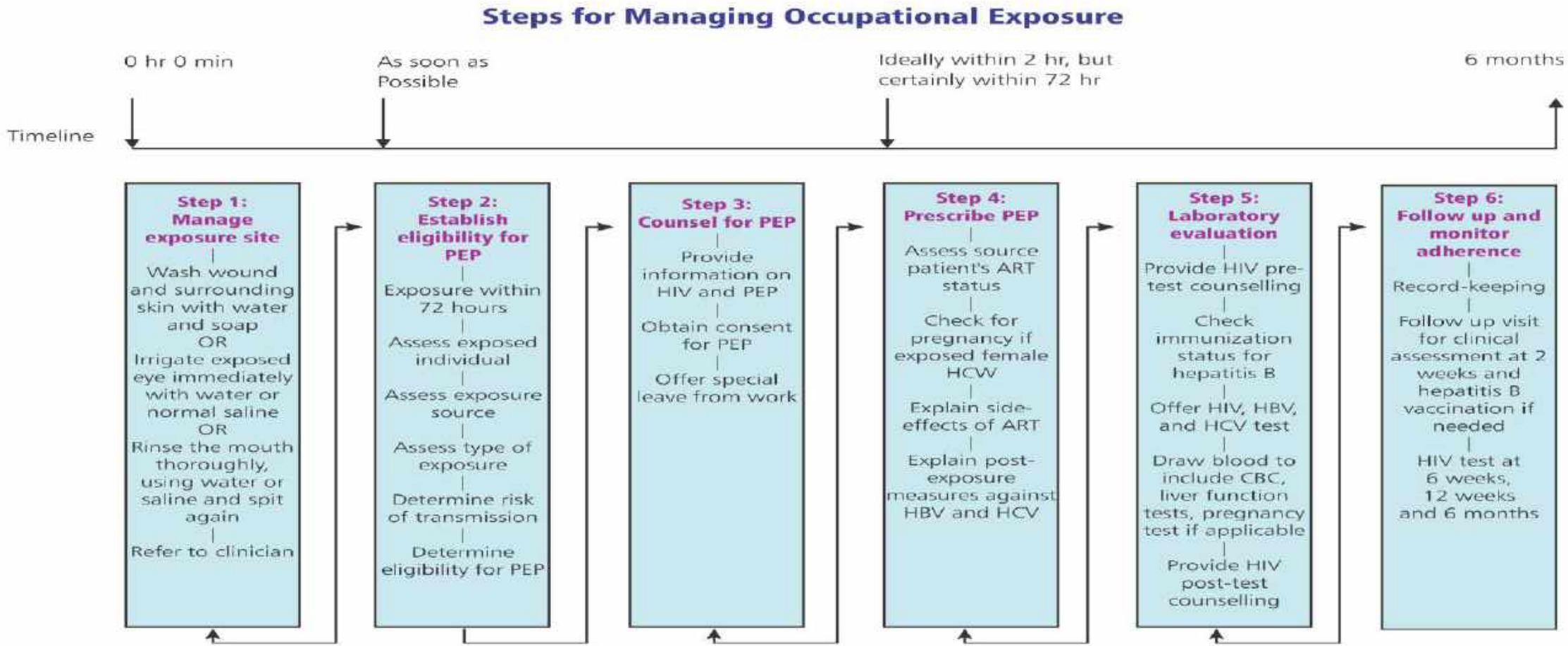

Figure-21: Steps for managing occupational exposure

16. The proper implementation and regular monitoring of Bio-Medical waste segregation and collection in all the patient care areas of the hospital and staff should be trained in handling the Bio-Medical waste and provided with all personal protective measure.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
a) Updated license available for Bio-Medical Waste Management practice as per BMW Rule 2016 b) SOP defined for the process of BMW as per Pollution control guidelines. c) Staff follows the SOP. d) Waste management bins available and BMW guideline chart is displayed in all patient care area e) Personal protective measures (e.g. gloves, mask, apron, gum boots, heavy duty rubber gloves, etc.) are used by all categories of staff handling Bio-Medical Waste. f) Infection control committee visits common biomedical treatment facility.	Direct observation, Record review & Staff interview	100% compliance of all six evidences.	10	a) Updated license of BMW. b) Available biomedical waste bins and displayed chart in patient care area. c) Biomedical waste storage area
		if any of the six evidence is found to be non-compliant.	5	
		Non-compliance of all six evidences.	0	

16. The proper implementation and regular monitoring of Bio-Medical waste segregation and collection in all the patient care areas of the hospital and staff should be trained in handling the Bio-Medical waste and provided with all personal protective measure.

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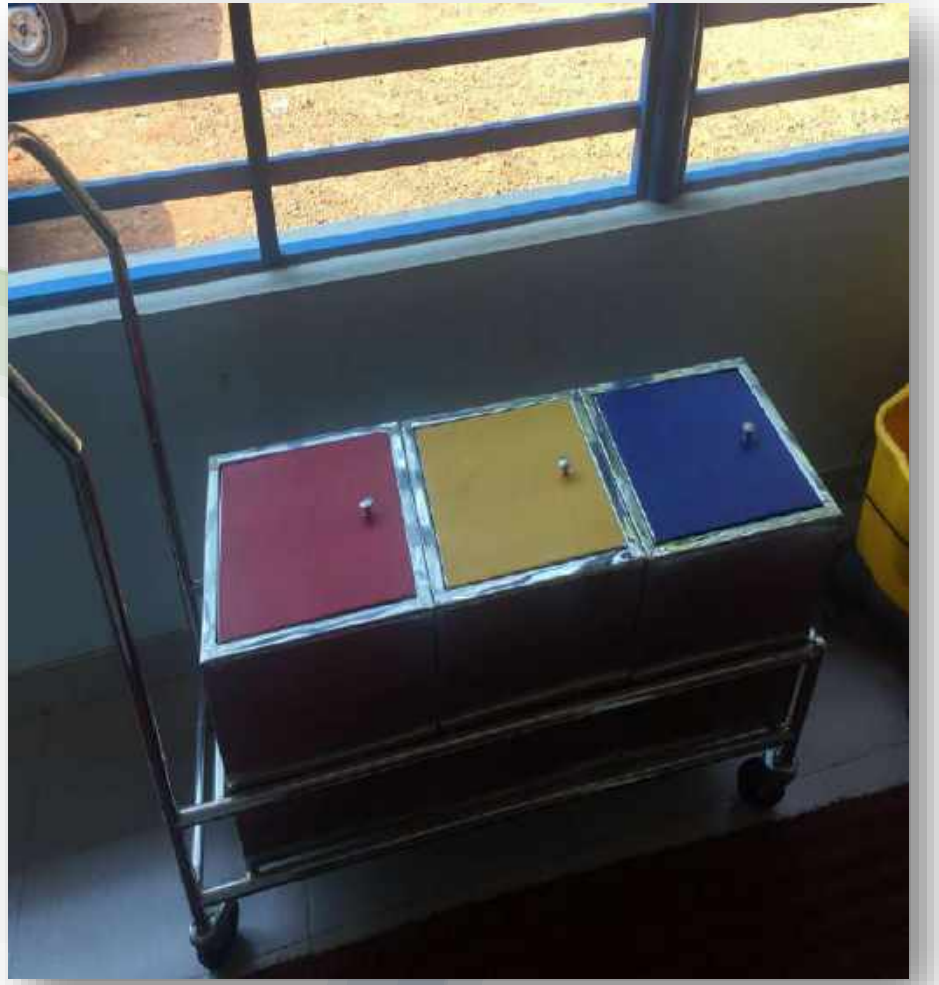


17. A defined mechanism to be there for regular updating of the licences / registration certifications.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
See the relevant statutory documents.	Record review	All aplicable legal liscence are upto date	10	List of applicable legal licences and MOU/Aggrement with date of issue and validity is maintained.
		If any applicable legal liscence is expired or not available	5	
		Non availability of legal liscence	0	

17. A defined mechanism to be there for regular updating of the licences / registration certifications.

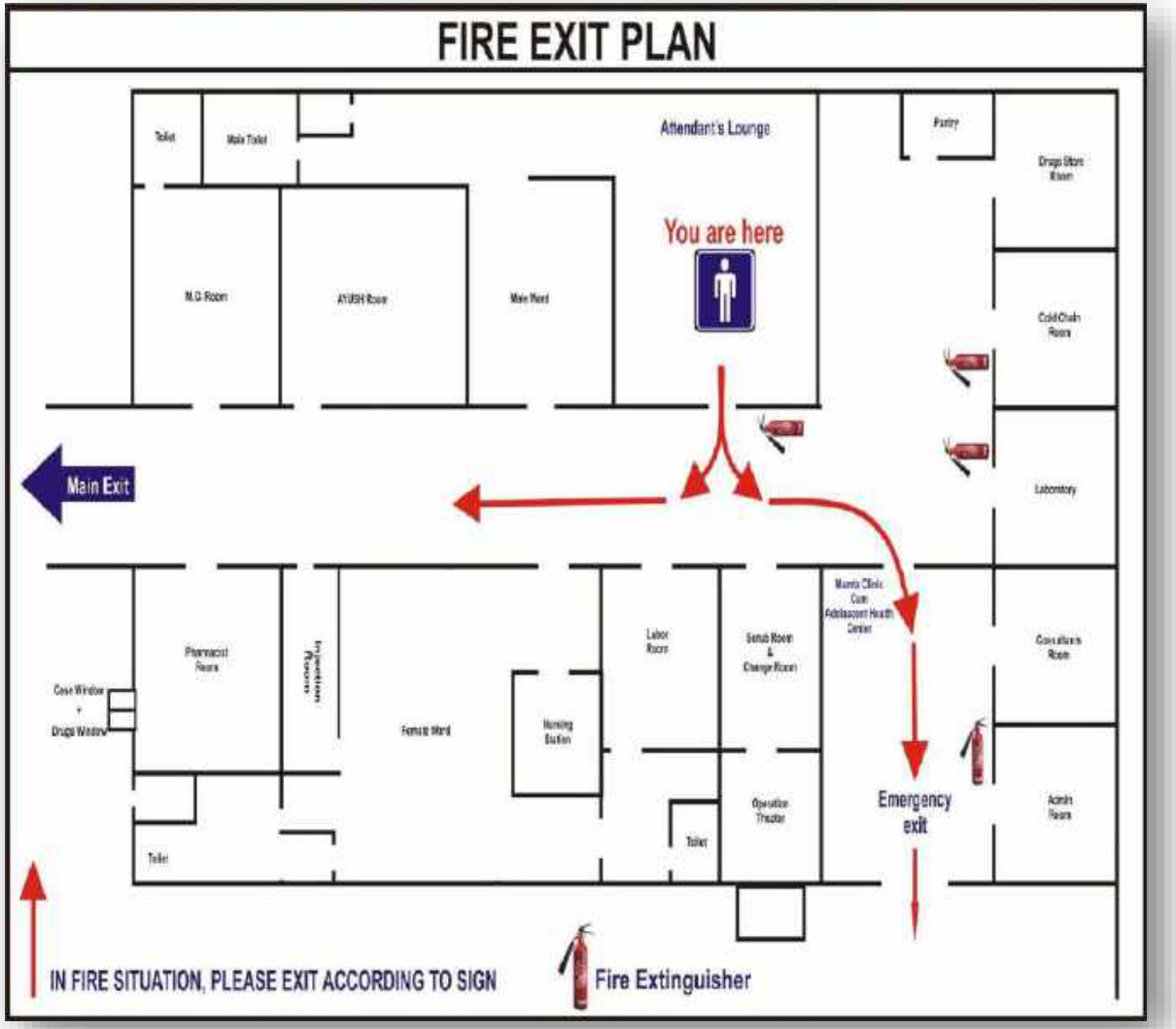
❖ Following are the list of laws applicable to the GSI:

Sr No	Name of License	Number & ID	Date of Issue	Valid Upto	Remarks
1	Bio-Medical Waste Authorization	PCB ID-40245, BMW Id:387557	15-06-2016	14-06-2021	
2	Drug and Cosmetic License	ADC- 84507	13-10-2014	12-10-2019	
3	Narcotic Drug License	04/2014-2015	09/04/2018	31/03/2019	
4	Spirit ,Denatured Sprit	44/10-13	01-04-2016	31-03-2021	
5	X-Ray Installation C-Arm-1	ALLENGER HF -49R G-XR-22917 14-RLXE-21287	19-12-2017	19-12-2022	
6	X-Ray Installation C-Arm-2	ProRAD Premium /G-XR-61335 17-LOP-181040	21-04-2017	21-04-2022	
7	X-RAY Mobile Machine	M.n.Allenger-60 G-XR-23830 17-LOEE -194387	22-06-2017	22-06-2022	
8	X-RAY Mobile Machine	M.n.Diagnox-100R G-XR-67128 17-LOEE-194392	22-06-2017	22-06-2022	
9	Radiography (Fixed)	DIAGNOX-300 G-XR-22885	19-12-2017	19-12-2022	

18. Safe exit plan for fire and non-fire emergencies should be documented and ensure the awareness amongst the hospital staff and Fire Mock drills should be conducted at least twice in a year.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
a) SOP defined and implemented for safe exit plan in case of fire and non-fire emergencies. b) Sinages displayed of do's and don't's in case of fire c) Display of fire exit plan in all patient care areas. c) Record of Mockdrill's conducted and CAPA done	Direct observation, Record review & Staff interview.	100% compliance of all four evidences.	10	a) All the signages are displayed with fire exit plan. b) Document of mock drills conducted at regular intervals
		if any of the four evidence is found to be non-compliant.	5	
		Non-compliance of all four evidences.	0	

18. Safe exit plan for fire and non-fire emergencies should be documented and ensure the awareness amongst the hospital staff and Fire Mock drills should be conducted at least twice in a year.



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FIRE MOCK DRILL /INCIDENT CHECKLIST

GOVERNMENT (CL&SC) SPINE INSTITUTE
AND PHYSIOTHERAPY COLLEGE, AHMEDABAD

Fire Drill and/or Incident Report

Date:	Time:	Location:
Section 1	**1st Response to fire**	

Describe fire drill scenario, fire incident or fire alarm occurrence:

Drill or Actual incident	Yes	No		Yes	No
Was the fire alarm activated					
Was the control room informed			At what time		
Was the code red activated			At what time		
Was the code announcement audible in all areas					
Rapid response team arrived			At what time		
Higher authorities informed					
Was the fire department called?					
Were people in immediate danger evacuated? See for stop, drop , cover and rolls technique			Zone of origin evacuated?		
Was immediate first aid provided if needed					
Were doors closed and latched to confine the fire and reduce smoke spread?					
Was an attempt made to extinguish the fire?			Was attempt appropriate?		
Did sufficient staff respond and evacuate endangered occupants in an organized and timely manner?					
Was scene being supervised?			Were instructions clear?		
Was evacuation conducted?					

19. The services provided by the medical professionals and nursing staff should be in line with their qualification, training and registration.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
See minimum 5 personal files of staffs (e.g. Consultant RMO & Nurses, etc.) and check for their qualification, training and privelaging a) Medical professionals are granted previlages to admit and care of patients in consonance with their qualification, training, experience and registration. b) Medical professionals admit and care care for patients as per their privelaging. c) Nursing staff is granted previlages in consonance with their qualification, training, experience and registration. d) Nursing professional care for patients as per their privelaging. e) System developed for updating the personal files of staff.	Record review & Staff interview	100% compliance of all five evidences.	10	All files are maintained by HR Dept. with all the the required details
		if any of the five evidence is found to be non-compliant.	5	
		Non-compliance of all five evidences.	0	

19. The services provided by the medical professionals and nursing staff should be in line with their qualification, training and registration.

PRIVILEGEFORM FOR NURSING STAFF

GOVERNMENT (CL&SC) SPINE INTIUTE AND PHYSIOTHERAPY COLLEGE AHMEDABAD

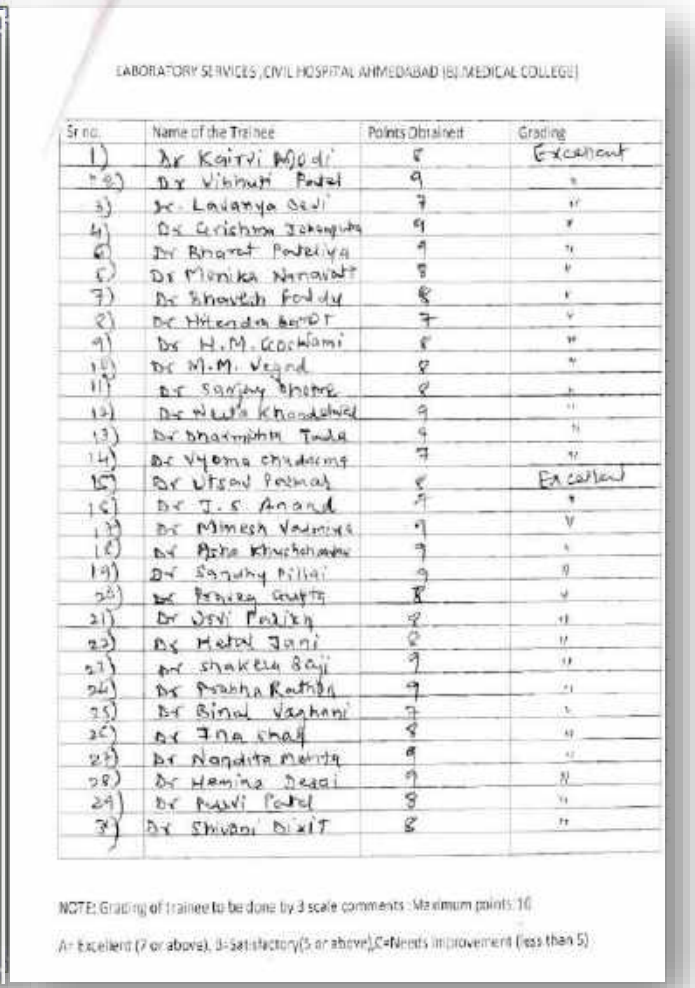
Employee Name: _____

Date of Joining: _____

Department: _____

Designation: _____

		Yes (√)
Required Qualifications	• GNM	
	• B.Sc. Nursing	
Privileges	**(1) Nursing Initial Assessment**	
	(2) General Nursing Care	
	• Back care, Mouth care, Sponge, Nail Cutting, Bed Making, Hair wash	
	(3) Intra Muscular Injection Administration	
	(4) Intra Venous Injection	
	(5)Blood Transfusion Monitoring	
	(6) Assisting Operation Procedure	
	(7) Oxygen Administration	
	(8)Administration of High Risk Medicine	
	(9)Urinary Catheterization	
	(10)Pre-Operative Care	
	• Patient Identity check	
	• Part Preparation	
	• Consent Signed	
	• Pre Mastication given	
	• Correct Side Marking	
	• Site Preparation	
	• Site Marking	
	• Bladder/Bowel-wash	
	(11)Post-Operative Care	
	• Vital Sign Monitoring	
	• Maintain Intake Output Chart	
	• Iv Injections	
	• Catheter Care	
	• Drainage care	
	• CVP Care	
	• Operation site Monitoring	
	• Proper Positioning to Patient	
	(12) Equipment Handling	
	• ECG	
	• Nebulizer	
	• Glucometer	
	• Defibrillator	
	• Vac Machine	
	(13) Multi Para Monitoring	
	(14)Bedsore Dressing	



LABORATORY SERVICES, CIVIL HOSPITAL AHMEDABAD (B.J.MEDICAL COLLEGE)

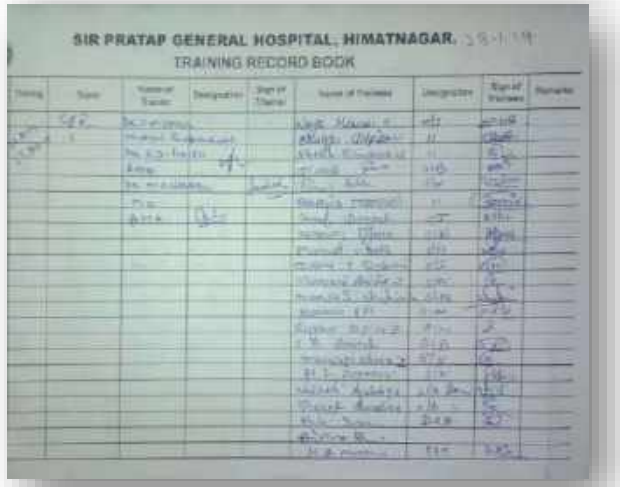
Sr no.	Name of the Trainee	Points Obtained	Grading
1)	Dr Kairvi Modi	8	Excellent
2)	Dr Vibhuti Patel	9	"
3)	Dr. Lavanya Devi	7	"
4)	Dr Krishna Jakhotia	9	"
5)	Dr Bharat Pateliya	9	"
6)	Dr Monika Nanavati	8	"
7)	Dr Bhavesh Foddy	8	"
8)	Dr Hitendra Bhatt	7	"
9)	Dr H.M. Goswami	8	"
10)	Dr M.M. Vegad	8	"
11)	Dr Sanjay Bhatt	8	"
12)	Dr Nilu Khandelwal	9	"
13)	Dr Bhavishya Tada	9	"
14)	Dr Vyoma Chudasama	7	"
15)	Dr Utsav Patwal	8	Excellent
16)	Dr J.S. Anand	9	"
17)	Dr Mitesh Vadmiya	9	"
18)	Dr Asha Khushalani	9	"
19)	Dr Sandhy Pillai	9	"
20)	Dr Pranay Gupta	8	"
21)	Dr Jasi Patel	8	"
22)	Dr Mehul Jani	8	"
23)	Dr Shakeel Baji	9	"
24)	Dr Prabha Rathod	9	"
25)	Dr Bipul Vaghani	7	"
26)	Dr Jha Shah	8	"
27)	Dr Nandita Mehta	9	"
28)	Dr Hemina Desai	9	"
29)	Dr Rupi Patel	8	"
30)	Dr Shivani Dixit	8	"

NOTE: Grading of trainee to be done by 3 scale comments : Maximum points: 10

A= Excellent (7 or above), B=Satisfactory(5 or above),C=Needs improvement (less than 5)

G.M.E.R.S. GENERAL HOSPITAL, HIMMATNAGAR

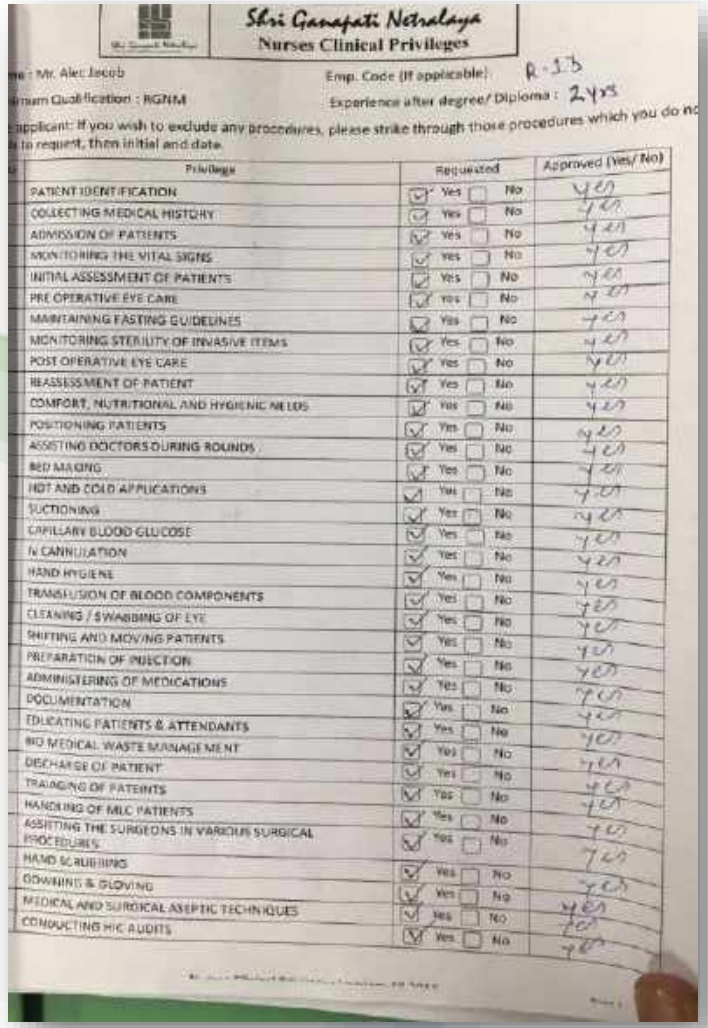
TRAINING RECORD BOOK



SIR PRATAP GENERAL HOSPITAL, HIMATNAGAR.

TRAINING RECORD BOOK

19. The services provided by the medical professionals and nursing staff should be in line with their qualification, training and registration.

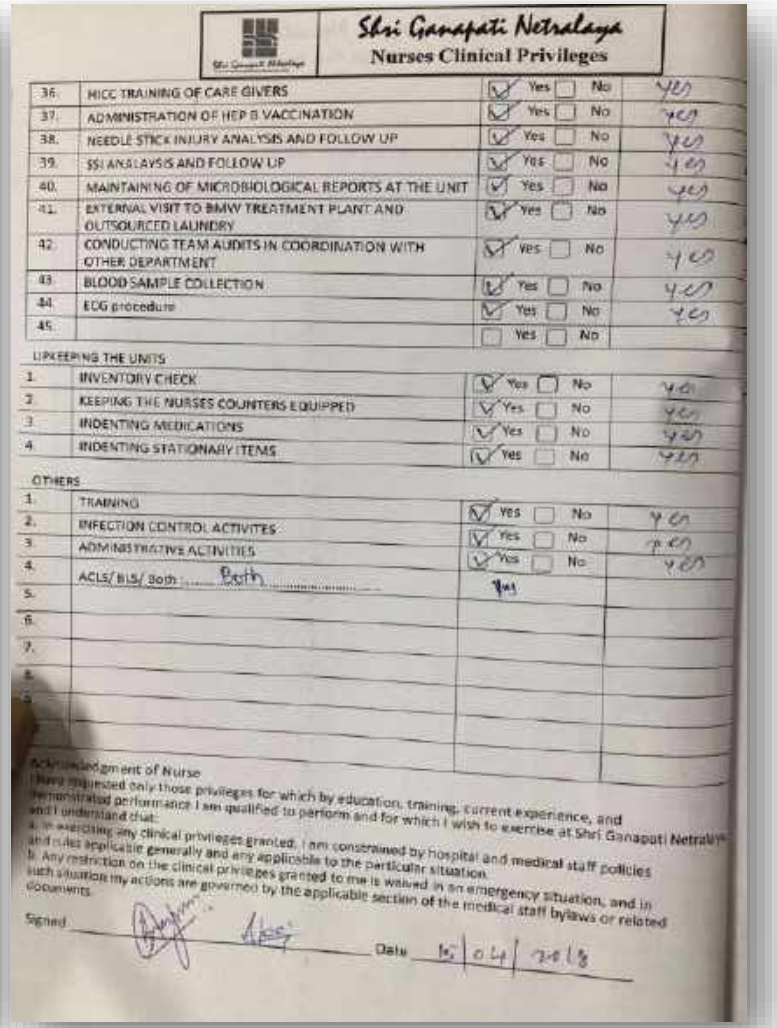


Shri Ganapati Netralaya
Nurses Clinical Privileges

Name : Mr. Alec Jacob
Emp. Code (If applicable) : R-33
Maximum Qualification : RGNM
Experience after degree/ Diploma : 24yrs

Applicant: If you wish to exclude any procedures, please strike through those procedures which you do not wish to request, then initial and date.

Privilege	Requested	Approved (Yes/ No)
PATIENT IDENTIFICATION	Yes	Yes
COLLECTING MEDICAL HISTORY	Yes	Yes
ADMISSION OF PATIENTS	Yes	Yes
MONITORING THE VITAL SIGNS	Yes	Yes
INITIAL ASSESSMENT OF PATIENTS	Yes	Yes
PRE OPERATIVE EYE CARE	Yes	Yes
MAINTAINING FASTING GUIDELINES	Yes	Yes
MONITORING STERILITY OF INVASIVE ITEMS	Yes	Yes
POST OPERATIVE EYE CARE	Yes	Yes
REASSESSMENT OF PATIENT	Yes	Yes
COMFORT, NUTRITIONAL AND HYGIENIC NEEDS	Yes	Yes
POSITIONING PATIENTS	Yes	Yes
ASSISTING DOCTORS DURING ROUNDS	Yes	Yes
BED MAKING	Yes	Yes
HOT AND COLD APPLICATIONS	Yes	Yes
SUCTIONING	Yes	Yes
CAPILLARY BLOOD GLUCOSE	Yes	Yes
IV CANNULATION	Yes	Yes
HAND HYGIENE	Yes	Yes
TRANSFUSION OF BLOOD COMPONENTS	Yes	Yes
CLEANING / SWABBING OF EYE	Yes	Yes
SHIFTING AND MOVING PATIENTS	Yes	Yes
PREPARATION OF INJECTION	Yes	Yes
ADMINISTERING OF MEDICATIONS	Yes	Yes
DOCUMENTATION	Yes	Yes
EDUCATING PATIENTS & ATTENDANTS	Yes	Yes
BIO MEDICAL WASTE MANAGEMENT	Yes	Yes
DISCHARGE OF PATIENT	Yes	Yes
TRAINING OF PATIENTS	Yes	Yes
HANDLING OF MLC PATIENTS	Yes	Yes
ASSISTING THE SURGEONS IN VARIOUS SURGICAL PROCEDURES	Yes	Yes
HAND SCRUBBING	Yes	Yes
GOWNING & GLOVING	Yes	Yes
MEDICAL AND SURGICAL ASEPTIC TECHNIQUES	Yes	Yes
CONDUCTING HIC AUDITS	Yes	Yes



Shri Ganapati Netralaya
Nurses Clinical Privileges

36.	HICC TRAINING OF CARE GIVERS	Yes / No	Yes
37.	ADMINISTRATION OF HEP B VACCINATION	Yes / No	Yes
38.	NEEDLE STICK INJURY ANALYSIS AND FOLLOW UP	Yes / No	Yes
39.	SSI ANALAYSIS AND FOLLOW UP	Yes / No	Yes
40.	MAINTAINING OF MICROBIOLOGICAL REPORTS AT THE UNIT	Yes / No	Yes
41.	EXTERNAL VISIT TO BMW TREATMENT PLANT AND OUTSOURCED LAUNDRY	Yes / No	Yes
42.	CONDUCTING TEAM AUDITS IN COORDINATION WITH OTHER DEPARTMENT	Yes / No	Yes
43.	BLOOD SAMPLE COLLECTION	Yes / No	Yes
44.	ECG procedure	Yes / No	Yes
45.		Yes / No	

UPKEEPING THE UNITS

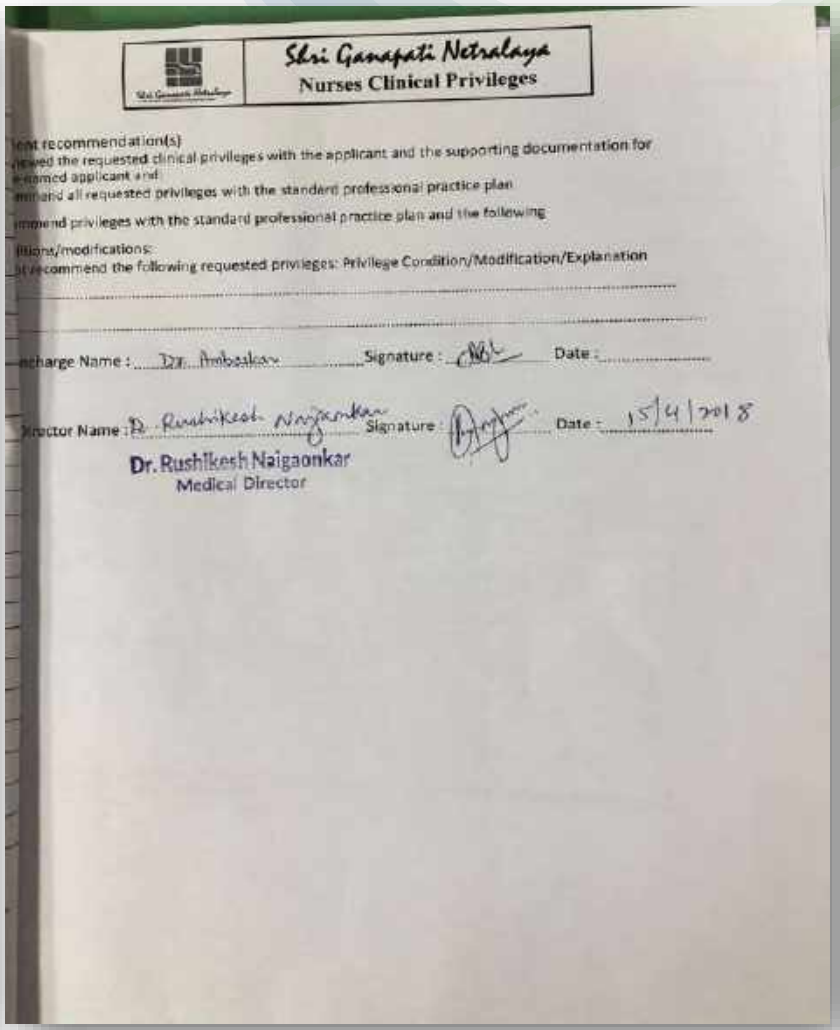
1.	INVENTORY CHECK	Yes / No	Yes
2.	KEEPING THE NURSES COUNTERS EQUIPPED	Yes / No	Yes
3.	INDENTING MEDICATIONS	Yes / No	Yes
4.	INDENTING STATIONARY ITEMS	Yes / No	Yes

OTHERS

1.	TRAINING	Yes / No	Yes
2.	INFECTION CONTROL ACTIVITES	Yes / No	Yes
3.	ADMINISTRATIVE ACTIVITIES	Yes / No	Yes
4.	ACLS/ BLS/ Both : Both	Yes	
5.			
6.			
7.			
8.			
9.			

Acknowledgment of Nurse
I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform and for which I wish to exercise at Shri Ganapati Netralaya and I understand that:
a. In exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.
b. Any restriction on the clinical privileges granted to me is waived in an emergency situation, and in such situation my actions are governed by the applicable section of the medical staff bylaws or related documents.

Signed _____ Date 15/04/2018



Shri Ganapati Netralaya
Nurses Clinical Privileges

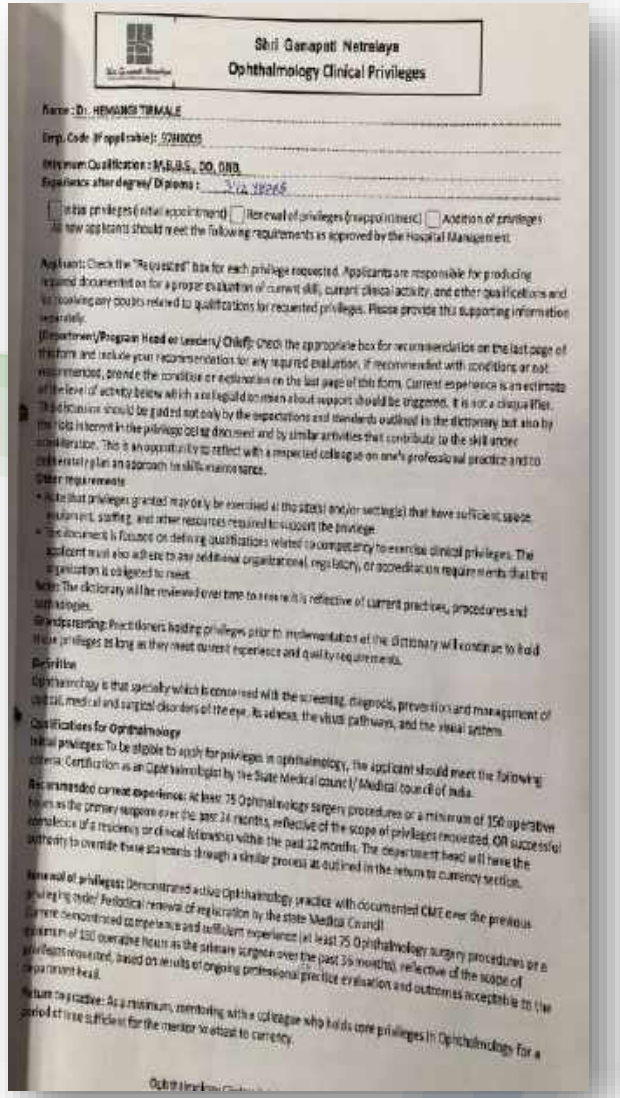
Department recommendation(s)
I have reviewed the requested clinical privileges with the applicant and the supporting documentation for the named applicant and
I recommend all requested privileges with the standard professional practice plan
I recommend privileges with the standard professional practice plan and the following
Conditions/modifications:
I do not recommend the following requested privileges: Privilege Condition/Modification/Explanation

Incharge Name : Dr. Ambekar Signature : Date :

Director Name : Dr. Rushikesh Naigaonkar Signature : Date : 15/4/2018

Dr. Rushikesh Naigaonkar
Medical Director

19. The services provided by the medical professionals and nursing staff should be in line with their qualification, training and registration.


Shri Ganapati Netralaya
Ophthalmology Clinical Privileges

Name : Dr. HEMANGI TIRMALE

Emp. Code (If applicable): 20H0005

Minimum Qualification : M.B.B.S., DO, DNB

Experience after degree/ Diploma : 3 Yrs 3Mths

Initial privileges (Initial appointment) Renewal of privileges (reappointment) Addition of privileges

All new applicants should meet the following requirements as approved by the Hospital Management

Applicant: Check the "Requested" box for each privilege requested. Applicants are responsible for producing required documentation for a proper evaluation of current skill, current clinical activity, and other qualifications and for resolving any doubts related to qualifications for requested privileges. Please provide this supporting information separately.

[Department/Program Head or Leader/ Chief]: Check the appropriate box for recommendation on the last page of this form and include your recommendation for any required evaluation. If recommended with conditions or not recommended, provide the condition or explanation on the last page of this form. Current experience is an estimate of the level of activity below which a privileged practitioner should be triggered. It is not a disqualifier. The practitioner should be guided not only by the expectations and standards outlined in the dictionary but also by the limits inherent in the privilege being discussed and by similar activities that contribute to the skill under consideration. This is an opportunity to reflect with a respected colleague on one's professional practice and to collaboratively plan an approach to skills maintenance.

Other requirements

- Note that privileges granted may only be exercised at the site(s) and/or setting(s) that have sufficient space, equipment, staffing, and other resources required to support the privilege.
- The document is focused on defining qualifications related to competency to exercise clinical privileges. The applicant must also adhere to any additional organizational, regulatory, or accreditation requirements that the organization is obligated to meet.

Note: The dictionary will be reviewed over time to ensure it is reflective of current practices, procedures and technologies.

Grandparenting: Practitioners holding privileges prior to implementation of the dictionary will continue to hold those privileges as long as they meet current experience and quality requirements.

Overview

Ophthalmology is that specialty which is concerned with the screening, diagnosis, prevention and management of ocular, medical and surgical disorders of the eye. Its adnexa, the visual pathways, and the visual system.

Qualifications for Ophthalmology

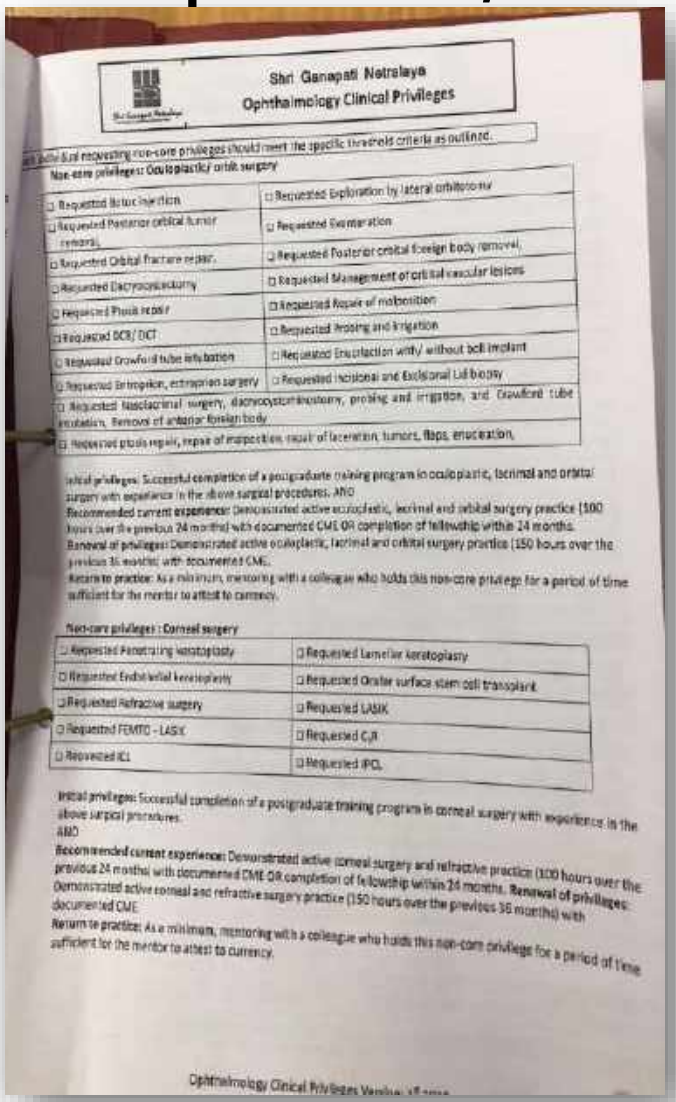
Initial privileges: To be eligible to apply for privileges in ophthalmology, the applicant should meet the following criteria: Certification as an Ophthalmologist by the State Medical council/ Medical council of India.

Recommended current experience: At least 75 Ophthalmology surgery procedures or a minimum of 150 operative hours as the primary surgeon over the past 24 months, reflective of the scope of privileges requested, OR successful completion of a residency or clinical fellowship within the past 12 months. The department head will have the authority to override these statements through a similar process as outlined in the return to currency section.

Renewal of privileges: Demonstrated active Ophthalmology practice with documented CME over the previous 36 months under Periodical renewal of registration by the state Medical Council

Current demonstrated competence and sufficient experience (at least 75 Ophthalmology surgery procedures or a minimum of 150 operative hours as the primary surgeon over the past 36 months), reflective of the scope of privileges requested, based on results of ongoing professional practice evaluation and outcomes acceptable to the department head.

Return to practice: As a minimum, mentoring with a colleague who holds core privileges in Ophthalmology for a period of time sufficient for the mentor to attest to currency.


Shri Ganapati Netralaya
Ophthalmology Clinical Privileges

Applicants requesting non-core privileges should meet the specific threshold criteria as outlined.

Non-core privileges: Oculoplastic/ orbit surgery	
☐ Requested Botox injection	☐ Requested Exploration by lateral orbitotomy
☐ Requested Posterior orbital tumor removal	☐ Requested Exenteration
☐ Requested Orbital fracture repair	☐ Requested Posterior orbital foreign body removal
☐ Requested Dacryocystectomy	☐ Requested Management of orbital vascular lesions
☐ Requested Ptosis repair	☐ Requested Repair of malposition
☐ Requested DCR/ DCT	☐ Requested Probing and irrigation
☐ Requested Crawford tube intubation	☐ Requested Enucleation with/ without bolt implant
☐ Requested Entropion, ectropion surgery	☐ Requested Incisional and Excisional Lid biopsy
☐ Requested Nasolacrimal surgery, dacryocystorhinostomy, probing and irrigation, and Crawford tube intubation. Removal of anterior foreign body	
☐ Requested ptosis repair, repair of malposition, repair of laceration, tumors, flaps, enucleation,	

Initial privileges: Successful completion of a postgraduate training program in oculoplastic, lacrimal and orbital surgery with experience in the above surgical procedures. AND

Recommended current experience: Demonstrated active oculoplastic, lacrimal and orbital surgery practice (100 hours over the previous 24 months) with documented CME OR completion of fellowship within 24 months.

Renewal of privileges: Demonstrated active oculoplastic, lacrimal and orbital surgery practice (150 hours over the previous 36 months) with documented CME.

Return to practice: As a minimum, mentoring with a colleague who holds this non-core privilege for a period of time sufficient for the mentor to attest to currency.

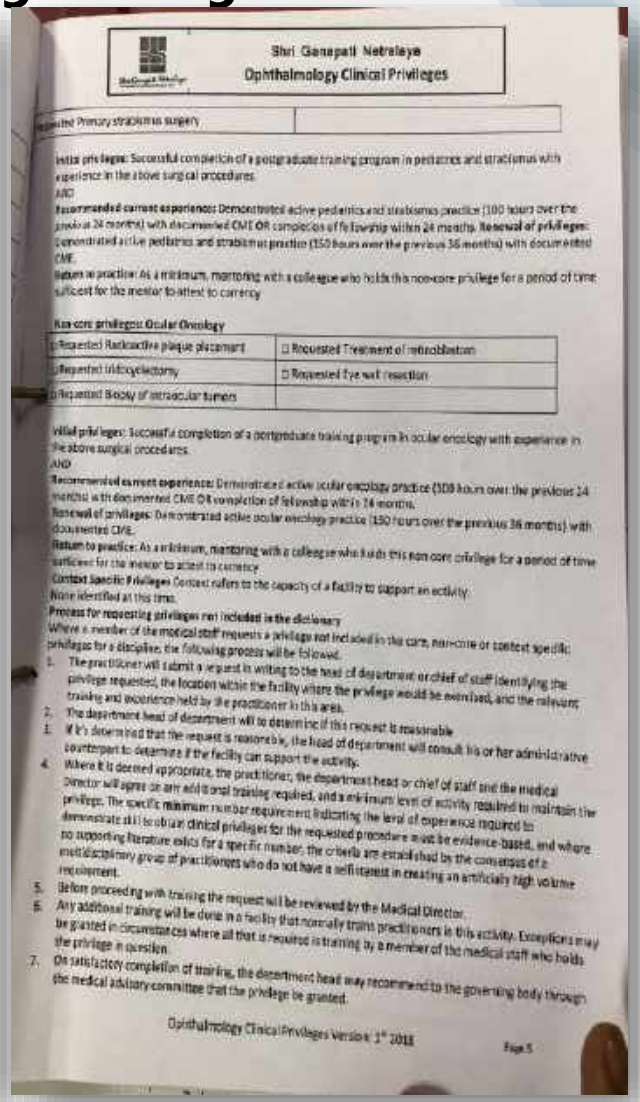
Non-core privileges : Corneal surgery	
☐ Requested Penetrating keratoplasty	☐ Requested Lamellar keratoplasty
☐ Requested Endothelial keratoplasty	☐ Requested Ocular surface stem cell transplant
☐ Requested Refractive surgery	☐ Requested LASIK
☐ Requested FEMTO – LASIK	☐ Requested CJR
☐ Requested ICL	☐ Requested IPCL

Initial privileges: Successful completion of a postgraduate training program in corneal surgery with experience in the above surgical procedures.

AND

Recommended current experience: Demonstrated active corneal surgery and refractive practice (100 hours over the previous 24 months) with documented CME OR completion of fellowship within 24 months. Renewal of privileges: Demonstrated active corneal and refractive surgery practice (150 hours over the previous 36 months) with documented CME

Return to practice: As a minimum, mentoring with a colleague who holds this non-core privilege for a period of time sufficient for the mentor to attest to currency.


Shri Ganapati Netralaya
Ophthalmology Clinical Privileges

Primary strabismus surgery

Initial privileges: Successful completion of a postgraduate training program in pediatrics and strabismus with experience in the above surgical procedures

AND

Recommended current experience: Demonstrated active pediatrics and strabismus practice (100 hours over the previous 24 months) with documented CME OR completion of fellowship within 24 months. Renewal of privileges: Demonstrated active pediatrics and strabismus practice (150 hours over the previous 36 months) with documented CME.

Return to practice: As a minimum, mentoring with a colleague who holds this non-core privilege for a period of time sufficient for the mentor to attest to currency

Non-core privileges: Ocular Oncology

☐ Requested Radioactive plaque placement	☐ Requested Treatment of retinoblastoma
☐ Requested Iridocyclectomy	☐ Requested Eye wall resection
☐ Requested Biopsy of intraocular tumors	

Initial privileges: Successful completion of a postgraduate training program in ocular oncology with experience in the above surgical procedures

AND

Recommended current experience: Demonstrated active ocular oncology practice (100 hours over the previous 24 months) with documented CME OR completion of fellowship within 24 months.

Renewal of privileges: Demonstrated active ocular oncology practice (150 hours over the previous 36 months) with documented CME.

Return to practice: As a minimum, mentoring with a colleague who holds this non-core privilege for a period of time sufficient for the mentor to attest to currency

Context Specific Privileges: Context refers to the capacity of a facility to support an activity.

None identified at this time.

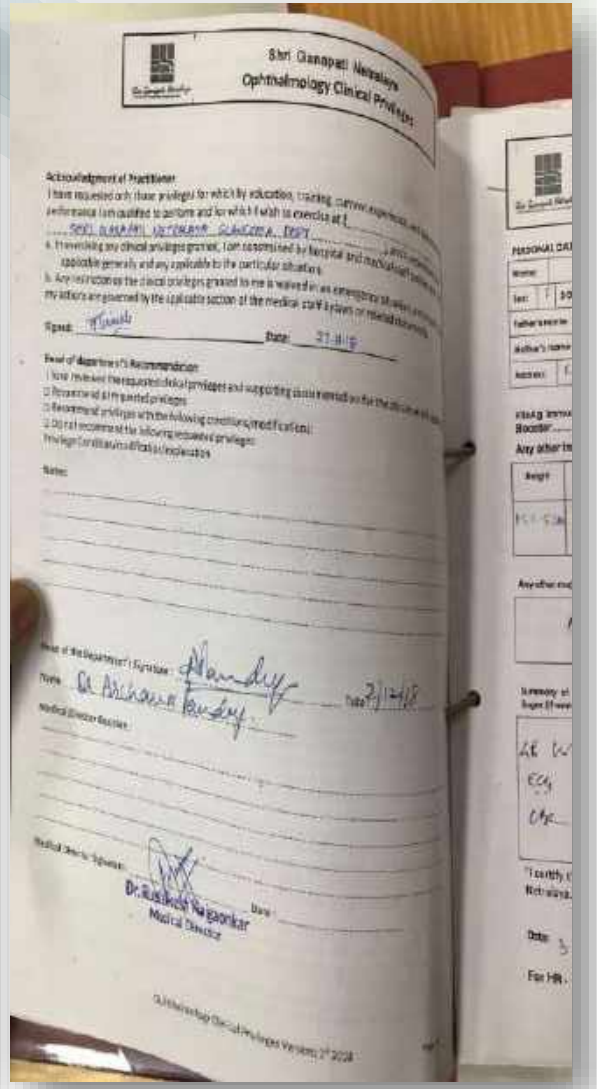
Process for requesting privileges not included in the dictionary

Where a member of the medical staff requests a privilege not included in the core, non-core or context specific privileges for a discipline, the following process will be followed.

1. The practitioner will submit a request in writing to the head of department or chief of staff identifying the privilege requested, the location within the facility where the privilege would be exercised, and the relevant training and experience held by the practitioner in this area.
2. The department head of department will to determine if this request is reasonable
3. If it's determined that the request is reasonable, the head of department will consult his or her administrative counterpart to determine if the facility can support the activity.
4. Where it is deemed appropriate, the practitioner, the department head or chief of staff and the medical Director will agree on any additional training required, and a minimum level of activity required to maintain the privilege. The specific minimum number requirement indicating the level of experience required to demonstrate skill to obtain clinical privileges for the requested procedure must be evidence-based, and where no supporting literature exists for a specific number, the criteria are established by the consensus of a multidisciplinary group of practitioners who do not have a self-interest in creating an artificially high volume requirement.
5. Before proceeding with training the request will be reviewed by the Medical Director.
6. Any additional training will be done in a facility that normally trains practitioners in this activity. Exceptions may be granted in circumstances where all that is required is training by a member of the medical staff who holds the privilege in question.
7. On satisfactory completion of training, the department head may recommend to the governing body through the medical advisory committee that the privilege be granted.

Ophthalmology Clinical Privileges Version 1st 2018

Page 5


Shri Ganapati Netralaya
Ophthalmology Clinical Privileges

Acknowledgement of Practitioner

I have requested only those privileges for which my education, training, current experience, and demonstrated performance I am qualified to perform and for which I wish to exercise at [redacted]

a. If I am granted any clinical privileges granted, I am recommended by hospital and medical staff committee applicable generally and any applicable to the particular situation.

b. Any restrictions on the clinical privileges granted to me is waived on an emergency basis or when my actions are governed by the applicable section of the medical staff bylaws or related documents.

Signed: [redacted] Date: 27-11-18

Head of department's Recommendation

I have reviewed the requested clinical privileges and supporting documentation for the clinician listed above.

☐ Recommend all requested privileges

☐ Recommend privileges with the following conditions/modifications:

☐ Do not recommend the following requested privileges:

Privilege Conditions/Modifications/Explanation:

Name: Dr Archana Pandey Date: 27/11/18

Medical Director Section

Name: Dr. Archana Pandey Date: 27/11/18

Medical Director's Signature

Dr. Rashmi Nagarkar

Medical Director

Date

Ophthalmology Clinical Privileges Version 1st 2018

20. Up to date and chronological details of the patient care should be available in the medical record including discharge summary

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
a) SOP defined for the process of keeping medical record file of discharge patient, MLC and Death case b) Staff is aware and follows the process defined in SOP c) See minimum 5 files from medical record (e.g. Surgery, Medicine, MLC, Death, LAMA, etc.) and check the chronological account of patient care. i) Availability of checklist for maintainaing records in chronological order d) Medical record audit with corrective and preventive action.	Record review & Staff interview	100% compliance of all five evidences.	10	a) All the files in MRD section are arranged in cronological order. LAMA Death and MLC files are kept seperately. b) Checklist for maintaining records in cronological order in patient file. c) Summary of medical record audit.
		if any of the five evidence is found to be non-compliant.	5	
		Non-compliance of all five evidences.	0	

20. Up to date and chronological details of the patient care should be available in the medical record including discharge summary

MRD CHECKLIST

GSI -IPD-FF-32

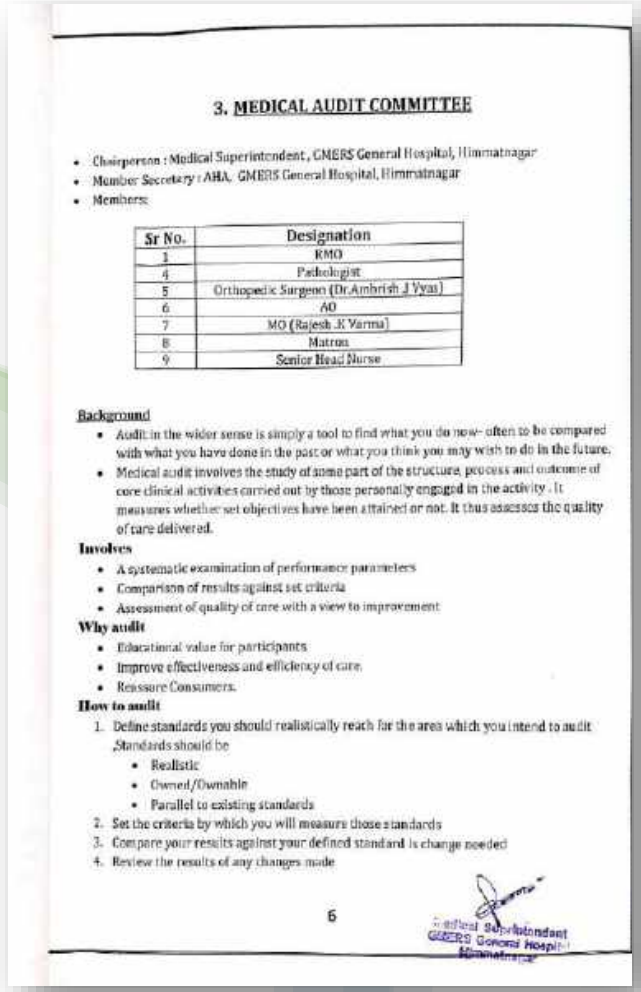
Nu of IPD Book and its booklet no _____.

SR No	Form NO	Indoor Booklet	Mark (Yes-Y or No) If yes Complete-C / Incomplete-IC		Mark No-N- if forms not present	Page No
1	1	Information Form				
2	2	Registration Form				
3	3A	General Consent Form (English)				
4	3B	General Consent Form(Gujarati)				
5	4	Initial assessment by Nurse				
6	5	Initial assessment by Doctor				
7	6	Initial assessment by physiotherapist & occupation therapist				
8	7	Initial assessment by p&o				
9	8	Initial assessment by dietician				
10	9	MSW assessment form				
11	10	Initial assessment by clinical psychologist				
12	11	Initial assessment by vocational				
13	12	Continuous sheet Reassessment by nurse				
14	13	Reassessment by Doctor				
15	14	Reassessment by Physiotherapist & occupational therapist				
16	15	physiotherapy Treatment sheet				
17	16	Occupational therapy Treatment Sheet				
18	17	Pre anaesthesia assessment moderate sedation form				
19	18A	Anaesthesia consent form (English)				
20	18B	Anaesthesia consent form (Gujarati)				
21	19	Pre induction Assessment by surgeon & anaesthesia				
22	20	Monitoring of patients during Anaesthesia				
23	21	Anaesthesia notes				
24	22	Recovery criteria				
25	23	Anaesthesia note for epidural injection				
26	24A	Consent for surgical, invasive, diagnostic, medical, intervention procedure				
27	24B	Consent for surgical, invasive, diagnostic, medical, intervention procedure				
28	25	Surgical check list				
29	26	operation note by surgeon				
30	27	Appliance Prescription P & O				
31	28	Input out put chart				
32	29	Nursing Medication Chart				
33	30	discharge card				
34	31A	Blood and blood products administration/ High risk medication monitoring form				
35	31B	Blood and blood products administration Consent form				
36	32	MRD checklist				

Remarks of MRD:
Signature: **Date:**
Name: **Time:**

Detail of Retrival:
Request By:
Purpose By:
Date Of Issue: **Date Of Received**
Signature of MRD: **Signature of MRO**

20. Up to date and chronological details of the patient care should be available in the medical record including discharge summary



3. MEDICAL AUDIT COMMITTEE

- Chairperson : Medical Superintendent, GMERS General Hospital, Himmatnagar
- Member Secretary : AHA, GMERS General Hospital, Himmatnagar
- Members:

Sr No.	Designation
1	RMO
4	Pathologist
5	Orthopedic Surgeon (Dr.Ambrish J Vyas)
6	AO
7	MO (Rajesh .K Varma)
8	Matron
9	Senior Head Nurse

Background

- Audit in the wider sense is simply a tool to find what you do now- often to be compared with what you have done in the past or what you think you may wish to do in the future.
- Medical audit involves the study of some part of the structure, process and outcome of care clinical activities carried out by those personally engaged in the activity . It measures whether set objectives have been attained or not. It thus assesses the quality of care delivered.

Involves

- A systematic examination of performance parameters
- Comparison of results against set criteria
- Assessment of quality of care with a view to improvement

Why audit

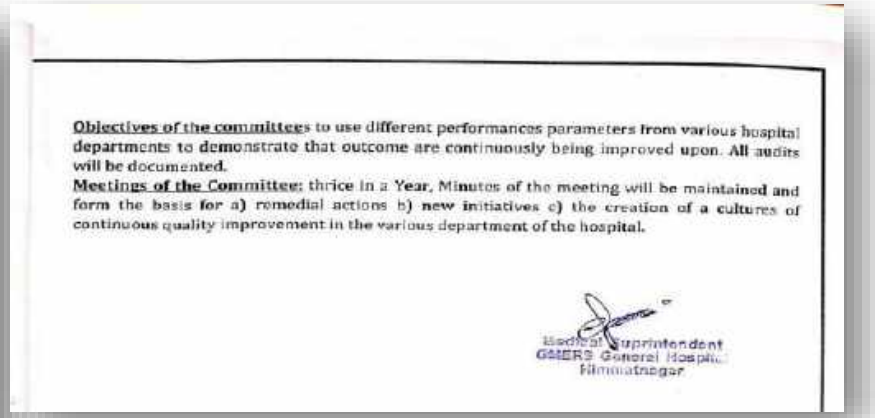
- Educational value for participants
- Improve effectiveness and efficiency of care.
- Reassure Consumers.

How to audit

1. Define standards you should realistically reach for the area which you intend to audit .Standards should be
   - Realistic
   - Owned/Ownable
   - Parallel to existing standards
2. Set the criteria by which you will measure those standards
3. Compare your results against your defined standard is change needed
4. Review the results of any changes made

6

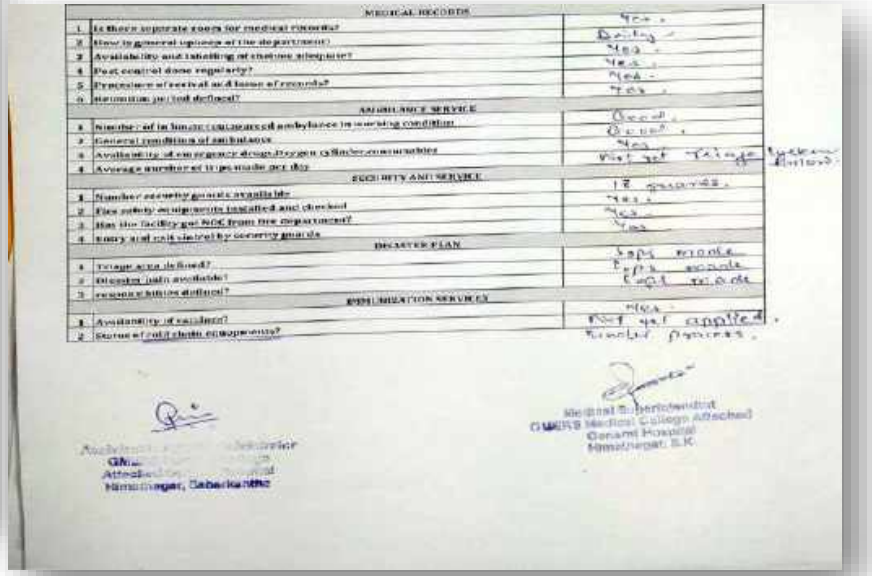
Medical Superintendent
GMERS General Hospital
Himmatnagar



Objectives of the committees to use different performances parameters from various hospital departments to demonstrate that outcome are continuously being improved upon. All audits will be documented.

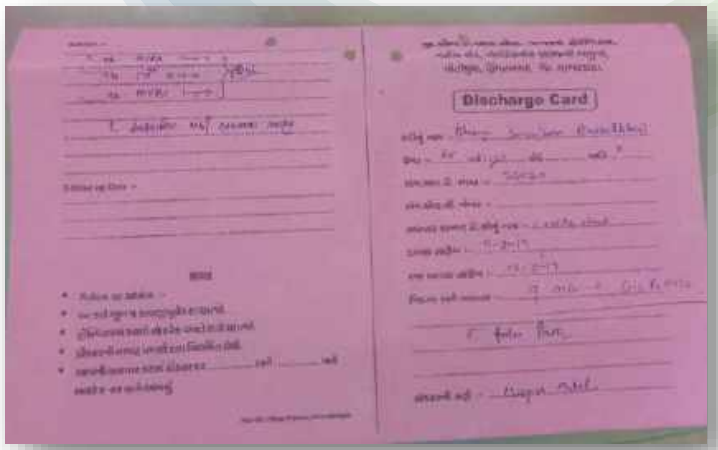
Meetings of the Committee: thrice in a Year, Minutes of the meeting will be maintained and form the basis for a) remedial actions b) new initiatives c) the creation of a cultures of continuous quality improvement in the various department of the hospital.

Medical Superintendent
GMERS General Hospital
Himmatnagar

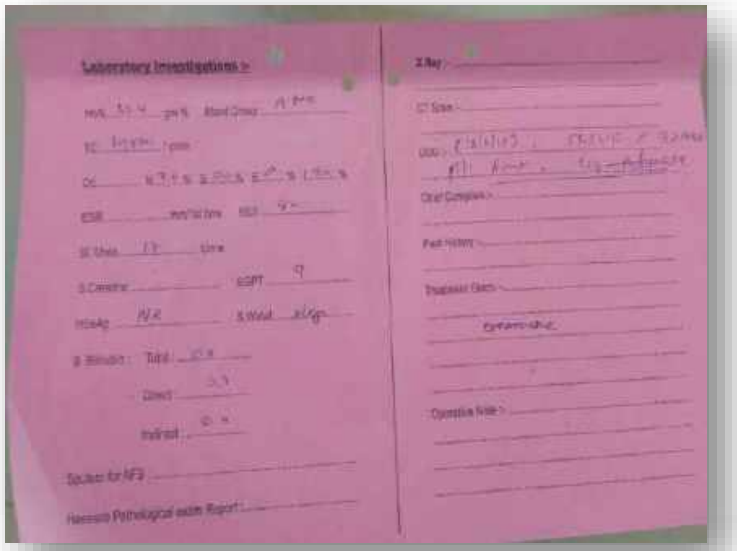


	MEDICAL RECORDS	
1	Is there separate room for medical records?	Yes
2	How is general upkeep of the department?	Daily
3	Availability and labelling of shelves adequate?	Yes
4	Pest control done regularly?	Yes
5	Presence of receival and issue of records?	Yes
6	Retention period defined?	Yes
	AMBULANCE SERVICE	
1	Number of in house ambulances & ambulance in running condition	Second
2	General condition of ambulance	Second
3	Availability of emergency drugs, Oxygen cylinder, consumables	Yes
4	Average number of trips made per day	Visit not taking system
	SECURITY AND SERVICE	
1	Number security guards available	12
2	Fire safety equipments installed and checked	Yes
3	Has the facility got NOC from fire department?	Yes
4	Entry and exit checked by security guards	Yes
	DISASTER PLAN	
1	Triage area defined?	Yes, inside
2	Disaster drill available?	Yes, inside
3	Resource human defined?	Yes, inside
	FIRE/MEDICATION SERVICES	
1	Availability of ambulance?	Yes
2	Status of cylinder & equipments?	Not yet supplied. Under process.

Medical Superintendent
GMERS Medical College Attached
General Hospital
Himmatnagar, S.K.



Discharge Card



Laboratory Investigations :-

GUIDELINE FOR HOW TO ACHIEVE BRONZE QUALITY CERTIFICATE IN AB PM-JAY EMPANELED HOSPITALS

ELIGIBILITY

Hospitals that are empanelled with AB PM-JAY scheme and which do not possess any accreditation or certification from any other recognized certification body (NQAS, NABH & JCI) can apply for this certificate.

STEPS FOR CERTIFICATION PROCESS

Hospitals that are empanelled with AB PM-JAY scheme and which do not possess any accreditation or certification from any other recognized certification body (NQAS, NABH & JCI) can apply for this certificate.

STEPS FOR CERTIFICATION PROCESS

1. Login on HEM Portal
2. Click “Apply for certificate”
3. Fill the “Registration Form”
4. Fill-up the “Application Form”
5. Submit and pay the nominal Application Fee
6. Desktop Assessment
7. Reply to the desktop Non-Compliances (if any)
8. On-site Assessment
9. Reply to on-site Non-Compliances (if any)
10. Review of the application
11. Issue of the Digital Quality Certificate

BENEFITS OF THE BRONZE QUALITY CERTIFICATION

Additional Support to Create Quality Culture: Bronze Quality Certification will help hospitals to acquire recognized quality standards. The AB PM-JAY Bronze Quality Certification are inclusive and captures all the aspects of patient care and safety. The standards are also universally applicable as they remain same for all kinds of hospitals irrespective of their ownership and the scope of services provided.

Nationwide Recognized: The list of certified hospitals will be published online in a public domain that would help hospitals obtain a recognition among its peers.

Increased Credibility of Healthcare Provider: This certificate will establish trust amongst the beneficiaries for quality treatment in certified hospital.

Patient Safety and Increased Care for Patient: The certification focuses on quality protocols and patient safety which will help hospital in increasing their service quality with time.

THE SUMMARY OF THE CHAPTER OF BRONZE QUALITY STANDARDS ARE AS FOLLOWS

Chapters	No. of Standards	No. of Means of Verification
Chapter 1 : Key Inputs	10	40
Chapter 2 : Clinical Services	11	41
Chapter 3 : Support Services	10	40
Chapter 4 : Patient Care	11	41
Chapter 5 : Health Outcome	11	20
Total	**53**	**182**

CHAPTER 1:
KEY INPUTS (OVERVIEW)

It is essential that a hospital should have a framework to support ongoing quality improvements and patient wellbeing. This section of key inputs broadly covers the structural part of the hospital. The certification criteria given in this chapter take into consideration the facility infrastructure, human resources requirements and training, appropriate space in hospital for patient movement, proper lighting facility in the hospital, medical instruments and equipment requirements and maintenance, fire-fighting equipment and basic amenities like drinking water, waiting area, canteen, suitable toilets for men and women etc. However, the focus of the standards has been in ensuring compliance to minimum level of inputs, which are required for ensuring delivery of committed level of the services.

Chapter 1: Key Inputs

KI 1	Physical facility of the building and hospital environment shall be developed and maintained for the safety of Patients, visitors, and staff
KI 2	Hospital should have adequate space for ambulance and patient movement
KI 3	Access to the hospital should be provided without any physical barrier and friendly to people with disabilities
KI 4	The indoor and outdoor areas of the facility should be well-lit
KI 5	Basic amenities should be provided for all patients, hospital staff and visitors
KI 6	The hospital should ensure that all medical staff is adequately credentialed as per the statutory norms
KI 7	The facility has functional equipment & instruments as per scope of services
KI 8	Hospital should have fire detection and fire-fighting equipment installed as per fire safety norms along with staff training
KI 9	Staff involved in direct patient care shall be trained in Cardio Pulmonary Resuscitation (CPR) and Basic Life Support (BLS) along with a display of the same in all critical care areas
KI 10	Annual Training Plan should be prepared for all staff covering all training needs.

KI 1 - PHYSICAL FACILITY OF THE BUILDING AND HOSPITAL ENVIRONMENT SHALL BE DEVELOPED AND MAINTAINED FOR THE SAFETY OF PATIENTS, VISITORS, AND STAFF

Interpretation – The standard guide the provision of safe and secure environment for patients, visitors and staff. To ensure this, the hospital premises must have basic essentialities of infrastructure and shall have annual maintenance plan for infrastructure development. This includes appearance of the facility, cleaning processes, infrastructure maintenance and control of stray animals at the facility.

KI 1 - PHYSICAL FACILITY OF THE BUILDING AND HOSPITAL ENVIRONMENT SHALL BE DEVELOPED AND MAINTAINED FOR THE SAFETY OF PATIENTS, VISITORS, AND STAFF

(Means of verification)

1. There should be no cattle or stray animals within the premises
2. The facility should have a guard available 24*7
3. The hospital boundary should be intact and not broken
4. Hospital (Building(s)) should be well maintained i.e. walls are well plastered (no cracks or seepage) and painted
5. Windows and doors are intact and have grill/ wire meshwork
6. The facility should have an annual maintenance plan for its infrastructure
7. Non-structural components such as cupboards, cabinets and other heavy equipment or hanging objects should be properly fastened and secured
8. Hospital building should not have wire hanging loosely
9. There should be no stains, grease, cobwebs and bird nest on walls and roofs of the hospital
10. There should be a closed drainage system with no direct contact with the environment

THERE SHOULD BE NO CATTLE OR STRAY ANIMALS WITHIN THE PREMISES

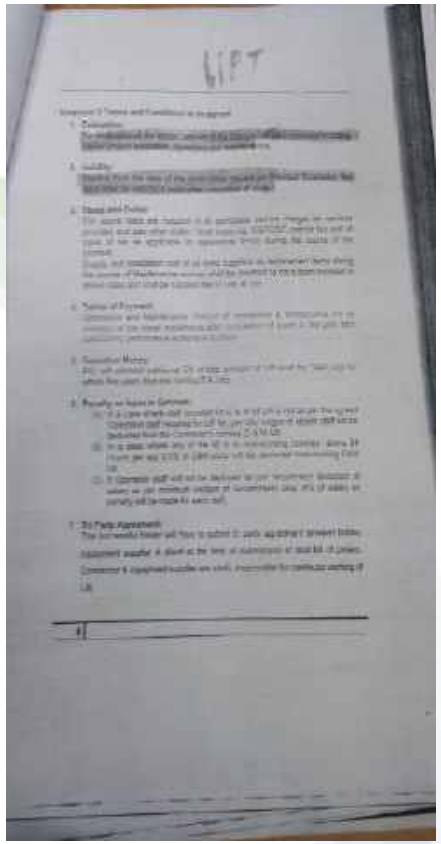
THE FACILITY SHOULD HAVE A GUARD AVAILABLE 24*7

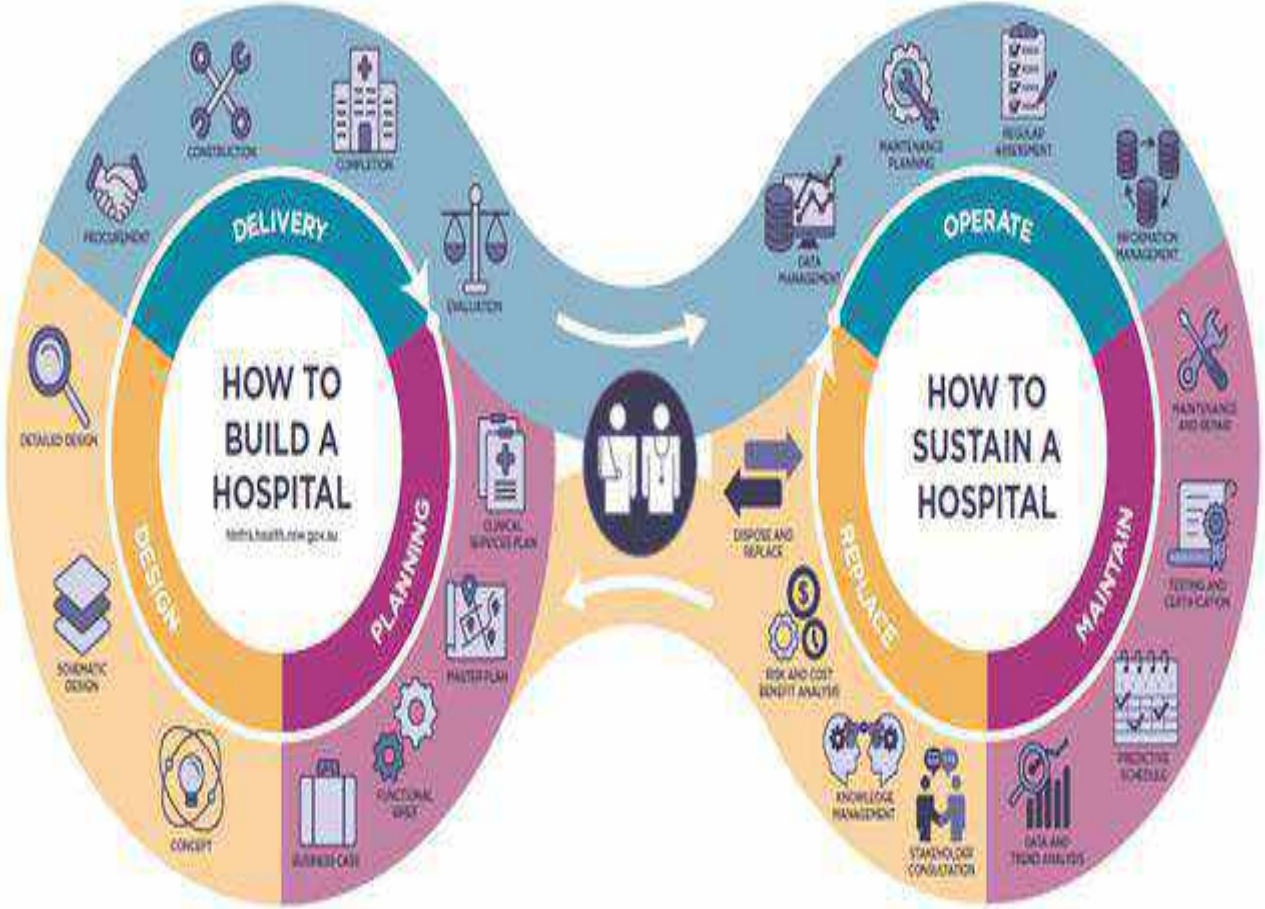
THE HOSPITAL BOUNDARY SHOULD BE INTACT AND NOT BROKEN

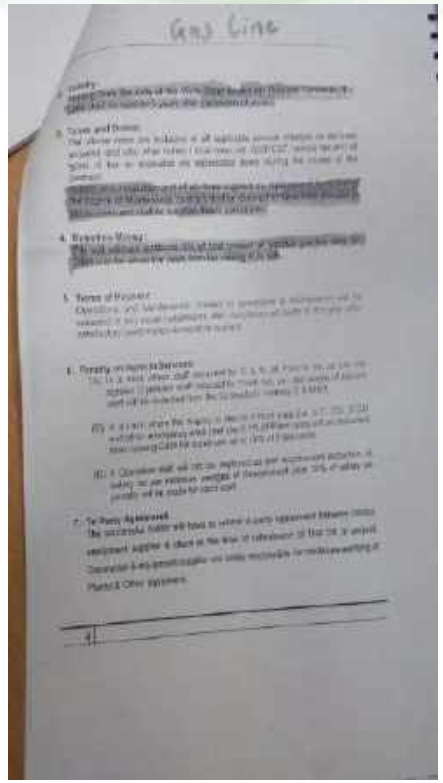
HOSPITAL (BUILDING(S)) SHOULD BE WELL MAINTAINED
I.E. WALLS ARE WELL PLASTERED (NO CRACKS OR SEEPAGE) AND PAINTED

WINDOWS AND DOORS ARE INTACT AND HAVE GRILL/ WIRE MESHWORK

THE FACILITY SHOULD HAVE AN ANNUAL MAINTENANCE PLAN FOR ITS INFRASTRUCTURE







NON-STRUCTURAL COMPONENTS SUCH AS CUPBOARDS, CABINETS AND OTHER HEAVY EQUIPMENT OR HANGING OBJECTS SHOULD BE PROPERLY FASTENED AND SECURED

HOSPITAL BUILDING SHOULD NOT HAVE WIRE HANGING LOOSELY

THERE SHOULD BE NO STAINS, GREASE, COBWEBS AND BIRD NEST ON WALLS AND ROOFS OF THE HOSPITAL

THERE SHOULD BE A CLOSED DRAINAGE SYSTEM WITH NO DIRECT CONTACT WITH THE ENVIRONMENT

KI 2 - HOSPITAL SHOULD HAVE ADEQUATE SPACE FOR AMBULANCE AND PATIENT MOVEMENT

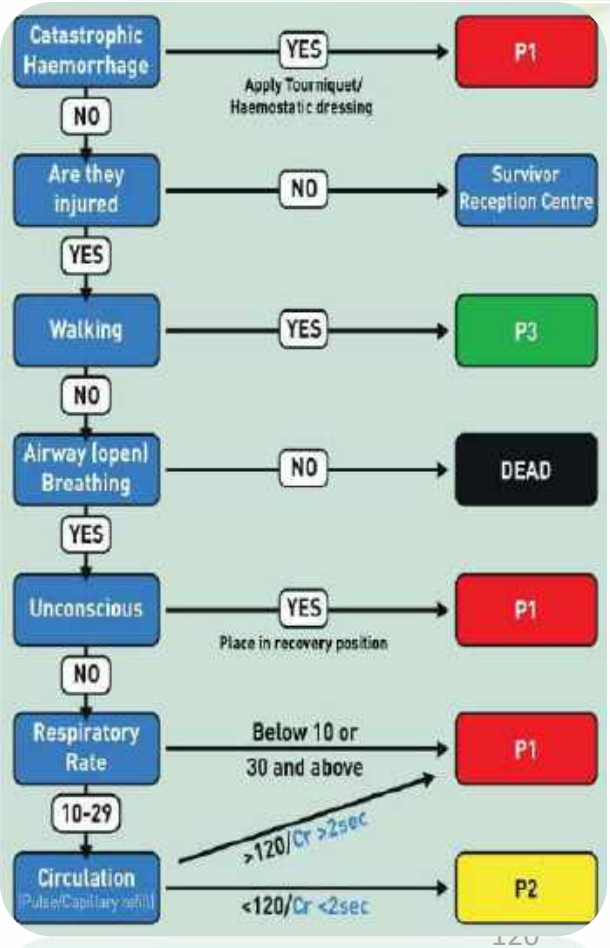
Interpretation – This standard requires that facility should ensure adequate space for ambulance movement and parking. The access to the emergency/ receiving area should be smooth and spacious for the ease of patient movement and safe handling.

Means of verification:

1. Ambulance should have direct access to the emergency/ receiving/ triage area and access road to emergency should be wide enough to streamline the movement of the patient till the emergency/ receiving area
2. No vehicle should be parked on the way or in front of the emergency entrance
3. Dedicated parking area for the ambulance

AMBULANCE SHOULD HAVE DIRECT ACCESS TO THE EMERGENCY/ RECEIVING/ TRIAGE AREA AND ACCESS ROAD TO EMERGENCY SHOULD BE WIDE ENOUGH TO STREAMLINE THE MOVEMENT OF THE PATIENT TILL THE EMERGENCY/ RECEIVING AREA

Triage category	Priority	Color	Conditions
Immediate	1	RED	Chest wounds, shock, open fractures, 2-3 burns
Delayed	2	YELLOW	Stable abdominal wound, eye and CNS injuries
Minimal	3	GREEN	Minor burns, minor fractures, minor bleeding
Expectant	4	BLACK	Unresponsive, high spinal cord injury



NO VEHICLE SHOULD BE PARKED ON THE WAY OR IN FRONT OF THE EMERGENCY ENTRANCE

DEDICATED PARKING AREA FOR THE AMBULANCE

KI 3 - ACCESS TO THE HOSPITAL SHOULD BE PROVIDED WITHOUT ANY PHYSICAL BARRIER AND FRIENDLY TO PEOPLE WITH DISABILITIES

Interpretation –Provisions should be available for physically challenged/ vulnerable person to make the entrance accessible with ramps and grab bars. The facility should have facility of wheelchair, stretcher and trolleys with safety belts for immediate support of the patient.

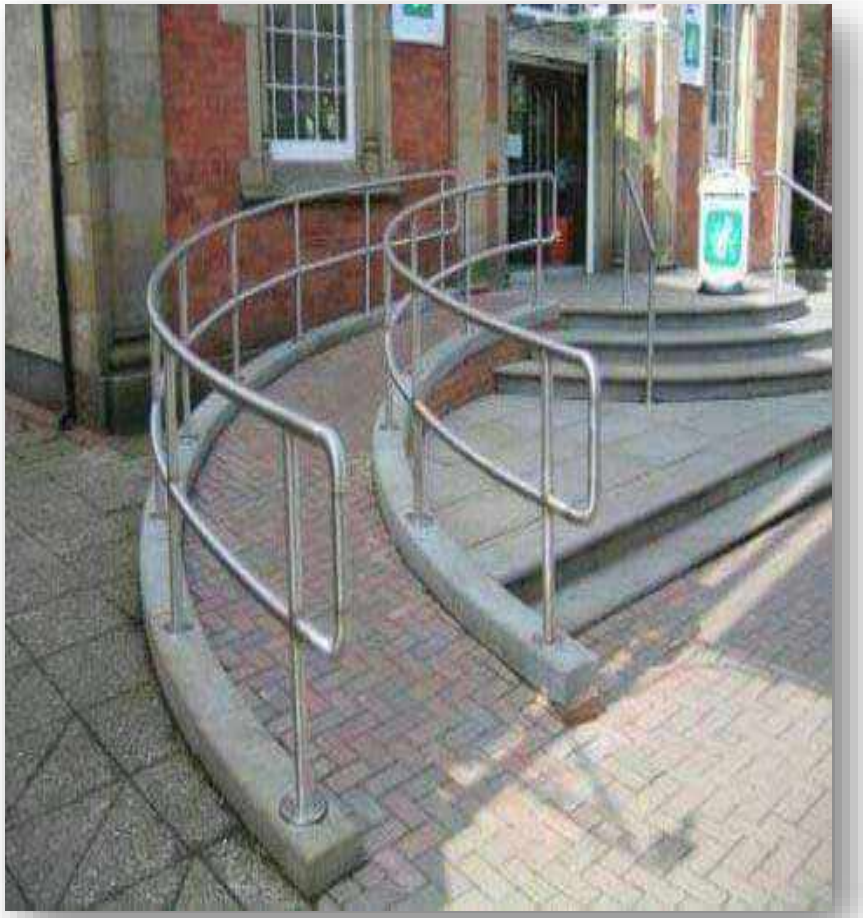
Means of verification:

1. Availability of wheelchair, stretcher for emergency with straps to protect the patient from falling
2. The wheelchair, stretcher and trolleys should be clean, operational and their wheels should be properly aligned.
3. Availability of ramps with railings at the entrance of the facility

AVAILABILITY OF WHEELCHAIR, STRETCHER FOR EMERGENCY WITH STRAPS TO PROTECT THE PATIENT FROM FALLING

THE WHEELCHAIR, STRETCHER AND TROLLEYS SHOULD BE CLEAN, OPERATIONAL AND THEIR WHEELS SHOULD BE PROPERLY ALIGNED

AVAILABILITY OF RAMPS WITH RAILINGS AT THE ENTRANCE OF THE FACILITY



KI 4 - THE INDOOR AND OUTDOOR AREAS OF THE FACILITY SHOULD BE WELL-LIT

Interpretation – In order to provide safe, secure and comfortable environment to patients and staff the hospital should have provision of comfortable environment in terms of illumination either through electric bulbs and tubes at all the places, accompanied by natural source of light. Also, the front, entry and exit areas should also be well lit.

Means of verification:

1. There should be proper lighting in the indoor areas through natural light and by using sufficient electric bulbs
2. The facility's front, entry gate and access road are well illuminated

THERE SHOULD BE PROPER LIGHTING IN THE INDOOR AREAS THROUGH NATURAL LIGHT AND BY USING SUFFICIENT ELECTRIC BULBS

THE FACILITY'S FRONT, ENTRY GATE AND ACCESS ROAD ARE WELL ILLUMINATED

KI 5 - BASIC AMENITIES SHOULD BE PROVIDED FOR ALL PATIENTS, HOSPITAL STAFF AND VISITORS

Interpretation – The hospital must have an appropriate waiting area with seating arrangement, drinking water, clean toilets sensitive to gender and physically challenged visitors and staff personnel should be present within the premises.

Means of verification:

1. Availability of seating arrangement in the waiting area(s) within the hospital premises for attendants
2. Availability of potable drinking water on each floor (functional RO/filters)
3. There should be a provision of canteen facility for visitors & staff inside the premises
4. Every floor should have at least one toilet for hospital staff and visitors
5. Availability of clean and functional toilets with no foul smell in and around the toilet along with functional water taps
6. The toilets floor should be dry and no drain should be overflowing
7. Availability of disabled friendly toilet with bars or railings and is accessible through a ramp
8. Availability of 24*7 working telephone help line in hospital for effective communication

AVAILABILITY OF SEATING ARRANGEMENT IN THE WAITING AREA(S) WITHIN THE HOSPITAL PREMISES FOR ATTENDANTS

AVAILABILITY OF POTABLE DRINKING WATER ON EACH FLOOR (FUNCTIONAL RO/FILTERS)

THERE SHOULD BE A PROVISION OF CANTEEN FACILITY FOR VISITORS & STAFF INSIDE THE PREMISES

EVERY FLOOR SHOULD HAVE AT LEAST ONE TOILET FOR HOSPITAL STAFF AND VISITORS

AVAILABILITY OF CLEAN AND FUNCTIONAL TOILETS WITH NO FOUL SMELL IN AND AROUND THE TOILET ALONG WITH FUNCTIONAL WATER TAPS

TOILET CLEANING CHECKLIST

Date	HANDWASH						URINALS		TOILET				GENERAL			CLEANING FREQ.					CHECKED BY
	Water Availability	Liquid Soap	Mirror	Taps	Wash Basin	Hand Dryers	Urinals	Urinal Cakes	Commode	Toilet Roll	Waste Bin	Toilet Freshner	Wall	Floor	Waste Bin	Mention Cleaning Time					HOUSE KEEPING SUPERVISOR
1-Jul-14																					
2-Jul-14																					
3-Jul-14																					
4-Jul-14																					
5-Jul-14																					
6-Jul-14																					
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31-Jul-14																					

THE TOILETS FLOOR SHOULD BE DRY AND NO DRAIN SHOULD BE OVERFLOWING

AVAILABILITY OF DISABLED FRIENDLY TOILET WITH BARS OR RAILINGS AND IS ACCESSIBLE THROUGH A RAMP

AVAILABILITY OF 24*7 WORKING TELEPHONE HELP LINE IN HOSPITAL FOR EFFECTIVE COMMUNICATION

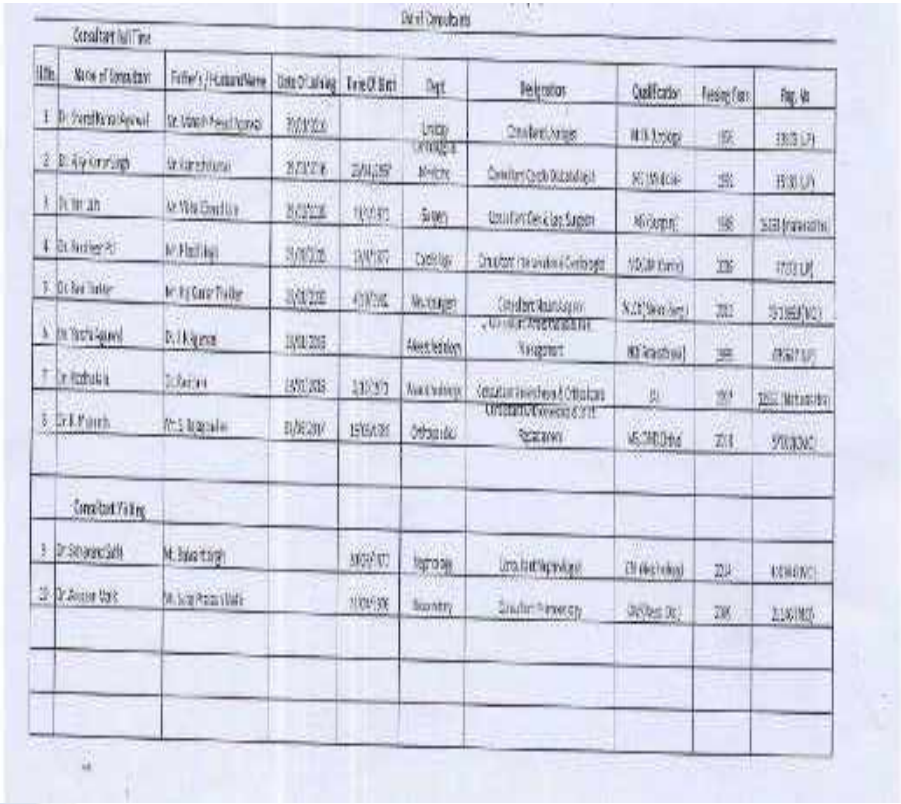
KI 6 - THE HOSPITAL SHOULD ENSURE THAT ALL MEDICAL STAFF IS ADEQUATELY CREDENTIALED AS PER THE STATUTORY NORMS

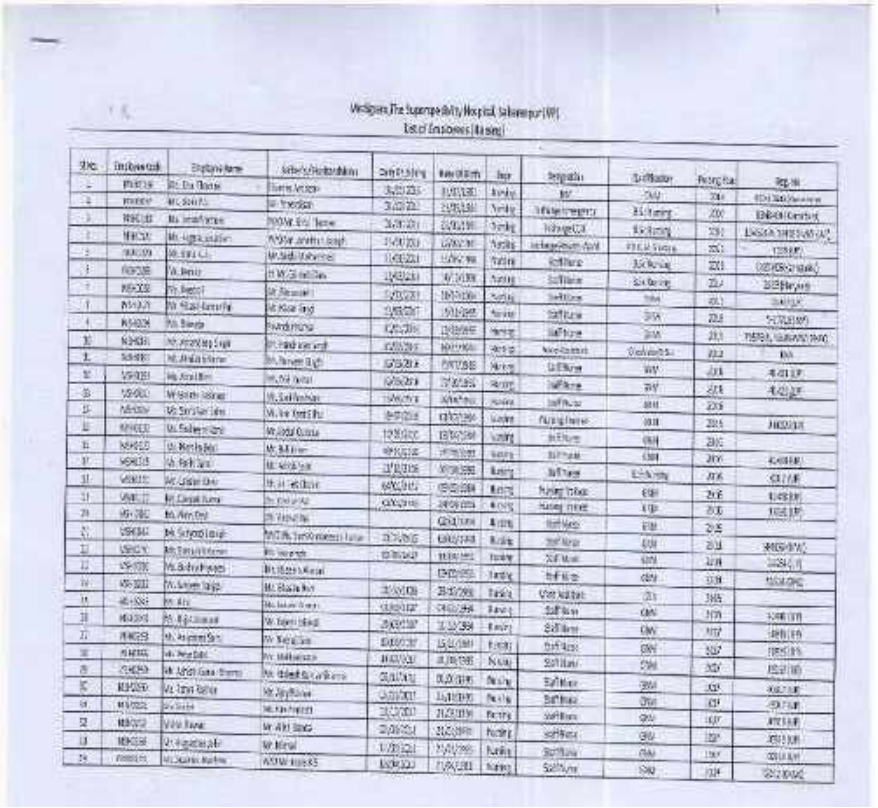
Interpretation – The organization shall ensure that the medical professionals who have required qualification, training, experience and consonance with the law are permitted to provide the services and such information should be appropriately verified. Also, the facility should maintain an adequate number and mix of staff to meet the care, treatment and services needs of patients.

Means of verification:

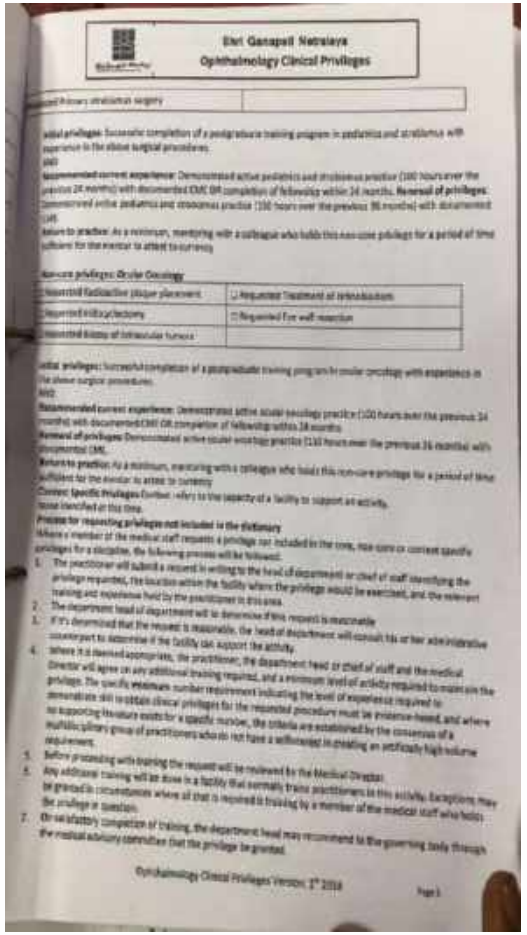
1. Doctor/ Nurse/ Paramedic Staff/ Admin & Support Staff along with the current designation, educational qualification, registration council of name and the associated registration number along with the date of joining and area/working department
2. Organization should plan human resource with adequate number and with mix and credentials of staff as per the statutory norms
3. Hospital has dedicated staff (3 members) for AB PM-JAY

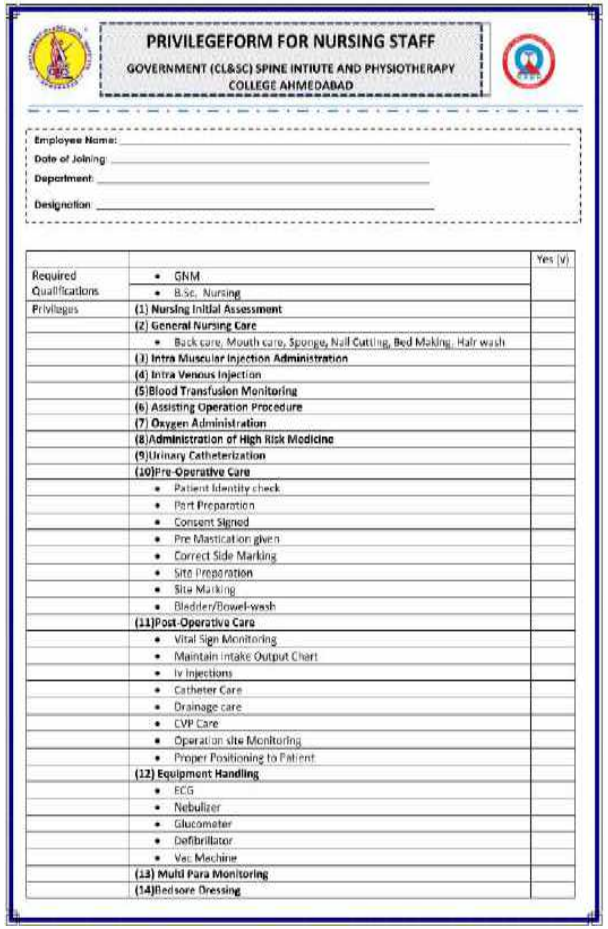
DOCTOR/ NURSE/ PARAMEDIC STAFF/ ADMIN & SUPPORT STAFF ALONG WITH THE CURRENT DESIGNATION, EDUCATIONAL QUALIFICATION, REGISTRATION COUNCIL OF NAME AND THE ASSOCIATED REGISTRATION NUMBER ALONG WITH THE DATE OF JOINING AND AREA/WORKING DEPARTMENT





ORGANIZATION SHOULD PLAN HUMAN RESOURCE WITH ADEQUATE NUMBER AND WITH MIX AND CREDENTIALS OF STAFF AS PER THE STATUTORY NORMS


Shri Ganapati Netralaya
Ophthalmology Clinical Privileges


PRIVILEGEFORM FOR NURSING STAFF
GOVERNMENT (CL&SC) SPINE INTIUTE AND PHYSIOTHERAPY COLLEGE AHMEDABAD

Employee Name:
Date of Joining:
Department:
Designation:

		Yes (V)
Required Qualifications	• GNM	
	• B.Sc. Nursing	
Privileges	(1) Nursing Initial Assessment	
	(2) General Nursing Care	
	• Back care, Mouth care, Sponge, Nail Cutting, Bed Making, Hair wash	
	(3) Intra Muscular Injection Administration	
	(4) Intra Venous Injection	
	(5)Blood Transfusion Monitoring	
	(6) Assisting Operation Procedure	
	(7) Oxygen Administration	
	(8)Administration of High Risk Medicine	
	(9)Urinary Catheterization	
	(10)Pre-Operative Care	
	• Patient Identity check	
	• Part Preparation	
	• Consent Signed	
	• Pre Mastication given	
	• Correct Side Marking	
	• Site Preparation	
	• Site Marking	
	• Bladder/Bowel-wash	
	(11)Post-Operative Care	
	• Vital Sign Monitoring	
	• Maintain Intake Output Chart	
	• Iv Injections	
	• Catheter Care	
	• Drainage care	
	• CVP Care	
	• Operation site Monitoring	
	• Proper Positioning to Patient	
	(12) Equipment Handling	
	• ECG	
	• Nebulizer	
	• Glucometer	
	• Defibrillator	
	• Vac Machine	
	(13) Multi Para Monitoring	
	(14)Bedsore Dressing	

HOSPITAL HAS DEDICATED STAFF FOR AB PM-JAY

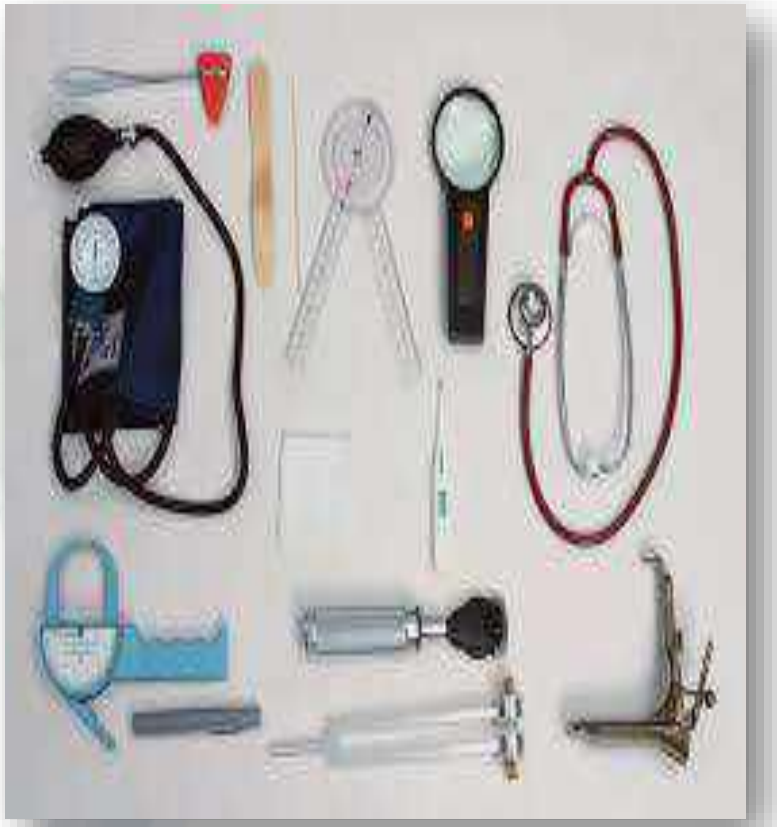
KI 7 - THE FACILITY HAS FUNCTIONAL EQUIPMENT AND INSTRUMENTS AS PER SCOPE OF SERVICES

Interpretation – The hospital must have all the equipment and instruments according to the scope of services they are offering. Basic functional diagnostic equipment should also be ready available.

Means of verification:

1. Availability for examination and monitoring of patients - BP apparatus, Multipara meter Torch, hammer, an instrument to measure height, weight and Blood Pressure (BP) to conduct a general examination

AVAILABILITY FOR EXAMINATION AND MONITORING OF PATIENTS - BP APPARATUS, MULTIPARA METER TORCH, HAMMER, AN INSTRUMENT TO MEASURE HEIGHT, WEIGHT AND BLOOD PRESSURE (BP) TO CONDUCT A GENERAL EXAMINATION



KI 8 - HOSPITAL SHOULD HAVE FIRE DETECTION AND FIRE-FIGHTING EQUIPMENT INSTALLED AS PER FIRE SAFETY NORMS ALONG WITH STAFF TRAINING

Interpretation – The facility should have plan and provisions for early detection, abatement and containment of fire emergencies such as documented safe fire exit plan and trained staff. The periodic training shall include information, demonstration to use fire extinguisher and mock drills.

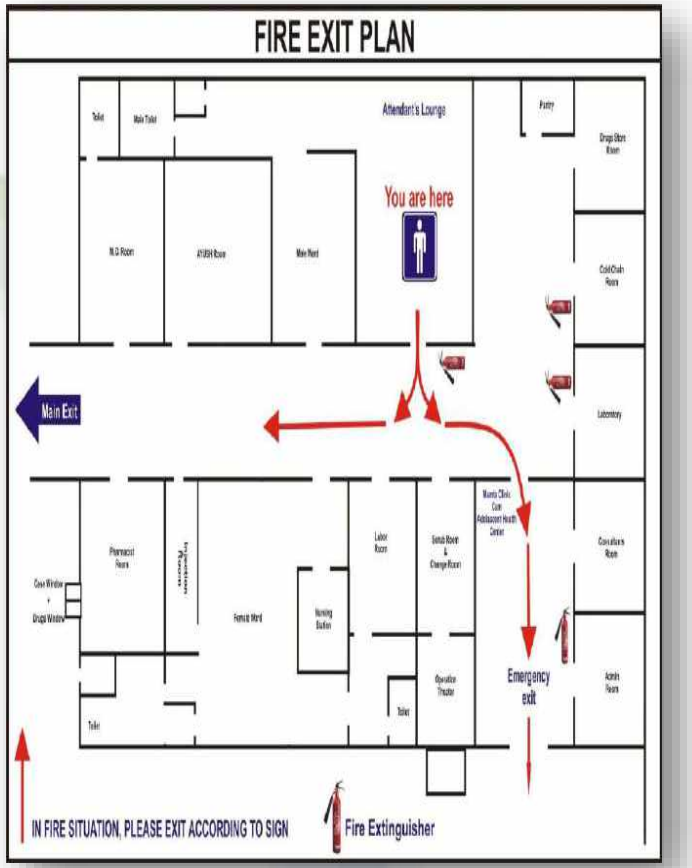
Means of verification:

1. Check if fire extinguisher, fire/smoke detectors are installed in patient care areas with fire-panel
2. Check for date of expiry on fire extinguisher which should be the beyond current date
3. The organization has a documented safe exit plan in case of fire and non-fire emergencies
4. Periodic training with mock drill is provided for using fire extinguishers

CHECK IF FIRE EXTINGUISHER, FIRE/SMOKE DETECTORS ARE INSTALLED IN PATIENT CARE AREAS WITH FIRE-PANEL

CHECK FOR DATE OF EXPIRY ON FIRE EXTINGUISHER WHICH SHOULD BE THE BEYOND CURRENT DATE

THE ORGANIZATION HAS A DOCUMENTED SAFE EXIT PLAN IN CASE OF FIRE AND NON-FIRE EMERGENCIES



PERIODIC TRAINING WITH MOCK DRILL IS PROVIDED FOR USING FIRE EXTINGUISHERS

KI 9 - STAFF INVOLVED IN DIRECT PATIENT CARE SHALL BE TRAINED IN CARDIO PULMONARY RESUSCITATION (CPR) AND BASIC LIFE SUPPORT (BLS) ALONG WITH A DISPLAY OF THE SAME IN ALL CRITICAL CARE AREAS

Interpretation – The organization shall provide regular training to the staff providing direct patient care. If the facility has a CPR team (e.g. code blue team) it shall ensure that it is trained in advanced cardiopulmonary resuscitation (adult, pediatric and neonatal) and is present in all shifts. All doctors and nurses working in ICU/ HDU should undergo appropriate training and display the CPR algorithm at all the critical areas.

Means of verification:

1. Training Records for Basic Life Support (BLS)
2. There should be a code blue protocol in the organization
3. Check the display of CPR algorithm in or near ICU, Clinical area and Emergency areas.
4. Check the records for CPR events & CPR Mock drill along with the corrective & Preventive measures taken

TRAINING RECORDS FOR BASIC LIFE SUPPORT (BLS)

American Heart Association

GUIDELINES 2015 CPR & ECC

Certificate

YOUR NAME

has successfully completed

HeartCode® BLS Online Portion

Hands-on skills practice and testing, either conducted by an authorized AHA BLS Instructor or using a voice-assisted manikin system, is required to receive a Basic Life Support Provider course completion card.

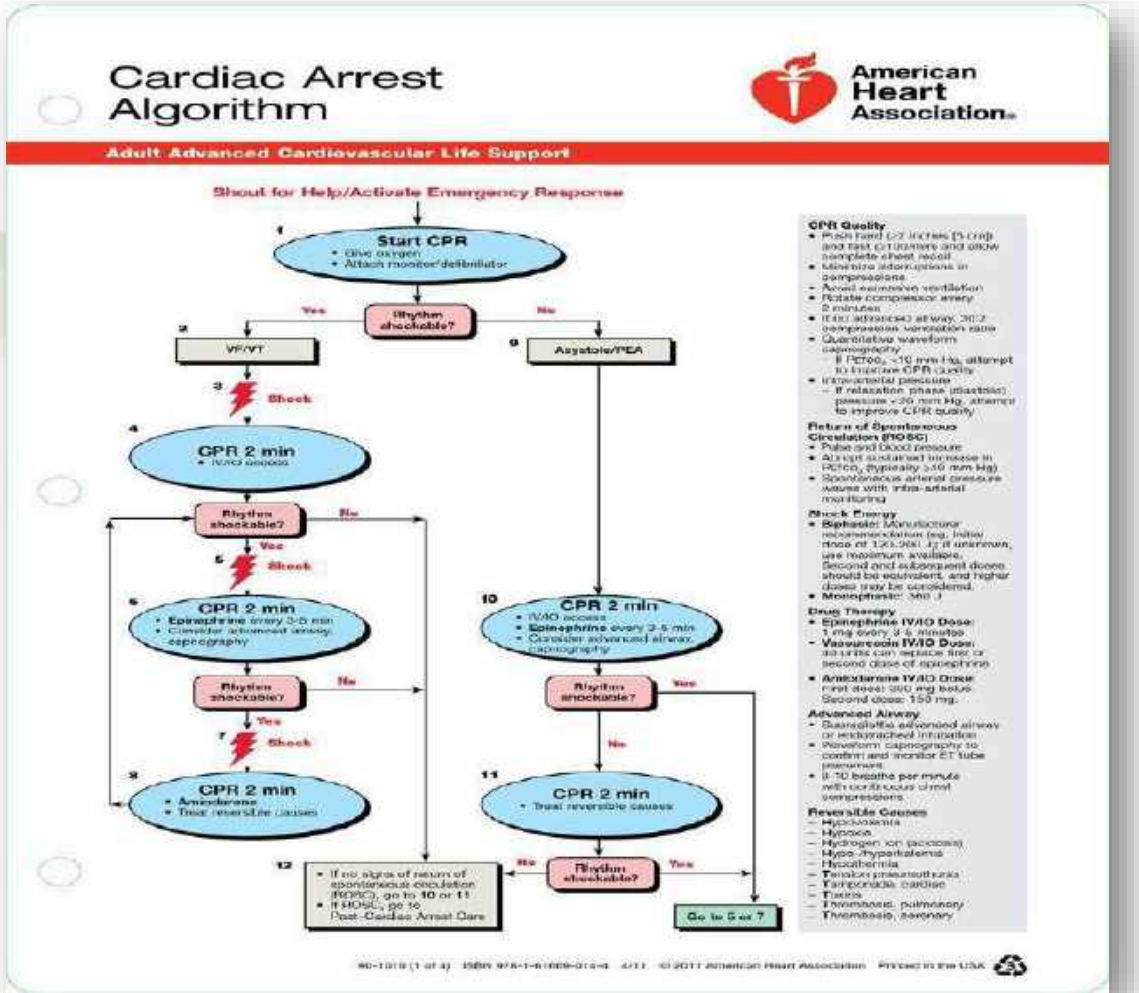
For greater success, it is recommended the hands-on skills session be conducted shortly after completing the online portion. Please take this certificate with you to your hands-on skills session.

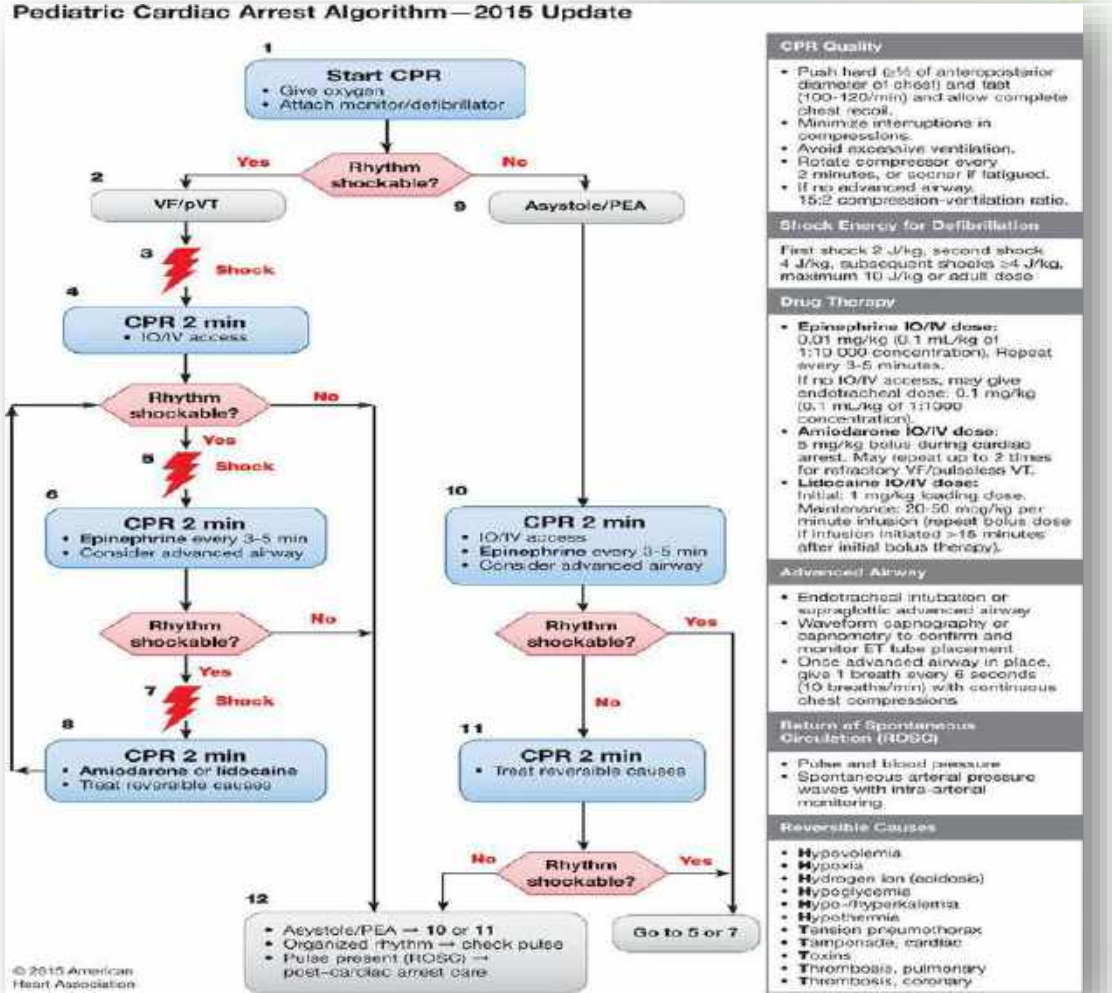
This certificate does not constitute successful completion of the full Basic Life Support Provider Course.

SAMPLE0666ABC — Certificate Number

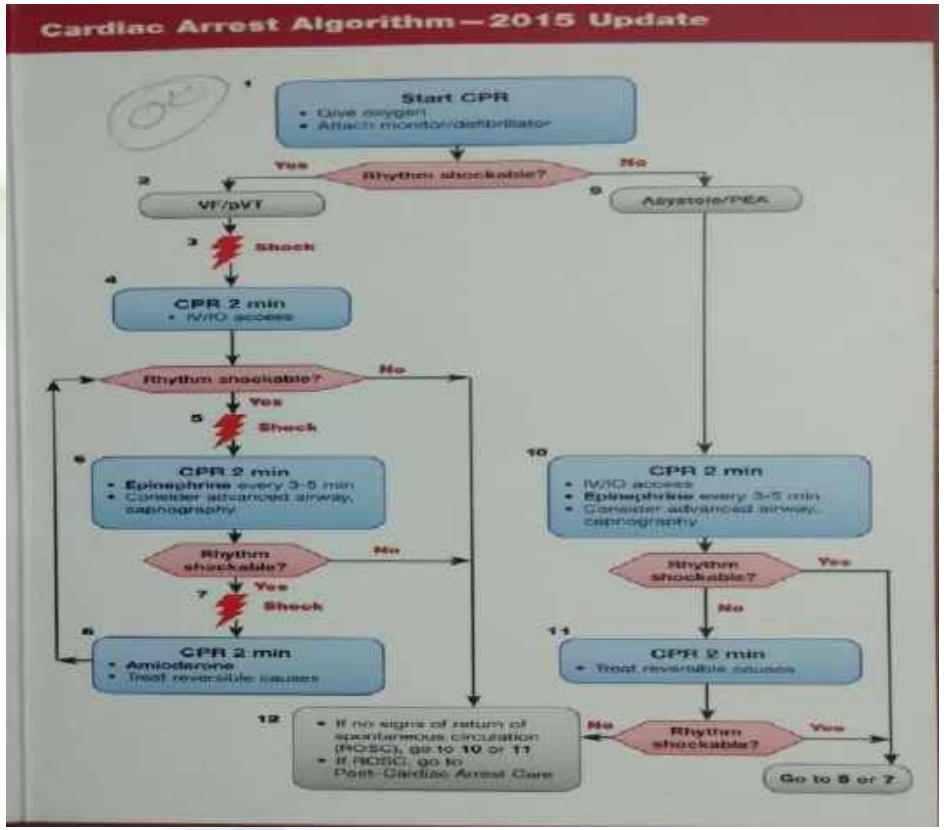
September 20, 2016 — Date Completed

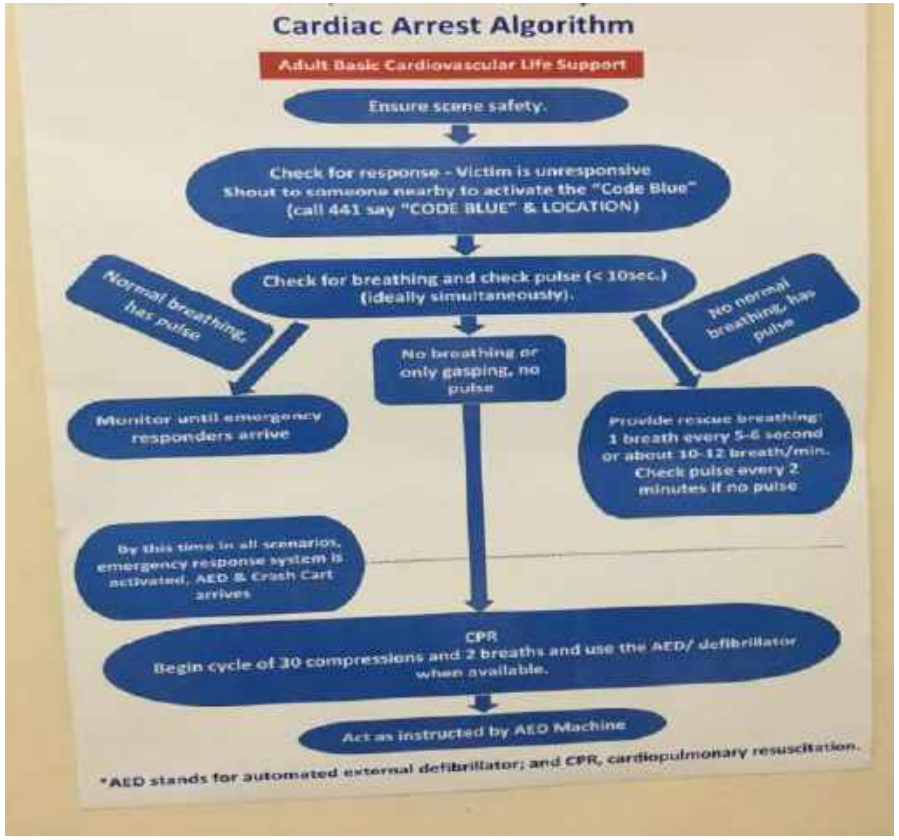
THERE SHOULD BE A CODE BLUE PROTOCOL IN THE ORGANIZATION



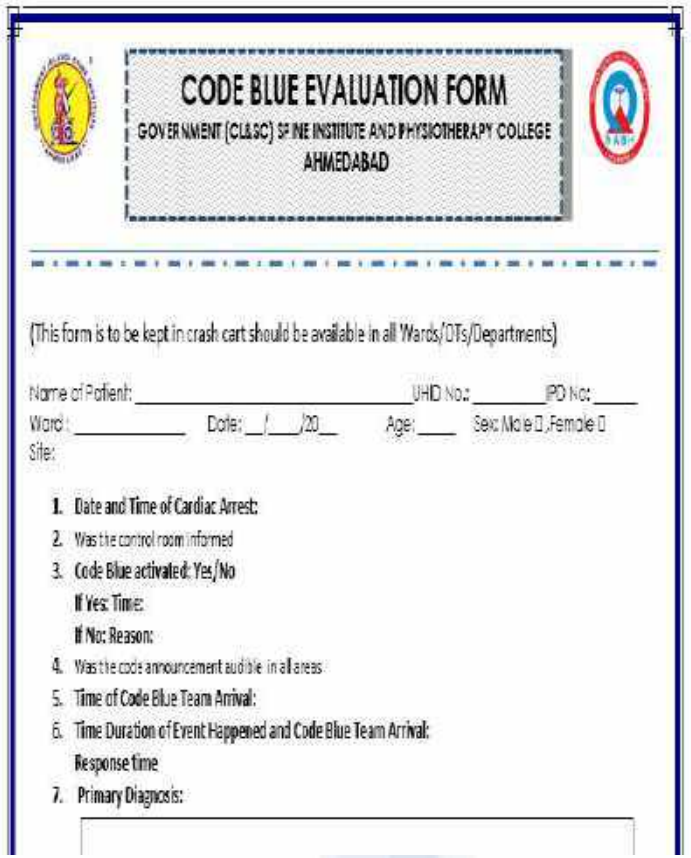


CHECK THE DISPLAY OF CPR ALGORITHM IN OR NEAR ICU, CLINICAL AREA AND EMERGENCY AREAS





CHECK THE RECORDS FOR CPR EVENTS & CPR MOCK DRILL ALONG WITH THE CORRECTIVE & PREVENTIVE MEASURES TAKE



CODE BLUE EVALUATION FORM

GOVERNMENT (CL&SC) SPINE INSTITUTE AND PHYSIOTHERAPY COLLEGE AHMEDABAD

(This form is to be kept in crash cart should be available in all Wards/OTs/Departments)

Name of Patient: _____ UHID No.: _____ IPD No: _____

Ward: _____ Date: __/___/20__ Age: ____ Sex: Male ☐, Female ☐

Site:

1. Date and Time of Cardiac Arrest:
2. Was the control room informed
3. Code Blue activated: Yes/No

   If Yes: Time:

   If No: Reason:
4. Was the code announcement audible in all areas
5. Time of Code Blue Team Arrival:
6. Time Duration of Event Happened and Code Blue Team Arrival:

   Response time
7. Primary Diagnosis:

KI 10 - ANNUAL TRAINING PLAN SHOULD BE PREPARED FOR ALL STAFF COVERING ALL TRAINING NEEDS

Interpretation – The hospital should document plan and prepare a training calendar to ensure staff is able to identify the patient's rights and responsibilities, potential hazards, maintain required quality and take appropriate actions during any disaster.

Means of verification:

1. Facility prepares training calendar as per training need assessment, training feedback records - Training on Disaster Management, Patient safety and rights, facility level Quality Assurance.
2. AB PM-JAY specific training (e.g. BIS, TMS, HEM & Support Portal, etc) to all concerned staff.

FACILITY PREPARES TRAINING CALENDAR AS PER TRAINING NEED ASSESSMENT, TRAINING FEEDBACK RECORDS - TRAINING ON DISASTER MANAGEMENT, PATIENT SAFETY AND RIGHTS, FACILITY LEVEL QUALITY ASSURANCE

AB PM-JAY SPECIFIC TRAINING (E.G. BIS, TMS, HEM & SUPPORT PORTAL, ETC) TO ALL CONCERNED STAFF

CHAPTER 2: CLINICAL SERVICES (OVERVIEW)

The definitive motive of a hospital is to provide clinical care. Therefore, clinical services are the most basic and significant in hospitals. These are the processes that determine the outcome of services and quality of care. These standards include processes such as consultation, clinical assessment, continuity of care, nursing care, identification of high risk and vulnerable patients, prescription practices, safe drug administration, blood bank requirement, antibiotic policy, maintenance of clinical records etc. These standards are based on the technical guidelines published by the Government of India (GoI) on individual programs and processes. It may be difficult to assess clinical processes; as direct observation of clinical procedure may not always be possible at the time of certification assessment. Therefore, assessment of these standards would largely depend upon a review of the clinical records and documents as well.

CHAPTER 2: CLINICAL SERVICES

CS 1	Patients privacy should be maintained in Out Patient Department (OPD) and In-Patient Department (IPD)
CS 2	The lab diagnostic services, whether in house or outsourced, should be as per the scope of services
CS 3	Blood bank services if available shall be as per the statutory/regulatory norms.
CS 4	The hospital should adhere to the radiation safety precautions as per the regulatory requirements
CS 5	Intensive Care unit (ICU) services should be available as per the scope of services along with the required infrastructure and manpower
CS 6	OT complex should be available as per the regulatory requirements
CS 7	Look-alike and sound-alike medicines need to be identified and stored separately to avoid any dispensing and administration errors.
CS 8	Policies and procedures for identification, safe dispensing and administration of all high-risk medicines should be documented and implemented
CS 9	The facility has defined and established antibiotic policy
CS 10	Pre-operative, Intra-operative and post-operative assessment should be done and documented by appropriately qualified staff in standardized format.
CS 11	Pre-Anesthesia assessments, type of Anesthesia and Post Anesthesia status should be documented.

CS 1 - PATIENTS PRIVACY SHOULD BE MAINTAINED IN OUT PATIENT DEPARTMENT (OPD) AND IN-PATIENT DEPARTMENT (IPD)

Interpretation – During all the stages of patient care, be it examination or carrying out a procedure, hospital staff shall ensure that the patient's privacy and dignity is maintained. There should be a provision of screens and curtains to ensure precautions are taken while providing care to patients.

Means of verification:

1. Check availability for privacy screens or curtains in OPD and wards for maintaining visual privacy for the patients

CHECK AVAILABILITY FOR PRIVACY SCREENS OR CURTAINS IN OPD AND WARDS FOR MAINTAINING VISUAL PRIVACY FOR THE PATIENTS

CS 2 - THE LAB DIAGNOSTIC SERVICES, WHETHER IN HOUSE OR OUTSOURCED, SHOULD BE AS PER THE SCOPE OF SERVICES

Interpretation – The facility should have MoU/ Agreement for the out-sourced laboratory services, which incorporates quality assurance and requirements of this standard. Also, a list of services provided by the hospital or outsourced should be available. If the services are outsourced, then the hospital should ensure safe and timely transportation of specimens.

Means of verification:

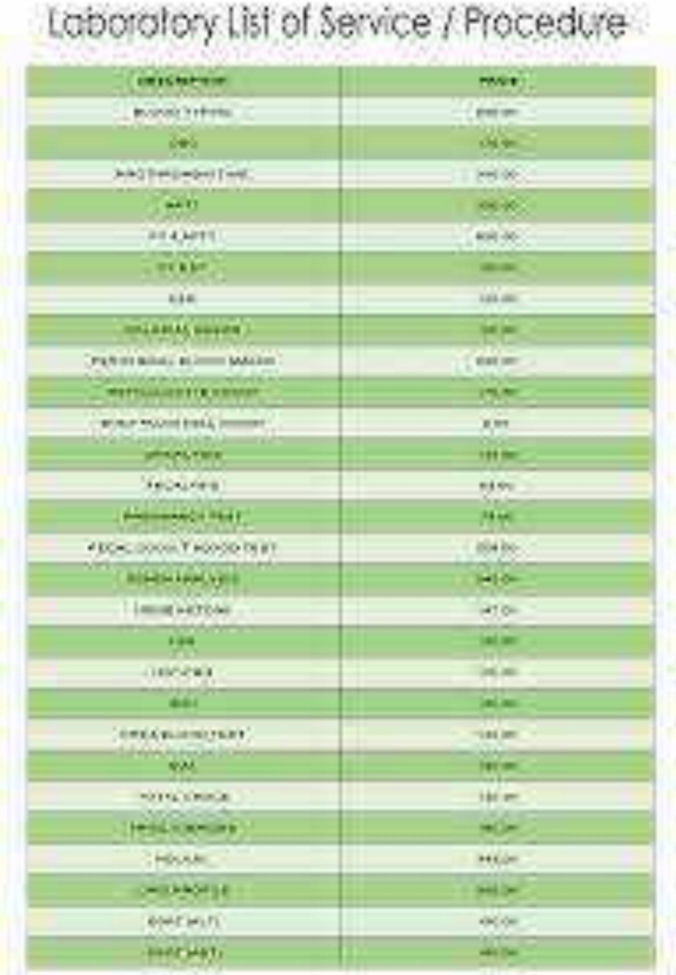
1. List the number of in-house lab services
2. List the number of outsourced lab services with their scope of work.
3. In the case of outsourced services, is there a sample collection room and a procedure to monitor the quality and adequacy of these services.
4. There should be a system in place for the daily round by matron/hospital manager/ hospital superintendent/ Hospital Manager/ Matron in charge of monitoring diagnostic services

LIST THE NUMBER OF IN-HOUSE LAB SERVICES

Laboratory Services

Laboratory Procedures

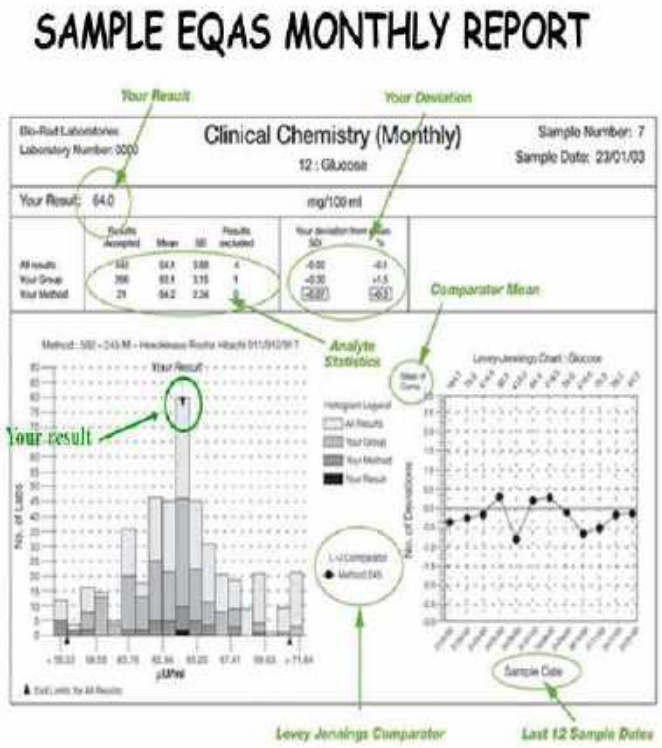
Lab Work Provided in the Provider's Office



Laboratory List of Service / Procedure

LIST THE NUMBER OF OUTSOURCED LAB SERVICES WITH THEIR SCOPE OF WORK

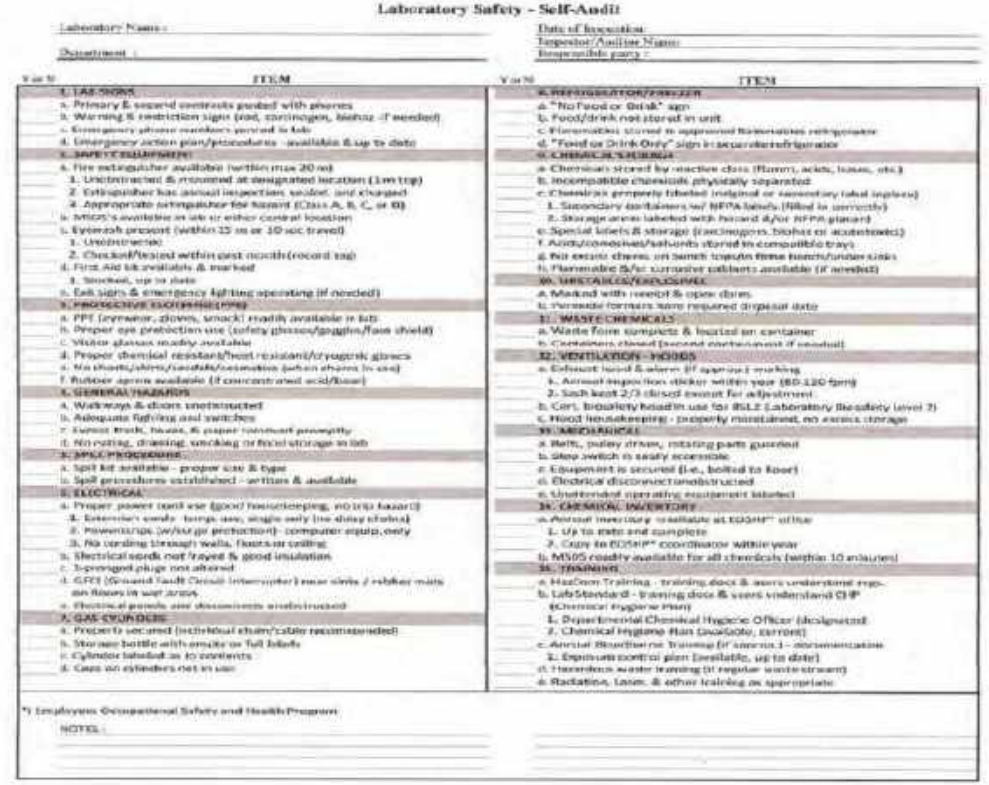
IN THE CASE OF OUTSOURCED SERVICES, IS THERE A SAMPLE COLLECTION ROOM AND A PROCEDURE TO MONITOR THE QUALITY AND ADEQUACY OF THESE SERVICES



THERE SHOULD BE A SYSTEM IN PLACE FOR THE DAILY ROUND BY MATRON/HOSPITAL MANAGER/ HOSPITAL SUPERINTENDENT/ HOSPITAL MANAGER/ MATRON IN CHARGE OF MONITORING DIAGNOSTIC SERVICES

Annual Building Inspection Checklist

Facility Exterior	*YES*	*NO*	*N/A*
Is the building address or identification clearly visible?			
Are exterior lights in working order?			
Are the exits onto public streets free from visibility obstructions?			
Are all building sides accessible to emergency equipment?			
Does the building appear to be in good repair?			
Are exterior walls free from cracks or other damages?			
Are windows free from cracks or broken panes?			
Are paved surfaces inspected and repaired (i.e., lifts, cracks, etc.)?			
Are stairs, landings and handrails in good repair and fastened securely? (inspect the bottom of each step)			
Are facilities periodically inspected and documented?			
Are all sewer clean out caps in place?			
Are all irrigation covers in place?			
Do entrance doors close slowly to avoid hazards to fingers?			
Facility Interior	*YES*	*NO*	*N/A*
Electrical Systems			
Are all electrical panels secured?			
Have all electrical circuits been identified?			
Are all electrical switches and receptacles in good repair?			
Have Ground Fault Interrupters been provided on circuits in proximity to water?			
Is there a "lock-out" procedure in place?			



Laboratory Safety - Self-Audit

Laboratory Name :

Department :

Date of Inspection :

Inspector/Auditee Name:

Responsible party :

Y or N	ITEM	Y or N	ITEM
	1. LAB SIGNS		**8. REFRIGERATOR/FREEZER**
	a. Primary & second contacts posted with phones		a. "No Food or Drink" sign
	b. Warning & restriction sign (red, carcinogen, biohaz - if needed)		b. Food/drink not stored in unit
	c. Emergency phone numbers posted in lab		c. Flammables stored in approved flammables refrigerator
	d. Emergency action plan/procedures - available & up to date		d. "Food or Drink Only" sign in secured refrigerator
	2. SAFETY EQUIPMENT		**9. CHEMICALS (GENERAL)**
	a. Fire extinguisher available (within max 20 m)		a. Chemicals stored by reactive class (flamm., acids, bases, etc.)
	1. Unobstructed & mounted at designated location (1m up)		b. Incompatible chemicals physically separated
	2. Extinguisher has annual inspection, sealed, and charged		c. Chemicals properly labeled (original or secondary label applied)
	3. Appropriate extinguisher for hazard (Class A, B, C, or D)		1. Secondary containers w/ NFPA labels (filled in correctly)
	b. MSDS's available on site or other central location		2. Storage areas labeled with hazard &/or NFPA placard
	c. Eyewash present (within 15 m or 10 sec travel)		e. Special labels & storage (carcinogens, biohaz or acutetoxic)
	1. Unobstructed		f. Acids/corrosives/bases/oxs stored in compatible trays
	2. Checked/tested within past month (record tag)		g. No excess chems on bench tops/fume hoods/under sinks
	d. First Aid kit available & marked		h. Flammable &/or corrosive cabinets available (if needed)
	1. Stocked, up to date		**10. DISTANCES/EXPLOSIVES**
	e. Exit signs & emergency lighting operating (if needed)		a. Marked with name & open date
	3. PROTECTIVE CLOTHING/GEAR		b. Peroxide formers have required disposal date
	a. PPE (eyewear, gloves, smock) readily available in lab		**11. WASTE CHEMICALS**
	b. Proper eye protection use (safety glasses/goggles/face shield)		a. Waste tape complete & located on container
	c. Visitor glasses readily available		b. Containers closed (except during use)
	d. Proper chemical resistant/heat resistant/cryogenic gloves		**12. VENTILATION - HOODS**
	e. No sharps/skins/needle/cannulas (when sharps in use)		a. Exhaust hood & alarm (if applicable) working
	f. Rubber aprons available (if concentrated acid/base)		b. Annual inspection sticker within year (80-120 fpm)
	4. GENERAL HAZARDS		2. Sash kept 2/3 closed except for adjustment
	a. Walkways & doors unobstructed		c. Cert. biosafety hood in use for BSL2 Laboratory Biosafety Level 2)
	b. Adequate lighting and switches		d. Hood housekeeping - properly maintained, no excess storage
	c. Eyewash trash, boxes, & paper removed promptly		**13. MECHANICAL**
	d. No eating, drinking, smoking or food storage in lab		a. Belts, pulley drives, rotating parts guarded
	5. SPILL PROCEDURES		b. Step switch is easily accessible
	a. Spill kit available - proper size & type		c. Equipment is secured (i.e., bolted to floor)
	b. Spill procedures established - written & available		d. Electrical disconnect unobstructed
	6. ELECTRICAL		e. Unattended operating equipment labeled
	a. Proper power (unit use (good housekeeping, no trip hazard)		**14. CHEMICAL INVENTORY**
	a. Extension cords - temp use, single only (no daisy chains)		a. Annual inventory available at EOSHP* office
	b. Power strips (w/surge protection) - computer equip. only		1. Up to date and complete
	c. No cording through walls, doors or ceiling		2. Copy to EOSHP* coordinator within year
	d. Electrical cords not frayed & good insulation		b. MSDS readily available for all chemicals (within 10 minutes)
	e. 3-pronged plugs not altered		**15. TRAINING**
	f. GFCI (Ground Fault Circuit Interrupter) near sinks / rubber mats on floors in wet areas		a. HazCom Training - training docs & users understand requ.
	g. Electrical panels and disconnects unobstructed		b. Lab Standard - training docs & users understand CHP (Chemical Hygiene Plan)
	7. GAS CYLINDERS		1. Department Chemical Hygiene Officer designated
	a. Properly secured (individual chain/cable recommended)		2. Chemical Hygiene Plan (available, current)
	b. Storage bottle with empty or full labels		c. Annual Refresher Training (if required) - documentation
	c. Cylinder labelled as to contents		1. Exposure control plan (available, up to date)
	d. Caps on cylinders not in use		d. Hazardous waste training (if regular waste stream)
			e. Radiation, Laser, & other training as appropriate

*) Employee Occupational Safety and Health Program

NOTES :

CS 3 - BLOOD BANK SERVICES IF AVAILABLE SHALL BE AS PER THE STATUTORY/REGULATORY NORMS

Interpretation – The blood bank should be functioning and adhere to standards procedures for blood collection and testing. In case the hospital doesn't have the blood bank, it shall have a MoU with the blood bank or the organization having a blood bank which has a valid license. IEC material for blood donation should also be displayed at all strategic locations.

Means of verification:

1. Blood bank services are available in house or outsourced. If outsourced then adequate supply/storage shall be ensured from a nearby authorized blood bank
2. Blood bank has a valid license under Rule 122(G) Drug and cosmetic act
3. Blood bank has a facility of blood collection and storage along with emergency stock of blood
4. IEC material is displayed in blood bank and nearby area to provide information and promote blood donation
5. Check for availability of adequate functional equipment for blood products - Blood bags refrigerator with thermograph and alarm device, Insulated carrier boxes with ice packs, Blood bag weighing machine and deep freezer

BLOOD BANK SERVICES ARE AVAILABLE IN HOUSE OR OUTSOURCED. IF OUTSOURCED THEN ADEQUATE SUPPLY/STORAGE SHALL BE ENSURED FROM A NEARBY AUTHORIZED BLOOD BANK

BLOOD BANK HAS A VALID LICENSE UNDER RULE 122(G) DRUG AND COSMETIC ACT

GOVERNMENT OF KERALA
DRUGS CONTROL DEPARTMENT

ML2. 6850/2014/DC
Dated: 23/05/2014

Office of the Drugs Controller
Thiruvananthapuram-695 035

VALIDITY CERTIFICATE

This is to certify that Vadanam, Alappuzha Dist., is holding Blood Bank Licence in Form 28C bearing No. 181/28C/KER/DC-CLAA/2009 dated 25/04/2009, issued by this department to operate a Blood Bank, for processing Whole Human Blood I.P. & its components as per the provision of Drugs & Cosmetics Act, 1940 and Rules there under.

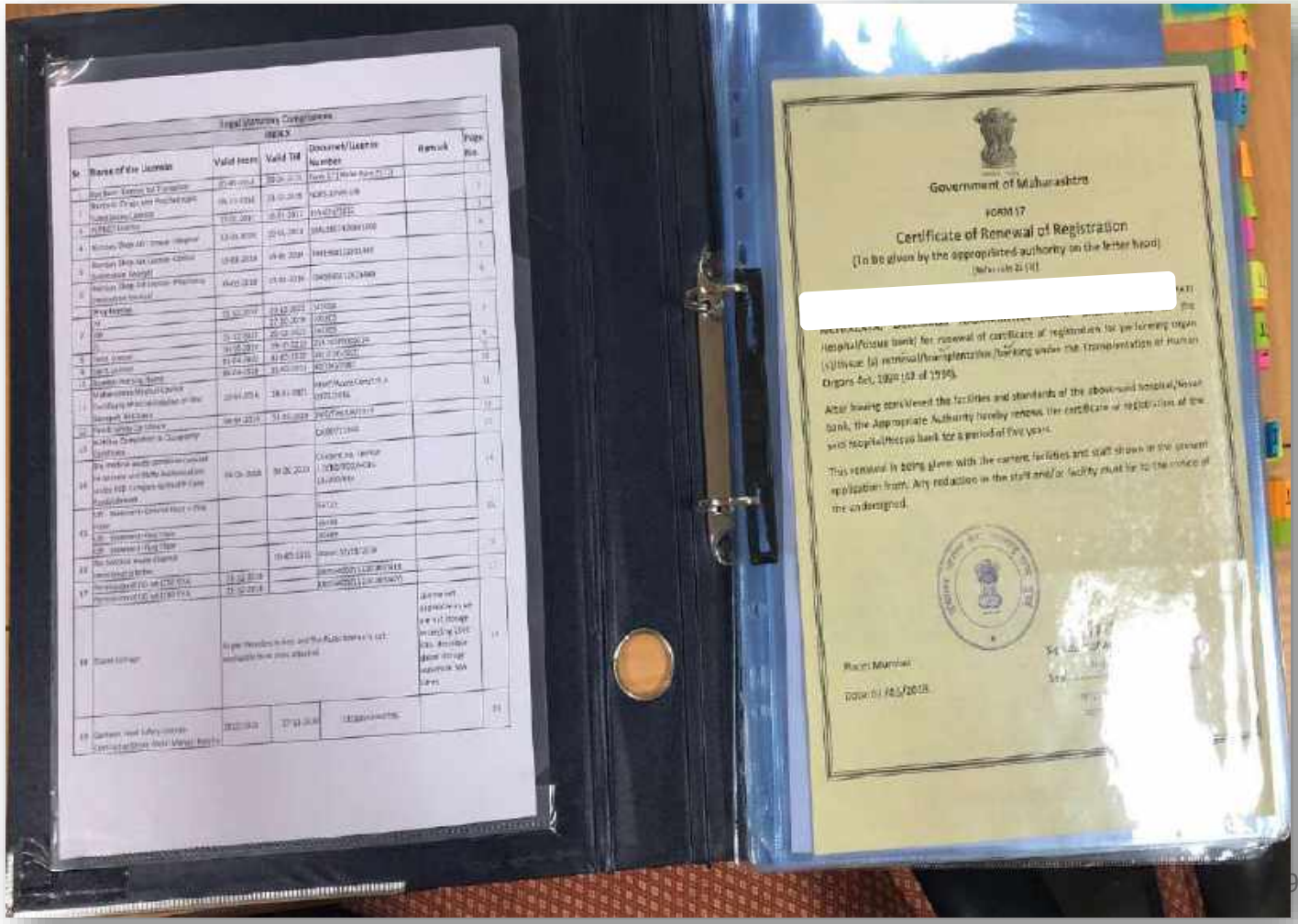
It is further certified that the renewal application of the license of the institution is received in this office for the period 25/04/2014 to 24/04/2019 and the file is under process.

As per the provisions of Drugs and Cosmetics Act, 1940 and Rules there under, the licence shall continue to be in force, until orders are passed on the application and as such the institution is entitled to collect, storage and process Whole Human Blood I.P. & Blood Components under the above license.

The licence is currently valid under rule 122G and 122F of the Drugs and Cosmetic Rules 1945.

This certificate is issued on the request of the institution, for submitting before the Medical Council of India and is valid up to 22/05/2015.

P. HARI PRASAD
Drugs Controller and Licensing Authority
Kerala State



BLOOD BANK HAS A FACILITY OF BLOOD COLLECTION AND STORAGE ALONG WITH EMERGENCY STOCK OF BLOOD

IEC MATERIAL IS DISPLAYED IN BLOOD BANK AND NEARBY AREA TO PROVIDE INFORMATION AND PROMOTE BLOOD DONATION

CHECK FOR AVAILABILITY OF ADEQUATE FUNCTIONAL EQUIPMENT FOR BLOOD PRODUCTS - BLOOD BAGS REFRIGERATOR WITH THERMOGRAPH AND ALARM DEVICE, INSULATED CARRIER BOXES WITH ICE PACKS, BLOOD BAG WEIGHING MACHINE AND DEEP FREEZER

CS 4 - THE HOSPITAL SHOULD ADHERE TO THE RADIATION SAFETY PRECAUTIONS AS PER THE REGULATORY REQUIREMENTS

Interpretation – Shielding of body parts of staff and patients, attendants should be adhered to by using protective devices and equipment, along with precautions as per law for radiation safety. The facility should also ensure standard practices, usage and supply of Personal Protective Equipment (PPE).

Means of verification:

1. Clean gloves, aprons and masks are available at the point of use
2. TLD badges should be provided to each staff member in the radiation room
3. Lead aprons, thyroid shields and other radiation protection devices should be provided for the staff in the radiation field. These should be tested once in 2 years as per AERB norms
4. Availability of ECG services

CLEAN GLOVES, APRONS AND MASKS ARE AVAILABLE AT THE POINT OF USE

Bouffant Caps

Disposable Apron

Face Mask

Nitrile Examination

Plastic Gloves

PP Nose Mask

Shoe Cover

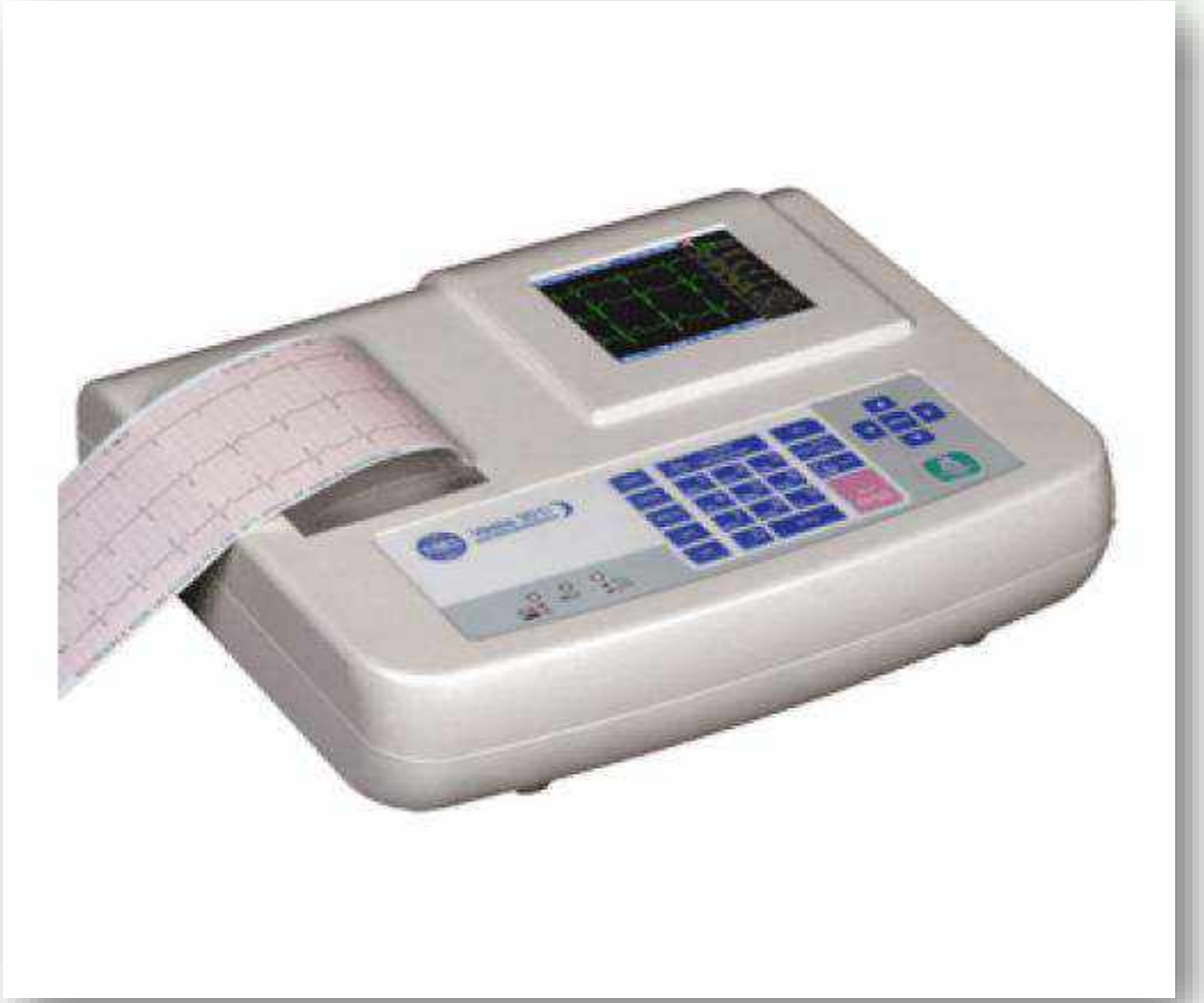
Surgcial Gloves

Surgeon Caps

TLD BADGES SHOULD BE PROVIDED TO EACH STAFF MEMBER IN THE RADIATION ROOM

LEAD APRONS, THYROID SHIELDS AND OTHER RADIATION PROTECTION DEVICES SHOULD BE PROVIDED FOR THE STAFF IN THE RADIATION FIELD. THESE SHOULD BE TESTED ONCE IN 2 YEARS AS PER AERB NORMS

AVAILABILITY OF ECG SERVICES



CS 5 - INTENSIVE CARE UNIT (ICU) SERVICES SHOULD BE AVAILABLE AS PER THE SCOPE OF SERVICES ALONG WITH THE REQUIRED INFRASTRUCTURE AND MANPOWER

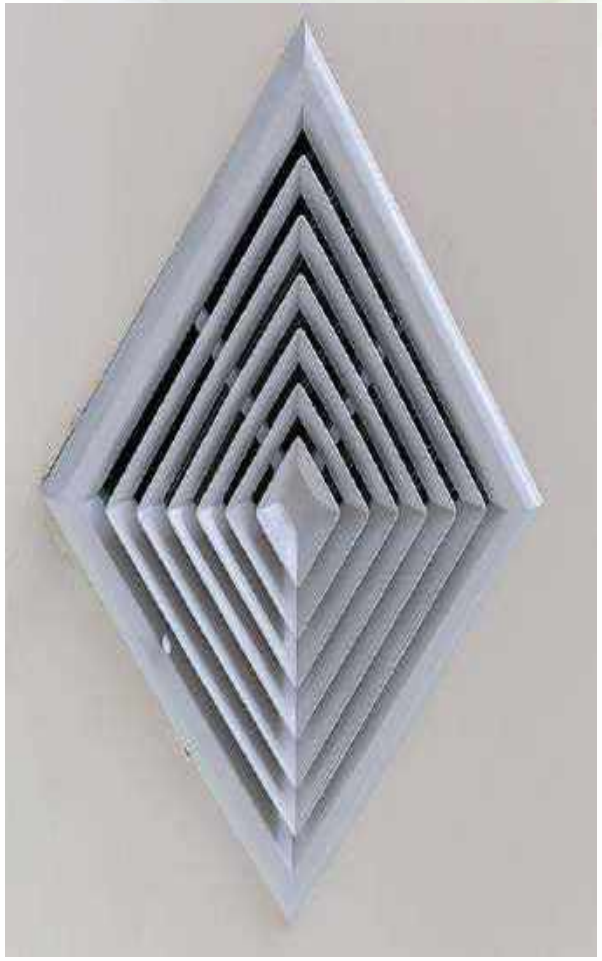
Interpretation – The ICU should be equipped with necessary monitoring equipment along with the suitably manned by trained staff. The hospital should provide proper and safe environment to the infected patients and necessary procedures should be followed for the same.

Means of verification:

1. Flooring of the ICU should be non-slippery and smooth
2. Windows/ air vents if any should be intact and sealed
3. Comfortable temperature & humidity should be maintained
4. Availability of general duty doctor, nursing staff, paramedic and security staff as per requirements
5. Critical care equipment is available and maintained- Refrigerator, Crash cart/Drug trolley, instrument trolley, dressing trolley, Ventilator, Infusion pump, C-PAP, tray, monitors, Electrical panel with a bed, bedhead panel with an outlet for Oxygen and vacuum, X-ray view box, defibrillator
6. Availability of isolated area for infectious patient
7. Isolation and barrier nursing procedures are followed for septic cases

FLOORING OF THE ICU SHOULD BE NON-SLIPPERY AND SMOOTH

WINDOWS/ AIR VENTS IF ANY SHOULD BE INTACT AND SEALED



COMFORTABLE TEMPERATURE & HUMIDITY SHOULD BE MAINTAINED

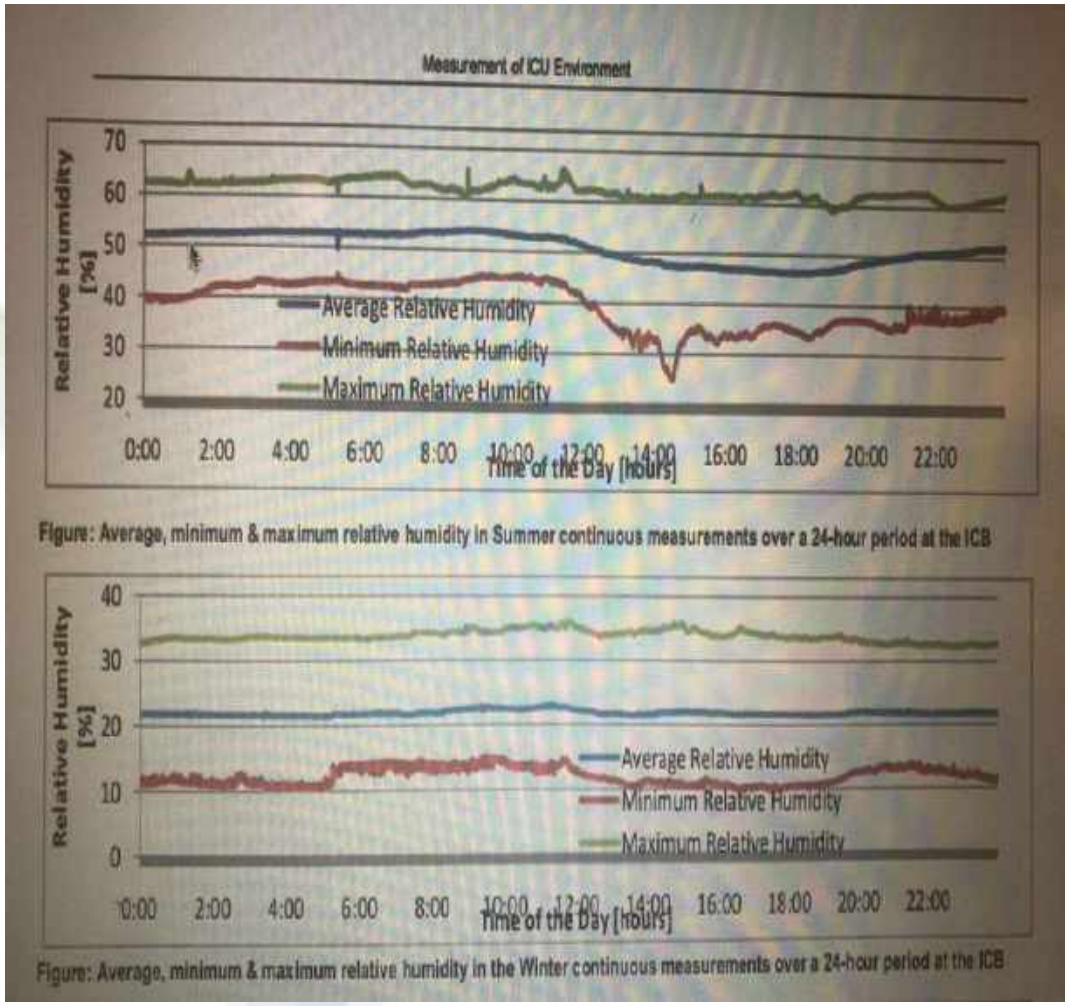


Figure: Average, minimum & maximum relative humidity in Summer continuous measurements over a 24-hour period at the ICB

Figure: Average, minimum & maximum relative humidity in the Winter continuous measurements over a 24-hour period at the ICB

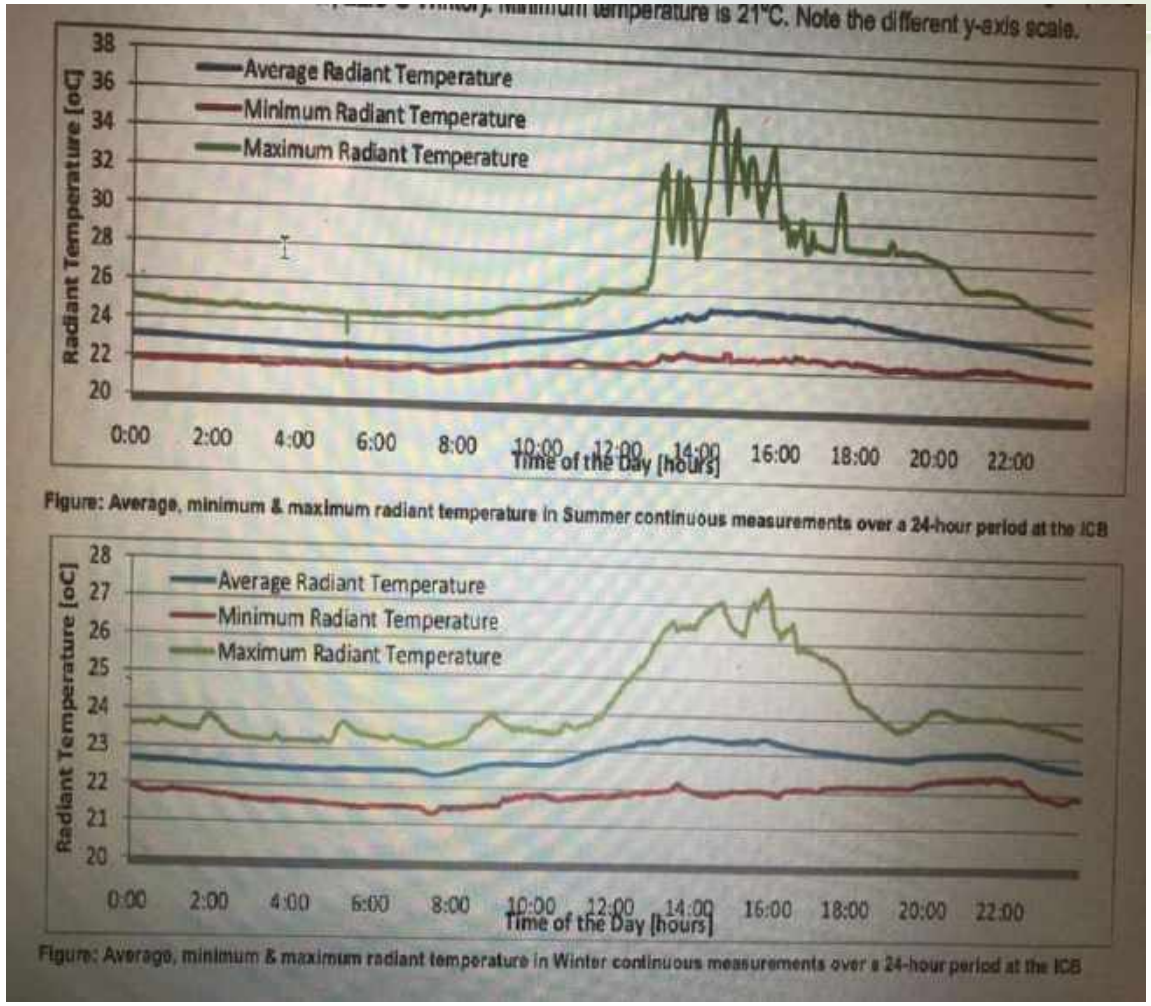


Figure: Average, minimum & maximum radiant temperature in Summer continuous measurements over a 24-hour period at the ICB

Figure: Average, minimum & maximum radiant temperature in Winter continuous measurements over a 24-hour period at the ICB

AVAILABILITY OF GENERAL DUTY DOCTOR, NURSING STAFF, PARAMEDIC AND SECURITY STAFF AS PER REQUIREMENTS

DOCTOR ROSTER

General Practitioners

Sessions	Mon Morning	Mon Evening	Mon After Hours	Tue Morning	Tue Evening	Tue After Hours	Wed Morning	Wed Evening	Wed After Hours	Thu Morning	Thu Evening	Thu After Hours	Fri Morning	Fri Evening	Fri After Hours	Sat Morning 10am-12n	Sun Morning 10am-12n
	M	E	A	M	E	A	M	E	A	M	E	A	M	E	A		
Dr R Ark	Off	Start 12:30pm Finish 05:30pm		Start 09:00am Finish 12:00n	Start 02:00pm Finish 05:00pm		Start 09:00am Finish 12:00n	Start 02:00pm Finish 05:00pm		Start 09:00am Finish 12:00n	Start 02:00pm Finish 05:00pm		Off	On/Off		Dr On-call	Dr On-call
Dr Z Pervaiz	Start 08:00am Finish 12:00n	Start 01:30pm Finish 04:00pm		Start 08:00am Finish 12:00n	Start 01:30pm Finish 04:00pm		Start 08:00am Finish 11:00n	Start 02:00pm Finish 05:00pm		Start 09:00am Finish 11:00am	Start 12:00n Finish 04:00pm		Start 08:00am Finish 12:00n	Start 02:30pm Finish 05:00pm		Dr On-call	Dr On-call
Dr C Zaldan-Solazar	Start 09:00am Finish 12:00n	Start 02:00pm Finish 05:00pm		Start 08:00am Finish 12:00n	Off		Start 09:00am Finish 11:00am	Start 12:00n Finish 03:00pm		Start 09:00am Finish 12:00n	Start 02:00pm Finish 05:00pm		Start 08:00am Finish 12:00n	Start 02:30pm Finish 05:00pm		Dr On-call	Dr On-call
Dr S Selvaraj ali	Start 09:00am Finish 12:00n	Start 02:00pm Finish 05:00pm		Off	Start 12:00n Finish 08:00pm		Start 09:00am Finish 12:00n	Start 02:00pm Finish 05:00pm		Start 08:00am Finish 12:00n	Start 02:00pm Finish 04:30pm		Start 09:00am Finish 12:00n	Start 02:30pm Finish 05:00pm		Dr On-call	Dr On-call
Dr C Ajaero	Start 09:00am Finish 12:00n	Start 02:00pm Finish 05:00pm		Start 09:00am Finish 12:00n	Start 02:00pm Finish 05:00pm		Off	Start 02:00pm Finish 05:00pm		Start 09:00am Finish 12:00n	Start 02:00pm Finish 05:00pm		Start 09:00am Finish 12:00n	Start 02:30pm Finish 05:00pm		Dr On-call	Dr On-call
Dr Mac Thu	Start 09:00am Finish 12:00n	Start 02:00pm Finish 05:00pm		Start 09:00am Finish 12:00n	Start 02:00pm Finish 05:00pm		Start 09:00am Finish 12:00n	Start 02:00pm Finish 05:00pm		Start 09:00am Finish 12:00n	Start 02:00pm Finish 05:00pm		Start 09:00am Finish 12:00n	Start 02:30pm Finish 05:00pm		Dr On-call	Dr On-call
Dr D Saaravanakaa	Start 09:00am Finish 12:00n	Start 02:00pm Finish 05:00pm		Start 09:00am Finish 12:00n	Start 02:00pm Finish 05:00pm		Start 09:00am Finish 12:00n	Start 02:00pm Finish 05:00pm		Start 09:00am Finish 12:00n	Start 02:00pm Finish 05:00pm		Start 09:00am Finish 12:00n	Start 02:30pm Finish 05:00pm		Dr On-call	Dr On-call
GP Assist and Dr On-call			08:00pm - 08:00am			08:00pm - 08:00am			08:00pm - 08:00am			08:00pm - 08:00am			08:00pm - 08:00am	01:00pm - 06:00am	01:00pm - 09:00am

DUTY ROSTER

Make Roster | View Roster | Duty Report

Welcome NIS | LogOut

LOCATION N.I.S. | Month AUGUST | View ROSTER

Duty Roster of N.I.S. for the month of AUGUST 2013

STAFF	DESIGNATION	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
METILDA ROBIN	Sister Grade II	P	P	P	OFF	P	P	P	P	OFF	P	OFF	P	P	P	OFF	P	P	OFF	P	P	P	P	P	P	OFF	P	P	P	P	P	P
ASWATHY I	Sister Grade II	OFF	B	B	P	P	OFF	N	OFF	B	P	B	P	OFF	[redacted]																OFF	B	P
PRAVEEN KR GUPTA	Sister Grade II	P	A	OFF	B	B	OFF	OFF	N	N	N	N	OFF	B	A	P	OFF	A	P	P	B	OFF	A	P	OFF	B	B	P	A	OFF	B	OFF
ALTAF ALI	Sister Grade II	OFF	P	A	B	P	OFF	B	A	OFF	OFF	[redacted]		P	E	B	OFF	P	A	P	OFF	OFF	E	N	N	N	OFF	B	A	A	OFF	P
SUBASH T.S.	Sister Grade II	P	P	B	OFF	OFF	OFF	[redacted]		P	B	P	B	P	OFF	N	N	N	OFF	B	P	B	B	B	OFF	OFF	OFF	B	OFF	B	OFF	P
YASA ARAFATH A.C	Sister Grade II	B	OFF	P	N	N	N	OFF	B	OFF	B	A	A	P	OFF	A	P	B	OFF	A	P	B	OFF	A	OFF	B	B	OFF	OFF	N	N	N
NAVED IQBAL	Sister Grade II	N	N	N	OFF	B	B	P	P	OFF	OFF	[redacted]		B	P	B	P	P	OFF	P	A	B	OFF	OFF	A	OFF	N	N	N	OFF	P	P
SALONI	Sister Grade II	A	B	P	OFF	P	B	P	A	OFF	OFF	P	B	P	P	OFF	B	N	N	N	OFF	OFF	P	B	P	A	B	OFF	OFF	P	A	OFF
SHINY THOMAS	Sister Grade II	P	P	OFF	OFF	P	A	P	B	OFF	B	N	N	N	OFF	OFF	B	B	P	OFF	[redacted]		P	A	P	OFF	OFF	P	P	B	OFF	P	B
PRAVEENA C.K	Sister Grade II	OFF	[redacted]		A	A	P	A	OFF	A	A	OFF	P	B	A	OFF	P	A	OFF	B	N	N	h	OFF	B	OFF	A	P	OFF	OFF	B	A

STAFF	STAFF ID	DESIGNATION	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
METILDA ROBIN	10449	Sister Grade II	In:8:33 out: 17:11 P	In:9:36 out: 17:17 P	In:9:18 out: 13:17 P	NO PUNCH	In:8:55 out: 17:14 P	In:9:36 out: 17:9 P	In:9:48 out: 17:28 P	In:8:34 out: 17:55 P	NO PUNCH P	NO PUNCH P	In:8:14 out: 17:12 P	In:8:29 out: 17:37 P	In:8:23 out: 18:2 P	NO PUNCH	In:7:55 out: 17:4 P	In:9:29 out: 13:29 P	NO PUNCH P
ASWATHY I	10449	Sister Grade II	In:8:17 out: 8 :17 OFF	In:13:58 out: 20:9 B	In:13:56 out: 20:16 B	In:9:8 out: 17:11 P	In:8:33 out: 16:43 P	NO PUNCH	In:19:50 out: 19:50 N	In:8:10 out: 8 :10 OFF	In:13:47 out: 20:12 B	In:9:9 out: 17:3 P	In:13:52 out: 20:7 B	In:9:8 out: 16:41 P	NO PUNCH	NO PUNCH	NO PUNCH	NO PUNCH	NO PUNCH	NO PUNCH
PRAVEEN KR GUPTA	10450	Sister Grade II	In:9:14 out: 17:0 P	In:14:12 out: 15:12 A	NO PUNCH	In:13:55 out: 20:7 B	In:11:34 out: 20:8 B	NO PUNCH	NO PUNCH	In:20:3 out: 20:3 N	In:8:21 out: 20:4 N	In:8:9 out: 20:4 N	In:7:58 out: 7 :58 OFF	In:14:12 out: 20:4 B	In:13:56 out: 20:7 A	In:9:33 out: 17:20 P	NO PUNCH	In:8:10 out: 14:52 A	In:9:26 out: 17:1 P	In:9:31 out: 16:52 P
ALTAF ALI	10451	Sister Grade II	NO PUNCH	In:9:8 out: 16:35 P	In:8:0 out: 14:36 A	In:20:7 out: 20:7 B	In:8:19 out: 16:47 P	NO PUNCH	NO PUNCH	In:7:58 out: 13:0 A	NO PUNCH	NO PUNCH	NO PUNCH	NO PUNCH	In:9:26 out: 10:27 P	In:14:11 out: 20:35 B	In:12:11 out: 20:12 B	NO PUNCH	In:9:13 out: 17:3 P	In:7:59 out: 15:42 A
SUBASH T.S.	10452	Sister Grade II	In:9:5 out: 17:19 P	In:9:13 out: 17:8 P	In:13:18 out: 20:19 B	In:9:6 out: 17:33 OFF	NO PUNCH	NO PUNCH	NO PUNCH	In:9:4 out: 15:31 P	In:13:38 out: 20:15 B	In:9:3 out: 17:28 P	In:13:38 out: 20:11 B	In:9:8 out: 17:11 P	NO PUNCH	In:19:40 out: 19:40 N	In:8:28 out: 19:27 N	In:8:27 out: 19:38 N	In:8:20 out: 8 :20 OFF	In:13:4 out: 20:13 B

CRITICAL CARE EQUIPMENT IS AVAILABLE AND MAINTAINED- REFRIGERATOR, CRASH CART/DRUG TROLLEY, INSTRUMENT TROLLEY, DRESSING TROLLEY, VENTILATOR, INFUSION PUMP, C-PAP, TRAY, MONITORS, ELECTRICAL PANEL WITH A BED, BEDHEAD PANEL WITH AN OUTLET FOR OXYGEN AND VACUUM, X-RAY VIEW BOX, DEFIBRILLATOR

Equipment Item	Location in Health Centre	Asset # or Serial #	Frequency of Service	Loan required for Backfill?	Last Serviced	Sent	Returned	Next Due	Comment
Air nebuliser			Annual	Yes					
Baby scales			Annual	Yes					
Centrifuge			Annual	Yes					May be able to arrange a loan through Westerns
Defibrillator - ZOLL monitor			6 mthly	Yes					
Defibrillator - ZOLL battery charger			Annual	No					
Defibrillator - HEARTSTART			6 mthly	Yes					
ECG machine			Annual	Yes					
Examination light 1 (Welch Allyn)			As required						
Examination light 2 (Welch Allyn)			As required						
Foetal Doppler 1			Annual						
Foetal Doppler 2			Annual						
Haemoglobinometer Hemocue 1			Annual						
Haemoglobinometer Hemocue 2			Annual						
Haemoglobinometer Hemocue 3			Annual						
i-STAT analyser			Six Monthly software upgrade	No					*Coordinate with the PPN (CN ph 9951 6946*
IVAC infusion pump			Annual						
Oto/Opthalmoscope set 1			As Required						
Oto/Opthalmoscope set 2			As Required						
Oto/Opthalmoscope set 3			As Required						
Oxy flow meter 1			Annual						
Oxy flow meter 2			Annual						
Oxy flow meter 3			Annual						
Oxy flow meter 4			Annual						
Oxy flow meter 5			Annual						
Oxy regulator 1			Annual						
Oxy regulator 2			Annual						

AVAILABILITY OF ISOLATED AREA FOR INFECTIOUS PATIENT

ISOLATION AND BARRIER NURSING PROCEDURES ARE FOLLOWED FOR SEPTIC CASES

A Nurse's Guide To Isolation Precautions

- Contact Isolation Precautions
- Droplet Isolation Precautions
- Airborne Isolation Precautions
- Neutropenic and Radiation Precautions

National HEALTH CARE PROVIDER SOLUTIONS

Follow CONTACT ISOLATION

- Used to prevent transmission of microorganisms spread by direct/indirect contact with the source
- examples:
  - MRSA
  - VRE
  - C. diff
  - contagious skin infections... Lice & Scabies

Five major routes of transmission

1. Contact:
   - Direct (person-person)
   - Indirect (through an object)
2. Droplet
3. Airborne
4. Common vehicle
5. Vector borne

The same organism may be transmitted by more than one route

CS 6 - OT COMPLEX SHOULD BE AVAILABLE AS PER THE REGULATORY REQUIREMENTS

Interpretation – The organization shall ensure that the operation theater has facilities for demarcated areas, separate changing rooms for males and females along with proper illumination and temperature.

Means of verification:

1. Proper demarcation of the following areas: protective zone, clean zone, sterile zone and disposal zone
2. Availability of signage stating that the entry to OT is restricted
3. Pre-operative and post-operative area should be well-lit
4. Change rooms are available for male and female staff; entry in OT should be allowed only after change in attire
5. Temperature and humidity are maintained and record of same is kept

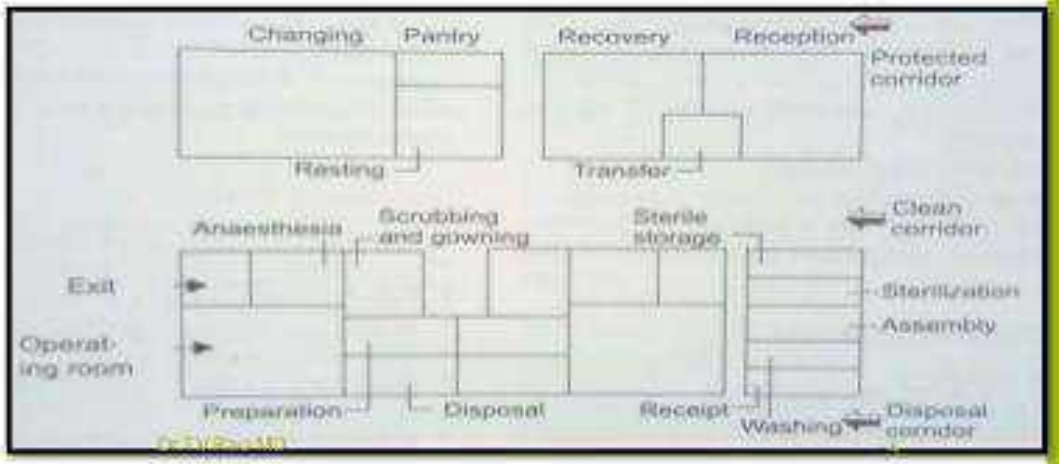
PROPER DEMARCATION OF THE FOLLOWING AREAS: PROTECTIVE ZONE, CLEAN ZONE, STERILE ZONE AND DISPOSAL ZONE

Planning consideration

Zoning :

To ensure the aseptic condition the operating dept is divide into 4 zone :

1. Protective zone
2. Clean zone
3. Sterile zone
4. Disposal zone



AVAILABILITY OF SIGNAGE STATING THAT THE ENTRY TO OT IS RESTRICTED

PRE-OPERATIVE AND POST-OPERATIVE AREA SHOULD BE WELL-LIT

CHANGE ROOMS ARE AVAILABLE FOR MALE AND FEMALE STAFF; ENTRY IN OT SHOULD BE ALLOWED ONLY AFTER CHANGE IN ATTIRE

TEMPERATURE AND HUMIDITY ARE MAINTAINED AND RECORD OF SAME IS KEPT

Maintaining the Operation theaters is a priority

- Stress must be laid on
- Temperature
- Humidity
- Ventilation
- Temperature : 24-270 C
- Relative Humidity : 450 – 600 C for adult
- 550 – 650 C for infants

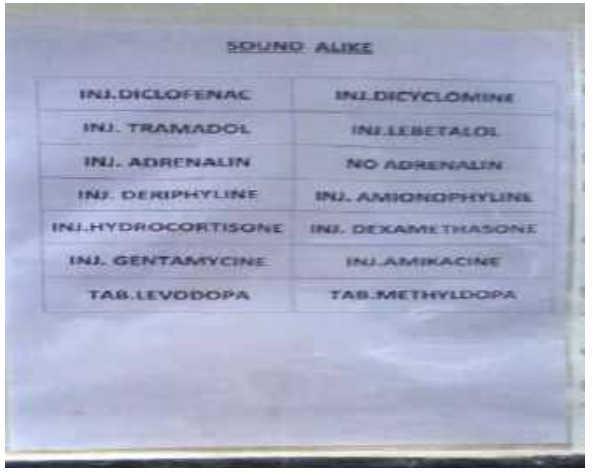
CS 7 - LOOK-ALIKE AND SOUND-ALIKE MEDICINES NEED TO BE IDENTIFIED AND STORED SEPARATELY TO AVOID ANY DISPENSING AND ADMINISTRATION ERRORS.

Interpretation – The drug store should arrange the stock in alphabetic/ uniform/ standardised order and storage requirement of the drugs should be adhered to. The overall cleanliness and temperature of the storage area should be maintained. One look alike should be stored apart from its other look alike.

Means of verification:

1. Product of similar name and different strength (look alike and sound alike drugs) should be stored separately.
2. Medicine storage shall be in a clean, well lit, and in a safe environment in accordance with the applicable laws and regulations.
3. Stock is arranged neatly in alphabetic order with the name facing the front and labels must have drug name, strength and frequency
4. Drug store has inventory management software

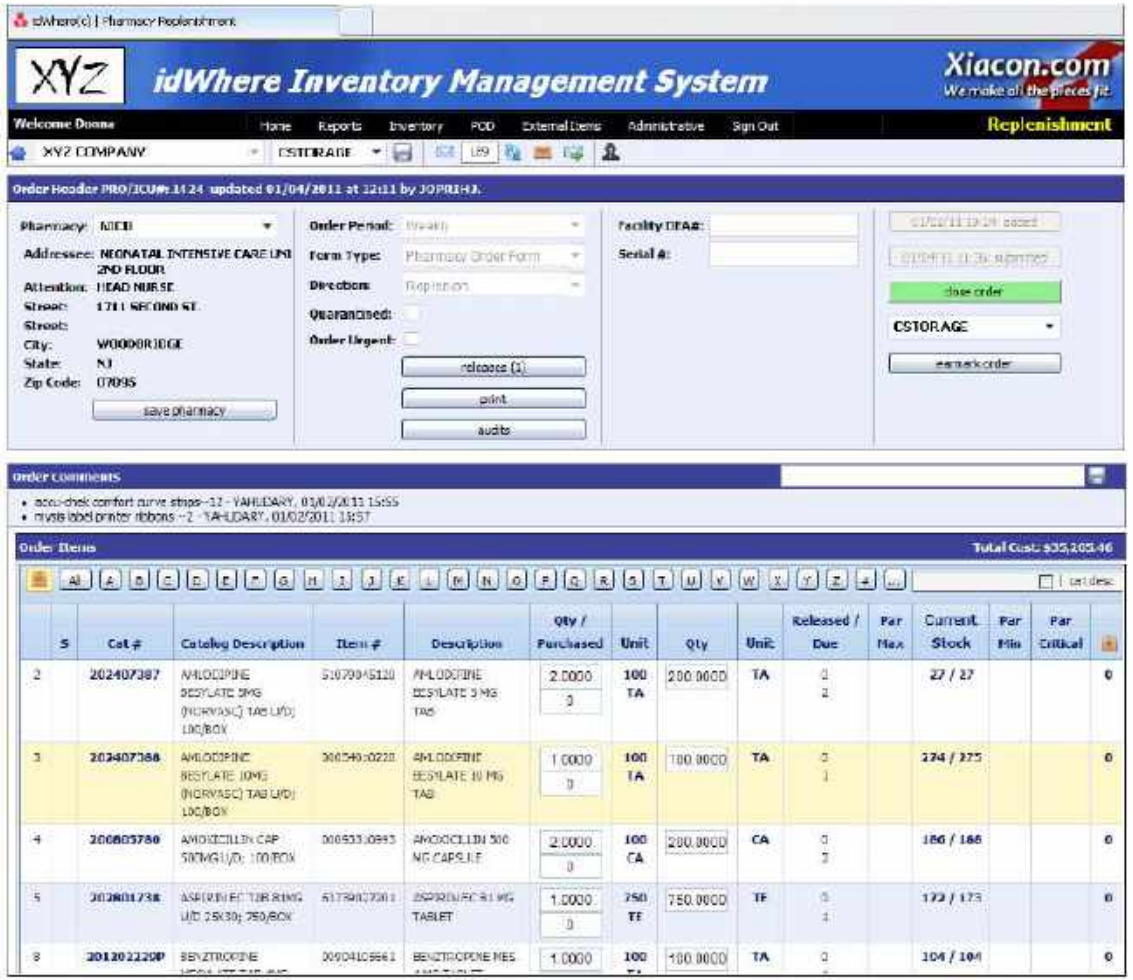
PRODUCT OF SIMILAR NAME AND DIFFERENT STRENGTH (LOOK ALIKE AND SOUND ALIKE DRUGS) SHOULD BE STORED SEPARATELY



MEDICINE STORAGE SHALL BE IN A CLEAN, WELL LIT, AND IN A SAFE ENVIRONMENT IN ACCORDANCE WITH THE APPLICABLE LAWS AND REGULATIONS

STOCK IS ARRANGED NEATLY IN ALPHABETIC ORDER WITH THE NAME FACING THE FRONT AND LABELS MUST HAVE DRUG NAME, STRENGTH AND FREQUENCY

DRUG STORE HAS INVENTORY MANAGEMENT SOFTWARE



(A) Stock Control Card

(B) Report and Requisition Form

CS 8 - POLICIES AND PROCEDURES FOR IDENTIFICATION, SAFE DISPENSING AND ADMINISTRATION OF ALL HIGH-RISK MEDICINES SHOULD BE DOCUMENTED AND IMPLEMENTED

Interpretation – Clear policies to be laid down for dispensing of high-risk medicines and the list of such medicines should be available at the drug store. The narcotics drugs should be stored in secure manner.

Means of verification:

1. Documented procedure incorporating storage, prescription and dispensing of medications
2. Narcotic medicines are kept in double lock
3. Pharmacy has a list of high-risk drugs available with it

DOCUMENTED PROCEDURE INCORPORATING STORAGE, PRESCRIPTION AND DISPENSING OF MEDICATIONS

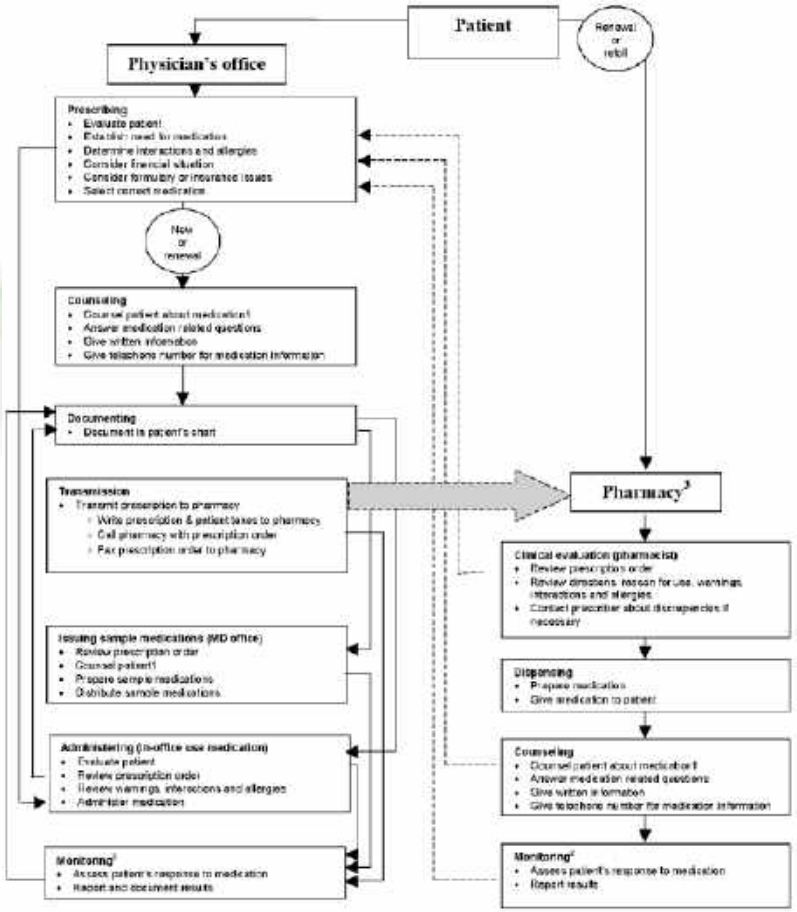
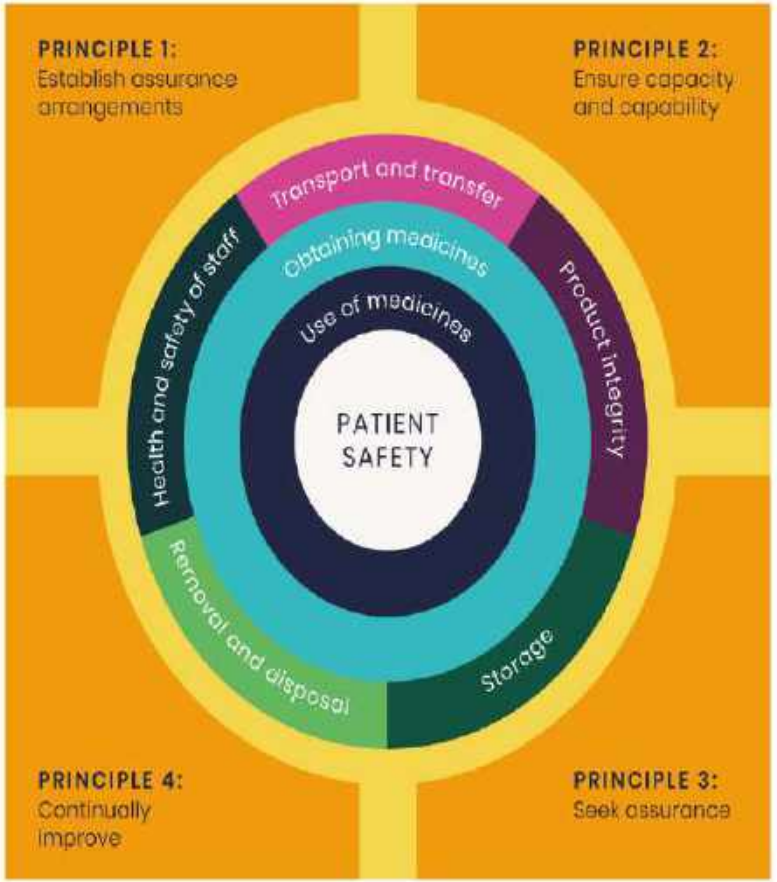


FIGURE 3:

Framework for the safe and secure handling of medicines



NARCOTIC MEDICINES ARE KEPT IN DOUBLE LOCK

PHARMACY HAS A LIST OF HIGH-RISK DRUGS AVAILABLE WITH IT

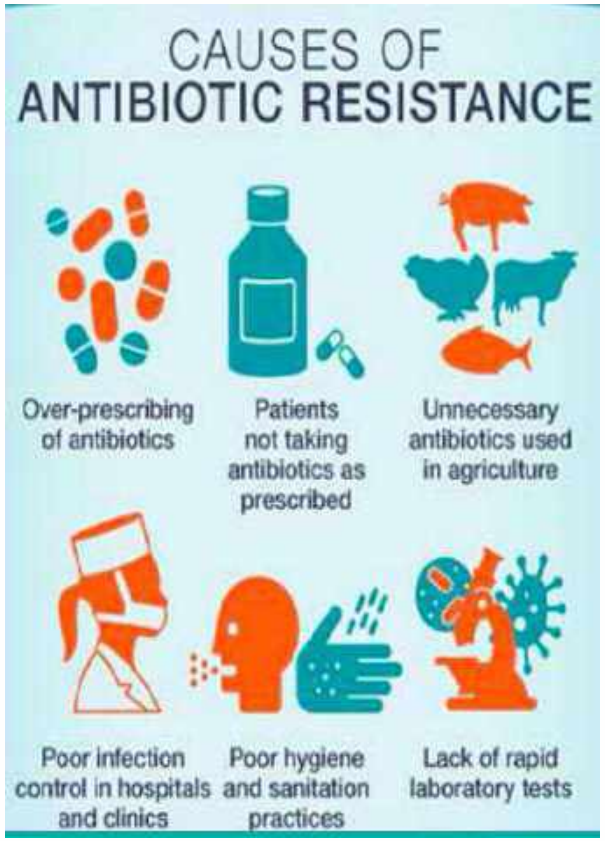
CS 9 - THE FACILITY HAS DEFINED AND ESTABLISHED ANTIBIOTIC POLICY

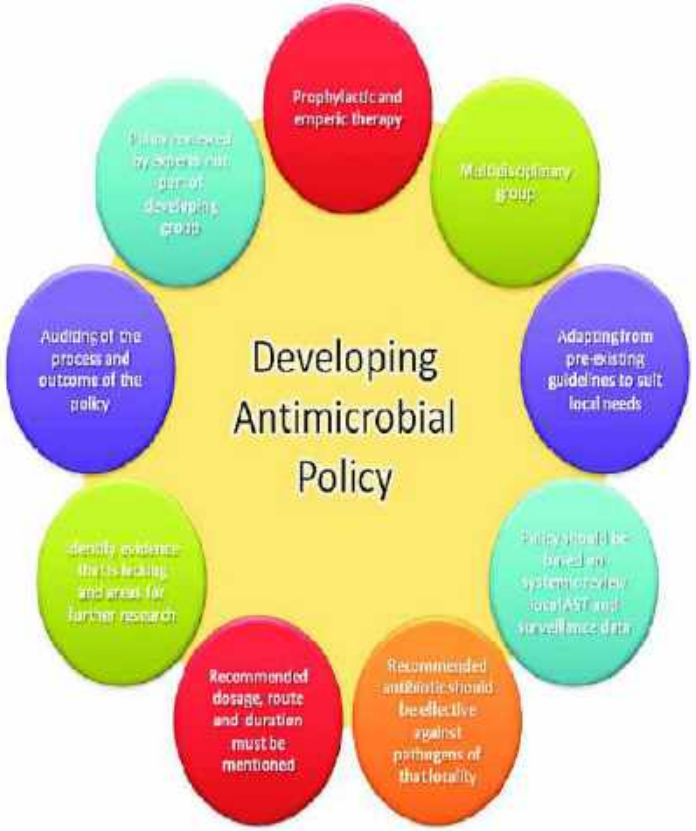
Interpretation – The Hospital must have an established antibiotic policy ensuring rational use of antibiotic/drug.

Means of verification:

1. Facility should ensure the rational usage of antibiotics/ drugs and policy for the same is in place and implemented.

FACILITY SHOULD ENSURE THE RATIONAL USAGE OF ANTIBIOTICS/ DRUGS AND POLICY FOR THE SAME IS IN PLACE AND IMPLEMENTED





CS 10 - PRE-OPERATIVE, INTRA-OPERATIVE AND POST-OPERATIVE ASSESSMENT SHOULD BE DONE AND DOCUMENTED BY APPROPRIATELY QUALIFIED STAFF IN STANDARDIZED FORMAT

Interpretation – All the patients undergoing surgery should be assessed pre-operative, intra-operative and post-operative by the trained staff, which should be documented in a standardized format. Also, a documented procedure should be available for preventing adverse like wrong site, wrong patient and wrong surgery.

Means of verification:

1. There is a procedure for pre-operative and intra-operative assessment - Physical examination, result of lab investigation, diagnosis and proposed surgery (3 samples)
2. Patient reports with post-operative notes that should contain vital signs, pain control, urine and gastrointestinal fluid output, other medications and Laboratory investigations (3 samples)
3. Documented procedure to address the prevention of adverse events like wrong site, wrong patient and wrong surgery.

THERE IS A PROCEDURE FOR PRE-OPERATIVE AND INTRA-OPERATIVE ASSESSMENT - PHYSICAL EXAMINATION, RESULT OF LAB INVESTIGATION, DIAGNOSIS AND PROPOSED SURGERY

A UNIT OF MAHYCO RESEARCH FOUNDATION TRUST

CHECKLIST BEFORE SURGERY

Name of the patient : MRD Number :

Name of the doctor : Date :

Sr. No.	Have you checked ?	Ward NA	Recovery Room
1	Patient NBM since		
2	Any known allergy/DM/HTN/Asthma		
3	Surgery Side marked		
4	Surgery Side : OD ☐ OS ☐ OU ☐		
5	Surgery Consent		
6	Guarded visual prognosis consent (if required)	NA	
7	HIV consent		
8	Anaesthesia consent		
9	Anaesthesia fitness done		
10	Physician/Paediatrician fitness done		
11	Amniotic membrane graft ordered/Not ordered		
12	Consent for disposal of clinical histopathology samples		
13	Any pre-medication/ Inj. Manitol given		
14	BP		
15	Lab investigations		
16	A-Scan		
17	Final IOL power decided by surgeon	NA	
18	IOL BRAND	NA	
19	Eye Dilated		
	Hand over staff Name and Time		

REMARK :
CASH PAID / TPA / ECHS / CGHS / FREE / WEAKER / BEFORE DISCHARGE / AMOUNT TO BE PAID TOMORROW MORNING

SGMMRD/08

Identify high-risk surgical patient

Shoemaker/Boyd criteria, P-POSSUM
Establish functional capacity

Ensure optimum management of chronic disease and acute physiology

Refer to ACC/AHA guidelines

SURGERY

Institute flow monitoring and goal-directed fluid therapy pre-operatively and intra-operatively if possible

Admit to intensive care unit post-operatively

Institute flow monitoring
Ensure adequate oxygenation and haematocrit

Target oxygen delivery/tissue perfusion goals

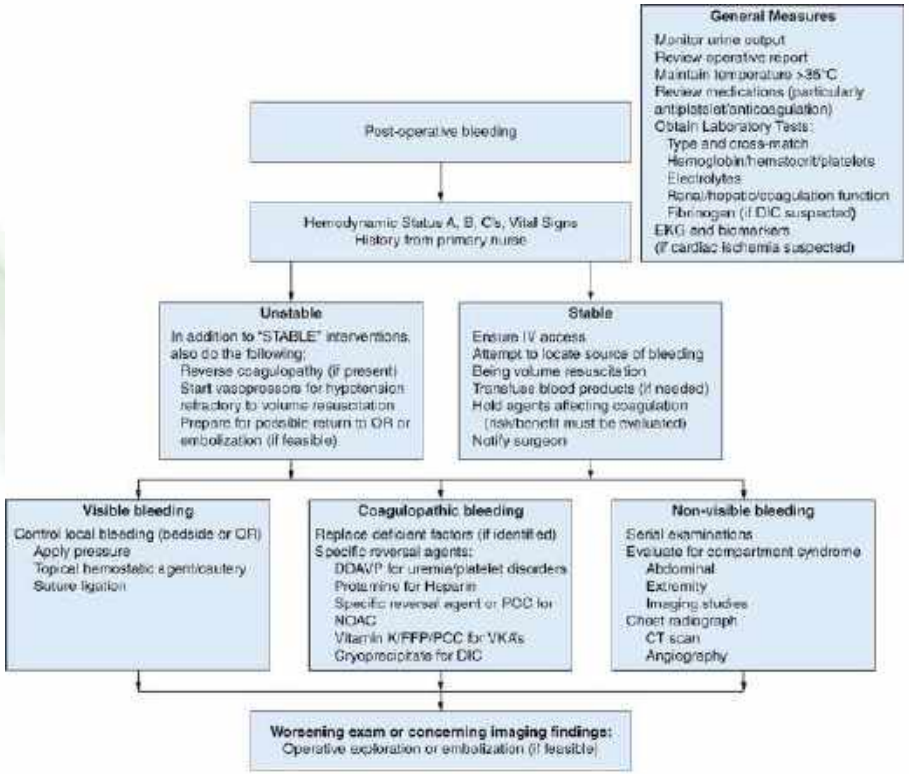
i.e. $DO_2i \geq 600ml/min/m^2$ and $CI \geq 4.5l/min/m^2$ using fluids initially until no longer preload responsive
Add inodilators e.g. dopexamine up to 1 microgram/kilogram/minute if goals not achieved

Maintain monitoring and goals

For up to 8 hours

Adapted from Lees et al (2009) Clinical review: Goal-directed therapy in high risk surgical patients. *Critical Care*, **13**:231
CI = cardiac index, DO_2i = oxygen delivery index

PATIENT REPORTS WITH POST-OPERATIVE NOTES THAT SHOULD CONTAIN VITAL SIGNS, PAIN CONTROL, URINE AND GASTROINTESTINAL FLUID OUTPUT, OTHER MEDICATIONS AND LABORATORY INVESTIGATIONS



Source: Sylvia C. McKean, John J. Ross, Daniel D. Dressler, Daniella B. Scheurer: Principles and Practice of Hospital Medicine, Second Edition, www.accessmedicine.com
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World Health Organization

Postoperative care

Post operative note and orders

The patient should be discharged to the ward with comprehensive orders for the following:

- Vital signs
- Pain control
- Rate and type of intravenous fluid
- Urine and gastrointestinal fluid output
- Other medications
- Laboratory investigations

The patient's progress should be monitored and should include at least:

- Assessment by medical and nursing observations
- A specific comment on the wound or operation site
- Any complications
- Any changes made in treatment

Aftercare: Prevention of complications

- Encourage early mobilization
  - Deep breathing and coughing
  - Active daily exercise
  - Joint range of motion
  - Muscular strengthening
  - Make walking aids such as canes, crutches and walkers available and provide instructions for their use
- Ensure adequate nutrition
- Prevent skin breakdown and pressure sores:
  - Turn the patient frequently
  - Keep urine and faeces off skin
- Provide adequate pain control

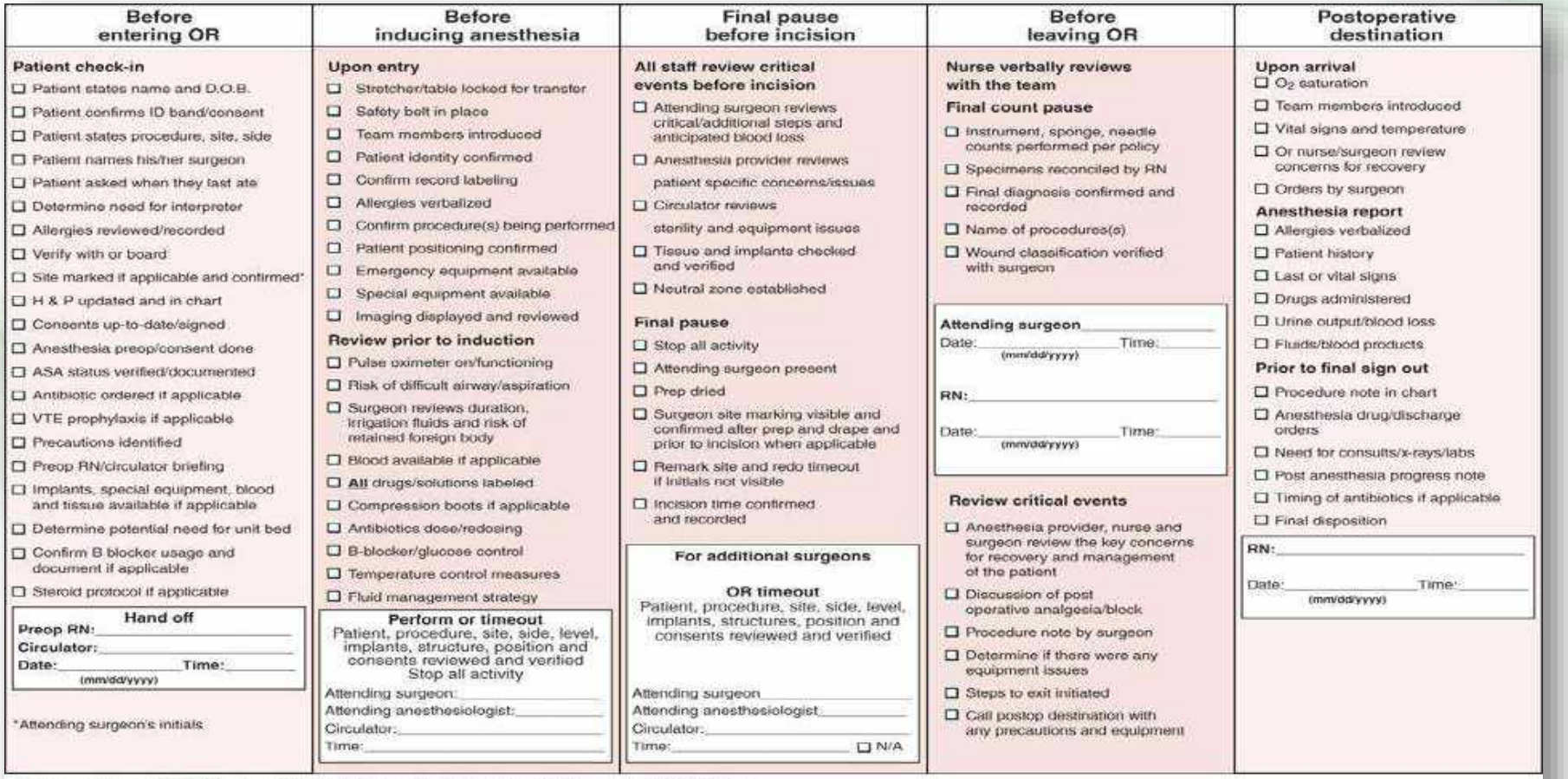
Discharge note

On discharging the patient from the ward, record in the notes:

- Diagnosis on admission and discharge
- Summary of course in hospital
- Instructions about further management, including drugs prescribed

Ensure that a copy of this information is given to the patient, together with details of any follow-up appointment

DOCUMENTED PROCEDURE TO ADDRESS THE PREVENTION OF ADVERSE EVENTS LIKE WRONG SITE, WRONG PATIENT AND WRONG SURGERY



Before entering OR

Patient check-in
- ☐ Patient states name and D.O.B.
- ☐ Patient confirms ID band/consent
- ☐ Patient states procedure, site, side
- ☐ Patient names his/her surgeon
- ☐ Patient asked when they last ate
- ☐ Determine need for interpreter
- ☐ Allergies reviewed/recorded
- ☐ Verify with or board
- ☐ Site marked if applicable and confirmed*
- ☐ H & P updated and in chart
- ☐ Consents up-to-date/signed
- ☐ Anesthesia preop/consent done
- ☐ ASA status verified/documented
- ☐ Antibiotic ordered if applicable
- ☐ VTE prophylaxis if applicable
- ☐ Precautions identified
- ☐ Preop RN/circulator briefing
- ☐ Implants, special equipment, blood and tissue available if applicable
- ☐ Determine potential need for unit bed
- ☐ Confirm B blocker usage and document if applicable
- ☐ Steroid protocol if applicable

Hand off
Preop RN:_____
Circulator:_____
Date:_____ Time:_____
(mm/dd/yyyy)

*Attending surgeon's initials

Before inducing anesthesia

Upon entry
- ☐ Stretcher/table locked for transfer
- ☐ Safety belt in place
- ☐ Team members introduced
- ☐ Patient identity confirmed
- ☐ Confirm record labeling
- ☐ Allergies verbalized
- ☐ Confirm procedure(s) being performed
- ☐ Patient positioning confirmed
- ☐ Emergency equipment available
- ☐ Special equipment available
- ☐ Imaging displayed and reviewed

Review prior to induction
- ☐ Pulse oximeter on/functioning
- ☐ Risk of difficult airway/aspiration
- ☐ Surgeon reviews duration, irrigation fluids and risk of retained foreign body
- ☐ Blood available if applicable
- ☐ All drugs/solutions labeled
- ☐ Compression boots if applicable
- ☐ Antibiotics dose/redosing
- ☐ B-blocker/glucose control
- ☐ Temperature control measures
- ☐ Fluid management strategy

Perform or timeout
Patient, procedure, site, side, level, implants, structure, position and consents reviewed and verified
Stop all activity
Attending surgeon:_____
Attending anesthesiologist:_____
Circulator:_____
Time:_____

Final pause before incision

All staff review critical events before incision
- ☐ Attending surgeon reviews critical/additional steps and anticipated blood loss
- ☐ Anesthesia provider reviews patient specific concerns/issues
- ☐ Circulator reviews sterility and equipment issues
- ☐ Tissue and implants checked and verified
- ☐ Neutral zone established

Final pause
- ☐ Stop all activity
- ☐ Attending surgeon present
- ☐ Prep dried
- ☐ Surgeon site marking visible and confirmed after prep and drape and prior to incision when applicable
- ☐ Remark site and redo timeout if initials not visible
- ☐ Incision time confirmed and recorded

For additional surgeons

OR timeout
Patient, procedure, site, side, level, implants, structures, position and consents reviewed and verified

Attending surgeon_____
Attending anesthesiologist_____
Circulator:_____
Time:_____ ☐ N/A

Before leaving OR

Nurse verbally reviews with the team

Final count pause
- ☐ Instrument, sponge, needle counts performed per policy
- ☐ Specimens reconciled by RN
- ☐ Final diagnosis confirmed and recorded
- ☐ Name of procedures(s)
- ☐ Wound classification verified with surgeon

Attending surgeon_____
Date:_____ Time:_____
(mm/dd/yyyy)

RN:_____

Date:_____ Time:_____
(mm/dd/yyyy)

Review critical events
- ☐ Anesthesia provider, nurse and surgeon review the key concerns for recovery and management of the patient
- ☐ Discussion of post operative analgesia/block
- ☐ Procedure note by surgeon
- ☐ Determine if there were any equipment issues
- ☐ Steps to exit initiated
- ☐ Call postop destination with any precautions and equipment

Postoperative destination

Upon arrival
- ☐ O_2 saturation
- ☐ Team members introduced
- ☐ Vital signs and temperature
- ☐ Or nurse/surgeon review concerns for recovery
- ☐ Orders by surgeon

Anesthesia report
- ☐ Allergies verbalized
- ☐ Patient history
- ☐ Last or vital signs
- ☐ Drugs administered
- ☐ Urine output/blood loss
- ☐ Fluids/blood products

Prior to final sign out
- ☐ Procedure note in chart
- ☐ Anesthesia drug/discharge orders
- ☐ Need for consults/x-rays/labs
- ☐ Post anesthesia progress note
- ☐ Timing of antibiotics if applicable
- ☐ Final disposition

RN:_____

Date:_____ Time:_____
(mm/dd/yyyy)

Source: Gerard M. Doherty: Current Diagnosis & Treatment: Surgery, 14th Edition
www.accessmedicine.com

CS 11 - PRE-ANESTHESIA ASSESSMENTS, TYPE OF ANESTHESIA AND POST ANESTHESIA STATUS SHOULD BE DOCUMENTED

Interpretation – The pre-anesthesia, post anesthesia and type of anesthesia should be monitored and documented in a standardized format. Also the patient records must contain regular and periodic monitoring records of patients who are under observation Post Operative/Anesthesia for the purpose of taking corrective and preventive actions.

Means of verification:

1. Department has documented procedure for pre-operative anesthesia checkup
2. Anesthesia plan is documented before entering into OT
3. Post anesthesia status is monitored and recorded
4. Post-Operative/Anesthesia monitoring includes regular and periodic recording of heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation, airway security and patency

DEPARTMENT HAS DOCUMENTED PROCEDURE FOR PRE-OPERATIVE ANESTHESIA CHECKUP

UNIVERSITY OF CHICAGO HOSPITALS

PRE-OPERATIVE CHECK LIST

CHECK YES, NO OR NA FOR ITEMS 1 THRU 20 AND RECORD INITIALS

	YES	NO	N/A	INITIALS
1. 2 ID bands applied (different extremities)				
2. 2 Blood bands applied. # Autologous/donor directed blood avail (different extremities)				
3. Blood consent signed and witnessed and on chart				
4. If no blood consent, blood refusal form signed and on chart				
5. Advance directives signed and on chart				
6. Consent signed and witnessed and on chart				
7. Laterality identified on the consent form. Surgery will be on the (circle one) Right Left Bilateral Midline				
8. Laterality on the consent form is consistent with the patient's response				
9. Allergies NKA Latex				
10. NPO since				
11. Pre-op medication Time Medication				
* 12. Vital Signs BP HR Temp Resp				
13. Voided Time				
14. Height Wt.				
* 15. Patient personal belongings dentures corrective lenses hearing aid jewelry clothing other Disposition ☐ Admission Services ☐ Family Member (name) ☐ Remains w/Patient ☐ Other				
16. Nail Polish Removed				
17. Isolation *See Isolation Guidelines on opposite side. Type				
18. H & P on chart				
19. Previous Medical record with chart				
20. Addressograph plate on chart				

* Signature Initials

* If admit assessment form (54.41) is completed in DCAM pre-op or GOP pre-op, mark NA

ADDRESSOGRAPH

O.R. PRE-OPERATIVE CHECK LIST

CHECK YES, NO OR NA FOR ITEMS 1 THRU 4 AND RECORD INITIALS

	YES	NO	N/A	INITIALS
1. Wearing two I.D. Bands that are legible (one on wrist, one on ankle)				
2. Blood Bank two I.D. Bands in place (one on wrist, one on ankle)				
3. Consent Signed and Witnessed				
4. Laterality on the consent form is consistent with: - the OR schedule - patient response - the pre-op checklist				

5. Allergies

6. Time Arrived in Pre-op Holding

7. Chart Checked for Completeness

8. IV Fluids Amount

Signature: Initials:

NOTE:

STATEMENT OF PATIENT COMPLIANCE

I AM AWARE OF THE DANGER TO ME OF FOOD OR LIQUID (INCLUDING WATER, COFFEE, OR TEA) IN MY STOMACH DURING ANESTHESIA AND I CERTIFY THAT I HAVE HAD NOTHING TO EAT OR DRINK SINCE

EXCEPTIONS

I CERTIFY THAT I HAVE AN ESCORT HOME WHOSE NAME IS:

PATIENT:

WITNESS: DATE

Isolation Precautions Guidelines

	May go to Pre-op	May go to PACU
Airborne	No	No
Respiratory (Droplet)	No	No
Strict	No	No
Contact	No	Yes (in isolation room)
Special Handling (CJD)	Yes	Yes
Protective	No	No

ANESTHESIA RECORD

AGE SEX: M F PRE MED: O U ASA

DENTITION NPO PROPOSED SURGERY

☐ PT. IDED ☐ CONSENT ✓ED ☐ CHART REVIEWED SURGEON

OPERATION PERFORMED

PRE OP: BP P R T Hct ALLERGIES

TIME TOTALS

OXYGEN

NITROUS OXIDE

HALOTHANE/ISOFLURANE/SEVOFLURANE

TEMP

URINE

FLUIDS/BLOOD

IV #

BP

PULSE

RESP

MONITORS:

☐ MONITORED ANESTHESIA CARE ☐ REGIONAL ☐ GENERAL

GLADE

ETT#

BBS

CUFF

☐ ATRAUMATIC ☐ CO_2

COMMENTS:

EYE PROTECTION:

VENT V T/kg AIRWAY P

BLOOD LOSS

POSITION

REMARKS:

RECOVERY ROOM B.P. P. R.R. TIME O_2 SAT.

CONDITION

SIGNED (RESIDENT) M.D.

SIGNED (STAFF) M.D.

DATE

PAGE OF

PATIENT NAME

#

Source: Butterworth JF, Mackey DC, Wasnick JD: *Morgan & Mikhail's Clinical Anesthesiology*, 6th Edition: www.accessanesthesiology.com

ANESTHESIA PLAN IS DOCUMENTED BEFORE ENTERING INTO OT

Anesthesia Care Plan Development:

DOS

- ✓ Review current lab data
- ✓ Review medical & surgical history with the patient
- ✓ Perform physical assessment for anesthesia
- ✓ Discuss plan with supervisor
- ✓ Revise the plan as needed
- ✓ Discuss plan with patient and obtain consent

The anesthetic care plan is based on:

- A review of the medical record available
- Medical history
- Prior anesthetic experiences
- Drug therapies
- Medical examination and assessment of any physical conditions that might affect the decision about the preoperative risk management
- A review of medical test and consultations that might reflect on the anesthesia administration
- An appropriate preoperative medications needed for the conduct of anesthesia
- Providing appropriate preoperative instructions and other preparations as needed

3 Stages of Plan Development

Prior to Day of Surgery (DOS):

Patient / nursing completes a health assessment including pre-anesthesia

Old medical records, including anesthesia, may be reviewed

Develop a care plan based on this information

DOS:

Conduct patient interview

Perform anesthesia physical assessment

Review current lab data

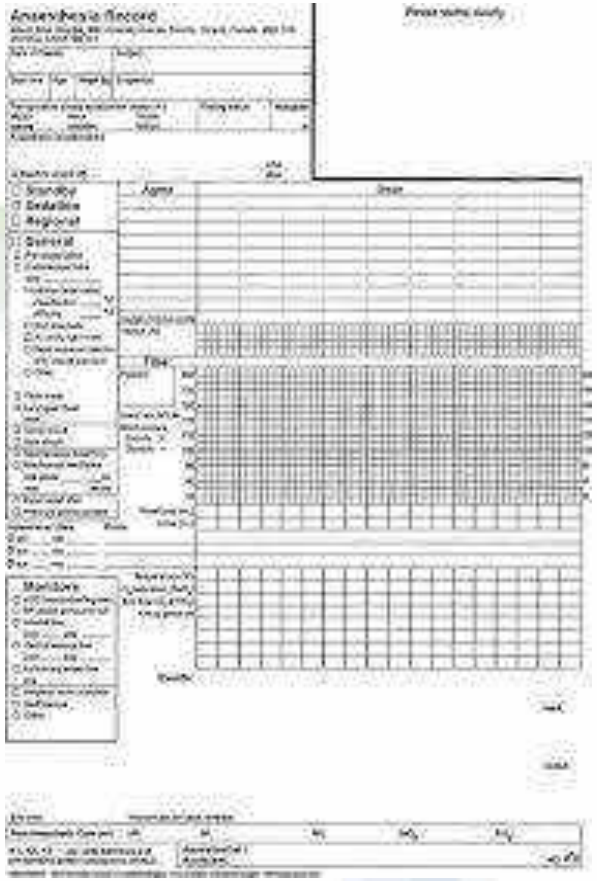
Revise the preliminary plan if needed

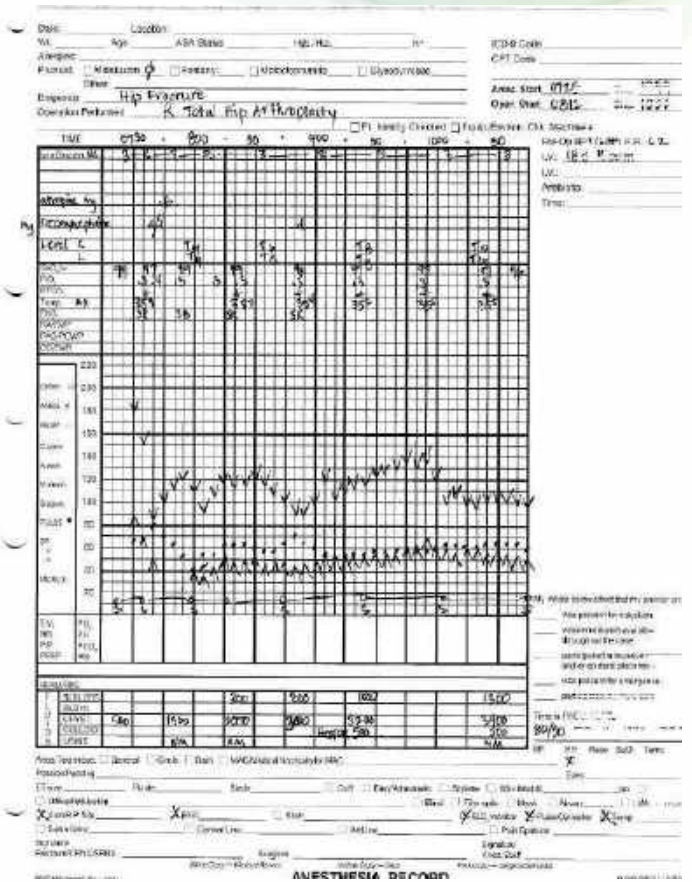
Intraoperative:

Provide vigilant care

Continually assess the plan and prepare to revise as needs arise

POST ANESTHESIA STATUS IS MONITORED AND RECORDED





POST-OPERATIVE/ANESTHESIA MONITORING INCLUDES REGULAR AND PERIODIC RECORDING OF HEART RATE, CARDIAC RHYTHM, RESPIRATORY RATE, BLOOD PRESSURE, OXYGEN SATURATION, AIRWAY SECURITY AND PATENCY

MONITORING OF PATIENTS DURING ANAESTHESIA (To be filled in by Anesthesiologist)

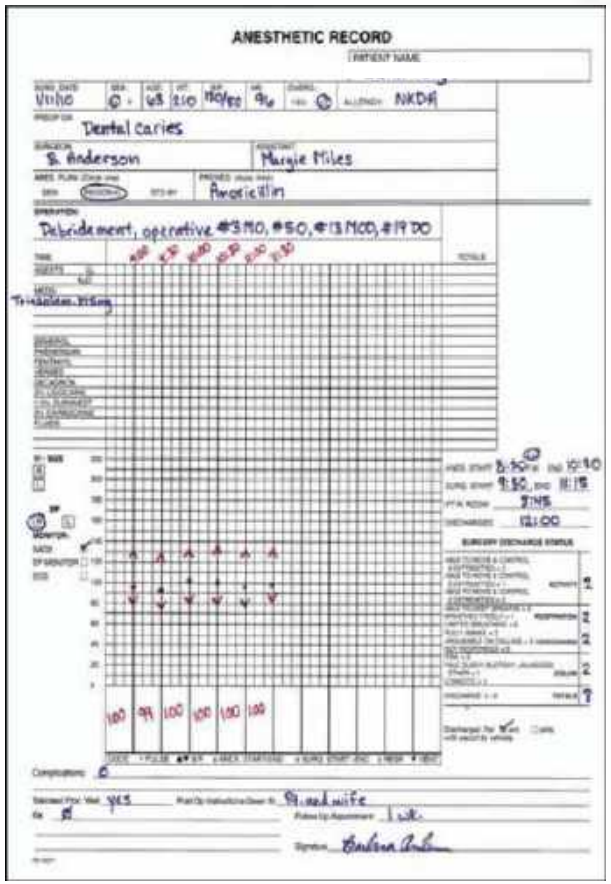
GSI - IPD-FF-20

Name of Patient: _____ Date: __/___/20__ UHID No.: _____ I.P.D. No.: _____

Unit/ Ward: _____ Diagnosis: _____

Procedure/ Operation: _____

Crystalloids	
Colloids	
Blood	
Reg Anaesthesia- Drug Catheter	
KEY	250
Pulse / min °	240
Systolic BP v	230
Diastolic BP ^	220
Respiratory rate r	
SpO2 % •	210
EtCO2 ⊖	200
	190
Temp. □	180
CVP ✱	170
	160
	150



CHAPTER 3:
SUPPORT SERVICES (OVERVIEW)

Support services are fundamental foundation of every healthcare facility and helps other departments things run smoothly. And when things are running well, patients receive better care, so the expected clinical outcome cannot be visualized in the absence of support services. This chapter includes parameters to evaluate cleanliness, sterilization, infection control practices, security and facility management, water and power supply, dietary services and laundry. These standards also cover some of the administrative processes like legal and statutory compliances, contract management, Bio-Medical waste disposal etc. If these services and facilities are in place and are managed efficiently, supported and maintained, mainline healthcare delivery will be effective.

CHAPTER 3: SUPPORT SERVICES

SS 1	Hospital should be clean and have well managed flooring
SS 2	Temperature control and ventilation should be maintained in patient care and nursing area
SS 3	The hospital should have arrangement of water storage and should be tested periodically as per requirement
SS 4	The hospital should have 24 hours supply of electricity, either through direct supply or from other sources
SS 5	Medical gases and vacuum shall be made available all the time and stored safely. Compressed air should be made available as per the scope of services.
SS 6	The facility should adhere to the practices specified under statutory compliances as per the scope of services - Licenses with Certificate number, date of issue and date of expiry
SS 7	The hospital should ensure that appropriate infection control practices are being followed along with hand hygiene practices
SS 8	Hospital should ensure Bio-Medical Waste management practices as per the statutory norms (BMW (Amendment) Rules, 2018)
SS 9	Hospital should ensure that services i.e. (Laundry, Housekeeping, Dietary, security, Ambulance, Mortuary, Central Sterile Supply Department (CSSD) etc. are available (in-house or outsourced).
SS 10	Sexual harassment and grievance handling procedure should be available.

SS 1 - HOSPITAL SHOULD BE CLEAN AND HAVE WELL MANAGED FLOORING

Interpretation – The flooring of the hospital should be well managed and have adequate cleaning processes like mopping, scrubbing etc. conducive for the infection control.

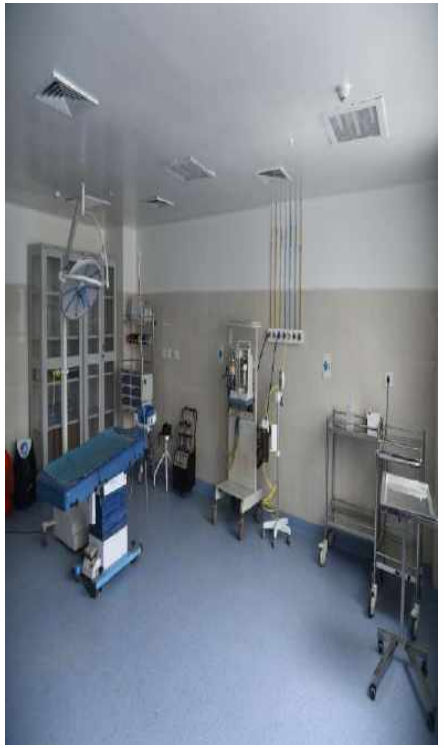
Means of verification:

1. The floor should be non-slippery and dry
2. The floor surface should be smooth enough for effective cleaning and walking
3. The facility should be cleaned at least twice in the day with a wet mop and are also rigorously cleaned with scrubbing at least once in a month. Check cleaning records for regular and frequency of cleaning

THE FLOOR SHOULD BE NON-SLIPPERY AND DRY

THE FLOOR SURFACE SHOULD BE SMOOTH ENOUGH FOR EFFECTIVE CLEANING AND WALKING

THE FACILITY SHOULD BE CLEANED AT LEAST TWICE IN THE DAY WITH A WET MOP AND ARE ALSO RIGOROUSLY CLEANED WITH SCRUBBING AT LEAST ONCE IN A MONTH. CHECK CLEANING RECORDS FOR REGULAR AND FREQUENCY OF CLEANING



SS 2 - TEMPERATURE CONTROL AND VENTILATION SHOULD BE MAINTAINED IN PATIENT CARE AND NURSING AREA

Interpretation – Arrangement for comfortable work environment in terms of temperature control should be available in patient care areas and work stations.

Means of verification:

1. Availability of fans/ air conditioning/ heating/ exhaust/ air vents as per the requirement and weather condition.

AVAILABILITY OF FANS/ AIR CONDITIONING/ HEATING/ EXHAUST/ AIR VENTS AS PER THE REQUIREMENT AND WEATHER CONDITION

SS 3 - THE HOSPITAL SHOULD HAVE ARRANGEMENT OF WATER STORAGE AND SHOULD BE TESTED PERIODICALLY AS PER REQUIREMENT

Interpretation – The hospital shall ensure that there is sufficient water supply to meet the requirements at all point of use round the clock. Alternate source of water should be available as backup for any failure or shortage and same should be tested on regular basis. The results of the tests should be documented.

Means of verification:

1. At least 200 liters of water per bed per day is available on a daily 24x7 basis. Adequate backup for continuous water supply should be available (check alternate sources also)
2. Water is available at all points of use for hand washing, OT, Labor room, wards, Patients toilet & bathroom.
3. All water tanks are kept tightly closed to ensure safety
4. Check the records for periodic tests of the quality of water from the source (municipal supply, borewell, etc.) for bacterial and chemical content as per the guidelines

AT LEAST 200 LITERS OF WATER PER BED PER DAY IS AVAILABLE ON A DAILY 24X7 BASIS. ADEQUATE BACKUP FOR CONTINUOUS WATER SUPPLY SHOULD BE AVAILABLE (CHECK ALTERNATE SOURCES ALSO)

According to WHO guidelines, the **minimum water** requirement of **a hospital** is about 50 litres **per** person **per day**. Normally, the **water** requirement is 115 litres **per** person **per day**. **A** district **hospital** with about 100 patients and 200 personnel, or **a** total of 300 people, will **need** at least 34,500 litres of **water per day**.

Examples of alternative water sources include:

- **Harvested rainwater from roofs**
- **Harvested storm water**
- **Reclaimed wastewater**
- **Gray water**
- **Captured condensate**
- **Additional alternative water sources**
  - **Atmospheric water generation**
  - **Discharged water from water purification processes**
  - **Foundation water**
  - **Blowdown water**
  - **Desalinated water.**

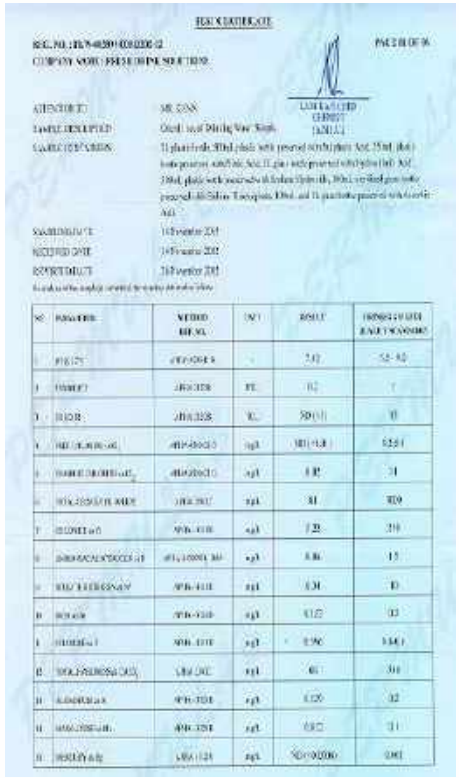
WATER IS AVAILABLE AT ALL POINTS OF USE FOR HAND WASHING, OT, LABOR ROOM, WARDS, PATIENTS TOILET & BATHROOM

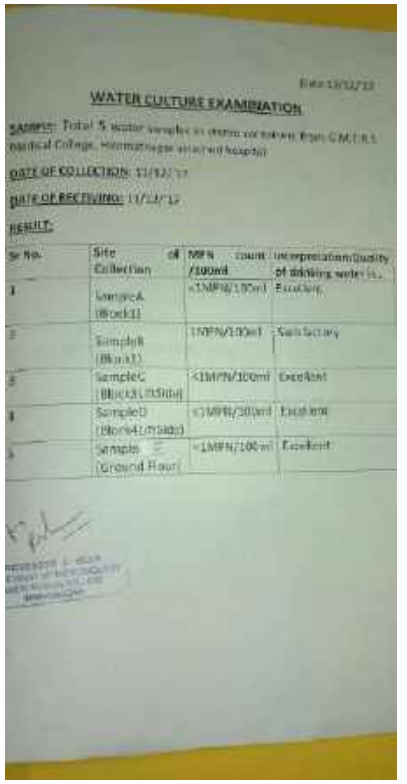
ALL WATER TANKS ARE KEPT TIGHTLY CLOSED TO ENSURE SAFETY

CHECK THE RECORDS FOR PERIODIC TESTS OF THE QUALITY OF WATER FROM THE SOURCE (MUNICIPAL SUPPLY, BOREWELL, ETC.) FOR BACTERIAL AND CHEMICAL CONTENT AS PER THE GUIDELINES

Parameter	Drinking water quality as per		
	EQS standard	WHO standard	EC standard
pH	6.0–8.5	6.5–8.5	6.5–8.5
TDS (mg/l)	1,000	1,000	1,000
Iron (mg/l)	0.3–1.0	0.3	0.20
Sodium (mg/l)	200	200	175
Chloride (mg/l)	150–600	250	250
Sulphate (mg/l)	400	400	25
Fluoride (mg/l)	1.0	1.5	1.5
Arsenic (mg/l)	0.05	0.05	0.05
Ammonium (mg/l)	0.5	1.5	0.5
Nitrate (mg/l)	10	10	10
Phosphate (mg/l)	6.0	–	5.0
Potassium (mg/l)	12.0	–	10
Endrin (mg/l)	0	0.2	0.2
Heptachlor (µg/l)	0	0.1	0.1
DDT (µg/l)	0	1.0	0.1

Source [10]





SS 4 - THE HOSPITAL SHOULD HAVE 24 HOURS SUPPLY OF ELECTRICITY, EITHER THROUGH DIRECT SUPPLY OR FROM OTHER SOURCES

Interpretation – Hospital should have availability of power back up in the form of emergency lights, DG sets, solar energy, UPS, noiseless generators or any other suitable source. The staff involved in maintenance of electricity must have rubber mats, gloves and boots for safe working and prevention from any mis happening.

Means of verification:

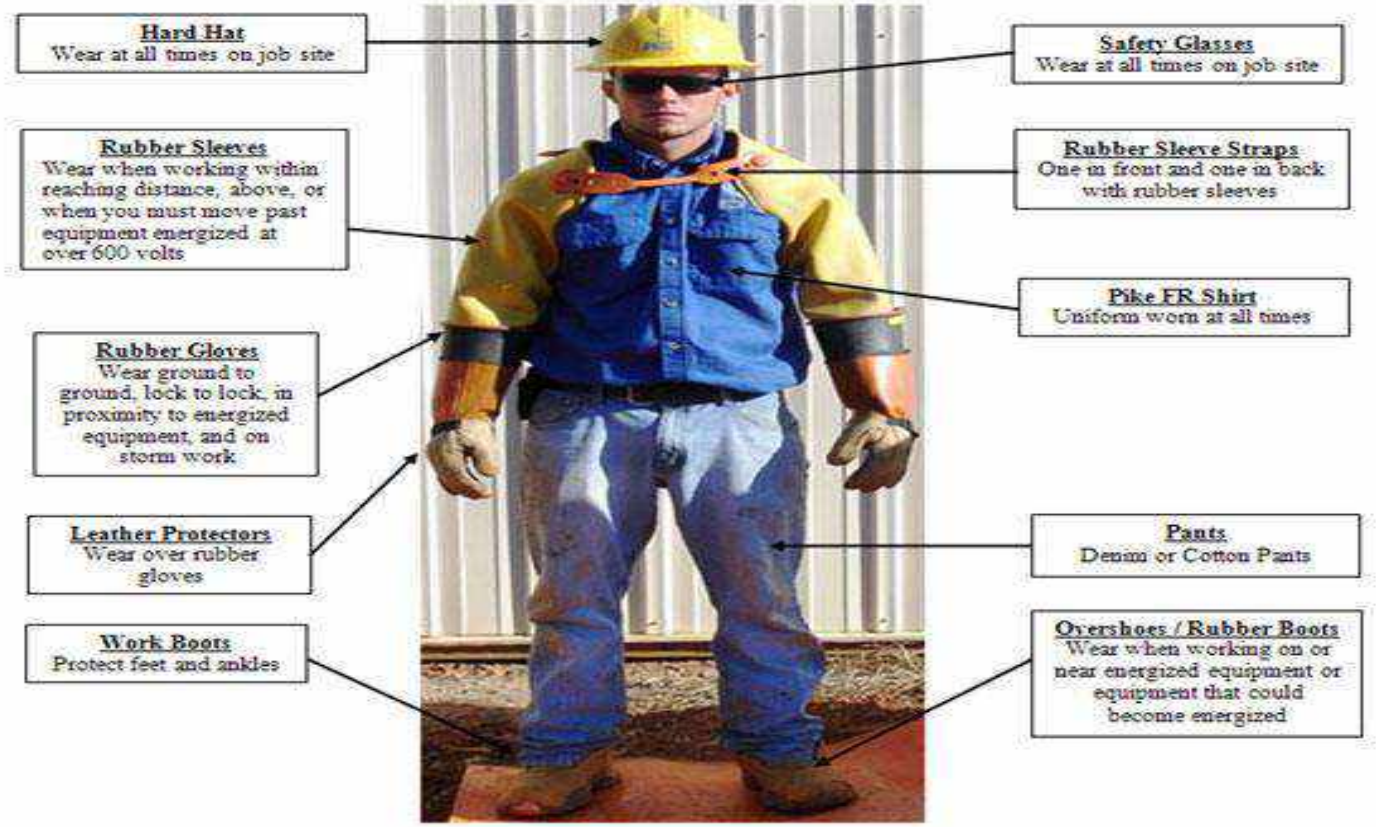
1. Check the availability of power back up, availability of UPS, emergency lights or noiseless generators
2. Rubber mats are available in the electrical room below the panels and rubber gloves, boots and safety gears are provided to the electrical staff

CHECK THE AVAILABILITY OF POWER BACK UP, AVAILABILITY OF UPS, EMERGENCY LIGHTS OR NOISELESS GENERATORS

UPS

Emergency lights

RUBBER MATS ARE AVAILABLE IN THE ELECTRICAL ROOM BELOW THE PANELS AND RUBBER GLOVES, BOOTS AND SAFETY GEARS ARE PROVIDED TO THE ELECTRICAL STAFF



SS 5 - MEDICAL GASES AND VACUUM SHALL BE MADE AVAILABLE ALL THE TIME AND STORED SAFELY. COMPRESSED AIR SHOULD BE MADE AVAILABLE AS PER THE SCOPE OF SERVICES.

Interpretation – Manifold room should be accessible and have adequate back up of oxygen cylinders. Availability of central oxygen and vacuum supply should especially be assessed in critical area like OT and ICU with standardized colour coding of cylinders and pipelines. A prompt replacement procedure and alarm system should be available to indicate any abnormal pressure change in the room. The instructions for operating different equipment's in manifold room should be displayed clearly.

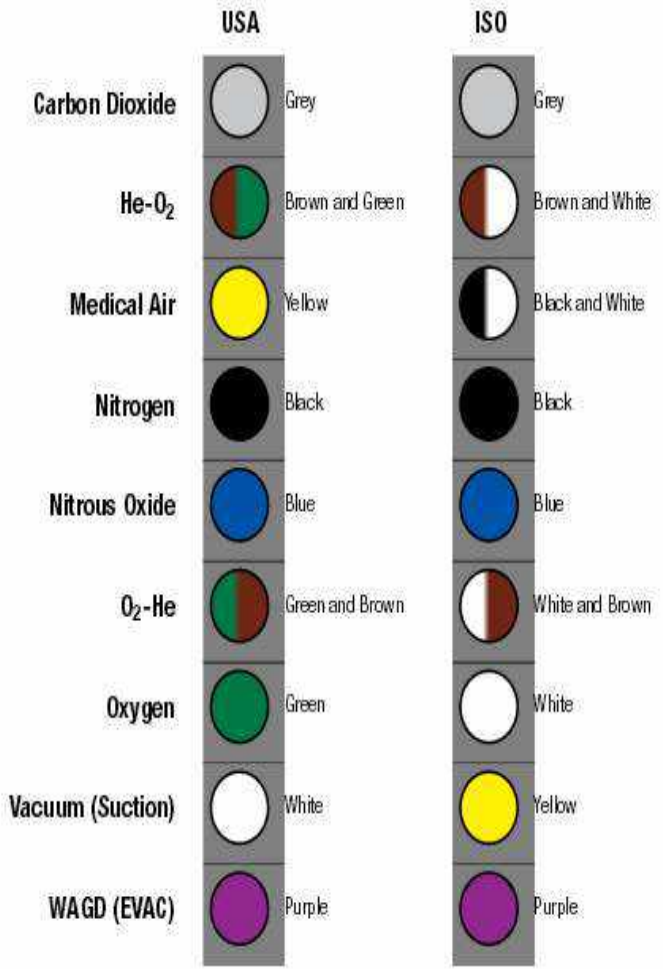
Means of verification:

1. The manifold room should be located on the ground floor and entry to the room is prohibited for the unauthorized people.
2. The manifold room should have at least 3 days of oxygen and other medical gases stock, that is chained appropriately
3. Colour of the gas pipeline (if applicable) and the gas cylinder has to be as per the standards
4. The alarm system should be operational to indicate any abnormal pressure change
5. Adequate back-up of B-type cylinders in critical areas like ICU, OT and for patient transfer purpose
6. The procedure being followed for prompt replacement of empty cylinders with filled cylinders
7. Instruction for operating different equipment in the manifold room should be clearly displayed

THE MANIFOLD ROOM SHOULD BE LOCATED ON THE GROUND FLOOR AND ENTRY TO THE ROOM IS PROHIBITED FOR THE UNAUTHORIZED PEOPLE

THE MANIFOLD ROOM SHOULD HAVE AT LEAST 3 DAYS OF OXYGEN AND OTHER MEDICAL GASES STOCK, THAT IS CHAINED APPROPRIATELY

COLOUR OF THE GAS PIPELINE (IF APPLICABLE) AND THE GAS CYLINDER HAS TO BE AS PER THE STANDARDS



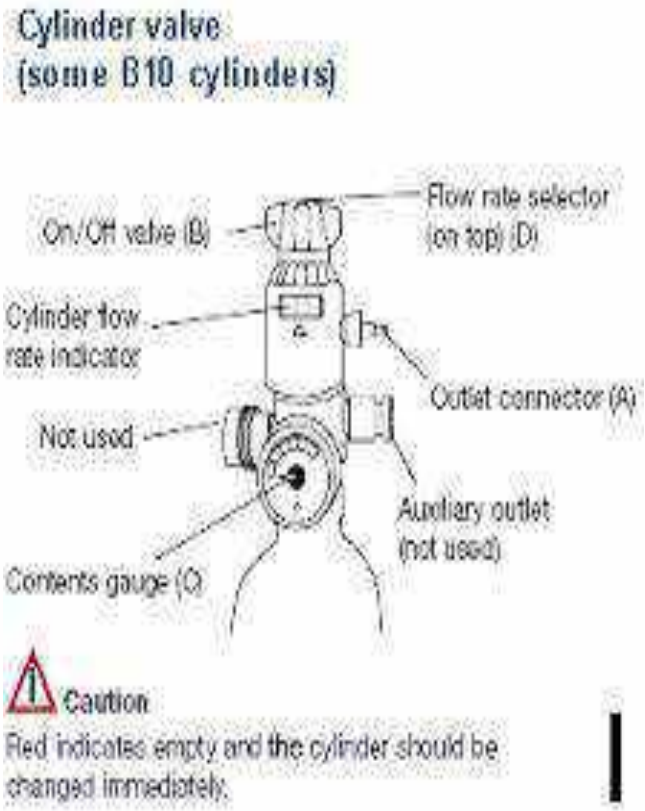
Gas Cylinder

Gas pipeline

Material Property	Letter Color on Field Color	Example
Single Gases		
Oxygen USP†	White on Green	OXYGEN 50-55 PSI
Carbon Dioxide†	White on Gray	CARBON DIOXIDE
Nitrous Oxide†	White on Blue	NITROUS OXIDE
Cyclopropane‡	Black on Orange	CYCLOPROPANE
Helium USP†	White on Brown	HELIUM 50-55 PSI
Nitrogen NF†	White on Black	NITROGEN 160-200 PSI
Medical Air USP†	Black on Yellow	MEDICAL AIR
Instrument Air†	White on Red	INSTRUMENT AIR
Waste Anesthetic Gas Disposal†	White on Purple	WASTE ANESTHETIC
Laboratory Air†	Black on White/Yellow Checkerboard	LABORATORY AIR
Laboratory Vaccum†	Black on Black/White Checkerboard[2]	LABORATORY VACUUM
Medical-Surgical Vaccum†	Black on White	MEDICAL VACUUM

THE ALARM SYSTEM SHOULD BE OPERATIONAL TO INDICATE ANY ABNORMAL PRESSURE CHANGE

ADEQUATE BACK-UP OF B-TYPE CYLINDERS IN CRITICAL AREAS LIKE ICU, OT AND FOR PATIENT TRANSFER PURPOSE



THE PROCEDURE BEING FOLLOWED FOR PROMPT REPLACEMENT OF EMPTY CYLINDERS WITH FILLED CYLINDERS

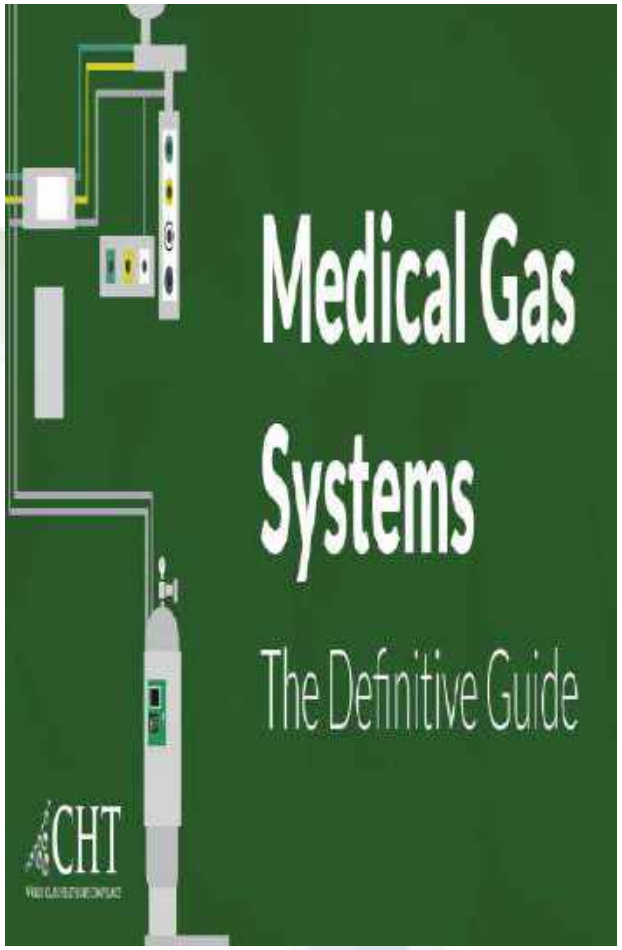
Storage and Handling of Gas Cylinders Guidelines Contents

Cylinder Safety

Below is a summary of the **DO's/DON'Ts** when working with gas cylinders

DO	DON'T
Ensure a regulator is fitted before use	Repaint a cylinder
Ensure cylinder is firmly secured	Change the markings on a cylinder
Ensure connections are tight and suitable	Use oil or lubricants on cylinder valve
Ensure cylinders are stored and used away from ignition sources	Tamper with the gas cylinder test tag
Store full and empty cylinders separately	Tamper with or remove the barcode from a gas cylinder
Ensure valve guards or caps are fitted when cylinders are not in use	Roll cylinders along the ground
Use mechanical assistance when handling cylinders	Attempt to fight a fire involving a gas cylinder
Ensure adequate ventilation is available for the gas in question	Transport gas cylinders in the passenger compartment of a vehicle
Ensure exposure limits are not exceeded	Use a cylinder that shows evidence of damage or corrosion
Read the SDS	Fill cylinders with any material at all
Follow appropriate SWP	
Have gas detection devices installed if required	

INSTRUCTION FOR OPERATING DIFFERENT EQUIPMENT IN THE MANIFOLD ROOM SHOULD BE CLEARLY DISPLAYED



4. GAS MANIFOLD

Gas manifolds are designed to supply the pipeline system with sufficient quantity of gas by cylinders and/or tanks.

The typical manifold for medical gases usually consists of a two-sided cylinder supply with automatic changeover between the empty and full side, and an additional third source for emergency supply.

MANIFOLD ROOM

- Consists of a cylinder manifold and a control panel
- Manifold can be of 2 banks of 2 cylinders each or 2 banks of 20 cylinders each.
- Control panel: primary and secondary pressure regulations: warning lamp.

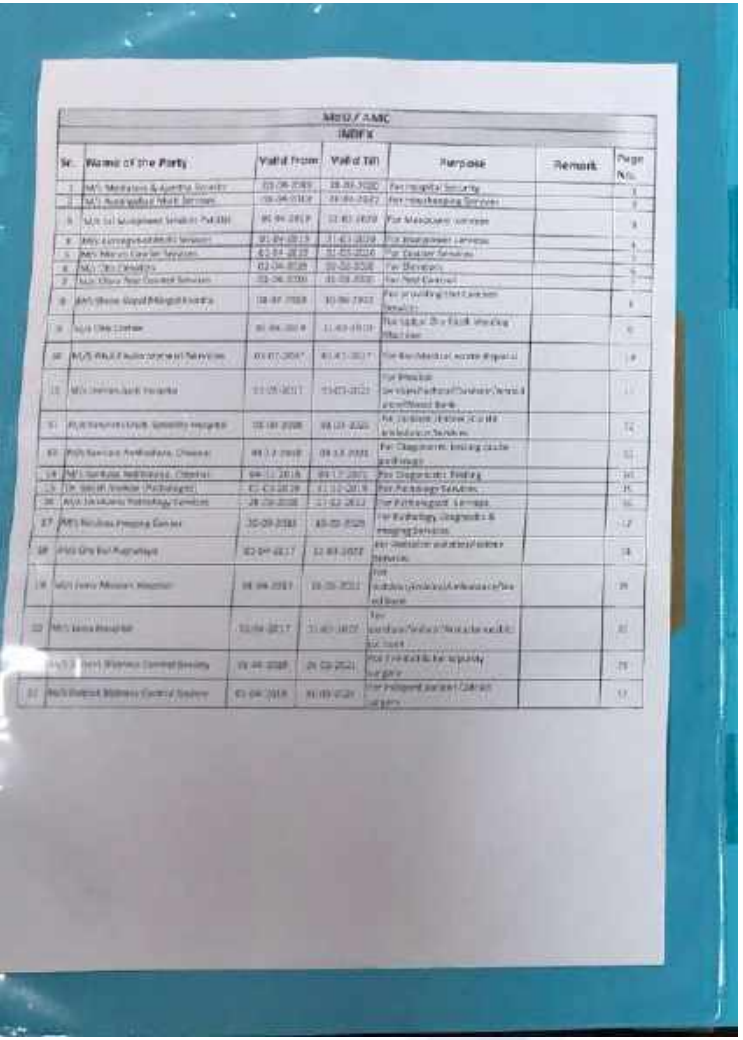
SS 6 - THE FACILITY SHOULD ADHERE TO THE PRACTICES SPECIFIED UNDER STATUTORY COMPLIANCES AS PER THE SCOPE OF SERVICES - LICENSES WITH CERTIFICATE NUMBER, DATE OF ISSUE AND DATE OF EXPIRY

Interpretation – Hospital should adhere to the statutory norms/ compliances laid down by government as per the scope of services and must provide certificates/ licenses for the same.

Means of verification:

1. Fire Department Clearance Certificate
2. NOC from Pollution Control Board for air and water pollution
3. Lift License (if applicable)
4. Hospital Registration Certificate
5. Bio-Medical Waste Management
6. PCPNDT Act Registration
7. AERB
8. Pharmacy License & Narcotics Drugs License (if applicable)
9. Ambulance Registration Certificate, insurance Policy, pollution control and Driver License (if in house or outsourced)

FIRE DEPARTMENT CLEARANCE CERTIFICATE



MOU / AMC

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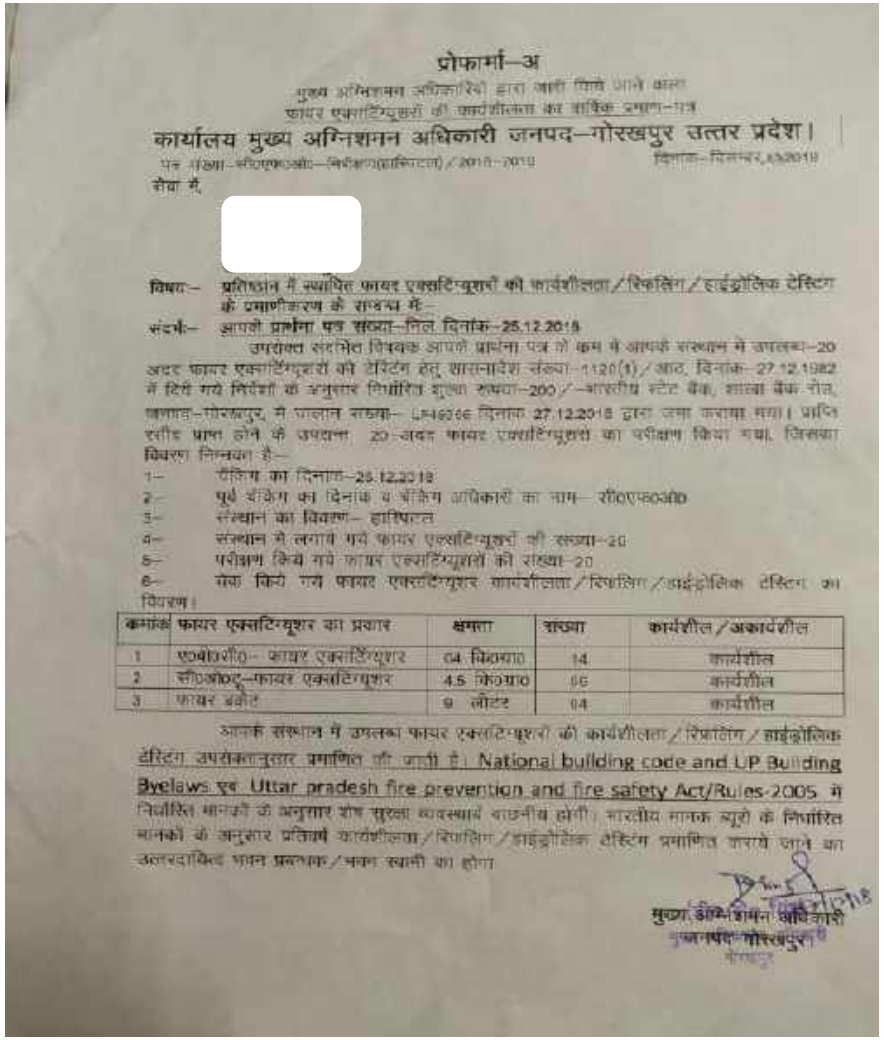
Sr.	Name of the Party	Valid From	Valid Till	Purpose	Remark	Page No.
1	M/S. Mediwaste & Ayantika Services	03.06.2019	28.05.2020	For Hospital Security		1
2	M/S Aarogyadoot Med. Services	08.04.2019	07.04.2022	For Housekeeping Services		2
3	M/S Sri Sivaganesh Services Pvt.Ltd	06.04.2019	05.03.2020	For Manpower services		3
4	M/S Lavanya Facilities Services	01.04.2019	31.03.2020	For Manpower services		4
5	M/S Mercury Courier Services	01.04.2019	31.03.2020	For Courier Services		5
6	M/S Otis Elevator Co.	02.04.2019	01.04.2020	For Elevators		6
7	M/S Shree Ram Pest Control Services	03.04.2019	02.04.2020	For Pest Control		7
8	M/S Shree Good Morning Enterprises	08.04.2019	30.04.2019	For providing Hand Sanitizer Dispensers		8
9	M/S Otis Limited	06.04.2019	31.03.2020	For Lifts & Esc. Facility Washing Machines		9
10	M/S. R&D Automotive Services	03.07.2017	02.07.2022	For Bio-Medical waste disposal		10
11	M/S. Indian Bank Hospital	01.05.2017	31.03.2022	For Medical Services/Technical Services & Miscellaneous Work		11
12	M/S Karunya Health Specialty Hospital	03.08.2018	02.08.2021	For Medical Waste Collection & Disposal Services		12
13	M/S Services Technocrats, Chennai	09.12.2018	08.12.2021	For Diagnostic Imaging Centre Maintenance		13
14	M/S. Sankara Nethralaya, Chennai	04.12.2018	03.12.2021	For Diagnostic Imaging		14
15	Dr. Sakthi Shankar Pathologist	01.04.2019	31.03.2020	For Pathology Services		15
16	M/S Sankara Nethralaya Trustees	28.09.2018	27.09.2021	For Pathological Services		16
17	M/S Krishna Imaging Center	20.09.2018	19.09.2020	For Radiology, Diagnostic & Imaging Services		17
18	M/S Shri Sai Radiology	02.04.2017	31.03.2022	For Radiation and Allied Medical Services		18
19	M/S Guru Mission Hospital	08.04.2017	07.04.2022	For Ambulance/Medical Waste Collection		19
20	M/S Guru Hospital	03.04.2017	31.03.2022	For Ambulance/Medical Waste collection & Disposal		20
21	M/S Shanmuga Medical Centre & Hospital	01.04.2018	31.03.2021	For Pre-Medical Examination for Maternity Surgeries		21
22	M/S Sathguru Maternity Centre & Hospital	01.04.2018	31.03.2021	For Pre-Medical Examination for Maternity Surgeries		22



प्रोफार्मा–अ

मुख्य अग्निशमन अधिकारी द्वारा जारी किये जाने वाला

फायर एक्सटिंग्यूशरों की कार्यशीलता का वार्षिक प्रमाण–पत्र

कार्यालय मुख्य अग्निशमन अधिकारी जनपद–गोरखपुर उत्तर प्रदेश।

पत्र संख्या–सी0एफ0ओ0–सिविल(हास्पिटल) / 2018–2019 दिनांक– दिसम्बर, 2018

सेवा में,

[redacted]

विषय:– प्रतिष्ठान में स्थापित फायर एक्सटिंग्यूशरों की कार्यशीलता / रिफलिंग / हाईड्रोलिक टेस्टिंग के प्रमाणीकरण के सम्बन्ध में।

संदर्भ:– आपके प्रार्थना पत्र संख्या–निल दिनांक–26.12.2018

उपरोक्त संदर्भित विषयक आपके प्रार्थना पत्र के क्रम में आपके संस्थान में उपलब्ध–20 अदद फायर एक्सटिंग्यूशरों की टेस्टिंग हेतु शासनादेश संख्या–1120(1) / आठ, दिनांक–27.12.1982 में दिये गये निर्देशों का अनुपालन निर्धारित शुल्क राशि–200/–भारतीय स्टेट बैंक, शाखा बैंक रोड, जनपद–गोरखपुर, में भुगतान राशि– LP46016 दिनांक 27.12.2018 द्वारा जमा कराया गया। प्रति रसीद प्राप्त होने के उपरान्त 20 अदद फायर एक्सटिंग्यूशरों का परीक्षण किया गया, जिसका विवरण निम्नवत है–

1– टेस्टिंग का दिनांक–26.12.2018

2– पूर्व चेकिंग का दिनांक व चेकिंग अधिकारी का नाम– सी0एफ0ओ0

3– संस्थान का विवरण– हास्पिटल

4– संस्थान में लगाये गये फायर एक्सटिंग्यूशरों की संख्या–20

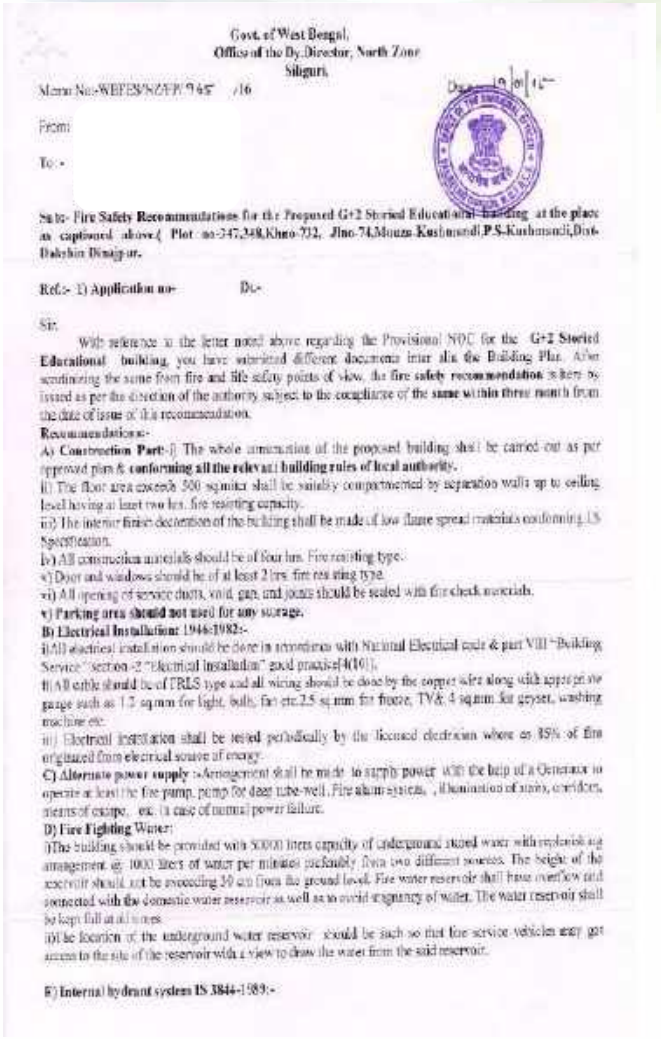
5– परीक्षण किये गये फायर एक्सटिंग्यूशरों की संख्या–20

6– सेवा किये गये फायर एक्सटिंग्यूशर कार्यशीलता / रिफलिंग / हाईड्रोलिक टेस्टिंग का विवरण।

क्रमांक	फायर एक्सटिंग्यूशर का प्रकार	क्षमता	संख्या	कार्यशील / अकार्यशील
1	एम0सी0टी0– फायर एक्सटिंग्यूशर	04 किग्रा0	14	कार्यशील
2	सी0ओ2–फायर एक्सटिंग्यूशर	4.5 किग्रा0	06	कार्यशील
3	फायर बकेट	9 लीटर	04	कार्यशील

आपके संस्थान में उपलब्ध फायर एक्सटिंग्यूशरों की कार्यशीलता / रिफलिंग / हाईड्रोलिक टेस्टिंग उपरोक्तानुसार प्रमाणित की जाती है। National building code and UP Building Byelaws एवं Uttar pradesh fire prevention and fire safety Act/Rules-2005 में निर्धारित मानकों के अनुसार शेष सुरक्षा व्यवस्थायें वाछनीय होगी। भारतीय मानक ब्यूरो के निर्धारित मानकों के अनुसार प्रतियेक कार्यशीलता / रिफलिंग / हाईड्रोलिक टेस्टिंग प्रमाणित कराये जाने का उत्तरदायित्व भवन प्रबन्धक / भवन स्वामी का होगा।

मुख्य अग्निशमन अधिकारी
जनपद–गोरखपुर



Govt. of West Bengal,
Office of the Dy.Director, North Zone
Siliguri.

Memo No.-WBFES/NZ/FP/945 /16 Dated 19/8/16

From

To :-

Sub:- Fire Safety Recommendations for the Proposed G+2 Storied Educational building at the place as captioned above.(Plot no-247,248,Khata-732, Jlno-74,Mouza-Kushamodi,P.S-Kushamodi,Dist-Dakshin Dinajpur.

Ref:- 1) Application no- Dt-

Sir,

With reference to the letter noted above regarding the Provisional NOC for the G+2 Storied Educational building, you have submitted different documents inter alia the Building Plan. After scrutinizing the same from fire and life safety points of view, the fire safety recommendation is here by issued as per the direction of the authority subject to the compliance of the same within three month from the date of issue of this recommendation.

Recommendations:-

A) Construction Part:- i) The whole construction of the proposed building shall be carried out as per approved plan & conforming all the relevant building rules of local authority.

ii) The floor area exceeds 500 sq.mtrs shall be suitably compartmented by separation walls up to ceiling level having at least two hrs. fire resisting capacity.

iii) The interior finish decoration of the building shall be made of low flame spread materials conforming IS Specification.

iv) All construction materials should be of four hrs. Fire resisting type.

v) Door and windows should be of at least 2 hrs. fire resisting type.

vi) All opening of service ducts, void, gaps, and joints should be sealed with fire check materials.

v) Parking area should not used for any storage.

B) Electrical Installation: 1946:1982:-

i) All electrical installation should be done in accordance with National Electrical code & part VIII "Building Service" section-2 "Electrical Installation" good practice(4(10)).

ii) All cable should be of FRLS type and all wiring should be done by the copper wire along with appropriate gauge such as 1.5 sq.mm for light, bulb, fan etc.2.5 sq.mm for freeze, TV& 4 sq.mm for geyser, washing machine etc.

iii) Electrical installation shall be tested periodically by the licensed electrician where no 85% of fire originated from electrical source of energy.

C) Alternate power supply :-Arrangement shall be made to supply power with the help of a Generator to operate at least the fire pump, pump for deep tube-well, Fire alarm system, , Illumination of stairs, corridors, means of escape, etc. in case of normal power failure.

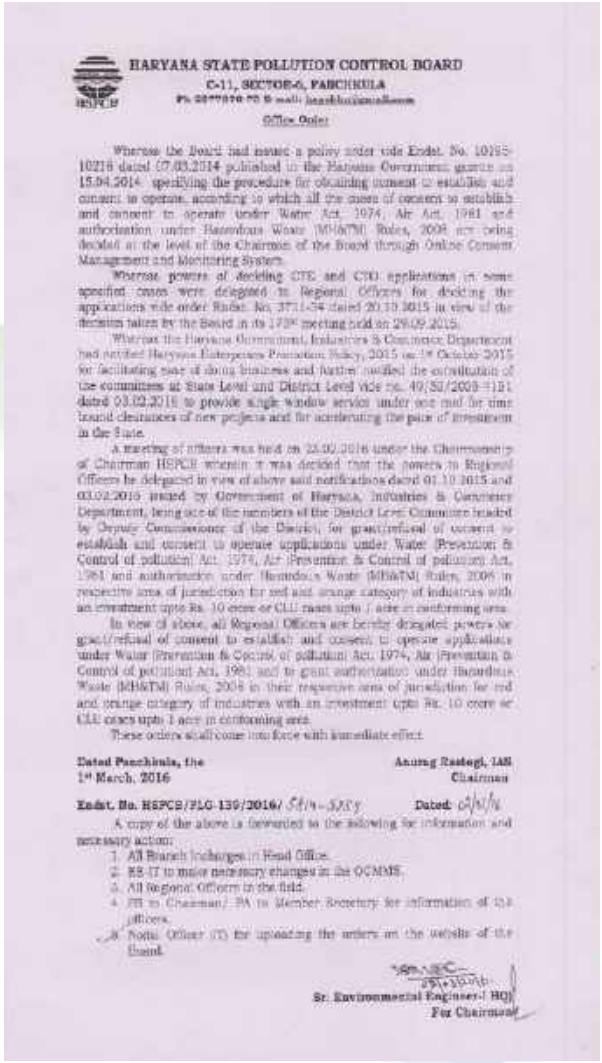
D) Fire Fighting Water:

i)The building should be provided with 50000 liters capacity of underground stored water with sprinkler arrangement @ 1000 liters of water per minutes preferably from two different sources. The height of the reservoir should not be exceeding 30 cm from the ground level. Fire water reservoir shall have overflow and connected with the domestic water reservoir as well as to avoid stagnancy of water. The water reservoir shall be kept full at all times.

ii)The location of the underground water reservoir should be such so that fire service vehicles may get access to the site of the reservoir with a view to draw the water from the said reservoir.

E) Internal hydrant system IS 3844-1989:-

NOC FROM POLLUTION CONTROL BOARD FOR AIR AND WATER POLLUTION



HARYANA STATE POLLUTION CONTROL BOARD
C-11, SECTOR-6, PANCHKULA

Office Order

Whereas the Board had issued a policy order vide Endst. No. 10195-10210 dated 07.03.2014 published in the Haryana Government gazette on 15.04.2014 specifying the procedure for obtaining consent to establish and consent to operate under Water Act, 1974, Air Act, 1981 and authorization under Hazardous Waste (M/H&TM) Rules, 2008 are being decided at the level of the Chairman of the Board through Online Consent Management and Monitoring System.

Whereas powers of deciding CTE and CTO applications in some specified cases were delegated to Regional Officers for deciding the applications vide order Endst. No. 3771-94 dated 20.10.2015 in view of the decision taken by the Board in its 173rd meeting held on 29.09.2015.

Whereas the Haryana Government, Industries & Commerce Department had notified Haryana Enterprises Promotion Policy, 2015 on 1st October 2015 for facilitating ease of doing business and further notified the constitution of the committees at State Level and District Level vide no. 40/SI/2008-1181 dated 03.02.2016 to provide single window service under one roof for time bound clearances of new projects and for accelerating the pace of investment in the State.

A meeting of officers was held on 25.02.2016 under the Chairmanship of Chairman HSPCB wherein it was decided that the powers to Regional Officers be delegated in view of above said notifications dated 01.10.2015 and 03.02.2016 issued by Government of Haryana, Industries & Commerce Department, being one of the members of the District Level Committee headed by Deputy Commissioner of the District, for grant/refusal of consent to establish and consent to operate applications under Water (Prevention & Control of pollution) Act, 1974, Air (Prevention & Control of pollution) Act, 1981 and authorization under Hazardous Waste (M/H&TM) Rules, 2008 in respective area of jurisdiction for red and orange category of industries with an investment upto Rs. 10 crore or CLU cases upto 1 acre or conforming area.

In view of above, all Regional Officers are hereby delegated powers for grant/refusal of consent to establish and consent to operate applications under Water (Prevention & Control of pollution) Act, 1974, Air (Prevention & Control of pollution) Act, 1981 and to grant authorization under Hazardous Waste (M/H&TM) Rules, 2008 in their respective area of jurisdiction for red and orange category of industries with an investment upto Rs. 10 crore or CLU cases upto 1 acre in conforming area.

These orders shall come into force with immediate effect.

Dated Panchkula, the
1st March, 2016

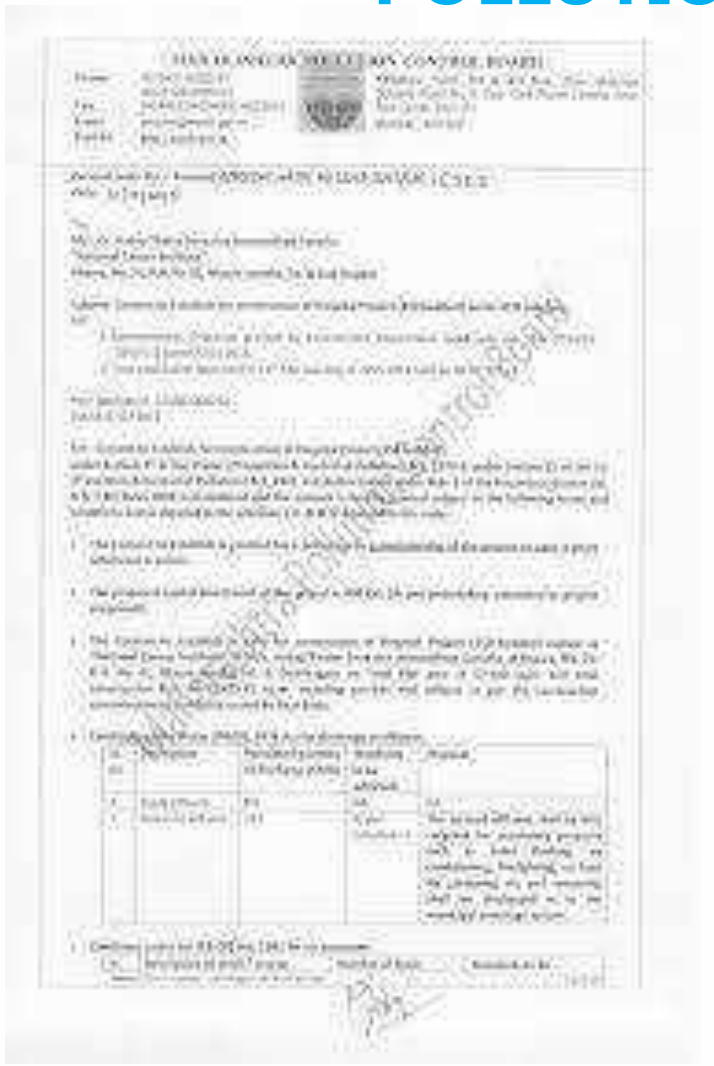
Anurag Rastogi, IAS
Chairman

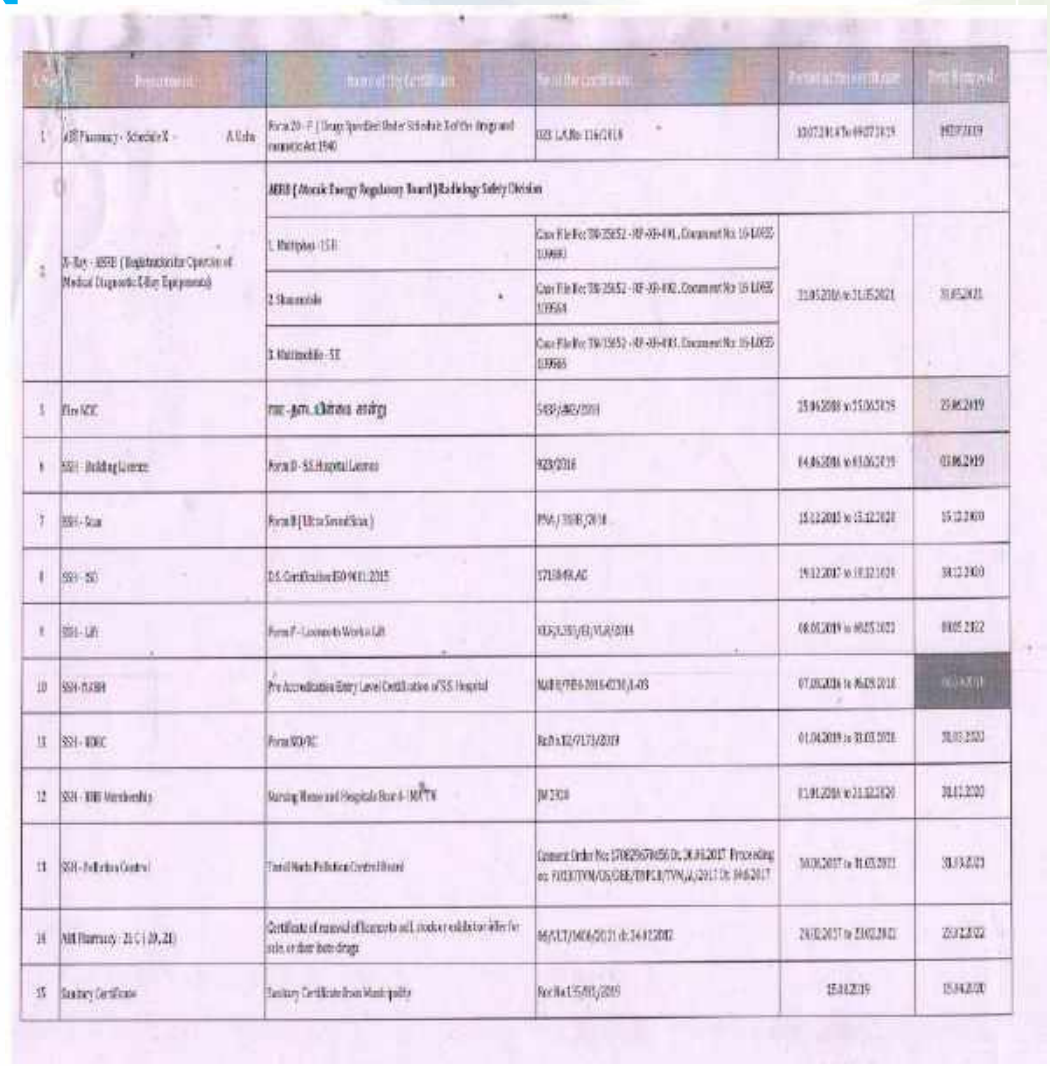
Endst. No. HSPCB/PLG-139/2016/ **Dated:**

A copy of the above is forwarded to the following for information and necessary action:

1. All Branch In-charges in Head Office.
2. MS-IT to make necessary changes in the OCMMS.
3. All Regional Officers in the field.
4. PS to Chairman / PA to Member Secretary for information of the officers.
5. Nodal Officer (IT) for uploading the orders on the website of the Board.

Sr. Environmental Engineer-I (HQ)
For Chairman





S.No.	Department	Name of the Certificate	Serial No. Certificate	Period of Issue of Certificate	Date of Expiry of
1	ARB Pharmacy - Schedule X - A Units	Form 20 - F [Drugs Specified Under Schedule X of the Drugs and Cosmetics Act 1940	020 LA/Re-116/2018	10.07.2018 To 09.07.2023	09.07.2023
2	X-Ray - AERB (Registration for Operation of Medical Diagnostic X-Ray Equipments)	AERB (Atomic Energy Regulatory Board) Radiology Safety Division			
		1. Multiplan - 150	Case File No: TN/25652 - RF-XR-001, Document No: 15-LO025 (100001)	23.05.2016 to 31.05.2021	31.05.2021
		2. Shimadzu	Case File No: TN/25652 - RF-XR-002, Document No: 15-LO025 (100004)		
		3. Multimobile - 32	Case File No: TN/25652 - RF-XR-003, Document No: 15-LO025 (100005)		
3	Fire NOC	[illegible]	5439/ARO/2018	25.06.2018 to 25.06.2019	25.06.2019
4	BMW - Building Licence	Form B - BMW Hospital Licence	9239/2018	04.06.2018 to 03.06.2019	03.06.2019
5	BMW - Boiler	Form B (Ulto Steam Boiler)	PWA / 3308 / 2018	15.12.2018 to 15.12.2020	15.12.2020
6	BMW - ISO	ISO Certification ISO 9001:2015	5710.09.AQ	19.12.2017 to 18.12.2020	18.12.2020
7	BMW - Lift	Form F - Licence to Works Lift	03(5.3.35)/(E)/VLR/2018	08.05.2019 to 08.05.2022	08.05.2022
8	BMW - NABH	Pre Accreditation Entry Level Certification of BMW Hospital	NABH/PRE-2018-0230/L-0/5	07.08.2018 to 06.08.2018	[illegible]
9	BMW - BMWC	Form BMWC	Rec/Form 2(2)/7173/2019	01.04.2019 to 31.03.2020	31.03.2020
10	BMW - BMW Membership	Nursing Home and Hospitals Rent-A-Bed TN	BM 2308	01.04.2018 to 31.03.2020	31.03.2020
11	BMW - Pollution Control	Tamil Nadu Pollution Control Board	Consent Order No: 1702295/TNPCB/TPN/(4)/2017 Dt: 30.03.2017 Proceeding no: 0/TNPCB/TPN/CTO/BMW/TPN/(4)/2017 Dt: 04.04.2017	30.03.2017 to 31.03.2022	31.03.2022
12	ARB Pharmacy - 21 C (20, 21)	Certificate of renewal of licence to sell, stock or exhibit or offer for sale, or distribute drugs	96/LIT/14/04/2021 dt: 24.12.2002	28.02.2017 to 27.02.2022	27.02.2022
13	Sanitary Certificate	Sanitary Certificate from Municipality	Rec No: 15/505/2019	15.04.2019	15.04.2020

LIFT LICENSE (IF APPLICABLE)

GAC/1592

GOVERMENT OF GUJARAT

GOVERMENT OF GUJARAT

LICENSE

TO

ELECTRICAL CONTRACTORS

Authorized by Govt. Notification, E & P Deptt.,
No. GU/2013/37/ELA/11-2012/2401/K, dated the 22nd APRIL 2013

M/s. *is hereby authorized to carry out Electrical Installation Works in the Gujarat State, subject to the conditions mentioned in the Regulations issued the Government of Gujarat under Government Notification, Energy Petrochemical Department,No. GU/ 2013/ 37/ ELA/ 11/ 2012/2401/K, Dated 22nd April 2013.*

Energy & Petrochemicals Dept.
Gujarat State,Gandhinagar.
Issue Date:02/03/1998

President
Licensing board
Gandhinagar

Secretary
Licensing board
Gandhinagar

Date of Renewal	Date of Expiry	Secretary's Initials
01/01/2014	31/12/2018	

Licence No.: 50890000006361 Form C

GOVT. OF N.C.T OF DELHI

LABOUR DEPARTMENT

(ELECTRICAL SECTION)

DISTRICT : SOUTH . DELHI

LICENCE FOR WORKING A LIFT

1.-

110017 is/are hereby authorised to work the lift no. 1 installed in the premises owned by Sh/Smt/M/s GARRY LAKHANPAL and situated at E-18, GEETANJALI ENCLAVE, NEW DELHI - 110017 subject to the terms & conditions mentioned below as per the Delhi Lifts Rules, 1942.

Terms & conditions :- Every owner(s) of the place, where the lift is installed, shall be responsible to make necessary arrangements so as to maintain the lift as per the requirements set forth in the First Schedule to the Delhi Lifts Rules, 1942.

Reference EP No.: 50890000007055

Dated: 22/04/2019

Digitally signed by MUKESH GUPTA,
Deputy Electrical Inspector,
2019.04.22 16:22:35

1. This Certificate is valid as per Information Technology Act 2000 as amended from time to time.
2. The Authenticity of this document should be verified at http://edistrict.delhigovt.nic.in. Any discrepancy in the details on this document when compared to those available on the website renders it invalid.
3. The onus of checking the legitimacy is on the users of this document.
4. In case of any discrepancy please inform the Authority issuing this Certificate.

217070

Regd. No.GE.02.19.0022XX

AA/830 /04 /2019

Licence No. 20022 /2019

महाराष्ट्र शासन

विद्युत अभिनिरीक्षण उद्योग, ऊर्जा व कामगार विभाग उद्वाहन (नवीन)

मुख्य विद्युत निरिक्षक

३रा मजला, प्रशासकीय इमारत रामकृष्ण प्रेबूरकर मार्ग

चेंबूर (पूर्व), मुंबई ४०० ०७१

उद्वाहन चालविण्याची अनुज्ञप्ती

२६जे, सेक्टर - ५, खारघर, नवी मुंबई.

उद्वाहनाचा तपशील

DETAILS OF THE LIFT

(1) Make of lift : शिंडलर (2) Capacity of lift : ४४४ kg/6 Persons

(3) Horse Power of Motor : ६.२० कि.वॅ. (4) Speed of lift १.५० मि.प्र.से बदलते गतिमान

(5) Type of Drive : गियरलेस - ए.सी (6) No. of Stop : G+16 floors १७ मजले

विद्युत निरिक्षक (सचिव, अनुज्ञाप्ती मंडळ व उद्वाहन निरिक्षक) मुंबई
Electrical Inspector
(Secretary Licensing Board & Lift Inspector) Mumbai

मुख्य विद्युत निरिक्षक
Chief Electrical Inspector

Conditions :

0 5 OCT 2016

(1) Change of Name of the Owner or Society shall be communicated to this office to modify the licence accordingly.
(2) It will be the responsibility of the Owner to give the Maintenance of the Lift to the Registered Lift Contractor.
(3) Owner and the Lift Contractor are fully responsible to keep the lift in safe working condition.

To be displayed in the lift car duly framed.

HOSPITAL REGISTRATION CERTIFICATE

Provisional registration No:3564000123

GOVERNMENT OF ANDAMAN & NICOBAR ISLANDS (UT)

District Registering Authority
SOUTH ANDAMAN

CERTIFICATE OF PROVISIONAL REGISTRATION

(Registration and Regulation) Act, 2010. The Clinical Establishment is registered for providing medical services as a Hospital, Polyclinic, Haematology/Biochemistry, X-ray Centre/ICG Centre/Ultrasound Centre under Allopathy System of Medicine.

This Certificate is valid for a period of one year from the date of issue.

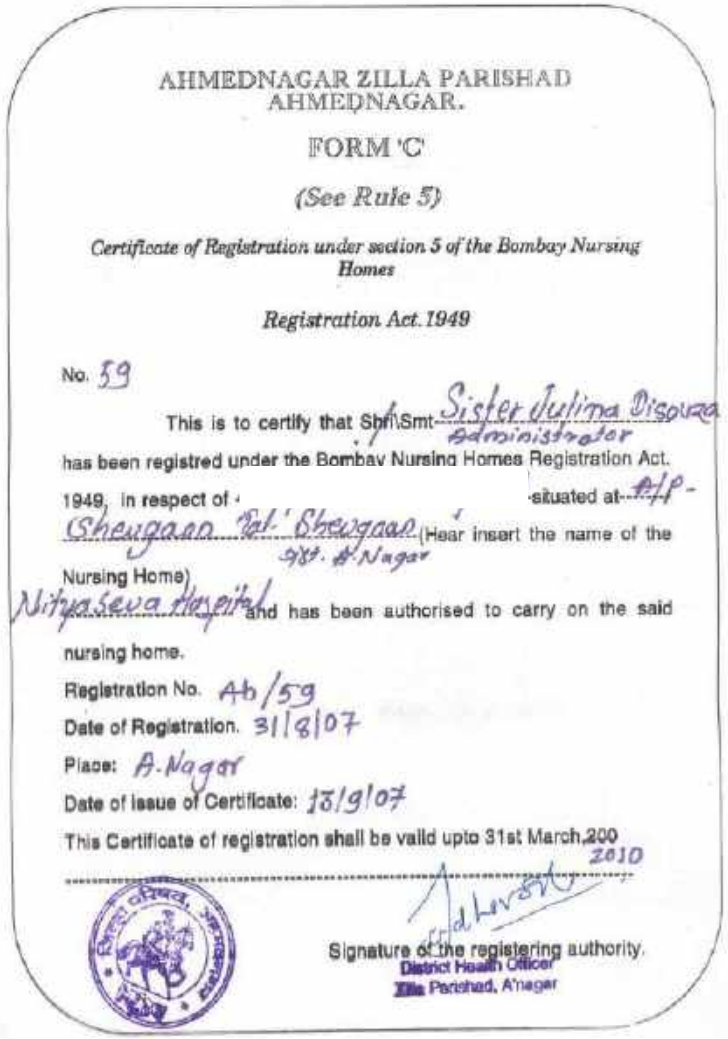
DRA: South Andaman
Designation of the Issuing Authority

Place: South Andaman
Date of issue: 27/11/2015

Terms and Conditions of registration

1. The holder of this Certificate of Registration shall comply with all the provisions of Clinical Establishment Act (Registration and Regulation) 2010 and the Rules made there under.
2. The Certificate of Registration is not transferable. The Certificate of Registration shall be displayed in a prominent place in a part of the premises open to the public.
3. Any change of ownership or change of category or change of management or on ceasing to function as a clinical establishment, the certificate of registration shall be surrendered to the authority and application for fresh registration submitted.

*Additional terms and conditions as are stipulated by the appropriate registering authority.



AHMEDNAGAR ZILLA PARISHAD
AHMEDNAGAR.

FORM 'C'

(See Rule 5)

Certificate of Registration under section 5 of the Bombay Nursing Homes

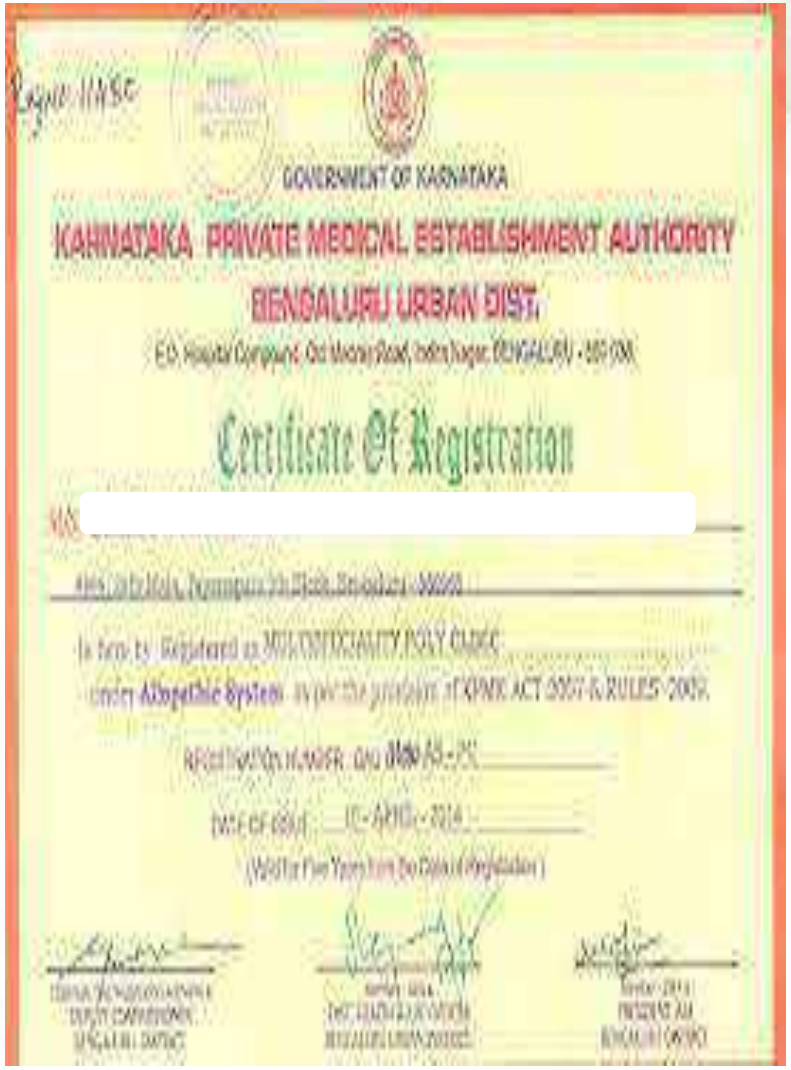
Registration Act. 1949

No. 59

This is to certify that Shri\Smt. Sister Julina Disouza Administrator has been registred under the Bombay Nursing Homes Registration Act. 1949, in respect of Sheugaon Tal. Sheugaon Dist. A.Nagar situated at A/P - (Hear insert the name of the Nursing Home) Nityaseva Hospital and has been authorised to carry on the said nursing home.

Registration No. Ab/59
Date of Registration. 31/8/07
Place: A.Nagar
Date of issue of Certificate: 13/9/07
This Certificate of registration shall be valid upto 31st March 2010

Signature of the registering authority.
District Health Officer
Zilla Parishad, A'nagar



GOVERNMENT OF KARNATAKA

KARNATAKA PRIVATE MEDICAL ESTABLISHMENT AUTHORITY

BENGALURU URBAN DIST.

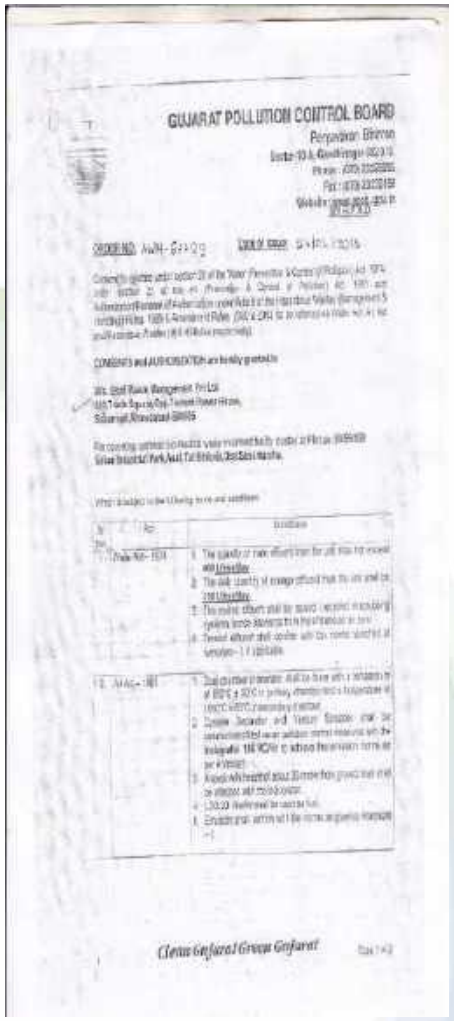
Certificate of Registration

is here by Registered as MULTISPECIALITY POLY CLINIC

under Allopathic System as per the provisions of KPME ACT 2007 & RULES 2009.

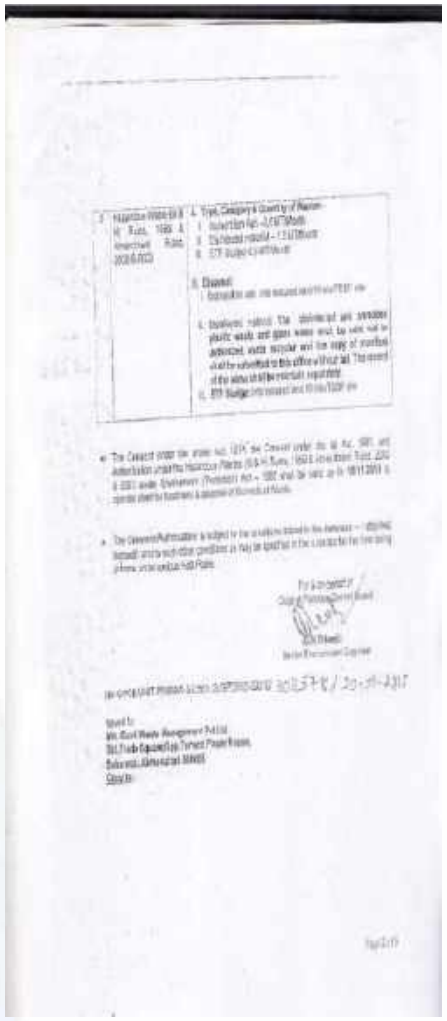
(Valid for Five Years from the Date of Registration)

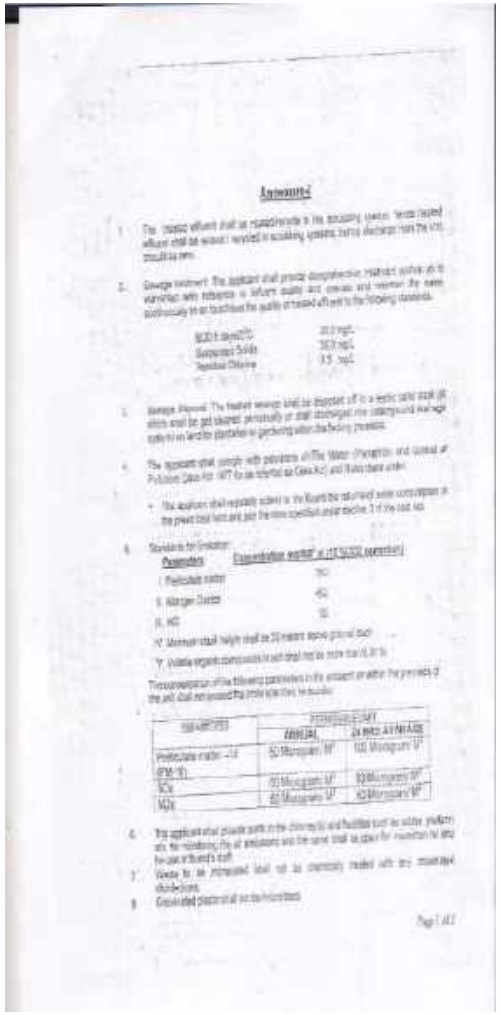
BIO-MEDICAL WASTE MANAGEMENT

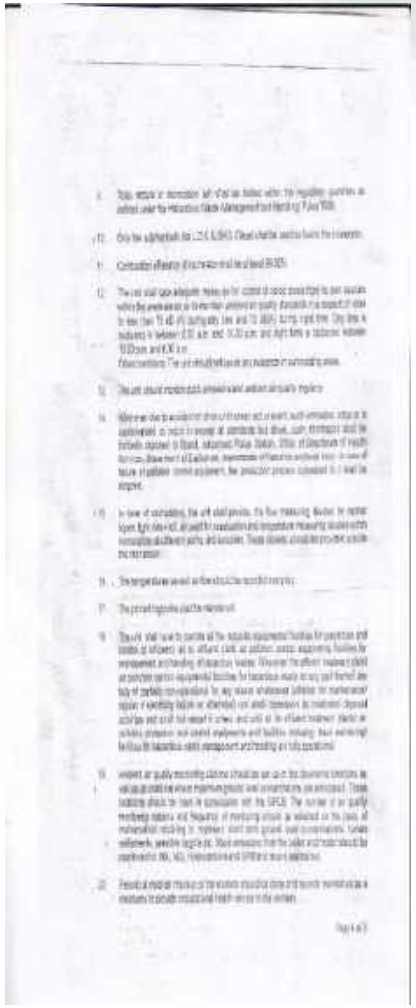

GUJARAT POLLUTION CONTROL BOARD

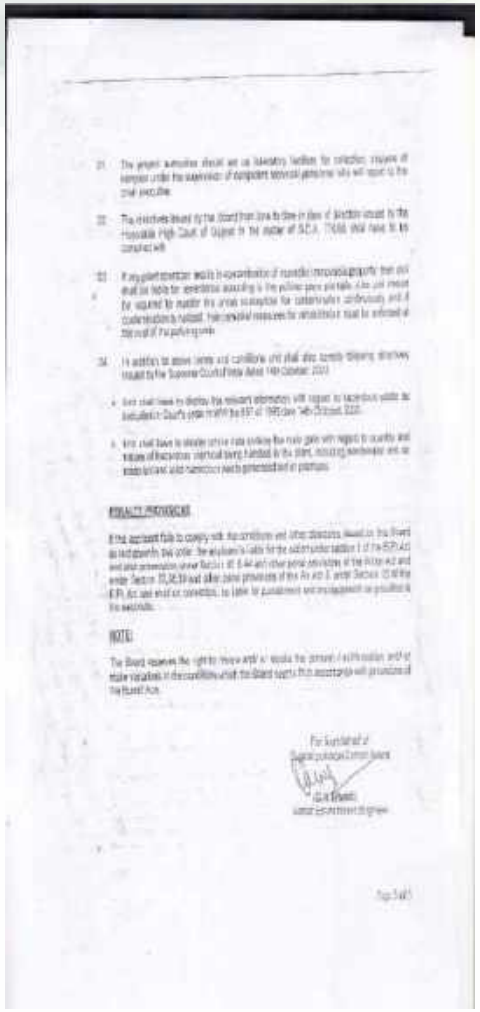
Parivesh Bhavan

Clean Gujarat Green Gujarat




Annexure-I





PCPNDT ACT REGISTRATION

GOVERNMENT OF GUJARAT

Department of Health and Family Welfare
Pre-conception and Pre-Natal Diagnostic Techniques
(Prohibition of Sex Selection) Act, 1994

CERTIFICATE OF REGISTRATION

Registration No. : GUJ/MTC/PCPNDT/ 116 /2015
Date of Registration : 21/12/2015

This is to certify that

India Pvt. Ltd.

is registered as Manufacturer / Distributor / Dealer / Importer / Refurbisher for the purpose of Ultrasonography machine / Imaging machine / Sonography machine or any equipment capable of detecting the foetal sex, with The State Appropriate Authority, under section 17 of the Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994 and Rules framed there under.

The above mentioned Manufacturer / Distributor / Dealer / Importer / Refurbisher is hereby authorized to do his/her business of Sonography and Imaging Machine in Gujarat State.

Note :- Registration No. should be mentioned in all correspondence.

Date :- 21/12/2015

for Commissioner
State Appropriate Authority, PNDT
Gujarat State

GOVERNMENT OF MAHARASHTRA

Public Health Department
(PRE-CONCEPTION AND PRE-NATAL DIAGNOSTIC TECHNIQUES
(PROHIBITION OF SEX SELECTION) ACT, 2003)

Certificate of Registration

This is to certify that

is registered as Manufacturer / distributor / dealer / importer / refurbisher for WIPRO GE, ALOKA, PHILIPS *with The State Appropriate Authority constituted under Section 17 of Pre-conception and Pre Natal Diagnostic Techniques Act 1994 & Rules 1996.*

The above mentioned company is authorized to do his/her business of Sonography and Imaging Machine in Maharashtra State.

Registration No. MAH / PCPNDT / 128 / 2016

Date of Registration 29/12/2016
(Note :- Registration No. should be mentioned in all correspondence.)

Date :- 29/12/2016

Signature
State Appropriate Authority

State Appropriate Authority
& Commissioner (Family Welfare)

Government of Karnataka

State PC and PNDTCell
Directorate of Health & Family Welfare Services,
Anand Rao Circle, Bangalore-560009

Certificate of Registration

This is to Certify that "34/1347-A, Florican Road, Malaparamba, Calcut-673009 Kerala is registered with State Appropriate Authority constituted under section 17 of Pre Conception and Pre Natal Diagnostic Techniques Act 1994 to sell, buy back or repair Ultrasonography / Imaging Machines in Karnataka as per rule 3A of PC & PNDT Rules-1996

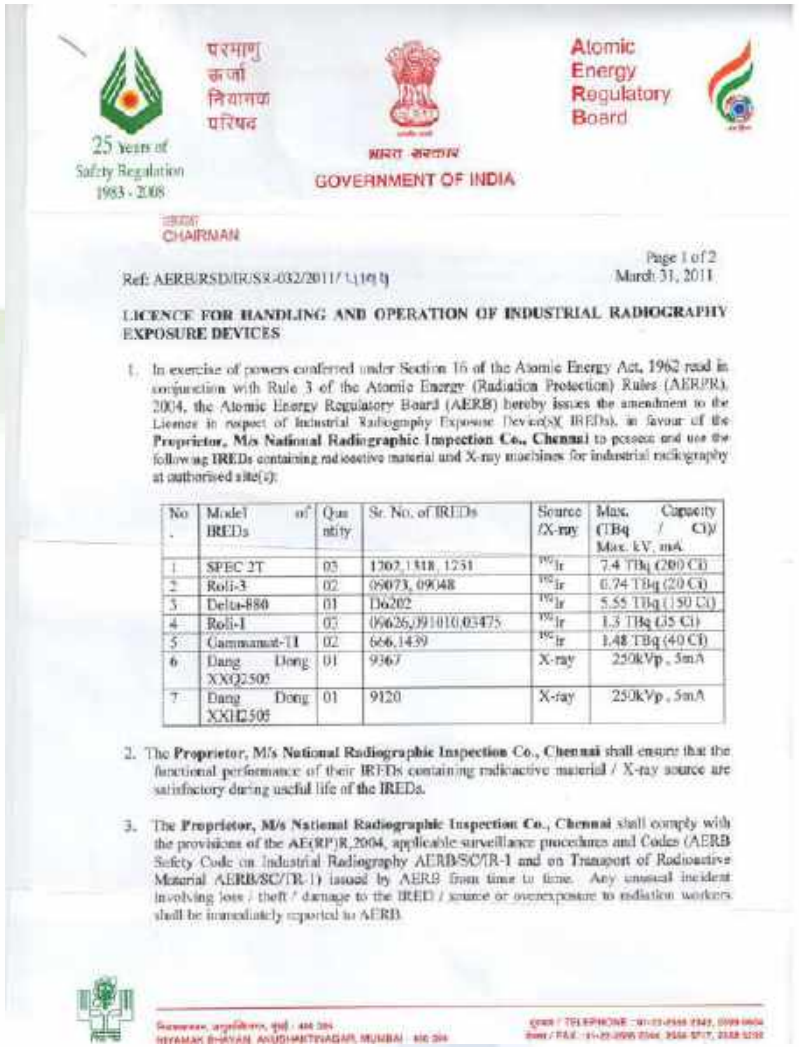
Registration No. : PCPNDTMMKAR 0004

Date of Registration: 26-09-2016

Authorized signatory

For State Appropriate Authority, PC & PNDT
Dept. of Health & Family Welfare Services

ATOMIC REGULATORY ENERGY BOARD (AERB)



परमाणु ऊर्जा नियामक परिषद

Atomic Energy Regulatory Board

25 Years of Safety Regulation 1983 - 2008

भारत सरकार
GOVERNMENT OF INDIA

CHAIRMAN

Ref: AERB/RSD/IR/SR-032/2011/ [illegible]

Page 1 of 2
March 31, 2011

LICENCE FOR HANDLING AND OPERATION OF INDUSTRIAL RADIOGRAPHY EXPOSURE DEVICES

1. In exercise of powers conferred under Section 16 of the Atomic Energy Act, 1962 read in conjunction with Rule 3 of the Atomic Energy (Radiation Protection) Rules (AERPR), 2004, the Atomic Energy Regulatory Board (AERB) hereby issues the amendment to the Licence in respect of Industrial Radiography Exposure Device(s)(IRED)s, in favour of the **Proprietor, M/s National Radiographic Inspection Co., Chennai** to possess and use the following IREDs containing radioactive material and X-ray machines for industrial radiography at authorised site(s):

No.	Model of IREDs	Quantity	Sr. No. of IREDs	Source /X-ray	Max. Capacity (TBq / Ci)/ Max. kV, mA
1	SPEC 2T	03	1202,1318, 1251	^{192}Ir	7.4 TBq (200 Ci)
2	Roli-3	02	09073, 09048	^{192}Ir	0.74 TBq (20 Ci)
3	Delta-880	01	D6202	^{192}Ir	5.55 TBq (150 Ci)
4	Roli-1	02	09626,091010,03475	^{192}Ir	1.3 TBq (35 Ci)
5	Gammamat-TI	02	666,1459	^{192}Ir	1.48 TBq (40 Ci)
6	Dang Dong XXQ2505	01	9367	X-ray	250kVp , 5mA
7	Dang Dong XXH2505	01	9120	X-ray	250kVp , 5mA

2. The **Proprietor, M/s National Radiographic Inspection Co., Chennai** shall ensure that the functional performance of their IREDs containing radioactive material / X-ray source are satisfactory during useful life of the IREDs.

3. The **Proprietor, M/s National Radiographic Inspection Co., Chennai** shall comply with the provisions of the AE(RP)R,2004, applicable surveillance procedures and Codes (AERB Safety Code on Industrial Radiography AERB/SC/IR-1 and on Transport of Radioactive Material AERB/SC/TR-1) issued by AERB from time to time. Any unusual incident involving loss / theft / damage to the IRED / source or overexposure to radiation workers shall be immediately reported to AERB.

Atomic Energy Regulatory Board

GOVERNMENT OF INDIA

CHAIRMAN

RENEWAL OF CERTIFICATE FOR ACCREDITATION OF LABORATORY FOR ASSESSMENT OF PERSONNEL RADIATION EXPOSURES BY RADIOBIOASSAY

This certificate shall be valid upto October 31, 2011.

GOVERNMENT OF INDIA

ATOMIC ENERGY REGULATORY BOARD

CERTIFICATE OF RECOGNITION OF LABORATORIES FOR CALIBRATION OF RADIATION MONITORING INSTRUMENTS (MIs)

PHARMACY LICENSE & NARCOTICS DRUGS LICENSE (IF APPLICABLE)

DRUG
NATIONAL AUTHORITY

The National Drug Policy and Authority
(Issue of Licences) Regulations 1995

Licence to Operate a Retail Pharmacy

This is to certify that the business trading under the name of

[redacted]

is licensed to operate a retail pharmacy

at the Physical Location [redacted]
and Postal Address [redacted] K'LA
with Supervising Pharmacist [redacted]
having Registration No [redacted] FIN: [redacted]
Licence No. [redacted] Valid up to 31-Dec-16
Fee Paid Ushs 300,000 Issue Date 09-Dec-16

LICENCED
DEC 2016
(Secretary to the Authority)

This Licence must be prominently displayed in the premises to which it refers

Form II (r. 6)

THE PHARMACY AND POISONS ACT
(Cap. 244)

THE PHARMACY AND POISONS (REGISTRATION OF DRUGS) RULES

REGISTRATION OF DRUGS CERTIFICATE

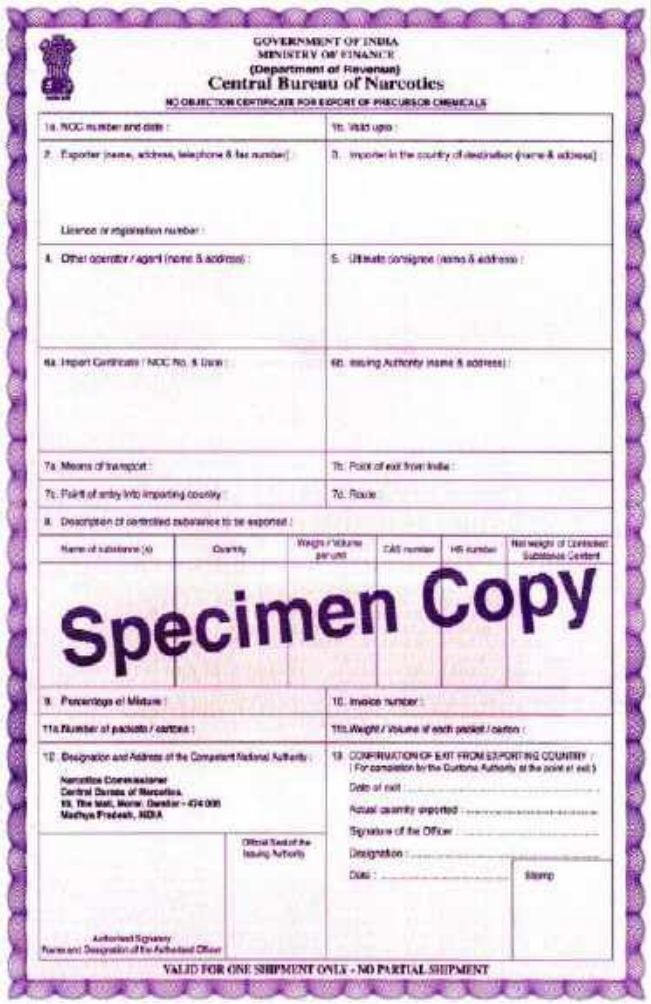
Number [redacted]

It is hereby certified that the drug as described hereunder, has been registered subject to the conditions indicated hereunder:

1. Trade name under which marketed [redacted]
2. Approved name [redacted]
3. Form of preparation [redacted]
4. Active ingredients and quantities per unit [redacted]
5. Condition(s) under which medicine is registered UNCONDITIONAL
6. Name and business address of manufacturer [redacted]
7. Registered in the name of [redacted]
   Business address [redacted]
8. Date of Registration 17TH DECEMBER 2015
   TO BE RETAINED ANNUALLY
9. Expiry date of Registration [redacted]

Date 20.1.2016

Registrar,
Pharmacy and Poisons Board



GOVERNMENT OF INDIA
MINISTRY OF FINANCE
(Department of Revenue)
Central Bureau of Narcotics
NO OBJECTION CERTIFICATE FOR EXPORT OF PRECURSOR CHEMICALS

1a. NOC number and date :
1b. Valid upto :
2. Exporter (name, address, telephone & fax number) :
Licence or registration number :
3. Importer in the country of destination (name & address) :
4. Other operator / agent (name & address) :
5. Ultimate consignee (name & address) :
6a. Import Certificate / NOC No. & Date :
6b. Issuing Authority (name & address) :
7a. Means of transport :
7b. Point of exit from India :
7c. Point of entry into importing country :
7d. Route :
8. Description of controlled substance to be exported :

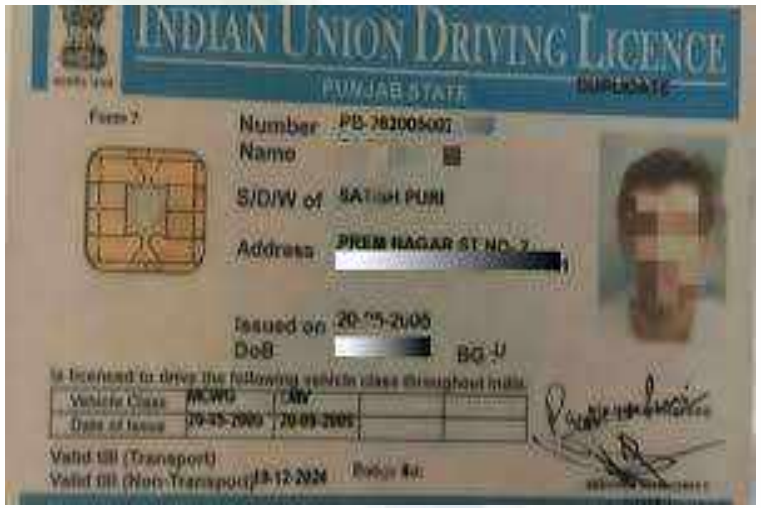
Name of substance (s)	Country	Weight / Volume per unit	CAS number	HS number	Net weight of Controlled Substance Content

Specimen Copy

9. Percentage of Mixture :
10. Invoice number :
11a. Number of packets / cartons :
11b. Weight / Volume of each packet / carton :
12. Designation and Address of the Competent National Authority :
Narcotics Commissioner
Central Bureau of Narcotics
93, The Mall, Morar, Gwalior - 474 006
Madhya Pradesh, INDIA
13. CONFIRMATION OF EXIT FROM EXPORTING COUNTRY
(For completion by the Customs Authority at the point of exit)
Date of exit :
Actual quantity exported :
Signature of the Officer :
Designation :
Date :
Stamp
Official Seal of the Issuing Authority
Authorised Signatory
Name and Designation of the Authorised Officer

VALID FOR ONE SHIPMENT ONLY - NO PARTIAL SHIPMENT

AMBULANCE REGISTRATION CERTIFICATE, INSURANCE POLICY, POLLUTION CONTROL AND DRIVER LICENSE (IF IN HOUSE OR OUTSOURCED)



SS 7 - THE HOSPITAL SHOULD ENSURE THAT APPROPRIATE INFECTION CONTROL PRACTICES ARE BEING FOLLOWED ALONG WITH HAND HYGIENE PRACTICES

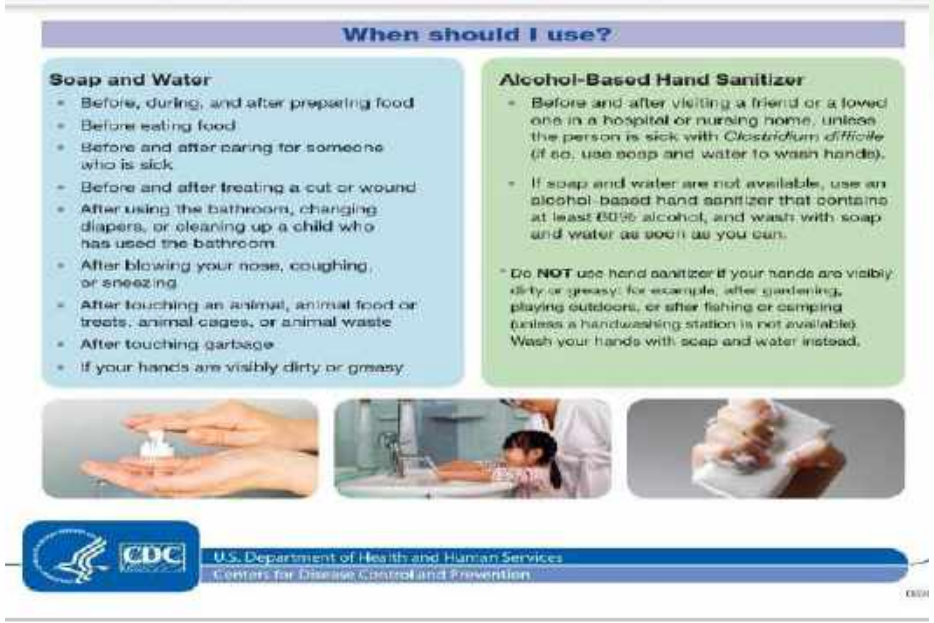
Interpretation – The hospital infection control and prevention process should be documented which aims at preventing and reducing risk of healthcare associated infection. The organsiation shall also adhere to hand hygiene, cleaning, disinfection and sterilization guidelines.

Means of verification:

1. Availability of wash basin near the point of use along with antiseptic soap with soap dish/ liquid antiseptic with dispenser
2. Availability of alcohol-based hand rub
3. Availability of disinfectant/cleaning agent as per requirement
4. Check if infection control manual showing periodic update and surveillance activities available/ monitoring takes place
5. The facility should follow standard practices and materials for disinfection and sterilization of instruments/ equipment
6. Staff should be trained for all infection control practices, hand hygiene guideline, occupational risk and its prevention.

AVAILABILITY OF WASH BASIN NEAR THE POINT OF USE ALONG WITH ANTISEPTIC SOAP WITH SOAP DISH/ LIQUID ANTISEPTIC WITH DISPENSER

AVAILABILITY OF ALCOHOL-BASED HAND RUB

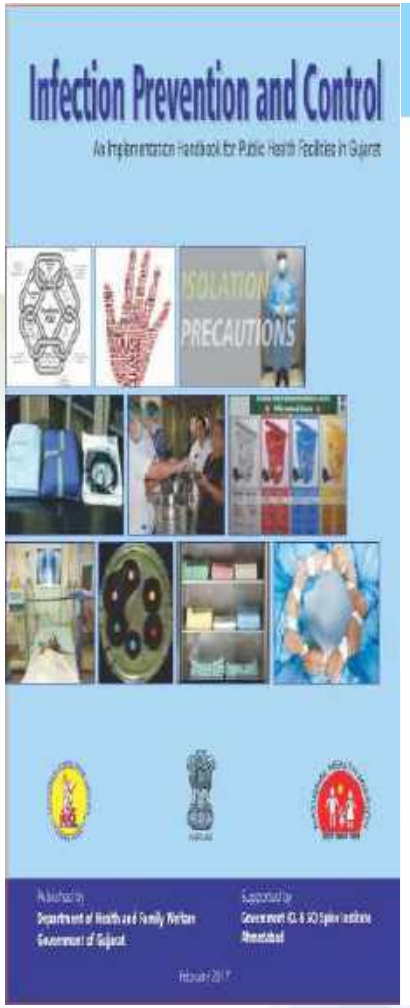


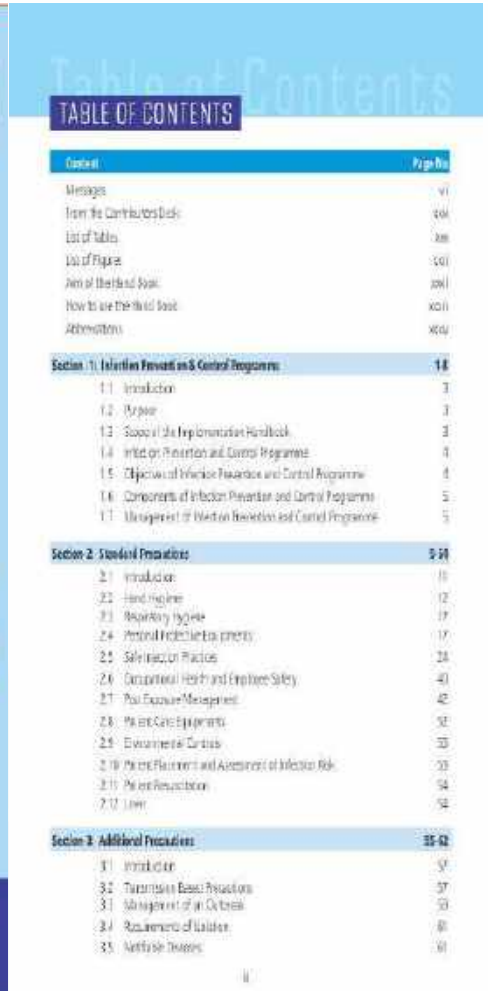
AVAILABILITY OF DISINFECTANT/CLEANING AGENT AS PER REQUIREMENT

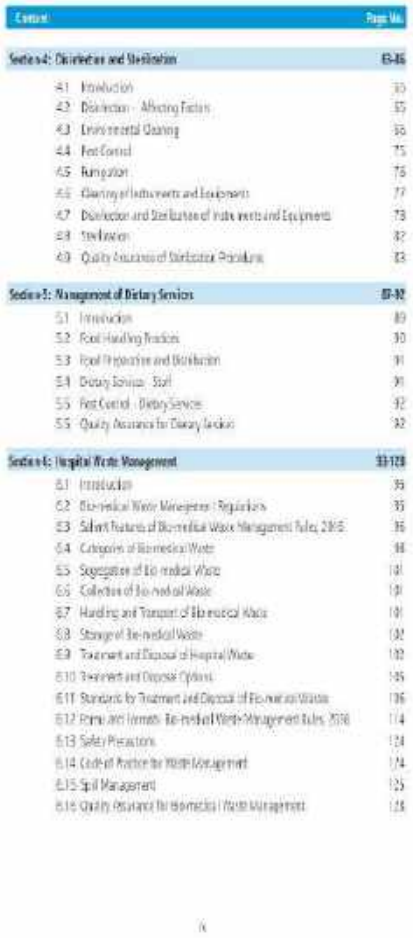
Cleaning and Disinfectant Agents

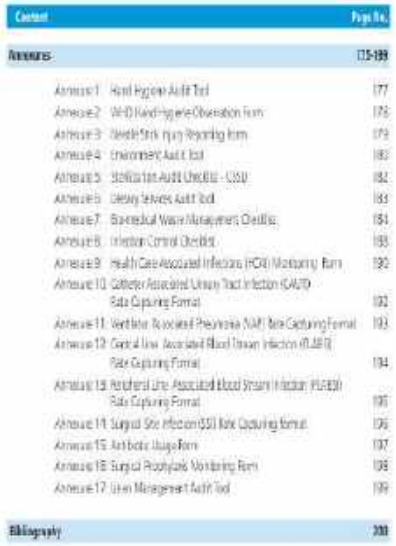
- **Hospital Grade Disinfectants**
- Alcohols (60-90% ethyl or isopropyl)
- Chlorine - sodium (bleach) and calcium hypochlorite
- Phenolics
- Quaternary Ammonium Compounds (Quats)
- Iodophors
- Accelerated Hydrogen Peroxide (AHP)

CHECK IF INFECTION CONTROL MANUAL SHOWING PERIODIC UPDATE AND SURVEILLANCE ACTIVITIES AVAILABLE/ MONITORING TAKES PLACE



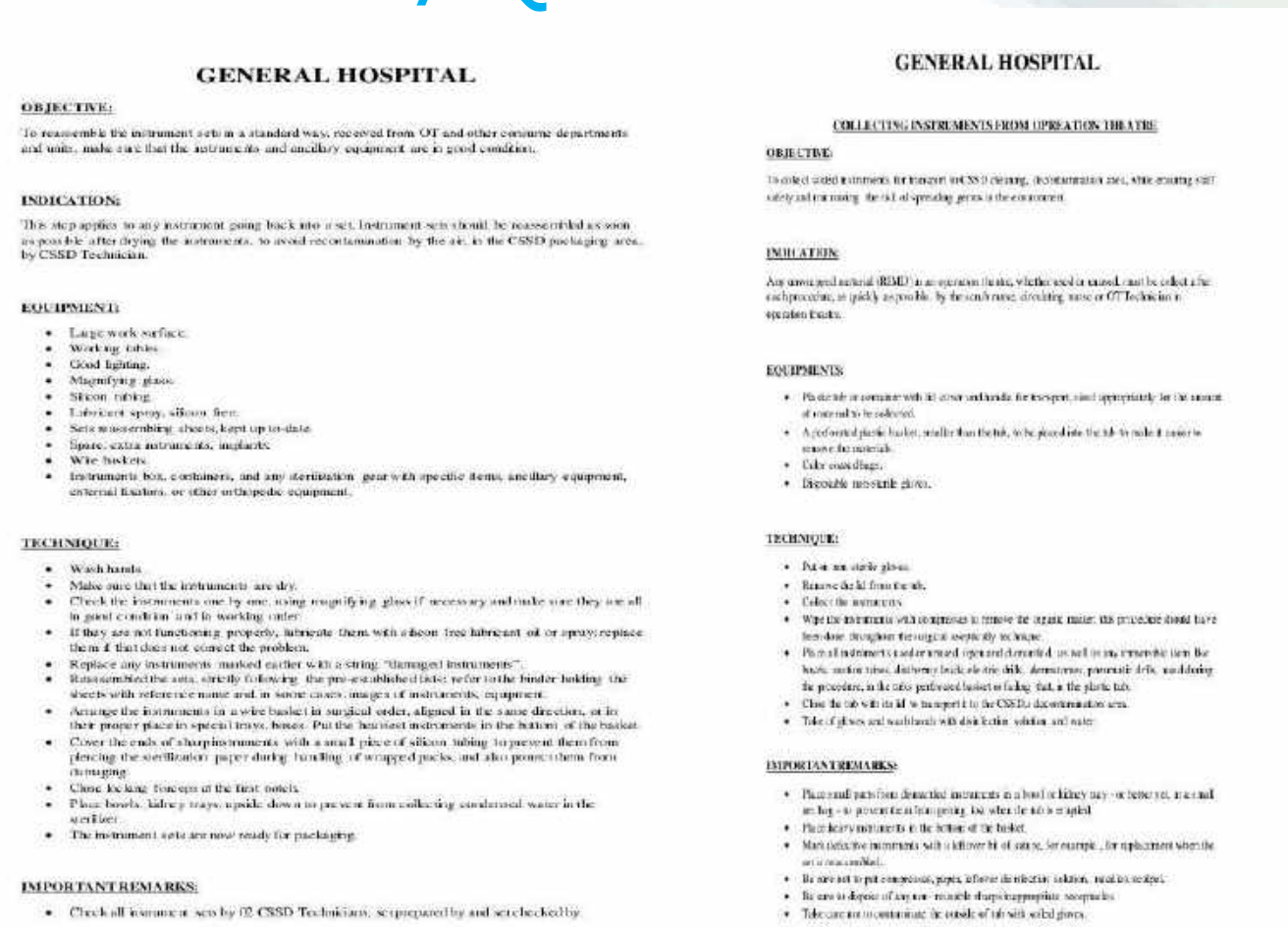






THE FACILITY SHOULD FOLLOW STANDARD PRACTICES AND MATERIALS FOR DISINFECTION AND STERILIZATION OF INSTRUMENTS/ EQUIPMENT

The organisation provides adequate space and appropriate zoning for sterilization activities.
Documented procedure guides the cleaning, packing, disinfection and/or sterilization, storing and issue of items.
Reprocessing of instruments and equipment are covered.
Regular validation tests for sterilization are carried out and documented.
There is an established recall procedure when breakdown in the sterilization system is identified.



GENERAL HOSPITAL

OBJECTIVE:

To reassemble the instrument sets in a standard way, received from OT and other consume departments and units, make sure that the instruments and ancillary equipment are in good condition.

INDICATION:

This step applies to any instrument going back into a set. Instrument sets should be reassembled as soon as possible after drying the instruments, to avoid recontamination by the air, in the CSSD packaging area, by CSSD Technician.

EQUIPMENT:

- Large work surface.
- Working tables.
- Good lighting.
- Magnifying glass.
- Silicon tubing.
- Lubricant spray, silicon free.
- Sets reassembling sheets, kept up-to-date.
- Spare, extra instruments, implants.
- Wire baskets.
- Instruments box, containers, and any sterilization gear with specific items, ancillary equipment, external fixators, or other orthopedic equipment.

TECHNIQUE:

- Wash hands.
- Make sure that the instruments are dry.
- Check the instruments one by one, using magnifying glass if necessary and make sure they are all in good condition and in working order.
- If they are not functioning properly, lubricate them with silicon free lubricant oil or spray; replace them if that does not correct the problem.
- Replace any instruments marked earlier with a string "Damaged Instruments".
- Reassemble the sets, strictly following the pre-established lists; refer to the binder holding the sheets with reference name and, in some cases, images of instruments, equipment.
- Arrange the instruments in a wire basket in surgical order, aligned in the same direction, or in their proper place in special trays, boxes. Put the heaviest instruments in the bottom of the basket.
- Cover the ends of sharp instruments with a small piece of silicon tubing to prevent them from piercing the sterilization paper during handling of wrapped packs, and also protect them from damaging.
- Close locking forceps at the first notch.
- Place bowls, kidney trays, upside down to prevent from collecting condensed water in the sterilizer.
- The instrument sets are now ready for packaging.

IMPORTANT REMARKS:

- Check all instrument sets by 02 CSSD Technicians, set prepared by and set checked by.

GENERAL HOSPITAL

COLLECTING INSTRUMENTS FROM OPREATION THEATRE

OBJECTIVE:

To collect soiled instruments for transport to CSSD cleaning, decontamination area, while ensuring staff safety and minimizing the risk of spreading germs in the environment.

INDICATION:

Any unwanted material (RMD) in an operation theatre, whether used or unused, must be collect after each procedure, as quickly as possible, by the ward nurse, circulating nurse or OT Technician in operation theatre.

EQUIPMENTS:

- Plastic tub or container with lid, cover and handle for transport, sized appropriately for the amount of material to be collected.
- A perforated plastic basket, smaller than the tub, to be placed into the tub to make it easier to remove the materials.
- Color coded bags.
- Disposable non-sterile gloves.

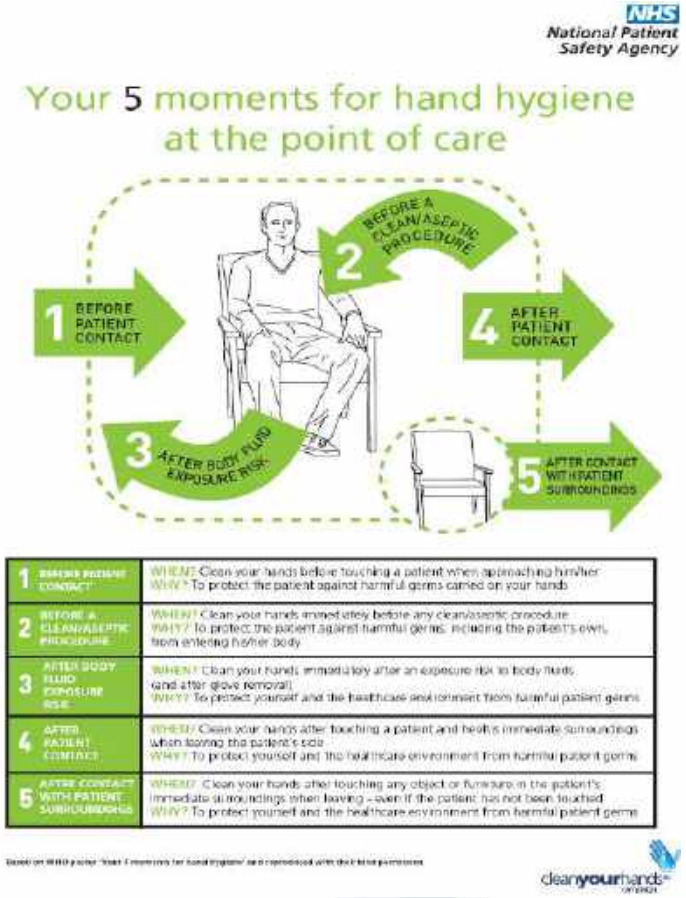
TECHNIQUE:

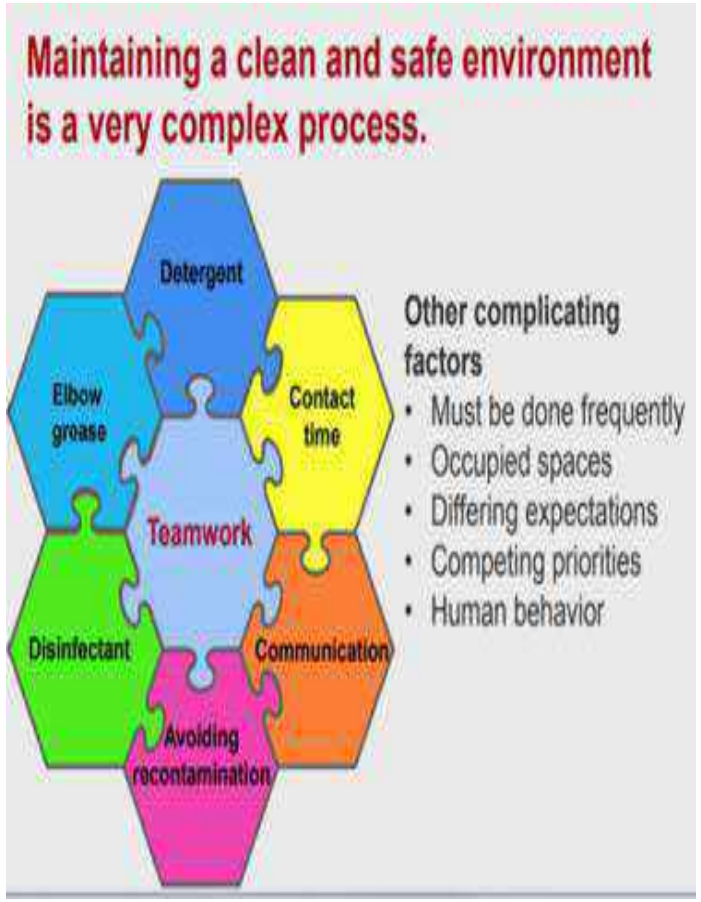
- Put on non sterile gloves.
- Remove the lid from the tub.
- Collect the instruments.
- Wipe the instruments with compresses to remove the organic matter; this procedure should have been done throughout the surgical aseptically technique.
- Place all instruments used or unused, open and dismantled, as well as any removable item like blades, suction tubes, disposable bucket, electric drill, dermatome, pneumatic drills, used during the procedure, in the color perforated basket or bag, that, in the plastic tub.
- Close the tub with its lid to transport it to the CSSD's decontamination area.
- Take off gloves and wash hands with disinfection solution and water.

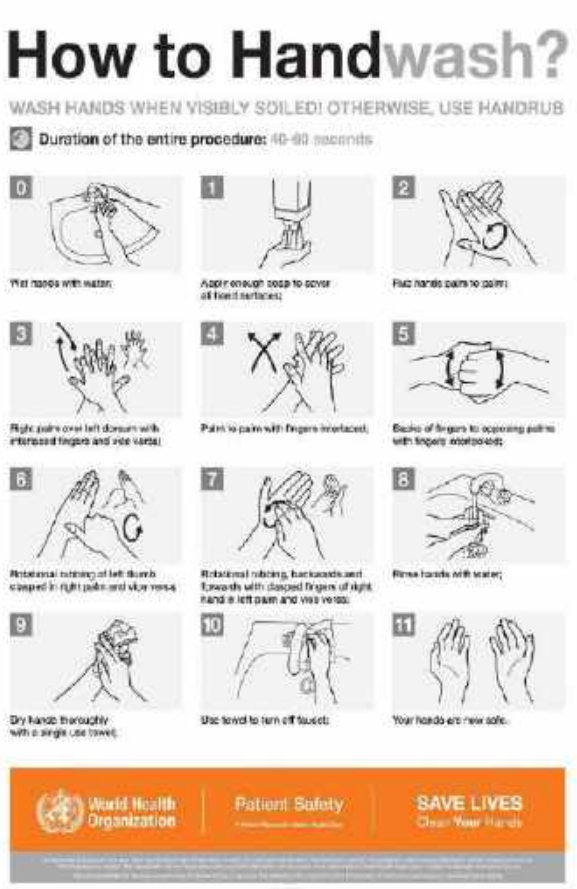
IMPORTANT REMARKS:

- Place small packs from dismantled instruments in a bowl or kidney tray - or better yet, in a small mesh bag - to prevent them from getting lost when the tub is emptied.
- Place heavy instruments in the bottom of the basket.
- Mark defective instruments with a leftover bit of suture, for example , for replacement when the set is reassembled.
- Be sure not to put compresses, paper, leftover disinfection solution, metal in recipient.
- Be sure to dispose of any non-reusable sharps in appropriate receptacles.
- Take care not to contaminate the outside of tub with soiled gloves.

STAFF SHOULD BE TRAINED FOR ALL INFECTION CONTROL PRACTICES, HAND HYGIENE GUIDELINE, OCCUPATIONAL RISK AND ITS PREVENTION







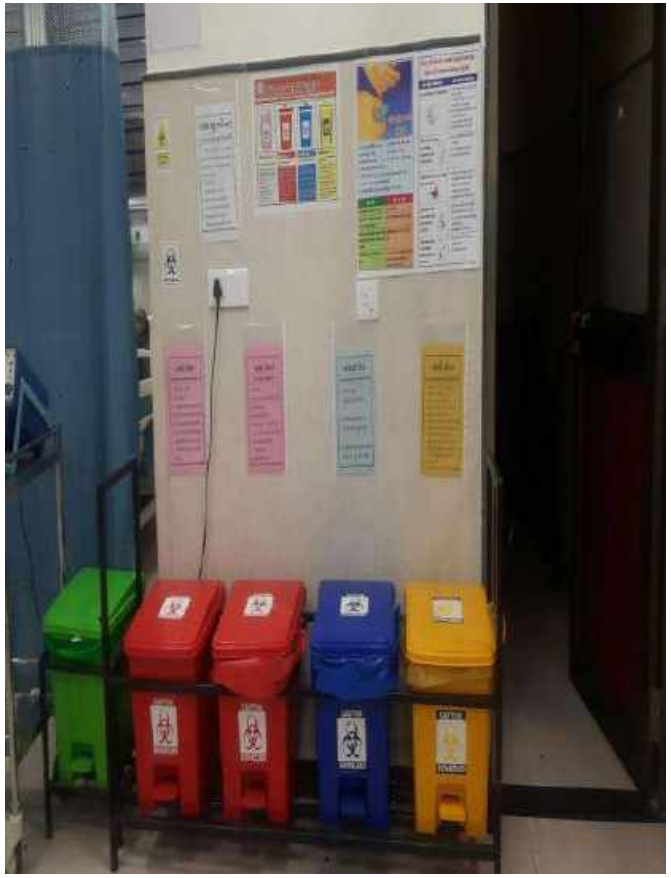
SS 8 - Hospital should ensure Bio-Medical Waste management practices as per the statutory norms (BMW (Amendment) Rules, 2018)

Interpretation – The organization shall be authorized by the appropriate authority for management of bio-medical waste. The waste should be segregated and collected in different color coded bags and containers as per statutory norms and same should be available at all the point of waste generation. Management of biomedical waste including its segregation, transportation, management and disposal of waste should be done by an authorized agency with a designated place for waste collection and segregation near the premises.

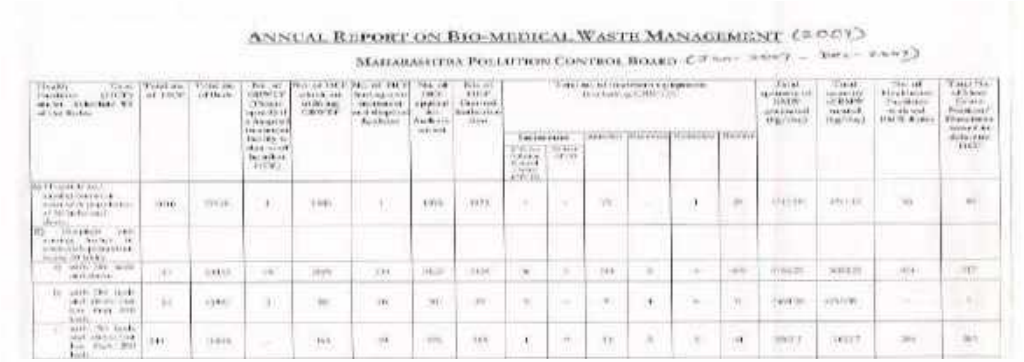
Means of verification:

1. Availability of color-coded bins at the point of waste generation along with the display of work instructions for segregation and handling of Biomedical waste
2. The waste should be handed over to an authorized agency and not discharged in any drain. If outsourced, check the contract document of outsourced services. Register with the weight of waste collected from different colored bags should be maintained
3. Facility has secured designated place for segregation and storage of Bio-Medical waste before disposal at the waste collection site
4. Transportation of bio-medical waste should be done in a closed container/trolley

AVAILABILITY OF COLOR-CODED BINS AT THE POINT OF WASTE GENERATION ALONG WITH THE DISPLAY OF WORK INSTRUCTIONS FOR SEGREGATION AND HANDLING OF BIOMEDICAL WASTE

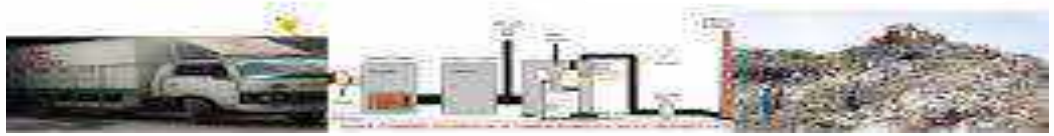


THE WASTE SHOULD BE HANDED OVER TO AN AUTHORIZED AGENCY AND NOT DISCHARGED IN ANY DRAIN. IF OUTSOURCED, CHECK THE CONTRACT DOCUMENT OF OUTSOURCED SERVICES. REGISTER WITH THE WEIGHT OF WASTE COLLECTED FROM DIFFERENT COLORED BAGS SHOULD BE MAINTAINED

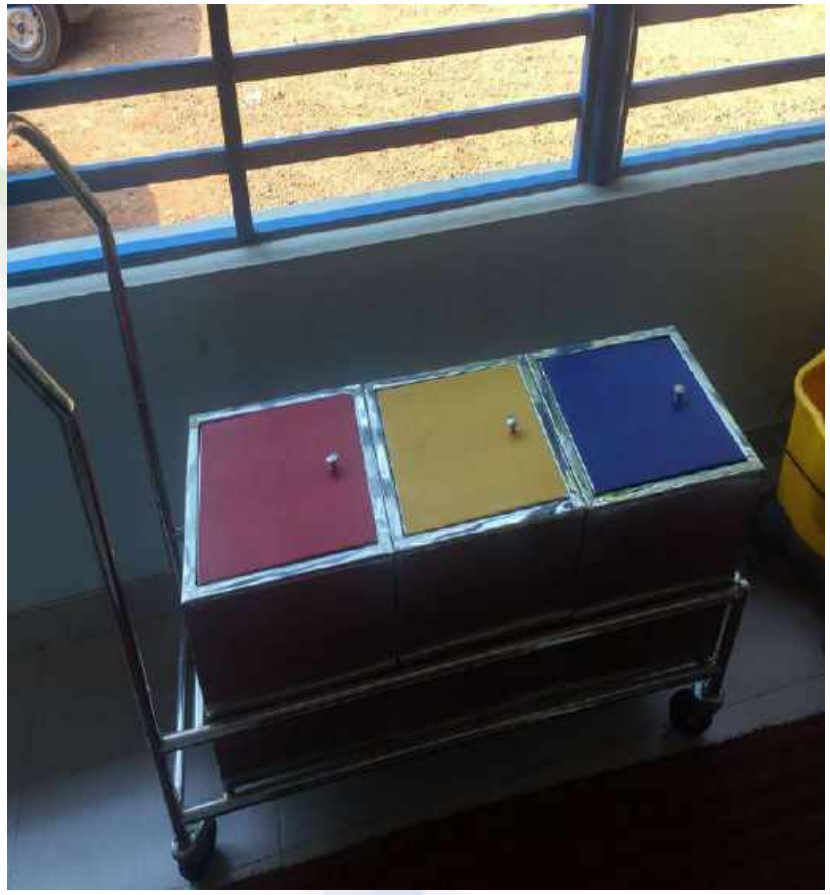

ANNUAL REPORT ON BIO-MEDICAL WASTE MANAGEMENT

MAHARASHTRA POLLUTION CONTROL BOARD

Common Biomedical Waste Treatment Facility –Process of Treatment



FACILITY HAS SECURED DESIGNATED PLACE FOR SEGREGATION AND STORAGE OF BIO-MEDICAL WASTE BEFORE DISPOSAL AT THE WASTE COLLECTION SITE



TRANSPORTATION OF BIO-MEDICAL WASTE SHOULD BE DONE IN A CLOSED CONTAINER/TROLLEY

SS 9 - HOSPITAL SHOULD ENSURE THAT SERVICES I.E. (LAUNDRY, HOUSEKEEPING, DIETARY, SECURITY, AMBULANCE, MORTUARY, CENTRAL STERILE SUPPLY DEPARTMENT (CSSD) ETC. ARE AVAILABLE (IN-HOUSE OR OUTSOURCED).

Interpretation – The services like laundry, housekeeping, dietary, security, mortuary, ambulance CSSD etc. should be available in-house or out-sourced. The hospital shall ensure that they establish adequate controls by having a policy to monitor/ audit these services. If these services are outsourced, then they should have MoU/ agreement for the same.

Means of verification:

1. Checklist for Desktop Assessment - Availability Yes/No & If outsourced, MoU should be available for the same.
2. Internal audits of the services to be conducted on regular intervals

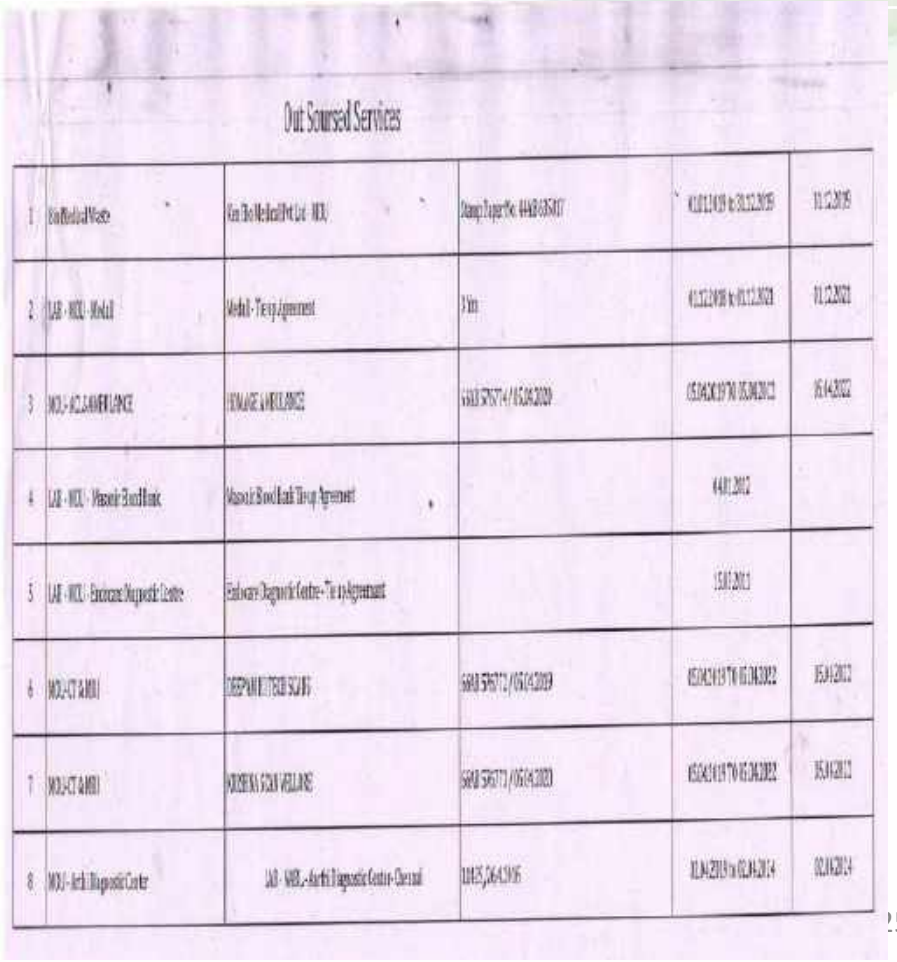
CHECKLIST FOR DESKTOP ASSESSMENT - AVAILABILITY YES/NO & IF OUTSOURCED, MOU SHOULD BE AVAILABLE FOR THE SAME

AREAS TO BE CLEANED

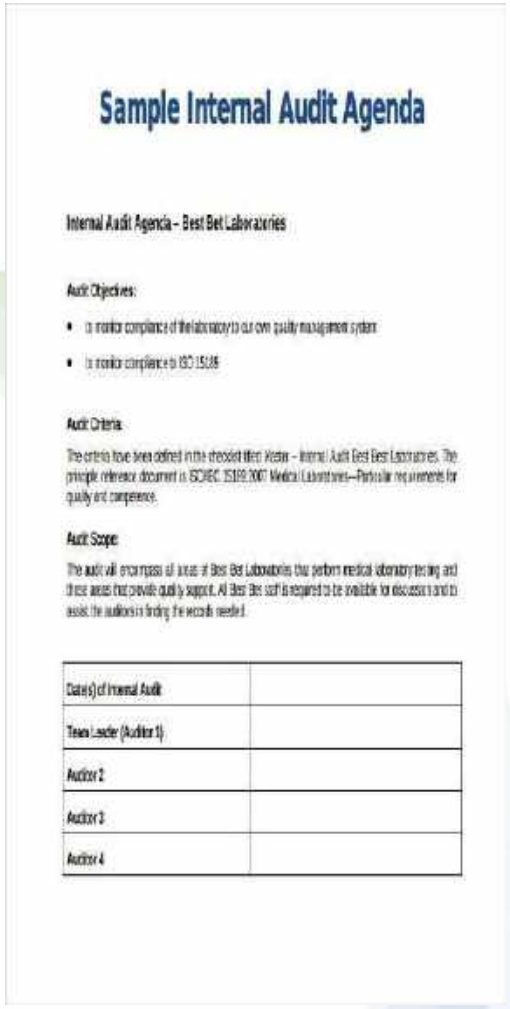
S.NO.	AREA/ ITEM	DISINFECTION METHOD	FREQUENCY
1.	Floor	Cleanser	3 in each shift/ week
2.	Walls	Pesticide Spray 2% Glutaridehyde + Formaldehyde	Once daily/ Once in two weeks
3.	Fans	Wet Mopping	One in two weeks
4.	AC	Vacuum Cleaning	Once in two weeks/ once a week
5.	Refrigerator	2% Gluterdehide Defrost cleaning with soap	Once in two weeks
6.	Sinks	Clean so	Daily Once
7.	Buckets	Soap Water	Daily
8.	Windo pans	Mopping	Daily
9.	Doors/ pale mates	Mopping	Daily
10.	Toilets Mirror, Basin Pots	Cleaning with detergent	Three times daily
11.	Machine Cleaning	Scrubbing	Once Week

Cleaning Supplies Checklist

☐ Broom	☐ Air Freshener	☐ Old Rags
☐ Dustpan	☐ All Purpose Cleaner	☐ Old Toothbrush
☐ Vacuum Cleaner	☐ Antibacterial Cleaner	☐ Garbage Bags
☐ Sponge/Cotton Mop	☐ Baking Soda	☐ Paper Towels
☐ Extendable Duster	☐ Bleach	☐
☐ Bucket	☐ Dishwashing Liquid	☐
☐ Supply Caddy	☐ Disinfecting Wipes	☐
☐ Toilet Brush	☐ Fabric Cleaner/Spray	☐
☐ Scrub Brush	☐ Fabric Softener Sheets	☐
☐ Hand Duster	☐ Floor Cleaner	☐
☐ Microfiber Cloths	☐ Furniture Polish	☐
☐ Sponges	☐ Glass Cleaner	☐
☐ Scour Pads	☐ Laundry Detergent	☐
☐ Rubber Gloves	☐ Mild Abrasive Cleaner	☐
☐ Spray Bottle	☐ Oven Cleaner	☐
☐ Squeegee	☐ White Vinegar	☐



INTERNAL AUDITS OF THE SERVICES TO BE CONDUCTED ON REGULAR INTERVALS



Sample Internal Audit Agenda

Internal Audit Agencia – Best Bet Laboratories

Audit Objectives:

- to monitor compliance of the laboratory to our own quality management system
- to monitor compliance to ISO 15189

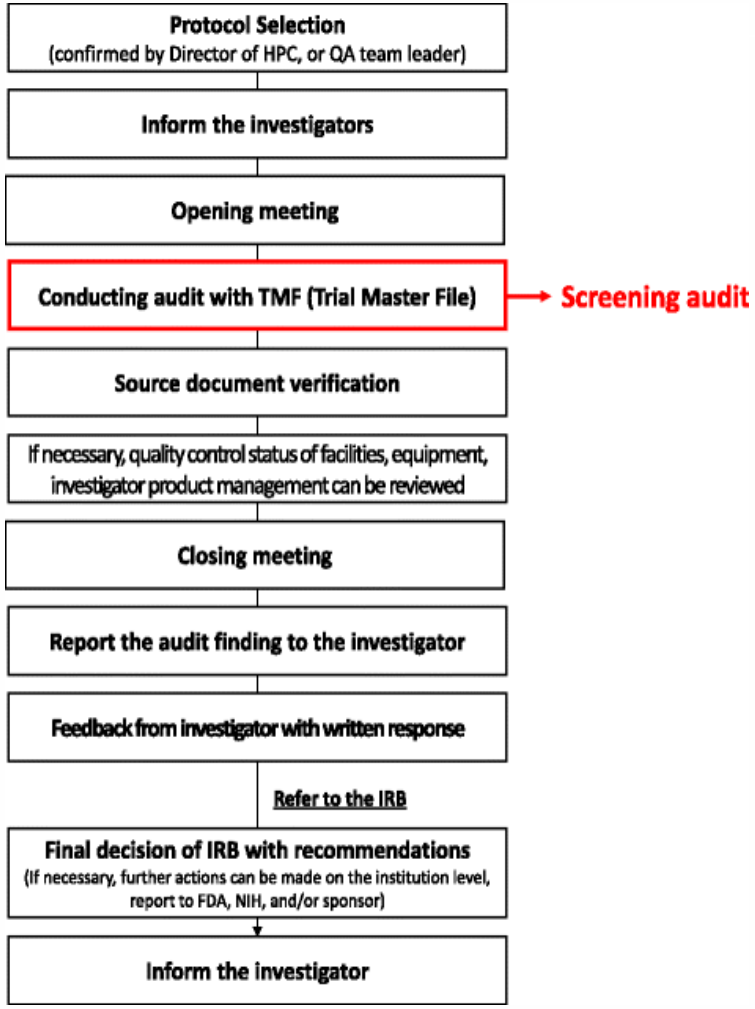
Audit Criteria:

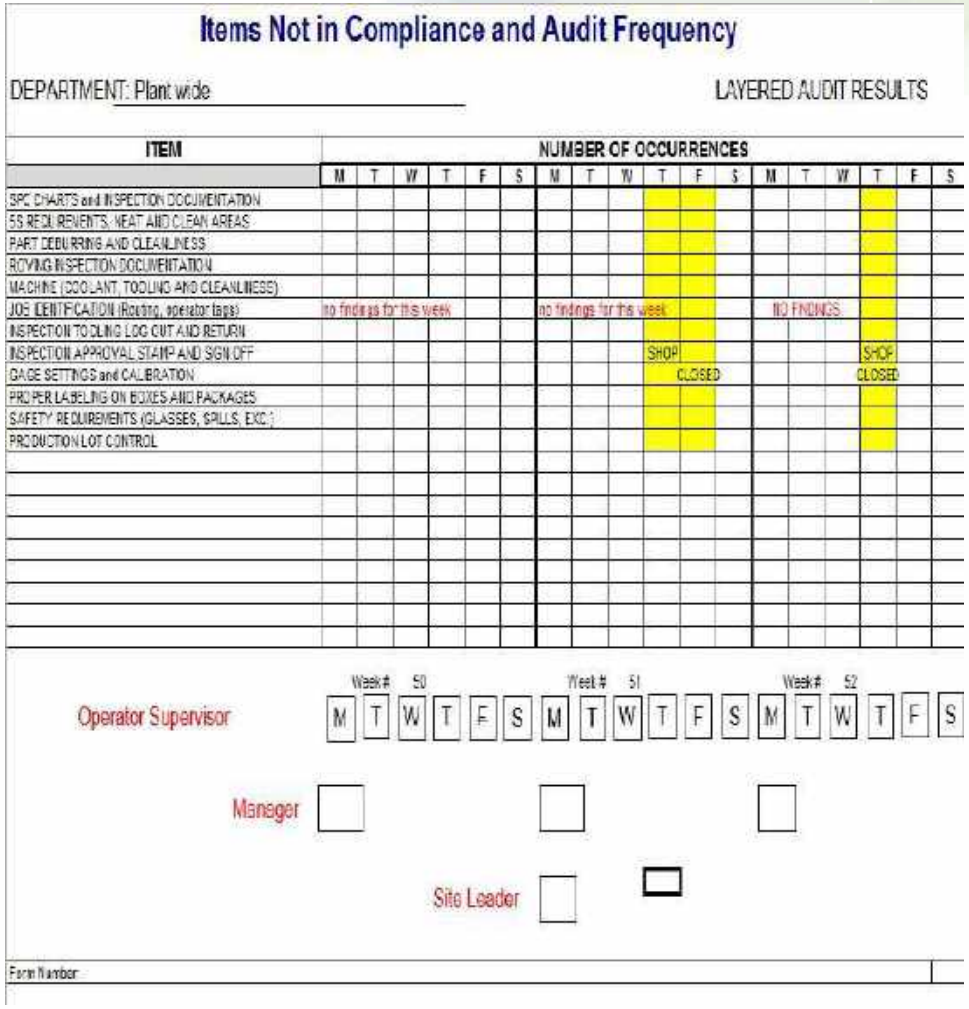
The criteria have been defined in the checklist titled 'Annex – Internal Audit Best Best Laboratories'. The principle reference document is ISO/IEC 15189:2007 'Medical Laboratories—Particular requirements for quality and competence'.

Audit Scope:

The audit will encompass all areas of Best Bet Laboratories that perform medical laboratory testing and those areas that provide quality support. All Best Bet staff is required to be available for discussion and to assist the auditors in finding the records needed.

Date(s) of Internal Audit	
Team Leader (Auditor 1)	
Auditor 2	
Auditor 3	
Auditor 4	





Items Not in Compliance and Audit Frequency

DEPARTMENT: Plant wide

LAYERED AUDIT RESULTS

ITEM	NUMBER OF OCCURRENCES																	
	M	T	W	T	F	S	M	T	W	T	F	S	M	T	W	T	F	S
SPC CHARTS and INSPECTION DOCUMENTATION																		
5S REQUIREMENTS: NEAT AND CLEAN AREAS																		
PART DEBURRING AND CLEANLINESS																		
ROVING INSPECTION DOCUMENTATION																		
MACHINE (COOLANT, TOOLING AND CLEANLINESS)																		
JOB IDENTIFICATION (Routing, operator tags)	no findings for this week						no findings for this week						NO FINDINGS					
INSPECTION TO DLING LOG OUT AND RETURN																		
INSPECTION APPROVAL STAMP AND SIGN OFF										SHOP						SHOP		
GAGE SETTINGS and CALIBRATION											CLOSED					CLOSED		
PROPER LABELING ON BOXES AND PACKAGES																		
SAFETY REQUIREMENTS (GLASSES, SPILLS, EXC.)																		
PRODUCTION LOT CONTROL																		

	Week # 50						Week # 51						Week # 52					
Operator Supervisor	M	T	W	T	F	S	M	T	W	T	F	S	M	T	W	T	F	S
Manager																		
Site Leader																		

Form Number

SS 10 - SEXUAL HARASSMENT AND GRIEVANCE HANDLING PROCEDURE SHOULD BE AVAILABLE

Interpretation – There should be disciplinary and grievance handling procedures in place with a dedicated committee/team established to handle cases against sexual harassment and various other grievances.

Means of verification:

1. Committee against sexual harassment is constituted at the facility
2. Documented disciplinary and grievance handling procedure

COMMITTEE AGAINST SEXUAL HARASSMENT IS CONSTITUTED AT THE FACILITY

MEMBERS OF THE COMMITTEE FOR PREVENTION OF SEXUAL HARASSMENT

Please reach out to any of the Members of the Committee for Prevention of Sexual Harassment whose names are placed below in case you have any concerns or complaints.

Name	Committee Designation	E-mail ID	Contact Number
[redacted]	Chairperson	[redacted]	
	Member		
	Member		
	Member Secretary		
	Member		

DOCUMENTED DISCIPLINARY AND GRIEVANCE HANDLING PROCEDURE

DISCIPLINE AND GRIEVANCES: Discipline and Grievances are each one side of the same 'complaints coin's.

DISCIPLINE AND GRIEVANCES: Discipline is a 'Management's Complaints' against an employee. • Grievance is an 'Employee's complaint' against management.

WHY DISCIPLINING EMPLOYEES: Employees experience conflict at work and sometimes break the rules. • It then becomes your job to minimize the conflict and get things going back on track. • Disciplinary policies and actions play the prime role in prohibiting unwanted employee behaviors.

DISCIPLINARY POLICY GROUND RULES: Employees should know what they can and can't do. • You should clearly communicate the discipline that will take place if employees break your rules. • For this reason, company need to have a good disciplinary policy in place and well communicated to everyone.

DISCIPLINARY POLICY: The policy must be communicated to employees by periodically providing a copy, posting it, or including it in an employee handbook. • Employees should be required to sign an acknowledgment that they have received and read the policy. • The policy also should be covered in new employee orientation.

CORRECTIVE DISCIPLINE: The purpose of discipline is to assist employees in changing their unwanted behavior. • Absenteeism • Poor Performance or • Inappropriate Behavior • Employees should have adequate information about their current performance versus the desired performance. • This will also decrease your legal risk!

DISCIPLINARY SYSTEMS: There are many systems available for disciplining employees. • One system, called progressive discipline, is very popular. • It requires the employer to progress through each step before proceeding to the next.

DOCUMENTED DISCIPLINARY AND GRIEVANCE HANDLING PROCEDURE

TYPES OF DISCIPLINARY ACTIONS: 1. Verbal counselling 2. Written warning 3. Suspension 4. Termination

1. Verbal counselling: This is generally the first step. However, for a serious problem, skip this step. Verbal warnings should always be done privately. Verbal counselling sessions should be documented by a formal memo or informal note in the employee's personnel file.

2. Written Warning: Should include, at a minimum, the following elements: • The date of the warning • The employee's name • The name of the supervisor administering the warning • A description of the misconduct or inadequate performance • The date of the misconduct or poor performance • A signature line for the supervisor • A signature line for the employee, indicating his receiving only! • A signature line for the witness. • An action plan to fix the behavior in a given time frame!

3. Suspension: This may range from one day to two weeks or more, depending upon the circumstances, and is almost always unpaid. • Next step may be suspension of increasing length or directly go to termination. • Whatever it is, should be stated in the suspension letter!

4. Termination: Before termination, the personnel file and all relevant documents must be reviewed to ensure that the termination is appropriate and defensible in a subsequent lawsuit • Some behavior warrants automatic dismissal, like: • Violent behavior or threats of violence; • Drug and alcohol use on duty; • Carrying a weapon on company property; • Theft, destruction of company property • Insubordination; • Abandonment of job

Other forms of discipline: Demotion, • Transfer and • Reduced raises or bonuses. • Many employees can be very satisfactorily managed by economic concerns, such as bonuses and raises.

DISCIPLINE: THE UNION CONTEXT: If a union represent your employees, your disciplinary system is most likely governed by your collective bargaining agreement or CBA. • All of your managers and supervisors are well trained on how to follow the disciplinary procedure in the CBA. • The CBA will most likely have progressive discipline steps and provide that the employee can grieve any disciplinary action. • Disputes that are not resolved through the grievance process end up in the hands of an arbitrator!

FACTORS TO CONSIDER: Mitigating factors • long service with the company • history of satisfactory appraisals • prior commendations or awards • Aggravating factors • short length of service • history of unsatisfactory performance • prior instances of performance/conduct/attendance problems • Once you have made the choice, stick with it and remember to document all of your steps!

DOCUMENTED DISCIPLINARY AND GRIEVANCE HANDLING PROCEDURE

EMPLOYEE GRIEVANCES: A method for employees to use to resolve conflicts when they feel they have been treated unfairly by management.

EMPLOYEE GRIEVANCES Typical procedure: • Discuss problem with manager • Discuss problem with manager's superior • Superior may refer problem to grievance committee or CEO • Union employee grievances are handled differently...

UNION EMPLOYEE GRIEVANCES: Union grievances are often resolved through: • Arbitration - A hearing before someone empowered to resolve the dispute. • Mediation - Negotiation between two parties, using a neutral intermediary to assist in settling a dispute.

GRIEVANCE IDENTIFICATION TECHNIQUES: Observations, Grip Boxes, Exit Interview & Open Door Policy

1. OBSERVATION: Knowledge of human behavior is requisite quality of good manager. From the changed behavior of any employee , he should snuff the causes of grievances, without its knowledge to the employee.

2. GRIP BOXES: The suggestion boxes, for instance are placed at easily accessible spots to most employees in the organization. The employees can file anonymous complaints about their dissatisfaction in these boxes.

3. OPEN DOOR POLICY: Most of the organizations still don't practice this but open door policy demands that the employees, even at the lowest rank, should have easy access to the Chief Executive to get his grievances redressed.

4. EXIT INTERVIEW: These interviews are conducted to know the reasons for leaving the job. Properly conducted exit interviews can provide significant information about the strengths and weaknesses of the organization and can pave way for further improvements.

BENEFITS: Enables the management to know the pulse of its employees. Provides a channel to the aggrieved to express their grievances. Provides clues about the behavior and attitude of the managers and supervisors towards their subordinates. Gives an assurance to the employees about the existence of a mechanism for the prompt redressal of their grievance. Keep up the morale of the employees.

CONCLUSION: Managers must use judgment, empathy, consistency, and fairness when administering employee discipline. • All disciplinary actions should be documented in a factual, nonjudgmental way. • Employees can use the grievance procedure to resolve conflicts with management.

CHAPTER 4: PATIENT CARE (OVERVIEW)

The sheer availability of healthcare services does not serve the purpose until the services are accessible to the users, and are provided with dignity and confidentiality. Access to healthcare services includes physical access as well as financial access. The government has launched AB PM-JAY schemes for ensuring that the service packages are available cashless to different targeted groups. Giving quality patient care have a positive effect on patient outcomes and recovery experience. Patients' rights are also an integral part of patient care. The important patient rights include informed consent, confidentiality of medical records, legible prescription etc. This chapter includes standards such as uniform user-friendly signage, IEC for educating patients, patient-friendly admission and referral process, consent policies, retaining of medical record and education of patients.

CHAPTER 4: PATIENT CARE

PC 1	Hospital should have uniform and user friendly signage system in English and in the local language understood by Patient / family and community.
PC 2	All signage those are required by law should be displayed at all strategic location
PC 3	Contact information of key medical staff and specialist should be readily available in the emergency department
PC 4	Service counters for the enquiry are available as per the patient load and are duly managed by hospital staff for the registration of patients
PC 5	Hospital should have established procedure for admission of patients
PC 6	The patient should be referred to another facility along with the documented clinical information, in case of non-availability of services and/or beds.
PC 7	General Consent and Informed Consent should be taken during the admission and before any procedures /surgery and anesthesia/ sedation.
PC 8	User charges are displayed and communicated to patients effectively at the time of registration, admission to the ward and in case of a change in medical and surgical plan.
PC 9	Patient should be properly educated on additional care as deem required and all the vital information should be recorded for continuity of care.
PC 10	Hospitals should ensure that all medications and associated instructions are written in the prescription.
PC 11	Medical records should be retained as per the policies of Hospital based on national and local law.

PC 1 - HOSPITAL SHOULD HAVE UNIFORM AND USER-FRIENDLY SIGNAGE SYSTEM IN ENGLISH AND IN THE LOCAL LANGUAGE UNDERSTOOD BY PATIENT / FAMILY AND COMMUNITY.

Interpretation – Adequate signage should be displayed at all strategic locations which are permanent in nature. The services, departmental and directional signage, and list of departments should be prominently displayed at all strategic locations in a uniform color scheme. Also the essential information like list of emergency contact numbers, list of doctors, patient rights and responsibilities etc. should be displayed within the hospital premises. It is preferable that the signage is displayed in bilingual language for the ease and understanding of patients.

Means of verification:

1. Name of the hospital and entry-exit should be clearly displayed outside the hospital. Entry to the emergency department should also be defined and displayed strategically
2. Hospital has directional signage with a uniform color scheme.
3. List of departments (as per scope of services) should be displayed in bilingual language
4. The scope of services should be displayed in the waiting area/ OPD/ Emergency/ Reception in bilingual language
5. All the services registered under AB PM-JAY are clearly defined & displayed in prominent places in understandable language.
6. Display of floor layout at each floor
7. Display of patients' rights and responsibility & other related IEC material (outdated and torn posters/wallpapers etc. should not be put on display)
8. Hospital has IEC specific to AB PM-JAY.
9. List of doctors (as per scope of services) with their departments and availability
10. No smoking signage to be present within the hospital premises
11. Display of hand washing instruction at the point of use (5 moments and 7 steps of hand hygiene)
12. Display of emergency numbers including ambulance, blood bank, police and referral centers

NAME OF THE HOSPITAL AND ENTRY-EXIT SHOULD BE CLEARLY DISPLAYED OUTSIDE THE HOSPITAL. ENTRY TO THE EMERGENCY DEPARTMENT SHOULD ALSO BE DEFINED AND DISPLAYED STRATEGICALLY

HOSPITAL HAS DIRECTIONAL SIGNAGE WITH A UNIFORM COLOR SCHEME

LIST OF DEPARTMENTS (AS PER SCOPE OF SERVICES) SHOULD BE DISPLAYED IN BILINGUAL LANGUAGE

THE SCOPE OF SERVICES SHOULD BE DISPLAYED IN THE WAITING AREA/ OPD/ EMERGENCY/ RECEPTION IN BILINGUAL LANGUAGE

ALL THE SERVICES REGISTERED UNDER AB PM-JAY ARE CLEARLY DEFINED & DISPLAYED IN PROMINENT PLACES IN UNDERSTANDABLE LANGUAGE

Name of Hospital:----------

AVAILABLE SERVICES	ઉપલબ્ધ સેવાઓ
1. ORTHOPAEDIC (SPINE) RELATED	૧. ઓર્થોપેડિક (સ્પાઈન) ને લગતી સુવિધાઓ
2. O.P.D. DEPARTMENT	૨. બહારના દર્દીઓનો વિભાગ (ઓ.પી.ડી.)
3. I.P.D. DEPARTMENT	૩. અંદરના દર્દીઓનો વિભાગ (આઈ.પી.ડી.)
4. OPERATION THEATRE	૪. ઓપરેશન થીયેટર
5. X-RAY DEPARTMENT	૫. એક્સ-રે વિભાગ
6. LABORATORY (SAMPLE COLLECTION CENTRE)	૬. લેબોરેટરી વિભાગ (સેમ્પલ કલેકશન સેન્ટર)
7. NURSING SERVICES	૭. નર્સિંગ સેવાઓ
8. PHYSIOTHERAPY DEPARTMENT	૮. ફિઝીયોથેરાપી વિભાગ
9. OCCUPATIONAL THERAPY DEPT.	૯. ઓક્યુપેશનલ થેરાપી વિભાગ
10. PROSTHETIC & ORTHOTIC DEPT.	૧૦. પ્રોસ્થેટીક એન્ડ ઓર્થોટીક વિભાગ
11. MEDICAL SOCIAL DEPARTMENT	૧૧. મેડિકલ સોશ્યલ વિભાગ
12. PUBLIC RELATION DEPARTMENT	૧૨. જન સંપર્ક વિભાગ
13. SPEECH THERAPY/AUDIOGRAPH SERVICES	૧૩. સ્પીચ થેરાપી / ઓડિયોગ્રાફ સેવાઓ
14. CLINICAL PSYCHOLOGY DEPT.	૧૪. ક્લીનીકલ સાયકોલોજી વિભાગ
15. VOCATIONAL TRAINING CENTRE	૧૫. વોકેશનલ ટ્રેનિંગ સેન્ટર
16. PSYCHOMOTOR LABORATORY	૧૬. સાયકોમોટર લેબોરેટરી
17. JAIPUR FOOT CENTRE	૧૭. જયપુર ફૂટ સેન્ટર
18. SAFARI - FOLLOW-UP PROGRAMME AND CAMPS INRURAL AREAS	૧૮. સફારી - ફોલો-અપ પ્રોગ્રામ અને ગ્રામ્ય વિસ્તારોમાં કેમ્પોનું આયોજન
19. AMUBULANCE SERVICES	૧૯. એમ્બ્યુલન્સ સેવાઓ
20. CANTEEN SERVICES	૨૦. કેન્ટીન સેવાઓ
21. DIETRY SERVICES	૨૧. ડાયેટ (આહાર) સેવાઓ
22. C. M. SETU YOJNA	૨૨. મુખ્ય મંત્રી સેતુ યોજના

SERVICES NOT AVAILABLE સેવાઓ ઉપલબ્ધ નથી	
(A) Clinical :	(અ) ક્લિનિકલ :
Emergency Services	સંકટકાલીન સેવાઓ
General Medicine	જનરલ મેડિસિન
General Surgery	સામાન્ય સર્જરી
Obstetrics & Gynecology	પ્રસૂતિશાસ્ત્ર & સ્ત્રીરોગવિજ્ઞાન
Pediatric Surgery	બાળકોના સર્જરી
Pulmonary Medicine	પલ્મોનરી દવા
Psychiatry	મનોચિકિત્સા
Medical Oncology	મેડિકલ ઓન્કોલોજી
Surgical Oncology	સર્જિકલ ઓન્કલોજી
Eye	આંખ
Dentistry	ડેન્ટિસ્ટ્રી
Homoeopathic	હોમિયોપેથિક
Ayurvedic	આયુર્વેદિક
(B) Diagnostic :	(બ) ડાયગ્નોસ્ટિક :
USG,CT Scan, MRI	USG, સીટી સ્કેન, એમઆરઆઈ
Nuclear Medicine	ન્યુક્લિયર મેડિસિન
Bone Marrow Densitometry	બોન મેરો ડેન્સીટોમેટ્રી

DISPLAY OF FLOOR LAYOUT AT EACH FLOOR

DISPLAY OF PATIENTS' RIGHTS AND RESPONSIBILITY & OTHER RELATED IEC MATERIAL (OUTDATED AND TORN POSTERS/WALLPAPERS ETC. SHOULD NOT BE PUT ON DISPLAY

HOSPITAL HAS IEC SPECIFIC TO AB PM-JAY

LIST OF DOCTORS (AS PER SCOPE OF SERVICES) WITH THEIR DEPARTMENTS AND AVAILABILITY

CARDIOLOGIST	Days:	Timing:
Dr. Prem Aggarwal	Mon to Sat	01:00pm-04:00pm
Dr. K. K. Srivastava	Mon to Sat	11:00am-01:00pm
Dr. D.S. Mathur	Mon to Sat	12:00pm-02:00pm
Dr. Javed		On Call
Dr. Sarita Gulati		On Call

CHEST, TB & BRONCHOSCOPIST		
Dr. Ajay Kochhar	Mon,Wed,Fri	08:00am-10:00am
Dr. Mohit Garg	Mon to Sat	11:00am-03:00pm
Dr. Chaku Gorge		On Call

CONSULTANT SURGEON		
Dr. A.N. Srivastav	Mon,Wed,Fri	01:00pm-03:00pm
Dr. P. N. Sinha	Mon to Sat	06:00pm-08:00pm
Dr. Ajay Sood	Tue,Thurs,Sat	06:00pm-08:00pm

DERMATOLOGIST		
Dr. Ratan Singh	Mon,Wed,Fri	11:00am-01:00pm
Dr. Amit Vij	Mon to Sat	01:00pm-02:30pm
Dr. R. K. Bhatia	Mon to Sat	04:00pm-06:00pm
Dr. Kamlender singh	Mon,wed,Fri	07:00pm-08:00pm

ENDOCRINOLOGIST		
Dr. S. S. Rastogi	Sunday	10:00am-12:00noon

ENT SPECIALIST		
Dr. Adarsh Tarwar	Mon to Sat	02:00pm-05:00pm
Dr. K. B. Puri	Mon to Sat	03:00pm-05:00pm
Dr. Sanjay Gupta		On Call
Dr. Rakesh Kumar		On Call

GASTROENTROLOGIST		
Dr. R. C. Mishra	Mon,Wed,Fri	06:00pm-07:00pm
Dr. Deepak Lohoti		On Call
Dr. P. S. Gupta		On Call
Dr. Munish Sachdev		On Call

GASTRO SURGEON		
Dr. Dinesh Singhal		On Call

GENERAL PHYSICIAN		
Dr. Manav Aggarwal	Mon to Sat	09:00am-11:00am
Dr. Sanjay Sachdev	Mon to Sat	11:00am-01:00pm
Dr. B. B. Aggarwal	Mon to Sat	11:00am-01:00pm
Dr. Vinay Kumar	Mon to Sat	01:00pm-03:00pm
Dr. Ashish Rohtagi		On Call
Dr. S. M. Kazim		On Call
Dr. A. S. Dave		On Call
Dr. M. M. Mittal		On Call
Dr. Sarvesh Kumar		On Call
Dr. Virendera Jain		On Call
Dr. D. K. Chauhan		On Call

GYNECOLOGIST & OBSTETRICIAN		
Dr. Alka Vohra	Mon to Sat	09:00am-11:00am
Dr. M. Khera	Mon to Sat	11:00am-01:00pm 06:00pm-08:00pm
Dr. Deepika Rastogi	Mon to Sat	11:00am-01:00pm
Dr. Anjali Srivastava	Mon to Sat	11:00am-01:00pm
Dr. Hamrah Siddiqui	Mon to Sat	12:00noon-02:00pm
Dr. Sarla Mukherjee		On Call
Dr. Shalini Pal		On Call

NEPHROLOGIST		
Dr. Uma Kishor	Mon to Sat	09:00am-11:00am
Dr. S. N. A. Rizvi	Mon to Fri	05:00pm-07:00pm
Dr. Pradeep Chhatree	Mon to Sat	04:00pm-06:00pm

NEUROLOGIST		
Dr. B. C. Bansal	Mon to Fri	03:00pm-05:00pm
Dr. Guru Bax Singh		On Call

NEURO SURGEON		
Dr. V. K. Rajoria		On Call
Dr. K. K. Chawdhri		On Call
Dr. Dhruv Chaturvedi		On Call

ONCOLOGIST		
Dr. Ajay Mehta		On Call

ONCO SURGEON		
Dr. Sanjeev Chibbar	Mon,Thur	01:00pm-03:00pm

ORTHOPAEDIC		
Dr. Harvinder Singh	Mon to Sat	11:00am-01:00pm
Dr. Anmol Maria	Mon to Sat	01:30pm-03:00pm
Dr. Vivek Aggarwal	Mon to Sat	06:00pm-08:00pm
DR. Sachin Yadav		On Call

PEDIATRIC		
Dr. Girish Srivastava	Mon to Sat	10:00am-12:00noon
Dr. Sanjeev Sehgal		On Call
Dr. Dinesh Rustogi	Mon,Wed,Sat Tue,Thurs,Fri	03:00pm-05:00pm 11:00am-01:00pm
Dr. K. K. Jain		On Call
Dr. Sumit Jain		On Call
Dr. P. Jain		On Call

PEDIATRICS SURGEON		
Dr. B. D. Diwedi		On Call

PLASTIC SURGEON		
Dr. Pradeep Bhargava	Mon,Wed,Fri	09:00am-11:00am
Dr. Charan Jeev sobti		On Call

PSYCHIATRIST		
Dr. M. Mandhekar	Mon to Sat	03:00pm-05:00pm
Dr. Dutta Ray	Tue,Thurs,Sat	05:00pm-07:00pm
Dr. Vikas Singhal	Mon to Sat	04:00pm-08:00pm

RADIOLOGIST		
Dr. Nidhi Bhatnagar	Mon to Sat	10:00am-02:00pm

THYROID SPECIALIST		
Dr. Rajeev Sharma	Mon,Wed,Fri	09:00am-11:00am

URO SURGEON		
Dr. P. Gulati	Mon, Wed, Fri	09:00am-11:00am
Dr. S.N. Budhiraja	Mon,Wed,Fri	11:00am-01:00pm
Dr. Atul Bhatnagar	Tue,Wed,Fri,Sat	12:00pm-02:00pm
Dr. Shilpi Tiwari		On Call

VASCULAR SURGEON		
Dr. Shohel Bukhari		On Call

DENTAL SURGEON		
Dr. S. K. Dua	Mon-Sat	11:00am-01:00pm 03:00pm-05:00pm
Dr. Dilip Sukla		On Call
Dr. Mahesh Chawhan		On Call
Dr. Sameer Sachdeva		On Call
Dr. A.S. Davey		On Call

DIET & LIFE STYLE		
Ms. Upasna	Mon to Sat	10:00am-01:00pm

HOMEOPATHIC		
Dr. Kanchan		On Call
Dr. Himani Jain		On Call

PHYSIOTHERAPIST		
Dr. M. M. Kumar	Mon to Sat	09:00am-01:00pm
Dr. Bharal	Mon to Sat	04:00pm-06:00pm

NO SMOKING SIGNAGE TO BE PRESENT WITHIN THE HOSPITAL PREMISES

DISPLAY OF HAND WASHING INSTRUCTION AT THE POINT OF USE

DISPLAY OF EMERGENCY NUMBERS INCLUDING AMBULANCE, BLOOD BANK, POLICE AND REFERRAL CENTERS

Emergency Phone No.
Ambulance:----------
Blood Bank:----------
Police:----------
Referral Centers:----------

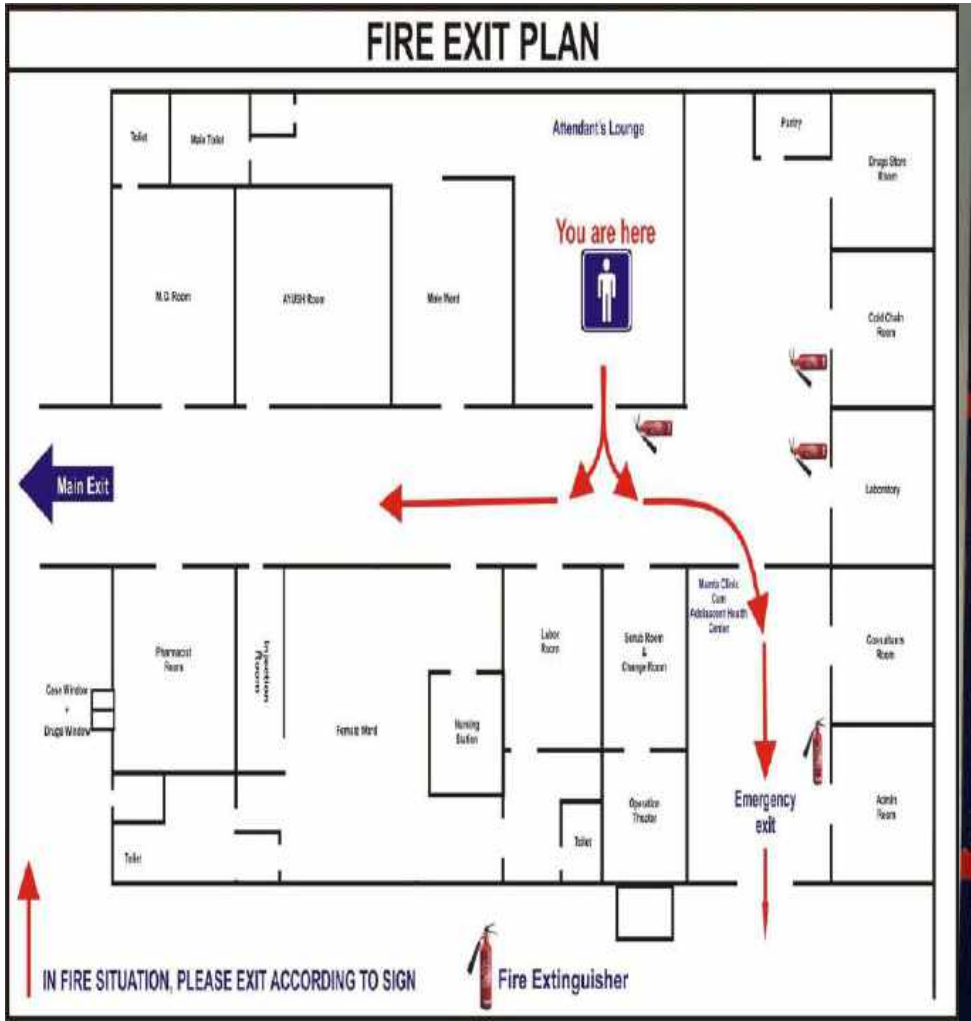
PC 2 - ALL SIGNAGE'S THOSE ARE REQUIRED BY LAW SHOULD BE DISPLAYED AT ALL STRATEGIC LOCATION

Interpretation – All such signage which are compulsory by law for hospitals to display such as PC&PNDT Act, AERB and radian hazard, Bio hazard signage and Fire exit signage should be displayed in the hospitals at all strategic locations.

Means of verification:

1. Fire exit signage to be displayed at exit route plan along with the do's and don'ts in case of fire
2. PC&PNDT Act Signage board to be displayed at the waiting room and reception area
3. AERB and Radiation hazard signage
4. Bio-hazard signage to be present

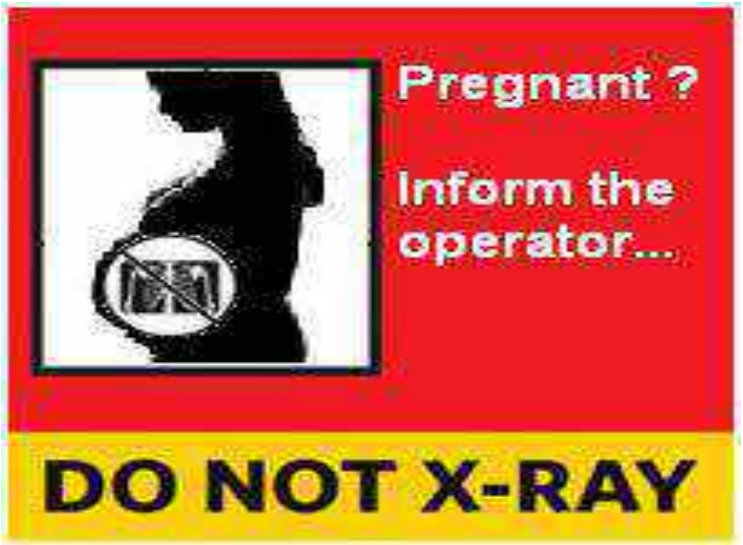
FIRE EXIT SIGNAGE TO BE DISPLAYED AT EXIT ROUTE PLAN ALONG WITH THE DO'S AND DON'TS IN CASE OF FIRE



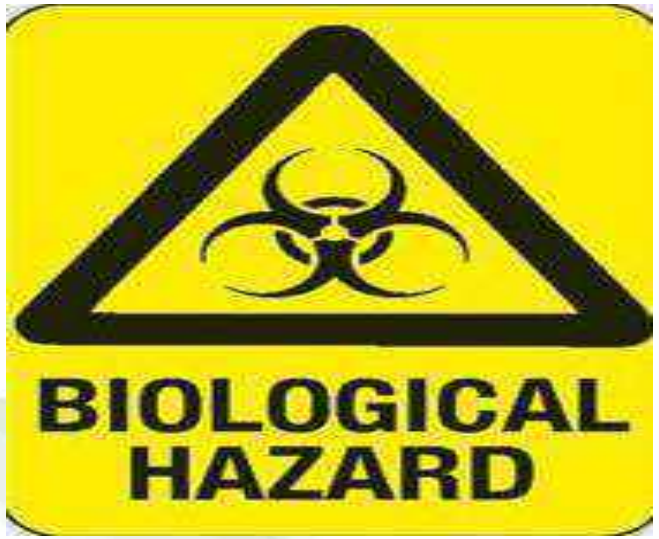
FIRE EXIT SIGNAGE TO BE DISPLAYED AT EXIT ROUTE PLAN ALONG WITH THE DO'S AND DON'TS IN CASE OF FIRE

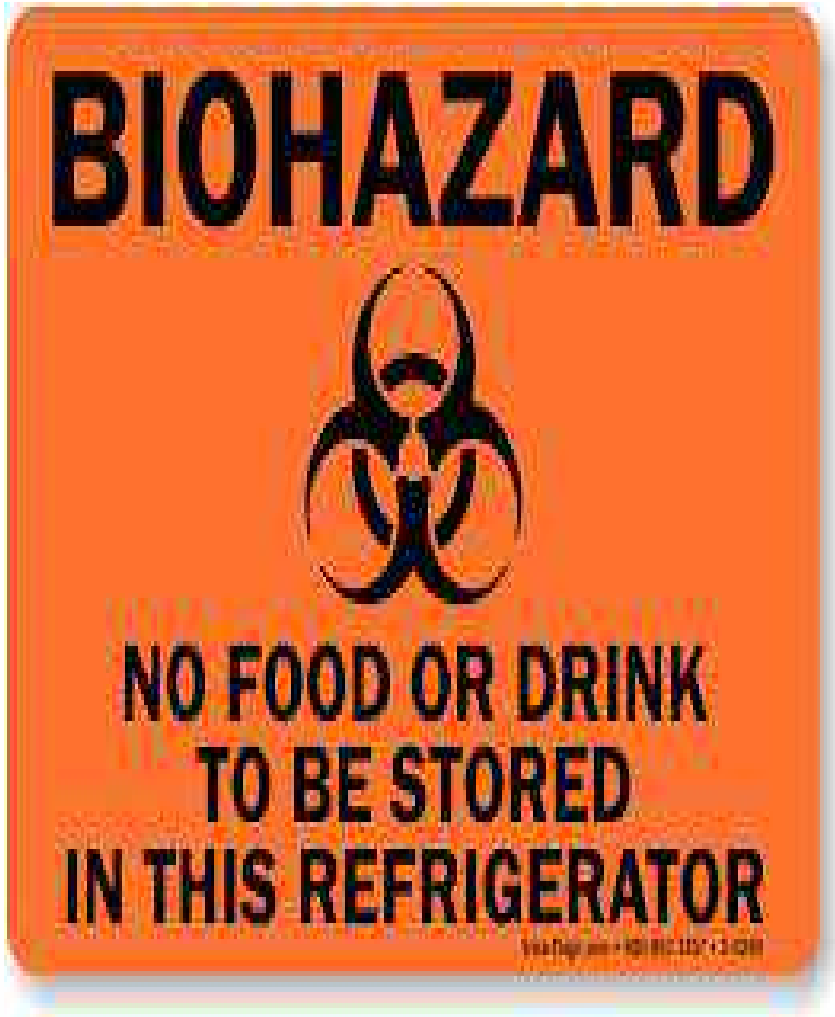
PC&PNDT ACT SIGNAGE BOARD TO BE DISPLAYED AT THE WAITING ROOM AND RECEPTION AREA

AERB AND RADIATION HAZARD SIGNAGE



BIO-HAZARD SIGNAGE TO BE PRESENT





PC 3 - CONTACT INFORMATION OF KEY MEDICAL STAFF AND SPECIALIST SHOULD BE READILY AVAILABLE IN THE EMERGENCY DEPARTMENT

Interpretation – The hospital must have accessible and readily available contact details of doctors and staff members. Also, a nurse call facility and at least one medical officer should be available at all times in the hospital in case of emergencies.

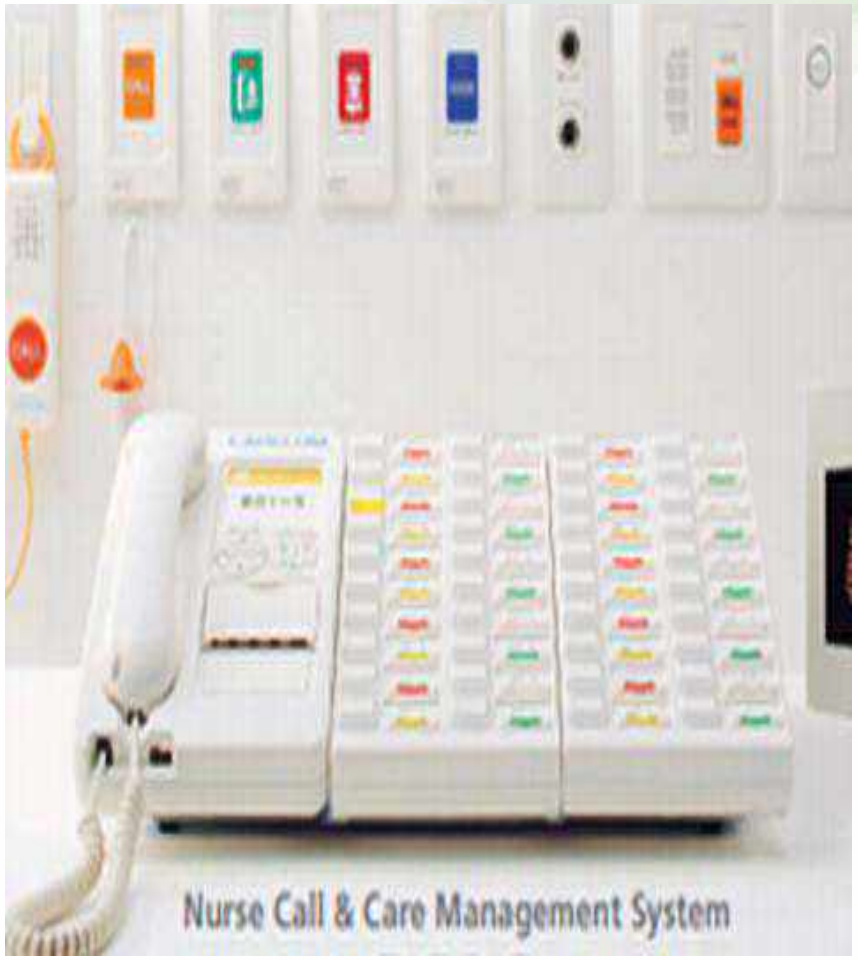
Means of verification:

1. Check if the contact details (telephone or residence address) of doctors/staff are readily available
2. Nurse call facility should be available to address any patient emergency.
3. At least one medical officer and a nurse should be available all the time for the emergency cases.

CHECK IF THE CONTACT DETAILS (TELEPHONE OR RESIDENCE ADDRESS) OF DOCTORS/STAFF ARE READILY AVAILABLE

S. No.	Name of Doctor / Staff	Telephone No.	Address
1			
2			
3			
4			
5			

NURSE CALL FACILITY SHOULD BE AVAILABLE TO ADDRESS ANY PATIENT EMERGENCY



AT LEAST ONE MEDICAL OFFICER AND A NURSE SHOULD BE AVAILABLE ALL THE TIME FOR THE EMERGENCY CASES

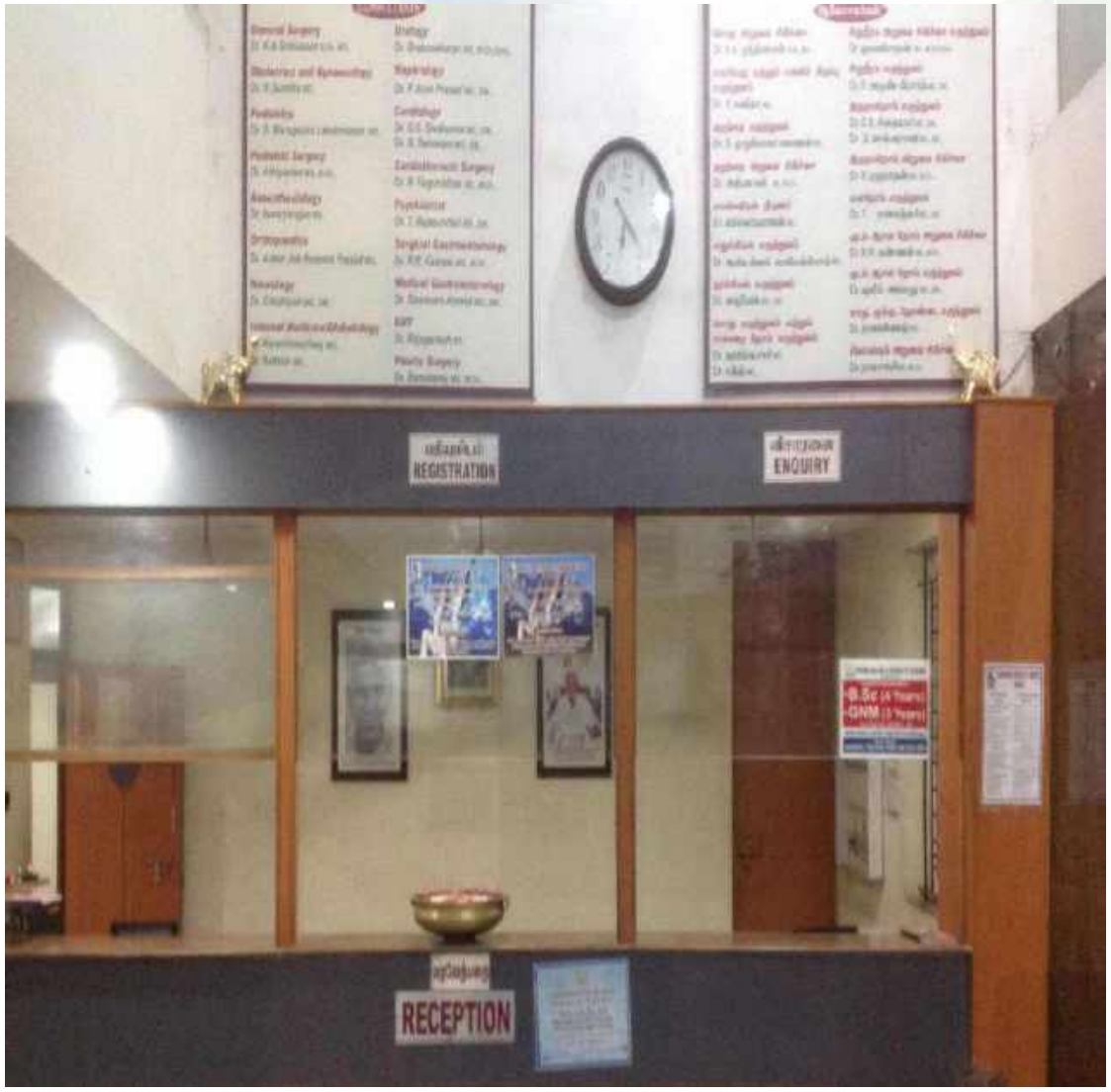
PC 4 - SERVICE COUNTERS FOR THE ENQUIRY ARE AVAILABLE AS PER THE PATIENT LOAD AND ARE DULY MANAGED BY HOSPITAL STAFF FOR THE REGISTRATION OF PATIENTS

Interpretation – There should be a dedicated area for enquiry as per the number of patients that visits the hospital and dedicated kiosk for AB PMJAY manned round the clock. Hospital must make sure that every patient is given a unique identification number at the time of registration of the first interaction if the patient with the organisation. To ensure continuity of care these numbers shall be linked to the unique number.

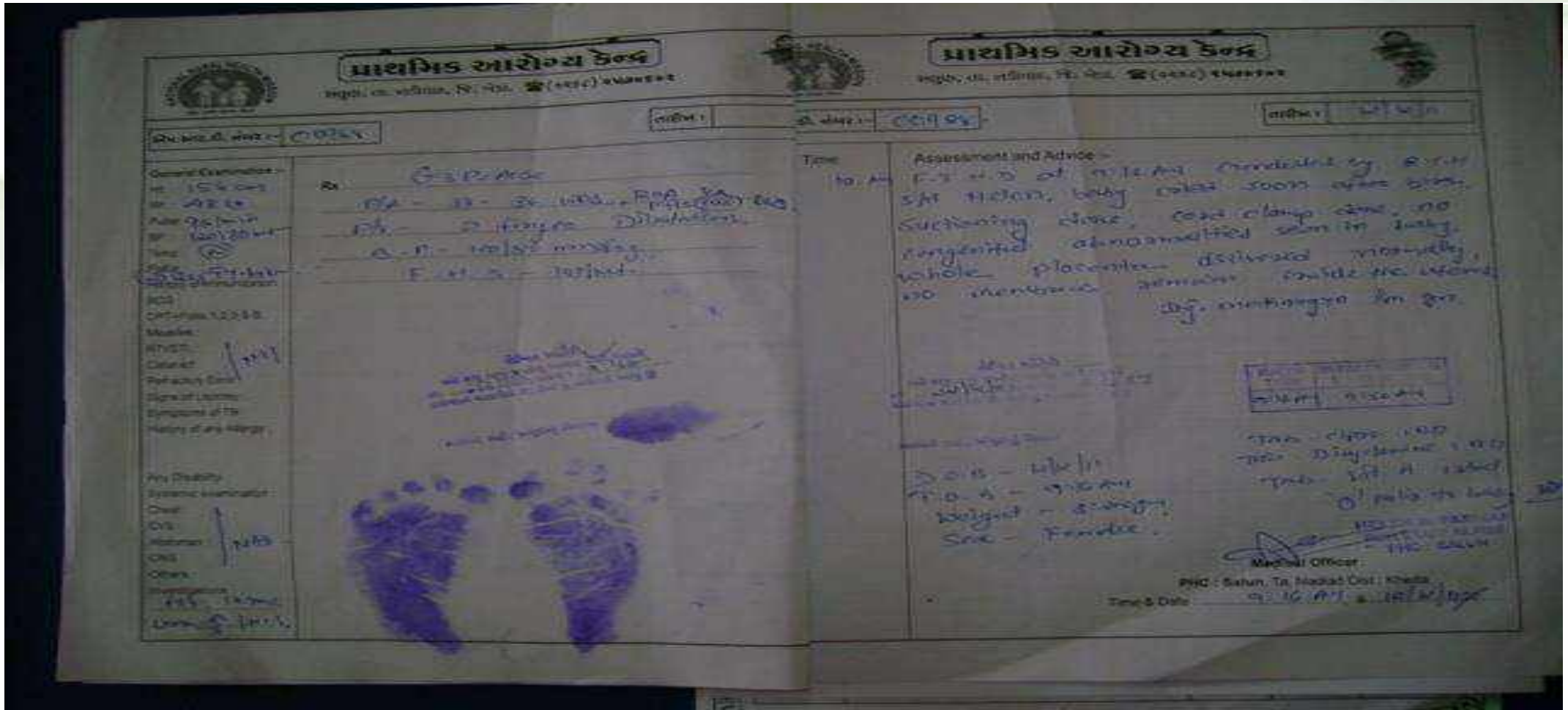
Means of verification:

1. Check availability of a dedicated enquiry area or reception
2. Unique identification number is given to each patient during the process of registration while also recording patient details such as name, age, sex, address and chief complaint etc.
3. Hospital has AB PM-JAY Kiosk manned 24*7

CHECK AVAILABILITY OF A DEDICATED ENQUIRY AREA OR RECEPTION



UNIQUE IDENTIFICATION NUMBER IS GIVEN TO EACH PATIENT DURING THE PROCESS OF REGISTRATION WHILE ALSO RECORDING PATIENT DETAILS SUCH AS NAME, AGE, SEX, ADDRESS AND CHIEF COMPLAINT ETC.



HOSPITAL HAS AB PM-JAY KIOSK MANNED 24*7

PC 5 - HOSPITAL SHOULD HAVE ESTABLISHED PROCEDURE FOR ADMISSION OF PATIENTS

Interpretation – There should be documented procedures for registering and admitting the patient. All patients assessed in hospital shall be registered and all admissions must be authorized by a doctor. The policy should be defined with respect to documentation and intimation to police in case of Medico Legal Cases (MLC) as per statutory requirement.

Means of verification:

1. Admission is done by written order of a qualified doctor
2. There is an established criterion for admission through the emergency department
3. There is established procedure for admission of Medico-Legal Cases (MLC) as per prevalent laws and procedure to inform the police. Records for such patients are also maintained.

ADMISSION IS DONE BY WRITTEN ORDER OF A QUALIFIED DOCTOR

Chapter: Admission and Discharge (AD)
Section 1: Admission of Adult Patients

Policy

1. Civilly committed patients admitted to Utah State Hospital are screened through a community mental health center to determine the appropriateness of referral. Referrals are to be made to the hospital's Admissions Liaisons in the Admissions, Discharge and Transfer Office (ADT).

2. Criteria for admission to Utah Sate Hospital are defined in the Utah State Code Annotated 1953, Title 62A, as amended, and the Utah State Board of Mental Health Policies. These general policy guidelines are interpreted as follows in determining eligibility for admission to the Utah State Hospital.

   2.1. The patient must be suffering from a major mental illness.

   2.2. The patient normally has a chronic mental illness, even though the current episode may be an acute exacerbation of the illness.

   2.3. Community based facilities have been utilized first and found not adequate to the need, or do not exist in the area of the state where the patient is found.

   2.4. A longer hospitalization is anticipated than what is normally considered for short-term acute care.

   2.5. The severity of the illness makes management and treatment at Utah State Hospital the most reasonable alternative.

   2.6. Dangerousness or violence of behavior factors makes management and treatment at Utah State Hospital the most reasonable alternative.

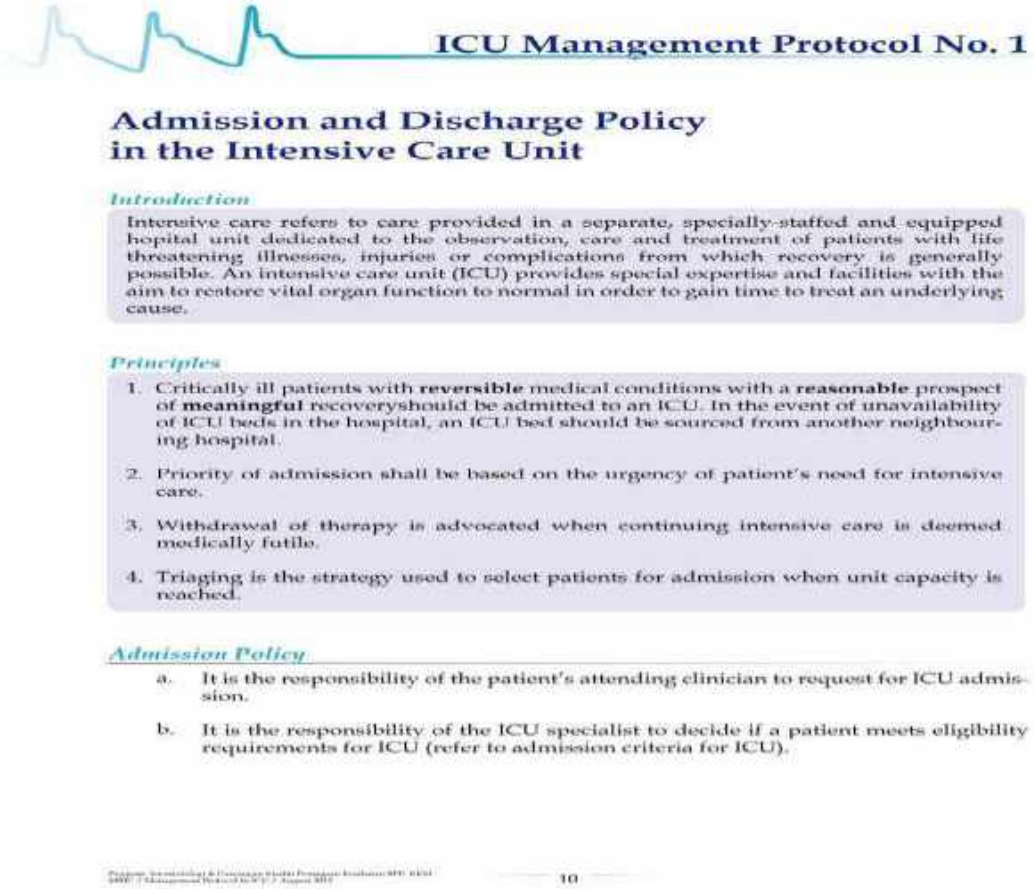
   2.7. The patient's needs may be best met by a specialized treatment program only available at Utah State Hospital.

   2.8. Referrals are made based on the availability of bed allocation for each Community Mental Health Center (CMHC).

      2.8.1. If a CMHC wishes to loan or sell a bed to another mental health center, the appropriate approval forms are signed through the Admissions Office.

   2.9. The referred individual is an established client of a community mental health center and has been referred by that center. The referred individual may also be committed to another state institution, and meet the criteria for inter-institutional transfer as defined in Utah Code Annotated 62A-15-801.

   2.10. The patient may be either voluntary or meet the criteria for civil commitment as defined in Utah Code Annotated, Title 62A. Voluntary admissions are discouraged if it seems likely that the patient will request release before treatment has been completed.



ICU Management Protocol No. 1

Admission and Discharge Policy in the Intensive Care Unit

Introduction

Intensive care refers to care provided in a separate, specially-staffed and equipped hospital unit dedicated to the observation, care and treatment of patients with life threatening illnesses, injuries or complications from which recovery is generally possible. An intensive care unit (ICU) provides special expertise and facilities with the aim to restore vital organ function to normal in order to gain time to treat an underlying cause.

Principles

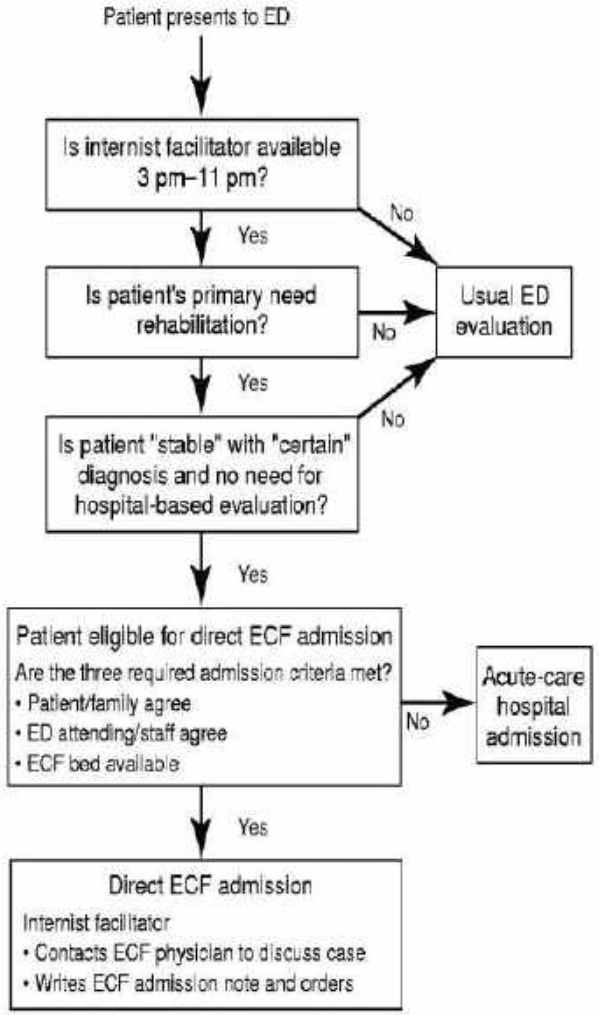
1. Critically ill patients with **reversible** medical conditions with a **reasonable** prospect of **meaningful** recoveryshould be admitted to an ICU. In the event of unavailability of ICU beds in the hospital, an ICU bed should be sourced from another neighbouring hospital.
2. Priority of admission shall be based on the urgency of patient's need for intensive care.
3. Withdrawal of therapy is advocated when continuing intensive care is deemed medically futile.
4. Triaging is the strategy used to select patients for admission when unit capacity is reached.

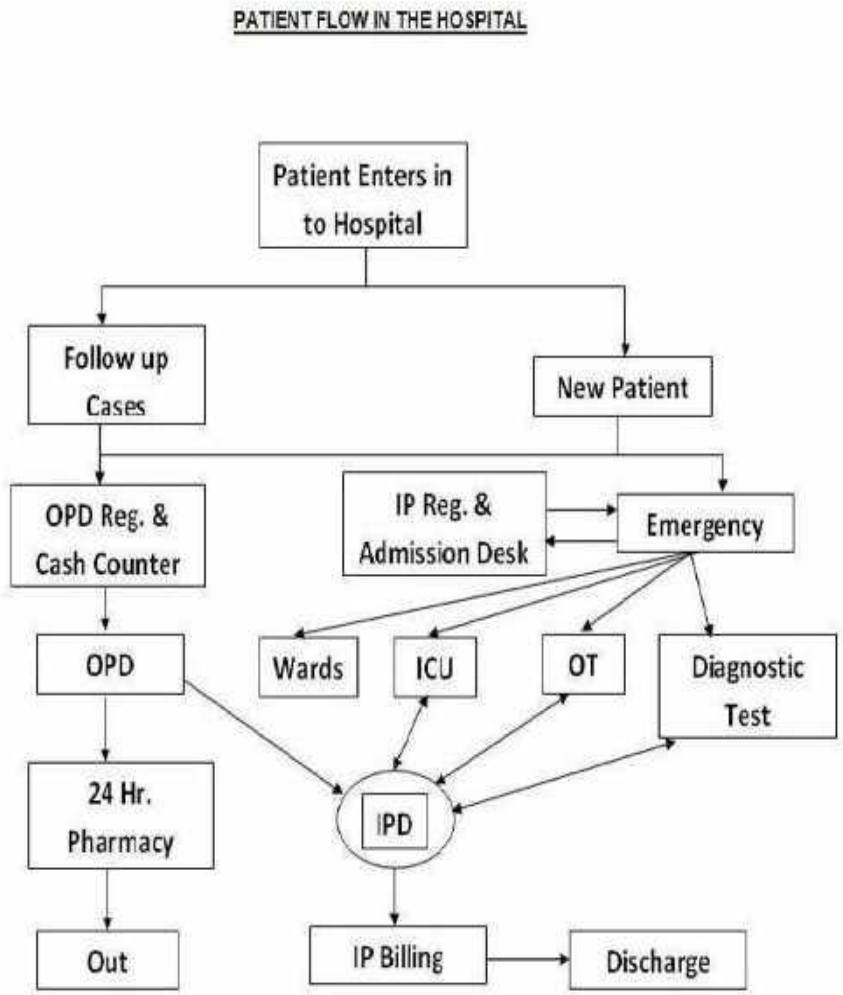
Admission Policy

a. It is the responsibility of the patient's attending clinician to request for ICU admission.

b. It is the responsibility of the ICU specialist to decide if a patient meets eligibility requirements for ICU (refer to admission criteria for ICU).

THERE IS AN ESTABLISHED CRITERION FOR ADMISSION THROUGH THE EMERGENCY DEPARTMENT





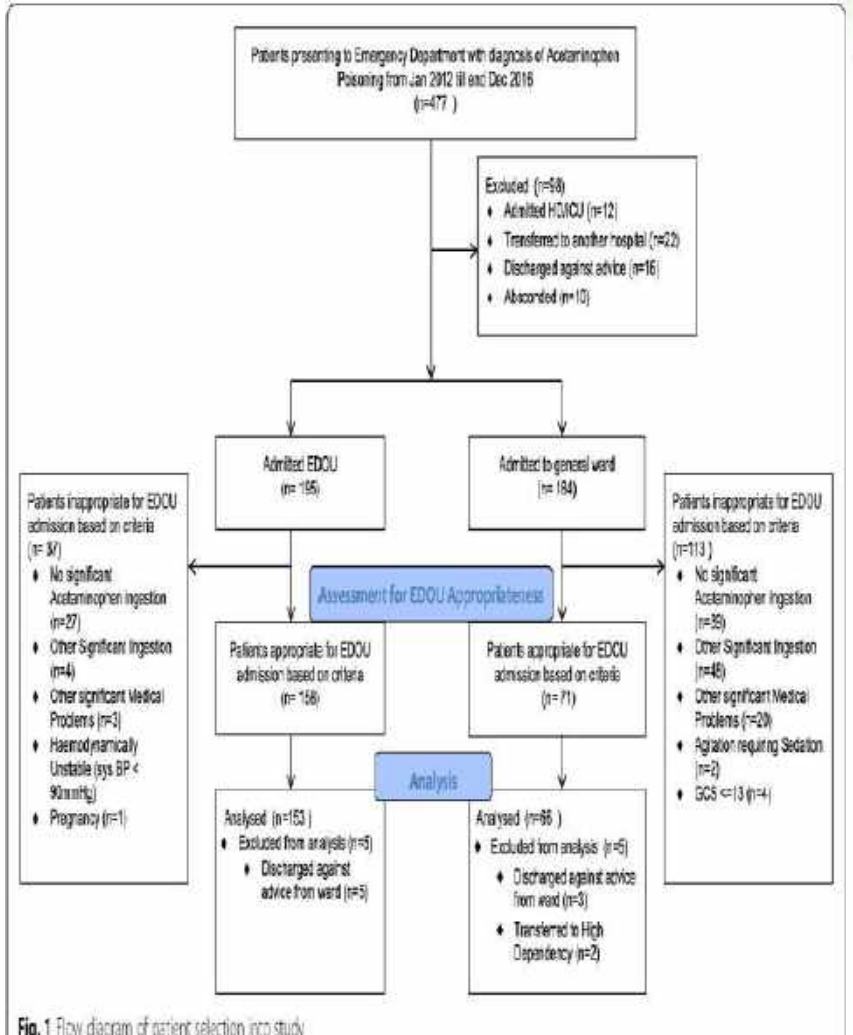


Fig. 1 Flow diagram of patient selection into study

THERE IS ESTABLISHED PROCEDURE FOR ADMISSION OF MEDICO-LEGAL CASES (MLC) AS PER PREVALENT LAWS AND PROCEDURE TO INFORM THE POLICE. RECORDS FOR SUCH PATIENTS ARE ALSO MAINTAINED

ADMISSION AND DISCHARGE

- Whenever a medico-legal case is admitted or discharged, the same should be intimated to the nearest police station at the earliest.
- It is always better to inform the police through the casualty of the hospital where the medico-legal register is usually maintained and necessary entries can be made in it.
- While discharging or referring the patient, care should be taken to see that he receives the Discharge Card/Referral Letter, complete with the summary of admission, the treatment given in the hospital and the instructions to the patient to be followed after discharge.
- Failure to do so renders the doctor liable for "negligence" and "deficiency of service"

TREATMENT OF MEDICO-LEGAL CASES

- The patient should immediately be given treatment without waiting for the medico legal formalities of reporting.
- Treatment to be started after examination and recording findings.
- First Aid to be given immediately without waiting for completion of MLC sheet
- If specialist consultation is required, patient to be referred to concern specialist for further treatment
- All cases requiring constant observation and treatment to be admitted into the hospital.

LAW AND MEDICINE

1.Medical Jurisprudence : It deals with legal aspects of medical practice of doctors.

2.Forensic Medicine : It deals with medical aspects of law and medico legal case management.

PC 6 - THE PATIENT SHOULD BE REFERRED TO ANOTHER FACILITY ALONG WITH THE DOCUMENTED CLINICAL INFORMATION, IN CASE OF NON-AVAILABILITY OF SERVICES AND/OR BEDS.

Interpretation – The documented procedure addressing the managing patients in case of non-availability of beds. Patients needing transfer including those who have come to the emergency but needs to be transferred after basic first-aid, the hospital shall have documented procedure for managing patients. The transferring/referring patients to another facility should be done through issuing referral slips.

Means of verification:

1. There is an established procedure for managing patients in case beds are not available at the facility
2. Patient should be referred while issuing a referral slip and should be bi-directional referral system. The record of the same should be maintained
3. Adequate emergency facilities should be available to provide basic first aid before transfer/referral
4. AB PM-JAY Benefices referred to AB PM-JAY empaneled Hospitals

THERE IS AN ESTABLISHED PROCEDURE FOR MANAGING PATIENTS IN CASE BEDS ARE NOT AVAILABLE AT THE FACILITY

BED MANAGEMENT POLICY – ADULT ACUTE WARDS

1. INTRODUCTION

This policy clarifies action to be taken at Bassetlaw Hospital, as bed occupancy nears or exceeds full capacity. It describes the internal escalation principles to be considered by the Ward teams and Clinical Site Management teams (CSM) and the communication cascade to Managers and Clinicians, as well as to other organisations.

2. PRINCIPLES OF THE POLICY

This policy defines:

2.1 the circumstances for transferring existing in-patients within the hospital to create beds in appropriate locations for anticipated new admissions

2.2 the requirement of the clinical teams to undertake additional review of those patients who may be deemed fit for discharge, in order to create additional bed availability

2.3 the use and function of the designated discharge lounge in order to create additional bed availability

2.4 the communication within the hospital to alert teams with regard to the bed status, which may inform the decision to cancel non-urgent elective admissions

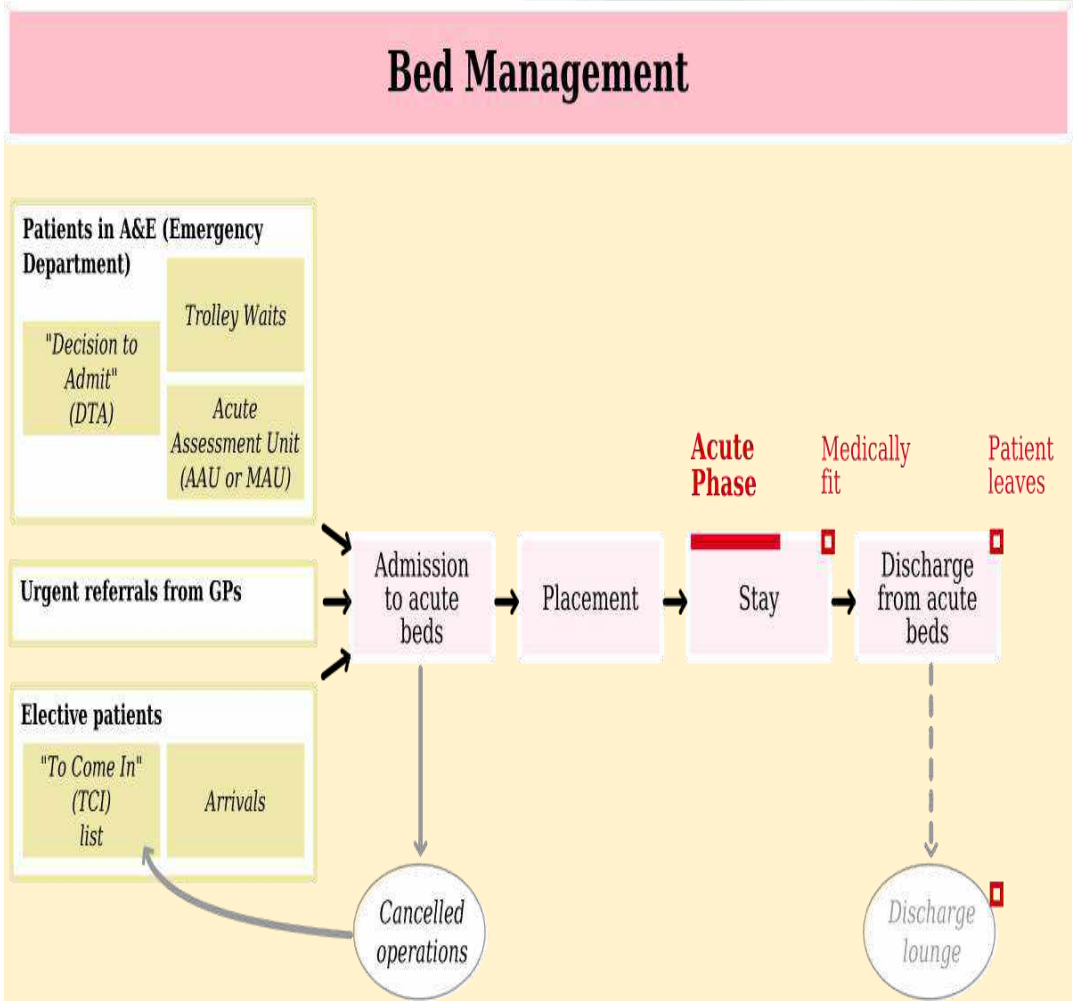
2.5 the communication necessary with other organisations e.g. the PCT and the Ambulance Services

2.6 the communication with the Manager on Call teams

3. MANAGEMENT RESPONSIBILITY

3.1 All adult beds within the Trust will be managed corporately under the direction of the Executive Team. The overall specialty bed allocation will be reviewed annually.

3.2 The 'bed holding' management teams are responsible for ensuring the efficient use of beds. This includes creating the capacity required to meet all elective and non-elective admissions and ensuring that all patients are regularly reviewed for discharge. The CSM is responsible for overviewing the appropriate use of the adult beds on site.



PATIENT SHOULD BE REFERRED WHILE ISSUING A REFERRAL SLIP AND SHOULD BE BI-DIRECTIONAL REFERRAL SYSTEM. THE RECORD OF THE SAME SHOULD BE MAINTAINED

Take feedback of Patient condition from the Hospital where you refer and documented.

ADEQUATE EMERGENCY FACILITIES SHOULD BE AVAILABLE TO PROVIDE BASIC FIRST AID BEFORE TRANSFER/REFERRAL

Provide basic first aid before transfer/referral.

AB PM-JAY BENEFICES REFERRED TO AB PM-JAY EMPANELED HOSPITAL

AB PM-JAY Benefices referred to nearest AB PM-JAY empaneled Hospital.

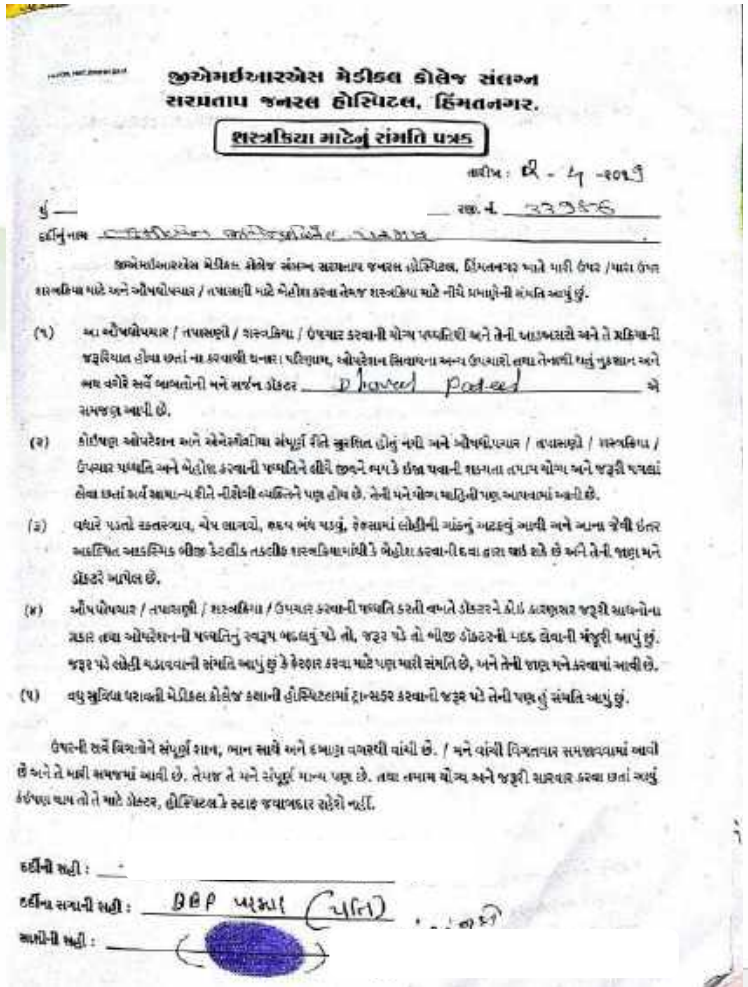
PC 7 - GENERAL CONSENT AND INFORMED CONSENT SHOULD BE TAKEN DURING THE ADMISSION AND BEFORE ANY PROCEDURES /SURGERY AND ANAESTHESIA/ SEDATION.

Interpretation – Patients and family rights include that hospital shall take informed consent, preferably in bi-lingual and language they can understand, signed by patient/relatives/caretaker at the time of admission and before undergoing any surgery or procedure which discuss about all the risks and benefits. The informed consents should be taken at all specific steps pf patient care involved with responsibility.

Means of verification:

1. Consent forms available in bilingual language should be signed by the patients or any caretaker during admission and before surgery (separate forms)
2. All risks, benefits and alternatives about anaesthesia should be discussed and mentioned as part of the consent form signed by the patients or their caretaker.

CONSENT FORMS AVAILABLE IN BILINGUAL LANGUAGE SHOULD BE SIGNED BY THE PATIENTS OR ANY CARETAKER DURING ADMISSION AND BEFORE SURGERY (SEPARATE FORMS)



જીએમઈઆરએસ મેડીકલ કોલેજ સંલગ્ન
સરદાર પટેલ જનરલ હોસ્પિટલ, હિંમતનગર.

શસ્ત્રક્રિયા માટેનું સંમતિ પત્રક

તારીખ : ૧૬ - ૮ -૨૦૧૭

રજી. નં. 83966

દર્દીનું નામ

જીએમઈઆરએસ મેડીકલ કોલેજ સંલગ્ન સરદાર પટેલ જનરલ હોસ્પિટલ, હિંમતનગર ખાતે મારી ઉપર / મારા ઉપર શસ્ત્રક્રિયા માટે અને ઓપરેશન / તપાસણી માટે જેટલા કરવા તેમજ શસ્ત્રક્રિયા માટે નીચે પ્રમાણે સંમતિ આપું છું.

(૧) આ ઓપરેશન / તપાસણી / શસ્ત્રક્રિયા / ઉપચાર કરવાની યોગ્ય પધ્ધતિથી અને તેની બાંહેધરીથી અને તે મર્યાદાની જરૂરિયાત હોવા છતાં ના કરવાથી થનાર પરિણામ, ઓપરેશન સિવાયના અન્ય ઉપચારો તથા તેનાથી થતું નુકશાન અને બધા વગેરે સર્વે બાબતોની મને ડૉક્ટર Dr Dharmesh Patel એ સમજણ આપી છે.

(૨) કોઈપણ ઓપરેશન અને એનેસ્થેસિયા સંપૂર્ણ રીતે ચુકવિત હોતું નથી અને ઓપરેશન / તપાસણી / શસ્ત્રક્રિયા / ઉપચાર પધ્ધતિ અને બેહોશ કરવાની પધ્ધતિને લીધે જીવને ભયંકર ઈજા પહોચી શકવાના તદ્દન ઓછા અને જરૂરી પગલાં લેવા છતાં કયારે પણ અણધાર્યા કોઈ નીકળેલી વ્યક્તિને પણ હોય છે. તેની મને પૂરેપૂરી માહિતી પણ આપવામાં આવી છે.

(૩) વધારે પડતો રક્તસ્ત્રાવ, ચેપ લાગવો, હૃદય બંધ પડવું, કેફસામાં લોહીની ગાંઠનું બદલવું આવી અને અન્ય જેવી ઇતર અકલ્પિત આકસ્મિક બીજી કેટલીક તકલીફ શસ્ત્રક્રિયાથી કે બેહોશ કરવાની દવા દ્વારા થઈ શકે છે અને તેની જાણ મને ડૉક્ટરે આપેલ છે.

(૪) ઓપરેશન / તપાસણી / શસ્ત્રક્રિયા / ઉપચાર કરવાની પધ્ધતિ કરતી વખતે ડૉક્ટરને કોઈ બાબતસર જરૂરી આકસ્મોના સંકટ તથા ઓપરેશનની પધ્ધતિનું સ્વરૂપ બદલવું પડે તો, જરૂર પડે તો બીજા ડૉક્ટરની મદદ લેવાની મંજૂરી આપું છું. જરૂર પડે લોહી ચઢાવવાની સંમતિ આપું છું કે કેફશર કરવા માટે પણ મારી સંમતિ છે, અને તેની જાણ મને કરવામાં આવી છે.

(૫) વધુ સુવિધા પરાક્રમી મેડીકલ કોલેજ કક્ષાની હૉસ્પિટલમાં ટ્રાન્સફર કરવાની જરૂર પડે તેની પણ હું સંમતિ આપું છું.

ઉપરની સર્વે વિગતોને સંપૂર્ણ જ્ઞાન, ભાન સાથે અને કબાડા વગરથી વાંચી છે. / મને વાંચી વિગતવાર સમજાવવામાં આવી છે અને તે મારી સમજમાં આવી છે. તેમજ તે મને સંપૂર્ણ માન્ય પણ છે. તથા તમામ યોગ્ય અને જરૂરી સારવાર કરવા છતાં કાંઈ કોઈપણ ચાપ તો તે માટે ડૉક્ટર, હૉસ્પિટલ કે સ્ટાફ જવાબદાર રહેશે નહીં.

દર્દીની સહી :

દર્દીના સગાની સહી : DBP પરમાર (પતિ)

સાક્ષીની સહી :

CONSENT FOR SURGICAL, INVASIVE, DIAGNOSTIC, MEDICAL, INTERVENTION PROCEDURE

(To be taken by Doctor)

GSI-IPD-FF-24 A

Name of Patient:

Date: __/__/20__ UHD No. : _____ I.P.D. No.: _____ Age: ____ Sex: Male/ Female

Address:

Diagnosis:

Operative Procedure/ Operation:

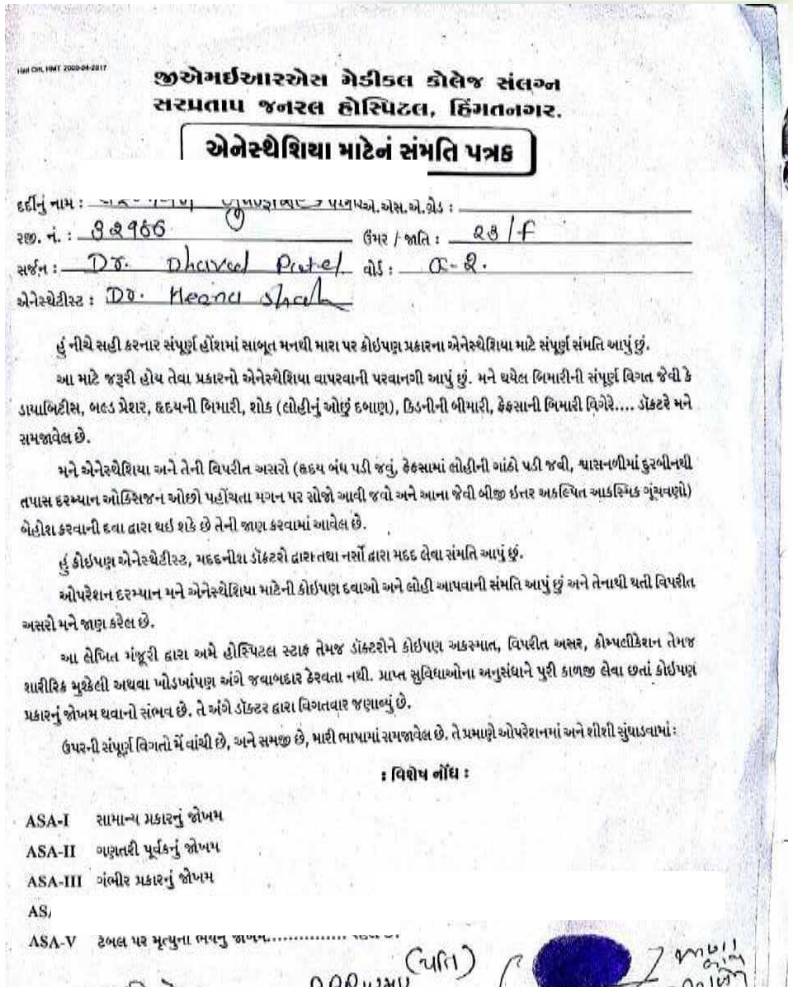
Type of Anaesthesia: Local/ General/ Spinal/ Epidural/ Nerve Block

I, _____ (Patient's name), give my full consent/authorisation as an act of my own free will to undergo the following medical treatment operation or intervention procedures _____ at **Government Spine Institute, Ahmedabad**, under Dr. _____ and his team of assistants, nurses, and hospital staff as supervision and guidance of Dr. _____ deemed necessary.

I have been explained in the language known and understood by me about the nature of the medical treatment operation or procedure being performed, its benefits and costs; risks associated with it; other alternatives and its prognosis.

I am aware that the practice of medicine and surgery is not an exact science and I have not been given any guarantees about results of this procedure.If I develop any complications I hereby authorize the surgical team to take decisions on my behalf.

I agree to allow Government Spine Institute to keep use or properly dispose of any tissues or parts of



જીએમઈઆરએસ મેડીકલ કોલેજ સંલગ્ન
સરદાર પટેલ જનરલ હોસ્પિટલ, હિંમતનગર.

એનેસ્થેશિયા માટેનં સંમતિ પત્રક

દર્દીનું નામ : [illegible] એસ.એ.ગ્રેડ :

રજી. નં. : 83966 ઉંમર / જાતિ : 28 / F

સર્જન : Dr. Dharmesh Patel વોર્ડ : G-2.

એનેસ્થેટીસ્ટ : Dr. Heena Shah

હું નીચે સહી કરનાર સંપૂર્ણ હોંશમાં સાબૂત મનથી મારા પર કોઇપણ પ્રકારના એનેસ્થેશિયા માટે સંપૂર્ણ સંમતિ આપું છું.

આ માટે જરૂરી હોય તેવા પ્રકારનો એનેસ્થેશિયા વાપરવાની પરવાનગી આપું છું. મને થયેલ બિમારી-ની સંપૂર્ણ વિગત જેવી કે ડાયાબિટીસ, બલ્ડ પ્રેશર, હૃદયની બિમારી, શોક (લોહીનું ઓછું દબાણ), કિડનીની બીમારી, કેફસાની બિમારી વિગેરે.... ડૉક્ટરે મને સમજાવેલ છે.

મને એનેસ્થેશિયા અને તેની વિપરીત અસરો (હૃદય બંધ પડી જવું, કેફસામાં લોહીની ગાંઠો પડી જવી, શ્વાસનળીમાં દુરબીનથી તપાસ દરમ્યાન ઓક્સિજન ઓછો પહોંચતા મગજ પર સોજો આવી જવો અને આના જેવી બીજી ઇતર અકલ્પિત આકસ્મિક ગૂંચવણો) બેહોશ કરવાની દવા દ્વારા થઇ શકે છે તેની જાણ કરવામાં આવેલ છે.

હું કોઇપણ એનેસ્થેટીસ્ટ, મદદનીશ ડૉક્ટરો દ્વારા તથા નર્સો દ્વારા મદદ લેવા સંમતિ આપું છું.

ઓપરેશન દરમ્યાન મને એનેસ્થેશિયા માટેની કોઇપણ દવાઓ અને લોહી આપવાની સંમતિ આપું છું અને તેનાથી થતી વિપરીત અસરો મને જાણ કરેલ છે.

આ લેખિત મંજૂરી દ્વારા અમે હોસ્પિટલ સ્ટાફ તેમજ ડૉક્ટરોને કોઇપણ અકસ્માત, વિપરીત અસર, કોમ્પલીકેશન તેમજ શારીરિક મુશ્કેલી અથવા ખોડખાંપણ અંગે જવાબદાર ઠેરવતા નથી. પ્રાપ્ત સુવિધાઓના અનુસંધાને પુરી કાળજી લેવા છતાં કોઇપણ પ્રકારનું જોખમ થવાનો સંભવ છે. તે અંગે ડૉક્ટર દ્વારા વિગતવાર જણાવ્યું છે.

ઉપરની સંપૂર્ણ વિગતો મેં વાંચી છે, અને સમજી છે, મારી ભાષામાં સમજાવેલ છે. તે પ્રમાણે ઓપરેશનમાં અને શીશી ચુંથાડવામાં:

: વિશેષ નોંધ :

ASA-I સામાન્ય પ્રકારનું જોખમ

ASA-II ગણતરી પૂર્વકનું જોખમ

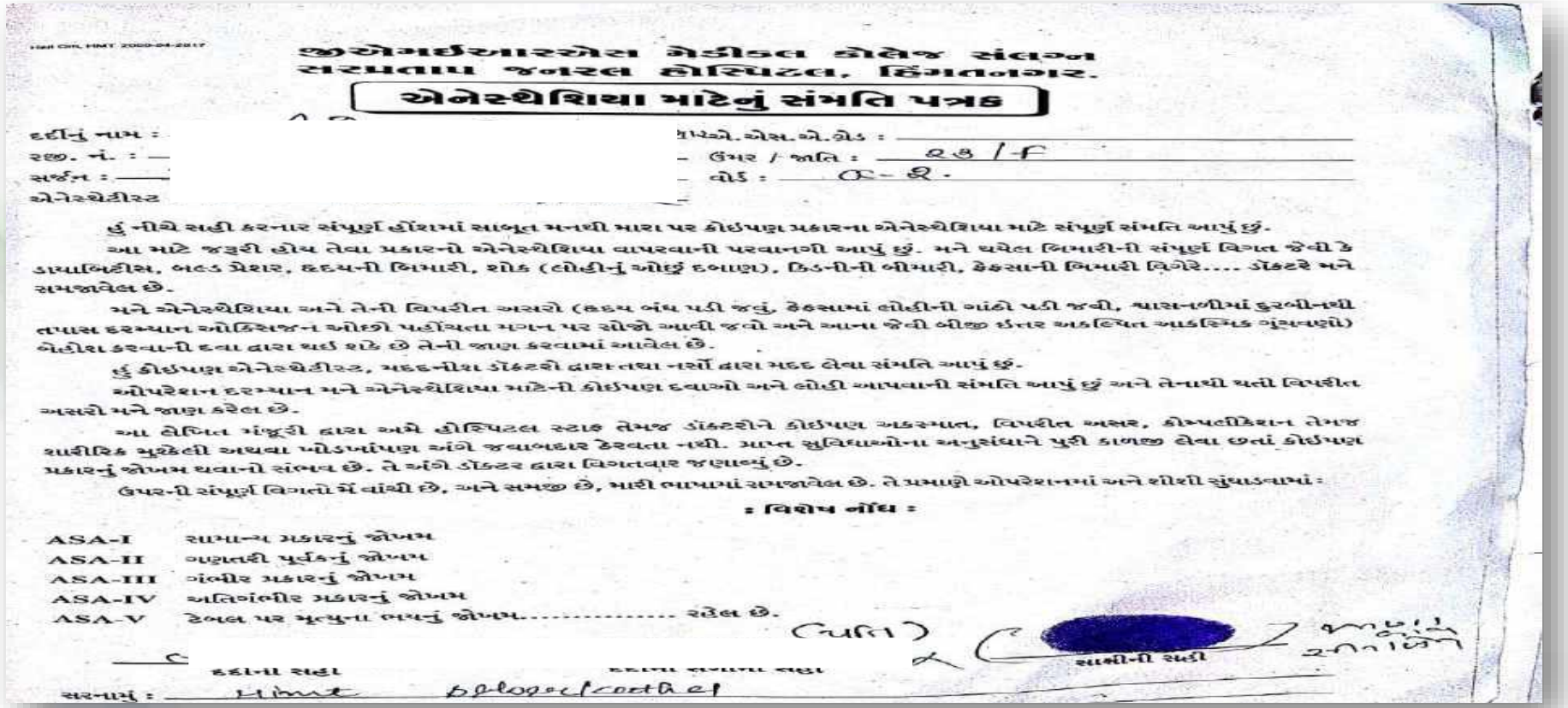
ASA-III ગંભીર પ્રકારનું જોખમ

AS,

ASA-V કલાક પર મૃત્યુના ભયનું જોખમ.....

DBP પરમાર (પતિ)

ALL RISKS, BENEFITS AND ALTERNATIVES ABOUT ANAESTHESIA SHOULD BE DISCUSSED AND MENTIONED AS PART OF THE CONSENT FORM SIGNED BY THE PATIENTS OR THEIR CARETAKER



જીએમઈઆરએસ મેડીકલ કોલેજ સંલગ્ન
સમતાપ જનરલ હોસ્પિટલ, હિંમતનગર.

એનેસ્થેશિયા માટેનું સંમતિ પત્રક

દર્દીનું નામ :
રજી. નં. :
સર્જન :
એનેસ્થેટીસ્ટ

ઉંમર / જાતિ : ૪૭ / F
વોર્ડ : OC - ૪.

હું નીચે સહી કરનાર સંપૂર્ણ હોંશમાં સાબૂત મનથી મારા પર કોઇપણ પ્રકારના એનેસ્થેશિયા માટે સંપૂર્ણ સંમતિ આપું છું.

આ માટે જરૂરી હોય તેવા પ્રકારનો એનેસ્થેશિયા વાપરવાની પરવાનગી આપું છું. મને થયેલ બિમારી-ની સંપૂર્ણ વિગત જેવી કે ડાયાબિટીસ, બ્લડ પ્રેશર, હૃદયની બિમારી, શોક (લોહી-નું ઓછું દબાણ), કિડની-ની બીમારી, કેફસા-ની બિમારી વિગેરે.... ડૉકટરે મને સમજાવેલ છે.

મને એનેસ્થેશિયા અને તેની વિપરીત અસરો (હૃદય બંધ પડી જવું, કેફસામાં લોહી-ની ગાંઠો પડી જવી, શ્વાસનળીમાં કુરચી-નથી તપાસ દરમ્યાન ઓક્સિજન ઓછો પહોંચતા મગજ પર સોજો આવી જવો અને આના જેવી બીજી ઈમર્જન્સ અકલ્પિત આકસ્મિક ગુંચવણો) થવાની દવા દ્વારા થઈ શકે છે તેની જાણ કરવામાં આવેલ છે.

હું કોઇપણ એનેસ્થેટીસ્ટ, મદદનીશ ડૉકટરો દ્વારા તથા નર્સો દ્વારા મદદ લેવા સંમતિ આપું છું.

ઓપરેશન દરમ્યાન મને એનેસ્થેશિયા માટે-ની કોઇપણ દવાઓ અને લોહી આપવાની સંમતિ આપું છું અને તેનાથી થતી વિપરીત અસરો મને જાણ કરેલ છે.

આ લેખિત મંજૂરી દ્વારા અમે હોસ્પિટલ સ્ટાફ તેમજ ડૉકટરોને કોઇપણ અકસ્માત, વિપરીત અસર, કોમ્પલીકેશન તેમજ શારીરિક મુશ્કેલી અથવા ખોડખાંપણ અંગે જવાબદાર ઠેરવતા નથી. પ્રાપ્ત સુવિધાઓના અનુસંધાને પુરી કાળજી લેવા છતાં કોઇપણ પ્રકારનું જોખમ થવા-ની સંભવ છે. તે અંગે ડૉકટર દ્વારા વિગતવાર જણાવ્યું છે.

ઉપર-ની સંપૂર્ણ વિગતો મેં વાંચી છે, અને સમજી છે, મારી ભાષામાં સમજાવેલ છે. તે પ્રમાણે ઓપરેશનમાં અને શીશી સુંઘાડવામાં :

: વિશેષ નોંધ :

ASA-I સામાન્ય પ્રકારનું જોખમ
ASA-II ગણતરી પૂર્વકનું જોખમ
ASA-III ગંભીર પ્રકારનું જોખમ
ASA-IV અતિગંભીર પ્રકારનું જોખમ
ASA-V ટેબલ પર મૃત્યુના ભયનું જોખમ..... રહેલ છે.

(પતિ)

દર્દીના સહી

સ્વજનની સહી

સગપણ : Husband

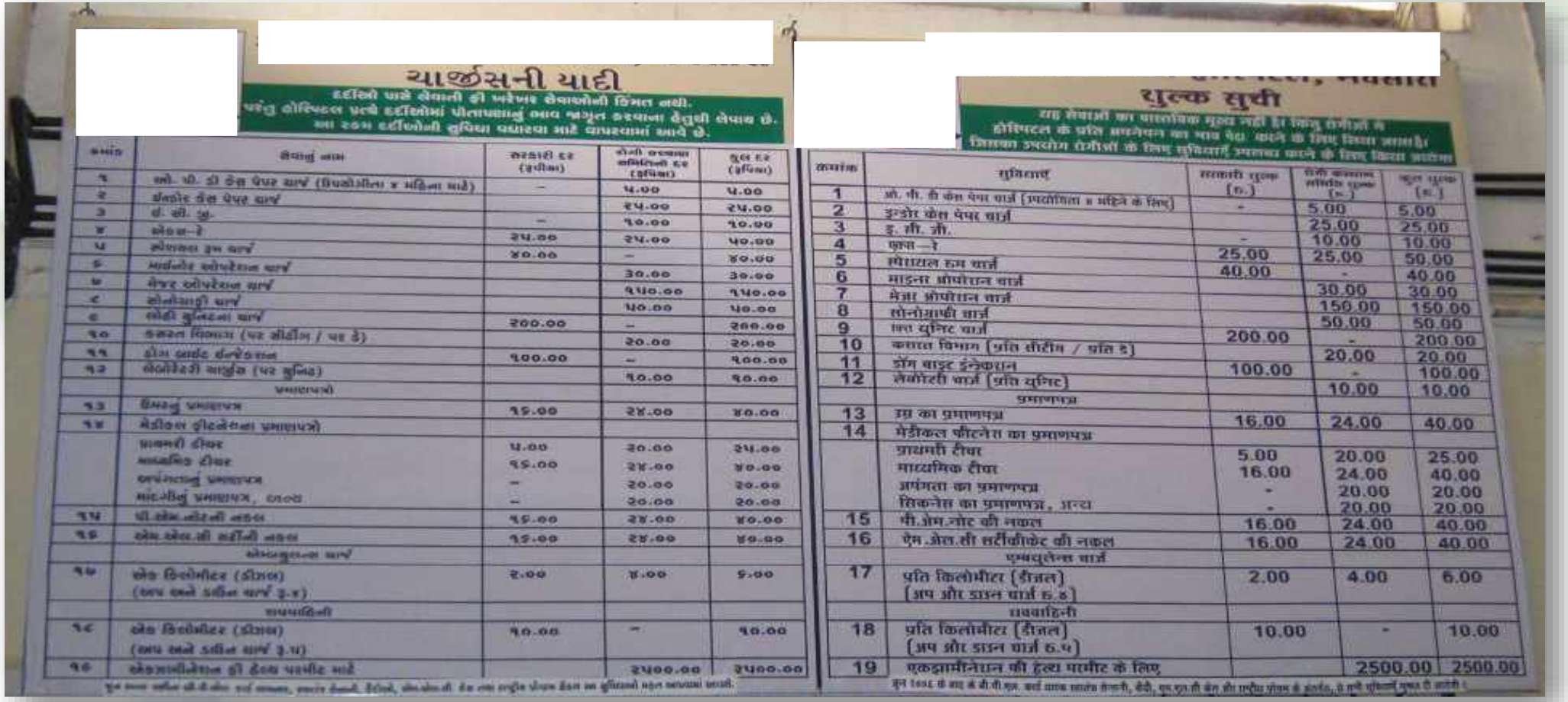
PC 8 - USER CHARGES ARE DISPLAYED AND COMMUNICATED TO PATIENTS EFFECTIVELY AT THE TIME OF REGISTRATION, ADMISSION TO THE WARD AND IN CASE OF A CHANGE IN MEDICAL AND SURGICAL PLAN.

Interpretation – The list of user charges must be displayed at strategic places (Reception, waiting areas, lobby) in the hospital premises for better communication to patients and to maintain transparency. The list must be updated in case of any change in medical and surgical plan.

Means of verification:

1. Facility prepares a comprehensive list of user charges and display at strategic points in the hospital.
2. AB PM-JAY beneficiaries are provided cashless services

FACILITY PREPARES A COMPREHENSIVE LIST OF USER CHARGES AND DISPLAY AT STRATEGIC POINTS IN THE HOSPITAL



ચાર્જીસની યાદી

ક્રમાંક	સેવાનું નામ	સરકારી દર (રૂપિયા)	ખાનગી હોસ્પિટલનો દર (રૂપિયા)	કુલ દર (રૂપિયા)
૧	ઓ. પી. ડી કેસ પેપર ચાર્જ (ઇમરજન્સી ૪ મહિના માટે)	–	૫.૦૦	૫.૦૦
૨	ઇનડોર કેસ પેપર ચાર્જ		૨૫.૦૦	૨૫.૦૦
૩	ઈ. સી. જી.	–	૧૦.૦૦	૧૦.૦૦
૪	એક્સ-રે	૨૫.૦૦	૨૫.૦૦	૫૦.૦૦
૫	હોસ્પિટલ રૂમ ચાર્જ	૪૦.૦૦	–	૪૦.૦૦
૬	માઈનર ઓપરેશન ચાર્જ		૩૦.૦૦	૩૦.૦૦
૭	મેજર ઓપરેશન ચાર્જ		૧૫૦.૦૦	૧૫૦.૦૦
૮	સોનોગ્રાફી ચાર્જ		૫૦.૦૦	૫૦.૦૦
૯	લોહી યુનિટના ચાર્જ	૨૦૦.૦૦	–	૨૦૦.૦૦
૧૦	કલરત વિભાગ (પર સીટીંગ / પર ડે)		૨૦.૦૦	૨૦.૦૦
૧૧	ડોગ બાઈટ ઈન્જેક્શન	૧૦૦.૦૦	–	૧૦૦.૦૦
૧૨	લેબોરેટરી ચાર્જીસ (પર યુનિટ)		૧૦.૦૦	૧૦.૦૦
	પ્રમાણપત્રો			
૧૩	જન્મનું પ્રમાણપત્ર	૧૬.૦૦	૨૪.૦૦	૪૦.૦૦
૧૪	મેડીકલ ફીટનેસના પ્રમાણપત્રો			
	પ્રાથમી ટીચર	૫.૦૦	૨૦.૦૦	૨૫.૦૦
	માધ્યમિક ટીચર	૧૬.૦૦	૨૪.૦૦	૪૦.૦૦
	અપંગતાનું પ્રમાણપત્ર	–	૨૦.૦૦	૨૦.૦૦
	માંદગીનું પ્રમાણપત્ર, બીજા	–	૨૦.૦૦	૨૦.૦૦
૧૫	પી.એમ.નોટની નકલ	૧૬.૦૦	૨૪.૦૦	૪૦.૦૦
૧૬	એમ.એલ.સી સર્ટીની નકલ	૧૬.૦૦	૨૪.૦૦	૪૦.૦૦
	એમ્બ્યુલન્સ ચાર્જ			
૧૭	પ્રતિ કિલોમીટર (ડીઝલ) (અપ અને ડાઉન ચાર્જ ૩.૪)	૨.૦૦	૪.૦૦	૬.૦૦
	રાયવાહિની			
૧૮	પ્રતિ કિલોમીટર (ડીઝલ) (અપ અને ડાઉન ચાર્જ ૩.૫)	૧૦.૦૦	–	૧૦.૦૦
૧૯	એકઝામીનેશન ફી હેલ્થ પરમીટ માટે		૨૫૦૦.૦૦	૨૫૦૦.૦૦

शुल्क सूची

क्रमांक	सुविधाएं	सरकारी शुल्क (रु.)	निजी अस्पताल शुल्क (रु.)	कुल शुल्क (रु.)
1	ओ. पी. डी केस पेपर चार्ज (एमरजेंसी 4 महीने के लिए)	-	5.00	5.00
2	इनडोर केस पेपर चार्ज		25.00	25.00
3	ई. सी. जी.	-	10.00	10.00
4	एक्स-रे	25.00	25.00	50.00
5	हॉस्पिटल रूम चार्ज	40.00	-	40.00
6	माइनर ऑपरेशन चार्ज		30.00	30.00
7	मेजर ऑपरेशन चार्ज		150.00	150.00
8	सोनोग्राफी चार्ज		50.00	50.00
9	ब्लड यूनिट चार्ज	200.00	-	200.00
10	कलरल विभाग (प्रति सीटींग / प्रति दे)		20.00	20.00
11	डॉग बाइट इंजेक्शन	100.00	-	100.00
12	लेबोरेटरी चार्ज (प्रति यूनिट)		10.00	10.00
	प्रमाणपत्र			
13	जन्म का प्रमाणपत्र	16.00	24.00	40.00
14	मेडीकल फीटनेस का प्रमाणपत्र			
	प्राथमी टीचर	5.00	20.00	25.00
	माध्यमिक टीचर	16.00	24.00	40.00
	अपंगता का प्रमाणपत्र	-	20.00	20.00
	सिकनेस का प्रमाणपत्र, अन्य	-	20.00	20.00
15	पी.एम.नोट की नकल	16.00	24.00	40.00
16	एम.एल.सी सर्टीफीकेट की नकल	16.00	24.00	40.00
	एम्बुलेन्स चार्ज			
17	प्रति किलोमीटर (डीजल) (अप और डाउन चार्ज 6.8)	2.00	4.00	6.00
	राववाहिनी			
18	प्रति किलोमीटर (डीजल) (अप और डाउन चार्ज 6.५)	10.00	-	10.00
19	एकझामीनेशन की हेल्थ परमीट के लिए		2500.00	2500.00

AB PM-JAY BENEFICIARIES ARE PROVIDED CASHLESS SERVICES

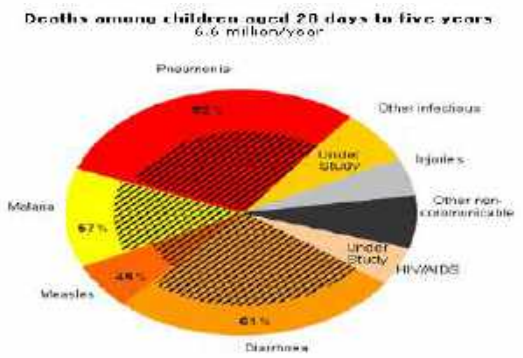
PC 9 - PATIENT SHOULD BE PROPERLY EDUCATED ON ADDITIONAL CARE AS DEEMED REQUIRED AND ALL THE VITAL INFORMATION SHOULD BE RECORDED FOR CONTINUITY OF CARE.

Interpretation – Patient should be educated for additional care in respect to usage and effect of medication, diet and nutrition which can be done with the help of discharge summary and growth summary respectively. All the vital information must be recorded for reassessment of patients undergoing observation in the language the patient/ family members can understand.

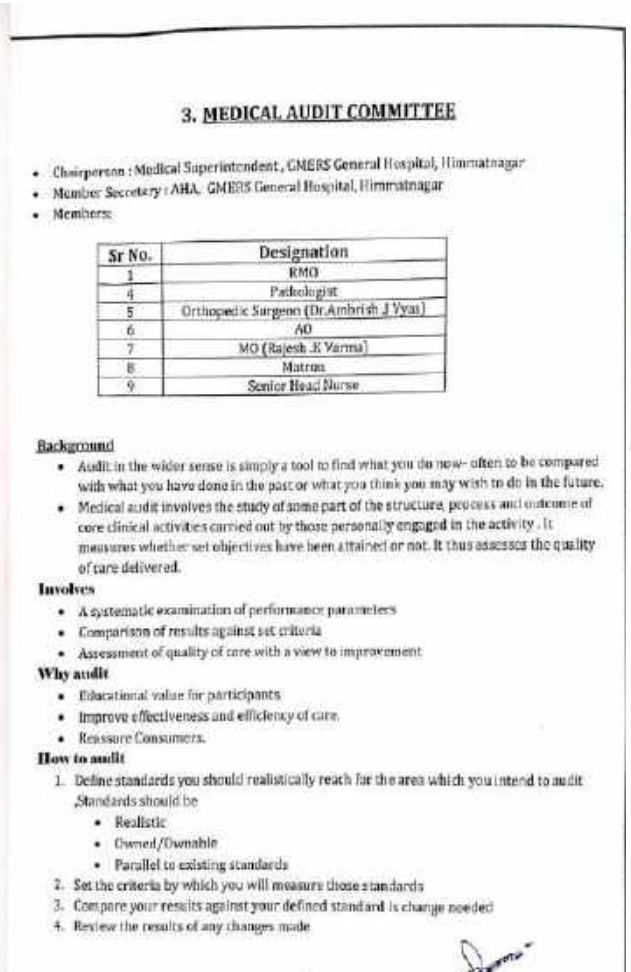
Means of verification:

1. Patients should be educated for usage and effect of medication, diet and nutrition, immunizations and to prevent infections (as deemed appropriate)
2. Discharge summary should contain a diagnosis, history, physical examination, investigation details, treatment provided and instructions thereof in easy to understand manner (Check 3 samples)
3. There should be a fixed schedule for reassessment of patient under observation based on clinical need

PATIENTS SHOULD BE EDUCATED FOR USAGE AND EFFECT OF MEDICATION, DIET AND NUTRITION, IMMUNIZATIONS AND TO PREVENT INFECTIONS (AS DEEMED APPROPRIATE)



DISCHARGE SUMMARY SHOULD CONTAIN A DIAGNOSIS, HISTORY, PHYSICAL EXAMINATION, INVESTIGATION DETAILS, TREATMENT PROVIDED AND INSTRUCTIONS THEREOF IN EASY TO UNDERSTAND MANNER



3. MEDICAL AUDIT COMMITTEE

- Chairperson : Medical Superintendent, GMERS General Hospital, Himmatnagar
- Member Secretary : AHA, GMERS General Hospital, Himmatnagar
- Members:

Sr No.	Designation
1	RMO
4	Pathologist
5	Orthopedic Surgeon (Dr.Ambrish J Vyas)
6	AO
7	MO (Rajesh K Varma)
8	Matron
9	Senior Head Nurse

Background

- Audit in the wider sense is simply a tool to find what you do now- often to be compared with what you have done in the past or what you think you may wish to do in the future.
- Medical audit involves the study of some part of the structure, process and outcome of care clinical activities carried out by those personally engaged in the activity . It measures whether set objectives have been attained or not. It thus assesses the quality of care delivered.

Involves

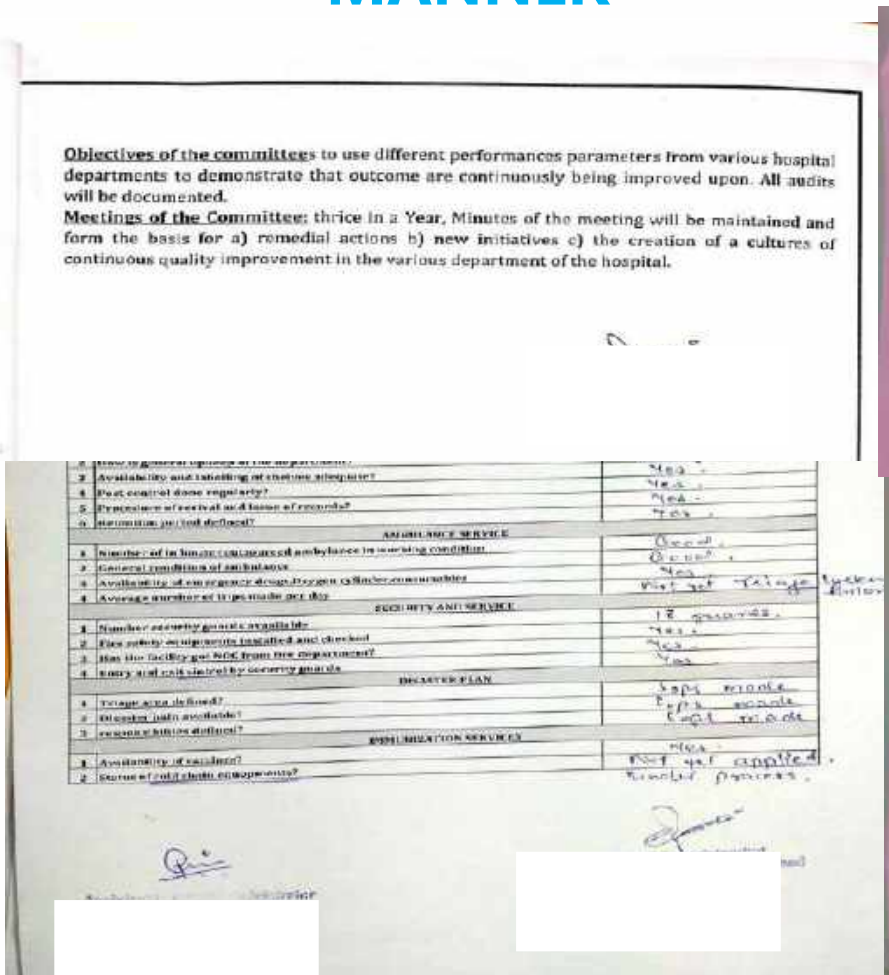
- A systematic examination of performance parameters
- Comparison of results against set criteria
- Assessment of quality of care with a view to improvement

Why audit

- Educational value for participants
- Improve effectiveness and efficiency of care
- Reassure Consumers.

How to audit

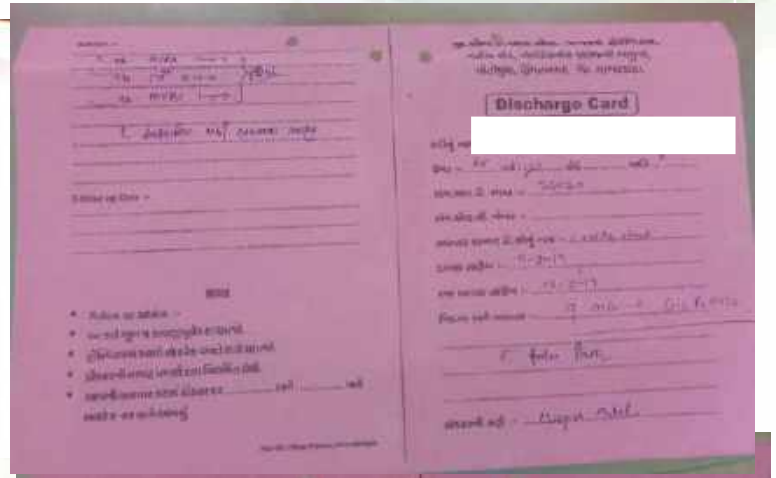
1. Define standards you should realistically reach for the area which you intend to audit .Standards should be
   - Realistic
   - Owned/Ownable
   - Parallel to existing standards
2. Set the criteria by which you will measure those standards
3. Compare your results against your defined standard is change needed
4. Review the results of any changes made



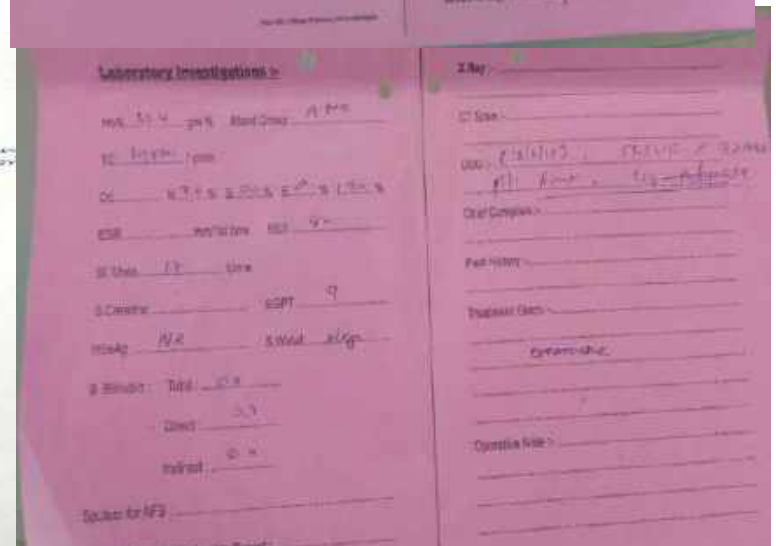
Objectives of the committees to use different performances parameters from various hospital departments to demonstrate that outcome are continuously being improved upon. All audits will be documented.

Meetings of the Committee: thrice in a Year, Minutes of the meeting will be maintained and form the basis for a) remedial actions b) new initiatives c) the creation of a cultures of continuous quality improvement in the various department of the hospital.

Availability and labelling of chemicals adequate?	Yes
Pest control done regularly?	Yes
Presence of central medical records?	Yes
Maintained/not defined?	Yes
AMBULANCE SERVICE	
Number of ambulances and adequacy in working condition	Yes
General condition of ambulance	Good
Availability of emergency drugs, Oxygen cylinder, consumables	Good
Average number of trips made per day	Yes
SECURITY AND SERVICE	
Number security guards available	12 approved
Fire safety equipments installed and checked	Yes
Has the facility got NOC from fire department?	Yes
Entry and exit checked by security guards	Yes
DISASTER PLAN	
Triage area defined?	Separate Room
Disaster drills available?	Every month
resuscitation drilled?	Every month
EMERGENCY SERVICES	
Availability of ambulance?	Yes
Status of cold chain equipments?	Not yet supplied



Discharge Card



Laboratory Investigations :

THERE SHOULD BE A FIXED SCHEDULE FOR REASSESSMENT OF PATIENT UNDER OBSERVATION BASED ON CLINICAL NEED

Table 3.1 – Components of the comprehensive diabetes medical evaluation at initial and follow-up visits

		INITIAL VISIT	EVERY FOLLOW-UP VISIT	ANNUAL VISIT
PHYSICAL EXAMINATION	• Height, weight, and BMI; growth/pubertal development in children and adolescents	✓	✓	✓
	• Blood pressure determination	✓	✓	✓
	• Orthostatic blood pressure measures (when indicated)	✓		
	• Fundoscopic examination (refer to eye specialist)	✓		✓
	• Thyroid palpation	✓		✓
	• Skin examination (e.g., acanthosis nigricans, insulin injection or insertion sites, lipodystrophy)	✓	✓	✓
	• Comprehensive foot examination			
	◦ Visual inspection (e.g., skin integrity, callous formation, foot deformity or ulcer, toenails)	✓	✓	✓
	◦ Screen for PAD (pedal pulses; refer for ABI if diminished)	✓		✓
	◦ Determination of temperature, vibration or pinprick sensation, and 10-g monofilament exam	✓		✓
LABORATORY EVALUATION	• A1C, if the results are not available within the past 3 months	✓	✓	✓
	• If not performed/available within the past year			
	◦ Lipid profile, including total, LDL, and HDL cholesterol and triglycerides[#]	✓		✓^
	◦ Liver function tests[#]	✓		✓
	◦ Spot urinary albumin-to-creatinine ratio	✓		✓
	◦ Serum creatinine and estimated glomerular filtration rate[†]	✓		✓
	◦ Thyroid-stimulating hormone in patients with type 1 diabetes[#]	✓		✓
	◦ Vitamin B12 if on metformin (when indicated)	✓		
	◦ Serum potassium levels in patients on ACE inhibitors, ARBs, or diuretics[†]	✓		✓
ASSESSMENT AND PLAN	**Goal setting**			
	• Set A1C/blood glucose target and monitoring frequency	✓	✓	✓
	• If hypertension diagnosed, establish blood pressure goal	✓		✓
	• Incorporate new members to the care team as needed	✓	✓	✓
	• Diabetes education and self-management support needs	✓	✓	✓
	Cardiovascular risk assessment and staging of CKD			
	• History of ASCVD	✓	✓	✓
	• Presence of ASCVD risk factors (see Table 9.2)	✓	✓	✓
	• Staging of CKD (see Table 10.1)[§]	✓	✓	✓
	Therapeutic treatment plan			
	• Lifestyle management	✓	✓	✓
	• Pharmacologic therapy	✓	✓	✓
	• Referrals to specialists (including dietitian and diabetes educator) as needed	✓	✓	✓
	• Use of glucose monitoring and insulin delivery devices	✓	✓	✓

ABI, ankle-brachial pressure index; ARBs, angiotensin receptor blockers; ASCVD, atherosclerotic cardiovascular disease; CGM, continuous glucose monitoring; CKD, chronic kidney disease; PAD, peripheral arterial disease.

^65 years.

[†]may be needed more frequently in patients with known chronic kidney disease or with changes in medications that affect kidney function and serum potassium (see Table 10.2).

[#]may also need to be checked after initiation or dose changes of medications that affect these laboratory values (i.e., diabetes medications, blood pressure medications, cholesterol medications, or thyroid medications).

[§]In people without dyslipidemia and not on cholesterol-lowering therapy, testing may be less frequent.

Table 3.1 – Components of the comprehensive diabetes medical evaluation at initial and follow-up visits

		INITIAL VISIT	EVERY FOLLOW-UP VISIT	ANNUAL VISIT
PAST MEDICAL AND FAMILY HISTORY	**Diabetes history**			
	• Characteristics at onset (e.g., age, symptoms)	✓		
	• Review of previous treatment regimens and response	✓		
	• Assess frequency/cause/severity of past hospitalizations	✓		
	Family history			
	• Family history of diabetes in a first-degree relative	✓		
	• Family history of autoimmune disorder	✓		
	Personal history of complications and common comorbidities			
	• Macrovascular and microvascular	✓		
	• Common comorbidities	✓		
	• Presence of hemoglobinopathies or anemias	✓		
	• High blood pressure or abnormal lipids	✓		✓
	• Last dental visit	✓		✓
	• Last dilated eye exam	✓		✓
	• Visits to specialists	✓	✓	✓
	Interval history			
	• Changes in medical/family history since last visit		✓	✓
SOCIAL HISTORY	**Assess lifestyle and behavior patterns**			
	• Eating patterns and weight history	✓	✓	✓
	• Sleep behaviors and physical activity	✓	✓	✓
	• Familiarity with carbohydrate counting in type 1 diabetes	✓		
	• Tobacco, alcohol, and substance use	✓		
	• Identify existing social supports	✓		
	Interval history			
	• Changes in social history since last visit		✓	✓
MEDICATIONS AND VACCINATIONS	• Medication-taking behavior	✓	✓	✓
	• Medication intolerance or side effects	✓	✓	✓
	• Complementary and alternative medicine use	✓	✓	✓
	• Vaccination history and needs	✓		✓
TECHNOLOGY USE	• Assess use of health apps, online education, patient portals, etc.	✓		✓
	• Glucose monitoring (meter/CGM): results and data use	✓	✓	✓
	• Review insulin pump settings	✓	✓	✓
SCREENING	**Psychosocial conditions**			
	• Screen for depression, anxiety, and disordered eating; refer for further assessment or intervention if warranted	✓		✓
	• Consider assessment for cognitive impairment[*]	✓		✓
	Diabetes self-management education and support			
	• History of dietitian/diabetes educator visits	✓	✓	✓
	• Screen for barriers to diabetes self-management	✓		✓
	• Refer or offer local resources and support as needed	✓	✓	✓
	Hypoglycemia			
	• Timing of episodes, awareness, frequency and causes	✓	✓	✓
	Pregnancy planning			
	• For women with childbearing capacity, review contraceptive needs and preconception planning	✓	✓	✓

PC 10 - HOSPITALS SHOULD ENSURE THAT ALL MEDICATIONS AND ASSOCIATED INSTRUCTIONS ARE WRITTEN IN THE PRESCRIPTION

Interpretation – The organization shall ensure that the at the minimum the prescription shall have the name of the patient, unique patient number, name of medicine with the frequency of administration, name and signature of the doctor. All hand written prescription should be legible, clear and understandable by the patient/ family member i.e. preferably in capital letters.

Means of verification:

1. Prescription should be legible, clear and be explained in the language understood by the patients and is comprehendible by the clinical staff
2. Every medical advice and procedure is accompanied with date, time and signature, unique patient number.

PRESCRIPTION SHOULD BE LEGIBLE, CLEAR AND BE EXPLAINED IN THE LANGUAGE UNDERSTOOD BY THE PATIENTS AND IS COMPREHENDIBLE BY THE CLINICAL STAFF

MBBS, MD, DM - Gastroenterology
Regd. No. –

Doctor's Details

Rx

Name
Age
Gender

Prescription Date 25-01-2019

DIAGNOSIS: GERD
Description: gerd
Additional Comments: None

Sl.No.	Prescribed Medicines	Dosage	Instructions
1.	CAPSULE NEXPRO L ESOMEPRAZOLE+LEVOSULPIRIDE(40)	1-0-0	10 Days Days; Before Meal;
2.	SYRUP ULGEL ELAICHI FLAV MAGALDRATE+SIMETHICONE(10 ML)	1-1-1	5 Days Days; Before Meal; After Meal;

SubstitutesPermitted

LAB TESTS
1. Blood Sugar - Fasting test(FBS) tsh, ugi endoscopy

FOLLOW UP
1 Week

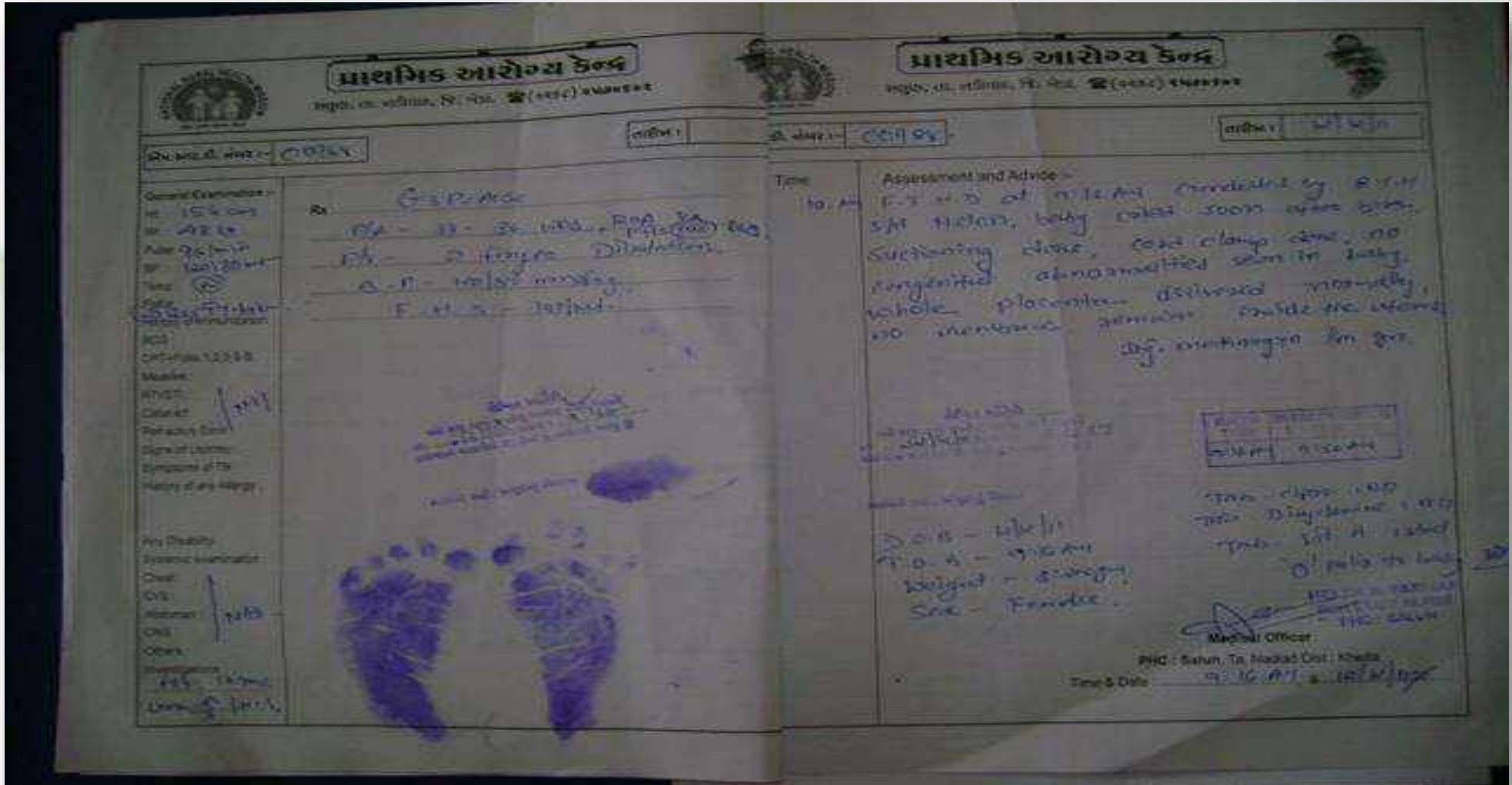
DOCTOR ADVICE
None

SAMPLE PRESCRIPTION

Doctor's Signature

MBBS, MD, DM - Gastroenterology

EVERY MEDICAL ADVICE AND PROCEDURE IS ACCOMPANIED WITH DATE, TIME AND SIGNATURE, UNIQUE PATIENT NUMBER



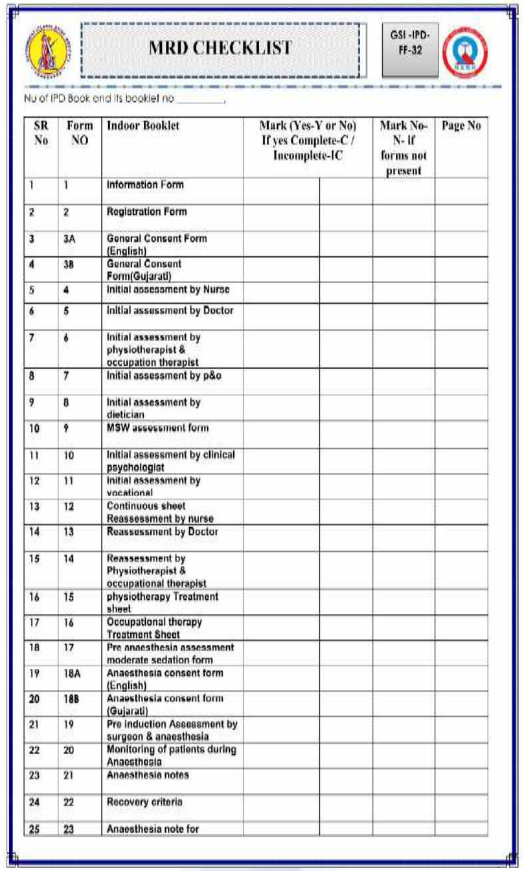
PC 11 - MEDICAL RECORDS SHOULD BE RETAINED AS PER THE POLICIES OF HOSPITAL BASED ON NATIONAL AND LOCAL LAW

Interpretation – Hospital must abide by the national and local laws for retaining medical records for each category of records: Out-patient, in-patient and MLC. The retention and destruction process should be included in the process to maintain confidentiality and security of both manual and electronic records system. Also, there should be a documented process for medical records of AB PMJAY scheme beneficiaries.

Means of verification:

1. Hospital has a policy of retention period with respect to different kinds of records and their disposal.
2. Confidentiality of patient records should be maintained by keeping them properly in the record room or digitally saved on a secure network
3. Hospital has process documentation for AB PM-JAY scheme

HOSPITAL HAS A POLICY OF RETENTION PERIOD WITH RESPECT TO DIFFERENT KINDS OF RECORDS AND THEIR DISPOSAL



MRD CHECKLIST

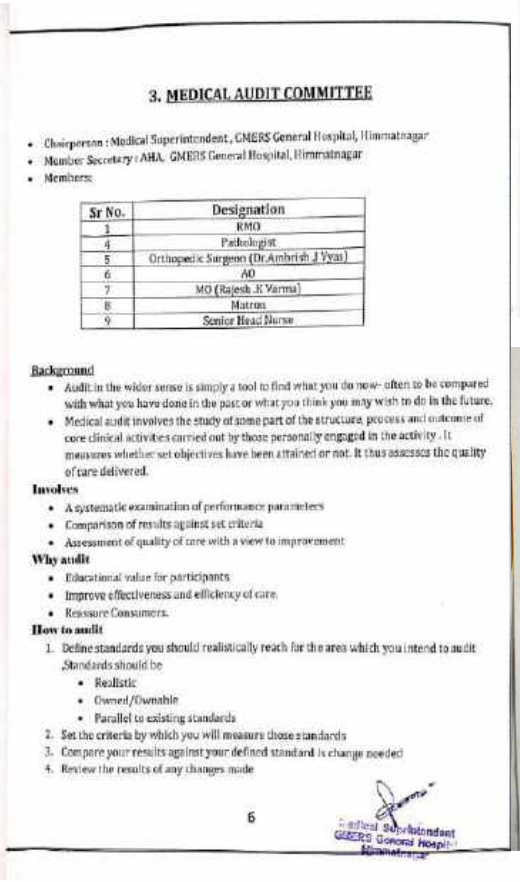
GSI -IPD-FF-32

No of IPD Book and its booklet no _____

SR No	Form NO	Indoor Booklet	Mark (Yes-Y or No) If yes Complete-C / Incomplete-IC		Mark No-N- if forms not present	Page No
1	1	Information Form				
2	2	Registration Form				
3	3A	General Consent Form (English)				
4	3B	General Consent Form(Gujarati)				
5	4	Initial assessment by Nurse				
6	5	Initial assessment by Doctor				
7	6	Initial assessment by physiotherapist & occupation therapist				
8	7	Initial assessment by p&o				
9	8	Initial assessment by dietician				
10	9	MSW assessment form				
11	10	Initial assessment by clinical psychologist				
12	11	Initial assessment by vocational				
13	12	Continuous sheet Reassessment by nurse				
14	13	Reassessment by Doctor				
15	14	Reassessment by Physiotherapist & occupational therapist				
16	15	physiotherapy Treatment sheet				
17	16	Occupational therapy Treatment Sheet				
18	17	Pre anaesthesia assessment moderate sedation form				
19	18A	Anaesthesia consent form (English)				
20	18B	Anaesthesia consent form (Gujarati)				
21	19	Pre induction Assessment by surgeon & anaesthesia				
22	20	Monitoring of patients during Anaesthesia				
23	21	Anaesthesia notes				
24	22	Recovery criteria				
25	23	Anaesthesia note for epidural injection				
26	24A	Consent for surgical, invasive, diagnostic, medical, intervention procedure				
27	24B	Consent for surgical, invasive, diagnostic, medical, intervention procedure				
28	25	Surgical check list				
29	26	operation note by surgeon				
30	27	Appliance Prescription P & O				
31	28	Input out put chart				
32	29	Nursing Medication Chart				
33	30	discharge card				
34	31A	Blood and blood products administration/ High risk medication monitoring form				
35	31B	Blood and blood products administration Consent form				
36	32	MRD checklist				

Remarks of MRD:
Signature: Date:
Name: Time:

Detail of Retrival:
Request By:
Purpose By:
Date Of Issue: Date Of Recived
Signature of MRD: Signature of MRO



3. MEDICAL AUDIT COMMITTEE

- Chairperson : Medical Superintendent , GMERS General Hospital, Himmatnagar
- Member Secretary : AHA, GMERS General Hospital, Himmatnagar
- Members:

Sr No.	Designation
3	RMO
4	Pathologist
5	Orthopedic Surgeon (Dr.Ambrish J Vyas)
6	AO
7	MO (Rajesh K Varma)
8	Matron
9	Senior Head Nurse

Background
- Audit in the wider sense is simply a tool to find what you do now- often to be compared with what you have done in the past or what you think you may wish to do in the future.
- Medical audit involves the study of some part of the structure, process and outcome of care clinical activities carried out by those personally engaged in the activity . It measures whether set objectives have been attained or not. It thus assesses the quality of care delivered.

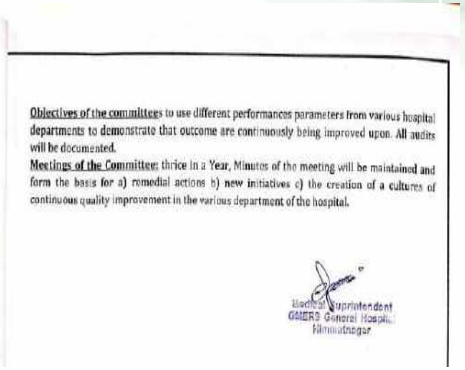
Involves
- A systematic examination of performance parameters
- Comparison of results against set criteria
- Assessment of quality of care with a view to improvement

Why audit
- Educational value for participants
- Improve effectiveness and efficiency of care.
- Reassure Consumers.

How to audit
1. Define standards you should realistically reach for the area which you intend to audit ,Standards should be
   - Realistic
   - Owned/Ownable
   - Parallel to existing standards
2. Set the criteria by which you will measure those standards
3. Compare your results against your defined standard is change needed
4. Review the results of any changes made

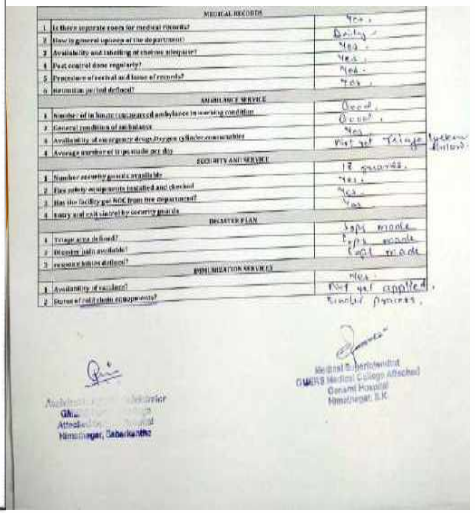
6

Medical Superintendent
GMERS General Hospital
Himmatnagar



Objectives of the committees to use different performances parameters from various hospital departments to demonstrate that outcome are continuously being improved upon. All audits will be documented.
Meetings of the Committee: thrice in a Year, Minutes of the meeting will be maintained and form the basis for a) remedial actions b) new initiatives c) the creation of a cultures of continuous quality improvement in the various department of the hospital.

Medical Superintendent
GMERS General Hospital,
Himmatnagar



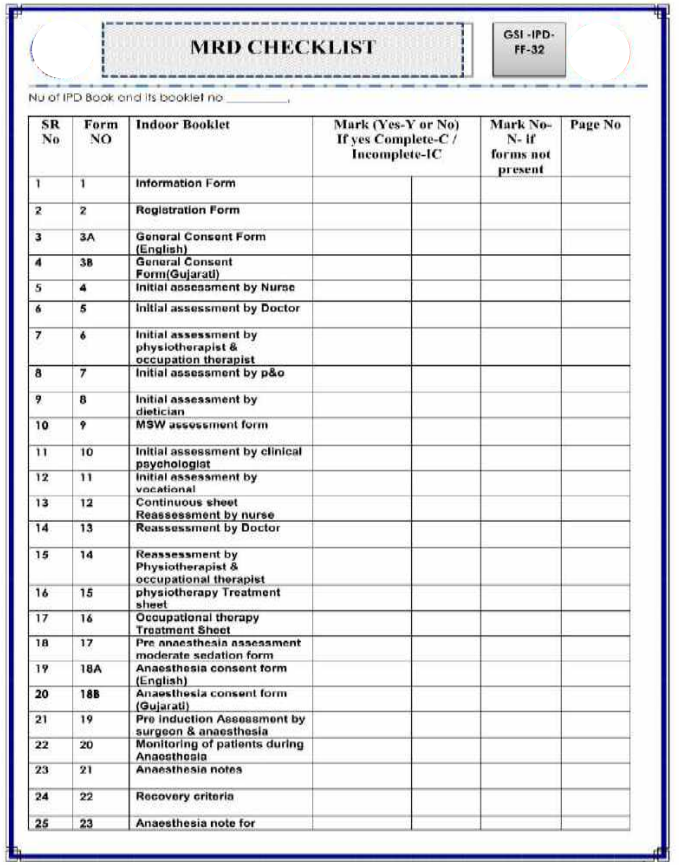
CONFIDENTIALITY OF PATIENT RECORDS SHOULD BE MAINTAINED BY KEEPING THEM PROPERLY IN THE RECORD ROOM OR DIGITALLY SAVED ON A SECURE NETWORK

POLICY FOR SECURITY, PROTECTION FROM LOSS, TAMPERING OR UNAUTHORIZED USE

- The MRD shall apply various methods and tools to prevent any damage /tampering to the medical records occurring due misplacement, pests, fire or any other factor.

Specific Information:

- No files will be taken out of department except for the conditions mentioned in the policy for access.
- Files are issued outside the department in accordance to process mentioned in the policy for access to
- medical record.
- A reminder dummy is placed in the filing cabinet.
- A retrieval process is in place to take care of files issued.
  - – A record issue slip is filled by the person taking out the file which includes the purpose as well as the expected
  - date of return.
  - – Telephone call is made to the person on the expected date of return and a request is made to return the file.
  - – If any extension is to be made, the same is noted down on the same issue slip.
  - – In case the file is still not returned and no extension has been sought, the medical record technician goes to the person to collect the documents.



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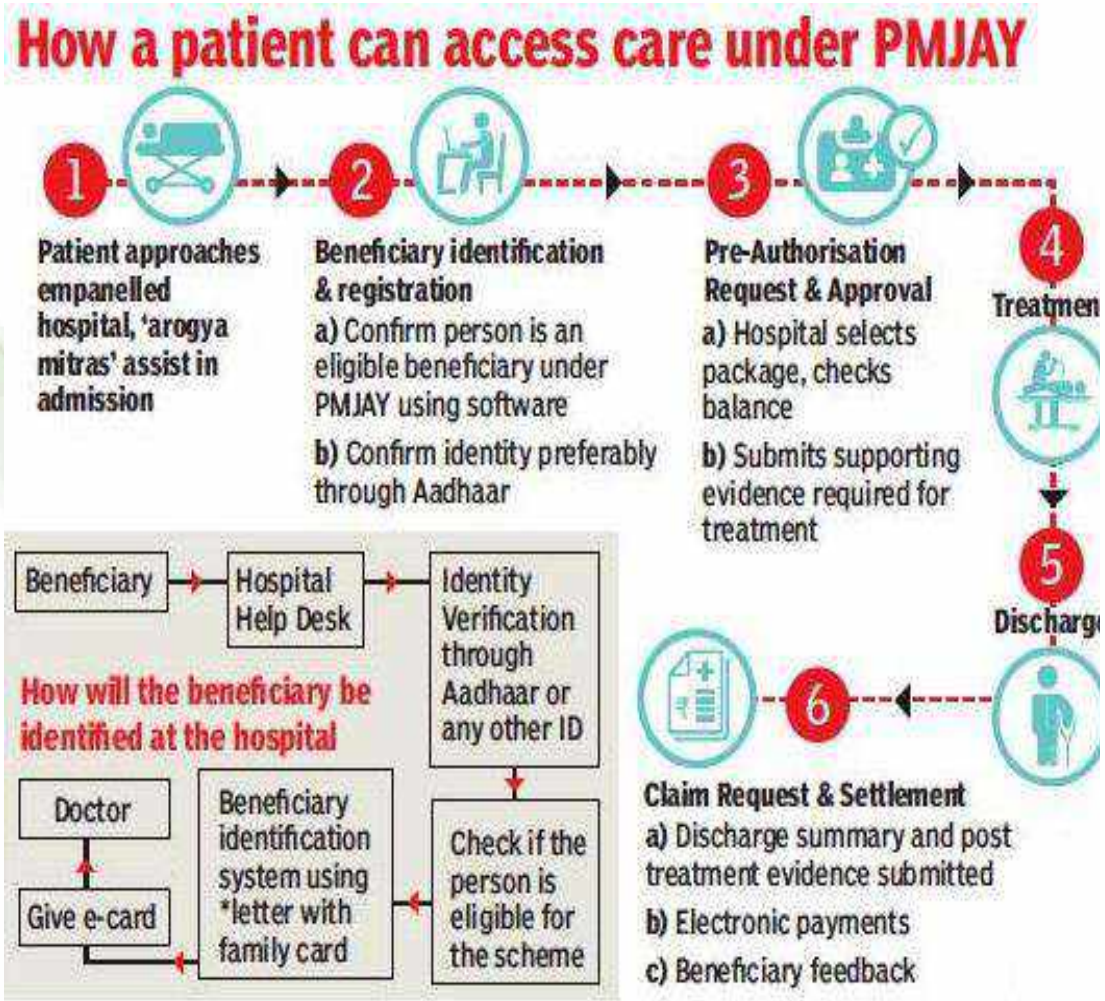
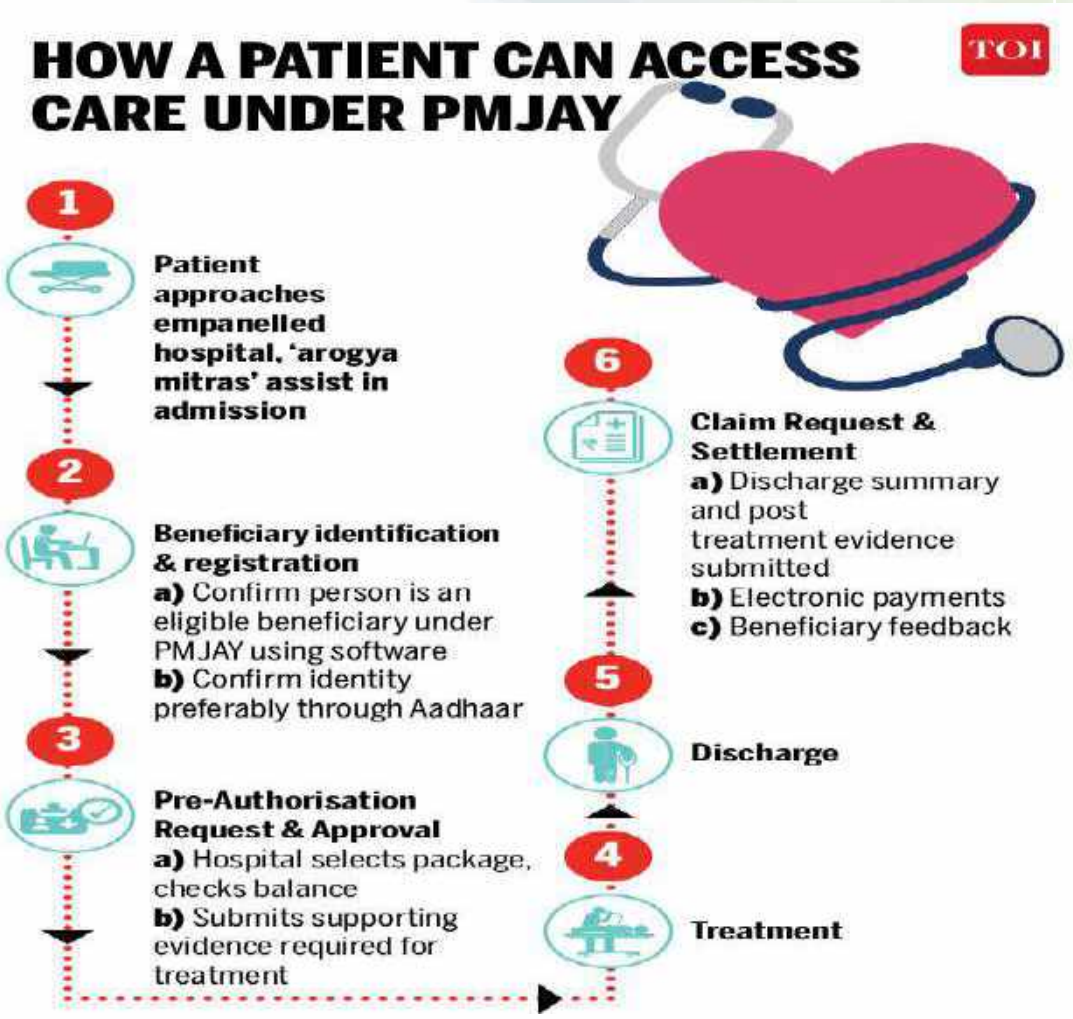
23	21	Anaesthesia notes				
24	22	Recovery criteria				
25	23	Anaesthesia note for				

HOSPITAL HAS PROCESS DOCUMENTATION FOR AB PM-JAY SCHEME





CHAPTER 5:
HEALTH OUTCOMES (OVERVIEW)

The importance of measuring and reporting the healthcare outcomes is to improve patient experience of care and fosters improvement and adoption of best practices, thus further improving outcomes. This chapter has standards for measuring healthcare outcomes like OPD and IPD census, mortality rate, average length of stay, Surgical Site Infection, Urinary Tract Infection, Blood Stream Infection, Ventilator Associated (VAP) Infection / Hospital Acquired Pneumonia, Transfusion reaction, Bed occupancy, Patient and employee satisfaction, reporting of adverse events, theft and security related events etc. The data provided by health outcomes guide decision and effective policy making process.

CHAPTER 5:
HEALTH OUTCOMES

HO 1	Monthly Out Patient Department (OPD) and In-Patient Department (IPD) census
HO 2	Mortality Rate and average length of stay
HO 3	Infection Rates - Surgical Site, Urinary Tract, Blood Stream, Ventilator Associated (VAP)/ Hospital Acquired Pneumonia
HO 4	Transfusion reaction (if applicable)
HO 5	Bed occupancy
HO 6	Percentage of Patient satisfaction
HO 7	Percentage of Employee satisfaction
HO 8	Waiting time - Out Patient Department (OPD) and discharge
HO 9	Reporting of Adverse events
HO 10	Reporting of Thefts / Security related incidents
HO 11	Reporting of needle stick injuries

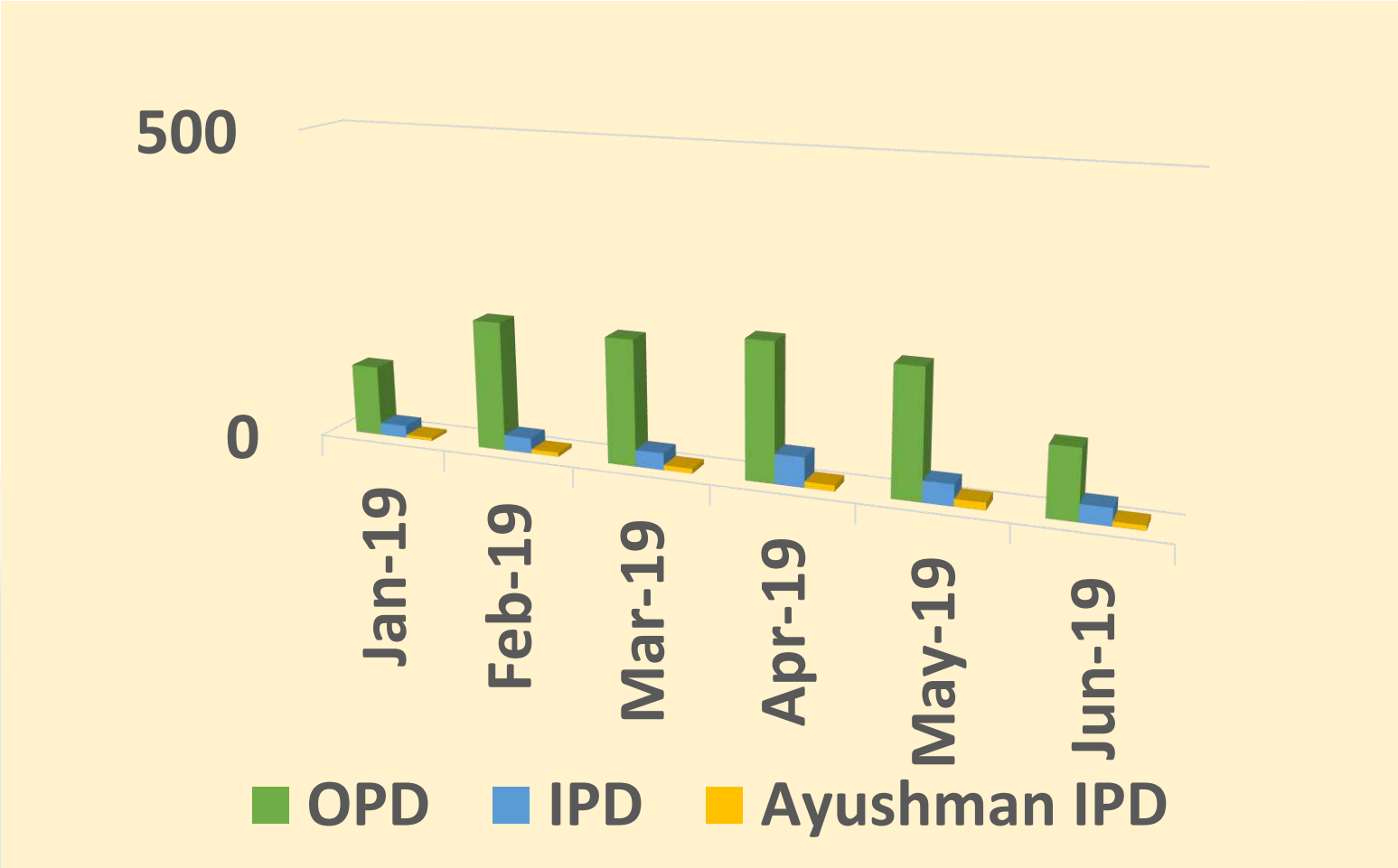
HO 1 - MONTHLY OUT-PATIENT DEPARTMENT (OPD) AND IN-PATIENT DEPARTMENT (IPD) CENSUS

Interpretation: A monthly Out-Patient Department (OPD) and In-Patient Department (IPD) census data can help to monitor how much OPD patients are converting into IPD, how many patients visited the OPD and IPD and track the trend of OPD to IPD conversion. The rate is generally affected by poor patient satisfaction, high cost of IPD or low motivation of doctors to admit OPD patient.

Means of verification:

1. Out Patient Department (OPD) census for last 6 months
2. In-Patient Department (IPD) census for last 6 months
3. AB PM-JAY In-Patient Department (IPD) census for last 6 months

MONTHLY OUT-PATIENT DEPARTMENT (OPD), IN-PATIENT DEPARTMENT (IPD) AND AB PM-JAY IN-PATIENT DEPARTMENT (IPD) CENSUS



HO 2- MORTALITY RATE AND AVERAGE LENGTH OF STAY (ALS)

Interpretation: Mortality statistics provide a valuable measure for assessing community health status. The importance of mortality statistics derives both from the significance of death in an individual's life as well as their potential to improve the public's health when used to systematically assess and monitor the health status of a whole community. ALS is a very common performance measure which is used not only important for hospital performance but also for clinical quality and infection control.

Means of verification:

1. Mortality Rate (from the data of last 6 months)
   = Number of Patient died/ Total number of patient admitted *100 Average

2. Length of Stay (from the data of for last 6 months)

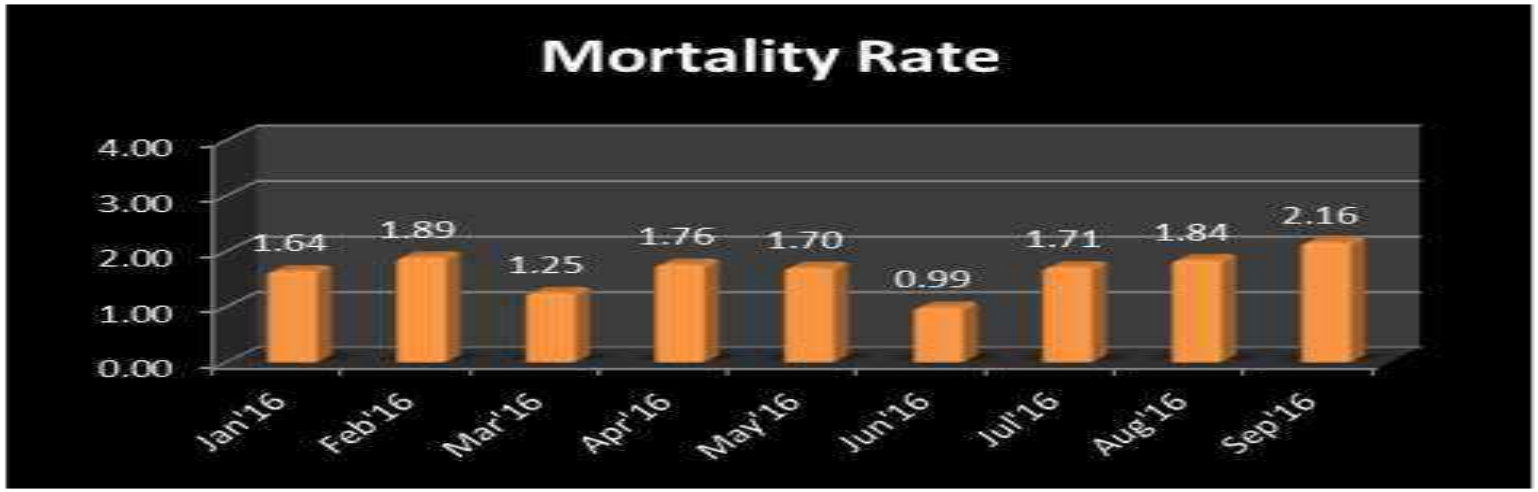
= Sum of days spend by each patient/ Total number of patient admitted

MORTALITY RATE

Jan'16	**1.64%**	**11/670**
Feb'16	1.89%	13/688
Mar'16	1.25%	9/721
Apr'16	1.76%	12/682
May'16	1.70%	12/704
Jun'16	0.99%	7/709
Jul'16	1.71%	13/759
Aug'16	1.84%	15/814
Sep'16	2.16	21/974

No of deaths X 100

No of discharges and death for the month



RCA –

1.Most of the deaths were associated with the multi-organ involvement / failure, supra added infection, pneumonia, septicaemia etc.

2.Sick patients being referred from near by RMP's & small nursing home/clinics who have very less chance of survival. given the short duration of treatment protocol to be followed in view of their deteriorating condition.

CAPA –

1.Prevention of hospital acquired infection.

2.Regular mortality meet to review the delivery of care/ adequacy of treatment or deficiencies so that remedial measures can be taken.

AVERAGE LENGTH OF STAY (ALS)

	BOR	ALOS
Jan'16	71.28%	3.72
Feb'16	72.44%	3.45
Mar'16	69.94%	3.39
Apr'16	77.07%	3.83
May'16	74.42%	3.7
Jun'16	71.06%	3.39
Jul'16	83.43%	3.78
Aug'16	91.10%	3.95
Sep'16	99.16%	3.66

HO 3 - INFECTION RATES

Interpretation: An infection rate is the probability or risk of infection in a population. It is used to measure the frequency of occurrence of new instances of infection within a population during a specific time period. It will help to identify if any recurrent infections persist and improve infection control in the hospital.

Means of verification:

1. Surgical Site Infection (from the data of for last 6 months)
   = Number of surgical site infections/ Number of patients operated *100

2. Urinary Tract Infection (from the data of for last 6 months)
   = Sum of Urinary Tract Infection Complaints/ Total Number of patients admitted *100

3. Blood Stream Infection (BSI) (from the data of for last 6 months)
   = Number of Catheter related BSI/ Number of patients on IV line * 100

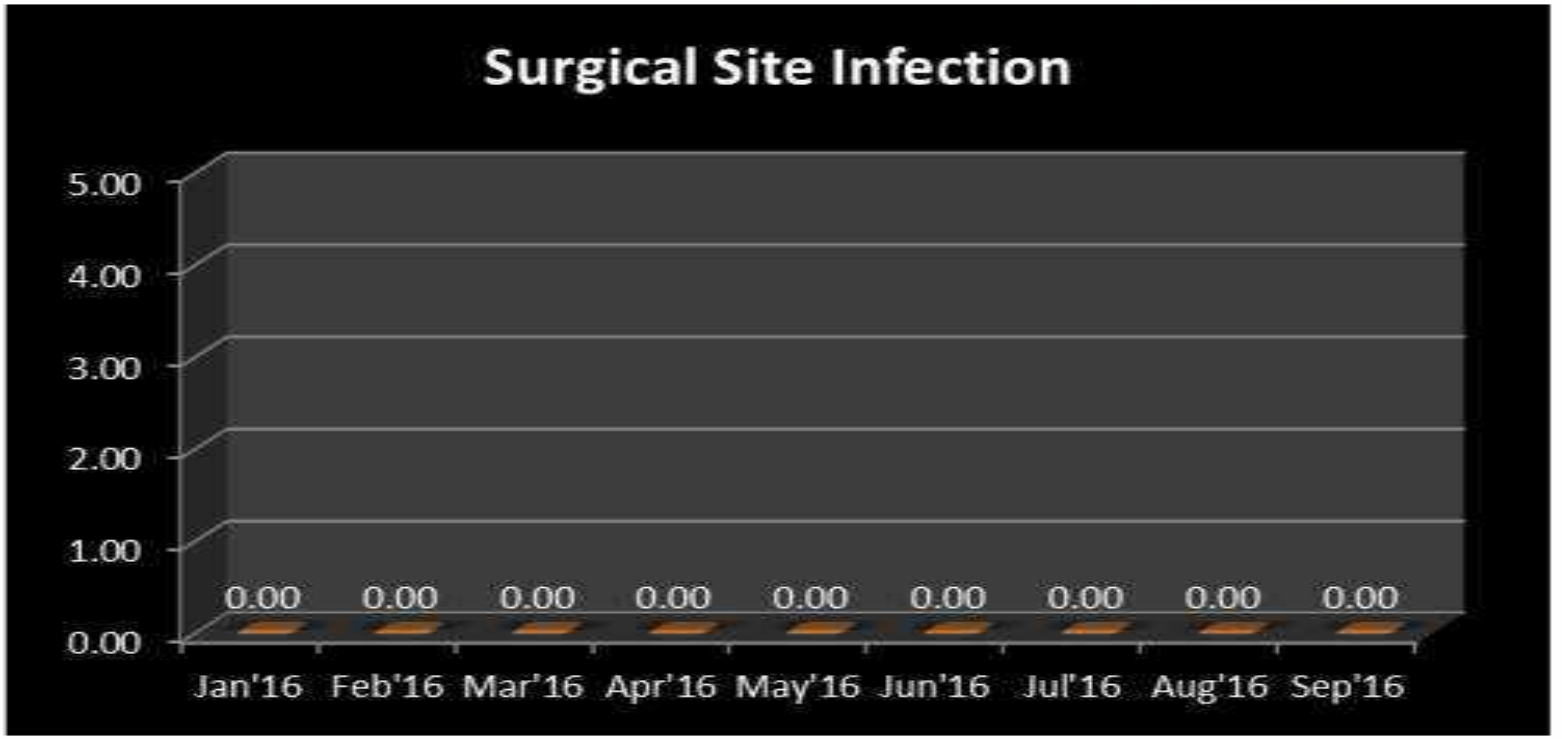
4. Ventilator Associated Pneumonia (VAP)/ Hospital Acquired Pneumonia (HAP) (from the data of last 6 months)
   = Sum of Ventilator Associated Pneumonia/ Number of patients on ventilator *100

SURGICAL SITE INFECTION

Bench mark		
1	Criteria	Target
2	% of Compliance	Not > 4.2 %

No of surgical site infections in a given month X 100
No of surgeries performed in that month

Jan'16	**0.00%**	**0/168**
Feb'16	0.00%	0/173
Mar'16	0.00%	0/193
Apr'16	0.00%	0/216
May'16	0.00%	0/204
Jun'16	0.00%	0/187
Jul'16	0.00%	0/153
Aug'16	0.00%	0/175
Sep'16	0.00%	0/180



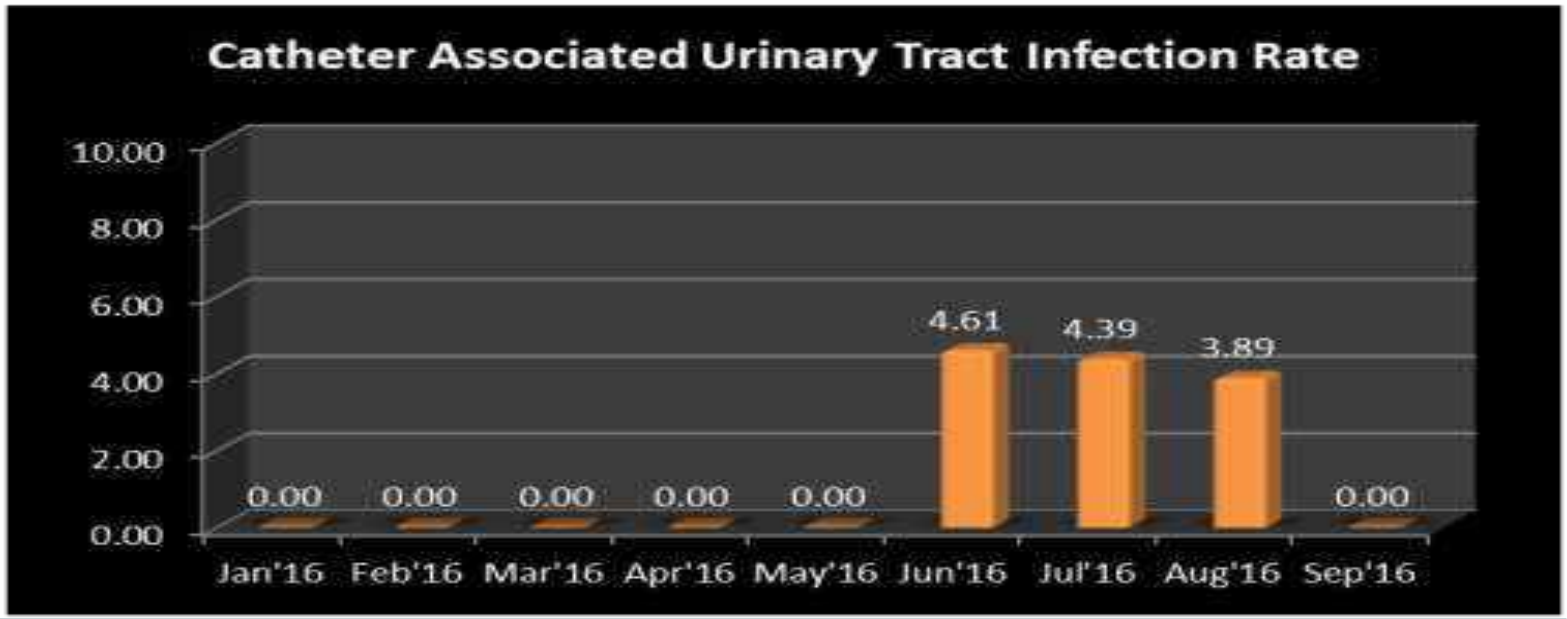
Observation – No incidences of SSI was observed during Jan'16 to Sep'16.
CAPA:-

URINARY TRACT INFECTION

Bench mark		
1	Criteria	Target
2	% of Compliance	Not > 6.5%

No of urinary catheter associated UTIs in a month X 1000
No of urinary catheter days in that month

Jan'16	**0.00%**	**0/269**
Feb'16	0.00%	0/320
Mar'16	0.00%	0/229
Apr'16	0.00%	0/272
May'16	0.00%	0/281
Jun'16	4.61%	1/217
Jul'16	4.39%	1/228
Aug'16	3.89%	1/257
Sep'16	0.00%	0/239



RCA – Reasons for incidences of CAUTI might have been–
1.Proper catheter care might not given in each shift
2.Prolonged catheterization
CAPA - changing of Antibiotics & foleys catheter done as corrective actions and training of staff regarding Catheter care is being imparted regularly.

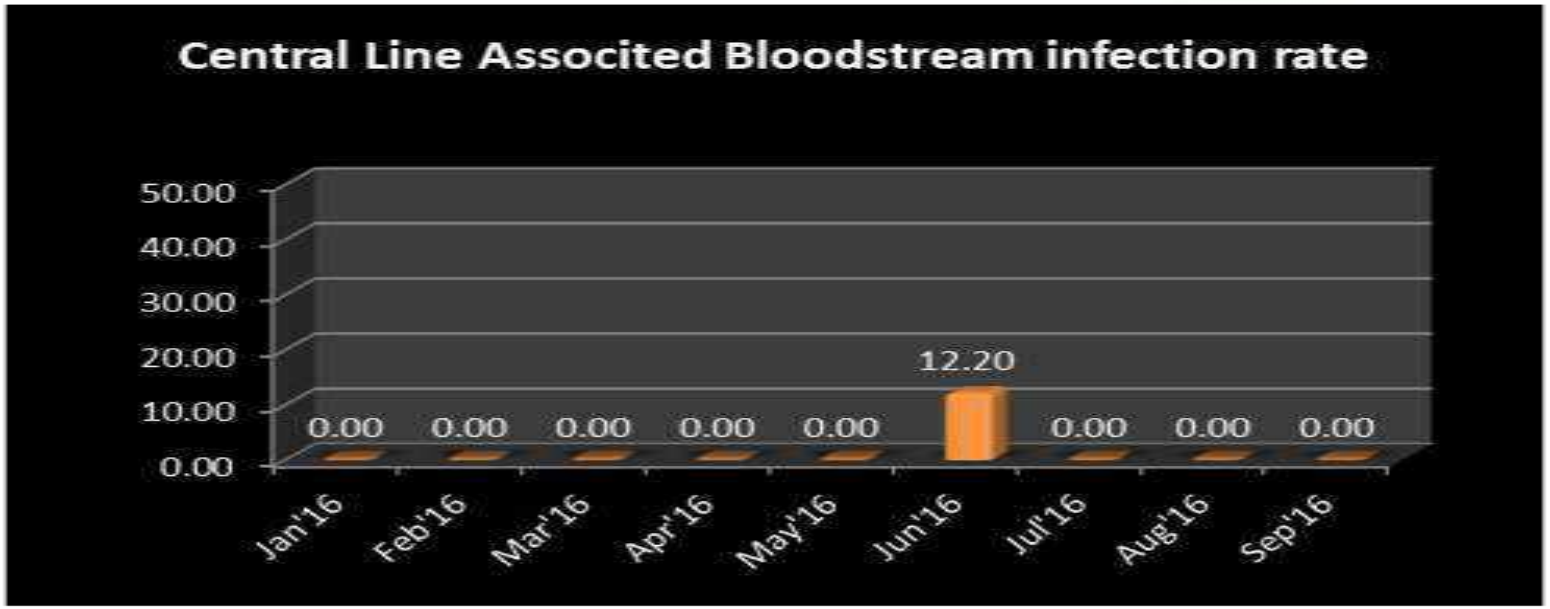
BLOOD STREAM INFECTION

Bench mark		
1	Criteria	Target
2	% of Compliance	Not > 6.1%

No of central line associated blood stream infections in a month X 1000

No of central line days in that month

Jan'16	**0.00%**	**0/159**
Feb'16	0.00%	0/107
Mar'16	0.00%	0/94
Apr'16	0.00%	0/94
May'16	0.00%	0/39
Jun'16	12.2%	1/82
Jul'16	0.00%	0/121
Aug'16	0.00%	0/129
Sep'16	0.00%	0/86



RCA – most possible causes of the same found to be as -

1. Underlying heart & lung disease – ARDS, Septic Shock & AKI.
2. Proper sterile techniques were not followed and emergency insertion was done
3. Prolong catheterization

CAPA – antibiotic changed according to the sensitivity pattern and training of staff on preventive bundle

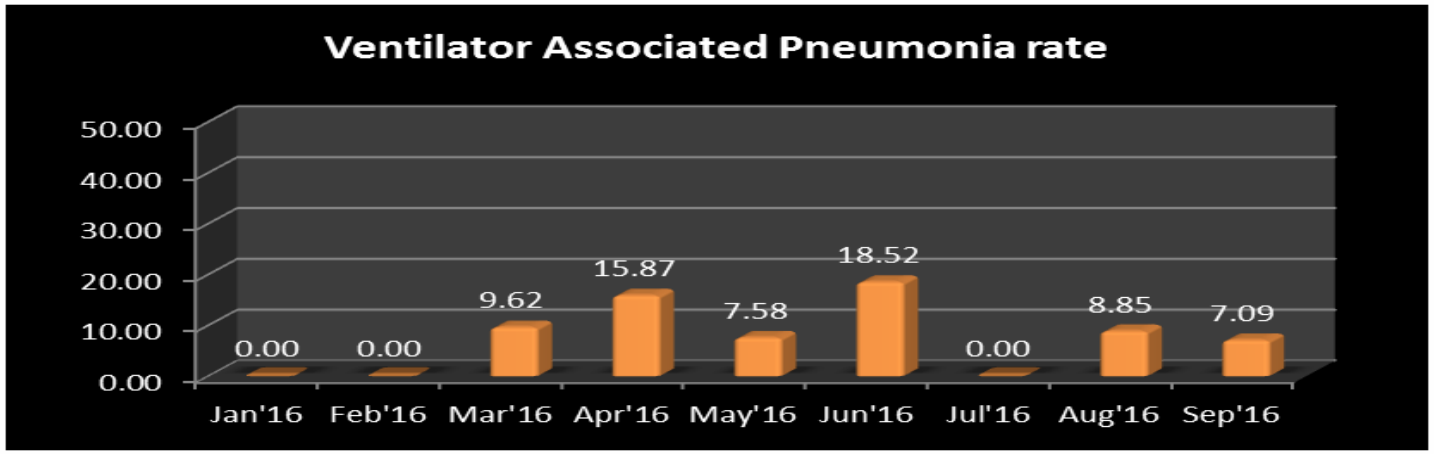
VENTILATOR ASSOCIATED PNEUMONIA (VAP)/ HOSPITAL ACQUIRED PNEUMONIA (HAP)

Bench mark		
1	Criteria	Target
2	% of Compliance	Not > 19.5%

No of Ventilator Associated pneumonias in a month X 1000

No of ventilator days in that month

Jan'16	0.00	0/108
Feb'16	0.00	0/152
Mar'16	9.62	1/104
Apr'16	15.87	2/126
May'16	7.58	1/132
Jun'16	18.52	2/108
Jul'16	0.00	0/128
Aug'16	8.85	1/113
Sep'16	7.09	1/141



RCA – Most possible causes of VAP were found as -

1. underlying debilitating disease / neurologic disease or trauma
2. Asepsis not followed during insertion.
3. Prolonged duration of ET/tracheal tube.

CAPA - Antibiotic was changed according to the sensitivity pattern

HO 4 – REPORTING OF TRANSFUSION REACTION

Interpretation: They are responsible for completing blood request forms, administering blood, monitoring transfusions and being vigilant for the signs and symptoms of adverse reactions. These guidelines are intended to enhance the implementation of standard clinical transfusion practices for improved patient safety.

Means of verification:

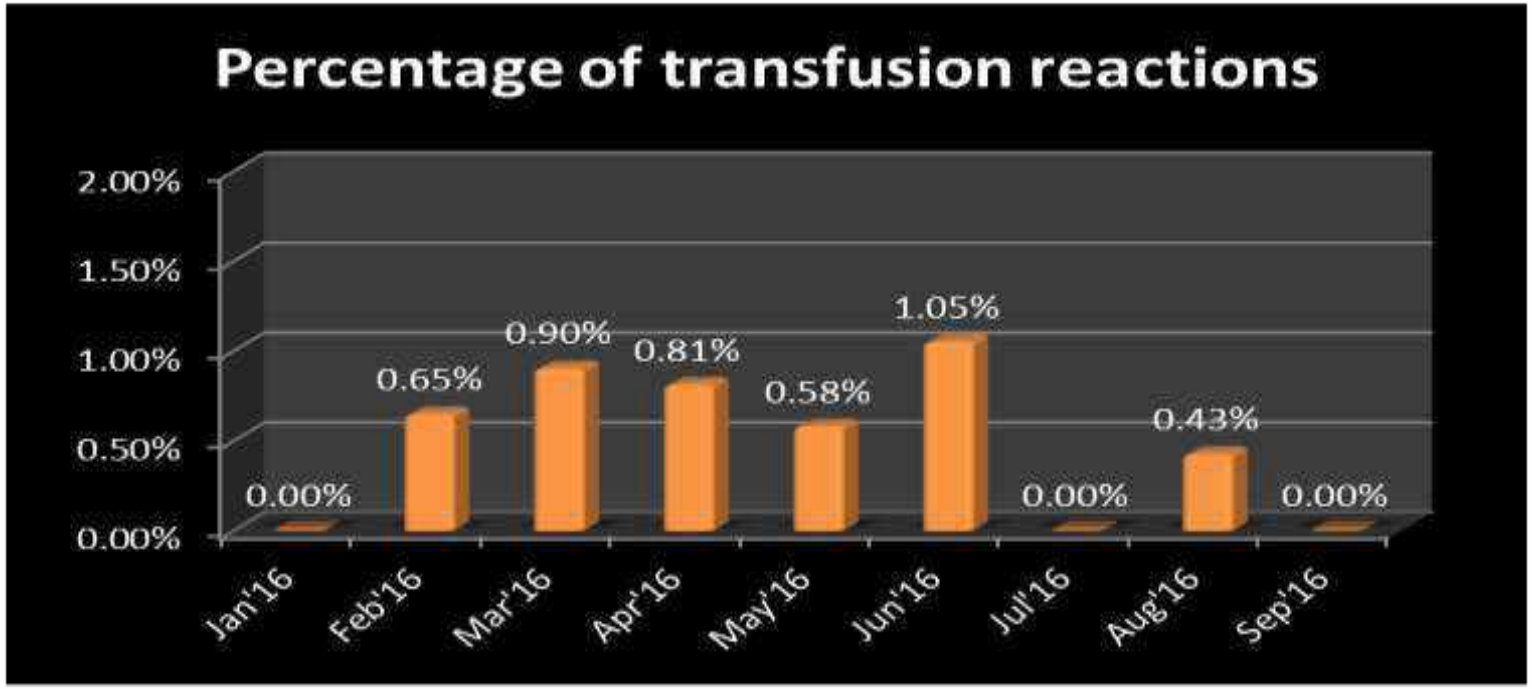
1. Number of Transfusion Reactions in last 6 months

REPORTING OF TRANSFUSION REACTION

Bench mark		
1	Criteria	Target
2	% of Compliance	Not > 2.0%

$$\frac{\text{No of transfusion reactions X 100}}{\text{Total no of transfusions}}$$

Jan'16	**0.00%**	**0/208**
Feb'16	0.65%	1/154
Mar'16	0.90%	2/221
Apr'16	0.81%	1/123
May'16	0.58%	1/172
Jun'16	1.05%	2/190
Jul'16	0.00%	0/222
Aug'16	0.43%	1/234
Sep'16	0.00%	0/234



RCA – In most of the cases, minor reactions were observed as Itching, redness & in a few of cases severing has also been observed which might have occurred cause of inadequate temperature of blood unit and irregularity to antigen & antibodies of human body.

CAPA - Continuous supervision & adequate monitoring of patients & regular training of staff regarding transfusion reactions are being done.

HO 5 - BED OCCUPANCY

Interpretation: A good hospital management includes an effective allocative planning for beds in a hospital. Bed-occupancy rates and length of stay are the measures that reflect the functional ability of a hospital.

Means of verification:

1. Bed Occupancy = Inpatient days of care/ Total number of beds available *100

BED OCCUPANCY

	BOR	ALOS
Jan'16	71.28%	3.72
Feb'16	72.44%	3.45
Mar'16	69.94%	3.39
Apr'16	77.07%	3.83
May'16	74.42%	3.7
Jun’16	71.06%	3.39
Jul’16	83.43%	3.78
Aug’16	91.10%	3.95
Sep’16	99.16%	3.66

HO 6 - PERCENTAGE OF PATIENT SATISFACTION

Interpretation: Patient satisfaction is an important and commonly used indicator for measuring the quality in health care. A measure of care quality, patient satisfaction gives providers insights into various aspects of medicine, including the effectiveness of their care and their level of empathy.

Means of verification:

1. Copy of the filled feedback form clearly showing the questions asked (at least 5 samples)
2. Patient Satisfaction = Number of patients responding extremely satisfied/ Total number of patients surveyed *100

COPY OF THE FILLED FEEDBACK FORM CLEARLY SHOWING THE QUESTIONS ASKED

[Your Clinic Name Here]

Patient Satisfaction Survey

We would like to know how you feel about the services we provide so we can make sure we are meeting your needs. Your responses are directly responsible for improving these services. All responses will be kept confidential and anonymous. Thank you for your time.

Your Age: _____

Your Sex: Male ____

Native

Hispanic or Latino)

Female ____

Your Race/Ethnicity: ___ Asian

___ Pacific Islander

___ Black/African American

___ American Indian/Alaska

___ White (Not

___ Hispanic or Latino (All

Please circle how well you think we are doing in the following areas:	GREAT 5	GOOD 4	OK 3	FAIR 2	POOR 1
Ease of getting care:					
Ability to get in to be seen	5	4	3	2	1
Hours Center is open	5	4	3	2	1
Convenience of Center's location	5	4	3	2	1
Prompt return on calls	5	4	3	2	1
Waiting:					
Time in waiting room	5	4	3	2	1

Patient Satisfaction Survey

Dear Patient,

At _____ we are committed to excellence. We are interested in knowing what you think about our services. Your performance by completing this brief (5 minute) survey regarding your visit.

Thank you for taking time to share your experience with us.

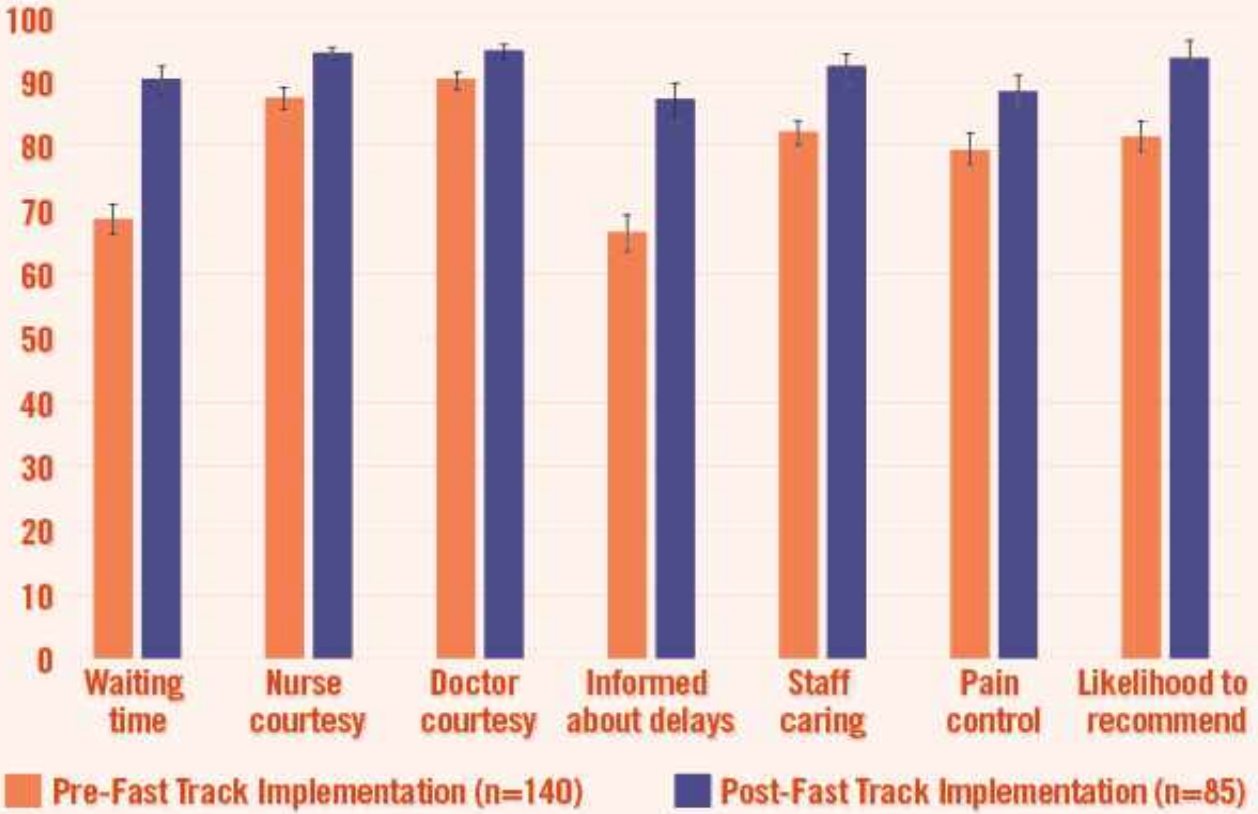
Date of your Procedure _____ AM/PM Physician Appointment Time _____

	Rating	Very poor	fair	very good	n/a
1	If you spoke to the facility by phone, how helpful was the person you spoke with	1	3	5	
2	Ease of scheduling your procedure	1	3	5	
3	The ease of the check-in process	1	3	5	
4	The comfort, cleanliness, and amenities of the facility	1	3	5	
5	Clear and sufficient instructions on what to do and what to expect before your procedure	1	3	5	
6	The wait time in the endoscopy unit, compared to your expectation	1	3	5	
7	The courtesy and caring of your physicians	1	3	5	
8	The courtesy and caring of the nursing and support staff	1	3	5	
9	Skills of assisting staff, for instance when starting your IV	1	3	5	
10	Comfort level within the procedure room	1	3	5	
11	Usefulness of the information provided about what was done during your procedure	1	3	5	
12	Clear and sufficient instructions on what to do and what to expect after your procedure	1	3	5	
13	Overall how would you rate the teamwork between the doctor, nurses and other staff	1	3	5	
14	Overall how satisfied were you with the procedure experience	1	3	5	

PATIENT SATISFACTION

Figure 1 Assessing Satisfaction Before & After Fast Track Implementation

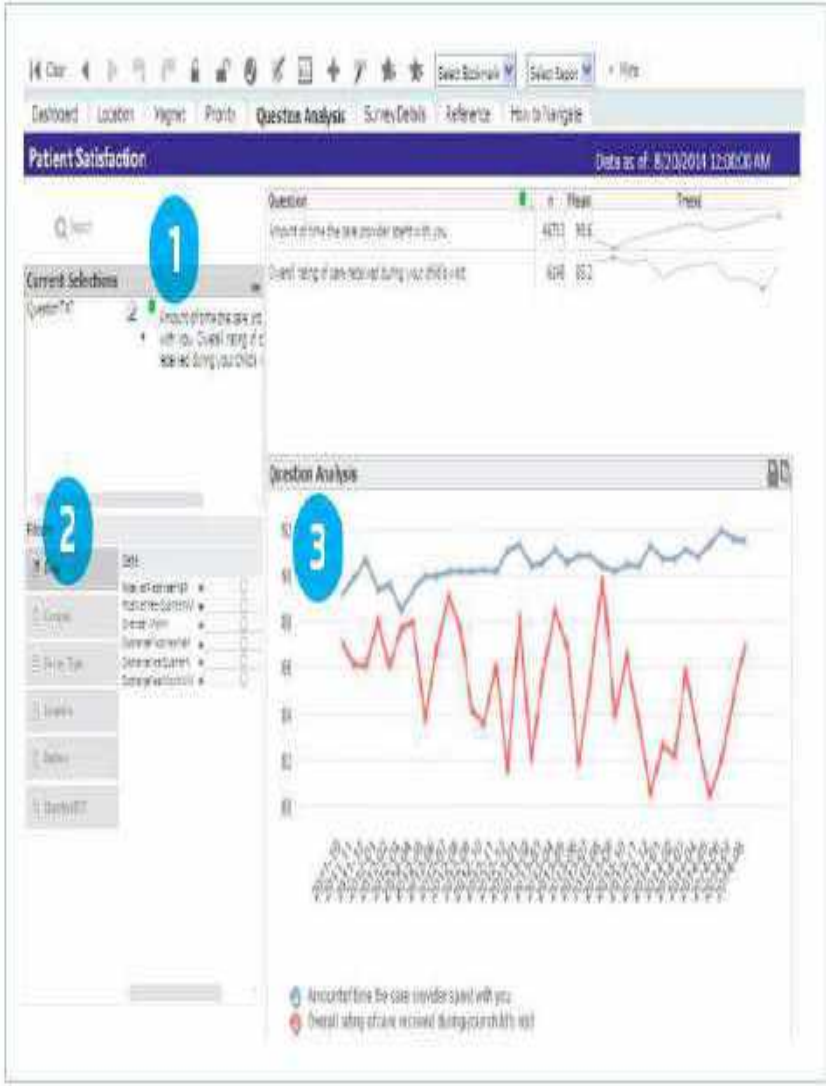
The figure below compares patient satisfaction scores before and after implementation of an ED Fast Track program:



Source: Adapted from: Hwang C, et al. *West J Emerg Med.* 2015;16:34-38.

SAMPLE EXECUTIVE HEALTHCARE DASHBOARD

1. Drill down into a specific questions (e.g., amount of time the care provider spent with you and overall rating of care received)
2. Filter the question by date, campus, service type, location or section
3. Analyze performance of selected questions side by side, trended over time



HO 7 - PERCENTAGE OF EMPLOYEE SATISFACTION

Interpretation: Strong employee satisfaction is linked with significant improvements in patient care and satisfaction therefore it becomes crucial to study the percentage of employees who are satisfied and perform to their best of efforts in the hospital.

Means of verification:

1. Copy of the filled feedback form clearly showing the questions asked (at least 5 samples)

2. Employee Satisfaction = Number of employees responding extremely satisfied/ Total number of employees surveyed *100

COPY OF THE FILLED FEEDBACK FORM CLEARLY SHOWING THE QUESTIONS ASKED

Satisfaction Survey Template

Employee Satisfaction Survey

*This is a survey for the employees of **[Write Name of Company Here]**. This survey is intended to give the management of the company guidance to improve the workplace environment. This survey is to be answered anonymously.*

Ratings:

Please give your assessment of the Company on the following matters by circling one the numbers from one to ten where one is for awful and then for being great.

Compensation to Employees	1	2	3	4	5	6	7	8	9	10
Opportunity for Advancement	1	2	3	4	5	6	7	8	9	10
Benefits	1	2	3	4	5	6	7	8	9	10
Friendly Environment Work	1	2	3	4	5	6	7	8	9	10
Training	1	2	3	4	5	6	7	8	9	10
Performance Evaluation	1	2	3	4	5	6	7	8	9	10
Supervision	1	2	3	4	5	6	7	8	9	10
Culture	1	2	3	4	5	6	7	8	9	10
Job Security	1	2	3	4	5	6	7	8	9	10
Flexibility in Job Performance	1	2	3	4	5	6	7	8	9	10
Overall Satisfaction with Job	1	2	3	4	5	6	7	8	9	10

Employee Morale:

Describe general employee morale: _____

Any recommendations to improve employee morale: _____

Guidance:

Are you given proper guidance to perform your job? _____

Employee Satisfaction Survey Sample[1] [2.1.2.b.1]

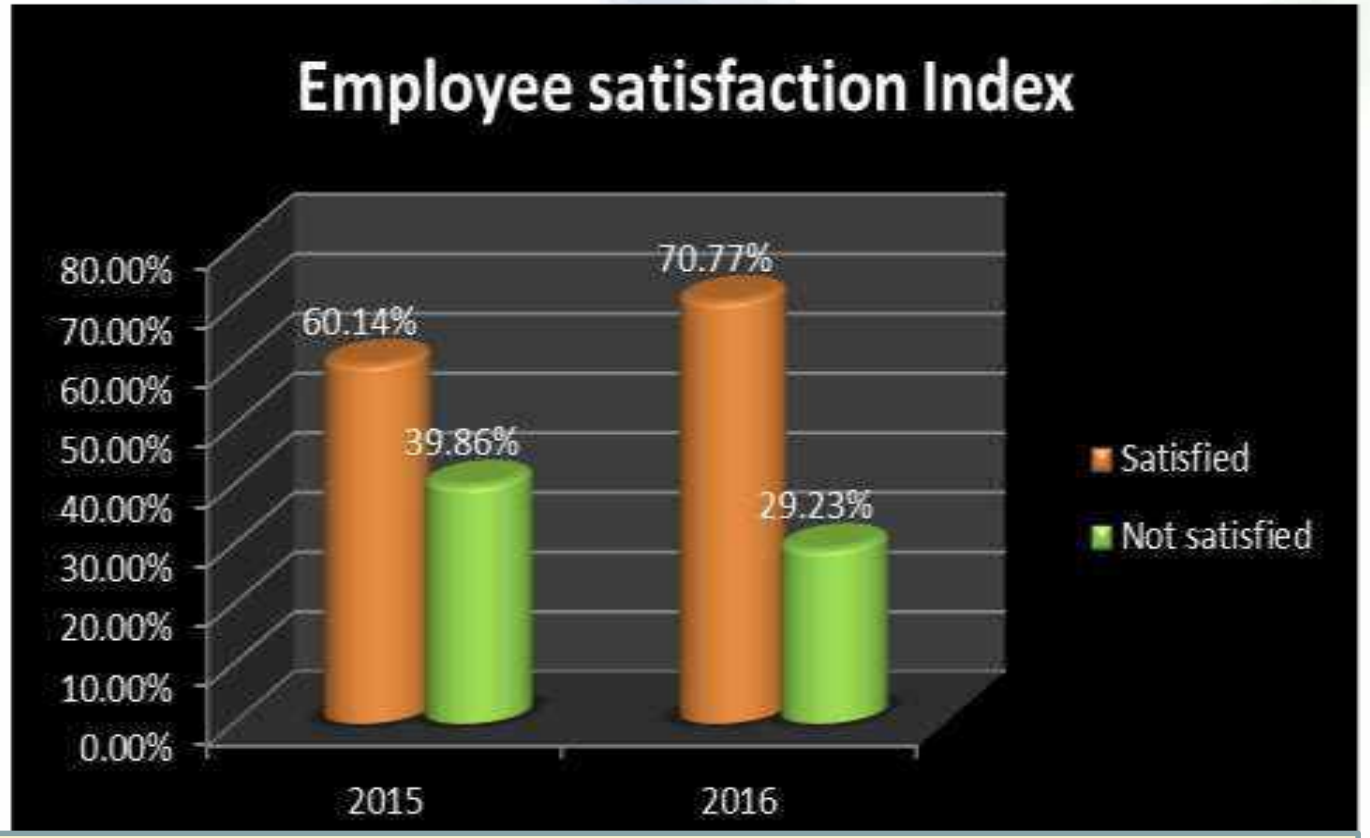
NOTE: Personalize the list of programs, job positions, shift, or departments to be surveyed and checked by respondent.

Division	☐ X Program	☐ Administration	☐ Prevention staff	Date:
Program	☐ Y Program	☐ Management	☐ Treatment staff	FOR OFFICE USE
Position	☐ Z Program	☐ Professional	☐ Mental health staff	Respondent number:

Evaluation Component **Please circle your level of agreement with the following:**	**Strongly Disagree**	**Disagree**	**Neither Agree nor Disagree**	**Agree**	**Strongly Agree**
I believe management encourages and recognizes new ideas.	1	2	3	4	5
I am committed to staying at the organization for the next 12 months.	1	2	3	4	5
I am satisfied with the opportunities for growth within the organization.	1	2	3	4	5
I am satisfied with the product or service I provide.	1	2	3	4	5
I am satisfied with the products or services the organization provides.	1	2	3	4	5
I believe clients/consumers are treated with respect by staff.	1	2	3	4	5
Members of my team pull together to complete a task.	1	2	3	4	5
My team will utilize constructive suggestions or criticism.	1	2	3	4	5
Management's expectations are consistent with the level of resources given.	1	2	3	4	5
I am satisfied with how the organization addresses external issues impacting our services and products.	1	2	3	4	5
I am satisfied with how the organization addresses internal issues impacting our services and products.	1	2	3	4	5
The organizational lines of communication flow easily.	1	2	3	4	5
If I share my work problems with my direct supervisor he/she would respond appropriately.	1	2	3	4	5
I am satisfied with the level and amount of supervision I receive.	1	2	3	4	5
I am satisfied with how my supervisor has worked with me to identify strengths and development areas.	1	2	3	4	5
My supervisor provides me resources to improve my work.	1	2	3	4	5
My supervisor encourages high achievement by reducing the fear of failure.	1	2	3	4	5
I receive fair and honest performance evaluations.	1	2	3	4	5
I believe that I receive the recognition I deserve for my contribution.	1	2	3	4	5
I am satisfied with the amount of training I receive to do my job.	1	2	3	4	5
My work environment is comfortable and adequate to the needs of the program/department.	1	2	3	4	5
My team utilizes appropriate problem solving skills.	1	2	3	4	5
I am given the tools I need to provide the services or products assigned to me.	1	2	3	4	5
The salary is competitive to similar organizations providing similar services.	1	2	3	4	5
The benefits are competitive to similar organizations providing similar services.	1	2	3	4	5

EMPLOYEE SATISFACTION

	Satisfied	Not Satisfied
Aug-Sep'15	60.14 %	39.86%
May-Jun'16	70.77 %	29.23 %



Observation – Satisfaction level of employee was found to be higher than previous survey.

PA –Suggestions made in the survey have been considered by the management as the same is in process.

HO 8 - WAITING TIME - OUT PATIENT DEPARTMENT (OPD) AND DISCHARGE

Interpretation: Delay in discharge of the patient increases the pressure on beds of the hospital and delay in discharge is bad for both hospitals and the patients. Thus it becomes important to calculate the waiting time in the hospital in order to decrease the waiting time and increase patient safety by providing prompt services.

Means of verification:

1. Out-Patient Department Waiting Time = Sum of time from when the patient entered the outpatient clinic to the time the patient actually leaves the OPD/ Total Number of Out-Patients
2. Discharge Waiting Time = (Total time taken for medical record to reach the billing department from the ward + Total time taken in the billing department)/Total Number of In-patients

OUT-PATIENT DEPARTMENT WAITING TIME

	Dept: Cardiology (Dr A)	Dept: Ortho	Dept: Int. Medicine	Dept: Cardiology (Dr B)	Dept. Resp. Medicine
Benchmark	(20 mins)	(20 mins)	(20 mins)	(20 mins)	(20 mins)
Jan'16	21.01	9.62	18.85	-	-
Feb'16	19.53	9.45	16.14	16.92	-
Mar'16	17.50	9.53	16.12	14.07	-
Apr'16	15.59	10.78	17.14	15.19	12.35
May'16	18.27	15.35	18.02	23.38	11.76
Jun'16	15.56	15.38	17.26	14.04	12.72
Jul'16	16.81	11.27	34.61	14.12	13.73
Aug'16	17.00	10.00	32.23	15.02	16.56
Sep'16	17.23	8.98	38.56	16.20	17.45

Observation – Average waiting time for Medicine Speciality was found to be in higher side due to increased number of patient during last 3 months however waiting time for other speciality was found to be within satisfactory range.

Jan'16	18.79
Feb'16	17.4
Mar'16	19.57
Apr'16	17
May'16	19.30
Jun'16	18.28
Jul'16	19.24
Aug'16	18.00
Sep'16	18.28

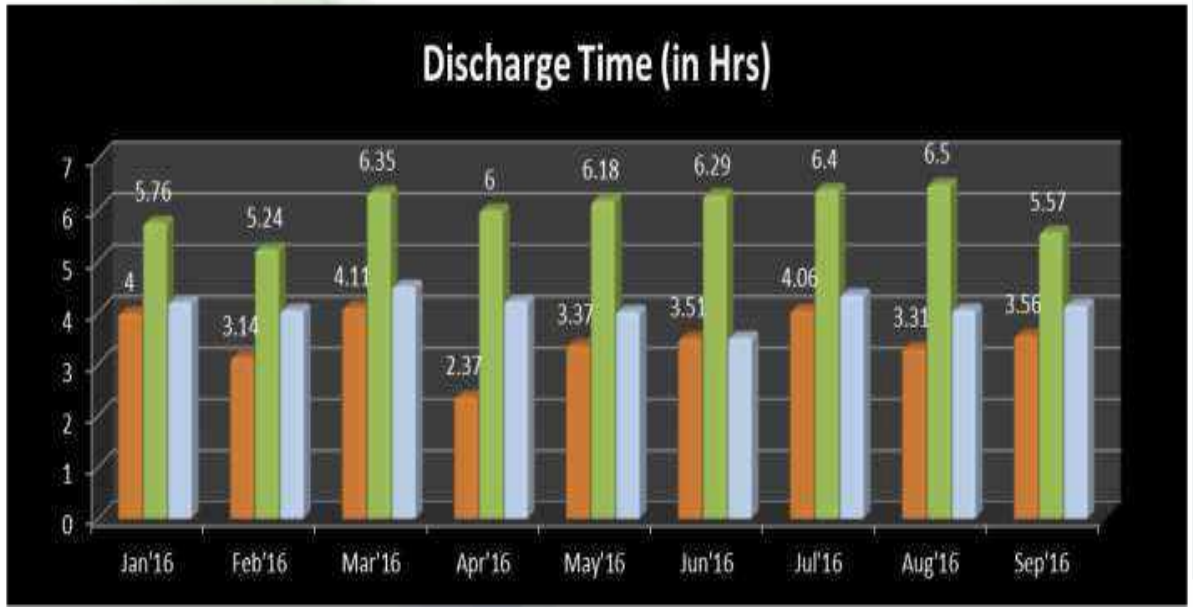
Observation – Average waiting time for ultrasound was found within the limit.

•Some case are excluded from the data which have taken more time to maintain the pressure for the requisite procedure however they were already informed for the preparation.

PA - counselling of patient for the same is being reinforced along with written preparation guidelines in the dept.

DISCHARGE WAITING TIME

	Cash (3 - 4 hrs.)	TPAs (5 – 6 hrs.)	Others (4 - 5 hrs.)
Jan'16	4	5.76	4.21
Feb'16	3.14	5.24	4.05
Mar'16	4.11	6.35	4.52
Apr'16	2.37	6	4.23
May'16	3.37	6.18	4.03
Jun'16	3.51	6.29	3.52
Jul'16	4.06	6.4	4.35
Aug'16	3.31	6.5	4.06
Sep'16	3.56	5.57	4.15



Observation –

Time for discharges were found to be little high in cash patients from the period of Jan ’16 to Sep’16; most possible reasons for the same were :

1.Time taken in billing activity.

2.Bill after being ready is sent to respective departments i.e. lab, imaging and pharmacy to verify the same.

3.Refund of medicine from pharmacy takes time

CAPA-

1.Concept for planned discharges is followed strictly, summary of the potential discharges is prepared by the Duty doctor in night and typed by the night MT /early morning so that the same can be available to the consultant during morning rounds.,

2.Reduction of discharge TAT due to introduction of Apex (HIS) as entry of all investigations are made directly when the requisition is raised, which ensures early billing and reduced billing errors; leading to early preparation of accurate bill.

3.Refund of medicines in during night hrs.

HO 9 - REPORTING OF ADVERSE EVENTS

Interpretation: Adverse events are usually defined as an unintended injury or complication resulting in prolonged hospital stay, disability at the time of discharge or death caused by healthcare management rather than by the patient's underlying disease. A substantial part of these events are avoidable and it is important to report them in order to prevent such events in future.

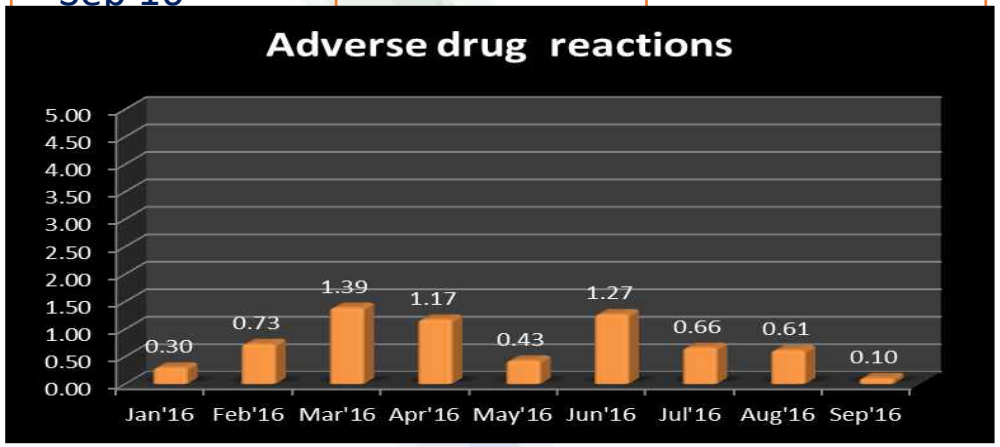
Means of verification:

1. Data for last 6 months

REPORTING OF ADVERSE EVENTS

Bench mark		
1	Criteria	Target
2	% of Compliance	Not > 2.0%

Jan'16	**0.30**	**2/670**
Feb'16	0.73	5/688
Mar'16	1.39	10/721
Apr'16	1.17	8/682
May'16	0.43	3/704
Jun'16	1.27	9/709
Jul'16	0.66	5/759
Aug'16	0.61	5/814
Sep'16	0.10	1/974



No. of adverse drug reactions X 100
No. of discharges and deaths

RCA – on analysing it was found that most of the medications errors were due to :

1.In most of the cases Rights of medication were not followed :
- a.wrong time
- b.wrong dose
- c.wrong route
- d.wrong documentation
  - 1.delayed documentation
  - 2.early documentation
  - 3.missed documentation i.e. medicine given but not documented
  - 4.Patient refused but not documented.

2.Wrong transcribing due to lack of cross checking.

3.4. In a few cases – prescription error by doctor.

4.Non – availability of drugs in pharmacy lead to delayed administration.

CAPA –

1. Staff was counselled to follow the rights of drug administration and cross check the doctor's orders while transcribing and administration of drugs.
2. Staff was instructed to follow the right procedure of drug administration and to document after administration.
3. The pharmacy was told to ensure the availability of the drugs at right time.
4. Checking & updating of drugs as required.
5. Training regarding "Management of Medication" in order to prevent such medication errors are reinforced as preventive action.

HO 10 - REPORTING OF THEFTS / SECURITY RELATED INCIDENTS

Interpretation: Thefts of medical equipment or medical records is a major concern in hospitals. Health records are being digitized and hence there is the danger of health information becoming compromised or stolen outright. It is important to decrease the number of such incidents by enhancing security in the facility.

Means of verification:

1. Data for last 6 months

REPORTING OF THEFTS / SECURITY RELATED INCIDENTS

SECURITY INCIDENT REPORT

Date of Incident: _____ Time of Incident: _____

Location of Incident: _____

Name of Member: _____

Vessel Name: _____

Vessel Type: _____

Contact details: Ph: _____ Mob: _____

Incident Details:

☐Break-in ☐Theft ☐Damage

Description of damage/equipment theft: _____

What action has been taken?: _____

Was any authority notified?

CAMPUS SECURITY INCIDENT REPORTING PROTOCOL

Objective

The Campus Security Incident Report Form should be used to record details of serious incidents that occur on the UL campus. Examples of serious incidents include activities that result in significant damage to property, physical assault, theft, riotous behaviour or any incident that causes serious distress/disruption to others.

A formal mechanism for reporting of incidents is currently used by campus security staff. However, security staff might not have been requested to attend, or alerted to, all serious incidents that occur on campus. The attached form is intended to address this and it provides a standard procedure for the recording of serious incidents. This process is to be adopted by staff/managers of campus facilities in order to ensure that the University is officially advised, in a timely manner, of all serious incidents that occur on campus.

Submission

Staff/managers are required to complete this form within 24 hours of the occurrence of a serious incident. Hard copies of this form to be submitted as soon as possible to UL Security (Visitors Car Park) where it will be logged and circulated to the relevant personnel for information and/or action.

Electronic copies of this form should be to be sent to: UniversitySecurity@UL.ie

In addition to the above all incidents resulting in accidents involving injury to people or dangerous occurrences (i.e. near-misses) should also be reported to the UL Health and Safety Department.

Biased Based Event

Bias Related Event	
Definition	Bias Related Events can be reported online. A bias related event is "A criminal offense committed against a person or property which is hate/bias based on race, national or ethnic origin, language, color, religion, sex, age, mental or physical disability, sexual orientation or any other similar factor. Bias Related Event-RCW: To see Washington State definition click: here
Examples	A swastika symbol spray painted on your front door.

Confirm Question(s)	
Are you familiar with: Bias Related Event-RCW:	○Yes ○No
Is this situation still in progress?	○Yes ○No
Did the damage or mischief involve the use of a gun (including BB gun, pellet gun, paintball gun, etc.)?	○Yes ○No
I understand that filing a false police report is a criminal offense.	○Yes ○No

Start Report

Identity Theft

Identity Theft	
Definition	Obtaining someone else's personal identifying information and using it to obtain credit, goods or services.
Examples	Someone obtains a credit card using your S.S.N. or obtains phone service using your personal information.

Confirm Question(s)	
Reports may only be filed where there are no known suspects or security video. Are there any suspects or any security video?	○Yes ○No
Reports may not be filed by a third party. Falsely reporting an incident or pretending to be someone else in order to file a report can be investigated and charged as a criminal offense. **Are you filing this report for yourself?**	○Yes ○No

Start Report

HO 11 - REPORTING OF NEEDLE STICK INJURIES

Interpretation: Needle stick injury is defined as a penetrating wound typically induced by a needle point or other sharp instrument or object which could be infected with another person's secretion. These injuries can lead to transmission of blood-borne viral infections. A continuous follow-up and reporting of needle stick injuries in surgeons is important to prevent future events of needle stick injuries for higher patient safety.

Means of verification:

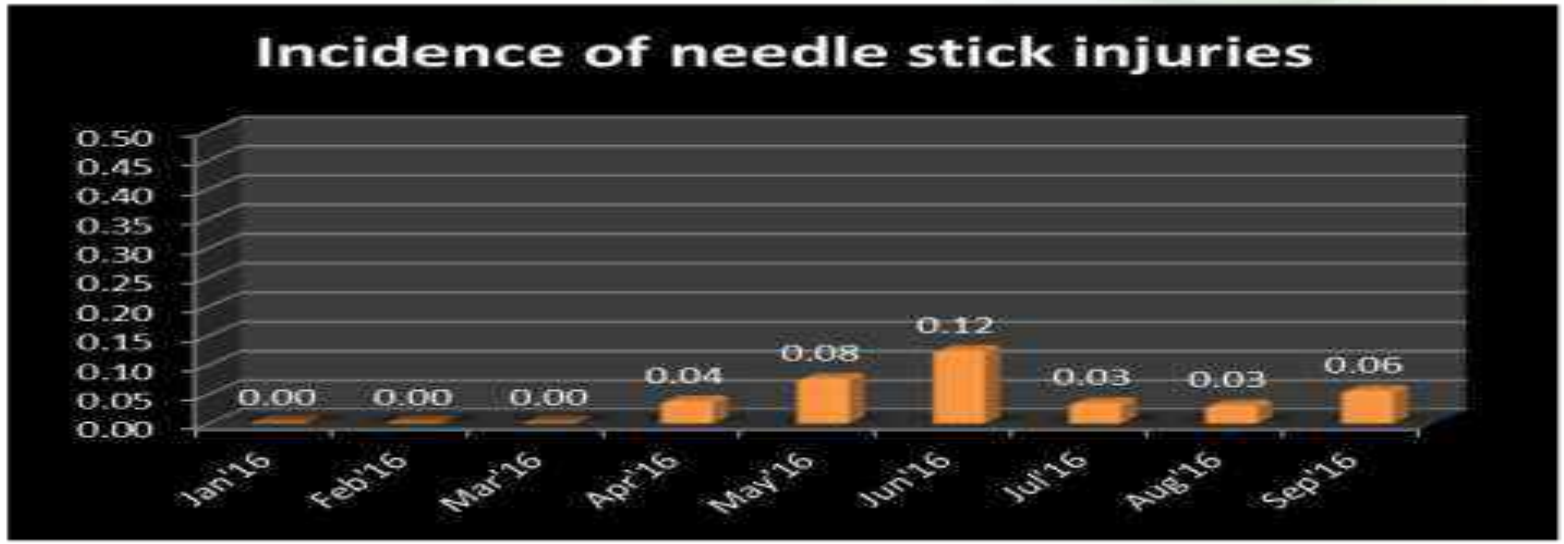
1. 6 months at least or annual

REPORTING OF NEEDLE STICK INJURIES

Bench mark		
1	Criteria	Target
2	% of Compliance	Not > 2.0%

No. of parenteral exposures x 100
No. of in-patient days

Jan'16	**0.00**	**0/2497**
Feb'16	0.00	0/2374
Mar'16	0.00	0/2450
Apr'16	0.04	1/2613
May'16	0.08	2/2607
Jun'16	0.12	3/2409
Jul'16	0.03	1/2871
Aug'16	0.03	1/3223
Sep'16	0.06	2/3570



RCA – Reasons for the same were found as –

1. Recapping of needles.
2. Improper handling of sharps material
3. Accidental prick after sample collection.

CAPA – Measures taken as per NSI protocol

Education & regular training regarding NSI protocol and prevention of NSI.

Training on Bio Medical Waste Management.

AB PM-JAY QUALITY CERTIFICATION

S. No.	Name of The Hospital	Type of Certificate (AB PM-JAY Gold/Silver/Bronze)	Name of State
1	U. N. Mehta Institute of Cardiology & Research Centre	AB PM-JAY Gold Quality Certificate	Gujarat
2	Cygnus Super specialty Hospital	AB PM-JAY Gold Quality Certificate	Haryana
3	Government Spine Institute	AB PM-JAY Gold Quality Certificate	Gujarat
4	Sanjiv Bansal Cygnus Hospital	AB PM-JAY Gold Quality Certificate	Haryana
5	Kashyap memorial Eye Hospital	AB PM-JAY Gold Quality Certificate	Jharkhand
6	VK Neurocare and Trauma Research Hospital	AB PM-JAY Gold Quality Certificate	Haryana
7	Apollo Hospitals International Ltd	AB PM-JAY Gold Quality Certificate	Gujarat
8	Felix Hospital	AB PM-JAY Gold Quality Certificate	Uttar Pradesh
9	Cygnus Super Specialty Hospital, Kurukshetra	AB PM-JAY Gold Quality Certificate	Haryana
10	Sidharth Hospital	AB PM-JAY Gold Quality Certificate	Haryana
11	Leelawati Hospital	AB PM-JAY Gold Quality Certificate	Haryana
12	Saraswati Nethralaya	AB PM-JAY Gold Quality Certificate	Haryana
13	Neelam Hospital	AB PM-JAY Gold Quality Certificate	Punjab

S. No.	Name of The Hospital	Type of Certificate (AB PM-JAY Gold/Silver/Bronze)	Name of State
14	Shri Balaji Aarogyam Hospital	AB PM-JAY Gold Quality Certificate	Haryana
15	Sterling Hospital, Vadodara	AB PM-JAY Gold Quality Certificate	Gujarat
16	Sal Hospital, Ahmedabad	AB PM-JAY Gold Quality Certificate	Gujarat
17	MGM Hospital & Research Centre	AB PM-JAY Silver Quality Certificate	Madhya Pradesh
18	SKR Hospitals & Trauma Centre Pvt. Ltd.	AB PM-JAY Silver Quality Certificate	Punjab
19	GCS Medical College Hospital, Ahmedabad	AB PM-JAY Silver Quality Certificate	Gujarat
20	Geetanjali Hospital, Hisar	AB PM-JAY Silver Quality Certificate	Haryana
21	Jaspal Nursing Home	AB PM-JAY Silver Quality Certificate	Haryana
22	Advanta Super Specialty Hospital	AB PM-JAY Silver Quality Certificate	Haryana
23	Thakur Eye and Maternity Hospital	AB PM-JAY Silver Quality Certificate	Haryana
24	Sterling Cancer Hospital, Vadodara	AB PM-JAY Silver Quality Certificate	Gujarat
25	Ambujanagar Multispecialty Hospital	AB PM-JAY Silver Quality Certificate	Gujarat
26	Balaji Hospital, Karnal	AB PM-JAY Silver Quality Certificate	Haryana

Total Application:- 61
Total Certified:- 0

Total Application:- 52
Total Certified:- 16

Total Application:- 62
Total Certified:- 10

LINKS FOR ACHIEVE AB PM-JAY BRONZE / SILVER / GOLD QUALITY CERTIFICATE:-

1. http://www.pmjay.qcin.org/tools

2. http://www.pmjay.qcin.org/assets/img/nha-img/docs/Bronze%20Quality%20Certificate%20Standards.pdf

3. http://www.pmjay.qcin.org/assets/img/nha-img/docs/Guideline%20for%20How%20to%20Achieve%20Bronze%20Quality%20Certificate.pdf

4. http://www.pmjay.qcin.org/assets/img/nha-img/docs/Guideline%20for%20Self-Assessment%20Quality%20-%20Checklist_V2.pdf

5. http://www.pmjay.qcin.org/assets/img/nha-img/docs/Silver%20Quality%20Certificate.pdf

6. http://www.pmjay.qcin.org/assets/img/nha-img/docs/Tech%20FAQs%20for%20bronze%20certificate.pdf

7. http://www.pmjay.qcin.org/assets/img/nha-img/docs/Tech%20FAQs%20for%20already%20certified%20Hospitals.pdf

THANKS

"Want your support for Improvement"