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GOVERNMENT OF PUDUCHERRY

RAJIV GANDHI GOVERNMENT WOMEN & CHILDREN HOSPITAL

QUALITY SYSTEM POLICIES

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QUALITY POLICY

Vision :

To provide state of the art, patient focused, integrated healthcare to all irrespective of class, creed and religion with compassion and dignity.

Mission :

- To provide preventive, promotive and curative RMNCH-A services free of cost to all.
- To ensure services with ethics and integrity to all irrespective of class, creed and religion.
- To ensure supply of quality essential drugs to all BPL free of cost/highly subsidized for others and promote rational use of drugs.
- To provide reliable and updated diagnostic services commensurating with clinical services.
- To ensure continuous quality improvement by regular updating of knowledge of professionals and by educating and empowering the client/service seeker.
- Striving for patient satisfaction and maintenance of mandatory Quality standards for achieving NQAS certification and NABH accreditation.

Quality policy :

RGGWCH, a secondary care Public Health Facility in Puducherry is committed to deliver comprehensive and high standard healthcare to all with compassion, dignity and dedication. We are further committed to consistently working towards continuous quality improvement by providing adequate and updated technological resources. Continuous updating of skills of the service providers and empowerment of service seekers through information, education and communication is ensured.

Condemnation Policy

G.O. for condemnation – condemnation committee – Process of condemnation

The condemnation policy of Rajiv Gandhi Government Women & Children Hospital is based on G.O.No. , (dated:) order for condemnation of government assets, vehicles, documents, equipment, linen etc. Different information is required as well as different procedures are adopted to declare an asset as condemned.

I- Format for declaration of Condemned equipment :-

In Hospital, there are various departments each having different equipment for example Labour Room equipment includes, suction apparatus, BP apparatus, Pulse oxy-meter, Standing lamps, weighing machines, Air Conditioner, Ceiling fan, Auto clave, etc…

For condemnation use this format for instrument particulars:

1- Name of equipment
2- Specification of equipment
3- Date of Purchasing
4- Date of installation
5- Cost at the time of purchase
6- Down time (total number of days for which the equipment remained non-functional)
7- Number of major repairs
8- Total amount spent of repairing
9- Present value of equipment
10- If non-functional, repairable or non-repairable

End of Life Care Policy

Care Activity:

- CPR to be given by Medical Officer on Duty and the attending nurse
- Information to the treating Consultant to be given by Medical Officer on duty
- Medical Superintendent / RMO / PRO of the hospital to be informed about the death.
- The necessary details regarding condition of the patient and details of CPR is to be written in patient's case sheet to ensure proper medical record for MRD.
- In case of the event of impending death of a patient, the medical team regularly updates the patient's representatives about the patient's condition. The patient's representatives are allowed to interact with the patient. Utmost sensitivity is maintained by the medical team in educating and counseling the patient representatives.
- Death of a patient is handled carefully with concern with contentment. Counseling of next of kin with sympathy is given at most importance. All help in shifting the body from the hospital is extended to the next of kin. The dead body is released as soon as possible after completion of all formalities.
- Acknowledgement is obtained from the Next of Kin/Legal representative, for receipt of the body and the Cause of Death. Handing-over of the body is done solemnly and it is ensured that hospital Staff takes due care and concern in this respect. Due arrangements are made for preserving the body in the mortuary at IGMCRI, Puducherry, as and when needed.
- Nursing personnel on duty ensure orderliness in handing over the body to the next of kin.
- Medico Legal Case will be informed to the Outpost Police personnel on duty / local police station. The body is handed over to the Mortuary after intimating to the police and entry made in the MLC register after informing the Casualty Medical Officer and Paediatric Department of IGMC&RI, Puducherry.
- Religious sentiments are given due consideration. Patients' relatives are allowed to be with the body. In case of impending death of a patient, relatives are allowed to perform the religious beliefs without disturbing other patients. The hospital Staffs extends all possible cooperation.

ANTIBIOTIC POLICY

A. Purpose:

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

B. Scope: Hospital Wide

Our policy is to rationally and judiciously use the antibiotics for patient treatment.

Antibiotics are categorized under following categories and authorization to prescribe those antibiotics is given according to the qualification and designation of doctor.

- **Watch drugs** -used to treat common infections
- **Access drugs**- slightly more potent than watch drugs
- **Reserve drugs**-last resort drugs

Watch drugs	Access drugs	Reserve drugs
Amoxycillin Cephelexin Ampicillin Azithromycin Nitrofurantoin Cefixime Ciprofloxacin Cefuroxime Doxycycline Metronidazole Co-trimoxazole Amoxycillin Cephelexin Ampicillin Azithromycin	Cefotaxime Ceftriaxone Amikacin Gentamicin Cefaperazone-Sulbactam Piperacillin-Tazobactam Ofloxacin	Vancomycin Colistin Meropenam Imipenam Tigecycline Linezolid

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

- Antibiotic are prescribed for the minimum length of time that is effective.
- Review the duration of antibiotic therapy is done after 5 days.

- Surgical Antimicrobial Prophylaxis
    - Inj.Cefotaxime1-2gm IV stat within 30-45 mins before the surgical incision and repeat dose after 12 hrs.
    - Continue antibiotics if, Prolonged surgery >3hrs
      Blood loss>1500ml
      BMI>35
- Pathogen is targeted first –cultures are obtained from the patient;
- Empiric therapy is targeted for likely pathogens;
- Definitive therapy is given for known pathogens.
- Standard infection control practices and isolation precautions are adopted to avoid hospital acquired infection.
- Medical audit is done to know who prescribed what.
- Training and education is provided to the antibiotic prescribers to keep them updated about judicious usage of antibiotics.

General Guideline for Antibiotic Treatment and Prophylaxis:

Disease	**Etiological agent**	**Primary antibiotics**	**Alternative antibiotics**
Acute uncomplicated cystitis	E.Coli	Ciprofloxacin Cefixime	Nitrofurantoin
Acute Uncomplicated Pyelonephritis	E.Coli	Ceftriaxone with Amikacin or Gentamicin	Piperacillin Tazobactam or cefaperazone sulbactam
Complicated Pyelonephritis	E.Coli Proteus Pseudomonas Acinetobacter	Piperacillin Tazobactam or cefaperazone sulbactam	Meropenam
Chorioamnionitis	E.Coli Group B Streptococci	Ampicillin	cefaperazone sulbactam
Dysentry	Shigella	Cefixime	Ceftriaxone
Cholera	Vibrio cholerae	Fluid replacement Doxycycline	Azithromycin
Enteric fever	S.typhi Paratyphi.A	Cefixime Azithromycin	Ceftriaxone Ofloxacin
Septic arthritis	S.Aureus E.Coli Gp.B streptococci	Ceftriaxone cefotaxime	Vancomycin Gentamycin
Bacterial Meningitis in Children	Streptococcus pneumoniae Neisseria H.Influenza	Ceftriaxone Or Cefotaxime	Meropenam

Visitor Policy

This policy is designed to balance the patient's need for visitors & it addresses the procedures and guidelines for Patient Visitors.

Visitors Policy for In-Patients

- One attendant is a must for all High risk mothers and one female birth attendant for labouring mothers in the Labour Room and for all Paediatric patients.
- Patients' attendants will be allowed to stay in the Dormitory within the hospital premises with a attendant pass and will be called when needed through the Public Addressal System
- The general visiting hours for all patients are 4.30 PM – 6.00 PM (Kindly keep the number of visitors to the barest minimum to avoid cross infections).
- One attendant with diet pass issued by the hospital will be allowed for each patient to bring
  diet (6 am to 7 am and 12.30 pm to 1.30 pm), if they prefer.
- Children (below 12 years) accompanying the visitors are strictly prohibited.
- Please refrain from visiting patients if you have symptoms such as fever, cough or cold.
- To respect the privacy of our patients, visitors and staff, taking photographs, audio or video recording using any devices (camera, video-camera, phone-camera, mobile voice recorder) are prohibited within the hospital premises.

Non Discrimination to Gender Policy

A. **Purpose** : To provide guideline instruction for Non-discrimination to gender for patients care and staff employed in the hospital.

B. **Scope**: This policy is applicable for OPD patients and Inpatients and Staff of this hospital

C. **C. Policy**:

- Patients have the right to be given impartial access to treatment or accommodations that are available and medically indicated, regardless of race, religion, sex, national origin or sources of payment.
- No discrimination of gender on the basis of taking treatment
- Any person who believes that he, she, or another person has been subjected to discrimination, which is not permitted by this Policy, may file a complaint using grievance procedure.
- Separate Queue for Registration and Paediatric Pharmacy
- All training and other educational programs offered by Hospital will be open to qualified applicants without regard to the protected categories.
- There should be equal respect for both male and female staff in the hospital
- Issues of a discriminatory nature involving patients, patient representatives and visitors will be referred to the Medical Superintendent / RMO / PRO of the hospital
- Employees will be assigned to patient services without any gender bias.
- Any written complaints pertaining to Gender discrimination and work place sexual harassment from any government employee/ post graduate working in this hospital will be directed to this Internal Complaints Committee (Gender Discrimination at workplace)

Religious and Cultural preferences policy

The patients come from a wide variety of religious and cultural backgrounds to the hospitals. The purpose of this document is to educate the staff to know the religious and cultural needs of the patients.

The beliefs of each person should be respected. This includes treating with respect that, which is important to them, whether religious or not. It may be offensive to put articles considered holy on the floor or in a locker or bag with dirty washing or shoes.

Some key issues to consider in Religious and Cultural Care:

a. **Diet** – Patients should always be asked to state their dietary needs; nutrition is an essential element in the treatment and recovery of patients, and patients could refuse food if it does not meet the requirements of their religion or belief.
   - An example of this could be offering a Egg to a Brahmin person, whose religion not allow for this food
   - During the month of Ramzan a Muslim fasts between sunrise and sunset

b. **Modesty** - Modesty in dress and a requirement to be treated by a doctor/nurse of the same sex is also important in some religions. However, it is not always possible or feasible to provide same-sex attendance, particularly without adequate notice that this might be an issue, and this should be made clear at the time of making appointments.

c. **Beginning of Life** – As described in the DH guidance, many religions will have concerns in relation to contraception, abortion / termination, prenatal medicine (artificial reproductive technologies (ARTs), prenatal diagnosis (PND), prenatal genetic diagnosis (PGD)) and practices at childbirth. Issues such as these should always be sensitively considered & discussed if there is a particular religious understanding.

d. **End of Life Concerns** - Many religions and beliefs include in their teachings views on dying, death and the afterlife. For many religions, life does not end with death. Often the process of dying is seen as an opportunity for spiritual insight. In Buddhism, Hinduism and Sikhism, for example, the way in which one dies may influence one's rebirth. In the event of a death, Hospital staff should consult the patient's relatives to determine their preferences with regard to preparation of the body and other religious requirements.

e. **Organ / Tissue Donation** – it should not be assumed that the patient who is of a particular religion will be against organ / tissue donation. Many religious groups are

positive about donation being a great gift of life to others. Sensitive discussion should take place with patients / families around this issue taking into consideration any religious perspectives / concerns.

f. **Care of the Dying -** Large numbers of family may wish to visit. This should be balanced with the needs of other patients. For many it is essential that the patient is supported and does not die alone, and that religious rituals are carried out correctly like some families may wish to bring clothes or money for the patient to touch before distribution to the needy or sprinkling water of Ganges.

Social Non Discrimination Policy

Hospital shall follow guidelines for Social Non-discrimination for patients care in the hospital.

- The right to freedom from discrimination extends to all employees, including full-time, part-time, temporary, probationary, casual and contract staff, as well as volunteers, co-op students, interns and apprentices.
- It is also unacceptable for members of Hospital to engage in discrimination when dealing with clients, or with others they have professional dealings with, such as suppliers or service providers.
- This policy applies at every level of the organization and to every aspect of the workplace environment and employment relationship, including recruitment, selection, promotion, transfers, training, salaries, benefits and termination. It also covers rates of pay, overtime, hours of work, holidays, shift work, discipline and performance evaluations.
- This policy also applies to events that occur outside of the physical workplace such as Hospital parties and CME's

This policy prohibits discrimination or harassment based on the following grounds, and any combination of these grounds:

- Age
- Religion
- Sex
- Sexual orientation
- Gender identity
- Gender expression
- Family status (such as being in a parent-child relationship)
- Marital status (including married, single, widowed, divorced, separated or living in a conjugal relationship outside of marriage, whether in a same-sex or opposite-sex relationship)
- Disability (including mental, physical, developmental or learning disabilities)

- Race
- Ancestry
- Place of origin
- Ethnic origin
- Citizenship
- Colour
- Record of offences (criminal conviction for a provincial offence, or for an offence for which a pardon has been received)
- Association or relationship with a person identified by one of the above grounds.
- Perception that one of the above grounds applies.

Privacy, Dignity & Confidentiality Policy

Hospital shall follow the guidelines to ensuring privacy, dignity and confidentiality of patient.

- All patients approaching the hospital for medical treatment will receive care appropriate to their healthcare need and scope of services provided by the hospital.
- Quality of medical care will be same in all care settings of the hospital and no discrepancy of any sort will be followed in the provision of medical care.
- All treatment orders would be signed, dated and timed by the concerned clinician.
- Any treatment order initiated by a hospital's clinician different from the primary treating consultant of the patient will be countersigned by the primary treating consultant within 24 hours.
- Incase required the primary treating consultant of the patient may consult other care providers available within the hospital for patients care related issues.
- Patients response to treatment, his /her health status , further treatment plan etc will be discussed among the clinical and nursing staff involved in provision of care to the patient.
- Proper curtain availability at Indoor / In Patient Department, Labour room, USG/ X-ray room for maintaining privacy of the patient
- The behavior of staff to the patient should be courteous and humble.
- If there is need of counselling, then there should be proper separation of room for the counselling of patient.
- The primary treating consultant can refer the patient to other clinical specialty either within the hospital or to the identified external healthcare institutions if the patients' medical need demand the same

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

- Convert information need into answerable questions.
- Track down the best evidence to answer the question (with maximum efficiency).
- Critically appraise the evidence for its validity and usefulness.
- Integrate appraisal results with clinical expertise and patient values.
- Evaluate outcomes.

Maintenance of Patient Records & information Policy

The Primary objective of the Medical Record Department is to develop good Medical Records containing sufficient data written in sequence of events to justify the diagnosis, treatment and end result of all patients treated in a hospital, keep them under safe custody and make the readily available as and when required for

- The Patient
- The Doctor
- Hospital Administrators
- Medico Legal Purposes
- External Reporting
- Study purpose

A. For Patient, it

- Serves to document the clinical history and activities of patient treatment.
- Serves to avoid omission or repetition of diagnostic and therapeutic measures.
- Assists in continuity of Care even in future illness whether it requires attention in or out of the Hospital.
- Serves as evidence in Medico-legal Cases.
- Give necessary certification for employment purposes.

B. For the **Doctor, it**

- Assures quality and adequacy of diagnostic and therapeutic measures undertaken.
- Serves as an assurance of continuity of medical care.
- Evaluates Medical Practices.
- Protection in litigation.

C. For Hospital administrator

- To document the type and quantity of work undertaken and accomplished.
- To evaluate proficiency of Medical Staff for administrative and clinical purposes.
- To evaluate the services of the hospital in terms of accepted norms and standards.
- To serve as an Administrative record and Performance.
- To assist in futures Programmers for Planning and developments of hospital.

D. For Medico Legal Purposes, it serves

- As a documentary evidence
- To dispose claims of the Insurances.
- For Patient's WILL to indicate if the patient was of normal mental state or not.
- Malpractice Suits.
- Authorization for operation etc. signed document for consent for operation will prove that the Patient / Relative have allowed the performance of such Procedure.
- Criminal cases - as a Potential Document.

E. Development Of Hospital Performance Statistics

Statistical and epidemiological Data are needed to implement and manage medical care planning and to obtain Health Indicators to monitor and evaluate their effectiveness for Hospital Management as follows:

- Bed Occupancy Rate
- Average No. of Out Patients
- Average No. of Admissions
- Sex wise Admissions
- Total Number of Deliveries in a hospital. (Sex wise distribution / sex ratio/ Still Births.)
- Average Length of Stay of Patients.
- Gross and Net Death Rate.
- Number of Types of Operations performed (Major & Minor)
- Number of X-ray / C.T.Scan, Ultra Sound etc.
- Laboratory Tests.
- Information about Institution Deaths (Deaths occurring over 48 hrs.)
- Non Institution Deaths (Deaths occurring under 48 hrs.)
- Daily Census of the Hospital.

F. Reporting to Health Authorities

This is the responsibility of the department to submit the following Diagnostic Reports to Health Agencies like DHFWS, Deputy Director(FW&MCH), NHM and Government of India.

- Daily / Weekly / Monthly Malaria and Dengue Fever cases to the Assistant Director, NVBDCP.
- All Communicable Diseases to the Director, DHFWS.
- Notifiable diseases are reported immediately to control room to Deputy Director(Public Health).
- Monthly Leprosy Cases to Asst. Director, NLEP.
- Morbidity / Mortality Statistics to the Directorate, on yearly basis or as and when required by the Directorate of Health and Family Welfare Department Government.

G. Process of Creating Medical Records

Medical Record contains different sections for recording the information as

- Identification Section
- Medical Section
- Nurses Section.

All entries made in the medical and nursing section of the patient record are entered by authorized care providers who authenticate the entries made so as to facilitate identification of the particular author of patients' medical records.

1. Identification

This section fills up the Bio Data / Socio economic data / Patient Identification Data at the time of Registration and Admission.

OPD file is generated at OPD registration counter; on the Admission Request of the Consultant Indoor patient Admission record is prepared.

Personal data for following particulars are provided at OPD registration and Admission counter by the Patient / Relatives.

- Name of Patient
- Father's / Husband's Name
- Age & Sex
- Occupation
- Permanent / Emergency Address.
- Telephone / Mobile Numbers
- Nationality
- Religion
- Aadhaar Number
- Medico Legal Case if any.

These details are filled in the register manually and the patient is given a unique identification number which is entered in the designated area of the patient.

2. Medical Section

The Medical Section is filled up by the Attending Consultant, and pertains to History, Physical examination, Diagnosis/ Treatment / progress of the patient, if operation is to be performed, then Indication For Surgery/ surgery notes are also recorded, the information is recorded in the following Medical Record Forms, keeping in view two types of forms - Basic + Special

Basic-

- Initial diagnosis Record Sheet
- History Record Form
- Physical Examination Record Form
- Progress And Treatment Record Form
- Consultation Record Forms (special)
- Different Investigations Report Forms
- **Registers**

In Special cases-

- Consent Forms, Operation Record Form.

Discharge summary is given in case of Discharged - cured, LAMA - Discharge on request. A copy of the same is preserved in the patients medical record.

Incase of death, Medical certification of cause of death forms is to be filled up by the attending consultant or emergency medical officer according to Registration of Birth and Death Act 1969. A copy of the Cause of Death Certificate is preserved in the patient's medical records file.

3. **Nurses Section**

The Nurses Section is responsible for filling up the following

- Medication Record Forms
- T.P.R. Chart.
- INTAKE and OUTPUT Record Form.
- Diet sheet

Flow of Medical Record from Admission to Post Discharge

- The Medical Record Department ensures a smooth flow of Medical Record of the patient from the day of his admission to the day of his discharge and onward maintenance till the retention period.
- Admission request form is filled by the treating doctor of the patient. Formalities for admission of the patient is carried in the registration counter (during working hours) or in the emergency department of the hospital (during non peak hours) .The general inpatient case sheet for patients is prepared at the time of admission in the respective inpatient admission counters.
- All data pertaining to the patients stay in the hospital and care provided are preserved in the patients bed head ticket which is maintained by the nursing staff of the concerned ward where the patient is admitted, all entries made in the Bed Head Ticket is recorded in a chronological manner and authenticated by the designated author of the particular entry clearly mentioning the time and date of the entry.
- After getting the orders of discharge of the patients from the treating Consultant, the Nursing Staff, on duty get the discharge summary prepared from the Consultant /Medical officer, the slip is sent to the Billing Department for necessary payment .(paying wards).
- Necessary payment done at Billing Department and receipt is given to patient relative. Nursing staff discharges the after getting clearance slip from billing department. Patient file is sent to medical record room.
- In case the patient is transferred or referred to another hospital the medical record contains information regarding reasons for transfer, name of the hospital where the patient is being transferred

Midnight Census :

Ward Census Reports from each ward is generated by nursing staff at night duty.
The reports are submitted to the Nursing Superintendent, Resident medical officer and Medical Superintendent by the duty nursing supervisor.
The record clerk collects the data from the Emergency Department the next morning and compiles the same for preparing the census report.

H. Confidentiality and Integrity of Record:

The hospital identifies its responsibility as custodian of medical records and observes the following procedure to maintain its confidentiality, security and integrity:

1. Patient is the owner of his medical record and no form of it would be made available to any third party without written authorization from the patient. The hospital observes the following guideline instruction for the purpose:

Retrieval / Accessibility of Medical Record:

- Maintain records in proper accessibility manner.
- Hand over the records as & when required for administrative purposes by getting slip signed by the person receiving the record.
- Physician / Surgeon for follow up purposes by getting permission from MS/RMO and get the records.
- Records required for Medico Legal Cases in the Court of Law by the Consultant / M.O.'s for Follow up of In-patients by the Consultants as well as by the Patients, as & when they require Discharge Summary, Investigation Reports etc.
- Patients' relatives will require a written authorization from the patient for obtaining information from the medical records. However such information would not be given in original, a xerox of the same would be handed over to the patient and signature taken in specific format.
- Incase loss or tampering of patient's medical record data is reported, the medical record clerk would immediately inform the same to the Medical Superintendent who would be responsible for taking appropriate action. He/She will inform the external agencies as applicable and would hold an internal enquiry for investigating the cause for such event. He/She would form an internal committee under the Medical Superintendents (M & F wing) officer who would hold the enquiry in reality and would submit the report to the Medical Superintendent as per the committee's finding for further action.
- Incase the internal committee confirms any sort of negligence or discrepancy on part of any hospital employee, Medical Superintendent would inform the same to higher authorities of the Health and Family Welfare Department for further action .
- The hospital maintains separate colored Inpatient/Outpatient medical record for the as per the policy of the Health and Family Welfare Department, Government of Puducherry.
- The Medical Record Department is responsible for proper storage, retrieval and maintenance of confidentiality and security of the record. During normal working hours it is the policy of the hospital to have at least one staff available in the department.
- At the end of the day medical record clerk is responsible to lock the department in the presence of a security staff .The key is handed over to the concerned security staff. There after the security department is made responsible for the protection of the medical record room.

Retention Policy :

- Policy : The Department is responsible for consolidation of all Forms belonging with patient is sent for storage in a manner with the help of Admission Number, which is assign at the time of Admission. These records are stored in the Medical Record Departments for the following Retention Period as per the Govt. Orders

  In - Patient Record : Ten (10) Years.
  Out- Patient Record : Five (05) Years.
  Medico Legal Record : Life time

2. Security :
   a. Access to Medical Records Department is limited to only person authorized department staff.
   b. Incase any record is issued to any designate individual as per the retrieval policy; the
      same is recorded in the outgoing patient record entry register for accountability.
   c. No form of record is issued to any person without proper authorization from the designated authorities.
   d. During non-working hours the security staff in responsible for safety of the department.
3. At the end of the designated retention period the medical record clerk will seek written approval from the Medical Superintendent for destruction of the medical records who have crossed the retention period. Only after obtaining written from the designated hospital authority, the medical records will be destructed by the department staff.

J. Medical Audit :

A. Medical Audit Committee:

Scope of Work: Evaluate medical record keeping, quality, content, format, accuracy, pertinence, staff compliance with documentation policies .Review and evaluate fatal cases/ Deaths in hospital.

Frequency of meeting: Quarterly/ as required

B. Members of the Committee:

1. Medical Superintendent
2. RMO
3. Doctor from Anesthesia
4. Doctor from Gyneac Department
5. Nursing superintendent
6. Medical Record Clerk
7. Quality Assurance person

Process:

The Medical Audit Committee meets at periodic interval to evaluate the patients' medical records. The Committees reviews both active and discharged patients in order to have an objective review of the completeness of patients' record.

C. Purpose and Objective of the Committee:

The committee periodically evaluates the medical record

- To review the completeness of the patient's records in the Medical Record.
- To see that all records are dated, timed and legibly signed by the persons authorized to make entries in patient's records.
- To review that the patients record contains all the necessary documents (as applicable)
- To identify any discrepancy in the records such as absence of date, time or signature, lack of proper documentation or incomplete record etc
- To instruct the medical record department to rectify the deficiency on an immediate basis.
- To provide guideline instruction for better management of patient's medical records
  The minutes of the meeting are recorded in the minutes in order to trace the points discussed in the meeting , decisions taken , discrepancy if any in patient's record noted, remedial measures suggested , actions taken etc. In case the committee issues any sort of instruction relating to the patients record, the progress on the same is reviewed at the next meeting.

Privacy of Patient with Social Stigma Policy

Hospital shall follow guidelines for Privacy of patients with social stigma.

- Confidentiality means that personal information is private, and may not be shared without permission of the patient
- Separate room availability for counseling of HIV/or any other serious disease which will be a stigma
- Health care, social service providers and clinical laboratories are required to report the names of people with HIV/AIDS/other serious disease to the concerned Assistant Director / Deputy Directors of the Health Department.
- The in-charge of the concerned Departments is required to keep HIV/ other serious disease reports confidential, and the reporting of HIV test results is intended to help keep better track of the epidemic.
- The in-charge of the concerned Department reports how many people have HIV/AIDS/other serious disease and other non-identifying information to the State Health Department.
- Allows patients to determine how their personal health information is used and disclosed.
- Protects the privacy of patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers.
- Provides patients with access to their medical records

Confidentiality

It relates to the right of an individual to the protection of their health information during investigation, examination, storage, transfer, and use, in order to prevent unauthorized disclosure of that information to third parties.

Security

It consists of the protections or safeguards put in place to secure protected health information (PHI). It requires that administrative, technical, and physical safeguards are developed and used.

Consent Policy

Hospital ensures that patient and his/her family members participate in her healthcare decisions Voluntary, Informed, written Consent is taken by the Doctor/ Nurse on duty - A patient's consent is informed:

The patient is given sufficient information so that she understands her condition, purpose and nature of the proposed treatment, the risks and consequences of the procedure/ treatment and the prognosis.

- General Consent :
  When the nature and probable risks of the procedure or treatment is general to all.

- Implied Consent in a Medical Emergency:
  Consent in emergencies may be implied if the condition of the patient precludes his/her ability to make a decision regarding treatment or procedures. A medical emergency is a situation where delay for the purposes of obtaining consent may reasonably be anticipated as endangering the life of the patient or significantly increasing the harm to the patient's health.

- Consent from patient attendant
  The priority order of is as follows: spouse, adult children, parents, adult brothers or sisters, adult grandchildren, significant other (close friend). A close friend may sign the consent form only in an emergency.

Policy Guidelines:

- **General Guidelines :**
  Written "informed consent" using the relevant Consent Form shall be obtained in the following instances:

  I. All procedures performed in the Operating Theatres / Delivery Rooms.
  II. Non-routine diagnostic or therapeutic procedures performed in the hospital and not having a specific consent form. Example:
    - Any procedure under any form of anesthesia
    - Normal Delivery with episiotomy
    - Forceps/Ventouse application
    - Blood transfusion

- Caesarean Section and Caesarean section with Sterilisation
- MTP/D&C/Instrumental Evacuation
- Medical Abortion
- Diagnostic Laparoscopy / Chromotubation / Hysteroscopy
- Lap ligation/Minilap
- Gynecological Surgery – D&C / Fractional Curettage / Cervical Biopsy / Hysterectomy (Vaginal/Abdominal)

Specific Guidelines

The treating Consultant shall discuss in lay terms about the procedure, its risks, benefits, costs (if applicable) and alternatives with the patient or the patient's surrogate decision maker. The Consultant shall document the discussion by obtaining the patient's or her attendant's written informed consent on the appropriate form.

The patient shall sign the consent form. An attendant may sign the consent on behalf of the patient if :

- The patient is a minor (less than 18 yrs of age).
- The patient is mentally incapable of making an informed consent.
- The patient is unconscious.
- The patient has received sedation within 3 hours.
- The patient is physically incapable of signing the form.

a. It is the responsibility of the person obtaining the consent to ensure that the consent form shall be properly filled prior to signing.
b. All entries shall be in ink.
c. Attendant's relationship to the patient shall be recorded.
d. The date and time of signing shall be clearly indicated.
e. The consent form must be signed by the Operating Surgeon, Anesthesiologist, patient or his decision maker and the witness prior to entry into the Operation Theatre.
f. If the Consultant or the Anesthetist's signature is not there on the consent form, the procedure shall be postponed or cancelled.
g. A patient or her attendant may revoke the consent for the procedure at any time before it is carried out. In such an event, the Consultant shall discuss the procedure again and if refused, the procedure shall not be carried out and a note to this effect should be added which should be signed by the patient/ attendant.

Consent Forms:

- ✓ General informed consent on admission.
- ✓ Informed consent for Anesthesia.
- ✓ Informed consent for Surgery.
- ✓ Informed consent for HIV testing.
- ✓ Informed consent for blood transfusions.
- ✓ Authorization for medical and / or surgical treatment and / or procedure .
- ✓ Informed consent for Radiology procedures .
- ✓ High risk consent form .
- ✓ Informed consent for Non-invasive investigations.
- ✓ Informed consent for High Risk Ante Natal Mothers.

CHANGE OF LINEN IN PATIENT CARE AREA POLICY

To provide process, instructions and methodology for Management of Laundry process in the hospital with the aims that

- ✓ Safe and dependable supply of clean linen
- ✓ Safety to workers
- ✓ Minimization of inventory loss

A. Collection of Laundry Items:

Soiled linen is collected and fetched from various departments by the housekeeping staff , register is maintained by Nurse in charge. The linen consist of

- Bed linen
- Body linen
- Operation theatre linen
- Staff linen
- Department/service linen.

After linen is collected, these are segregated as linen contaminated with body fluids and soiled linen and record of this maintained. Aprons, staff uniforms etc are kept separate from the other linens and are packed separately.

B. Disinfection of the linen:

Linen from Labour Room, OT, wards etc. soiled with blood and other body fluids are washed in the pre-wash area of the hospital for removal of the stain after decontaminating with 0.5% chlorine solution for ½ hour.

C. Collection of Linen for Washing:

After Decontamination the linen is transferred to the Laundry of the outsourced Department.

The Senior Nursing Officers of the respective wards is responsible for keeping an account of the number and type of linen taken for washing. A register containing details regarding the type of linen, their number, respective ward/unit from where they are collected etc.

D. **Delivery of Washed Linen:**

The washed linen are delivered by the housekeeping staff of Laundry department to the respective wards.

The Senior Nursing Officer in charge is responsible for physical verification of the linen at the time of delivery by cross matching the same with the details entered in the concerned register. This is done to ensure that there is no discrepancy with the number , type of linen and their condition etc as entered in the register while collection of the same by the outsourced agency for washing.

E. **Condemnation of Linen**

The damaged linen is returned to the user departments by the housekeeping staff of the hospital and record of the same is entered as "For Condemnation".

1. The Laundry Condemnation Committee:

- Medial Superintendent
- RMO
- PRO
- Nursing Superintendent
- Head Nurse in charge of Linen
- In charge clerk General store
- Housekeeping in-charge

F. Condemnation Procedure:

- The committee will meet once the identification and segregation of torn, unusable badly soiled linen comprising of bed sheets, pillow covers, gowns, draw sheets, towels, blankets, shoe covers is complete.
- The committee will inspect each and every item of linen meant for discard and recommend for their condemnation and replacement.
- List of items approved for condemnation has to be prepared by store keeper in-charge for linen.
- The committee will be empowered to approve the condemnation of linen.
- At the time of purchase of linen, the life of each category of linen items should be procured from the supplier. This will be a mandatory provision while placing the purchase orders. Linen items approaching expiry should be segregated and inspected by the committee to decide further course of action; i.e. whether to write off or recommend their use for further specified time.
- A condemnation certificate will be issued by the committee duly signed to the laundry section. After getting the certificate, the stores section will be requested to take appropriate steps for the proper disposal of the condemned linen.
- The laundry and purchase sections should ensure procurement of good quality detergent, soap, bleach, etc. to avoid undue damage to the linen.
- Replenishment of linen items condemned by the committee should be immediately done by the general stores in order to maintain adequate inventory level and to ensure smooth functioning of the hospital services.

G. Linen Store:

1. Departmental Activity:

a. Accountability:

A laundry stock register is maintained which contained details regarding the linen stock of the hospital.

A laundry issue and receipt register is maintained to keep a track of all items collected for washing by the outsourced agency and delivered back after washing.

A department issue a receipt register is maintained for accountability of the soiled linen received from the various department unit of the hospital and the delivery of the washed linen to the respective user departments.

b. Cleaning and Dusting

The Housekeeping department is responsible for preserving clean environment within the linen store.

Regular cleaning and dusting of the department is done twice a day by the housekeeping staff.

c. Indenting of Linen requirement:

- Indent request for new linen requirements are forwarded to the in-charge of general store by the NS of linen store.
- The in-charge general store will forward the request to the purchase committee for approval.
- Only after the consent of the purchase committee, procedure for purchase of the linen will be initiated by the in charge of general store.

JUDICIAL USE OF PPEs POLICY

This policy has been developed to give clear guidance to staff in relation to the procedure for the use of Personal Protective Equipments (PPEs). It describes the process for ensuring the delivery of effective infection prevention and control, Education and training for all relevant staff groups.

Personal Protective Equipment (PPE) means all equipment which is intended to be worn or held by a person to protect them from risk to health and safety while at work.

Examples of PPE include: protective footwear, gloves, mask, apron , googles, ,face protection.

Objectives:

- To ensure appropriate PPE is identified to minimize the hazards not able to be controlled by elimination or isolation.
- To ensure adequate training in the use of PPE is provided.
- To monitor the use of PPE and evaluate effectiveness.
- To be used in all patients who need Universal Precautions.

PRESCRIPTION BY GENERIC NAMES POLICY

This policy has been developed to give clear guidance to concern Doctors for ensuring that drug name should be written in generic name for the patient.

- The drugs prescribed to the patient should be in generic name.
- Any drug if antibiotic, antihistamine, hypertensive, or any kind of drug should be written in generic name like Paracetamol 500mg bid for 2 days not like brand name 500mg.
- Medication order should be clear and Readable form not in running hand for easy understanding to the staff and pharmacist. Prescription should be written preferably in capital letters.
- There should be regular interval of audit for prescription i.e. Prescription Audit.
- Medication order should have Date and time mentioned on the OPD slip and Indoor Bed Head Ticket.
- Route, dosage & frequency is also mentioned on the OPD slip and Indoor Bed Head Ticket.
- Drug should be relevant to the disease and condition.
- Prescription and medication order should be signed and named.
- Staff should have to write medicine in generic name for medicines if writing on different paper for providing medicine from outside or inside the hospital.
- Pharmacist should have to inform to the concerning doctor and staff if writing in an brand name for follow up of policy.
- There are a few circumstances when it is appropriate to prescribe a specific manufacturer product (Branded or generic). These include –
    - Drugs with narrow therapeutic index
    - Certain modified or controlled release drugs
    - Certain administration devices
    - Multiple ingredient products
    - Biological drugs including bio stimulants
    - Drugs with different licenced indications
    - Ensuring adherence to long term medication where difference in appearance between manufacturing products might cause confusion

REPORTING OF ADVERSE EVENTS POLICY

1.0 PURPOSE:

The Purpose of this policy is to define adverse events, identify those who can report adverse events, identify what should be reported, Reporter's and Manager's Responsibility, Reporting format, Frame-work for Root Cause analysis, and common database to be created of the reported events.

2.0 SCOPE:

The policy applies to all the clinical specialties, including operation theatre, ICU's, Inpatient area as well as all the clinical support services such as Radiology, Laboratory, Pathology, Pharmacy, and all the other allied support services.

3.0 RESPONSIBILITY:

Nurses, Doctors, Support staff, Management

4.0 DEFINITIONS:

Adverse Healthcare Events: A clinical event that results in unintended harm to the patient by an act of commission or omission rather an underlying disease or the condition of patient resulting in physical or physiological injury to the patient.

Adverse Health and safety events: These are defined as non-clinical events or omissions that cause physical or psychological injury to any person on the premises, such as verbal and/or physical abuse, theft, sharps injuries, falls etc.

Other Adverse events: These are other non-clinical incident such as fire, security event, equipment failings, service disruptions, utilities failure, that cause loss or damage to persons in hospital or affect the ability of the hospital to meet service delivery targets in any way.

Near Misses: Apply to all the above categories. A Near miss is defined as an act of commission or act of omission that could have harmed the patient but did not do so as result only by the virtue of good luck, skillful management and/or prompt evasive action. Eg: the patient received a contraindicated drug but did not experience an adverse drug reaction, prevention (a potentially lethal overdose was prescribed, but the nurse identified the error before administering the medication) or mitigation (a lethal overdose was administered but countered with an antidote).

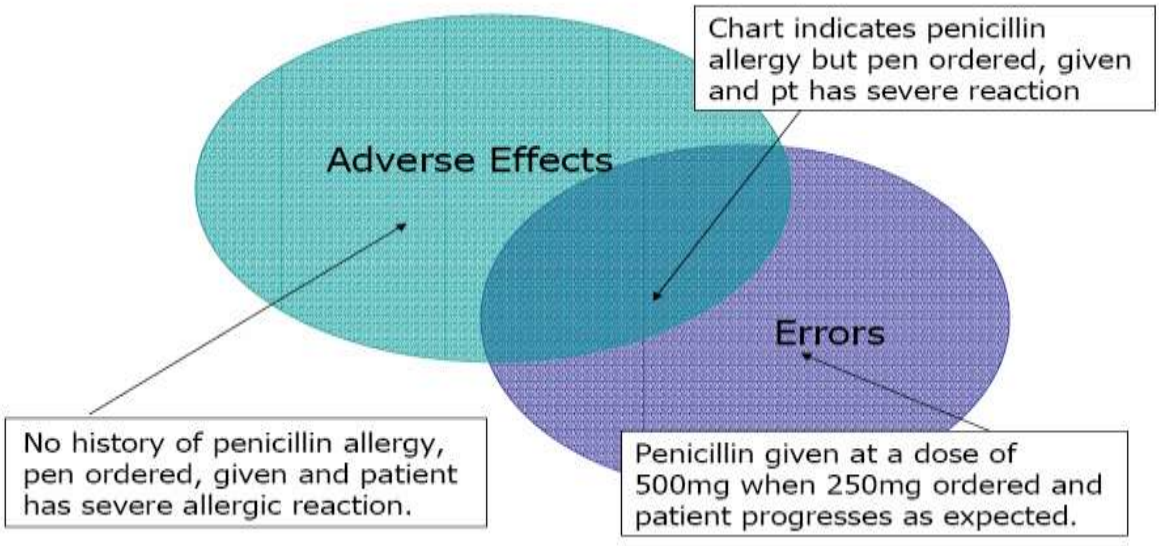
Sentinel event: A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury or risk thereof. Serious injury specifically includes loss of limb or function. Such events are called sentinel event because they signal the need for immediate investigation and response.

Medication Error: Medication error is a part of Adverse Healthcare event. Any Preventable event that may cause or lead to inappropriate medication use or patient harm, while the medication is in control of the staff. Such events may be caused by gaps in prescribing orders, labeling, packaging and nomenclature, dispensing, or administration etc.

Adverse Drug Reaction: Adverse Drug Reaction is a part of Adverse Healthcare event. An Adverse drug reaction is any noxious, unintended, undesirable, or unexpected response to a drug that occurs at doses used in human for prophylaxis, diagnosis or therapy, excluding therapeutic failure.

Act of commission: e.g. prescribing a medication that has a potentially fatal interaction with another drug the patient is taking.

Act of Omission: e.g. failing to prescribe a medication from which the patient would likely have benefited.



SENTINEL Adverse Events that **MUST** be reported **IMMEDIATELY:**

(The list is indicative, and any other incidents serious incidents not included below are also to be reported immediately.)

ENVIRONMENTAL EVENTS

Patient death or serious disability associated with:

- An Electric shock
- A burn incurred while being cared for in a facility
- A fall while being cared for in a facility
- The use of or lack of restraint or bedrails while being cared for in a facility and An incident in which a line for oxygen or other gas to be delivered to patient contains has wrong gas or is contaminated by toxic substances.

CRIMINAL EVENTS

- Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist or other healthcare staff
- Abduction of patient of any age;
- Sexual Assault on a patient within or on the grounds of a facility; and
- Death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility.
- Suicide by any individual receiving care, treatment or services in the hospital or within 72 hours of discharge:
- Rape

CARE MANAGEMENT EVENTS

Patient death or serious disability:

- Associated with a medication error
- An individual fall that results in death or major permanent loss of function as a result of direct injuries sustained in the fall.

List of other Incidents, Events and Near Misses

Clinical:

- Medication errors
    1. wrong dose
    2. wrong drug
    3. wrong infusion rate
    4. extra dose
    5. over dose
    6. missed dose
    7. IV infiltrations
    8. wrong patient
- Any other kind of Patient Identification problems

- Radiological errors

    1. Wrong radiological investigation been carried out
    2. Wrong amount of exposure to X-rays been used
    3. Wrong patient
    4. Overdose of X-rays been used to carry out an investigation

- Wrong or missing documents (e.g. notes) with direct consequences of care

- Prescribing errors

    1. dose
    2. drug
    3. route
    4. patient

Non Clinical:

- Chemical Spillage
- Equipment failure (critical equipment failure in OT , ICU or in Inpatient area)
- Fire
- Security incident
- Sharps incident
- Needle Stick Injuries
- Slip/trip/fall
- Theft

Adverse Event Reporting:

Adverse events will be reported by the Doctors, Nursing Staff and support staff as and when the adverse events occur in their area of work or department.

What should be reported?

- **Any Incident or event** that results in actual harm (physical or psychological) damage to a Patient or Individual should be reported.
- **This includes ALL Side effects/reactions to medications.**
- Near Misses that had the potential to result in harm or damage to the patient or staff should also be reported. The Staff should use their professional judgment and common sense.
- The Nosocomial Infection reporting is dealt with elsewhere.

Adverse Event Reporting Form:

The Adverse Event Reporting Form will be available in all the departments of the hospital.

REFERRAL OF PATIENTS IF SERVICES CANNOT BE PROVIDED

This policy has been developed to give clear guidance to concern Doctors to referring the patients to Higher facilities.

Following categories of patients are being referred

- Extremely complicated obstetric cases
- Neuro cases requiring surgery due to non availability of Neuro surgeon
- Patient requiring cardiac consultation due to non availability of cardiologist
- Urology cases
- Orthopedic cases required major surgeries.
- Psychiatric cases
- Opthomology cases required surgery

Referral Hospital: IGGGH&PGI, Puducherry / JIPMER, Puducherry

Mode of Transport :

- Ambulance being provided to the patients for referral to ensure smooth transport of the patients.
- Doctor (Junior Resident) and Paramedical Worker accompany
- Referral Protocol is followed
- Suitable Tertiary Centre contacted to ensure bed availability as well as to alert the facility regarding the shifting of patient
- A well written referral slip with all the details filled in is sent with the patient.
- The Hosptial staff will wait until the admission procedure is completed
- Referral Register detailed entry is made
- Follow-up of the patient is done and recorded in the Referral Register
- Referral Audit is carried out monthly or quarterly according to the number of cases. There is a Referral Audit Committee and the Assistant Nursing Superintendent is the Member Secretary.
- Monthly Referral statistics are calculated and compared with benchmark and is available in the MRD.

CONSULTATION OF PATIENTS WITHIN HOSPITAL

To provide guidelines/ instruction regarding the Consultation of patients within Hospital

Policy:

New Patient:

- Patients intending to consult the OPD clinic of any consultant of the hospital are required to get Registered prior to the consultations or Online Registration to avoid time lapse.
- Patient will attend the OPD registration desk for new patient registration and wait for their respective turn in the Lobby.
- As their turn comes patient will inform the following details to the registration clerk:
  - Name of the patient
  - Age , Sex and demographic details of the patient
  - OP clinic intending to consult will be guided by the registration clerk
- Patient is allotted an OPD registration number (UHID No.) / Patient OPD ticket is prepared.
- The OPD Ticket along with OPD case sheet is handed over to the patient.
- The OPD number of a particular specialty is indicated in the OPD Ticket of the patient.
- After Consultation, if admission is required IP case sheet will be made by the Casualty Medical Officer. The Nursing Officer and the Ward Attendant will guide them to the concerned Wards.

HANDOVER DURING INTERDEPARTMENTAL TRANSFERS POLICY

This policy has been developed to provide instructions to Inter Departmental Transfer of patient.

Policy:

a. All patient approaching the hospital will get appropriate care and receive all necessary investigation at the point of treatment
b. Patient like in Emergency / ICU/ SNCU and after treatment patient condition is in normal condition then shifting of the Patient will be required and after shifting of the patient whole condition of the patient should be explained to the receiving staff of the next department
c. In Handover should have to explain :-
   - Disease of the patient
   - Treatment given in previous department
   - Present status of the patient
   - Pending medicines of the patient
   - Pending investigation of the patient
   - Precaution for the patient should be explained which will be follow in next department
   - If the patient are not feeling well then shift the patient on urgent basis in the previous department
d. Quality of medical care will be same in all care settings of the hospital and no discrepancy of any sort will be followed in the provision of medical care.
e. All treatment orders would be signed, dated and timed by the concerned clinician. Any treatment order initiated by a hospital's clinician different from the primary treating consultant of the patient will be countersigned by the primary treating consultant within 24 hours.
f. Incase required the primary treating consultant of the patient may consult other care providers available within the hospital for patients care related issues.
g. Patients response to treatment ,his /her health status , further treatment plan etc will be discussed among the clinical and nursing staff involved in provision of care to the patient

h. The primary treating consultant can refer the patient to other clinical specialty either within the hospital or to the identified external healthcare institutions if the patients medical need demand the same

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

- Convert information need into answerable questions.
- Track down the best evidence to answer the question (with maximum efficiency).
- Critically appraise the evidence for its validity and usefulness.
- Integrate appraisal results with clinical expertise and patient values.
- Evaluate outcome

INTERNAL ADJUSTMENT IN CASE OF NON AVAILABILITY OF BEDS

The purpose of this policy and its supportive guidelines is to ensure safe and appropriate internal adjustment of patients in case of Non Availability of beds in the hospital.

The aim is to clarify the clinical accountability of the nursing staff, medical team and supportive staff who are responsible for the patient's care to ensure that safe, appropriate transfer of patients does occur and their care continues with minimal interruption and risk.

Policy :

- Extra Camp / Folding Bed availability should be there in facility for handling Disaster and over Patient in the facility
- Check whether if there is any Patient in the hospital who will be easily treated at home or who were less ill and can be treated on oral medication, and make a counselling for early discharge for a needy person to get treatment on that bed
- **In Emergency and ICU department**
  If there is non-availability of beds then with the consultation of the treating doctor if any patient is towards normal condition will be shifted to wards.

TRANSFER OF PATIENT TO OTHER HOSPITAL:

a. Non Availability of Required Medical Treatment

In case the patient is to be transferred to the Medical College and Hospital etc. due to non-availability of Medical Services of a particular specialty medical treatment, the on duty medical officer informs the patient's relatives and makes necessary arrangement for ambulance and staff required for transferring the patients. Prior to the transfer of the patient the Medical Officer informs the other hospital/Medical college about the shifting of the patient to their facility. Referral Slip containing information pertaining to the patients complain, diagnostic made and treatment given is prepared and given to the attendant accompanying the patient. Usually a nurse accompanies the patients to the other hospital, in case of critical patients, a medical officer along with a nurse accompanies the patient.

b. Transfer on Request

In case patient or his relative decide to transfer the patient to other hospital for further treatment, the Patient / relations are explained about the condition of the patient and the risk involved in transferring the patient. Consent is taken and the patient is transferred to other hospital in the hospitals Ambulance or outside Ambulance as per the patient wish.

If the patient condition is critical, the doctor accompanies the patient to other hospital and discharge on request summary is given to the patient .The nursing staff has to ensure that the patient is received by the hospital transferred to and adequate arrangement has been made for the admission of the patient in the transferred hospital.

DRESS CODE POLICY

Hospital shall follow the Dress code to differentiate the employees and inculcate a sense of uniformity & dignity.

The following is the dress code followed at the hospital

- All the clinicians and doctors should wear white apron.
- Nursing Superintendents – White saree with Apron
- Senior Nursing Officer– White saree with Apron
- Nursing Officer /ANM- white salwar with apron and batch with designation.
- Pharmacist & Lab technician – White apron
- Nursing Orderly – female - White Saree with green border / white blouse
  Male – White pants / white shirt
- Ward Attendants – Female – White saree with blue border/ white blouse
  Male – White pants and White shirt
- Multi Tasking Staff (General/Security) - Female – Blue saree/White blouse
  Male – Grey pants/White shirt
- Female security guard – Kaaki saree with white blouse.
- Male security guard - Blue shirt with navy blue pant/Brown pant and cream shirt.
- Housekeeping staff – green paijama with over coat

NARCOTIC DRUGS AND PSYCHOTROPIC SUBSTANCES POLICY

As per the Narcotic and psychotropic substances Act 1985, Hospital shall follow certain rules regarding use and storages of narcotic drugs.

Narcotic drugs used include:

- Inj. Fentanyl
- Inj. Pethidine
- Inj. Morphine
- Inj. Pentazocine

- The Narcotic drugs shall be procured from Chief of Government Pharmacy on a yearly basis after submitting the annual requirement.
- The drugs procured should be stored in a separate cupboard with double lock and key and dispensed under the direct supervision of the RMO of the Hospital.
- The drugs shall be issued to Operation Theatre, PICU, NICU, SNCU, CLR, Post Operative Ward after receiving the indent from the Head of the Departments.
- Stock Register and Issue Register shall be maintained by the Chief Pharmacist.
- Monthly utilization report mentioning the name, sex, age, address and aadhaar number of the patients shall be submitted by the Head of the departments and shall be forwarded to the Chief of Government Pharmacy.
- Empty vials/ampoules should be returned to the Pharmacy Store.
- The Chief Pharmacist shall dispose the empty vials after one year as per the guidelines issued by the Drug Controller.
- Records for receipt, issue and balance should be maintained and monthly statement of utilization should be submitted strictly on or before 5^{th} of every month to the Chief of Government Pharmacy and the department of Drugs Control.

Hospital shall follow the rules to use of narcotic drugs.

- A prescription by the doctor is necessary to dispense the drugs
- In Operation Theatre Anesthetist & Nurse in-charge shall hold the responsibility
- In regular pharmacy the pharmacist holds the responsibility.
- In Intensive Care Wards, the Head of the Department and Senior Nursing Officers shall hold the responsibility.

POLICY OF AVOIDING STOCK OUTS OF DRUGS AND CONSUMABLES AND ENSURING AVAILABILITY OF DRUGS AS PER EDL

Hospital shall follow the new guidelines from government of India / Puducherry,

Using computer based indenting, the drugs near stock out & near expiry will be visible in a separate colour & indenting can be done based on the expiry and stock out.

POLICY FOR REGULAR COMPETENCE TESTING AS PER JOB DESCRIPTION

Hospital provides regular trainings like CMEs and CNEs. Programmes are being conducted for doctors to improve the knowledge & acquire new developments in the field. Hospital provides training to Nursing Officers in skilled Birth Attendant, NSSK, BLS . Trainings are conducted for all category of staff in the field of Kayakalp and Quality Improvement of the hospital and also as per job description. For training purpose, a questionnaire is provided at the beginning and at the end to ascertain the knowledge. OSCE is conducted every year for all staff of this Institution and grading given.

TIMELY REIMBURSEMENT OF ENTITLEMENT AND COMPENSATIONS

- **Timely Reimbursement & compensation**
- **Free Treatment for BPL**

All monetary compensation done by DBT
Under the JSY Scheme -

1) Only for BPL & SC Category - Belonging to the Union Territory of Puducherry
2) Irrespective of the order of delivery
3) Both live / Still birth within Puducherry. (Govt. and Pvt. Hospital deliveries) –
4) Rural – Rs 700/-, Urban Rs. 600 /- (Based on the registration of the Tracking card Pregnant Women)

Under the JSSK Scheme -

MOHFW Provides facility for free and cashless services to pregnant Women including normal deliveries, C-Section and Sick New Born (up to 30 days after birth) in Government Health Institutions in both Rural and Urban. [JSSK Launched in 1st June 2011]

The following are the Free Entitlements for Sick New Born till 30 days after birth. This has now been expanded to cover Sick Infants.

1) Free Treatment
2) Free drugs and consumables
3) Free Diagnostics
4) Free Provision of blood
5) Exemption from user charges
6) Free Transport from home to health Institutions
7) Free Transport between facilities in case of referral
8) Free drop back form Institutions to home

The following are the Free Entitlements Pregnant Women :-

1) Free and cashless delivery
2) Free C- Section
3) Free drugs and consumables
4) Free diagnostics
5) Free diet during stay in the health Institutions
6) Free Provision of blood
7) Exemption from user charges
8) Free Transport from home to health Institutions
9) Free Transport between facilities of case of referral
10) Free drop back from Institutions to home after 48 hrs stay

*[Paid Rs. 500/- each for BPL & APL category only for Puducherry beneficiaries]

STERILIZATION COMPENSATION AND INDEMNITY

Under the National Family Planning Programme the Government has been implementing the Scheme to compensate sterilization beneficiaries for the loss of wages, for the period required for recuperation following sterilization.

All transactions to beneficiaries by DBT

For Female Sterilization

A sum of Rs. 600 is given for BPL beneficiaries

A sum of Rs. 250 is given for APL beneficiaries

For Male sterilization

A sum of Rs. 1500 is given to all categories of beneficiaries.

For Female sterilization – A follow up after 1 month and after the 1st period following sterilization is emphasized. Urine pregnancy test is performed, the sterilization scar is checked, any complaints/health issues are addressed and the compensation is given.

For Male sterilization – After 3 months of surgery the semen examination is done and the compensation process is given.

The National Family Planning Insurance Scheme since 25 Nov 2005 has been modified into Family Planning Indemnity Scheme (FPIS) with effect from 1st April 2013.

The available benefits under the Family Planning Indemnity Scheme are as under

Section	Coverage	Limits
SECTION I (A-D) : For Beneficiaries		
I A	Death following sterilization (inclusive of death during process of sterilization operation) in hospital or within 7 days from the date of discharge form the hospital	Rs. 2 Lakh
I B	Death following sterilization within 8 -30 days from the date of discharge from the hospital	Rs. 50, 000/-
I C	Failure of Sterilization	Rs. 30,000/-
I D	Cost of treatment ***in hospital and up to 60 days*** arising out of complication following sterilization operation (inclusive of complication during process of sterilization operation) form the date of discharge	Actual not exceeding Rs. 25,000/-
SECTION II: Empanelled Doctors under Public and Accredited Private/ NGO Sector and Health Facilities under Public and Accredited Private/ NGO Sector		
II*	Indemnity coverage up to 4 cases of litigations per doctor and per health facility in a year	Upto Rs. 2 Lakh per case of litigation

The claims will follow within the 'Family Planning Indemnity Scheme' only if the beneficiary files the claim with the District Indemnity Sub-Committee (DISC) within 90 days from the occurrence of the event of death/failure/complication.

Death following sterilization :

- Claims under Section I-A - Death following Sterilization (Inclusive of death during process of sterilization operation) in hospital or within 7 days from the date of discharge from hospital.
- If the death occurs within 7 days of discharge or during the process of sterilization operation the amount of Rs. 50,000/- (In cash only if there is no accounts/Jan Dhan accounts) should be released immediately. The balance amount of Rs. 1.5 lakhs will be released through account payee cheque/DBT – Later only when the DISC recommends compensation under "Death attributable to Sterilization".

- IF the death occurs beyond 7 days of discharge to one month, the DISC should examine the case and establish he cause. IF death is attributed to sterilization and subsequently endorsed to SISC, Rs. 50,000 (through account payee cheque/DBT, wherever account available)
- If the dependent children are minor, the payment shall be made by the District Health Society in the name of minor children.

Failure of Sterilization

See Chart

Complications arising following Sterilization

See Chart

II. PPIUCD Incentive Scheme also covering PAIUCD

This facility offers various methods of Post Abortion Contraception – Sterilization, IUCD, Injectable contraceptives, oral contraceptive pills and Centchroman and condom. The services includes 2nd trimester abortion.

- Rs. 300 paid to the acceptors of PAIUCD
- The incentive is only payable for PAIUCD insertions following induced (surgical) or spontaneous abortions and not for the medical methods of abortion (MMA).

III. PPIUCD

Rs. 300 is paid to all the beneficiaries who take up PPIUCD after delivery in this Facility.

FREE OF COST TREATMENT TO BPL PATIENTS

Purpose of this policy to define the scope of services being provided by the hospital for

ensuring free of cost treatment and diagnostics all pregnant women including those who are Below Poverty Line Patients.

Policy:

In hospital, for pregnant women JSY and JSSK Yojana is present in which following are the Free Entitlements for pregnant women irrespective of their status as BPL:

- Free and cashless delivery
- Free C-Section
- Free drugs and consumables
- Free diagnostics
- Free diet during stay in the health institutions
- Free provision of blood
- Exemption from user charges
- Free transport from home to health institutions
- Free transport between facilities in case of referral
- Free drop back from Institutions to home after 48hrs stay

The following are the Free Entitlements for Sick newborns till 30 days afterbirth.This has now been expanded to cover sick infants:

- Free treatment
- Free drugs and consumables
- Free diagnostics
- Free provision of blood
- Exemption from user charges
- Free Transport from Home to Health Institutions
- Free Transport between facilities in case of referral
- Free drop Back from Institutions to home

GRIEVANCE REDRESSAL POLICY

Purpose of this policy is to provide guideline instruction for handing patients complaints.

- Any complaint made by the patient/relatives either inlieu of violation of patient's rights , provision of medical care etc will be brought to the notice of the Medical Superintendent of the hospital either by the patient/relatives directly or through the Resident Medical Officer and Public Relations Officer of the hospital.
- In case the complaint is made through any hospital staff the Medical Superintendent will enquire the authenticity of the same from the particular patient/relative.
- The Medical Superintendent will immediately investigate the complaint either in person or through designated individual staff member/s to find out the authenticity of the complaint, reason for the complaint, staff member responsible (if any).
- Based on the findings of the investigations appropriate actions will be initiated to resolve the issue and address the patient/relative's grievance.
- Written instructions have been displayed in various areas of the hospital encouraging patient/relatives to report any grievance/complaint to the Medical Superintendent/Resident Medical Officer/Public Relations Officer of the hospital.
- Grievances sent to Directorate, Secretariat, Hon’ble Ministers, Hon’ble LG are rederessed suitably and appropriately as and when received.

NO SMOKING POLICY

Hospital recognizes the deleterious health effects of tobacco and supports a tobacco free environment. Therefore, use of any tobacco products, smoking of tobacco, use of smokeless tobacco, and other combustible materials by employees, patients, visitors and other individuals are prohibited in hospital.

The sale of tobacco materials is also prohibited on the premises of the hospital.

- The hospital has to be declared a "no smoking" zone.
- All patients and their attendees are counseled and educated about the adverse effects of smoking on people's health due to active and passive smoking & encouraged to give up smoking.
- Signage for "no smoking" are displayed in the hospital.
- Wall paintings describing a fine of Rs. 200/- will be charged if found smoking within the premises