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Chhatrapti Shahu Maharaj Shikshan Sanstha's
AYURVED MAHAVIDYALAYA & RUGNALAYA
Kanchanwadi, Paithan Road, Aurangabad- 431011 (M.S.)

AMENDMENT SHEET

Sr.No.	Section No & page No.	Details of the amendment	Reasons	Sign. of the Preparatory authority	Sign. of the approval authority

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CONTROL OF THE MANUAL

The holder of the copy of this manual is responsible for maintaining it in good and safe condition and in a readily identifiable and retrievable.

The holder of the copy of this Manual shall maintain it in current status by inserting latest amendments when the amended versions are received.

RMO is responsible for issuing the amended copies to the copyholders, the copyholder should acknowledge the same and she should return the obsolete copies to the RMO.

The amendment sheet, to be updated (as and when amendments received) and referred for details of amendments issued.

The manual is reviewed once a year and is updated as relevant to the hospital policies and procedures. Review and amendment can happen also as corrective actions to the non-conformities raised during the self-assessment or assessment audits by NABH.

The authority over control of this manual is as follows:

Preparation	Approval	Issue
RMO	Principal, Dr. S.G. Deshmuh, CSMSS Ayurved Mahavidyalaya & Rugnalaya Kanchanwadi, Aurangabad	Accreditation coordinator

The procedure manual with original signatures of the above on the title page is considered as 'Master Copy', and the photocopies of the master copy for the distribution are considered as "Controlled Copy".

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2	RMO
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AAC 01 – POLICY AND PROCEDURE ON SCOPE OF SERVICES

1.0 PURPOSE

1.1 To define and display the services provided by hospital

1.2 To ensure that all the concerned staff are oriented to these services.

2.0 SCOPE

The needs of the community are considered while providing services.

3.0 RESPONSIBILITIES

3.1 Medical Superintendent

3.2 All Consultants

3.3 Medical officers

3.4 Nursing Superintendent and all nursing staff

3.5 Pharmacy I/C and all pharmacy staff

3.6 Pathologist and lab technicians

3.7 Reception staff

3.8 Other Medical and Paramedical staff

4.0 POLICY

The hospital provides comprehensive Ayurvedic health care in the following areas: General medicine, Panchakarma, Para surgical, Preventive Medicine, Gynecological and Obstetric care, Eye & ENT, Pediatric care & Physiotherapy.

The following are the services provided at CSMSS Ayurved Mahavidyalaya & Rugnalaya, Kanchanwadi, Aurangabad.

1. Front office Registration, Enquiry, Billing and Accounts
2. Pharmacy and Dispending Unit
3. Laboratory Department
4. Radiology
5. Human resource
6. Quality Department
7. Information Technology
8. Maintenance
9. House Keeping
10. Medical Record Department (MRD)
11. Nursing
12. Hospital Infection Control

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13. Operation Theatre
14. Outpatient Department (OPD)
    a) Kayachikitsa
    b) Shalya Tantra
    c) Shalakya Tantra
    d) Streerog Prasuti
    e) Balrog
    f) Panchkarma
    g) Swasthavritta
    h) Casualty
15. Wards:-In Patient Departments (IPD)

5.0 DISPLAY OF SERVICES

5.1 The services provided by the hospital are displayed prominently in the language of English and Marathi.

5.2 The details of services provided are displayed in an area visible to patients and family members while entering respective facilities / areas.

5.3 Maintenance department is responsible to identify the requirement of signage boards, to provide the same and rectify in case of any damage.

5.4 Each floor contains sign boards at necessary junctions for direction and orientation of patients.

6.0 STAFF ORIENTATION

6.1 The staff of Help desk, Admission Counter, Billing, Outpatient department, Diagnostics and Casualty are to be trained on this policy for the following conditions: Joining of New staff, Changes/ Updating of charges/ services/policy.

6.2 If identified, any lack of awareness of staff through observation / complaints, the relevant staff is oriented on the services provided by the hospital either by in training program or by reading this document, as appropriate, the same to be recorded in training record form.

REFERENCE

Pre Accreditation Entry Level standards for Hospitals-Second Edition: April 2016

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AAC 02 – POLICY AND PROCEDURE ON REGISTRATION, ADMISSION

1.0 PURPOSE

To define Policy & Procedure for Registration, Admission in CSMSS Ayurved Mahavidyalaya & Rugnalaya, Kanchanwadi, Aurangabad

2.0 SCOPE

This Policy & procedure is applicable to outpatient and inpatient that undergoes Registration & Admission.

3.0 RESPONSIBILITIES

3.1 Registration Counter staff

3.2 Consultants

3.3 Medical Officers (MO)

3.4 Nursing superintendent

3.5 Other Paramedical staff

4.0 POLICY

4.1 Patients are admitted at CSMSS Ayurved Mahavidyalaya & Rugnalaya, Kanchanwadi, Aurangabad only if the Hospital can provide the required services to the patient.

4.2 All patients, out-patients, in-patients and emergency who are willing to avail services at CSMSS Ayurved Mahavidyalaya & Rugnalaya, Kanchanwadi, Aurangabad should undergo Registration / Admission process.

4.3 Emergency cases at OPD are not covered under scope of services, however the registration counter staff and medical officer in casualty are oriented to refer such patients to suitable centers.

4.3 Patient shall be registered only if they match the hospital services.

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4.4 Patients can be admitted from the following areas:

4.4.1 Admission from Outpatient Clinics: Patients may be directly admitted from one of the Outpatient Clinics.

4.4.2 Admissions from the Casualty: Emergency Room patients requiring inpatient admission must have the Admission recommendation by treating consultant.

4.4.3 Admission of Outpatient Observation Patients: When under observation patient is determined to require inpatient care, based on recommendation by treating consultant the patient can be admitted.

6.0 PROCEDURE

6.1 REGISTRATION PROCESS

6.1.1 Patient approaches Reception to avail consultation.

6.1.2 Reception staff to check with patient whether it is patient's first visit or subsequent visit.

6.1.3 Patient information is software to generate the unique Hospital ID.

6.1.4 If it is not first visit, reception staff enquires to patient for the registration number.

6.1.5 If registration detail is not available, a new registration number is given to Patient for the consultation.

6.1.6 Old and new registrations have separate counters

6.2 ADMISSION PROCESS

6.2.1 All patients who are to be admitted should complete registration process.

6.2.2 Admissions are referred from OPD department and Causality.

6.2.3 The doctor advices for the admission in the Admission note form for OPD patients.

6.2.4 RMO explains the admission process and rules and regulations of hospital.

6.2.5 Patient is admitted based on their diagnosis, and ward.

6.2.6 Every patient is provided unique Inpatient Number at the time of admission.

6.2.7 All possible efforts to be taken by the hospital staff to find the identification of patient; if patient is unidentified then the patient is to be shifted to Government Hospital through security department (also Police to be intimated) or if admitted, the patient is to be identified by the Inpatient number till patient name is identified as appropriate.

6.2.8 If the staff handling registration and admission needs any clarification on the services provided by hospital, they should contact Principal, RMO or DMS for necessary information.

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6.3 POLICY ON NON-AVAILABILITY OF BEDS

6.3.1 PURPOSE - To guide the staff when beds are not available for patients needing admission.

6.3.2 PROCEDURE

6.3.2.1 In case of non-availability of bed, the admission staff informs RMO to decide on arranging / adding more beds within the available space and the concerned treating doctor is informed.

6.3.2.2 The concerned treating doctor to decide on postponement or cancellation of admission in coordination with patient.

6.3.2.3 All staff handling registration and admission is to be trained on this Policy and Procedure (New Staff, Changes in duties etc).

6.4 MLC CASES:

6.4.1 In case of patients involved in medico legal cases the patient is referred to GHATI Hospital / Bajaj Hospital.

6.4.2 A list of MLC cases is shown below:

6.4.3 Poisoning.

6.4.4 Injury with sharp object/ fire arms.

6.4.5 Burns especially in women.

6.4.6 Drowning.

6.4.7 Death/Injury in a woman.

6.4.8 Road accidents / Industrial accidents.

6.4.9 Conditions which require notification as per the laws for time being in force.

6.4.10 Any other conditions where there is a suspicion of some foul play.

6.4.11 Where the cause of death is not certain.

7.0 REFERENCE

Pre Accreditation Entry Level standards for Hospitals-Second Edition: April 2016

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AAC 03 – POLICY AND PROCEDURE ON TRANSFER & REFERRAL OF PATIENTS

1.0 PURPOSE

To define Research Centre.

2.0 SCOPE

This are not available.

3.0 DEFINITIONS

Medically unstable condition- The term "Medically Unstable Condition" means - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in - Placing the health of the individual (or, with respect to a pregnant women, the health of the woman or her unborn child) in serious jeopardy, Serious impairment of bodily functions Serious dysfunction of any bodily organ or part.

Stabilized - The term "stabilized" means with respect to a medically unstable condition, which no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility.

4.0 RESPONSIBILITIES

Registration Counter, Casualty and OPD staff are responsible to implement this Policy and Procedure.

5.0 POLICY

5.1 REFERRAL OF UNSTABLE PATIENT TO OTHER CENTRE

In case of transfer of patients in a life threatening situation (like those who are on ventilator) to another organization, a doctor / Trained Staffs accompanies the patient. The ambulance driver helper, nurse, or doctor accompany during transfer for unstable Patients to other organizations.

5.2 TRANSFER OF STABLE PATIENTS

Stable Patient is transferred to another organization through the ambulance, accompanied by ambulance driver & helper

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6.0 PROCEDURE

6.1 If an emergency patient requires services not available the transfer is arranged with a recommendation to contact another facility with the necessary capability.

6.2 Transfer of patients is made by the referring physician contacting Senior Consultant / Consultant / Residential Medical Officer

6.3 The CSMSS Ayurved Mahavidyalaya & Rugnalaya, Kanchanwadi, Aurangabad& Research Centre staff member shall obtain the details of the patients' emergency medical condition and contact Admitting Desk. Admitting Desk shall verify that beds are available.

6.4 All departments who receive requests for transfer of patients shall maintain this policy and procedure statement in a place accessible to medical staff, and other personnel to ensure that physicians who are involved in transfers adhere to its content. Questions shall be referred to Director Medical Services.

6.5 Similarly, when resources matching the patient needs are not available at CSMSS Ayurved Mahavidyalaya & Rugnalaya, Kanchanwadi, Aurangabad patients shall be transferred GHATI Hospital / Bajaj Hospital in the Campus that can meet the patient's needs. The Consultant / Residential Medical Officer shall contact the faculty of the receiving hospital to ensure that eligibility guidelines are met.

7.0 RECORDS

7.1 OPD Case paper.

7.2 Referral Notes

7.3 Referral Registers

8.0 REFERENCE

Pre Accreditation Entry Level standards for Hospitals-Second Edition: April 2016

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AAC 04 – POLICY AND PROCEDURE ON PATIENT INITIAL ASSESSMENT

1.0 PURPOSE

1.1 To outline a systematic process for gathering pertinent clinical data about a patient.

1.2 To establish a comprehensive information base for decision making about patient care.

1.3 To provide patient with the right care at the time, it is needed.

1.4 To assure care provided to patient is based on an assessment of Patient's relevant physical, psychological and social needs.

2.0 SCOPE

This procedure applies to all Patients treated at CSMSS Ayurved Mahavidyalaya & Rugnalaya, Kanchanwadi, Aurangabad.

3.0 DEFINITION

3.1 ASSESSMENT

All activities including history taking, physical examination, and laboratory investigations that contributes towards determining the prevailing clinical status of the patient.

4.0 RESPONSIBILITY

4.1 Treating Doctor, Casualty Medical Officer, Duty Medical Officer and Nurses are responsible to implement this Policy and Procedure.

4.2 Patient assessment at CSMSS Ayurved Mahavidyalaya & Rugnalaya, Kanchanwadi, Aurangabad is an ongoing process that begins before the Patient is admitted and continues throughout treatment.

5.0 POLICY

5.1 INITIAL ASSESSMENT- Residential Medical Officer/ Treating Doctor, MO are responsible to carryout initial assessment within One hour or Admission and to document the same within the 24 hours of Admission.

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6.0 PROCEDURES

6.1 INITIAL ASSESSMENT

6.1.1 Initial assessments of Patient at emergency ward are to be carried out by Nurse, RMO immediately, as soon as patient arrives at casualty.

6.1.2 Assessment of Patient in Outpatient department is done by the Consultant. History and Physical examination of the patient is written in the OPD case paper which is given to patient after scanning at registration desk.

6.1.3 Initial Assessment for In Patient to be carried out by RMO, Treating Doctor or PG student on duty (as appropriate) within one hour of admission to determine immediate care needs and to decide on plan of care.

6.1.4 Nursing Initial Assessment is done within 30 minutes of patient admission into the ward.

6.1.5 Treating Doctor and Swasthvritta department together decide nutritional needs of the Patient.

6.1.6 Treating Doctor should document plan of care based on initial assessment.

6.1.7 This plan of care should include preventive aspect of the care, e.g. Diet,

6.1.8 Analysis of information from initial assessment drives the following

6.1.8.1 Initial treatment and upashay.

6.1.8.2 Other specialized treatment needs like panchkarma.

6.1.8.3 Pathyahar

6.2 CONTENT OF THE INITIAL ASSESSMENT

6.2.1 IN PATIENT

The Contents are Complaints, History, examination,

Provisional Diagnosis / Diagnosis, Investigations & treatment.

6.2.2 OUT PATIENT

Outpatient case paper is predefined.

OPD case paper has the following parameters

a) Complaints with duration and history

b) Physical Findings

c) Clinical Diagnosis

d) Investigations

e) Treatment and follow-up

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Outpatient Follow-up visit form has the following parameters

a) Provisional diagnosis / diagnosis

b) Medicines

c) Vitals

d) Investigations

e) Treatment and follow-up

As a minimum, following parameters are to be in the Outpatient Prescription Form:

a) Patient name

b) Personal data (like Sex, Age, Height, Weight),

c) Clinical history,

d) Quick examination (as appropriate)

e) Present illness

f) Investigation (if any) and

g) Medications.

6.3 DOCUMENTATION

Assessment and Reassessment are to be documented by

- Consultants, Medical Officer, Registrar, Houseman
- Nurse
- Records :OPD Case Paper

7.0 REFERENCE

Pre Accreditation Entry Level standards for Hospitals-Second Edition: April 2016

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AAC 05 – POLICY AND PROCEDURE ON PATIENT REGULAR RE-ASSESSMENT

1.0 PURPOSE

1.1 To provide continuous care to the patients admitted in CSMSS Ayurved Mahavidyalaya & Rugnalaya, Kanchanwadi, Aurangabad.

1.2 To monitor the care plan and modify it as per response to the treatment.

2.0 SCOPE

This procedure applies to all Patients treated at CSMSS Ayurved Mahavidyalaya & Rugnalaya, Kanchanwadi, Aurangabad.

3.0 RESPONSIBILITY

3.1 Treating Doctor, Casualty Medical Officer, Duty Medical Officer and Nurses are responsible to implement this Policy and Procedure.

3.2 Patient reassessment at CSMSS Ayurved Mahavidyalaya & Rugnalaya, Kanchanwadi, Aurangabad, is an ongoing process that begins before the Patient is admitted and continues throughout treatment.

4.0 POLICY -

4.1 Every Inpatient should be reassessed at least once in a day (Non-Critical Care areas) or, as and when necessary.

4.2 Critical care patient should be reassessed minimum of every 6 hours or, as and when necessary (depending on condition of the patient).

5.0 PROCEDURES

5.1 REASSESSMENT

5.1.1 Patient acuity and needs determine the frequency of reassessment i.e. a patient at high risk to be assessed continually while a stable patient to be assessed at least once in a day in non-critical care units & every 2 hours or as and when necessary in critical care units e.g. pregnancy hypertension

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5.1.2 Reassessment is performed by medical and nursing staff. Ancillary Services involved in the patients care also perform reassessment as required by patient's needs.

5.1.3 Reassessment is performed to identify and determine / monitor patient's response to care / treatment.

5.1.4 Reassessment of Patient care needs including treatment plan / plan of care review is to be initiated at the following condition;

- Whenever there is a significant change in patient condition and / or Diagnosis.
- When a Patient is transferred from one setting to another setting. Example: OT to ward.
- At the time of discharge.

5.1.5 Based on initial assessment of the Patient and established plan of care, reassessments are performed and to be documented throughout the care process (Hospitalization).

5.1.6 Multidisciplinary approach is adopted for performing patient assessment based on the patient diagnosis, the care setting, patient desire for care and patient response to any previous care. This includes involvement of treating Doctor, RMO, Nurse, Panchakarma therapist etc.

5.1.7 The plan of care is reviewed regularly by Treating Doctor or his / her Team Member. This review should include information from other Doctor, Patient and Patient family.

5.1.8 When required the plan of care is revised as appropriate to the patient condition and ongoing assessment process to be carried and this same to be documented.

5.1.9 Discharge planning needs is included in the initial assessment and reassessment process throughout the patient hospitalization.

5.1.10 The patient and Patient family is involved in discharge planning process, as appropriate by Treating Doctor or his/her Team Member.

5.1.11 The decision of discharge is to be taken in consultation with patient and/or family members. The same to be documented in IP Record with signature, name, date and time by Treating Doctor or his/her team member.

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5.2 DOCUMENTATION

Reassessments are to be documented by

- Consultants, Medical Officer, Registrar, Houseman
- Nurse

6.0 REFERENCE

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AAC 06 – POLICY AND PROCEDURE ON LABORATORY SERVICES

1.0 PURPOSE

To provide guidelines for laboratory services as per requirement of the patients.

2.0 SCOPE

All the patients those who avail laboratory services, the hospital ensures availability of laboratory services commensurate with the health care services offered.

3.0 RESPONSIBILITY

3.1 Head of the department

3.2 Consultant

3.3 Laboratory technicians

4.0 POLICY AND PROCEDURES

4.1 8 hours laboratory services are provided at CSMSS Ayurved Mahavidyalaya & Rugnalaya, Kanchanwadi, Aurangabad.

4.2 Laboratory services are in consonance with the hospital scope of services:

4.2.1 Hematology

4.2.2 Serology

4.3 CSMSS Ayurved Mahavidyalaya & Rugnalaya, Kanchanwadi, Aurangabad, clinical laboratory will engage competent personal for technical work which includes technician and Professionals.

4.3.1 Without written request from the treating doctor, sample shall not be drawn from the patient and criteria for written request are as follows:

- Name of the patient
- Age & sex
- UHID number
- OPD / IPD number
- Test examinations clearly indicated
- Signature

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- Name of Doctor
- Date and Time

4.3.2 Criteria for labeling the Samples – All samples must be labeled with Name of patient, Age, Sex, OPD / IPD number, Date and Time of sample taken.

4.3.3 All samples are discarded as per Biomedical Waste (BMW) Management Handling Rules 1998 (2000).

4.3.4 Turnaround Time (TAT) for each tests are defined and displayed. Laboratory results are issued within the defined time frame.

4.3.5 Critical results are defined and displayed. If critical results are observed then these are reported to the doctor through call / message by using intercom / mobile phones. It is the responsibility of the laboratory staff to communicate any critical test results to the concerned doctor.

4.3.6 Laboratory personnel are trained in safe practices and are provide with appropriate safety equipment / devices.

4.3.7 Tests not done in the hospital are outsourced to an approved outside laboratory.

5.0 REFERENCE

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TURN AROUND TIME FOR LABORATORY INVESTIGATIONS

Sr.No.	Test / (टेस्ट)	Time / (वेळ)
1	CBC & ESR test / (सी.बी.सी व ई.एस.आर टेस्ट)	2 Hrs. / (२ तास)
2	PBS Test / (पी.बी.एस टेस्ट)	2 Hrs / (२ तास)
3	PS for MP Test / (पी.एस.फॉर एम.पी टेस्ट)	1 Hrs / (१ तास)
4	BT CT Test / (बी.टी व सी.टी टेस्ट)	1 Hrs / (१ तास)
5	Blood Group / (ब्लड ग्रुप टेस्ट)	2 Hrs / (२ तास)
6	V.D.R.L. Test / (व्हीडीआरएल टेस्ट)	3 Hrs / (३ तास)
7	R.A Test / (आर ए टेस्ट)	3 Hrs / (३ तास)
8	Widal Test विडाल टेस्ट	3 Hrs / (३ तास)
9	Australia Antigen Test / (ऑस्ट्रेलिआ अँटीजेन टेस्ट)	3 Hrs / (३ तास)
10	HIV Test / (एच.आय.वि. टेस्ट)	3 Hrs / (३ तास)
11	A.S.O. Titer Test / (ए एस ओ टेस्ट)	3 Hrs / (३ तास)
12	Blood Sugar /(ब्लड शुगर टेस्ट)	3 Hrs / (३ तास)
13	Blood Urea /(ब्लड यूरिया टेस्ट)	4 Hrs / (४ तास)
14	Sr.Creatinine /(सीरम क्रिएटिनाईन टेस्ट)	4 Hrs / (४ तास)
15	Sr.Cholesterol/(सीरम कोलेस्टेरॉल टेस्ट)	4 Hrs / (४ तास)
16	Sr.Triglycerides /(सीरम ट्रायग्लिसरायड्स टेस्ट)	4 Hrs / (४ तास)
17	HDL /(एचडीएल टेस्ट)	4 Hrs / (४ तास)
18	Sr.Bilirubin /(सीरम बिलीरुबिन टेस्ट)	4 Hrs / (४ तास)
19	S.G.O.T. /(एसजीओटी टेस्ट)	4 Hrs / (४ तास)
20	S.G.P.T. /(एसजीपीटी टेस्ट)	4 Hrs / (४ तास)
21	Sr.Alkaline Phosphatase/(सीरम अल्कलीन फॉस्फेटेज टेस्ट)	4 Hrs / (४ तास)
22	Sr.Proteins /(सीरम प्रोटीन टेस्ट)	4 Hrs / (४ तास)
23	Sr.Uric Acid/(सीरम यूरिक ॲसिड टेस्ट)	4 Hrs / (४ तास)
24	Sr. Calcium/(सीरम कॅल्शियम टेस्ट)	3 Hrs / (३ तास)
25	Urine (Routine)/ (युरिन रुटीन टेस्ट (मूत्र परीक्षण)	3 Hrs / (३ तास)
26	Urine Sugar/(युरिन शुगर टेस्ट)	2 Hrs. / (२ तास)
27	Urine Pregnancy Test /(युरिन प्रेगनेंसी टेस्ट)	3 Hrs / (३ तास)
28	Stool Examination /(स्टूल टेस्ट (मल परीक्षण)	6 Hrs / (६ तास)
29	Sputum for A.F.B./(स्पुटम फॉर एएफबी (थुंकी परीक्षण)	6 Hrs / (६ तास)
30	Semen Analysis /(सीमेन एक्सामीनाशन (शुक्र परीक्षण)	6 Hrs / (६ तास)

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AAC 07 - POLICY AND PROCEDURE ON LABORATORY QUALITY ASSURANCE

1.0 PURPOSE

To provide excellent results with the help of established quality assurance programme.

2.0 SCOPE

All the patients referred to the Laboratory by doctor will have quality service of investigations.

3.0 RESPONSIBILITY

3.1 Head of the department

3.2 Laboratory technicians

4.0 POLICY AND PROCEDURES

4.1 The laboratory quality assurance programme is documented. Internal quality control is taken care of External quality assurance / calibration is done with the ACE Techno Services, CIDCO, Aurangabad, and it is documented.

4.2 The laboratory is capable of performing the analysis and verification.

4.3 Maintenance of equipment is periodically.

5.0 REFERENCE

Pre Accreditation Entry Level Standards For Hospital- Second Edition: April 2016.

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AAC 08 - POLICY AND PROCEDURE ON LABORATORY SAFETY PROGRAMME

1.0 PURPOSE

To provide safety for the staff in the laboratory.

2.0 SCOPE

All the staff working in the laboratory should be free from risk and hazards.

3.0 RESPONSIBILITY

3.1 Head of the department

3.2 Laboratory technicians

3.3 HR manager

4.0 POLICY AND PROCEDURES

4.1 The organization takes care of safety of work force and equipments.

4.2 The safety programme is aligned with the safety programme as whole organization.

4.3 Handling and disposal of infectious and hazardous material is done with standard precautions and it is documented.

4.4 Staff undergoes training regarding safe practices.

4.5 Adequate safety devices are available in the laboratory.

6.0 REFERENCE

Pre Accreditation Entry Level Standards For Hospital- Second Edition: April 2016.

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AAC 09 – POLICY AND PROCEDURE ON IMAGING SERVICES

1.0 PURPOSE

To provide guide lines for identification and safe transportation of patients for imaging services within the imaging departments.

2.0 SCOPE

All patients who receive services from imaging department.

3.0 RESPONSIBILITY

3.1 Radiologist,

3.2 Radiography Technician

4.0 ABBREVIATIONS

4.1 NABH : National Accreditation Board for Hospital And Healthcare Providers.

4.2 AAC : Access, Assessment and Continuity of care.

7.0 POLICY

7.1 Compliance with legal requirement:

7.1.1 AERB / BARC approval for imaging units has been obtained after inspection and the licenses are display in their respective areas to prove compliance on these issues.

7.1.2 Proper sign posting has been done in the radiology department.

7.1.3 Training of department staff.

7.2 diagnostic Imaging Includes the following:

7.2.1 X-Ray

7.2.2 Ultrasound and Color Doppler.

7.2.3 The Radiology Department is working once in a week on Friday.

7.3 Identification of patient:

7.3.1 CSMSS Ayurved Mahavidyalaya & Rugnalaya, Kanchanwadi, Aurangabad is insured that all the patients are identified prior to carrying out their investigations.

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7.3.2 All those patients who require assistance is transported safely without causing any injury to them in the process.

7.3.3 Where applicable patient is advised for pre-test preparation and appointment is scheduled for the test when pre-test preparation deserve times more than a day.

7.3.4 The cases are taken up on first serve basis, unless otherwise there is requirement to give priority for specific patients for clinical or other valuable reasons.

7.3.5 Technicians are orient the patient for taking shots based on to film / equipment positions / process norms and diagnostic requirements on request of medical practitioner.

7.4 Safe transportation of Patients: The hospital is ensuring the safe transportation of patients to the imaging services. For patient's transportation the Inter – Hospital transfer procedure is followed. The medical staffs arranging transportation is responsible for this task.

7.5 Time frame for all results: Imaging results are available within the defined time frame. Imaging results are made available on a prefixed schedule of timing. In case of critical patients the results are intimated as immediate as possible.

7.6 Critical results intimation: Critical results are intimated immediately to the concerned personnel.

7.7 Results reporting: The report is also including the results of any calculations and analysis of radioactive material deposited in the body of the employee. The report is in writing and containing the statement: "You should preserve this report for future reference."

7.8 Outsourced tests: Imaging test not available in the organization are outsourced

7.9 Qualified staff for department:

7.9.1 Adequately qualified and trained person is only employed for imaging services.

7.9.2 Only qualified, credentialed and authorized clinician Dr. Chirlikar Girish, DNB, Radiology is responsible for conducting or supervising all radiology procedures and reporting. He visits the organization once in a week i.e. on Friday.

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8.0 PROCEDURE

8.1 Radiology equipment:

8.1.1 The X-ray units in use in the hospital are fixed X-ray unit, placed in the high dependency area.

8.1.2 Radiation protective jackets and gloves should be worn by the staff in the department during procedure.

- The imaging staff should at all times wear the radiation protection badges issued to them while inside the department and whenever radiation equipment are operated.
- These badges are to be stored safely away from the radiation areas while not in use.
- Radiation protection badges are to be sent to the radiation monitoring office periodically, results are analyzed and remedial action, if any required to be taken to ensure the safety of the staff and patients.

8.1.3 Protection of bystanders while using X-rays, C-arm, etc. are ensured.

8.1.4 Protection of abdomen & vital structure of children / patients and staff are ensured.

8.2 Qualified personnel:

8.2.1 The radiology department is headed by qualified radiologist Dr. Chirlikar Girish who will issue reports on all imaging services provided to the patients, if so desired by the consultant.

8.2.2 The department has qualified and experienced radiographer who can conduct the procedure and develop the films for reporting.

8.3 waiting time for procedures and results:

8.3.1 The X-ray films with or without the reports of the investigations shall be issued within the time limit specified for the procedure.

8.3.2 The radiology department will ensure that all the results and emergency results are made available within a stipulated time frame.

8.3.3 Critical findings when noticed are to be immediately intimated through the telephone to the treating doctors by the radiologist / technician.

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8.3.4 In case any of the imaging equipment goes out of order, the patients requiring to undergo the procedure during such period are conveyed by the hospital ambulance accompanied by a staff nurse to other center or medical College Hospital or Hospital imaging center with whom the hospital has a working arrangement and the procedure the patient is brought back with the test result.

8.4 Reporting

8.4.1 Reports for inpatients are issued same day. However all inpatients are given either a verbal or a written provisional report at the time of completion of investigation. All casualties scan reports are communicated urgently and subsequently a written provisional report is issued.

8.4.2 All out patient reports are issued on Friday. In case of any examination which requires reference search or second opinion, the same is communicated to the patient and he is kept informed about the availability of the report.

TURN AROUND TIME FOR USG SCANNING RESULTS (ULTRASOUND SCAN)

SR. NO.	PROCEDURE	TAT
1	USG ABDOMEN AND PELVIS	15 MINUTES
2	KNEE JOINT	15-20 MINUTES
3	SCROTUM	15-20 MINUTES
4	THYROID	15-20 MINUTES
5	BREAST	15-20 MINUTES
6	**Color Doppler :-** 1. Arterial Doppler 2. Peripheral Vascular Arteries 3. Venous Doppler	 15-20 MINUTES 15-20 MINUTES 15-20 MINUTES

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TURN AROUND TIME FOR X RAY

SR. NO.	PROCEDURE	NO. OF VIEWS	TAT
1.	CHEST – PA	1	25 MINUTES
2.	SKULL AP & LATERAL	2	25 MINUTES
3.	MANDIBLE – AP	1	20 MINUTES
4.	BOTH MASTOID LATERAL	2	25 MINUTES
5.	ORBIT – PA	1	20 MINUTES
6.	PARA NASAL SINUS	1	25 MINUTES
7.	HAND – AP, LATERAL, OBLIQUE	3	25 MINUTES
8.	PELVIS – AP & LATERAL	2	25 MINUTES
9.	ELBOW – AP & LATERAL	2	25 MINUTES
10.	SHOULDER – AP & LATERAL	2	25 MINUTES
11.	BOTH HIP – AP & LATERAL	2	30 MINUTES
12.	SACRUM / COCCYX – AP & LATERAL	2	25 MINUTES
13.	WHOLE SPINE – AP & LATERAL	2	25 MINUTES
14.	KUB PLAIN	1	20 MINUTES
15.	FEMUR – AP & LATERAL	2	25 MINUTES
16.	KNEE – AP & LATERAL & AXIAL	3	25 MINUTES
17.	LEG – AP & LATERAL	2	25 MINUTES
18.	ANKLE – AP & LATERAL	2	25 MINUTES
19.	FOOT – AP, LATERAL, OBLIQUE	3	25 MINUTES
20.	CALCANEUS – LATERAL & AXIAL	2	25 MINUTES

9.0 REFERENCE

Pre Accreditation Entry Level Standards For Hospital- Second Edition: April 2016.

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AAC 10 – POLICY AND PROCEDURE IMAGING QUALITY ASSURANCE

1.0 PURPOSE

There is an establish quality assurance program.

2.0 SCOPE

All patients who receive services from imaging department.

3.0 RESPONSIBILITY

3.1 Radiologist

3.2 Radiography Technician

4.0 ABBREVIATION

4.1 NABH : National Accreditation Board for Hospital and Healthcare Providers.

4.2 AAC : Access, Assessment and Continuity of Care.

5.0 POLICY AND PROCEDURE

7.1 The quality assurance program includes the maintenance of equipment.

7.2 The institute is also planning to replace the conventional machinery into digital.

6.0 REFERENCE

Pre Accreditation Entry Level Standards For Hospital- Second Edition: April 2016.

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AAC 11 – POLICY AND PROCEDURE OF IMAGING SAFETY PROGRAMME

1.0 PURPOSE

There is established radiation safety program.

2.0 SCOPE

All staff is working in imaging department.

3.0 RESPONSIBILITY

3.1 Radiologist

3.2 Radiography Technician

4.0 ABBREVIATION

4.1 NABH : National Accreditation Board for Hospital and Healthcare Providers.

4.2 AAC : Access, Assessment and Continuity of Care.

5.0 POLICY AND PROCEDURE

5.1 The safety program is aligned with safety program of the organization.

5.2 Handling usages & disposal of radioactive & hazardous materials are as per statutory requirement. The material is disposed as pert guidelines.

5.3 The staff has radiation safety devices like lead aprons, shield & dosimeters.

5.4 All the workers of imaging service have been provided with the TLD badges for monitoring of their individuals exposures to radiation as part of radiation safety program. Regular monitoring of these badges has been out sourced and a record for the same is maintained in the radiology department of CSMSS Ayurved Mahavidyalaya & Rugnalaya, Kanchanwadi, Aurangabad.

7.5 Imaging technician is trained in a safety measures.

7.6 Imaging signage are promptly displayed.

6.0 REFERENCE

Pre Accreditation Entry Level Standards For Hospital- Second Edition: April 2016.

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AAC 12 – POLICY AND PROCEDURE ON PATIENT CARE

1.0 PURPOSE

To provide patient care continuously & multidisciplinary nature.

2.0 SCOPE

All patients who receive service from CSMSS Ayurved Mahavidyalaya & Rugnalaya, Kanchanwadi, Aurangabad, Kanchanwadi, Aurangabad.

3.0 RESPONSIBILITY

3.1 MS

3.2 DMS

3.3 RMO

3.4 Consultant

3.5 Paramedical staff

3.6 Hospital staff

3.7 Housekeeping staff

4.0 ABBREVIATION

4.1 NABH : National Accreditation Board for Hospital and Healthcare Providers.

4.2 AAC : Access, Assessment and Continuity of Care.

6.0 POLICY AND PROCEDURE

6.1 During all phases of care there are qualified resident Doctor (Dy. Register/ houseman), consultant, and nurse. These people work as team & record on OPD / IPD case paper sheet shows that.

6.2 Internal referral between departments is done as and when deemed necessary by the treating doctor / his / her team for opinion, co-management and take-over. The proceedings are documented in the OP/ IP case sheet. Internal Referral registers are maintained in each department.

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6.3 Patient after initially consulting with the Primary Consultant for his/her chief complaint is guided to the other respective OPD/s for his / her associated complaints with written referral from Primary Consultant on the OPD case sheet.

6.4 Referral to other department done for opinion with proper referral notes. The Referral Consultant accepts and approves his / her acceptance as gratitude in the OPD case sheet mentioning the Doctor name and complaints being addressed by him / her.

6.5 During follow up, patient first consults the Primary Consultant and then based on persisting complaints is referred to either priory referred OPD/s and / or other needful OPD/s by the Primary Consultant.

6.6 There is effective communication in all care providing departments.

6.7 Information about the patients care & response to treatment is shared among medical, nursing & other care provider.

6.8 Patient receives care in all care settings in the hospital which is coordinated by the treating doctor and his/her team through documented systems in every unit.

6.9 Information is exchanged & documented by nurses in overbook & Doctors take regular rounds, communicate and gives over verbally.

6.10 The IPD case files are the total record & they are kept in the nursing station.

7.0 REFERENCE

Pre Accreditation Entry Level Standards for Hospital- Second Edition: April 2016.

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AAC 13 – POLICY AND PROCEDURE ON DISCHARGE PROCESS

1.0 PURPOSE

To provide guidelines for discharge of in-patient from CSMSS Ayurved Mahavidyalaya & Rugnalaya, Kanchanwadi, Aurangabad.

2.0 SCOPE

The entire patient admitted in CSMSS Ayurved Mahavidyalaya & Rugnalaya, Kanchanwadi, Aurangabad.

3.0 RESPONSIBILITY

3.1 Consultant

3.2 RMO

3.3 Medical Officer

3.4 Registrar

3.5 Houseman

3.6 Nurse on duty

4.0 ABBREVIATION

4.1 NABH : National Accreditation Board for Hospital and Healthcare Providers.

4.2 AAC : Access, Assessment and Continuity of Care.

6.0 POLICY

6.1 Discharge procedure is followed to ensure patients are discharged effectively & efficiently, allowing for optimal utilization of available resources.

6.2 An authorized hospital discharge shall only be made by an order from primary consultant. However, a patient may discharge himself / herself against medical advice. Discharge planning will be initiated by the Consultant on the basis of the patient's condition; the same will be discussed with patient and their family.

6.3 The consultant or his designee shall document discharge instruction in patient's medical record at the time of anticipated discharge.

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6.6 A discharged summery is prepared.

6.7 The ward sister shall be the responsible person to ensure compliance with the policy.

6.8 In case of absconded cases, the MO will enquire regarding the same and he will report to the Public Relations Officer who will then report this to the relatives of the patient. This will be recorded in the LAMA register with remarks of absconding.

7.0 PROCEDURE

7.1 The discharge process is discussed with patient & family by on duty Doctor and Paramedical staff.

7.2 The patient will be assessed as 'medically stable' and fit for discharge. This may include assessment of functional, medical and nutritional needs.

7.3 The Medical Officers will fill the discharge sheet and the whole document will be forwarded to billing department so that the whole process will be completed as early as possible.

7.4 Discharge card summary is given to the patient.

7.5 Documentation at Registration Counter is done.

7.6 Patient is discharged with appropriate advises regarding medicine, follow up, diet and other.

8.0 REFERENCE

Pre Accreditation Entry Level Standards for Hospital- Second Edition: April 2016.

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AAC 14 – POLICY PROCEDURE ON DISCHARGE SUMMERY

1.0 PURPOSE

To provide guidelines for discharge of in- patient from CSMSS Ayurved Mahavidyalaya & Rugnalaya, Kanchanwadi, Aurangabad.

2.0 SCOPE

All the patients admitted in CSMSS Ayurved Mahavidyalaya & Rugnalaya, Kanchanwadi, Aurangabad.

3.0 RESPONSIBILITY

3.1 Consultant

3.2 Registrar

3.3 Houseman

3.4 Nurse on duty

4.0 ABBREVIATION

4.1 NABH : National Accreditation Board for Hospital and Healthcare Providers.

4.2 AAC : Access, Assessment and Continuity of Care.

4.3 DAMA : Discharge Against Medical Advice.

4.4 LAMA : Left Against Medical Advice.

5.0 POLICY AND PROCEDURE

5.1 Discharge Summary

Patients who are discharge are given discharge summery. Patients who leave hospital against medical advice are to be explained on the consequences of DAMA and signature to be obtained in DAMA form in inpatients record. Patient who comes to casualty, take treatment and leave hospital with RMO consent as OPD consultation basis are given prescription. All these contain patient condition and treatment is given.

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5.2 The Discharge Summary Shall Contain:

5.2.1 Particulars of Patient – Name, Age, Sex, Address
5.2.2 Unique ID Number, OPD and IPD Number
5.2.3 The reason for admission / Relevant Medical history
5.2.4 Date of Admission (DOA)
5.2.5 Date of Discharge (DOD)
5.2.6 Significant Findings
5.2.7 Diagnosis
5.2.8 Procedures performs
5.2.9 Significant Medications Administered
5.2.10 Therapy Conducted
5.2.11 Condition of patient at the time of Discharge
5.2.12 Discharge Modification and Follow-up Instructions
5.2.13 Emergency Contact number
5.2.14 Authentication of discharge summary duly signed by competent authority

5.3 In case of death, the discharge summary includes the cause of death.

5.4 The nurse shall responsible for completing the discharge checklist and explaining the discharge summary to the patients. Patient/ family understanding is documented on discharge checklist by obtaining the patient/ family signature.

5.5 All the patients are provided with a discharge summary at the time of discharge.

5.6 Patients requesting discharge against medical advice shall be explained the risk and consequences. The consent will be obtained from the patient/ family as per the informed consent policy.

5.7 Discharge summary is prepared in triplet, one copy is given to patient, second copy is attached to IPD case paper and third copy is attached in separate discharge card file.

6.0 RECORDS

In patient record

7.0 REFERENCE

Pre Accreditation Entry Level standards for Hospitals – Second Edition: April 2016.

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