



## **SRI LAKSHMI MEDICAL CENTRE AND HOSPITAL**

**18/121 MTP Road,**

**Thudiyalur, Coimbatore – 641 034.**

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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.

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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:**

<b>Preparation</b>	<b>Approval</b>	<b>Issue</b>
Management Representative	Chairman, Sri Lakshmi Medical Centre & Hospital.	Accreditation coordinator


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1	Chairman
2	Management Representative
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## **AAC 01 - POLICY AND PROCEDURE ON SCOPE OF SERVICES**

### **1.0 PURPOSE**

To define the services provided by hospital and ensure that the staff are oriented to these.

### **2.0 SCOPE**

To define the services provided by hospital and ensure that the staff are oriented to these.


### **3.0 RESPONSIBILITIES**

Managing representative is responsible to implement this policy and procedure.

### **4.0 POLICY**

The following are the services provided at Sri Lakshmi Medical Centre & Hospital.

1. Front office Registration, Enquiry, Insurance, Billing and Accounts
2. Pharmacy and Store
3. Laboratory Department
4. Radiology
5. Emergency Medicine and Trauma care
6. Outpatient
7. Human resource
8. Quality Department
9. Information Technology
10. Maintenance
11. Bio Medical
12. House Keeping
13. Medical Record

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14. Nursing
15. Hospital Infection Control
16. Operation Theatre
17. General Medicine
18. Surgery
19. Gastroenterology, Endoscopy, Colonoscopy
20. Obstetrics and Gynaecology
21. Cardiology and Cardio Vascular
22. Orthopaedics
23. Padiatrics
24. Physiotherapy
25. Intensive Care Unit
26. Ward

## **5.0 DISPLAY OF SERVICES**

- 5.1** The services provided by the hospital are displayed prominently in the language of English and Tamil.
- 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** Managing Representative is responsible to identify the requirement of signage boards, to provide the same and rectify in case of any damage.
- 5.4** Tariff of room and other basic services of hospital are made available at front office.

## **6.0 STAFF ORIENTATION**


- 6.1** The staff of Help desk, Admission Counter, Billing, Outpatient department, Diagnostics and Causality are to be trained on this policy for the following conditions: Joining of New staff, Changes / Updation of tariff / services / policy.
- 6.2** If identified, any lack of awareness of staff through observation / complaints.
- 6.3** The relevant staff is oriented on the services provided by the hospital either by in training

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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-First Edition: April 2014

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## **AAC 02 - POLICY AND PROCEDURE ON REGISTRATION, ADMISSION AND TRANSFER AND REFERRAL OF PATIENTS**

### **1.0 PURPOSE**

To define Policy & Procedure for Registration, Admission and transfer of the patients at Sri Lakshmi Medical Centre & Hospital.

### **2.0 SCOPE**

This Policy & procedure is applicable to patient who undergoes Registration & Admission and transfer in case of non-availability of beds / referral where the required services are not available in Sri Lakshmi Medical Centre & Hospital.

### **3.0 DEFINITION**

#### **DEFINITION OF UNSTABLE PATIENT**

- A Patient whose vital parameter needs external assistance for their maintenance.
- Unstable Patient include those who have come to the casualty but need to be transferred to another organization, or
- Those already admitted who now require care in another organization, or
- Those being shifted for diagnostic test.


### **4.0 RESPONSIBILITIES**

Front Office staff, Nursing Superintendent, OP staff are responsible to implement this Policy and Procedure.

### **5.0 POLICY**

- 5.1 Patients are admitted at Sri Lakshmi Medical Centre & Hospital only if the Hospital can provide the required services to the patient.
- 5.2 All patients, out-patients, in-patients and emergency who are willing to avail services at Sri Lakshmi Medical Centre & Hospital should undergo Registration / Admission process. In case of Emergency, the same to be carried out in parallel to treatment.
- 5.3 Patient shall be registered only if they match the hospital services
- 5.4 When there is no provision to treat the patient in the hospital, assist to transfer the patient to other hospitals where provision exists. For this a list of nearby Hospitals shall be maintained at the Front Office.



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5.5 Patients can be admitted from the following areas:

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

Admissions from the Casualty and Trauma care: Emergency Room patients requiring inpatient admission must have the Admission recommendation by treating medical practitioner.

Admission of Outpatient Observation Patients: When an observation patient is determined to require inpatient care, based on recommendation by medical practitioner the patient can be admitted.

Transfer of stable patients: Admission of stable patients transferred from other facilities.

Transfer of unstable patients: Admission of unstable patients transferred from other facilities.

## 6.0 PROCEDURE

### 6.1 REGISTRATION PROCESS

- 6.1.1.1 Patient approaches Reception to avail consultation.
- 6.1.1.2 Reception staff to check with patient whether it is patient's first visit or subsequent visit.
- 6.1.1.3 Patient information is software to generate the unique Hospital ID.
- 6.1.1.4 If it is not first visit, reception staff enquires to patient for the registration number.
- 6.1.1.5 If registration detail is not available, a new registration number is given to Patient for the consultation.


### 6.2 ADMISSION

- 6.2.1.1 All patients who are to be admitted should complete registration process.
- 6.2.1.2 Admissions are referred from OP department, Referrals and Casualty.
- 6.2.1.3 The doctor advises for the admission in the Admission note form for OP patients.
- 6.2.1.4 Billing staff explain the tariff details and availability of type of bed.
- 6.2.1.5 Patient is admitted based on their choice and availability of type of beds.
- 6.2.1.6 Every patient is provided unique Inpatient Number at the time of admission.
- 6.2.1.7 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.
- 6.2.1.8 If the staff handling registration and admission needs any clarification on the services provided by hospital, they should contact Chairman / Administrative Manager for necessary information.

### 6.3 POLICY ON NON –AVAILABILITY OF BEDS

#### 1.0 PURPOSE

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


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## **2.0 PROCEDURE**

- 2.1** Patients shall be offered a choice of patient rooms / beds.
- 2.2** In case of non-availability of bed, the admission staff informs Chairman to decide on arranging / adding more beds within the available space (converting single room to sharing room) and the concerned treating doctor is informed.
- 2.3** In the event of non-availability of the room of choice, the patient shall be allotted the best alternative rooms available.
- 2.4** Sri Lakshmi Medical Centre & Hospital has different kinds of room categories such as general ward, single room and deluxe room.
- 2.5** The concerned treating doctor to decide on postponement or cancellation of admission in coordination with patient.
- 2.6** All staff handling registration and admission is to be trained on this Policy and Procedure (New Staff, Changes in duties / tariff plans etc).

## **6.4 MLC CASES:**

- 6.4.1** In case of patients involved in medico legal cases the procedure enumerated below shall be followed.
- 6.4.2** All accidents / assaults / suspicious cases / poisoning and RTA related brought dead cases shall be enlisted as MLC and recorded in the case sheets and maintained separately.
- 6.4.3** The recording shall be done in Accident Register.
- 6.4.4** All such Cases are to be informed to the police in writing by the Residential Medical Officer.
- 6.4.5** A list of MLC cases are shown below:
1. Poisoning.
  2. Injury with sharp object / fire arms.
  3. Burns especially in women.
  4. Drowning.
  5. Death / Injury in a woman.
  6. Road accidents / Industrial accidents.
  7. Conditions which require notification as per the laws for time being in force.
  8. Any other conditions where there is a suspicion of some foul play.
  9. Where the cause of death is not certain.

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## **6.5 REFERRAL OF PATIENT TO OTHER CENTRE**

- 6.5.1** If there is no possibility of bed availability or if the patient is not agreeable to be admitted in another class, then the treating doctor is asked to possibly defer the admission of the patient or refer the patient to another centre.
- 6.5.2** In case of transfer of patients in a life threatening situation (like those who are on ventilator) to another organization, a doctor / ACLS Trained Staffs accompanies the patient. The ambulance driver helper, male nurse (Trained in BCLS and / or ACLS), or doctor accompany during transfer for unstable Patients to other organizations.

## **6.6 TRANSFER OF STABLE PATIENTS**

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

### **6.6.1 POLICY ON UNSTABLE PATIENTS**

#### **1.0 POLICY**

To provide a mechanism to facilitate the appropriate transfer of medically unstable patients.

#### **2.0 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

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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.

### 3.0 PROCEDURE

- 3.1 Requests from other health care providers to transfer patients who have an emergency medical condition and require emergency and tertiary level medical care not available at that facility should be immediately approved when services, space, facilities, and personnel are available to provide appropriate care.
  - 3.1.1 When the facility making the transfer request is capable of providing the necessary care, that facility must stabilize the emergency medical condition prior to transfer.
  - 3.1.2 When the transferring facility is requesting the transfer of an unstable patient, the following conditions must be met:
    - 3.1.2.1 Physician certification that the expected benefits of transfer outweigh the risks of transfer
    - 3.1.2.2 Patient or family consent when possible
    - 3.1.2.3 Attempts made by the transferring hospital, within its capability, to stabilize the patient in order to minimize any risks of the individual during transfer
    - 3.1.2.4 Our capacity and capability to treat the transferred patient
    - 3.1.2.5 Delivery of all appropriate medical records
    - 3.1.2.6 Transfer shall be made with qualified personnel and transportation equipment.
- 3.2 If an emergency patient requires services not available at Sri Lakshmi Medical Centre & Hospital, the transfer shall be refused with a recommendation to contact another facility with the necessary capability.
- 3.3 Transfer of patients shall be made by the referring physician contacting Senior Consultant / Consultant / Residential Medical Officer of Sri Lakshmi Medical Centre & Hospital.
- 3.4 The Sri Lakshmi Medical Centre & Hospital staff member shall obtain the details of the patients’ emergent medical condition and contact Admitting Desk. Admitting Desk shall verify that beds are available.
- 3.5 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.
- 3.6 Similarly, when resources matching the patient needs are not available at Sri Lakshmi Medical Centre & Hospital patients shall be transferred KG Hospital 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. Transportation arrangements



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and a medical escort (if needed) shall be made through the Residential Medical Officer.

**3.7 Indications for transfer to another facility:**

**3.7.1** Psychiatric condition

**3.7.2** No beds are available at all

**3.7.3** Patient desires to be transferred to another facility

**3.7.4** Services are not available at the hospital

**3.8** Patients being transferred from Sri Lakshmi Medical Centre & Hospital shall be accompanied by a transfer summary that shall include details of the patient medical condition, interventions done and the ongoing needs of the patient.

**3.9** Such transfers shall be accompanied by the residential medical officer.

**3.10** Stabilization prior to transfer shall include securing the airway (if needed), intravenous access, appropriate fluid replacement and pain control.

**6.6.2 POLICY ON STABLE PATIENTS**

**1.0 POLICY**

To provide a mechanism to facilitate the “appropriate transfer” of stable, non-emergent patients who request such a transfer.

**2.0 DEFINITIONS**

An “appropriate transfer” is defined as one in which:

The receiving facility has available resources and agrees to accept the transfer and provide necessary treatment, and the transferring facility provides the receiving hospital with a complete copy of the patient’s records and other information (such as discharge summary, copies of X-rays, etc.), and the transfer is effected through qualified personnel and transportation equipment, including use of necessary and medically appropriate life support measures during the transfer.


**3.0 PROCEDURE**

**3.1** It is the policy of Sri Lakshmi Medical Centre & Hospital to accept the transfer of stable, non-emergent patients when space, facilities, and personnel are available. Every effort shall be made to accept patients when the sending facility does not have the space, facilities or personnel to provide safe and appropriate care.

**3.2** Transfers of stable, non-emergent patients to higher referral centre may be made by contacting a Consultant physician of the Hospital.

**3.3** Stable, non-emergent transfers shall be directly admitted to hospital units.

**3.4** Acceptance of stable, non-emergent patients for transfer to Sri Lakshmi Medical Centre

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& Hospital shall be made contingent upon verification of available resources.


- 3.5** Transportation arrangements for patients to be transferred from Sri Lakshmi Medical Centre & Hospital shall be made through the Residential Medical Officer.
- 3.6** Similarly, when resources matching the patient needs are not available at Sri Lakshmi Medical Centre & Hospital, patients shall be transferred to facilities that can meet the patient's needs. Appropriate transportation arrangements and a medical escort (if needed) shall be made through the Residential Medical Officer.

## **7.0 RECORDS**

- 7.1 Registration Form
- 7.2 Admission Note

## **8.0 REFERENCE**

Pre Accreditation Entry Level standards for Hospitals-First Edition: April 2014

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## **AAC 03 & 04 - POLICY AND PROCEDURE ON PATIENT INITIAL ASSESSMENT & REGULAR RE-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 Sri Lakshmi Medical Centre & Hospital.

### **3.0 DEFINITION**

#### **ASSESSMENT**


All activities including history taking, physical examination, laboratory investigations that contribute 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 Sri Lakshmi Medical Centre & Hospital 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, DMO are responsible to carryout initial assessment within One hour or Admission and to document the same within the 24 hours of Admission.
- 5.2 Every Inpatient should be reassessed at least once in a day (Non – Critical Care areas) or, as and when necessary.

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

## **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 emergency ward.
- 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 prescription form 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 his / her Team Member (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 should assess 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, Drugs, etc.
- 6.1.8 Analysis of information from initial assessment drives the following
  - 6.1.8.1 Initial treatment and discharge planning.
  - 6.1.8.2 May trigger additional assessment for nutrition, physiotherapy, and education.
  - 6.1.8.3 Other specialized treatment needs.

### **6.2 REASSESSMENT**

- 6.2.1 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
- 6.2.2 Reassessment is to be performed by medical and nursing staff. Ancillary Services involved in the patients care also perform reassessment as required by patient's needs.
- 6.2.3 Reassessment is to be performed to identify and determine / monitor patient's response to care / treatment.
- 6.2.4 Reassessment of Patient care needs including treatment plan / plan of care



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review is to be initiated at the following condition;

6.2.4.1 Whenever there is a significant change in patient condition and / or Diagnosis.

6.2.4.2 When a Patient is transferred from one setting to another setting.

Example: ICU to ward.

6.2.4.3 At the time of discharge.

- 6.2.5 Based on initial assessment of the Patient and established plan of care, reassessments are to be performed and to be documented throughout the care process (Hospitalization).
- 6.2.6 Multidisciplinary approach to be 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, Dietician, Physiotherapist etc...
- 6.2.7 The plan of care to be reviewed regularly by Treating Doctor or his / her Team Member. This review should include information from other Doctor, Dietician, Physiotherapist, Patient and Patient family.
- 6.2.8 When required the plan of care should be revised as appropriate to the patient condition and ongoing assessment process to be carried and this same to be documented.
- 6.2.9 Discharge planning needs to be included in the initial assessment and reassessment process throughout the patient hospitalization.
- 6.2.10 The patient and Patient family to be involved in discharge planning process, as appropriate by Treating Doctor or his / her Team Member.
- 6.2.11 The decision of discharge to be taken in consultation with patient and/or family members. The same to be documented in IP Record as "FIT FOR DISCHARGE" with signature, name, date and time by Treating Doctor or his / her team member.


### 6.3 CONTENT OF THE INITIAL ASSESSMENT

#### 6.3.1 INPATIENT & EMERGENCY PATIENTS

The Contents are Complaints, History, examination, Provisional Diagnosis / Diagnosis, Investigations & treatment.

#### 6.3.2 OUTPATIENT

Outpatient prescription form is predefined.

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Outpatient prescription form has the following parameters

- a) Complaints with duration and history
- b) Physical Findings
- c) Clinical Diagnosis
- d) Investigations
- e) Treatment and follow-up

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.

#### 6.4 DOCUMENTATION

Assessment and Reassessment are to be documented by

- Doctors
- Nurse
- Other assessment are performed and documented, as appropriate by
  - 6.3.1.1 Dietician
  - 6.3.1.2 Physiotherapist


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## **7.0 RECORDS**

- 1) Prescription Form – Outpatient
- 2) Inpatient Case Sheet

## **8.0 REFERENCE**

Pre Accreditation Entry Level standards for Hospitals-First Edition: April 2014

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## **AAC 05 - POLICY AND PROCEDURE ON LABORATORY SERVICES, QUALITY ASSURANCE AND SAFETY PROGRAMME**

### **1.0 PURPOSE**

To provide guidelines for laboratory services as per the requirements 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 service offered

### **3.0 RESPONSIBILITY**

3.1 Head of the department,

3.2 Biochemist,

3.3 Laboratory technicians,

### **4.0 ABBREVIATION**

4.1 NABH : National Accreditation Board For Hospitals And Healthcare Providers

4.2 AAC : Access, Assessment and Continuity of Care

### **5.0 DEFINITION**

### **6.0 REFERENCE**

Pre Accreditation Entry Level standards for Hospitals-First Edition: April 2014


### **7.0 POLICY**

7.1 24 hours laboratory services are provided at Sri Lakshmi Medical Centre & Hospital.

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

7.2.1 Clinical Biochemistry

7.2.2 Hematology

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### 7.2.3 Serology

**7.3** Sri Lakshmi Medical Centre & Hospital clinical laboratory will engage competent personnel for technical work which includes technologist and Professionals. SMCH ensures that all staff of Laboratory Services is appropriately trained.

**7.4** The clinical laboratory services sets out the acceptance criteria for samples received to ensure quality and safe service.

**7.5** 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; MR. no (IP No.); Test examinations clearly indicated; Doctor’s Name, Signature, date and time.

**7.6** Criteria for labeling the samples.

**7.7** All samples must be labeled with Name of the patient, sex, age, IP.No, date and time of sample taken.

**7.8** All samples are discarded as per Biomedical Waste Management Handling Rules, 1998 (2000).

**7.9** Turnaround time for each tests are defined. Laboratory results are issued within the defined time frame- Critical results are defined and displayed. Critical results if any are reported to the concerned doctor through intercom these are recorded. It is the responsibility of the laboratory staff to communicate any critical test results to the concerned doctor.

**7.10** Laboratory personnel are trained in safe practices and are provided with appropriate safety equipment / devices.

**7.11** Tests not done in the hospital are outsourced to an approved outside lab. A “Outsourced Test Register” is maintained with the following details:

**7.11.1** Lab. No.,

**7.11.2** Age & Sex,


**7.11.3** MR No. / IP No.,

**7.11.4** Name of the patient & Consultant,


**7.11.5** Signature of the person sending the sample and receiving the test report.

**7.11.6** ID. No. & Name of the external Lab,

**7.11.7** Test results.

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**7.12** The above record is maintained in a separate register.

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## **AAC 06 - POLICY AND PROCEDURE ON IMAGING SERVICES AND SAFETY PROGRAMME**

### **1.0 PURPOSE**

To provide guide lines for identification and safe transportation of patient 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** Radiation Safety Officer,
- 3.3** Radiography Technicians

### **4.0 ABBREVIATIONS**

- 4.1** NABH : National Accreditation Board For Hospitals And Healthcare Providers
- 4.2** AAC : Access, Assessment and Continuity of Care

### **5.0 DEFINITION**


### **6.0 REFERENCE**

Pre Accreditation Entry Level standards for Hospitals-First Edition: April 2014

### **7.0 POLICY**

#### **7.1 Compliance with legal requirement:**

- 7.1.1** AERB / BARC approval for imaging unit has been obtained after inspection and the licenses are displayed in their respective areas to prove compliance on these issues
- 7.1.2** All the workers of the imaging services have been provided with TLD badges for monitoring of their individual exposures to radiation as part of radiation safety program. Regular

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monitoring of these badges has been out sourced and a record for the same is maintained in the radiology department, of SMCH.

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

7.1.4 Training of department staff.

**7.2 Diagnostic Imaging includes the following:**

7.2.1 Computerized Radiography

7.2.2 Mobile Radiography.

7.2.3 Ultrasound and Colour Doppler.

7.2.4 CT scan.

**7.3 Identification of patient:**

7.3.1 Sri Lakshmi Medical Centre & Hospital shall ensure that all the patients are identified prior to carrying out their investigations.

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

7.3.3 Where applicable patient shall be advised for pre-test preparation and appointment shall be scheduled for the test when pre-test preparation deserves time more than a day.


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

7.3.5 Technician shall 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 shall ensure the safe transportation of patients to the imaging services. For patient's transportation the Inter – Hospital transfer procedure shall be followed. The medical staffs arranging transportation is responsible for this task.

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



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**7.6 Critical result intimation:** Critical results shall be intimated immediately to the concerned personnel. Imaging test not available in the organization shall be outsourced to the organization based on their quality assurance programme.

**7.7 Results reporting:** The report shall also include the results of any calculations and analysis of radioactive material deposited in the body of the employee. The report shall be in writing and shall contain the statement: "You should preserve this report for future reference."

**7.8 Outsourced tests:** Imaging test not available in the organization shall be outsourced to the organization based on their quality assurance programme

**7.9 Qualified staff for department:**

**7.9.1** Adequately qualified and trained person shall only be deployed for imaging services.

**7.9.2** Only qualified, credentialed and authorized clinician shall be responsible for conducting or supervising all radiology procedures and reporting.

**8.0 PROCEDURE**


**8.1 Radiology equipment:**

**8.1.1** The X-ray units in use in the hospital are fixed X-ray unit, portable X-ray units placed in the high dependency areas, C-arm X-ray unit used in the OT. They are used for diagnostic purposes only.

**8.1.2** Radiation protective jackets and gloves should be worn by the staff in the department during procedures. 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 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., shall be ensured.

**8.1.4** Protection of abdomen & vital structures of children / patients and staff shall be ensured.

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## **8.2 Qualified personnel:**

- 8.2.1** The radiology department is headed by qualified radiologists who will issue reports on all imaging services provided to the patients if so desired by the consultant.
- 8.2.2** The department shall have qualified and experienced radiographers who can conduct the procedures 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 doctor by the radiologist / technician.
- 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 centre or Medical College Hospital, or Hospital imaging centre with whom the hospital has a working arrangement and after the procedure the patient is brought back with the test results.

## **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 casualty scan reports are communicated urgently and subsequently a written provisional report is also issued.
- 8.4.2** All out patient reports are issued the same day for investigations performed on the following working day if performed later. 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.
- 8.4.3** In some special cases (emergency hours or physician's request) the films are dispatched without reports. These are recorded in the Dispatch Register.



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### **8.5 Patient recall for outpatients**

**8.5.1** If the Radiologist needs to repeat the scans or requires additional history of a patient to aid in reporting- the patient needs to be recalled. The front office staff will call the patient on the available contact number and recall the patient with proper explanation and communicate the same to Radiologist.

### **ANNEXURE A**

#### **TURN AROUND TIME FOR USG SCANNING RESULTS (ULTRASOUND SCAN)**

<b>SL. NO.</b>	<b>PROCEDURE</b>	<b>TAT</b>
01	USG ABDOMEN AND PELVIS	10 MINS.
02	OBSTETRICS	15 – 20 MINS.
03	TRANS VAGINAL SCAN	10 MINS.
04	FOLICULAR STUDY	5 MINS.
05	SCROTUM	10 – 15 MINS.
06	THYROID	10 – 15 MINS.
07	BREAST	10 – 15 MINS.



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08	COLOUR DOPPLER STUDY	ARTERIAL DOPPLER	15 – 20 MINS.
		PERIPHERAL VASCULAR ARTERIES	15 – 20 MINS.
		VENOUS DOPPLER	15 – 20 MINS.
09	SMALL PARTS		10 MINS.

**X-RAYS:**

All types of plain X-ray, special investigation X-rays like IVP, Barium meal, Enema, Swallow

Timeframe to dispatch the report - 30 Minutes

**TURN AROUND TIME FOR X-RAY RESULTS**

SL. NO.	PROCEDURE	NO. OF VIEWS	TAT
01	SKULL AP/ LATERAL	02	15 MIN
02	MANDIBILE AP	01	10 MIN
03	BOTH MASTOID LATERAL	02	15 MIN
04	ORBIT PA	01	10 MIN
05	PARANASAL SINUS	01	10 MIN



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06	T M JOINT LATERAL	02	15 MIN
07	CERVICAL SPINE AP/ LATERAL/ OBLIQUE	03	20 MIN
08	CERVICAL SPINE. FLEXTION/ EXTENSION/OPEN MOUTH/ RAO/ LAO	05	30 MIN
09	SHOULDER AP/ AXIAL	02	15 MIN
10	CLAVICAL AP	01	10MIN
11	CHEST PA/LATERAL/ RAO/ LAO	04	30 MIN
12	RIBS AP	01	10 MIN
13	THORACIC SPINE AP/ LATERAL	02	20 MIN
14	D L SPINE AP/LATERAL, OBLIQUE	03	25 MIN
15	LUMBER SPINE AP/ LATERAL / OBLIQUE	03	30 MIN
16	LUMBER SPINE FLEXTION/ EXTENSION/RAO/ LAO	04	30 MIN
17	HUMEROUS AP/ LATERAL	02	15 MIN
18	ELBOW AP/ LATERAL	02	15 MIN
19	FOREARM / AP / LATERAL	02	15 MIN
20	WRIST / AP / LATERAL	02	15 MIN



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21	HAND / AP / LATERAL / OBLIQUE	03	20 MIN
22	PELVIS / AP / LATERAL	02	15 MIN
23	BOTH HIP / AP / LATERAL	04	25 MIN
24	SACRUM / COCCYX / AP / LATERAL	02	20 MIN
25	WHOLE SPINE / AP / LATERAL	02	15 MIN
26	AUG	04	35 MIN
27	IVP	06	2 HRS
28	BARIUM SOLLOW	06	1 HR
29	BARIUM MEAL	06	1 HR
30	HSG	03	1 HR
31	KUB	01	10 MIN
32	BED SIDE X-RAY	01	35 MIN
33	ABDOMEN ERRECT	01	10 MIN
34	FUMER / AP / LATERAL	02	15 MIN
35	KNEE / AP / LATERAL / AXIAL	03	20 MIN



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36	LEG / AP / LATERAL	02	15 MIN
37	ANKLE / AP / LATERAL	02	15 MIN
38	FOOT / AP / LATERAL / OBLIQUE	03	20 MIN
39	CALCANEUS / LATERAL / AXIAL	02	15 MIN

**CT:** Plain and contrast CT of Brain, Orbit, PNS, CT of spine [Cervical, Thoracic & Lumbo Sacral] CT of Abdomen, Thorax (Chest), Pelvis. CT of Extremities.

**TURN AROUND TIME FOR RECEIVING CT INVESTIGATION RESULTS**

SL. NO.	PROCEDURE		TAT
01	BRAIN	PLAIN	1 HR 15 MIN
		CONTRAST STUDY	1 HR 30 MIN
02	BRAIN WITH FACIAL BONE		1 HR 30 MIN
03	BRAIN WITH CERVICLE SPINE		1 HR 45 MIN
04	NECK	PLAIN	1 HR 15 MIN
		CONTRAST STUDY	1 HR 30 MIN



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05	PARANASAL SINUSES		1 HR 15 MIN
06	TEMPEROAL BONE		1 HR 15 MIN
07	CHEST	PLAIN	1 HR 15 MIN
		CONTRAST STUDY	1 HR 15 MIN
08	HRCT LUNGS		1 HR 15 MIN
09	SHOULDER		1 HR 15 MIN
10	WHOLE ABDOMEN	PLAIN	1 HR 15 MIN
		IV CONTRAST STUDY	1 HR 15 MIN
		ORAL + IV CONTRAST STUDY	1 HR 30 MIN
		ORAL + IV + RECTAL CONTRAST STUDY	3 HRS
11	UPPER ABDOMEN	PLAIN	1 HR 15 MIN
		CONTRAST STUDY	1 HR 30 MIN
12	PELVIS	PLAIN	1 HR 15 MIS
		CONTRAST STUDY	1 HR 30 MIN
13	CT UROGRAM	CONTRAST STUDY	2 HR 30 MIN





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14	ELBOW		1 HR 15 MIN
15	KNEE		1 HR 30 MIN
16	ANKLE		1 HR 30 MIN
17	OTHERS		1 HR 30 MIN
18	CT KUB		1 HR 30 MIN
19	C S SPINE		2 HRS
20	LUMBER SPINE		2 HRS
21	3D	FACE	3 HRS
		PELVIS	
		SKULL	
		OTHERS	
22	CT BIOPSY		2 HRS

## 9.0 REFERENCE

Pre Accreditation Entry Level standards for Hospitals-First Edition: April 2014

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## **AAC 07 - POLICY AND PROCEDURE ON DISCHARGE**

### **1.0 PURPOSE**


To provide guidelines for the discharge of in-patients from Sri Lakshmi Medical Centre & Hospital.

### **2.0 POLICY**

- 2.1** Discharge procedures shall be followed to ensure patients are discharged effectively and efficiently, allowing for optimal utilization of available resources.
- 2.2** An authorized hospital discharge shall only be made by an order from the primary consultant. However, a patient may discharge himself/herself against medical advice.
- 2.3** The Consultant or his designee shall document discharge instructions in the patient's medical record at the time of anticipated discharge.
- 2.4** A Discharge Summary shall be prepared.
- 2.5** The Ward Sister shall be the responsible person to ensure compliance with this policy.
- 2.6** The discharge summary shall contain:
  - The reason for admission
  - Significant findings
  - Any diagnosis
  - Procedures performed
  - Significant medications administered
  - Condition at discharge
  - Discharge medications and follow-up instructions
- 2.7** In case of death, the discharge summary includes the cause of death
- 2.8** The nurse shall be responsible for completing the discharge checklist and explaining the discharge summary to the patient. Patient/family understanding shall be documented on the discharge checklist by obtaining the patient/family signature.
- 2.9** All the patients are provided with a discharge summary at the time of discharge.
- 2.10** Patients requesting discharge against medical advice shall be explained the risks and consequences. The consent will be obtained from the patient/ family as per the informed consent policy.

### **3.0 DISCHARGE SUMMARY**

Patients who are discharged are given discharge summary. Patients who leave hospital against medical

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advice are to be explained on the consequences of LAMA and signature to be obtained in LAMA form in Inpatient Record. Patient who comes to casualty, take treatment and leave hospital with CMO consent as OP consultation basis are given prescription. All these contain patient condition and treatment given.

#### **4.0 RECORDS**

Inpatient Record

#### **5.0 REFERENCE**

Pre Accreditation Entry Level standards for Hospitals-First Edition: April 2014