NABH: National Accreditation Board for Hospitals & Health care Providers

NABH (6th Edition)
Chapters: 10
Standards: 100
Objective elements: *639*

Patient Centric Chapter:-

- Access Assessment and continuity of care (AAC)
- Care of Patients (COP)
- Management of Medication (MOM)
- Patient Rights and Education (PRE)
- ***Infection Prevention & Control (IPC)***

Organization Centric Chapter:-

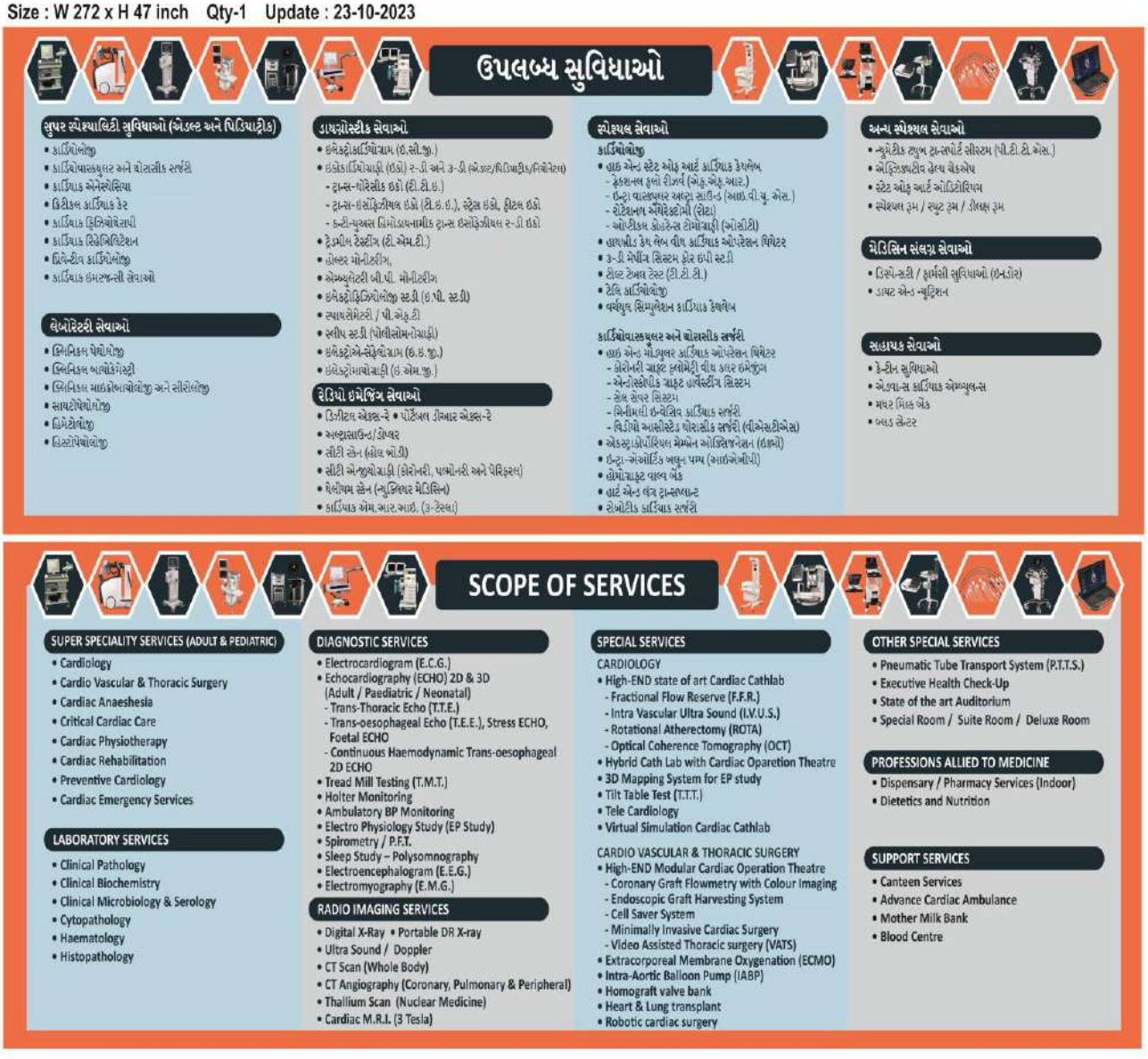
- Patient Safety and Quality Improvement (PSQ)
- Responsibilities of Management (ROM)
- Facility Management and Safety (FMS)
- Human Resource Management (HRM)
- Information Management System (IMS)

ACCESS, ASSESSMENT AND CONTINUITY OF CARE (AAC)

Q.1 Which are the scope of services (Diagnostic and Therapeutic services) provided at our hospital?

Answer:

Size : W 272 x H 47 inch Qty-1 Update : 23-10-2023



These Services are displayed at

a. Main Entry gates
b. Ground Floor, New Building – in patient waiting area opposite Reception counter
c. Ground Floor, Old Building

Q. 2 Which are the schemes being offered at our hospital?

Answer:

1. Emergency Medical Cardiac Services (EMCS): This Unique scheme only available at our Institute
2. Rashtriya Bal Swasthya Karyakram (School Health Program)
3. PM-JAY (Ayushman Bharat Pradhan Mantri Jan Arogya Yojana)
4. Scheduled Tribe (S.T.) Scheme :
5. Scheduled Cast (S.C.) Scheme
6. CM Fund (Chief Minister's ReliefFund)
7. PM fund (Prime Minister's ReliefFund)
8. Central Government HealthScheme (CGHS)
9. CAPF (Central Armed Police Force Scheme).
10. Below Poverty Line Scheme (BPL)

Q. 3 What is registration process in our organization?

Answer:

UNMICRC Registration Process:-

- Patients are accepted only if the hospital is able to cater the condition of the patient as per the scope of services. In case of any confusion regarding this, the registration and admission staff shall contact the I/C CMO or on duty consultant cardiologist/CVTS surgeon.
- In Case of emergency, lifesaving treatment is given by competent staff before any decision is taken regarding acceptance.
- Staff at registration counter shall ensure whether patient is coming for the first time or is already a registered patient.
- If the patient has come for the first time, the patient is requested to fill in the physical registration form manually.
- Registration Form shall include patient's general information along with his/her consent to initiate registration and treatment process.
- The registration form shall be made available at Registration counter, Emergency counter.
- The staff at reception shall ensure that all fields in the form have been correctly filled and patient / patient's relative has signed the form and also ensure that correct contact number is mentioned for the purpose of any further communication / verification.
- The registration staff shall verify that all the details in the form are correct.
- The registration staff shall enter this data, along with the patient's ABHA number (in OPD) and captured photograph of the patient into the HMIS system. The server will then generate a unique registration number as well as an OPD visit number, and the details shall be saved in the HMIS system.

- HMIS has a facility to identify duplicate patient entries and alert the registration staff on a duplicate values.
- Once registration is completed. The OPD case paper shall be printed and is handed over to the patient.
- The patient shall be advised to bring the hospital OPD case paper during all their subsequent visits/ follows up.

➢ **Registration in Emergency Department**:-

- The patients coming/brought in emergency condition shall be registered and provided unique registration number with OPD number at the Emergency Medical Cardiac Services (EMCS) reception counter.
- However, registration process shall be followed after completions of initial evaluation of the patient. If the relative of the patient is available, he/she fulfils the registration process.
- In situations when no one accompanies the patient, the staff shall contact the relatives of the patient. If there is no relative of patient or no data of patient or patient's relative is not available, at that time patient treatment is started and police is being informed about unknown person (Binvarsi).

➢ **Registration of Unidentified Patients**

- In case of unidentified patient is received in the hospital (not in a position to identify), immediately inform to I/C CMO / RMO / ARMO of the hospital. Then patient shall be registered as unidentified patient and admitted in Emergency for treatment. Simultaneously CMO of the Civil Hospital & Police shall be informed and if required EPR shall be generated.
- If unidentified patient dies during the course of treatment, inform to police & dead body of the patient shall be sent to Civil Hospital for Post-mortem.

- **UNMICRC Registration Process**

New patient

↓

Fill the physical registration form manually

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Submit filled form to registration counter

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Registration staff verify all the details in the form through government ID Proof

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Entry in HMIS system along with ABHA number and captured photograph of the patient

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Generate unique registration number along with OPD visit number

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Printed OPD case paper hand over to the patient

- **Follow up patients registration process (National & International):**

Registered/Follow up patients

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Show discharge card or old OPD case paper to Register counter

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After adding fresh photograph of patient in HMIS, follow up OPD case paper is generated along with new OPD visit number

(Unique registration number as previous)

- **Registration Process for International Patients:**

New patients

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Fill the physical registration form manually

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Submit filled form to registration counter

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Registration staff verify all the details in the form through Passport/Visa copy or certificate of citizenship

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Entry in HMIS system and captured photograph of the patients

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Generate unique registration number along with OPD visit number

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Printed OPD case paper handed over to the patient with 'Foreigner' stamp

Q.4 What are the timings for OPD Registration and OPD Consultation? Where arethey displayed?

Answer:

Timings for OPD Registration and OPD Consultation: 9:00 AM to 5:00 PM. It is displayed opposite Registration Counter.

Q.5 What is the Admission Procedure of our hospital

Answer :

UNMICRC Admission Process :-

- For admission, a request shall be given by consultant/Resident Doctor on OPD case paper.
- In OPD, Patient shall be educated about the need of the admission and also about the expected cost of treatment.
- Counselling of patient/patient's relative shall be done in OPD regarding various government run schemes. If patient falls under any of the scheme which in scope of the institute, then patient shall be explained about the documents required to avail the scheme and guided towards scheme verification room to complete the formality.
- Then the patient or the patient's relative shall be guided to complete IPD registration either at the admission counter in the case of OPD patients or at the emergency case registration counter for emergency patients. The patient's IPD registration information is entered into HMIS.
- Patient shall be asked to pay the required amount in advance as per the pre-defined tariff or package if the patient does not fall under any of the scheme which is in scope of the institute.
- At Registration counter, IPD case Paper shall be generated through HMIS and general consent for admission shall be taken from patient/patient's relative.
- After completion of all above formality, Patient ID Band and visitors passes shall be issued along with the file containing Initial Nursing Assessment Form, Nutritional Screening and assessment Form, nutritional Education on discharge, Patient valuable Form, Patient Education Form, Investigation Report chart, Progress Note, etc.
- Patient attendant shall accompany the patient from registration counter to the concerned department.
- In case of any conflict or further clarification related to admission, I/C CMO / RMO / ARMO shall be contacted.
- In case of Prisoner Patient, after OPD consultation, doctor shall provide estimated cost to concerned authority. Concerned authority shall sanction the required amount and patient shall be brought to hospital for admission. Before admission I/C CMO / RMO / ARMO shall verify all the documents and approve for the admission. Then rest of the admission process shall be carried out.

UNMICRC OPD Admission Process

Request shall be given by consultant/resident doctor on OPD case paper

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Counselling patient/relatives (For need of admission & govt. scheme)

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IPD registration in HMIS System

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IPD case paper generate along with new IPD visit number

Admission Process of International Patient:-

- At the time of admission of international patient, following procedure to be followed.
- Registration for admission is done at admission counter as per the written orders on OPD case paper by consultant or on duty doctor.
- In the indoor case paper, OPD case paper, and indoor payment record, a 'Foreigner' stamp is applied.
- Physical “C” form is completed at the time of admission on the admission counter and photocopy of passport and visa is taken.
- Patient’s Photograph along with the passport and visa photocopy and filled Form “C” are sent to FRRO department and/or police commissioner office.
- Intimation about visa will be send to FRRO department and/or police commissioner office.

Q.6 What procedure is followed in case of non-availability of beds?

Answer:

- UNMICRC is an emergency related tertiary Cardiac care hospital and patients are coming to emergency department from all over the state & from neighboring states also.

In case of Non Availability of Beds in Wards

Patient will be temporarily admitted to other department's general ward where beds are available

If general beds are not available in entire hospital, then patient will be given date & time of admission for further treatment considering stable patient or the patient is referred to another facility for the admission

In case of Non Availability of Beds in ICCU

Firstly, institute will try to admit all the patients on mobile couch in between the regular beds

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Emergency duty unit head will be contacted & team member of the respective unit will evaluate already admitted patients in ICU for shifting of stable patients to their ward

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If, despite all these measures, more ICU beds are still required, the institute will refer the patient to another hospital, and the hospital authorities will coordinate with the RMO/ARMO for the necessary admission.

Procedure Steps	Responsible
In case of Non Availability of Beds in ICCU	
ICU beds shall be allotted according to ICCU priority criteria.	On duty doctor - ICCU
On Duty Doctor at emergency department shall communicate to the on duty doctor of ICCU before admitting the patient.	On duty doctor - Emergency Department
In case of non-availability of beds in PICU/NICU respective paediatric patient will be shifted to any other ICU as per requirement or stable paediatric patients shall be shifted to Paediatric Wards and stable patients at Paediatric Wards shall be discharged.	On duty doctor – PICU & NICU
If still there is non-availability, then patient shall be shifted to the nearby hospital's emergency department.	I/C CMO / On duty doctor

In case of non-availability of beds in ICCU and if patient required to be shifted to other HCO, institute will provide necessary transport along with required hospital staff for smooth shifting of the patient to other HCO. Before shifting of patient necessary communication will be done to respective HCO and availability of beds will be confirmed.	I/C CMO / On duty doctor
In case of Non Availability of Beds in Special Rooms	
In case of Non Availability of special room, Patient shall be explained and temporarily shifted to general ward after getting consent from him/his relative to do so. On availability of the special room, the patient shall be given priority and immediately shifted to the particular room.	On Duty Doctor

Q-7 How do you confirm the identity of your patient?

Answer:

- The following approved identifiers and sources may be used for positive identification on patient band and medical record
  - Patient name,
  - Patient's Unique Registration No.
  - Patient's OPD /IPD no.
- A combination of two identifiers is used to confirm the patient's identify.
- Sources of patient identifiers may include: the patient, relative, guardian, domestic partner, or a health care provider who has previously identified the patient.
- Identification band must be tied on patient's wrist (preferably on right wrist) of all Inpatients.

Q. 8 Where is the tariff list available if patient wants to refer?

Answer:

Registration Counter (Both – OPD/IPD & EMCS), Reception Counter and "May I help you" Desk.

Q.9 What is procedure for transfer of patient within/ outside the hospital for stable and unstable patient? Who are responsible for transfer of patients? Do you provide any summary about patient's condition and treatment given, while transferring the patient?

Answer:

TRANSFER-IN /REFERRAL IN FROM OTHER ORGANIZATION:-

- Once patient is received from other organization for further treatment patient admitted as new patient and followed all the admission procedure as define in admission policy.
- First patient is received in emergency department from other organization where proper handover should be done and same should be documented in patient record.
- After emergency initial assessment and admission of patient is shifted to Ward/ICU.
- Discharge/Transfer summary to all patients with significant findings and treatment plan.

TRANSFER WITHIN THE HOSPITAL:-

- **ICU to Ward**
  - The consultant determines the requirement of transfer of patient.
  - Telephonic confirmation for bed availability in respected bed by in charge nurse.
  - The in charge nurse of that ICCU communicate about the transfer of patient on the phone with the on duty doctor.
  - The bed for transferring the patient is to be allotted by the in charge nurse/on duty doctor depending on the condition of the patient.
  - Bed allotment is confirmed by on duty doctor (Resident/Medical officer) to the ICU and ward staff.
  - After receiving confirmation from the in-charge nurse or on-duty doctor, enter the patient transfer details into HMIS and proceed with the physical transfer of the patient.
  - Transfer summary details are entered into HMIS.

- **Ward to ICU**
  - Information given to on duty doctor (Resident/Medical officer) regarding general condition of patient.
  - The need for transferring the patient from ward to ICU would be determined by the consultant or Resident Doctor.
  - Enter the patient transfer details into HMIS and proceed with the physical transfer of the patient.
  - Transfer summary details are entered into HMIS.

- **Ward/ ICU to OT Complex**
  - Any patient for surgery /procedure shall be assessed in the patient care unit by on duty Doctor to determine that the patient can undergo the surgery / procedure.
  - Patient shall be shifted to the OT Complex / Cath Lab accompanied by the nurse & hand over shall be done to the nurse – pre operative area/ICU/ward.
  - Enter the patient transfer details into HMIS and proceed with the physical transfer of the patient.
  - Transfer summary details are entered into HMIS.

- **OT Complex to Ward / ICU**
  - Patient shall be assessed post-operatively by the Surgeon & Anesthetist / Cardiologist prior to shifting the patient from the OT / Cath Lab. The Nurse shall receive the patient from OT / Cath Lab.
  - Enter the patient transfer details into HMIS and proceed with the physical transfer of the patient.
  - Transfer summary details are entered into HMIS.

- **Ward/ ICU to Radiology Department**
  - Requisition through requisition form is sent to the Radiology Department by the attending staff of the relevant patient care unit. Requisition shall include the details of patient's name, IP No., investigation to be done.
  - The Radiology department after receiving the requisition shall co-ordinate with nursing staff to verify the request and shall give the appointment time after confirming with the Radiologist.
  - Patient is brought to Imaging services Department by the attendant staff. A nursing staff or on duty Resident doctor accompanies the patient as per condition of patient.
  - For investigations, requiring pre-procedural orders, the patient is prepared in the ward before transferring him/her to the Radiology Department.
  - After the investigation procedure is over, the patient is transferred back to the ward accompanied with the same staff.

- **Class Transfer of the Patient**
  - Patient whoever come under any scheme are not allow in special room category.
  - For special room confirmation of vacancy done through telephonic talk with respected department.
  - Patient & relative are explain regarding charges of special room, investigation, any procedure or surgery.

- Telephonic confirmation for bed availability in respected room by in charge nurse.
- The bed for transferring the patient is to be allotted by the in charge nurse / on duty doctor depending on the condition of the patient.
- After receiving confirmation from the in charge nurse/on duty doctor, the patient's physical transfer is done.
- Transfer summary to all patients with significant findings and treatment.

- **TRANSFER-OUT/REFERRAL OF PATIENTS (UNSTABLE & STABLE):-**
  Any transfer to outside hospital shall be done as per following steps:
  - The decision for transfer shall be taken by the treating consultant depending on the medical condition of the patient.
  - As far as possible bed availability in the destination hospital should be confirmed by on duty doctor.
  - Prompt initial assessment and management of all emergency conditions shall be done by qualified staff within their capabilities and resources available.
  - Patient shall be stabilized and prompt and safe transfer to another facility shall be done if a decision to transfer has been established.
  - The transfer shall be done through qualified personnel (Nursing staff/ Doctor) and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.
  - Nursing Staff/Doctor shall be responsible to give the patient over with appropriate medical history.
  - A proper handover of the patient takes place when handing over is carried out at the destination hospital.
  - The hospital maintains comprehensive records of assessments, treatment details, and investigation reports completed prior to a patient transfer. These records are documented and maintained by the U.N. Mehta Institute of Cardiology & Research centre. A transfer summary is provided to the destination hospital.
  - This process ensures that all critical patient information is accurately communicated during the transfer for continuity of care.
  - In case of unplanned transfer if appropriate medical records not available at the time of transfer, they must be sent as soon as possible thereafter as per requirement.
  - W**hen the receiving organization or specialized services are not available, the hospital shall have a contingency plan by contacting alternate hospitals to ensure patient care needs are met.**
- **TRANSFER OUT/REFERRAL FOR DIAGNOSTIC PROCEDURE:-**
  - Diagnostic procedure shall be done as per consultant advice & on duty doctor (Resident/Medical officer) confirms the procedure date.

- Arrange the ambulance by confirmation from CMO/RMO.
- At the time of appointment, one patient attendant, nursing staff & on duty doctor are going with the patient by hospital ambulance to the Imaging Centre.
- Report of the procedure should be collected by the patient relative. Report is collected after few hours by patient relative.

➢ **APPROPRIATE STAFF DURING TRANSFER/ REFERRAL:**

- In case of transfer of stable patient, trained nurse accompany the patient, if patient is unstable or being shifted for diagnostic purpose, then doctor shall accompany a patient for transfer.
- In case of unplanned transfer, patient shall be accompanied with doctor as well as nurse.
- Nursing Staff/Doctor shall be responsible to give the patient over with appropriate medical history.
- Ancillary staff shall be responsible for help in the patient transfer.
- **All staff involved in patient transfers (internal or external) must maintain current training in emergency transport protocols (e.g., Basic Life Support (BLS), Advanced Cardiovascular Life Support (ACLS) for relevant patient conditions).**

➢ **Patient Monitoring during transport:**

- Vital Signs (Heart Rate, Respiratory Rate, Blood Pressure, SPO2)
- (* Other parameters shall be monitored as per patient's clinical condition and as per doctor's advice)

➢ **Mandatory Equipment & Medication Checklist for external transfer during transportation**:

- Equipment and medications required based on the patient's condition during transportation.
- A patient's transportation needs shall be assessed during transfer.
- The treating doctor shall determine the level of monitoring and required transport mode.
- Based on that, the appropriate type of transportation Basic Life Support (BLS) ambulance, or Advanced Life Support (ALS) / ICU on Wheels) is selected to match the patient's needs.
- Equipment and Medications requirements during transportation

➢ **HMIS Entries:**

- All internal or external transfers should be logged in HMIS, including date/time of transfer, reason, and receiving ward/facility.

➢ **IF TRANSFER IS NOT POSSIBLE**

- If the intended receiving facility cannot accept the patient (e.g., no bed available, lack of required services), the consultant and the Hospital Administration must:

- Attempt transfer to an alternate appropriate facility.
- Stabilize and manage the patient at UNMICRC, using available resources to the best extent possible.
- Communicate the situation clearly to the patient and family, providing possible alternatives.
  - **FOLLOW-UP FROM RECEIVING HOSPITAL**
    The sending nurse or doctor contacts the receiving facility to confirm the patient's arrival and condition (especially for unstable patients).

Q.10 Timeline for completion of Initial Assessment by Doctor / Nurse /Dietician / Physiotherapist?

Answer:

TIMELINE FOR INITIAL ASSESSMENT

Sr. No.	Assessment	Person authorized and responsible for assessment	Time lines for initiation of assessment	Timeline for completion of documentation
1	Complete assessment in case of emergency	On duty doctor	Within 15 minutes	Within 24 hours of admission
2	Admission History and Physical Initial Assessment (including plan of care) in non-critical area	On duty doctor	Within 1 hours of admission	Within 24 hours of admission
3	Nursing Assessment	Nursing Staff	Within 1 hour of admission	Within 24 hours of admission
4	Physiotherapy assessment	Physiotherapist	As per requirement	
5	Nutritional Assessment	Dietitian	As per requirement	
6	Psychological Assessment	Clinical Psychologist	As per requirement	

Entire documentation and verification to be completed within 24 hours.

Q.11 What is Timeframe for Reassessment of the patient?

Answer:

S.N	Department	Vitals & Intake/Output Monitoring	Doctor Reassessment	Nursing Re-assessment
1	Emergency Department	1 hourly	Minimum once in each shift	Minimum once in each shift
2	Cardio-thoracic recovery Room (Adult / Paediatric)	1 hourly	Minimum once in each shift	Minimum once in each shift
3	Medical ICUs	1 hourly	Minimum once in each shift	Minimum once in each shift
4	Surgical ICUs (Adult / Paediatric)	1 hourly	Minimum once in each shift	Minimum once in each shift
5	Paediatric ICU	1 hourly	Minimum once in each shift	Minimum once in each shift
6	Post Cath ICU	Every 2 hourly	Minimum once in each shift	Minimum once in each shift
7	Medical / Surgical / Paediatric Wards	Every 6 hourly or as per early warning score	Minimum once in each shift	Minimum once in each shift
8	Triage area/ Temporary Holding Area: - Depending on patient's condition, it varies from 5 min to at least 1 hour			

*Note:- Reassessment shall be done whenever patient's condition change or as per consultant advice.

Monitoring of Restraint Patients: Adult patients shall be monitored at every 2 hourly and children shall be monitored at every one hourly.

Pain Reassessment: Reassessment of the pain is done daily by the doctor/nursing staff at every 6 hourly and document it in the pain management chart. When the patient complaints the pain, reassessment of pain should be done within two hour or as per doctor's instruction until the intensity of pain rating is 0 or at an acceptable level according to the patient.

All patients shall be reassessed by a doctor at least once daily, including weekends, holidays.

Q.12 Which are the documentation to be done prior to transfer?

Answer:

- Transfer summary of patient stating medical necessity.

- Nursing documentation.
- Time at which the patient left the patient care unit.
- Vital data before leaving.
- Patient and/or family consent copy of agreeing to transfer, if transfer is outside thehospital.
- Proper advise given by consultant
- Time of patient reach the destination hospital/Diagnostic center.
- Vital data after receiving patient to department

Q.13 What are the early warning sign?

Answer:

It is signs of change or deterioration in clinical conditions for initiating prompt intervention.

- The organization trains the nursing staff to identify early warning signs of change ordeterioration in clinical condition. i.e.
- Bradycardia (Pulse < 60/min)
- Tachycardia (Pulse > 120/min)
- Hypotension (Systolic Blood Pressure <80 mm of Hg)
- Hypertension (Systolic Blood Pressure >180 mm of Hg)
- Chest Pain
- Sudden breathlessness
- Sudden Restlessness
- Sudden Sweating or perspiration
- If patient is on TPI- Loss of pacing in monitor
- Intermittent giddiness or worsening sensorium
- Onset of focal neurological deficit
- In intubated patients, Decreasing oxygen saturation at the monitor
- Cold extremities , Restlessness, Pallor and Hematoma on the local site
- Recurrent Vomiting
- Sudden onset pain in abdomen, upper and lower limbs in case of peripheral artery obstructive diseases
- Urine Output < 1 ml / kg / hour
- Wound bleeding

Q.14 What is Rapid Response Team?

Answer:

A **Rapid Response Team** (RRT) is a **team** of health care providers that responds to patients with early warning signs of deterioration in non-intensive care units to prevent medical emergency.

The goal is to treat these warning signs early so that the patient's outcome may be improved and a cardiac arrest prevented.

The Rapid Response Team consists of:-

- On Duty DM or M.Ch resident / Senior resident /Medical Officer
- On Duty Physiotherapist/Physician assistant
- Treating Nursing staff
- Departmental sister In-charge
- Unit coordinator

(* On duty Critical care Intensivist/Anaesthetist are asked to respond whenever required. If patient is very sick, he/she will be shifted to ICCU immediately.)

Procedure:-

- In event of any medical emergency situations, the identifier of the situation notifies it.
- One of the team members of the Rapid Response team shall assess the patient and will determine the sign of deterioration and activate the rapid response team.

Responsibilities:-

Member	Responsibilities
On Duty DM or M.Ch resident / Senior resident /Medical Officer	Manage emergency according to the situation of patient. To inform the patient's family about the situation. To complete the medical record by documenting the entire event in progress note and inform the admitting & attending consultant of the patient.
On Duty Physiotherapist /Physician assistant	To assist the On Duty DM or M.Ch resident/Senior resident/Medical Officer
Treating Nursing staff Departmental sister In-charge	To keep the required equipments and emergency medicines ready. To get the crash cart, if required To record the event in the chart. After the use, replace all used items of the crash cart, if required.
Unit Coordinator	To inform critical care physician, intensivist or other specialty consultant, if required.

Q.15 Does OPD patients are informed about their follow up visit?

Answer:

Yes, it is documented under plan of care in OPD case paper as well as in OPD prescription.

Q.16 What is waiting time for service delivery?

Answer:

Department		**Waiting Time line (Minutes)**
Laboratory	Patho Lab	30 Mins.
	Micro Lab	30 Mins.
Radiology Department	CT Scan	30 Mins.
	X Ray	30 Mins.
	Sonography	30 Mins.
	Nuclear Medicine	60 Mins.
OPD	Cardiology OPD	60 Mins
	CVTS OPD	60 Mins
	Pediatric OPD	60 Mins

Q. 17 Describe in detail about Discharge Process (including LAMA & especially in MLC Case?

Answer:

<u>Discharge process for MLC (Medico Legal Case) / Prisoner Patient:-</u>

- Once the doctor informs about the discharge, the patient is explained about the discharge.
- Then patient folder shall send to billing department to collect the payment if applicable and in case if amount is refundable, patient has to fill up a form to obtain refund.
- On the day of discharge, the complete discharge summary is filled online and signed by on duty doctor / M.Ch. /DM and pediatrician.
- Photocopy of the discharge summary is kept ready so that original copy of discharge summary can be handed over to the patient / patient relative and photocopy can be retained at the medical record department of the hospital. (Include LAMA patients)
- Get the prisoner call books written by the on duty doctor regarding discharge details.
- Signatures to be obtained in the call book from three places before discharging the patient.

- Consultant signature and stamp.
- U. N. Mehta R.M.O. signature and stamp.
- Civil R.M.O. Signature and stamp.
- Nurses check the discharge medicine and explain about the doses give advice regarding care at home and provide patient education.
- The doctor ensures continuity of care by referring patients requiring follow-up to appropriate specialists, clinics, rehabilitation services, home healthcare, or mental health professionals (if needed), and provides necessary contact details, follow-up schedules, and instructions for urgent care.
- The doctor educates the patient and family on safe and effective medication use (including potential side effects and drug interactions), dietary and nutritional recommendations, pain management techniques, proper use of any medical equipment, and necessary rehabilitation activities, documenting all details in the patient's medical record.
- Once the billing is completed check for refund and explain about the refund.
- Patient's uniform is collected as well as remove patient's ID band and Intra cath (if any) and also collect entry pass.
- Patient will be physically discharged then security will check the discharge date in the discharge card at exit point and after verification of date patient will be allowed to go.
- The prisoner patient is always handed over to policeman.

➢ **LAMA (Leaving against Medical Advice) discharge process: -**

- The relative will inform the on duty doctor for their willingness to have Discharge/Leave against Medical Advice.
- The on-duty doctor, I/C RMO and nursing staff must counsel the patient and family regarding the risks of LAMA.
- If the patient / relative insists on leaving, then the LAMA request form is filled and LAMA consent will be obtained from patient / patient relative.
- The Patient's reasons for leaving, Risks explained to the patient, Medical advice given shall be mentioned in LAMA consent form.
- Once LAMA is confirmed on duty doctor will prepare discharge summary.
- Meanwhile staff nurse will prepare the patients' file.
- Discharge summary will be attached to patient's discharge file and will be sent to billing department.
- Billing department will collect the payment and in case if amount is refundable, patient has to fill up a form to obtain refund.
- Nurse will explain about discharge medication to the patient and/or relative.
- Patient's uniform is collected as well as remove patient's ID band and Intra cath (if any) and also collect entry pass.
- Patient will be physically discharged.

- Follow-up contact should be attempted within 48 hours.
- If the patient has a primary care provider, they must be informed of the LAMA discharge.

➢ **No Shows Patient:**

- Patients receiving complex treatments (e.g. Heart transplant) who do not return for continued follow-up treatment shall be contacted by the hospital through follow-up calls to ensure continuity of care.

➢ **Absconded Patient:-**

- The member of staff who identifies that a patient is missing must immediately inform the nurse in charge of the ward or department.
- The bed area / immediate area must be searched to establish whether the patient has taken his or her belongings with them and to determine what they are likely to be wearing.
- The nurse in charge will implement a thorough search of the ward or department.
- The nurse in charge should notify security officer & I/C RMO/CMO that there is a patient missing from the department. Security officer should be requested to attend the department, to receive a briefing, as there may be a need to conduct a search.
- The nurse in charge or I/C CMO or RMO will contact the next of kin/parents/carers that the patient is missing.
- If the patient will trace then, counsel the patient.
- If the patient/patient family will not be traced, then RMO/CMO will inform to the police as and when required according to the circumstances.
- Nursing staff will fill the Abscond patient form in patient's medical record.

➢ **In case of Death:-**

- The cause of death will be mentioned in the Death Summary.
- In case of death in a Medico-legal Case, patient's relative is asked for post-mortem.
- Death Certificate is provided to patient's relative and in medico legal cases, same is provided to police.
- Dead body is handed over to patient's relatives where relatives have to sign on a note mentioning about their request to omit post-mortem and also about receipt of patient's dead body.

Q.18 What should be the content of discharge summary?

Answer:

- Name of patient
- Age/Gender
- Unique identification No. and / or IPD No.
- Scheme details
- Name of Ward

- Name of Consultant/Doctor Name
- Date of Admission
- Date of Discharge
- Type of Discharge
- Allergy
- Reason for admission
- Significant findings
- Diagnosis
- Brief summary of patient's condition on discharge
- Investigations
- Name & Date of Surgery/Procedure with details
- Details of implants (if applicable)
- Medications at time of discharge, including date/time of last dose given while hospitalized
- Other Treatment Given
- Discharge Medication
- Therapeutic equipment at time of discharge
- The patient's condition at the time of discharge
- Follow up advice (Medication, Diet, Appointment, Physiotherapy, Preventive aspects,)
- Instructions regarding when & how to obtain urgent care
- Signature of Resident Doctor/Medical Officer & countersigned by the consultant doctor (Assistant Professor & above) - Doctor member of the treating unit.
- Acknowledgement receipt
- In case of death, death summary also includes a cause of death.

➢ **Discharge Timeframe: -**

- Discharge process are monitored through quality indicator i.e. Time taken for discharge & analyze the indicator for any delays. Reasons for delays are identified and should take corrective & preventive action for the same.

Categories	Timeframe
For Paid Patients	180 Minutes
For Yojana Patients	Within 180 Minutes (After Yojana Clearance)
For LIG/SC/ST/School Health	Within 180 Minutes

Q.19 How does the hospital promote preventive care through education?

Answer:

By educating patients and relatives about infection prevention, immunization, diet, and nutrition through displays, brochures, and awareness programs.

Q.20 What are some key components of family education for pediatric and neonate patients?

Answer: Education on age-specific nutrition, immunization, safe parenting, breastfeeding, and weaning—conducted in understandable language and documented in medical records.

Q.21 What types of screening are included under patient screening at the hospital?

Answer: Screening includes communicable disease checks, mental health screening, and assessment of nutritional or functional needs.

Q.22 What topics are included in patient and family education?

Answer: Pain management, nutrition, treatment plans, potential complications, food-drug interactions, and preventive care.

Q.23 Why is patient and family education important?

Answer: It ensures informed decision-making, treatment adherence, and improves patient safety and outcomes.

Q.24 What is the aim of preventive & promotive care?

Answer: To encourage and enhance overall health and wellness through health education and lifestyle promotion.

Q.25What is "NEERUJ HRIDAYAM – PUBLIC AWARENESS PROGRAM"?

Answer:A weekly health education program in Gujarati for patients' relatives, focusing on different health topics each day to promote awareness and wellness.

Q.26 What is "Turn-Around-Time (TAT)" according to this policy?

Answer: Turn-Around-Time (TAT) is defined as the interval from the moment a sample is collected from the patient (T1) to the time the final report is approved by an authorized laboratory consultant in the Hospital Management Information System (HMIS) (T2). T1 is recorded when the sample barcode is scanned at collection, and T2 is recorded when the doctor electronically validates and approves the result.

Q.27 What are the major steps in the laboratory process flow that are considered part of the TAT calculation?

Answer:

- The process flow that impacts TAT includes:
- **Test Order & Sample Collection:** The clinician orders the test, and the sample is collected with T1 automatically recorded via barcode scanning.
- **Specimen Transport & Receipt:** Samples are transported (e.g., via pneumatic tube system) and received, verified, and logged into the Laboratory Information System (LIS).

- **Analysis & Result Entry:** Lab technicians process the samples, and instrument results are automatically sent to the LIS. Critical values are flagged for priority review.
- **Validation & Approval (T2):** Authorized doctors review results, including flagged values and quality control data, and electronically approve the report in the HMIS. This step marks T2.
- **Documentation:** All time stamps (T1-T2) are permanently recorded in the LIS for auditing purposes.

Q.28 .Where can the defined Turn-Around Times for specific pathology tests be found?

Answer:

- The defined Turn-Around Times for various pathology tests, including both routine and STAT times, whether the test is performed in-house or outsourced, and the required sample amount, are detailed in the Annexure of the policy document under Section 10.0 ANNEXURE – TURN AROUND TIME- PATHOLOGY TESTS. For clinical microbiology samples, the TAT is listed separately in the Clinical Microbiology section.

Q.29 What are the key criteria for accepting and rejecting patient samples?

Answer:

- The laboratory has defined specific criteria for both the acceptance and rejection of primary samples to ensure the quality and reliability of testing. General rejection criteria include samples collected in the wrong container, samples brought in unspecified containers (including syringes), blood samples collected with inappropriate anticoagulants, underfilled or overfilled tubes, leaking containers, haemolysed samples, lipaemic samples (with some exceptions), contaminated samples, and dried swabs. Additionally, discrepancies between patient information on the sample label and requisition form, as well as samples not collected according to standard procedures or with excessive transit time, are grounds for rejection. Specific criteria also exist for the rejection of Microbiology and Infectious Disease Serology samples, such as improper transport temperature, insufficient quantity, leakage, presence of fixatives, and incomplete requisition forms. However, in the best interest of patient care, compromised clinically critical or irreplaceable samples may be accepted with appropriate documentation and caution advised on the final report.

Q.30 Can additional tests be requested on a previously collected sample?

Answer:

- Yes, additional tests can be requested on previously collected samples, subject to certain conditions. These conditions include the availability of sufficient sample quantity for the additional test, the stability of the analytes being tested for the duration of storage, and the sample being stored in the desired container. If these

conditions are met, laboratory technicians can verbally confirm with clinicians or nursing staff to generate an add-on test request in the Hospital Management Information System (HMIS) and document it. If the conditions are not met, such as insufficient sample or compromised integrity, a fresh sample is required for the add-on testing.

Q.31 How are clinical samples stored, retained, and disposed of?

Answer:

- Clinical samples are handled through a documented procedure for identification, collection, indexing, storage, access, retention, maintenance, and safe disposal. After examination, most patient blood samples are stored in a refrigerator at 2-8°C in separate shelves based on sample type and defined retention periods. Positive samples are stored separately to prevent cross-contamination. Temperature logs for refrigerators are maintained daily. Urine samples are generally discarded the same day after examination. Samples for rechecking, retesting, or add-on testing are retained for defined periods, with the stability of the analytes checked before processing. Legal requirements may necessitate longer retention periods for certain samples. Upon completion of their retention period, samples are disposed of safely in accordance with local regulations for biomedical waste management. The institute contracts with an approved agency for the collection and disposal of biomedical waste, and records of discarded samples and waste are maintained.

Q.32 What are the visiting hours?

Answer:4:00 PM to 6:00 PM

CARE OF PATIENTS (COP)

Q.33 What is the primary purpose of the Uniform Patient Care policy?

Answer:

The main purpose is to provide guidelines that ensure uniform, high-quality patient care is delivered throughout the hospital. This includes developing and documenting individualized care plans, monitoring and updating these plans based on patient condition changes, ensuring comprehensive documentation by all healthcare providers, and aligning practices with evidence-based guidelines and regulatory requirements.

Q.34 Does the Uniform Patient Care policy apply equally to all patients?

Answer:

Yes, the policy states that all patients, whether inpatients or outpatients, will receive appropriate medical care aligned with their needs and the hospital's service scope, regardless of their financial status or ability to pay. All patients will also be treated with dignity and respect.

Q.35 What are the two unique identifiers used for patient identification?

Answer:

The two unique identifiers that must be used for every patient

- Unique Hospital Identification Number (UHID)
- full name

which must include their first, middle, and family names. **Room numbers, bed locations, or initials are explicitly stated as unacceptable identifiers.**

Q.36 What are the different color codes used for identification bands and what do they signify?

Answer:

There are several color codes used for ID bands:

- **White:** Adult inpatients.
- **Pink:** Pediatric inpatients.
- **Fluorescent Green:** Outpatients (OPD).
- **Maroon:** Patients with allergies (worn in addition to the standard band).
- **Purple:** Indoor vulnerable patients (worn in addition to the standard band, excluding neonates and children under 12). Additional color codes are used in the Emergency Department for triage based on the Emergency Severity Index (ESI) and for Mass Casualty situations, indicating priority levels and categories.

Q.37 When is patient identification verification required?

Answer:

Patient identification verification is a continuous process. It begins at registration and must be verified at every interaction with the patient, including before any treatment, procedure, diagnostic test, specimen collection (laboratory, radiology), medication administration, blood transfusion, surgery, or transfer of care.

Q.38 Who is responsible for implementing and adhering to the Uniform Patient Care policy?

Answer:

All hospital staff, including doctors, nurses, and paramedical staff, are responsible for implementing and adhering to this policy.

Q.39 Who does the Triage Policy apply to?

Answer:

The Triage Policy applies to all patients, both adult and pediatric, presenting to the hospital's Casualty (Emergency Department) during both routine operations and mass casualty events. It also applies to all healthcare professionals involved in the triage process, including doctors, nurses, paramedical staff, administrative staff, security personnel, and the infection prevention and control team.

Q.40 How are patients categorized during daily operations triage?

Answer:

During daily operations, adult patients are triaged using the Emergency Severity Index (ESI), and pediatric patients are triaged using the Pediatric Emergency Severity Index (p-ESI). Both systems use a five-level scale with corresponding color-coded identification bands: **Level 1 (Red)** for immediate, life-saving intervention needed (Resuscitation), **Level 2 (Orange)** for high-risk, time-sensitive conditions (Emergent), **Level 3 (Yellow)** for stable conditions requiring multiple resources (Urgent), **Level 4 (Green)** for stable conditions requiring one resource (Less Urgent), and **Level 5 (Blue)** for stable conditions requiring no immediate resources (Non-Urgent).

Q.41 What are the primary triage tools used during a mass casualty event?

Answer:

During a mass casualty event, the primary triage tool for adult patients (aged 8 years and older) is the Simple Triage and Rapid Treatment (S.T.A.R.T.) tool. For pediatric patients (under 8 years old), the Pediatric version of Simple Triage and Rapid Treatment (JumpSTART) is used. Both START and JumpSTART categorize patients into four priority levels: Red (First Priority - Most Immediate), Yellow (Second Priority - Urgent), Green (Third Priority - Non-Urgent), and Black (Last Priority - Dead).

Q.41 How are communicable diseases addressed within the triage process?

Answer:

Patients exhibiting symptoms suggestive of a communicable disease are immediately categorized as high priority for further evaluation and isolation. All patients visiting the hospital are screened for communicable diseases, and high-risk patients undergo mandatory screening for specific diseases such as C. diff, MRSA, TB, and COVID-19 depending on their presentation. Patients testing positive or highly suspected of having a communicable disease are promptly isolated.

Q.42 What is considered a "resource" when using the ESI triage tool?

Answer:

When using the ESI triage tool, "resources" are considered as interventions or diagnostic tests that typically require a significant amount of staff time and effort. Examples of considered resources include laboratory tests, cardiac enzymes, cardiac imaging, IV fluids for dehydration/shock, IV, IM, or Nebulized medications, specialist consultations, and complex procedures. Things generally not considered resources include history taking, physical examination, vital signs measurement, prescription refills, oral hydration or medications (like aspirin for stable ACS), simple procedures like IV line placement or wound dressing, crutches, splints, slings, routine follow-up appointment scheduling, and supplemental nasal cannula oxygen for minor cases.

Q.43 What is the process for patient triage during daily operations?

Answer:

The process for patient triage during daily operations involves several steps: identifying the patient as adult or pediatric, a quick visual triage upon arrival, initiating the appropriate ESI or p-ESI tool, screening for communicable diseases (including questionnaires and diagnostic tests if positive), measuring and recording vital signs, performing an immediate ECG, conducting an echocardiogram (if indicated), ordering diagnostic investigations, detailed doctor and nurse assessments and documentation, segregation of suspected communicable cases, documenting all findings, regular reassessment of the patient, completing the registration process, and finally, admission, discharge, or transfer decisions based on established criteria.

Q.44 What is the purpose of the Temporary Holding Area?

Answer:

The Temporary Holding Area is located near the Emergency Department and has 10 beds. Its purpose is to accommodate patients who are awaiting admission, investigation results, are under clinical observation, or as advised by a doctor. The duration of stay in this area is generally limited to 24 hours, but can be extended by a doctor based on clinical evaluation. Decisions regarding admission, discharge, or transfer from the Temporary Holding Area are made by the treating doctor after evaluating the patient's response to treatment and investigations.

Q.45 What is the main purpose of the transportation policy outlined in the document?

Answer:

The primary purpose of this transportation policy is to ensure that patients are provided with appropriate transportation during discharge or transfer. This is achieved through a thorough assessment of each patient's individual transportation needs, including their medical condition, to select the correct type of transportation (Basic Life Support - BLS or Advanced Life Support - ALS). Additionally, it aims to align ambulance services with the scope of services offered by the U.N. Mehta Institute of Cardiology & Research Centre, ensuring timely and safe patient transport is accessible.

Q.46 What are the responsibilities of the staff involved in patient transportation?

Answer:

Medical and nursing staff are responsible for assessing patient transportation needs and determining the appropriate level of care and mode of transport. Ambulance drivers, along with paramedics and nurses who may accompany the patient, are responsible for the safe and efficient transportation of the patient. This includes adhering to protocols, maintaining documentation, and ensuring the ambulance is properly equipped and decontaminated. Ancillary staff are responsible for assisting with the physical transfer of the patient. All staff involved in transfers must be trained in emergency transport protocols.

Q.47 How are patient transportation needs assessed?

Answer:

A patient's transportation needs are assessed initially upon admission and then reassessed at the time of discharge or transfer. This assessment considers the patient's clinical condition and any requirement for specific medical equipment or monitoring during transport. The treating doctor is responsible for determining the necessary level of monitoring and the mode of transport.

Q.48 What types of transportation are available and how are they determined?

Answer:

The document outlines two main types of transportation: Basic Life Support (BLS) ambulance and Advanced Life Support (ALS) / ICU on Wheels. The selection of the appropriate type of transportation is based on a thorough assessment of the patient's clinical needs, which is confirmed by the treating doctor or medical officer.

Q.49 What equipment is required in an ambulance, particularly an ICU on Wheels?

Answer:

An ICU on Wheels is required to have a comprehensive list of basic equipment, including a stethoscope, sphygmomanometer, emergency drugs and supplies, portable oxygen tank, wheel-type stretcher, resuscitator bags, defibrillator, ventilator, suction machine, ECG machine, glucometer, multi-parameter monitor,

thermometer, portable fridge, and a CUG phone for communication. Additionally, a specific emergency medicine kit and a list of consumable items are required.

Q.50 What measures are in place to ensure infection control during patient transportation?

Answer:

To ensure infection control, transportation vehicles are regularly inspected. Strict adherence to hand hygiene, comprehensive surface disinfection, sharps safety, and proper use of personal protective equipment (PPE) are enforced. Regular decontamination procedures for all equipment and vehicle interiors are conducted, following infection prevention and control programs. This includes using appropriate disinfectants and ensuring adequate air changes. Each decontamination process is documented.

Q.51 How is the quality and safety of transportation services monitored and improved?

Answer:

Quality monitoring includes daily checks of ambulance equipment by biomedical staff and regular checks of emergency medicine kits and consumables. A complaint process is in place to handle feedback, identify root causes of issues, and implement solutions. The hospital conducts periodic evaluations of transportation services to assess compliance with safety standards, timeliness, and patient satisfaction. A structured review of ambulance services, response time, equipment availability, and staff competency is conducted every six months as part of quality audits. Feedback is also sought from patients and families.

Q.52 What Procedure should be followed at casualty when any patient comes for emergency services?

Answer:

Emergency care <u>Emergency Care to be provided</u>:

- 24 *7 for 365 days
- Irrespective patient's cast, creed, religion, paying capacity or behavior of patient.

<u>Steps in Emergency Care:</u>

Sr. No.	Procedural steps	Responsibility
1.	As soon as the patient comes to emergency Department, On duty doctor and nurse shall immediately attend the patient and initiate assessment. After completion of primary assessment, necessary treatment shall be provided and if required,	Emergency on duty doctor and nurse

	urgent pathology or radiology investigation shall be done and patient shall be kept on observation.	
2.	On duty doctor or nurse shall direct the patient/patient's relative to registration counter to complete the registration formality.	Emergency on duty doctor or nurse
3.	Hospital has exclusive registration counter at emergency department for registration of emergency patients.	
4.	Staff at registration counter shall complete the registration formality and the general consent for initiation of treatment is taken from the patient/patient's relative. After registration, case paper is handed over to patient/patient's relative.	Emergency case registration counter staff
5.	On duty doctor shall record details of patient's complaint, vitals, investigations suggested and treatment given on the case paper.	On duty doctor
6.	Patients are in emergency department are reassessed depending on patient's condition, it varies from 5 min to at least 1 hour to identify any deterioration or improvement, and to modify the care accordingly.	On duty doctor
7.	Once the patient stabilized, is either transferred to another hospital or discharged to home or admitted to respective department as per the condition of the patient and health care need of the patient. All staffs in hospital are oriented to hospital scope of services and procedure to transfer/ referral to another organization. The hospital shall maintain the documentation in OPD case paper which indicates either patient admit/discharge/transfer to another organization. In case of discharge to home or transfer to another organization, a discharge note/transfer note shall be given to the patient in which patient clinical findings, investigations findings, treatment given, and condition at discharge/transfer.	On duty doctor and nurse
8.	Any patient requiring Isolation due to any infection or immune-compromised state shall be informed to the respective department before bed arrangement.	On duty doctor and nurse

9.	In case of MLC, entry shall be made in MLC register and shall be signed by consulting doctor, I/c CMO/RMO of the hospital and CMO/RMO of the civil hospital. Police is informed.	On duty doctor, nurse & I/C CMO or RMO
10.	In case of cardiac poisoning or road traffic accidents, they are considered as MLC cases and treated accordingly	On duty doctor, nurse & I/C CMO or RMO
11.	In case of mass casualties, triage will be done first followed by assessment. Colour Code for Triage: 1. **Red:** First Priority – Most Immediate 2. **Yellow:** Second Priority – Urgent 3. **Green:** Third Priority – Non Urgent 4. **Black:** Last Priority – Dead **Note:** Triage shall not be part of routine day-to-day functioning of the emergency department as U.N Mehta Institute of Cardiology & Research Centre is the cardiac institute and majority of patients received at emergency department having cardiac complaints considered as serious patients requiring immediate care.	Triage Team

Q.53 What are Basic Equipment's required in the ICU on Wheels?

Answer:

- Stethoscope
- Sphygmomanometer
- Emergency drugs and supplies
- Portable oxygen tank with regulator
- Wheel type stretcher Resuscitator bags (Ambu Bag for adult & paed patient, Stillet, Laryngoscope etc.)
- Defibrillator
- Ventilator
- Suction Machine
- ECG Machine
- Glucometer
- Multi Para monitor
- Thermometer
- Portable fridge with Digital thermometer
- CUG Phone

Q.54 What is Emergency Medicine Kit?

Answer:

Medicine kit should be prepared containing following listed medicines and bag should be kept in Casualty. Whenever Ambulance is used to transfer the patient, Emergency Medicine Kit will carry from casualty by Staff Nurse.

Q.55 List out emergency codes.

Answer:

CODE BLUE	CARDIAC ARREST -444
CODE RED	FIRE -555
CODE YELLOW	DISASTER-555
CODE PINK	CHILD ABDUCTION-555
CODE BLACK	BOMB THREAT-555
CODE PURPLE	INTERNAL VIOLENCE-555

- **Code Blue - Steps to be followed:**
  1. Ask other person to activate Code Blue by dialing 444.
  2. Ask someone to get the crash cart near to the victim.
  3. Put the victim in supine position and start BLS until the code blue team arrives.
  4. Team will reach the location with code blue kit. Doctor from the team will start CPR and nurse will start preparing medication defibrillator
  5. Person who activated Code will brief the team about the situation when team arrives.
  6. Document the event in Code Blue Reporting Form.
  7. Deactivate the Code.

- **Code Pink - Steps to be followed:**
  1. The staff who notice that a child is missing should activate Code Pink.
  2. The staff should check the place thoroughly.
  3. The staff should check the time of abduction and verify the time that has elapsed.
  4. The operator staff will notify to the code pink team
  5. The staff will notify CCTV Department.
  6. Staff should begin the search for the child in the each inpatient area. The staff will respond to departmental exits and will monitor the staircase and/or will stop suspicious person(s) from exiting their immediate area. If resistance is met, security will be notified about the exact location and description of the fleeing person.
  7. All exits are watched and someone should remain at the exit until the Code Pink has been deactivated.

8. Anyone carrying a bag larger than a normal handbag, anyone moving boxes, garbage bins should be detained and security notified.

- **Code Red - Steps to be followed:**
  1. Dial 555 & activate code red and mention type of Fire.
  2. For example: Code red - Type A activated at Quality Department, 4th Floor New building.
  3. Cordon off area
  4. Start firefighting with fire extinguisher
  5. Evacuate personnel/patients and material especially when any hazardous or combustible material is nearby.
  6. Cut off electricity supply.
  7. Assemble at assembly area.
  8. Do not use lift.
  9. Brief code red team when they arrive.
  10. Document the event in Code Red reporting Form
  11. Deactivate the code at the end of the event.

- **Code Black - Steps to be followed:**
  1. Dial 555 & activate code Black.
  2. Do not touch the suspected material.
  3. Cordon off the area.
  4. Brief Code Black team when team arrives.
  5. Team will reach with metal detector.
  6. Inform Police if required.
  7. Document the event in Code Black reporting Form
  8. Deactivate the code at the end of the event.

- **Code Yellow - Steps to be followed:**
  1. Dial 555 & activate code Yellow for internal/ external Disaster.
  2. Code yellow team will reach the location and decide to activate other teams as per requirement.
  3. Following teams will remain alert and becomes active if informed
     - Triage Team
     - First Aid Team
     - Rescue and Evacuation Team
     - Crowd Management Team
     - Code Blue/Code Red Team
  4. Teams will assemble at assembly point or at triage area as per instruction.
  5. If required, Code yellow team will inform Police, 108 and Fire authority.
  6. Document the event in Code Yellow Reporting Form & Code Yellow Register.

7. Deactivate the code at the end of the event.
8. Media Management is done.
9. Post event analysis by team is done.

Mock Drills for all the codes are done at least once in 6 months.

- **Code Purple - Steps to be followed:**
  - Any staff member confronted with or witnessing a combative / violent situation in the institute should initiate a Code Purple.
  - The Telephone operator will announce the Code Purple.
  - Pre-designated Code Purple team immediately report to the place of incident.
  - Team will give immediately protection to the victim.
  - Add distance/barriers between victim and assailant & Isolate area.
  - Counseling of victim and assailant at different isolated area.
  - Getting medical assistance if needed.
  - If the situation cannot be resolved using the Code Purple Strike Team, the local police department should be immediately contacted for assistance.
  - When the Code Purple has been resolved, the Safety officer will deactivate the code.

Q. 56 Mention steps of CPR.

Answer:

Steps for Cardio Pulmonary Resuscitation:

C- Cardiac compression

A - Airway

B - Breathing

D – Defibrillation

(* Adult & Pediatric Cardiac Arrest Algorithm is available at COP-5 CARDIAC RESUSCITATION)

Q.57 List out code blue teams and its members.

Answer:

Code Blue Team for A-Block & Hostel Block(Day time & Night time):-

- On duty Anesthetist at ACTRR (Leader)
- On duty SICU MCH Resident Doctor (Co- Leader)
- Two on duty Cardiac Physiotherapists from SICU (Coordinator)
- On duty SICU Staff Nurse
- On duty utility staff from SICU

Code Blue Team for B-Block (Day time & Night time):-

- On duty Cath Lab Anesthetist (Leader)
- On duty ICCU Cardiology Resident Doctor (Co Leader)

- Two on duty Cardiac Physiotherapists from ICCU (Coordinator)
- On duty ICCU Staff Nurse
- On duty utility staff from ICCU

Q.58 What is Roles & Responsibility of CODE BLUE Team?

Answer:

Member	Role & Responsibility
Anesthetist	Act as a team leader. He/she will manage airway, intubation. He/she will instruct the subordinates.
Cardiology Resident Doctor	Act as a Co-team leader. He/she will manage chest compression defibrillation.
Physiotherapist	One Physiotherapist assists the Resuscitation procedure. Another Physiotherapist work as a scribe & coordinator for real time monitoring and recording of events during CPR in HMIS & at the end he/she will deactivate the Code Blue.
Staff Nurse	Manage the IV lines and introducing medications as per the instructions of the team leader
Utility Staff	Carry the Code Blue kit & help to transfer the patient to ICU.

Q.59 Define the following:
Answer:

- **Disaster -** Any occurrence that causes damage, ecological disruption, loss of human life, deterioration of health and health services, on a scale sufficient to warrant an extraordinary response from outside the community. (WHO)
- **Horizontal Evacuation -** This stage involves patients who are secured from immediate danger but remain on the same floor. Horizontal evacuation typically means that everyone in the Unit should be moved to the opposite side of the building.
- **Vertical -** This stage refers to the complete evacuation of a floor. For a localized incident, occupants can be transferred to an area of refuge identified elsewhere in the hospital, typically at least two floors beneath the incident floor. In the case of a complete Hospital evacuation, occupants should be removed to the

assigned Refuge Area. All patients should be tagged and/or triaged by designated leadership before they leave their floor.

- **Total Evacuation -** This stage involves the complete evacuation of the facility. Total evacuation should be initiated only as a last resort. Patients should be transferred to alternate locations and facilities. This decision should require coordination between all Sections operating under the facility's safety committee**.**

Q.60 When and how to do Rehearsal of Disaster Plan?

Answer:

1. The disaster plan will be rehearsed at least twice a year, preferably as part of a coordinated drill in which other community emergency service agencies participate. The plan can be tested using a table –top exercise or/and mockdrill . There should be at least one mock drill from that exercise of rehersal.
2. The drills will involve professional, administrative, nursing and other hospital personnel. Actual evacuation of patients during drills is optional.

Q. 61 What is time frame for code blue mock drill?

Answer: Code Blue mock drill is done every quarterly.

Q. 62 What are the precautions to be taken at the time of blood transfusion/IV therapy? Time duration for transfusion of various Blood component? Procedure for transfusion in emergency? What is done in case of Blood transfusion reaction?

Answer:

Blood and blood products shall be used rationally and only based on the advice of thetreating consultant.

- **Informed consent** of patient/patient's relative shall be obtained whenever demand of blood or blood products is prescribed.
- Blood must be available as per given time frame:
- In case of Emergency, Blood and blood products shall be available within 1 hour.
- In case of planned transfusion, Blood and blood products shall be available within 24 hours or as recommended by clinician.
- Staff shall be trained for blood transfusion & family education for blood donation.

All transfusion reactions (minor and major) shall be reported to the blood bank in written and record shall be maintained for the same in the patient's medical record. The Quality Assurance Committee shall review and analyze blood transfusion reactions for preventive and corrective actions and record them accordingly for implementation.

PROCEDURE:

Blood Transfusion

No.	Procedure Steps	Responsibility
1	Identification of purpose of blood transfusion	Consultant/ Resident Doctor
2	Order for blood transfusion specifying the following: Type of component No. of units to be administered Warming of blood / blood components Premedication, if any Rate of transfusion especially in case of paediatric patients Special procedures such as filters, irradiation	Consultant/ Resident Doctor/Medical Officer
3	Filling up of Blood Transfusion Requisition Form and sending it to Blood centre through pneumatic tube system (PTS) or manually in person.	Resident Doctor /Medical Officer
4	Identification of patient and collection of blood sample. Labelling of blood sample and sending it to blood centre for cross matching	Nursing Staff/ Medical Officer
5	Receipt of blood or blood product and check for Patient's name, Indoor no., Type of blood component, blood group and expiry date of the blood unit and volume of blood component.	Resident Doctor/Medical Officer
6	Blood unit is allowed to stand at room temperature for 30 – 45 minutes before its administration.	Nursing Staff
7	Preparation of all bedside articles &patient for blood transfusion.	Nursing Staff
8	Explaining the patient & relatives about the procedure& taking Informed Consent before the transfusion of Blood and blood components.	Nursing Staff
9	Check IV Cannula for blockage or any complication	Nursing Staff

10	Check vital signs	Nursing Staff
11	Check site of Blood Transfusion	Nursing Staff
12	Use of 18 or 20 gauge Intra catheter and standard blood transfusion set for transfusion is recommended	Nursing Staff
13	Medical Officer & Nursing Staff has to verify the patient's name, IP No. on the sticker (attached on the blood bag) &cross match report received from the blood centre in the patient's presence, at the bedside, prior to transfusion.	Resident Doctor/ Medical Officer&Nursing Staff
14	The patient must be closely observed and assessed for: Vital sign Rate of flow Signs of circulatory overload Urinary output Needle site for signs of infiltration, haematoma & dislodgement of needle, etc. Any possible transfusion reaction / complication including fever, chills, back pain, dyspnoea, hypotension, haemoglobinuria etc. Patency of infusion set Keep the patient warm & comfortable with a blanket	Resident Doctor/ Medical Officer & Nursing Staff
15	On completion of Blood transfusion, Treating Consultant to be informed for further treatment	Resident Doctor/ Medical Officer & Nursing Staff
16	Following information needs to be recorded in Nursing sheet: • Start Time and completion Time of Blood Transfusion. • Volume of blood administered • Blood unit No., Blood Group & Type of blood administered • Rate of flow • Any reactions observed • Any medications administered	Nursing Staff
17	Disposal of Blood units:	Nursing Staff/ Doctor / Blood

	Unused Blood units, whole blood/ PCV (within 30 minutes of issue by Blood centre) are returned to the Blood centre provided cold chain is maintained. If the whole blood/ PCV remain unused (after being issued by the Blood Centre) and exceed 30 minutes (with cold chain maintenance) up to 120 mins, a written justification must be provided by the on-duty doctor/unit consultant for returning whole blood/ PCV to the blood centre, where further processing will be carried out. Partially used Blood units shall be discarded in yellow bag as per Bio medical waste management guideline. Used Blood units shall be discarded as per Bio Medical Waste Management Guidelines.	Centre Department

Q.63 What are the steps to be taken when there is Blood Transfusion Reaction?
Answer:

In the event of a suspected transfusion reaction, follow the following steps:

- **STOP the transfusion immediately**
- **INFORM the Medical Officer immediately**
- **RECHECK all blood unit labels and patient identification**
- **DRAW post transfusion blood sample in a separate tube – plain & EDTA both**
- **RECORD** the reactions in nursing sheet with time
- **INFORM** the Nursing Quality Manager immediately and fill the blood transfusion reaction form and Incident Reporting Form
- **SUBMIT** all documents with blood specimen, blood bag & transfusion set to Blood centre for further investigation of transfusion reaction

Q.64 What are the Safety measures for Blood Transfusion?

Answer:

1. Follow strict aseptic technique throughout the procedure
2. Appropriate filter has to be used for transfusion
3. Care is to be taken to prevent introduction of air in the apparatus.
4. No Medications shall be administered simultaneously with blood or blood componentsvia the same IV line.
5. If any IV fluids are to be given immediately before, during or after transfusion, alwaysuse physiologic Saline to prevent hemolysis of the blood in the tubing.

6. Blood/Blood products are to be transferred as early as possible once they are issuedfrom blood centre.
7. If blood bag is found broken or leaked, blood unit has to be discarded asper Biomedical Waste Management guidelines.

Q.65 What is Admission protocols in ICCU?

Answer:

Admission criteria are used to select patients who are likely to benefit from care in ICUs. Patients who meet any of the following criteria shall be admitted to the ICUs at the request of the treating doctor.

Admission criteria in ICCU:- (For Adult patients)

Preadmission screening: - The ICU admission decision based on several models utilizing

- Prioritization model
- Diagnosis model
- Objective parameters model

Prioritization model:-

Priority	**Sign & Symptoms**
Priority-1	• These are critically ill, unstable patients in need of intensive treatment and monitoring that cannot be provided outside of the ICU. • Usually, these treatments include ventilator support, continuous vasoactive drug infusions, requirement of urgent pericardial tapping, Arrhythmias requiring temporary pacemaker insertion etc.
Priority-2	• These patients require intensive cardiac care monitoring and may potentially need immediate intervene. No their limits are generally stipulated for these patients.
Priority-3	• These patients are relatively low risk stable cardiac patient who may require monitoring.

Diagnosis model:-

System	**Diagnosis**

Cardiac system	• Acute myocardial infarction with complications • LV Dysfunction • Unstable Valvular Heart Diseases • Cardiogenic shock • Arrhythmias requiring close monitoring and intervention • Acute congestive heart failure with respiratory failure and/or requiring hemodynamic support • Unstable angina, particularly with dysrhythmias, hemodynamic instability, or persistent chest pain • Cardiac arrest • Cardiac tamponed or constriction with hemodynamic instability • Dissecting aortic instability • Complete heart block
Pulmonary System	• Acute respiratory failure requiring ventilator support • Pulmonary embolism with hemodynamic instability
Endocrine	• Hypo or hyperkalemia with Arrhythmias • Hyper of Hypoglycemia • Hyper or hypomagnesaemia with hemodynamic compromise or Arrhythmias
CNS	• CV Stroke • Coma
Cardio Vascular Thoracic Surgery	• Post-operative patients requiring hemodynamic monitoring / ventilator support or extensive nursing care • Stuck Valve • Post MI VSR
Miscellaneous	• Septic shock with hemodynamic instability • Hemodynamic monitoring • Clinical conditions requiring ICU level nursing care

Objective parameters model :-

Vital signs/ parameters	**Findings**
Electrocardiogram	• Myocardial infarction with or without complex arrhythmias

	• Sustained ventricular tachycardia or ventricular fibrillation • Complete heart block with hemodynamic instability • Sinus Arrhythmia (Tachycardia / bradycardia)
Echocardiography	• Valve Thrombosis • Cardiac Temponade • Pericardial Effusion
Vital Signs	• Pulse < 40 or > 150 beats/minute • Systolic arterial pressure < 80 mm Hg or 20 mm Hg below the patient's usual pressure
Laboratory Values	• Altered Enzymes: Troponin I, CPK – MB, D-Dimer, LDH • Serum potassium < 2.0 mEq/L or > 7.0 mEq/L (Hypo or Hyperkalamia or sever electrolyte disurbance) • Abnormally low Haemoglobin
Radiography/ Ultrasonography/ Tomography	• Dissecting aortic aneurysm • Pulmonary embolism
Physical Findings (acute onset)	• Anuria • Airway obstruction • Continuous seizures • Cyanosis • Cardiac Tamponed

Admission criteria in ICCU:- (For pediatric patients)

Prioritization model	Cyanotic Spell Breathlessness Obstructive Airways Requirement of Ventilator Support Decompensated Cardiac Failure Requirement of Inotropes Drug dependent CHD Cardiac Arrhythmias Septicemia Respiratory Failure Patient require intensive monitoring

<u>Diagnosis</u> model	Unstable Cyanotic Congenital Heart Disease Unstable Acyanotic Congenital Heart Disease Unstable Rheumatic Heart Diseases Post-operative patient requiring monitoring / ventilator support Cardiogenic Shock Cardiac Temponade Infective Endocarditis
Objective <u>parameters</u> model	Pulse : Neonates <60/min or > 200/min Infants < 70/min or > 180/min Older Children < 40/min or > 150/min Blood pressure < 70 mmHg > 150 mmHg Respiratory rate:- Neonate > 80 breaths /min Infant > 60 breaths /min Older Children > 40 breaths /min SPO_2 < 70 % CRT > 3 seconds Cardiac Arrhythmia Serum sodium < 120 Eq / lit < 160 Eq /lit Serum potassium < 2.0 Eq/lit or > 6.0 Eq /lit Any acute acid base disturbance Serum calcium > 12 mg/dl/ < 7 mg/dl Acute onset – Anuria with renal failure Continuous seizures / New onset seizure

Q.66 What is Discharge/Shift/ Transfer criteria for ICCU?

Answer:

The status of patients admitted to an ICU should be revised continuously to identify patients who may no longer need ICU care.

Discharge/Shift/ Transfer criteria from ICCU for adult patients include (but not limited to):-

- The consultant determines the requirement of transfer of patient.
- Telephonic confirmation for bed availability in respected bed by in charge nurse.
- The in charge nurse of that ICCU communicate about the transfer of patient on the phone with the on duty doctor.

- The bed for transferring the patient is to be allotted by the in charge nurse/on duty doctor depending on the condition of the patient.
- Bed allotment is confirmed by on duty doctor (Resident/Medical officer) to the ICU and ward staff.
- After receiving confirmation from the in-charge nurse or on-duty doctor, enter the patient transfer details into HMIS and proceed with the physical transfer of the patient.
- Transfer summary details are entered into HMIS.

VISITORS POLICY IN ICCU:-

- Visitor's entry in the Intensive care area and Post-operative area is restricted only one attendant is allowed at a time during the visiting time.
- Visitors suffering from contagious disease are not allowed to enter.
- Shoes or chappals are not allowed in ICCU.
- Visitors must do hand rub before to enter in the ICCU.
- Visitors have to wear a cap & mask before entering in the ICCU.
- Visitors are not allowed to bring materials such as food, flowers and other materials, which can be a potential source of infections.

Q.67 What is Acuity Based Staffing?

Answer:

- Individual care need and acuity will be reviewed and updated as clinically indicated. The In charge will make assignments based on Acuity based staffing by giving special attention to the following areas as applicable.
- All individuals with an acuity level of 4 or 5 requiring an individual care assignment, or individuals with an acuity level of 3 needing a special care assignment or nursing intervention(s)
- Alerts (suicide behavior, assaultive behavior, fire setting, blood and body fluids precautions, medical-physical precautions related to behavioral intervention {e.g. containment risks}, etc.)
- Seclusion, restraints, special incidents.
- Individual Care assignments.
- Psychosocial Factors, subjective and objective observations (self-abusive behavior, delusional depression, manic behavior, impulsiveness, psychomotor agitation or retardation, social withdrawal, etc.)
- Significant information regarding PRN medication, treatments, physical and psychological profiles, conferences (including Staffing), and behavior unusual to specific individuals.
- Vital signs, special Diagnostic procedures and Consults.

- Behavior during the previous shift, sleep patterns and activity level (sleeping, wandering about dorm, smoking habits, incontinence, frequent trips to the rest room, etc.)
- Personal hygiene and general ADL care needs (appraisal of individual's ability for self-care including ability to shower, shampoo, care for dental, nail, skin, and foot care needs)
- Eating habits (compliance and non-compliance with restricted diets, diet intake, water intake)
- New physician orders and monthly medication reviews.
- Preps for lab work, x-ray, EEG/EKG, etc.
- Individuals scheduled for court visit, discharge, off grounds or on grounds clinic appointments.
- Specific documentation and/or follow-up needed.
- Other pertinent information related to individuals' care.

Q. 68 What is the difference between Consent and Informed consent?

Answer: General Consent is a broad, routine consent obtained from a patient (or legal representative) allowing the hospital and its staff to perform essential, non-invasive, and routine diagnostic and treatment procedures.

Informed Consent, on the other hand, is a more specific process where a patient is thoroughly informed about a particular procedure, treatment, clinical trial, or research study, including potential benefits, risks, and alternatives, so they can make a voluntary and informed decision to accept or refuse it.

Q. 69 What kind of procedure is being followed at your hospital to prevent Adverse Surgical Event?

Answer:

Following procedure is followed to prevent adverse surgical event

1. Proper identification of patient by using following identifiers
    - Verbally confirming the name with patient or relative
    - Patient's ID Band
    - Patient's File and Pre-operative Note
2. Surgical Site marking
3. Performing "Time Out"

In which entire team performing surgery will verify verbally

- Name of Patient
- Name of Procedure
- Surgical site and side
- Patient's position, and
- Availability/presence of implants, special equipment, required during the procedure.

Q.70 Which tool is used for nutritional screening?

Answer: For inpatients, nutritional screening is performed by a Doctor, Nursing staff, or Dietician within 3 hours of admission using the NRS Malnutrition screening tool-2002. If the screening score is 3 or more, a nutritional assessment is conducted by a Dietician within 24 hours using the Subjective Global Assessment (SGA) method. For outpatients, screening is done by nursing staff based on factors like unintentional weight loss, decreased food intake, and presence of co-morbidities. If a patient answers "yes" to two or more of these factors, a Dietician referral is required.

Q.71 Who can do Nutritional Screening and define timeline for it?

Answer:

For Indoor patients, Nutritional Screening is done by the Doctor/Nursing staff/Dietician within 03 hours of admission of patient (Both Adult Patients & Pediatric Patients)

Q.72 What are the Criteria for determining patient as Vulnerable?

Answer:

Following patients will be considered as vulnerable and need to undergo a risk assessment:-

- All patients aged 60 years (senior citizens) and infants and children (below the age of 12)
- Differently-abled and / or mentally challenged
- Mentally ill
- Comatose
- Critically ill
- Patient under sedation and anesthesia
- Pregnant Woman
- Patients on Dialysis
- Victim of Abuse or neglect
- Semiconscious/Unconscious
- Impaired communication or language barriers
- Immuno compromised patient
- Patient with suicidal tendencies

Q.73 What types of patients are considered vulnerable according to the hospital's predetermined list?

- persons with disabilities or chronic illnesses, people living with
- HIV/AIDS,
- prisoners,
- aged/elderly (specifically those aged 60 years and older),

- children/youth (including infants and children below 12), those involved in child abduction (code pink) or child corporal punishment, differently-abled and/or mentally challenged individuals, the
- critically ill, patients under sedation, anesthesia, or who are unconscious/semiconscious, pregnant women,
- patients on dialysis,
- victims of abuse or neglectimpaired communication or language barriers, immunocompromised patients,
- patients with suicidal tendencies, socioeconomically disadvantaged individuals, and ethnic minorities.

Q.74 What are some of the specific procedures implemented to ensure safe handling and a secure environment for vulnerable patients?

Several procedures are in place, including training all staff on the care of vulnerable patients and those receiving high-risk services, providing beds with guard rails, making wheelchairs with safety belts and locking facilities available, installing night lights in patient rooms and providing lighted pathways, installing safety bars in washrooms, and educating vulnerable patients and their attendants on safety measures during their stay. Additional measures include preventing deep vein thrombosis and decubitus ulcers, precautions for patient restraints, adherence to standard precautions and infection control measures, and following appropriate clinical practice guidelines for emergency patients.

Q.75 How is informed consent handled for vulnerable patients?

In cases involving vulnerable patients, informed consent is obtained from the appropriate legal representative, referred to as the Surrogate Decision Maker. The policy outlines a priority order for identifying the Surrogate Decision Maker, starting with the spouse, followed by adult children, parents, adult brothers or sisters, adult grandchildren, and finally a significant other (close friend) in emergency situations.

Q.76 How are vulnerable patients identified upon arrival at the hospital?

- All patients are screened for vulnerability upon admission, whether they are inpatients or outpatients. For inpatients identified as vulnerable, a purple ID band is applied immediately, with the exception of patients below 12 years old and socioeconomically disadvantaged patients. For outpatients, a vulnerability stamp is applied to their case record file.

Q.77 How will you identify patients who are risk at fall?

Answer:

- Morse fall risk assessment tool is used for the assessment of the patients who are at the risk of fall.
- Morse fall risk assessment tool is used to identify the patients who are at the

risk of fall on a daily basis.

Following Fall Risk Factors are included in Morse Fall Risk Assessment:-

- History of Falls
- Multiple Diagnosis/Multiple Medications
- Ambulatory Aid
- IV or IV Access
- Gait/Transferring
- Mental Status

Q. 78 What is Restraint? Describe your hospital's restraint management policy.

Answer:

- **RESTRAINT** is the involuntary use of a physical or mechanical device to limit or prevent movement of the whole or a portion of the patient's body as a means of controlling the patient's physical activities.
- **Mechanical Restraint** – Any device applied to a patient for the purpose of limiting free movement.
- **Chemical Restraint** – A drug used to inhibit a particular behavior or movement
- Verbal restraint orders must be co-signed by the Consultant within 24 hours of the initiation of restraint.
- Restraint must not exceed for 24 hours. If required to be continued, fresh consent needs to be taken.
- Patient under restraint must be reassessed every 2 hourly in adult patient and 1 hourly in Pediatric patient.
- Restraint administration form must be documented.

Q.79 How are patients screened and assessed for pain according to this policy?

- All patients entering the hospital, whether in the Outpatient Department (OPD) or Inpatient Department (IPD), are screened for pain using a simple yes/no question during their initial assessment. Pain assessment is performed at the time of admission, every 6 hours thereafter, after invasive procedures, and whenever a patient complains of pain. The assessment is conducted by a Doctor or Nursing staff and documented in the medical record.

Q.80 How pain is managed at your hospital? Do patient and family get educated about pain management techniques and is being documented?

Answer:

- Patient having pain as predominant symptom will be assessed and managed appropriately for pain.

- Initial assessment for pain for all patients to be done after admission by the staff nurse during complete admission assessment.
- Reassessment to be done by nursing staff on daily basis and score to be documented.
- Post-operative pain assessment to be done by Resident doctor.

Following are reviewed for assessing pain:

- Pain location
- Duration
- Quality
- Character
- Relieving factors
- Whether it affects daily routine
- Whether it affects sleep
- Most likely causes of pain
- Pain is managed by NSAIDs and Opioids & patient must be educated and counseled about pain.
- **To assess the intensity of pain, following scales are being used :**
  - Wong Baker pain scale - Adults & children > 7 years
  - FLACC scale (Face, Legs, Activity, Cry, Consolability)–Children (3 month to 7 Year)
  - NIPS scale (Neonatal & Infant Pain Scale) - infants < 3 months
  - BPS Scale (Behavioral Pain Scale) – Unconscious patient

Q.81 How pain is reassessed?

Answer:

- Reassessment of the pain is done daily by the doctor/nursing staff at every 6 hourly and documents it in the pain management chart.
- When the patient complaints the pain, pain reassessment should be done at least at every 2 hourly and more often as instructed by a doctor till the pain score is 0.

Q.82 What methods are used for pain management, and what is the role of patient education?

Pain management involves both pharmacological and non-pharmacological approaches. Pharmacological management generally uses the least invasive route, with round-the-clock dosing for consistent pain. NSAIDs are considered to reduce opioid dosage, and Fentanyl or Morphine are used for opioid therapy. Placebo use is not considered appropriate. Nerve blocks may also be used. Non-pharmacological methods include physical agents (heat, cold, massage, etc.) and psychological approaches (relaxation, biofeedback, education, etc.). Patient and family education is essential and covers understanding pain and its risks, the assessment process, the importance of

management, available methods (pharmacological, non-pharmacological, regional nerve blocks), patient/family roles, potential side effects of medications and nerve blocks, and symptoms requiring medical attention. Discharge planning also includes detailed instructions and contact information for managing pain post-hospitalization.

Q.83 What is end of life care?

Answer:

When patient is not dead but is on verge of death and about to die at that time we give end of life care which includes following things.

1. Respect the dignity of patient & Be sensitive and respectful to the patient's and family's wishes
2. Provide palliative care and guide for home health care.
3. Manage psychological, social, and spiritual/religious problems
4. Offer continuity of care and also respect the right to refuse treatment
5. Respect the Consultant's professional responsibility to discontinue some treatments when appropriate, with consideration of both patient and family preferences.
6. If Patient or relative wants to donate the organ after death, guide and assist for the same.

Q.84 Who is covered by the UNMICRC End-of-Life Care policy?

7. This policy applies to all patients, both adult and pediatric, who have life-limiting conditions. It also encompasses their families and all healthcare professionals and staff who are involved in providing end-of-life care at UNMICRC.

Q.85 How is the end-of-life phase identified and recognized for a patient?

8. Treating doctors are responsible for recognizing the signs that indicate a patient is transitioning to the end-of-life phase. These signs can include a decline in vital signs, reduced consciousness, lack of response to treatments, or significant deterioration in physical function. A cumulative decision regarding the proposed care is then made by the intensivist and other specialists involved in the patient's care.

Q.86 How are decisions made regarding a patient's care during the end-of-life phase?

Decision-making during the end-of-life phase involves compassionate communication of the prognosis and transition to EOLC to the patient (if possible) and their family. Doctors provide a realistic explanation of the prognosis, treatment goals, and limitations. Shared decision-making is emphasized, involving collaborative planning with patients and families to align care plans with the patient's values and goals. These plans are regularly reviewed and updated. All staff involved in care are informed of the plan, and

any differences of opinion among the care team can be referred to the End-of-Life Care Committee for guidance.

Q.87 What kind of support is provided for symptom management and emotional/spiritual needs?

The EOLC policy ensures patients have access to necessary medications for managing common end-of-life symptoms like pain, breathlessness, and nausea through a multidisciplinary approach and standardized assessment tools. Emotional support is offered to both patients and families through counseling services, with referrals to psychologists as needed. Spiritual care and religious support are also arranged based on the patient's and family's preferences, respecting cultural and religious diversity.

Q.88 .How does communication play a role in End-of-Life Care at UNMICRC?

Transparent and consistent communication is maintained with patients, families, and the healthcare team regarding the patient's condition and changes in the care plan. The ISBAR (Identification, Situation, Background, Assessment, and Recommendation) tool is used for communication among healthcare providers. Regular family counseling sessions are conducted to discuss the patient's status and adjust care plans accordingly.

Q.89 What are the specific considerations for pediatric patients receiving end-of-life care?

For pediatric patients, end-of-life care is provided in consultation with pediatric specialists, taking into account the emotional needs of both the child and their family. Family-centered support and grief counseling are particularly emphasized, and parents are fully involved in the decision-making process.

Q.90 What happens after a patient's passing under the EOLC policy?

After a patient passes, family members are informed sensitively and respectfully. Grief counseling is provided, and family members at high risk for complicated bereavement are identified. The deceased body is handled respectfully and in accordance with the family's cultural preferences, allowing family participation if desired. A timely and dignified transfer from the hospital is arranged, with assistance for necessary documentation and logistics. The policy also outlines detailed procedural steps for the physical preparation of the dead body by nursing and utility staff, ensuring respect and adherence to procedures.

Q.91 How many types of fire extinguishers are used? Specify for which type of fireeach to be used.

Answer:

A		Common Combustibles	Wood, paper, cloth etc.
B		Flammable liquids and gases	Gasoline, propane and solvents
C		Live electrical equipment	Computers, fax machines
D		Combustible metals	Magnesium, lithium, titanium
K		Cooking media	Cooking oils and fats

Fire Extinguisher Types

Extinguisher		Type of Fire					
Colour	Type	Solids (wood, paper, cloth, etc)	Flammable Liquids	Flammable Gasses	Electrical Equipment	Cooking Oils & Fats	Special Notes
	Water	✓ Yes	✗ No	✗ No	✗ No	✗ No	Dangerous if used on 'liquid fires' or live electricity.
	Foam	✓ Yes	✓ Yes	✗ No	✗ No	✓ Yes	Not practical for home use.
	Dry Powder	✓ Yes	✓ Yes	✓ Yes	✓ Yes	✗ No	Safe use up to 1000v.
	Carbon Dioxide (CO2)	✗ No	✓ Yes	✗ No	✓ Yes	✓ Yes	Safe on high and low voltages.

MANAGEMENT OF MEDICATION (MOM)

Q.92 Who is the Medication Safety Officer (MSO) of our organization?
Answer:- Dr. Viraj Patel (Clinical Pharmacist)

Q.93 What is the frequency of the hospital formulary revision?
Answer:- Annualy
Q. 94 What is medication recall?
Answer:

- On receiving any complain related to the quality of the medicines and / surgical items. For e.g.
  1. Syringe leakage problem.
  2. A suspended particle in I.V. fluids
  3. A suspended impurities noted on reconstitution.
- In any of such event, the Sister-In-charge/Nurse will immediately report to the duty pharmacist.
- Upon receipt of a complain, Pharmacist checks the complain of the medicines or surgical items.
- Immediately all the wards and departments are informed telephonically by the pharmacist to check their stocks with same batch number and they are informed to stop using the particular item and return to pharmacy package store.
- For implants recall may be based on communication from regulatory authorities, manufacturer or internal feedback.
- Recall procedure in response to internal feedback also includes providing information to appropriate regulatory authority and manufacturer.
- The recalled drugs/surgical items are collected and stored in an area labelled for recalled drugs until they are disposed of.
- A record of actions taken in written on the recall record, including the date of the action taken to dispose of the recalled medicine/surgical items.
- The sister-in-charge/Nurse is informed to return the defective medicines or surgical items to pharmacy for replacement and that will be replaced by new batch.
- The same is communicated immediately to the supplying vendor.
- Pharmaco therapeutic Committee members should be informed about the medication recall in each meeting.

Q.95 How many pharmacy stores are there in your hospital?

Answer:

Sr. No.	Process	Details
1	Medicine stores	1. Patient wise indent issue and discharge medicines as per indent for indoor patients, operation- 365 days-(24 hours) (B-block). 2. Coordinate with Clinicians for any substitute of the available medicines. 3. Coordinate with nursing staff for smooth functioning of patient care. 4. Stock is arranged as First Expiry First Out. 5. All items are placed categorically (Tablets, Capsules, Injections, Ointments/Lotions, Nutritional Drugs, etc.) and then arranged alphabetically in each category. 6. Separate storage for LASA, High risk, Hazardous material, emergency crash cart medicines and nutritional supplements is done. 7. Maintain stock in store as per consumption. 8. To verify physical stock of high value every month and all stocks every 3 months. 9. To immediately inform to respective authorities in case of recall. 10. To check the near expiry of the material and inform to the Main store or Package store.. 11. Maintain records of Quality indicators of Pharmacy Store; 12. Percentage of Stock out including emergency items. 13. Follow Double Cross Check System for dispensing of material by two different staff to prevent error of materials for supply in all departments.
2	CTOT Stores	1. Issue patient wise Items kit and used items entry in software and keep record for same. 2. Indent of surgical items and implants from Main store and indent of drugs and medicines from Pharmacy package store. 3. Maintain stock as per consumption. 4. To verify physical stock of high value every month and all stocks every 3 months. 5. To immediately inform to respective authorities in case of recall. 6. To arrange all stock as per First Expiry First Out.

		7. To check the near expiry of the material and inform to the Main store or Package store either for replacement. 8. Maintain records of Quality indicators of Pharmacy Store; 9. Percentage of Stock out including emergency items
3	Cath Stores	1. Issue patient wise Items kit and used items entry in software and keep record for same. 2. Indent of surgical items and implants from Main store and indent of drugs and medicines from Pharmacy package store. 3. Maintain stock as per consumption. 4. To verify physical stock of high value every month and all stocks every 3 months. 5. To immediately inform to respective authorities in case of recall. 6. To arrange all stock as per First Expiry First Out. 7. To check the near expiry of the material and inform to the Main store or Package store either for replacement. 8. Maintain records of Quality indicators of Pharmacy Store; 9. Percentage of Stock out including emergency items
4	Main Store	1. To make purchase orders for implants, consumables, Surgical items and disposable as per rate contract. 2. All purchase orders are prepared by pharmacist or technical assistant and checked by another store staff. Prepared purchase orders are signed by the purchase manager and issued after signature of the director in submission. 3. Receive ordered material from vendors with standard procedure of store gate pass entry i.e. Goods Receive Note (G.R.N.), Entry in the inventory software, Update stock, Invoice, Payment. 4. During receipt of the material, material is checked for expiry date, batch no. and rate. Also quality of the material like; damage, broken seal, etc. If, it does not comply, material is rejected before G.R.N. 5. To maintain stock as per minimum and maximum level. 6. To verify physical stock of high value every month and all stocks every 3 months. 7. To dispense the indents as per the request to other Pharmacy stores. 8. To immediately inform to respective authorities in case of recall. 9. To arrange all stock as per First Expiry First Out.

		10. To check the near expiry of the material and inform to the vendor either for replacement or credit note. 11. Maintain goods return note. 12. Follow double cross check system for dispensing of material by two different staff to prevent error of consumable items for supply in all departments. 13. Maintain records of Quality indicators of Pharmacy Store; Percentage of Stock out including emergency items.
7	Package store	1. To make purchase orders for drugs and medicines as per rate contract. 2. All purchase orders are prepared by pharmacist or technical assistant and checked by another store staff. Prepared purchase orders are signed by the purchase manager and issued after signature of the director in submission. 3. Receive ordered material from vendors with standard procedure of store gate pass entry i.e. Goods Receive Note (G.R.N.), Entry in the inventory software, Update stock, Invoice, Payment. 4. During receipt of the material, material is checked for expiry date, batch no. and rate. Also quality of the material like; damage, broken seal, etc. If, it does not comply, material is rejected before G.R.N. 5. To maintain stock as per minimum and maximum level. 6. To verify physical stock of high value every month and all stocks every 3 months. 7. To dispense the indents as per the request from other Pharmacy stores and wards. 8. To immediately inform to respective authorities in case of recall. 9. To arrange all stock as per First Expiry First Out. 10. All items are placed categorically (Tablets, Capsules, Injections, Ointments/Lotions, Nutritional Drugs, etc.) and then arranged alphabetically in each category. 11. Separate storage for LASA, High risk, Hazardous material and nutritional supplements is done. 12. To check the near expiry of the material and inform to the vendor either for replacement or credit note. 13. Maintain goods return note. 14. Follow double cross check system for dispensing of material

		by two different staff to prevent error of consumable items for supply in all departments. 15. Maintain records of Quality indicators of Pharmacy Store; Percentage of Stock out including emergency items. 16. The compiled central register of daily usage of Narcotic drugs from all wards is maintained in pharmacy store daily with Sr No. And Date, Patient Name and Id No., Purchase Bill No. Date, Purchase Order No. And Date, Name Of Purchase Party, Issue /Receive Qty., Ward, Dr. Name, Opening Balance , Qty. Issue, Balance, Closing Balance. This record is also maintained in Form 3H for daily usage.

Q.96 What is the colour code for medicines?

Answer:

For identification of high alert medicine, Medication is required to be labeled with

separate color sticker in storage area:

- High Risk Medication – Red color-Printed-"High Risk Medicine"
- Narcotics- Blue color
- Look alike- Yellow color
- Sound alike – Green color
- High Concentrated Electrolytes- Pink color-Printed-"High Concentration Medicine Dilute before Use".

Q.97 Which medicines are considered as High Risk Medication?

Answer:

- Narcotic drugs
- Anesthetic Agents
- Opioids Analgesic
- Anticoagulants
- Antiarrhythmic
- All Type of Insulin
- Drugs acting on Nervous system
- Investigational Medication (Iohexol)

Q.98 What are the precautions taken for High risk medication?

Answer:

- All look alike and sound alike medicines are considered as high risk medicines which are stored separately to avoid errors and are labelled properly.
- All narcotics are also considered as high risk medicines and are stored in double lock and key.
- There are certain other medicines like insulin, heparin, anticoagulants, etc. are considered as high risk.
- All the high risk medicines must be double verified before dispensing or before administration and the verification shall be done by doctor as well as double verification done by nurse and documented.

Refer list of LASA (Look alike and Sound alike Medicines) & also List of High RiskMedicines.

Q. 99 What is the procedure for near expiry medicine & consumables?

Answer:

Near expiry drug of consumables within 3 months of expiry date shall be sent back to pharmacy with return requisition.

Q. 100 What is MINIMUM REQUIREMENTS OF OPD PRESCRIPTION/INDOOR PATIENT TREATMENT SHEET?

Answer:

- Name of patient
- Unique Identification Number
- Name of Drug, Dose, Frequency of administration of medicine, Duration, Route, Instruction
- Name, Signature and Registration number of the prescribing doctor
- All hand written medication shall be written in capital letters only
- In case of addition or deletions in medication order are considered with a single strike.
- Modification in the medication order in the existing order for a particular drug that modification of medication must be printed out in a next day treatment sheet.
- Date and time of prescription written

Q. 101 What is the POLICY FOR TELEPHONE OR VERBAL ORDERS?

Answer:

- Verbal communication of prescription or medication orders should be limited to urgent situations where immediate written or electronic communication is not feasible.
- Safety is the overriding principle in accepting verbal or telephone orders. Verbal and telephone orders have a higher potential for errors as these orders can be misheard, misinterpreted and/or wrongly transcribed. Telephonic order should be mentioned under sign by consultants.
- Verbal or telephonic orders are to be accepted by the Medical Officer only when it is impossible/ impractical to write in the treatment sheet by consultant/resident doctor.
- Doctor should not use abbreviations when an order is given.
- Verbal orders never to be given directly to the patient.
- Hospital has defined the following list of medicines for verbal order.

Q.102 What is the PROCESS FOR GIVING VERBAL OR TELEPHONIC ORDERS?

Answer:

- The treating consultant/Resident Doctor call the on duty Medical Officer/treating nursing staff at concerned department.

- The treating consultant/resident doctor specifies the patient's name and patient unique identification number for each verbal order.
- The receiver has to document the order immediately on the progress note/treatment sheet including the date, time and the consultant name. The receivers have to mention his/her name and sign the order along with it.
- The Receiver should read back the order including the patient's name, Unique identification number, drug name and spelling of the drug to avoid an error due to sound alike drugs, dosage, pronouncing it in single digits (e.g. 15 mg should be read as one five), route, frequency (e.g. three times daily, not TID)
- The Receiver should also request the indication for the medication to assist in avoiding errors.
- The Receiver should question the treating consultant/resident doctor if there is any uncertainty regarding the order.
- The treating consultant/resident doctor must countersign the order as soon as possible or within 24 hours after communicating the order.

Q. 103 List out the medicines that can be given as verbal order.

Answer:

Sr. No.	Name of Medicine *
1	TAB. / SYP. CETIRIZINE
2	TAB. / SACHET SPORLAC
3	SYRUP / TAB. DOMSTAL (DOMPERIDONE)
4	TAB. AVIL (PHENIRAMINE)
5	TAB. PANTOPRAZOLE
6	TAB. RANITIDINE
7	TAB./SYP. DIGENE (MAGNESIUM HYDROXIDE + SIMETHICONE + SODIUM CARBOXYMETHYLCELLULOSE + DRIED ALUMINIUM HYDROXIDE GEL)
8	TAB. AMLODIPINE
9	TAB. / INJ. / SYRUP PARACETAMOL
10	DUOLIN / BUDECORT NEBULIZATION
11	TAB. / INJ. EMSET (ONDENSATRON)
12	INJ. HYDROCORTISONE
13	DULCOLAX SUPPOSITORY
14	TAB. / INJ. / SYP. FRUSEMIDE
15	NEOPEPTINE DROP (FOR PAEDIATRIC PATIENT)

Q.104 How medicines are stored?

Answer:

- Medicines are stored in Rack system and stock level is maintained as per FSN (Fast moving, Slow moving and Non-moving) System
- Surgical items are stored in Compact storage system and stock level is maintained as per FSN (Fast moving, Slow moving and Non-moving) System.

- Minimum level for one and half month and maximum level for two month is maintained considering the usage of last six month.

Q.105 What is Reconciliation of medications?

Answer:

- The purpose is to ensure that the list of medication that a patient is to receive is complete and up to date in relation to past clinical conditions and present care plan.
- The prescribed medicine shall be checked and documented for accuracy at the transition points, such as the time of admission, transfer of the patient from one ward to another and at the time of discharge.
- There is a system for effective communication during handover regarding reconciliation of medications.
- Detailed drug history of patient's medicines at home need to be taken in OPD, Emergency & at the time of hospitalization.
- Medicine Name, Dose, Frequency, Duration of the drug, Route & Time of last dose taken, any Instructions need to be clearly documented in the history sheet (as mentioned below).

Medical/Drug History:					
Patient is on following medications.					
Name of Medicine	**Frequency**	**Duration**	**Route**	**Last dose taken at**	**Instruction**

Q.106 At what temperature medicines are stored in refrigerator?

Answer:

- The Medicines are stored in refrigerator requires cooling (2 to 8 °C).
- Special refrigerator is required in OT store for storage of BioGlue (Evicel) which capacity is to maintain temperature up to -35 °C.

Q.107 What are the Principles of Safe Medications?

Answer:

1. Right Patient	**6. Right Route**
2. Right Medication	**7. Right to Refuse**
3. Right Dose	**8. Right Assessment**
4. Right Time	**9.Right Evaluation**
5. Right Education	**10.Right Documentation**

Q.108 What is the procedure for Narcotic Drug?

Answer:

- All narcotic drugs are kept in double lock & key.
- The prescription form (Form 3E) is filled by the prescribing doctor at patient care areas and are submitted to the central pharmacy store.
- Narcotic drugs usage record is maintained & documented in Narcotic stock book of respective store.
- The used empty vials/ampoules for narcotic drugs are returned from patient care areas to the central store which are duly checked by the pharmacist and record for the same are duly signed by pharmacist in empty vial register. These empty vials are then packed and disposal is done according to BMW disposal guidelines.
- The compiled central register of daily usage from all wards is maintained in pharmacy store. This record is also maintained in **Form 3H** for daily usage.

Q.109 What are the criteria's that nursing staff should verify before administer the medications?

Answer:

Nursing staff should verify before administer the medications nursing staff should verify the following:-

- Patient identity (Minimum two identifiers are used, i.e. patient name & patient ID number) before administration of drugs.
- Medication Order (Treatment Sheet)
- Appearance of medication (melting, clumping, etc.)
- Expiry date
- Any of the missing/incomplete parameter in medication order or Treatment sheet like Drug Name, Strength, Frequency, Duration, and Route.
- Where appropriate site of administration shall be verified.
- In case of high risk medication, the double verification is done by nurses and it must be documented.
- Care must be taken to avoid catheter and tubing mis-connections during medication administrations.
- Stay with the patient until all medication is taken by patient except for medications requiring continuous infusion.
- Discard the syringe & needle as per the BMW protocol.
- When appropriate I.V. pushes medications, fluid boluses, and blood products may be given manually or by gravity flow.
- In case of verbal ordering medication, staff should follow the procedure for the verbal orders.
- Medication administration documentation is done in a uniform location.

Q.110 What measures are to be taken to avoid catheter and tubing mis-connections?

Answer:

- The organization ensures that inadvertent administration of a drug through a wrong route is avoided.
- IV extension tubes should not be used for epidurals, irrigation, drains, and central lines or to extend enteric feeding tubes.
- Care must be taken to position functionally dissimilar tubes used in patient care away from one another.
- Staff administering medications could trace all lines from their origin to the connection port to verify attachments before making any connections or reconnections, or administering medications, solutions, or other products.

Q.111 List of medication errors.

Answer:

- Prescription error
- Transcription error
- Requisition error
- Dispense error
- Administration error
- Documentation error
- Others

Q.112 What is NCCMERP?

Answer:

On receiving the Medication error notification Pharmacist will conduct the Root cause analysis including assessment of error severity using NCCMERP Index followed by corrective actions taken and preventive actions implemented if any.

NCCMERP Index:-

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

Q.113 How medical supplies and consumables Storage, inventory control,distribution and safe storage takes place at your organization?

Answer:

- Maintain Stock level as per FSN (Fast moving, Slow moving and Non-moving) System. Minimum level for one and half month and Maximum level for two months is maintained in pharmacy store, considering usage of the last six months.

- Supply necessary material to all departments as per their weekly demand.
- Critical wards can indent and store consumables and disposable in their respective wards for about 3-4 days from pharmacy department.
- Non Critical wards can indent and store consumables and disposable in their respective wards for about 4-5 days from pharmacy department.
- Maintain proper storage of all material in Compact Storage System or racks in hygienic condition. Also follow First expiry first out
- To verify physical stock of consumable items every 3 months in pharmacy stores and maintain record for the same.
- To check the near expiry of the material and inform to the vendor either for replacement or credit note.
- Maintain goods return note.
- Follow double cross check system for dispensing of material by two different staffs to prevent error of consumable items for supply in all departments.
- Medical supplies and consumables are stored in a clean, safe and secure environment as per manufacturer's recommendation and incorporating infection control practices to maintain sterility and integrity of the products.
- Entry in stores is restricted to protect from loss or theft.
- The condition of these materials shall be checked before dispensing and usage which includes:
    - Proper packaging
    - Physical damage
    - Unwanted discoloration.
- Maintain records of Quality indicators of Pharmacy Store
    - Percentage of Stock out including emergency items

PATIENT RIGHTS & EDUCATION (PRE)

Q.114 List out patient's rights and responsibilities.

Answer:

Patient Rights	Patient Responsibilities
Accessibility and Availability	
To receive appropriate and professional health care regardless of age, gender, race, religion, nationality, social status, special needs, or payment source.	To follow the treatment plan advised by the care provider.
To receive care in an emergency.	To provide contact details of at least one relative who can be reached in case of an emergency.
To access one's own clinical records and request corrections, consistent with laws and regulations.	
To be treated in a safe environment and receive emotional support, including minimal separation from family (as permitted by care needs).	
To be actively engaged in all aspects of care, treatment, and services.	
To seek information and ask questions about care.	
To be informed about expected outcomes of planned care and treatment.	
To be informed when an unanticipated event or outcome occurs during care (e.g., hospital-acquired infections, medication errors, pressure ulcers, postoperative infections).	
Information Exchange	
To be informed about initial assessment findings, medical condition, treatment, and possible results in a language one understands, enabling informed decision-making.	To provide accurate and complete information about present and past medical conditions, hospitalizations, medications, and known allergies.
To be informed about the plan of care, including risks, side effects, and alternatives.	To provide correct demographic and general information.

Patient Rights	Patient Responsibilities
To know the names of attending doctors, nurses, and other staff responsible for one's care.	To update care providers about any changes in health status during treatment.
To be informed about medication name, purpose, and route of administration.	
To be informed about triage protocols.	
To be informed about diagnostic findings and confirmed diagnosis.	
To be informed about any second opinion and the process to obtain a second opinion.	
Involvement in Decision-Making	
To be actively involved in decisions regarding care.	To understand that discontinuing treatment against medical advice is at one's own risk.
To define whom one considers "family" or support persons and decide who may be involved in care decisions.	To specify which family members or others may receive information or updates about one's care.
To determine what information regarding one's care may be shared with family and others.	
To designate another person (e.g., family member, caregiver, surrogate) to make decisions on their behalf.	
Respect, Dignity, and Consideration	
To receive care that respects religious, spiritual, or cultural needs (as feasible within medical care).	To behave respectfully and courteously with other patients, staff, and doctors.
To refuse treatment, as allowed by law and regulations.	
To document personal preferences regarding family involvement in care and decision-making in medical records.	
Personal and Information Privacy & Confidentiality	
To maintain privacy during examinations, procedures, and treatments.	To acknowledge that while medical records are confidential, statutory bodies, insurance companies, or payers may legally require access.
To have personal and medical information kept confidential, in accordance with laws and regulations.	

Patient Rights	Patient Responsibilities
To be informed and provide consent before any release of health information, except when required by law or for continuity of care.	
Patients can request access to their medical records.	
To be informed about hospital policies on confidentiality and how medical information is shared.	
Treatment Cost	
To receive financial counselling and an estimated cost of hospital expenses upon admission.	To provide insurance or scheme-related documentation upon admission.
To view day-to-day bills upon request and receive a detailed bill at the time of discharge.	To pay bills promptly and make deposits as per hospital policy.
Complaints and Feedback	
To register a complaint and receive information on the complaint process.	To utilize the hospital's complaint and feedback systems to communicate issues or concerns constructively.
To share feedback and suggestions.	
To be informed about their right to report complaints and to be notified of errors related to their care.	
To be informed about the hospital's process for handling complaints, including time frames for resolution.	
To receive prompt disclosure of any clinical errors that occurred during care.	
To be informed about how the hospital prevents similar errors from happening again.	
Security	
To be protected from abuse, neglect, assault, harassment, manhandling, and unnecessary use of restraints.	To safeguard personal valuables and belongings.
To have the security of personal belongings if the hospital has assumed responsibility.	To respect hospital property (no smoking, no spitting, no vandalizing, etc.).
Consent	

Patient Rights	Patient Responsibilities
To provide informed consent or refuse medical care or recommended treatment, as permitted by law.	To report if one does not clearly understand the instructions given by the care provider.
To seek an additional second opinion regarding clinical care from within or outside the hospital.	To ask for additional information or clarification when needed.
To be informed about any research activity and to refuse participation.	
To be informed about available alternatives to care and treatment.	

Q.115 What can be considered as violation of patient rights?

Answer:

The violence of patient right's may include the following but not limited to:-

- Care recession including deprivation of the care givers presence and the delay /lack of needed response.
- Being disrespected including humility and aggression
- Altering, falsifying, miss –statement of facts or making a material omission on any patient chart /patient record
- Disclosure of confidential information to pertaining to patient
- Soliciting tips ,gifts or other gratuities or favors from patient /their families or accepting gifts
- Unauthorized person gains access to patient's health information without patient consent
- Expose the patient report regarding communicable disease
- Disrespect to the religious and cultural needs

Q.116 How will you capture violation of patient rights?

Answer:

Violation of patient rights shall be recorded through complaint/feedback mechanism. Patient Feedback form is used as a tool to capture violation of patient rights and are monitored, analyzed and corrective / preventive measures shall be taken by the in charge of concerned department and grievance redresser committee.

Q.117 Who can give consent?

Answer:

Consent is to be given by :-

- When the patient is capable of giving consent & above the legal age of giving consent, No one can consent on behalf of a competent adult.
- The patient, unless he or she is a minor or unconscious or not in a condition to give consent informed decision making, consent shall be obtained from next of kin/ parent/guardian, as per law of the land
- In situations when there is no consensus amongst children of the patient, they are asked to nominate one of their siblings in writing with signatures of two witnesses. The informed consent is obtained from the nominated person.
- In case of unidentified patient in unconscious condition, EPR (Emergency Preservation and Resuscitation) should be done and consultant shall take a decision in life threatening circumstances.
- In life threatening situation, where no next of kin is available then EPR (Emergency Preservation and Resuscitation) should be done and consultant shall take decision for the procedures that needs to be done.

Q.118 Who can take consent?

Answer:

Consent is to be taken by:-

The treating consultant/ team member of the treating consultant can take informed consent from the patients/patient's relative, explaining the nature of the intervention and possible risks involved.

Q.119 List out the topics on which you can provide Patient education.
Answer:

- Education about treatment plan and expected outcome at regular interval including possible complications.
- Hospital shall ensure that Care plan is prepared and modified in consultation with patient and/or family members. The religious, cultural and spiritual views of the patient and/or family shall be taken into consideration while preparing or modifying plan of care.
- Education about the result of diagnostic tests and diagnosis.
- Education about change in condition including improvement, deterioration or occurrence of complications.
- Education about procedure/surgery, its risk, benefits and alternatives.
- Education about Safe and effective use of medication and the potential side effects of the medication.
- Education about food drug interaction

- Education about diet and nutrition
- Education about immunizations
- Education about their specific disease process, complications, prevention strategies and preventing infections including lifestyle modifications (Stress management , physical exercise, cessation of smoking and substance abuse), diet changes, immunization where appropriate through booklets/ videos/leaflets.
- Education about hand washing, other techniques and avoiding overcrowding near the patient to prevent Healthcare associated infection.
- Special educational needs are identified and provide through the patient counselling, use of printed material and videos.
- Patient and relative are clearly explained in understandable language and format about their Care.
- Counselling about condition of critically ill patients, long-stay patients to family members by treating doctor/physiotherapist/nurse.

Q. 120 Where is the tariff list available if patient wants to refer?

Answer:

Registration Counter (Both – OPD/IPD & EMCS), Reception Counter and "May I help you" Desk.

Q.121 What is Patient Reports Experience Measures (PREM)?

Answer:

Along with the patient feedback, the organization also captures a patient's perception of their experience with health care or service by using patient reported experience measure tool.

Patient Reported Experience Measures:-

- The organization measures the patient's experience of their relationship to treatment by using Patient Reported Experience Measure tool.
- Management shall review the analysis report of patient reported outcome measure at least once in a month with clear action points and responsibility of implementation of it.
- Following dimensions of patients' experience are capture:-
    - Information & Education
    - Coordination of care
    - Physical Comfort
    - Emotional Comfort
    - Respect patient preference

- Involvement of family and friends
- Continuity and transition
- Overall impression

Q-122 How patient complaints are addressed?

Answer:

Patient and relatives register complaint by following ways

1. By approaching any member of the healthcare team who is involved in their care.
2. By using contact number displayed in hospital to register the complaint
3. By filling up the feedback form and handing it over to concerned department.
4. By approaching complaint/suggestion box available in departments.
    - Receiver of complaint may try to resolve the problem by talking to concerned person.
    - If patient is not satisfied complaint may go to grievance committee chairperson andhe/she tries to solve the problem.
5. If complaint is received in feedback form, patient may be informed after solving the complaint.

INFECTION PREVENTION AND CONTROL (IPC)

Q. 123 How to segregate Bio Medical Waste?
Answer:

Category	Type of Waste	Type of Bag/ Container to be used	Treatment and Disposal options
Yellow	(a) Human Anatomical Waste • Human tissues • Organs • Body parts • Fetus below the viability • period	Yellow coloured non-chlorinated plastic bags	Incineration or Plasma Pyrolysis or deep burial
	(b)Animal Anatomical Waste • Experimental animal carcasses • Body parts • Organs • Tissues • Waste generated from animals used in experiments or testing in veterinary hospitals or colleges or animal houses.		
	(c) Soiled Waste • Items contaminated with blood, body fluids like dressings • Plaster casts • Cotton swabs • Bags containing residual or discarded blood and blood components		Incineration or Plasma Pyrolysis or deep burial In absence of above facilities, autoclaving or micro-waving/ Hydroclaving followed by shredding or mutilation or

			combination of sterilization and shredding.
	(d) Expired or Discarded Medicines • Pharmaceutical waste like antibiotics • Cytotoxic drugs including all items contaminated with cytotoxic drugs along with glass or plastic ampoules, vials etc.	Yellow coloured non-chlorinated plastic bags or containers	<u>Expired cytotoxic drugs and items contaminated with cytotoxic drugs</u> • To be returned back to the manufacturer or supplier for incineration • To CBWTF for incineration at >1200^{0}C Or Encapsulation Or Plasma Pyrolysis at >1200^{0}C <u>All other discarded medicines shall</u> • Be either sent back to manufacturer OR Disposed by incineration
	(e) Chemical Waste • Chemicals used in production of biological • Used or discarded disinfectants.	Yellow coloured containers or non-chlorinated plastic bags	Incineration or Plasma Pyrolysis
	(f) Chemical Liquid Waste • Liquid waste	Separate collection	After resource recovery, the

	generated due to use of chemicals in production of biological • Used or discarded disinfectants • Silver X-ray film developing • liquid • Discarded Formalin • Infected secretions • Aspirated body fluids • Liquid from laboratories -Floor washings, cleaning, house-keeping and disinfecting activities etc.	system leading to effluent treatment system	chemical liquid waste • Shall be pre-treated before mixing with other waste water.
	(g) Discarded linen, mattresses, beddings contaminated with blood or body fluid, routine mask and gown.	Non-chlorinated yellow plastic bags or suitable packing material	• Non-chlorinated chemical disinfection followed by incineration or Plasma Pyrolysis or for energy recovery. In absence of above facilities, shredding or mutilation or combination of sterilization and shredding.
	(h) Microbiology, Biotechnology and other clinical laboratory waste • Blood bags	Autoclave or Microwave or	• Pre-treat to sterilize with non-chlorinated

	• Laboratory cultures • Stocks or specimens of microorganisms • Live or attenuated vaccines • Human and animal cell cultures used in research, industrial laboratories, production of biological, residual toxins, dishes and devices used for cultures	Hydroclave safe plastic bags or containers	chemicals on-site as per NACO or WHO guidelines • Autoclaving/ microwaving/ Hydroclaving And thereafter for incineration
Red	Contaminated Waste (Recyclable) • Tubing • IV bottles • IV tubes and sets • Catheters • Urine bags • Syringes • Vacutainers with their needles cut • Gloves	Red coloured non-chlorinated plastic bags or containers	Autoclaving/ micro- waving/ hydroclaving followed by shredding or mutilation or combination of sterilization and shredding. Treated waste to be sent to registered or authorized recyclers or for energy recovery or plastics to diesel or fuel oil or for road making, whichever is possible Plastic waste should not be sent to landfill site

White translucent	Waste sharps including metals (both used, discarded and contaminated) • Needles • Syringes with fixed needles, needles from needle tip cutter or burner • Scalpel • Blades Any other contaminated sharp object that may cause puncture and cuts	Puncture proof, leak proof, tamper proof containers	Autoclaving followed by Shredding or mutilation or encapsulation in metal container or cement concrete
Blue	(a) Glassware: Broken or discarded and contaminated glass including medicine vials and ampoules except those contaminated with cytotoxic wastes. (b) Metallic body implants	puncture proof and leak proof container	Disinfection (by soaking the washed glass waste after cleaning with detergent and Sodium hypochlorite treatment) or through autoclaving or microwaving or hydroclaving and then sent for recycling

Q.79 Seven Steps of Hand washing?

Answer:

1. Step 1: Palm to palm
2. Step 2: Right palm over left dorsum and left palm over right dorsum (Back of the palms)
3. Step 3: Palm to palm with fingers interlaced
4. Step 4: Backs of fingers to opposing palms with fingers interlocked
5. Step 5: Rotational rubbing of right thumb clasped in left palm and vice versa
6. Step 6: Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa
7. Step 7: Rotational rubbing of wrist

NOTE:

Time of duration for Social hand wash: Wash: 2-3minutes with 7 steps technique

Time of duration for Hand Rub: Rub: 20-30 seconds with 7 steps technique

Time of duration for Surgical Hand Hygiene Scrub: First scrub of the day- 5 min

Subsequent scrub-3 min

Q. 124 What to do in case of Blood/Mercury Spillage?

Answer:

Blood and Body Fluid Spillage Management

- Wear appropriate PPEs (cap, mask, clean glove, and apron) before spillage

management.

- Cover the spillage with absorbent material (tissue paper/wastage cloth).
- Carefully pour freshly prepared 1% sodium hypochlorite on tissue paper.
- Allow 20 minutes exposure time with disinfectant.
- Pickup tissue paper with gloved hand and place in yellow bin.
- Again mop with 1% sodium hypochlorite.
- Removes gloves, mutilate & discard in red bin & wash hands then remove goggle, gown, cap, mask & do hand wash again.

Note: Do not use hypochlorite solution directly, if urine and vomit spillage. First clean with wastage cloth/ tissue paper then disinfect with 1% sodium hypochlorite Acid in this substance may generate chlorine gas.

Mercury Spillage management

- Do not touch mercury with bare hands
- Remove jewelry
- Wear protective gloves
- Get a scotch tape
- A 10 CC syringe without needle and ready 3/4 water containing plastic bottle
- Flash torch on mercury
- Gather the mercury with card board
- Suck the mercury with 10 CC syringe without needle
- Pour the contain of the syringe in plastic bottle containing water
- Seal the bottle with scotch tape and send it to bio medical store

Note: Mercury should be collected in bottle containing water to prevent vaporization.

Q. 125 Procedure to be followed in case of needle stick injury.

Answer:

Do's

- Remove gloves, if appropriate
- Wash site thoroughly with running water with using antiseptic solution.
- Irrigate thoroughly with water or saline if splashes have gone into the eye or mouth.
- Immediate report to Infection Control Department.

Don't

- Do not panic
- Do not reflexly place finger into mouth
- Do not squeeze blood from wound, this causes trauma and inflammation, increasing risk of transmission
- Do not use bleach, alcohol, betadine, or iodine, which may be caustic trauma

Prevention of NSI

- Standard precautions
- Hand washing
- Covering cuts and abrasions
- Safe injection practice
- Immunization

Be Needle Smart

- Do not recap or re-use
- Do not bend
- Do not remove
- Do not transport

HEPATITIS B – THREE DOSE

Hepatitis B vaccination of all healthcare worker who are working in patient care area are vaccinated according to three dose schedule (0-1-6 month).

Q. 126 How are different types of soiled linen categorized and handled?

Answer:

Soiled linen is categorized into three main types:

- **Used/Soiled Linen:** This is linen that has been in contact with patients and may have moderate soiling but is not associated with high-risk infectious agents. It is collected daily from patient care areas using dedicated containers. If visibly contaminated with substances like blood or body fluids, it should be immediately separated and placed in leak-proof, white bags. Any solid excrement should be carefully removed and disposed of before bagging.
- **Infectious/Hazardous Linen:** This category includes heavily soiled linen or linen from patients with known infectious conditions, particularly high-risk infections (e.g., MRSA, VRE, MDRO, Category 4 pathogens). This linen is collected directly into designated, leak-proof red dotted bags clearly labeled as "infectious linen."
- **Category 4 Pathogen Linen:** Linen from patients with Category 4 pathogens (e.g., anthrax, viral haemorrhagic fever) requires special handling; it must be placed in yellow clinical waste bags and incinerated.

Q.127 When Hand Washing with soap and water should be done?

Answer:

- While entering work place
- Your hands are visibly soil or dirty
- Hands are visibly contaminated with blood, body fluids, secretions and excretions
- Before and after drinking, eating and food contact
- After using rest room

- Before leaving work place

Q.128 When Hand washing by using alcohol-based hand rub should be done?

Answer:

- Before having direct contact with patients
- Before entering and leaving isolation room
- Before taking care of susceptible patients
- Before performing any invasive procedures
- Before moving from a contaminated site to clean body site
- Before having contact with body fluids, wounds or broken skin
- Before wearing and after removing gloves
- Between contact with different patients
- After having direct contact with patient skin
- After touching equipment or furniture near the patients

Q.129 What are the 5 moment of Hand Hygiene?

Answer:

1. Before touching patient
2. Before clean/aseptic procedure
3. After Blood/Body fluid exposure risk
4. After touching patient
5. After touching patient surrounding

Q.130 How to prevent needle stick injury?

Answer:

Prevention of NSI

- Universal (or standard) precautions
- Hand washing
- Covering cuts and abrasions
- Safe injection practice
- Immunization
- Be Needle Smart
- Do not recap or re-use
- Do not bend
- Do not remove
- Do not transport

Q.131 What is standard precaution?

Answer:

Standard Precautions are the minimum infection prevention practices that apply to all patient care, regardless of suspected or confirmed infection status of the patient, in any setting where health care is delivered.

Q.132 Describe the elements of standard precautions.
Answer:

- Personal hygiene practices, particularly hand hygiene, aim to reduce the risk of contact transmission of infectious agents.
- The use of personal protective equipment.
- Safe Injection & Infusion Practices (i.e., aseptic Technique for parenteral medications).
- Cleaning, disinfection and sterilization of patient care equipment.
- Environment cleaning
- Linen Management
- Practicing respiratory hygiene and cough etiquette reduces risk of transmission of infection.
- Isolation(Barrier Nursing) & Reverse Barrier Nursing
- Appropriate handling and disposal of sharps assists in preventing transmission of blood-borne diseases with pre & post exposure prophylaxis to healthcare workers.
- Spills management(Blood /body fluid & mercury)
- Bio-Medical Waste management

Q.133 What is Barrier Nursing (Isolation)?
Answer:

Source Isolation (Barrier nursing) aims to confine the infectious agent and prevent itsspread from one patient to another.

Q.134 What is Reverse Barrier Nursing?
Answer:

Protective Isolation (Reverse barrier nursing) aims to protect an immune-compromised patient who is at high risk of acquiring micro-organisms from either the environment or from other patients, staff or visitors.

Q.135 How to prepare 1% Sodium Hypochlorite solution?
Answer:

Add one part of solution in four part of water.(800ml water+200 ml disinfectant)

Q.136 What is Cleaning, Disinfection & Sterilization?
Answer:

- **CLEANING**: Cleaning is the removal of visible soil (e.g., organic and inorganic material) from objects and surfaces and normally is accomplished manually or mechanically using water with detergents or enzymatic products.
- **DISINFECTION:** Disinfection describes a process that eliminates many or all pathogenic microorganisms, except bacterial spores, on inanimate objects.
- **STERILIZATION**: Sterilization describes a process that destroys or eliminates allforms of microbial life including bacterial spores.

Q.137 Describe Transmission Based Precautions.

Answer:

- Transmission-based Precautions are designed for patients documented (confirmed) or suspected to be infected or colonized with highly transmissible or epidemiologically important pathogens for which additional precautions beyond Standard Precautions are needed to interrupt transmission in hospital. Transmission-based Precautions are to be used on an empiric, temporary basis until a diagnosis can be made; these empiric, temporary precautions are to be used in addition to Standard Precautions.
- There are three types of Transmission-based Precautions:
  1. Airborne precautions
  2. Droplet precautions
  3. Contact precautions

Q.138 What is Bundle care?

Answer:

Care "bundles" in infection prevention and safety are simple sets of evidence-based practices that, when implemented collectively, improve the reliability of their delivery and improve patient outcomes.

Q.139 What are the recommended measures to reduce Hospital Associated Infection invarious bundles?

Answer:

A. <u>CLABSI Bundle</u>

- Hand Hygiene
- Maximal Barrier Precautions
- Chlorhexidine skin preparation
- Optimal Site selection
- Daily review of line necessity
- "Scrub the Hub" with 70% alcohol every time before and after assessing hub

B. <u>CAUTI Bundle</u>

- Daily assessment of catheter need
- Catheter secured to patient
- Hand Hygiene
- Daily meatal hygiene with soap and water
- Drainage bag emptied using a clean container
- Unobstructed flow maintained

C. <u>VAP Bundle</u>

- Head of Bed elevation at 30® to 45®
- Daily sedation vacation and daily assessment of readiness to wean
- Subglotic secretion drainage
- Daily mouth care with chlorhexidine

Q.140 What is HAI? Type of HAIs?
Answer:

HAI (Healthcare Associated Infection):
HAI is strictly and specifically an infection "not present or incubating prior to admissionto the hospital, but generally occurring 48 hours after admission."
Types of HAIs as quality indicator

- CAUTI –Catheter Associated Urinary Tract Infection
- VAP- Ventilator Associated Pneumoniae
- CLABSI- Central Lines Associated Blood Stream Infection
- SSI –Surgical Site Infection

Q.141 What is safe injection/Infusion practice?
Answer:

Injection safety or safe injection practices are practices intended to prevent transmission of infectious diseases. Patients and healthcare providers must both insist on nothing less than "One Needle, One Syringe, and Only One Time" for each and every injection.

Q.142 What is MSDS? What should we do in case of spillage of hazardous material or exposure to body parts?
Answer:

MSDS is Material Safety Data Sheet. Management of hazardous material All the hazardous materials must have "Caution" sticker on them and MSDS for the same must be displayed in the department.
In case of spillage of these hazardous material, steps mentioned under 'Accidental release measure' to be followed.
In case any body parts get exposed to these hazardous material, 'First measure steps' mentioned in MSDS to be followed by the person.

Q.143What are some of the key mitigation strategies outlined for high-risk areas and procedures?
Answer:

For areas and procedures identified as high-risk, specific mitigation strategies are implemented. In dialysis units, which are high risk due to invasive device use and immunocompromised patients, strategies include using dedicated equipment, enforcing stringent disinfection protocols, conducting staff training, and continuously monitoring device care. For procedures like central line insertion, which carry a moderate-to-high risk, strict adherence to aseptic technique, sterile barrier precautions, ultrasound guidance (if available), rigorous hand hygiene, and post-procedure monitoring are emphasized. These tailored strategies aim to

directly address the specific infection risks associated with different hospital settings and activities.

Q.144 What roles and responsibilities are outlined for the Hospital Infection Prevention and Control Committee (HICC)?

Answer:

The Hospital Infection Prevention and Control Committee (HICC), also referred to as the Infection Control Committee (ICC), is responsible for overseeing the IPC program. Its composition includes various stakeholders such as the Infection Control Officer (ICO), Infection Control Nurse(s) (ICN), representatives from clinical departments, diagnostic services, facility and support services, and relevant medical faculties. The HICC is integral to the committee for expert guidance and ensuring the program's effectiveness across the hospital.

Q.145 What types of training and education are provided as part of the IPC program?

Answer:

The IPC program emphasizes continuous education and training for all hospital staff, including clinical and non-clinical personnel, support staff, and even patients and their relatives. Training methods include annual mandatory sessions, event-driven training in response to specific incidents or outbreaks, and bedside/unit-area demonstrations for practical skill reinforcement. The content covers various IPC practices such as hand hygiene, respiratory etiquette, use of personal protective equipment (PPE), and safe injection practices, among others.

Q.146 What are some of the main strategies and interventions used by the ASP to promote appropriate antimicrobial use?

Answer:

The ASP employs several strategies. These include formulary management and restricting certain high-impact antimicrobials (like carbapenems and polymyxins) that require prior justification. The hospital also develops and updates evidence-based clinical guidelines and empiric therapy protocols for common infections. A key intervention is the "antibiotic time-out" at 48-72 hours to reassess the need for antibiotics and de-escalate or narrow therapy when possible. Dose optimization and switching from intravenous to oral therapy when appropriate are also emphasized. The program conducts prospective audits with feedback to prescribers and uses infection surveillance data to adjust protocols.

Q.147 How does the hospital monitor for infections in the environment?

Answer:

Environmental surveillance is a crucial part of the IPC program. This includes targeted sampling of air quality in high-risk areas such as operating theatres

(OT), catheterization laboratories (CATH), and the Central Sterile Supply Department (CSSD). Water sources, including drinking water, OT scrub stations, ICU handwashing sinks, and dialysis ports, are also regularly tested for bacterial contamination. Environmental surfaces in patient care areas, operating rooms, ICUs, and wards are sampled, and food sampling is conducted in preparation areas and the kitchen. This comprehensive approach helps identify potential sources of infection within the hospital environment.

Q.148 What are the key considerations and procedures for the safe reprocessing and reuse of single-use devices (SUDs)?

Answer:

The reprocessing and reuse of single-use devices (SUDs) are governed by strict policies and procedures to ensure patient safety. Only SUDs listed in an approved reprocessing appendix may be reprocessed. Each approved device has a defined maximum number of reuses and must be inspected for damage before each reprocessing cycle and before use. Informed consent should be obtained from the patient if they inquire about reuse, and a new device must be used if the patient objects. A robust quality assurance process involving detailed cleaning, disinfection, sterilization, packaging, labelling, and tracking is essential. Opened but unused disposable devices also require reprocessing. All reprocessed devices must be confirmed safe and fit for purpose according to current guidelines.

Q.149 What documentation and tracking are required for reprocessed single-use devices?

Answer:

Rigorous documentation and tracking are crucial for reprocessed single-use devices. Devices must be clearly identified and their reprocessing cycles documented in a "Post-Use Inspection" log by clinical staff and a "CSSD Check and discard items" register by CSSD personnel. A unique, non-repeatable identification number should be assigned and permanently marked on the device along with the number of reprocessing cycles it has undergone. The Central Sterile Supply Department (CSSD) maintains detailed reprocessing and tracking registers, and a "Reuse Register" in clinical areas like the Cath lab/CTOT tracks patient information, device identification, sterilization details (including method and expiration date), and the number of reuse cycles. Any device failing inspection at any stage must be documented as unfit and discarded. Condemnations must also be recorded in the CSSD register

PATIENT SAFETY & QUALITY IMPROVEMENT (PSQ)

Q.150 Who is accreditation co-ordinator or representative of quality Department?

Answer: Dr. Kalgi Shah

Q-151 Who is looking after safety aspects of your hospital?

Answer: Dr. Dushyant Bhatt (Patient Safety Officer) & Mr. Nishanpuri Goswami (Fire Safety officer).

Q.152 Who is looking after Clinical safety aspects of your hospital?

Answer: Dr. Paresh Rathod (Clinical Safety Officer)

Q.153 Define the following:

Answer:

- **Hazardous materials: -** These are those substances that are dangerous to human & other living organisms. They include radioactive or chemical materials.
- **Near Miss Event: -** A near-miss is an unplanned event that did not result in injury, illness, or damage-but had the potential to do so. Errors that did not result in patient harm, but could have, can be categorized as near-miss.
- **No harm-** No harm is defined as the error is not recognized and the deed is done but fortunately for the health care professional, the expected adverse event does not occur.
- **Adverse Events-** An injury related to medical management, in contrast to complications of disease. Medical management includes all aspects of care, including diagnosis and treatment, failure to diagnose or treat, and the systems and equipment used to deliver care.
- **Sentinel Events**- A relatively infrequent, unexpected incident, related to system or process deficiencies, which leads to death or major and enduring loss of function for a recipient of health-care services.

  Major and enduring loss of function refers to sensory, motor physiological or psychological impairment not present at the time services were sought or begun. The impairment lasts for a minimum period of two weeks and is not related to an underlying condition.

Q.154 What is Quality Improvement Project?

Answer:

- Quality improvement projects involve a combined effort among health care staff and top management to make a continual improvement in the health care delivery system.
- The organization undertakes the two quality improvement projects at every year.
- The quality Improvement projects should a time bond activity with a definite purpose, measurement parameters under improvement at the beginning and end of the project.
- For example; topic on patient safety, cost effectiveness, patient centered, timeliness, efficiency and equity in healthcare.

Q.155 How many quality improvement project are under taken by the organization?

Answer: The organization under takes the two quality improvement projects at every years.

Q.156 What is Clinical Audit & it's frequency?

Answer:

A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. The frequency of audit is one clinical audit per clinical department once in two years.

Q.157 When will quality improvement committee review quality improvement programme?

Answer:

The Quality Improvement Programme is reviewed by the Quality Improvement Committee at once in a three months.

Q.158 When is nursing audit done?

Answer:

The organization monitors the quality of nursing care through nursing audits and it is done at once in a three months.

Q.159 When is internal audit done?

Answer:

A Quality Improvement Committee formulates a multidisciplinary team or identified the staff who conduct an internal audit at once in a six month in a hospital-wide. A summary report is generated at the end of the audit & corrective & preventive measures are taken & document it. Implementation of changes is verified and record it.

Q.160 What is PATIENT REPORTED OUTCOME MEASURES?

Answer:

- Patient Reported Outcome Measure (PROM) is used to measures the outcome of healthcare or service intervention from patient's own perspectives.
  - It is used to gather information directly from patients about their symptoms, general condition, and overall quality of life.
  - The collection of this data use in conjunction with, existing information on the quality of services.
  - PROM includes the questionnaires which are answered by the patient, after surgery/procedure (at least one month & three months after cardiac surgery/procedure).
  - Patients' self-reported health status is assessed through a mixture of generic and condition-specific questions.

Q.161 List out KEY PERFORMANCE INDICATORS.

Answer:

Sr. No.	Indicator
1.	Time for initial assessment of indoor patients
2.	Number of reporting errors per 1000 investigations
3.	Percentage of adherence to precautions by staff working in diagnostics.
4.	Incidence of Medication Errors
5.	Percentage of in-patients developing adverse drug reaction (s).
6.	Percentage of unplanned return to OT
7.	Percentage of surgeries where the organisation's procedure to prevent adverse event like wrong site, wrong patient and wrong surgery have been adhered to.
8.	Percentage of transfusion reactions
9.	Standardised Mortality Ratio for ICU
10.	Return to the ICU within 48 hours
11.	Return to the emergency department within 72 hours with similar presenting complaints
12.	Incidence of hospital associated pressure ulcers after admission (Bed sore per 1000 patient days)

13.	Catheter associated Urinary tract infection rate
14.	Ventilator associated Pneumonia rate
15.	Central line associated Blood stream infection rate
16.	Surgical site infection rate
17.	Compliance to Hand Hygiene Practises
18.	Percentage of cases who received appropriate prophylactic antibiotics within the specified timeframe
19.	Percentage of re-scheduling of surgeries
20.	Turn around time for the issue of blood and blood components
21.	Nurse-Patient ratio for ICUs and wards
22.	Waiting time for out-patient consultation
23.	Waiting time for diagnostics
24.	Time taken for discharge
25.	Percentage of medical records having incomplete and/or improper consent
26.	Number of stock-outs of emergency medications
27.	Number of variations observed in mock drills
28.	Incidence of patient falls
29.	Percentage of near missess
30.	Rate of needle stick injuries
31.	Appropriate handovers during shift change (for doctors and nurses)
32.	Percentage of safe & rational prescriptions
Departmental Indicators	
Cardiology	
1	Percentage of Beta blocker prescription with a diagnosis of CHF with reduced EF
2	Percentage of patients with myocardial infarction for whom Door to Balloon time of 90 minutes is achieved
Nuclear Medicine	
1	Percentage of adverse reaction to radio-pharmaceutical
Radiology	
1	Percentage of Intravenous contrast media extravasation

Emergency Medicine	
1	Time taken for triage
Other Clinical and Managerial Indicators	
1	Percentage of adverse anaesthesia events
2	Percentage of return in ICU with 48hrs
3	Re-intubation Rate
4	Percentage of employees provided pre-exposure prophylaxis
5	Bed Occupancy Rate
6	Average Occupancy Rate
7	Critical Equipment Down time
8	Out patient satisfaction index
9	In patient satisfaction index
10	Number of sentinel events reported, collected and analysed within the defined timeframe
11	Incidence of blood body fluid exposure
12	Percentage of missing records (File)
13	Incidence of Patient Identification errors
14	Employee satisfaction index
15	Employee Attrition Rate
16	Employee Absenteeism Rate
17	Compliance Rate of BMW Management
18	Employee Salary Release Time
19	Timely Refilling of Fire Extinguisher
20	Waiting time for on call visiting consultant
21	Door to Balloon Time in MI Patients
22	Cancellation Rate of Cath Procedure

Q.162 Which tool is used to measure culture of safety?

Answer:

AHRQ surveys on Patient Safety Culture (SOPS™) tool is used to measure a culture of safety. It emphasizes patient safety and error and event reporting.

AHRQ surveys on Patient Safety Culture (SOPS™) :-

- It is designed for hospital staff and examines safety culture from a hospital staff perspective.
- The survey can be used to:-
  - Raise staff awareness about patient safety
  - Assess the current status of patient safety culture

- Identify strengths and areas for patient safety culture improvement
- Examine trends in patient safety culture change over time
- Evaluate the cultural impact of patient safety initiatives and interventions

Q.163 List out Constitution of Hospital Committees.
Answer:

S.N	Hospital Committees	Committee Co-ordinators
1	Core Committee	Dr. Naitik Patel
2	Quality Improvement committee	Dr. Kalgi Shah
3	Hospital Safety Committee	Mr. Nishanpuri Goswami
4	Infection Prevention and Control Committee	Dr. Harmika Parmar
5	Pharmaco Therapeutic Committee	Swati Savaliya/ Pathik Patel
6	Grievance Redressal Committee	Dr. Ashish Dave
7	Internal Complaint committee	Dr. Khyati Pandya
8	CPR Analysis Committee	Dr. Visarad Trivedi
9	Medical Record Audit Committee	Dr. Khushbu patel
10	Radiation Safety Committee	Dr. Vishal Patel
11	Nursing Quality Assurance Committee	Mrs. Raksha Patel
12	Nursing Management Committee	Mrs. Parlin Deepak
13	Emergency Department Quality Improvement Committee	Dr Meena Parmar
14	Hospital Blood Transfusion Committee	Dr Shital Soni
15	MRI Safety Committee	Dr Dinesh Patel
16	Quality Improvement Committee for NABH Digital Health Standards	Ms. Mita Dhruv
17	Incident Review Committee	Dr. Dushyant Bhatt
18	Management Review Committee	Dr. Payal Tripathi
19	Clinicopathology Committee	Dr. Payal Tripathi
20	Clinicomicrobiology Committee	Dr. Dinesh Khandhadiya
21	Clinicoradiology Committee	Dr. Megha Sheth
22	Condemnation Committee	Dr. Arti Chaudhary

23	Credentialing & Privileging committee	Dr. Ashish Dave
24	Antimicrobial Stewardship Committee	Dr. Harmika Parmar
25	IT Technical Committee	Ms. Mita Dhruv

RESPONSIBILITIES OF MANAGEMENT (ROM)

Q.164 What is the Mission & Vision of your Hospital?

Answer:

Vision: Our vision is to be recognized as World Class facility in quality cardiac care and as a center of excellence in Cardiovascular Research.

Mission: To Offer World Class Quality Care in cardiology at No cost or Concessional cost and to provide free super specialty higher education in Cardiology, Cardiovascular Thoracic Surgery & Cardiac Anesthesia.

Q.165 Differentiate between near miss event, no harm event. Adverse event, sentinel event.

Answer:

NEAR MISS EVENT, NO HARM EVENT, ADVERSE EVENT & SENTINEL EVENT

An unsuspected incident related to system or process failure which

Could Have Caused Damage, But Didn't		**Caused Damage that was Not Serious / Lasting**	**Caused death / Major Enduring Loss of Function Lasting at least Two Weeks**
Near Miss event	**No Harm Event**	**Adverse event**	**Sentinel event**
Employee slips due to wet floor but did not fall	Slip/Trip/Fall occurred but no injury	Slip/Trip/Fall causing minor injuries	Slip/Trip/Fall causing Permanent disability/Death
Administration of wrong medicine to wrong patient is aborted just in time	Medication error causing no harm	Medication error causing minor allergy	Medication error causing death/severe complication
Fungus in the IV bottle detected just in time	Plaster falling from ceiling. No injuries	Plaster falling on patient Minor injuries	Ceiling matter falling on the head causing death
	Short circuit detected, Fire prevented	Thefts of patient's/hospital properties	Wrong site/Wrong patient/Wrong surgery

	Sudden equipment failure but no damage done	Fall from bed causing minor injuries	Physical assault/rape/molestation of a patient

Q.166 What is ESG (Environment Social & Governance) in terms of hospital's environment sustainability program?

Answer:

ESG stands for environmental, social and governance and refers to a set of standards used to measure an organization's environmental and social impact.

Q.167 what initiatives shall be taken by any organization towards an energy-efficient and environmentally friendly hospital?

Answer:

- Energy efficient lighting
- Rainwater harvesting
- Increase usage of solar power
- Wind energy
- Use of battery operated/ E-vehicles
- Recycling of STP/ETP water for gardening & flush water
- Reduction of plastic usage where possible
- Use of 'green' materials in construction
- Use of volatile organic compounds free paints

FACILITIES MANAGEMENT & SAFETY (FMS)

Q.168 What is Green Hospital?

Answer:

- There are gardening and plantation in front of hospital.
- We are purchase only high energy efficient equipment (i.e. 5 star rated split Air conditioner, IE-3 electrical motor, LED light in place of CFL light etc….)
- Rejected water which are generated by reverse osmosis plant used in flush water as well as gardening water.
- Natural light provided in waiting area Cardiology ward, CTRR, Special Room and Administrative wing through glass partition.
- Use solar plant for hot water generation.
- Water pump operate through sensor in each underground and over ground tank.
- Recharge pits are used for rain water harvesting.
- Each air handling unit have variable frequency drive for fan speed.
- Water meter are provided in each bore well and regular meter reading carried out by maintenance department.
- All air conditioning area (i.e. cath lab, OT, ICCU, CTRR, Special Room, Administrative room, central lecture hall and waiting area) parameters design as per ASHRAE like humidity, air changes, fresh air etc.
- Maintenance work in critical area well protected to prevent infection.
- The whole HVAC system operate by Building management system so AHU On/Off, Temp increase and decrease by building management system software.
- Water Saving Plumbing fixtures adopted for conserving water.
- Wall paints for internal and external are used which are free from volatile organic compound.
- STP plant (Sewage Treatment Plant) of capacity 800 KLD with MBR (Membrane Bio-Reactor) Technology & ETP plant (Effluent Treatment Plant) of capacity 60 KLD has been installed.
- The source of sewage is soil and waste water from toilets and pantry. Drain lines for sewerage and pantry waste are planned right up to the sewage treatment area.
- Treated Waste Water will be used for meeting Cooling Tower, Flushing for Existing Hospital Block, Residential Block and Landscape Irrigation with Dual

Plumbing System.

- Dual plumbing system with separate tanks and lines shall be provided for utilization of treated sewage for flushing.

Q.169 What aspects of safety does Clinical Safety Officer observes and takes actions?

Answer:

- To conduct safety round regularly with patient safety officer to ensure safety in patient care area.
- Identify training needs of staff on safety aspects.
- To take follow up of victim in case of any safety regarding incidents within the hospital as & when required.
- Identify the potential risks in the hospital in terms of clinical domains.

Q.170 What are international Patient Safety Goals?

Answer:

- Hospital defined following patient safety goals (As per National safety goals, 2018-Hospital Accreditation Program guideline)
  Goal 1:- Improve the accuracy of patient identification.
  Goal 2:- Improve the effectiveness of communication among caregivers.
  Goal 3:- Improve the safety of high alert medications.
  Goal 4:- Ensure the Safe Surgery.
  Goal 5:- Reduce the risk of health care–associated infections.
  Implement the patient safety goals shall be done at the department level and it is monitored by the safety committee & / quality department.

Q.171 List out Hazardous Materials and its uses at your organization.

Answer:

Sr. No.	Material Name	Content	MSDS Name
1	Alcohol based disinfectant •Aerodesin 250 ml, •Bacinill-30 •Bectacept-500ml	33g Propan-1-ol,18g ethanol I.P (With 0.5% Acetone) Exicipients cetrimide Isopropyl Alcohol	Aerodesin MSDS
2	ANAESTHETIC ETHER	ethyl ether	Anasthetic Ether (Ethyle Ether) MSDS
3	Hand rub •BACTORUB 5 LTR.	chlorhexidine gluconate IP	

	•HOSPISEPT PLUS 500 ML • Cutarub- CHG	2.5%,0.5% w/v chlorhexidine gluconante ethenol IP 70 %	Bactorub
4	Handscrub •BACTOSCRUB •LYSOWASH PLUS 5 LTR. •LYSOWASH •HOSPIPLUS •BIOCHEK 500 ML •Sterillscrub	4% w/v chlorhexidine skin cleanser	Bactoscrub
5	BARIUM SUSPENSION 1 LTR	Barium sulphate 95 gm,palatable base 100 ml,calsium erythrosim	Barium Sulphate
6	BETADINE SCRUB	Povidone Iodine 7.57 % w/v	Povidone Iodine MSDS
7	CITRO STERIL	Sodium bicarbonate IP 44.03% W/W	CITRO STERIL MSDS
8	DEVELOPER 22.5 LT. •PHOTON • LASERTECH	Sodium Carbonate Hydroquinone	Developer MSDS
9	ETO GAS CARTRIDGE 3M	Ethylene oxide 100%	ETO GAS CARTRIDGE
10	FIXER 5 LTR (UNIQUE IMAGIN) & HARDENER 550 ML.	Amonium Thiosulphate	FIXER (UNIQUE IMAGIN) & HARDENER MSDS
11	GLUTRARAL DISINFECTANT •CIDEX (HOSPAL G PLUS) •Endox	Glutruldehyde 2.0 % w/v	GLUTRARAL DISINFECTANT CIDEX (HOSPAL G PLUS)
12	HAEMODYALYSIS SOLUTION PART A	sodium chloride 165 gm potasium chloride 6 gm calcium chloride 8.1 gm magnesium chloride 3.7 gm actic acid chloride 8.9 gm	HAEMODYALYSIS SOLUTION PART A MSDS

13	HAEMODYALYSIS SOLUTION PART B	Sodium Chloride IP- 235 gm Sodium Bicarbonate IP - 660 gm	HAEMODYALYSIS SOLUTION PART B MSDS
14	LIQ.FORMALDEHYDE	Formaldehyde 37.40 % w/v	Formaldehyde 37% solution MSDS
15	LIQ.GLUTRALDEHYDE 2%	Glutraldehyde 2%	Glutaraldehyde 2% MSDS
16	LIQ.GLYCEROL	Glycerol	Glycerol MSDS
17	LIQ.HYDROGEN PEROXIDE	Hydrogen Peroxide 6% w/v	Hydrogen Peroxide 30% MSDS
18	LIQ.PARAFFIN	Paraffin	Paraffin MSDS
19	LIQ.POVIDONE IODINE 7.5 % W/V	povidone iodine 7.57 w/v	Povidone Iodine MSDS
20	LIQ.SODIUM HYPOCHLORITE	Sodium Hypochlorite	SODIUM HYPOCHLORITE MSDS
21	LIQUID OXYGEN	oxygen	Liquid oxygen MSDS
22	•LIQUIZIME • Hospal- MI Plus • Korsozyme	Liquizime	Liquizime
23	•LOTION CALAMINE • CALACARE	Calamine 15.00% w/v, Zinc Oxide 5.oo % w/v, Bentonite , sodium citrate , Liq.Phenol , glycerine IP, Purified water	Lotion Calamine (Zinc Oxide) MSDS
24	LPG	Propane or butane	Butane MSDS
25	Water based disinfectant •HOSPAL-H •Ultrabasil 5Q	Benzalkonium chloride solution IP 4.5% v/v Equivalent to benzalkonium chloride 2.25% w/v	Hospal-H

		5th generation quaternary ammonium coumpound Alkyl dimethyl benzyl ammonium chloride	
26	SOLUTION IOPREP	Iodine 1% w/v	Povidone Iodine
27	SPIRIT	Ethanol 60% to 70 %	Spirit
28	TERPENTINE OIL	Tempentine Oil	Turpentine MSDS
29	TINCTURE BENZOIN	Compound Benzoin tincture	Benzoin tincture MSDS
30	(HAND WASH) •WASA SOFT • SANILIN •Dermakleen	Sodium salicylate - o.46 gm sodium Benzoine - 0.59 gm	WASA Soft MSDS
31	Solution for fumigation •ENVISHIELD	Hydrogen peroxide silver nitrate	Envishield
33	GLUTRARAL DISINFECTANT CIDEX OPA	Ortho-Phraladehyde 0.55 % w/w	GLUTRARAL DISINFECTANT CIDEX OPA MSDS
34	LUBRICANT INSTRUMENT ENZYME SOLUTION	_	LUBRICANT INSTRUMENT ENZYME SOLUTION MSDS
35	LYSOFORMIN SPECIAL	2.9 g guanidine derivate 9.8 g didecyl dimethyl ammounium chloride	LYSOFORMIN SPECIAL MSDS
36	Detergent for washer Disinfectant , ultrasonic baths and manual cleaning Getinge	Potassium Carbonate	Getinge MSDS
37	Neutralizer for washer disinfectant Neodisher N DR. Weigert	Phosphoric acid, Citric acid	Neodisher N MSDS

Q 172. What are the non-fire emergency?
Answer:

- Terrorist attack
- Invasion of swarms of insects and pests
- Earthquake
- Floods
- Invasion of stray animals
- Civil disorders affecting the organization
- Anti-social behavior by patients/relatives
- Mob violence
- Toxic gas and chemical leaks
- Building or structural collapse
- Fall or slips or collision of personnel in passageway
- Bursting of pipelines
- Sudden flooding of areas for example basement due to clogging in pipelines
- Sudden failure of supply of electricity, gas, vacuum
- Bursting of boilers and autoclaves.

Q 173. What is the frequency of the electrical safety audit in the organization?
Answer:
Electrical safety audit shall be conducted once in a year.

Q 174.What is the minimum frequency of the fire & non-fire mock drills?
Answer:
Answer. Minimum frequency of the fire & non-fire mock drills is twice a year.

Q 175. In which committee incidents were discussed?
Answer. Incident review committee.

HUMAN RESOURCE MANAGEMENT (HRM)

Q.176 How Institute plans manpower?
Answer:

- **Nurse & Patient Ratio for critical care areas:-**
  - 1:1 for ventilated patients
  - 1:2 for non-ventilated patients
- **Nurse & Patient Ratio for High Dependency areas is 1:3.**
- **Nurse & Patient Ratio for Non- critical care areas is 1:6.**
- **Doctors**-Medical Officers manpower planning has been carried out accordingly standard guidelines for doctors.
  - Doctor & Patient Ratio for critical care areas is 1:15
  - Doctor& Patient Ratio for Non- critical care areas is 1:30

Q .177 Describe stages of performance appraisal.
Answer:

- Stage 1 - **At** this stage, concerned employee will rate his / her performance duringthe year and handover the form to the immediate supervisor. (note: stage 1 is not applicable for junior level staff)
- Stage 2 - Immediate supervisor will rate the performance of the employee based on self-rating by the employee and objective assessment by the supervisor.
- Stage 3 - At this stage the reviewing authority will review the rating given by theimmediate **supervisor** and finalize the rating.

Q.178 How does the organization appreciate employees apart from performance appraisal?
Answer:

All the employees are assessed by the institute on various individual qualities (parameters) and regardless of their designation or seniority, qualified employees are being awarded with:

- Star of the week
- Star of the month

Q.179 How employees grievances are addressed?
Answer:

- Employee can directly raise complaint to their immediate HOD
- Employee can also use Complaint Box
- Employee can directly raise their complaint into Grievance Redressal

Committee by contacting coordinator of the committee.

- Employee can raise their complaint in feedback form also as employee feedback is also received two times in a year.

Q.180 How patient complaints are addressed?

Answer:

Patient and relatives register complaint by following ways

- By approaching any member of the healthcare team who is involved in their care.
- By using contact number displayed in hospital to register the complaint
- By filling up the feedback form and handing it over to concerned department.
- By approaching complaint/suggestion box available in departments.
- Receiver of complaint may try to resolve the problem by talking to concerned person.
- If patient is not satisfied complaint may go to grievance committee chairperson and he/she tries to solve the problem.
- If complaint is received in feedback form, patient may be informed after solving the complaint.

Q. 181 Mention 5 employees' rights and responsibilities.

Answer:

Employee rights:

1. Right to be treated equally
2. Right to receive salary on periodic basis
3. Right to have leave as per policy
4. Right to have safe and secure working environment
5. Right to be treated with respect and dignity
6. Right to complaint
7. Right to have privacy and confidentiality of information

Employee responsibilities:

1. To treat others equally
2. To complete assigned work sincerely.
3. To follow rules and regulation of hospital
4. Not to damage or misuse hospital property
5. Not to participate in Fraud or corruption and notify the authority about the same if anyone is involved in such thing.
6. To treat others with respect and dignity and not to harass any one.
7. Not to disclose hospitals' confidential matter to anybody.

Q. 182 What is Credentialing & Privileging and which committee is responsible for this?

Answer:

Credentialing: Process of obtaining, verifying and assessing the qualification of a healthcare provider

Privileging: Process of authorizing all medical professionals to admit and treat patients as per their qualifications and skills.

Credential & Privileging Committee is responsible for this.

Q. 183 How employee health need is being addressed at your hospital?

Answer:

- Pre-Employment Health Checkup
- Regular Annual Employment Health Checkup
- Pre and post exposure prophylactic vaccination against Hepatitis
- Training on Occupational Hazards
- PPEs for safety
- Health Insurance Coverage
- Health Insurance Coverage
- Adequate and appropriate facilities for hand hygiene in all patient care area such as liquid hand wash, large wash basin with elbow operated taps, tissue paper/ hand dry, hand rubs etc.
- The hospital defines the conditions where isolation, barrier nursing or both isolation and barrier nursing is required. The organization provides barrier nursing facilities such as clothing, mask, gloves etc.
- For Driver – Audiometry and visual Test.
- For Employees working in Medical Air Compressor unit /Vacuum Compressor Unit/HVAC Plan (High Noise Areas) –
- Audiometry test.
- For Employees working in Radiation areas-
    - Thyroid Profile as and when required.
    - Institute provides TLD badges and lead apron and appropriate glass wear.
    - Regular test of TLD and lab apron are being performed.

Q-184 What is your job description & job responsibilities? Have you received your JD & JR?

Answer:

A Job description is a list that a person might use for general task or functions and responsibilities of a position. It may often include to whom position report, specification in job and salary range.

Q.185 Do we have uniform dress code policy?

Answer: Yes, we follow uniform dress code policy.

Q.186 What is hospital's Code of Conduct?

Answer:

Do's
Respect the dignity and privacy of each patient and treat all the patients with courtesy and respect. And treat all the employees with respect and not to discriminate any colleague or staff member.
To fulfill all the requirements of Hospital medical record.
To promote a continuous quality and performance improvement program throughout the Hospital.
To continuously strive toward a culture of patient safety.
To report actual or potential conflicts of interest to the immediate supervisor or manager.
To maintain the confidentiality of patient and employee information in accordance with legal and ethical standards.
To ensure safeguard the hospitals assets and physical property and ensure the appropriate use of the hospitals resources.
To maintain a safe and secure environment for the health and safety of patients, visitors and employees.
To report who are involved in fraud, corruption, nepotism, maladministration and any other act which constitutes an offence irrespective of his or her position.
To comply with all policies in relation to his job. And comply with organizational discipline.
To promptly notify the HR department of any changes in their personal data like change in name, address, contact number, marital status, number of their dependents, bank account details etc.
All personal and confidential papers are kept securely.
Follow the hospital's dress code policy
To report to the work place as per schedule time.

Don'ts
To discriminate on the basis of caste, religion, gender, disability, age, political persuasion, conscience, culture, language.
Negligency in Medical record
Demote continuous quality and performance improvement program
Discuss patient information in any public area
To engage in an activity, practice or act that creates an actual or apparent conflict with the interests of the Hospital.
Breaches of confidentiality
To involve themselves in fraud, corruption, nepotism, maladministration and any other act which constitutes an offence.
To issue any statement to the media directly or indirectly.
To converse in their local vernacular (language) while in patient contact areas
Jeopardize the hospital's assets and physical property.
Violation of patient rights
Defy the hospital's policy.

INFORMATION MANAGEMENT SYSTEM (IMS)

Q.187 What is Medical Record Audit?

Answer:

- Medical Record Audit is a detailed review and evaluation of selected clinical records by qualified professional personnel for evaluating quality of medical care.
- Both Active & discharge patient's record shall be included in Medical record audit

Q.188 Who can make entry in medical records?

Answer:

The medical records can be entered by:

- Treating Consultant and Cross Referred Consultant
- Resident doctors / Medical Officer
- Physiotherapist
- Dietician
- Nurse (only in nursing records)
- Perfusionist

Q.189 How inpatient files are coded ?

Answer:

All the inpatient files (diagnosis) shall be coded according to the ICD (International Classification of Diseases) -10 coding

Q.190 Do you have access to various hospital Policies? Where are they available?

Answer: Yes, we have soft copy in the computer.

Q.191 Mention retention period of medical records?

Answer:

RETENTION OF MEDICAL RECORDS (Adult & Pediatric):-

Medical Records shall be retained for following given minimum period.

Medical Recordsss	Storage area	Retention Time
IPD Record	MRD	10 Years
OPD case record	MRD	10 years

		(*OPD Case paper shall be retained for 10 years in case of hospitalization.)
MLC case file	MRD	Life Time
Death Records	MRD	10 Years
Departmental Registers	Hospital wide	1 year
Legal Documents	Director Office	Life Time

(* Registers, Forms & Formats of Inpatients shall be kept for 10 years
*** Registers, Forms & Formats of Outpatients shall be kept for 3 years)**

Q.192 Mention approved list of abbreviations?

Answer:

Approved List Of abbreviations:-

SR NO	ABBREVIATION
1	**ACS-** Acute Coronary Syndrome
2	**AKI-** Acute Kidney Injury
3	**ABG –** Arterial Blood Gas
4	**ACLS –** Advanced Cardiac Life Support
5	**AF –** Atrial Fibrillation
6	**AFB –** Acid-Fast Bacilli
7	**ARF –** Acute Renal Failure
8	**ASCVD –** Atherosclerotic Cardiovascular Disease
9	**ASD –** Atrial Septal Defect
10	**AV –** Atrio Ventricular
11	**AICD-** Automated Implantable Cardioverter Defibrillator
12	**AR-** Aortic Regurgitation
13	**AS -** Aortic Stenosis
14	**AVR -** Aortic Valve Replacement
15	**AWMI-** Anterior Wall Myocardial Infarction
16	**AP WINDOW -** Aorto Pulmonary Window
17	**BBB –** Bundle Branch Block
18	**BMR –** Basal Metabolic Rate
19	**BLS-** Basic Life Support
20	**BP –** Blood Pressure
21	**BX –** Biopsy
22	**BMV-** Balloon Mitral Valvuloplasty

SR NO	ABBREVIATION
23	**BPV-** Balloon Pulmonary Valvuloplasty
24	**BDC-** Balloon Dilatation Coarctation
25	**BAV-** Balloon Aortic Valvotomy
26	**BDG-** Bidirectional Glenn
27	**BT SHUNT-**Blalock-Taussing
28	**C&S –** Culture And Sensitivity
29	**CAG-** Coronary Angiography
30	**CHB-** Complete Heart Block
31	**CKD-** Chronic Kidney Disease
32	**COA-** Coarctation Of Aorta
33	**CABG –** Coronary Artery Bypass Grafting
34	**CAD –** Coronary Artery Disease
35	**CBC –** Complete Blood Count
36	**CHF –** Congestive Heart Failure
37	**CO –** Cardiac Output
38	**CVA-** Cerebro Vascular Accident
39	**COD-** Cause Of Death
40	**C/O –** Complaining Of
41	**COPD –** Chronic Obstructive Pulmonary Disease
42	**CPAP –** Continuous Positive Airway Pressure
43	**CPK-MB–** Creatinine Phosphokinase Muscle Band
44	**CPR –** Cardiopulmonary Resuscitation
45	**CSF –** Cerebrospinal Fluid
46	**CT –** Computerized Tomography
47	**CVP –** Central Venous Pressure
48	**CXR –** Chest X-Ray
49	**CFA-** Common Femoral Artery
50	**CHD-** Congenital Heart Disease
51	**CRT-** Cardiac Resynchronization Therapy
52	**DM –** Diabetes Mellitus
53	**DOE –** Dyspnoea On Exertion
54	**DVT –** Deep Venous Thrombosis
55	**DKA-** Diabetic Ketoacidosis
56	**DCMP-** Dilated Cardiomyopathy
57	**DORV-** Double Outlet Right Ventricle

SR NO	ABBREVIATION
58	**DSE-** Dobutamine Stress Echo
59	**DVR-** Double Valve Replacement
60	**DOE-**Dyspnoea On Exertion
61	**DTGA-** Dextro-Transposition of the Great Arteries
62	**EP STUDY-** Electro Physiology Study
63	**EA-** Effort Angina
64	**IE-** Infective Endocarditis
65	**ECG –** Electrocardiogram
66	**ESR –** Erythrocyte Sedimentation Rate
67	**ET –** Endotracheal
68	**ECMO-** Extracorporeal Membrane Oxygenation
69	**FBS –** Fasting Blood Sugar
70	**FFP –** Fresh Frozen Plasma
71	**GI –** Gastrointestinal
72	**HUTT-** Head Up Till Table Test
73	**HIV –** Human Immunodeficiency Virus
74	**HR-** Heart Rate
75	**Hb-** Haemoglobin
76	**Ht-** Height
77	**HTN –** Hypertension
78	**IVUS-** Intra Vascular Ultrasound
79	**I&D –** Incision And Drainage
80	**INR-** International Normalized Ratio
81	**I&O –** Intake And Output
82	**ID –** Infectious Disease
83	**IVC-** Inferior Vena Cava
84	**IRBBB –** Incomplete Right Bundle Branch Block
85	**K+ -** Potassium
86	**KUB –** Kidneys, Ureters, Bladder
87	**LVD-** Left Ventricular Dysfunction
88	**LRTI-** Lower Respiratory Tract Infection
89	**LIMA & RIMA-**Left And Right Internal Mammary Arteries
90	**LBBB –** Left Bundle Branch Block
91	**LFT-** Liver Function Test
92	**LV –** Left Ventricle

SR NO	ABBREVIATION
93	**LVH –** Left Ventricular Hypertrophy
94	**LV ANGIO-** Left Venricular Angiography
95	**MI –** Myocardial Infarction
96	**MR-** Mitral Regurgitation
97	**MRI-** Magnetic Resonance Imaging
98	**MODs-** Multiple Organ Dysfunction
99	**NA^+ -** Sodium
100	**NAD-** Nothing Abnormal Discovered
101	**NSTEMI-**Non-ST-Elevation Myocardial Infarction
102	**NYHA-** New York Heart Association
103	**NSVT-** Non Sustain Ventricular Tachycardia
104	**MVR-** Mitral Valve Replacement
105	**PA BAND-** Pulmonary Artery Banding
106	**PAH-** Pulmonary Arterial Hypertension
107	**PAMI-** Primary Angioplasty In Myocardial Infarction
108	**PAP –** Pulmonary Artery Pressure
109	**PDA –** Patent Ductus Arteriosus
110	**PE –** Pulmonary Embolism
111	**PFT –** Pulmonary Function Tests
112	**POD –** Post-Op Day
113	**PS –** Pulmonic Stenosis
114	**PT –** Prothrombin Time
115	**Pt –** Patient
116	**PAOD -**Peripheral Artery -Obstructive Disease
117	**PTCA –** Percutaneous Transluminal Coronary Angioplasty
118	**PLHA-**People Living With HIV AIDS
119	**PVD –** Peripheral Vascular Disease
120	**PAG-** Peripheral Angiography
121	**PPI-** Permanent Pacemaker Implantation
122	**PWMI-** Posterior Wall Myocardial Infarction
123	**PCI-** Percutaneous Coronary Intervention
124	**RT-**Ryles Tube
125	**RBBB –** Right Bundle Branch Block
126	**RS-** Respiratory System
127	**RHD-** Rheumatic Heart Disease

SR NO	ABBREVIATION
128	**Rx –** Treatment
129	**RV-** Right Ventricle
130	**RA/LA MYXOMA-** Right Atrium/Left Atrium Myxoma
131	**RSOV-** Rupture Sinus Of Valsalva
132	**SVT-** Supraventricular Tachycardia
133	**SMA-** Superior Mesenteric Artery
134	**SAM RESECTION-**Systolic Anterior Motion
135	**SFA-** Superficial Femoral Artery
136	**RVOT-** Right Ventricular Outflow Tract Repair
137	**SA –** Sinoatrial
138	**Stat-** Immediately
139	**SVC-** Superior Vena Cava
140	**SVD-** Single Vessel Disease
141	**TVD-** Triple Vessels Disease
142	**TAPVC-** Total Anomalous Pulmonary Venous Connection
143	**TPI-** Temporary Pacemaker Implantation
144	**TOF-** Tetralogy Of Fallot
145	**TB –** Tuberculosis
146	**TEE-** Trans Oesophageal Echocardiography
147	**TMT-** Tread Mill Test
148	**TR-** Tricuspid Regurgitation
149	**TVR-** Tricuspid Valve Replacement
150	**VT-** Ventricular Tachycardia
151	**VF-** Ventricular Fibrillation
152	**VSD-** Ventricular Septal Defect
153	**VSR-** Ventricular Septal Rupture
154	**UA-**Unstable Angina
155	**UTI-** Urinary Tract Infection