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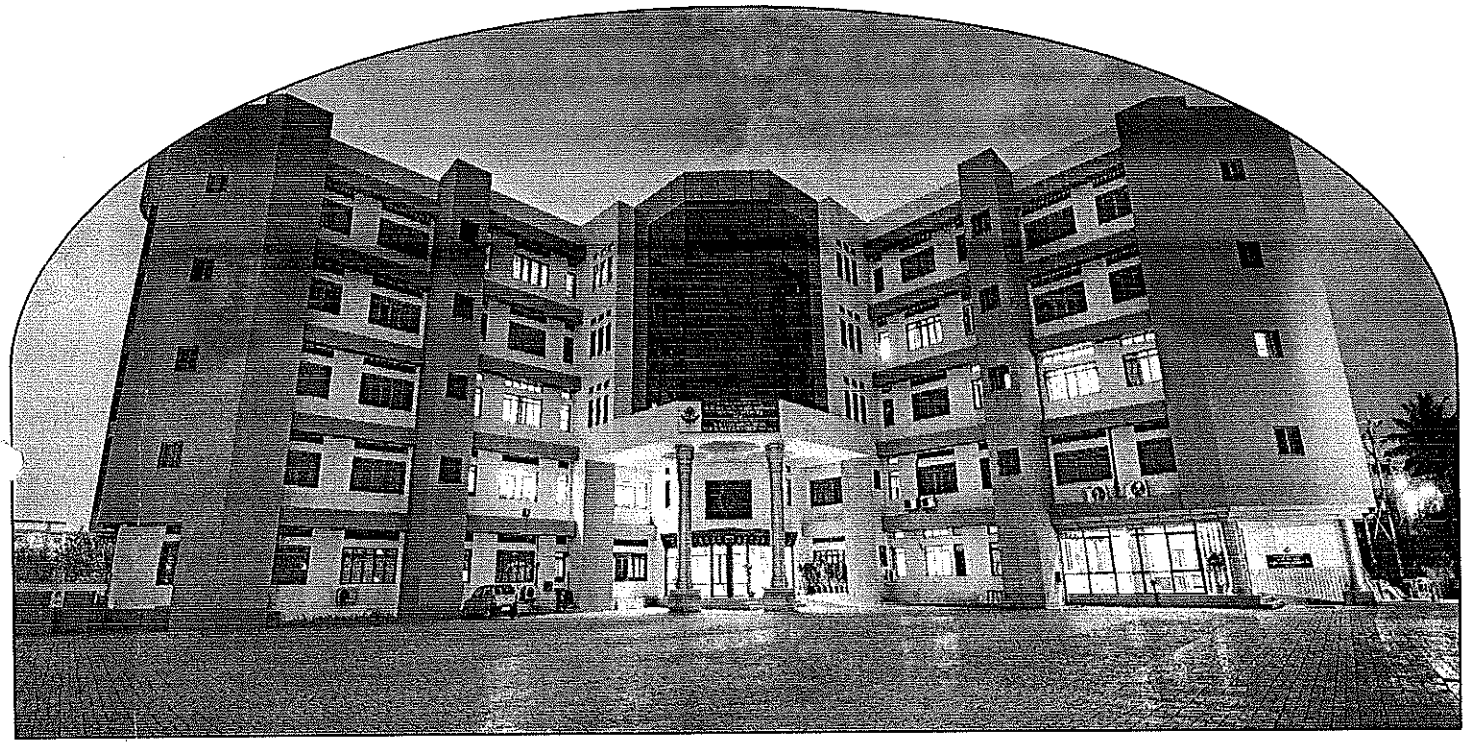
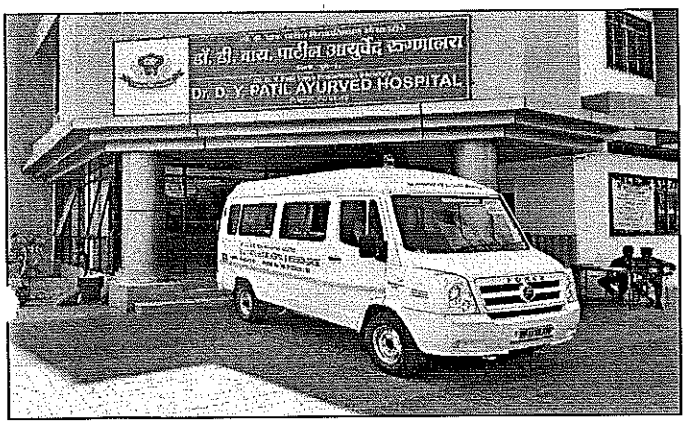
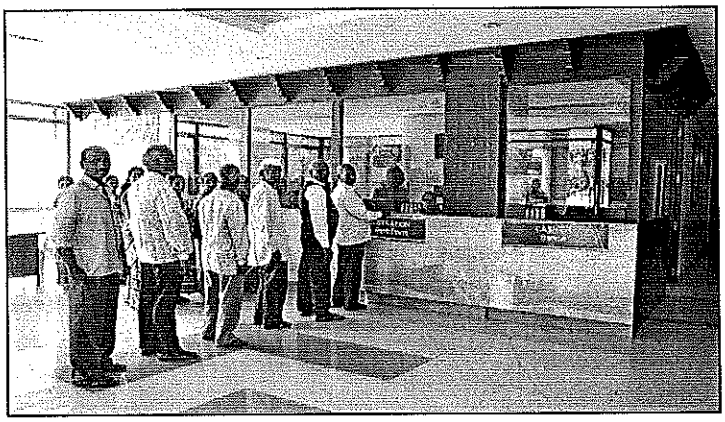
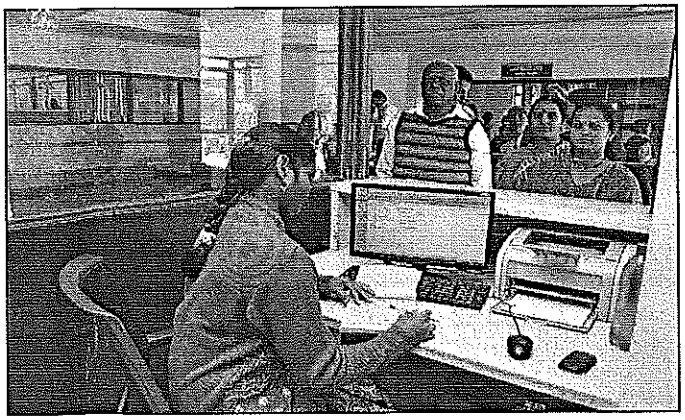
Dr. D. Y. Patil Vidya Pratishthan Society's
DR. D. Y. PATIL COLLEGE OF AYURVED, HOSPITAL & RESEARCH CENTRE, PIMPRI, PUNE

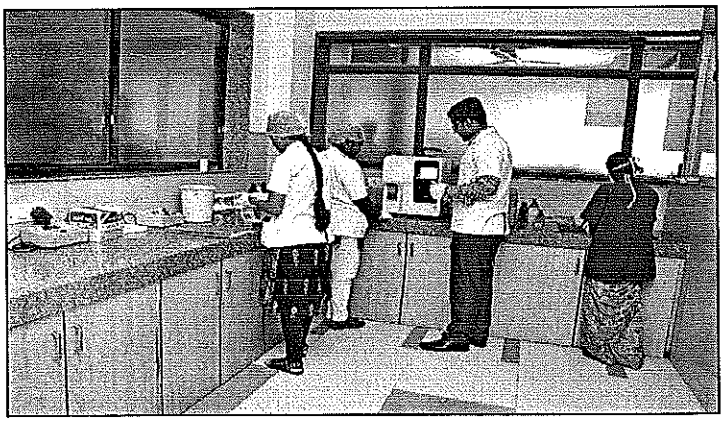
ACCESS ASSESSMENT AND CONTINUITY OF CARE (AAC)











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PRINCIPAL
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AMENDMENT SHEET

Sr. No.	Section no & page no	Details of the amendment	Reasons	Signature of the preparatory authority	Signature of the approval authority

CONTROL OF THE MANUAL

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

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

Management Representative is responsible for issuing the amended copies to the copyholders, the copyholder should acknowledge the same and he /she should return the obsolete copies to the Management Representative.

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

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

The authority over control of this manual is as follows:

Preparation	Approval	Issue
Incharge of AAC Committee	Principal, Dr. D.Y. Patil College of Ayurved, Hospital & Research Centre, Pimpri, Pune	Accreditation coordinator

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

Distribution List of the Manual:

Sr. No.	Designation
1	Principal / MS
2	Incharge of AAC Committee
3	Accreditation Coordinator

CONTENTS

AAC 01 - POLICY AND PROCEDURE ON SCOPE OF SERVICES

1.0 PURPOSE

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

2.0 SCOPE

The needs of the community are considered while providing services.

3.0 RESPONSIBILITIES

Managing representative is responsible to implement this policy and procedure.

4.0 POLICY

The following are the services provided at Dr. D. Y. Patil College of Ayurved, Hospital & Research Centre

1. Front office Registration, Enquiry, Billing and Accounts
2. Pharmacy and Dispending Unit
3. Laboratory Department
4. Radiology
5. Human resource
6. Quality Department
7. Information Technology
8. Maintenance
9. House Keeping
10. Medical Record Department(MRD)
11. Nursing
12. Hospital Infection Control
13. Operation Theatre
14. Outpatient Department (OPD)
    a) Kayachikitsa
    b) Shalya Tantra
    c) Shalakya Tantra
    d) Streerog Prasuti
    e) Balrog
    f) Panchkarma
    g) Physiotherapy
    h) Swasthavritta
15. Wards :-In Patient Departments (IPD)

DISPLAY OF SERVICES

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

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

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

6.0 STAFF ORIENTATION

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

6.2 If identified, any lack of awareness of staff through observation / complaints.

6.3 The relevant staff is oriented on the services provided by the hospital either by in training program or by reading this document, as appropriate, the same to be recorded in training record form.

REFERENCE

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

AAC 02 - POLICY AND PROCEDURE ON REGISTRATION, ADMISSION

1.0 PURPOSE

To define Policy & Procedure for Registration, Admission in Dr. D. Y. Patil College Ayurved Hospital And Research Centre.

2.0 SCOPE

This Policy & procedure is applicable to patient who undergoes Registration & Admission

3.1 RESPONSIBLITIES

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

4.0 POLICY

4.1 Patients are admitted at Dr D. Y. Patil College of Ayurved, Hospital & Research Centre only if the Hospital can provide the required services to the patient.

4.2 All patients, out-patients, in-patients and emergency who are willing to avail services at Dr D. Y. Patil College of Ayurved, Hospital & research centre should undergo Registration / Admission process. In case of Emergency, the same to be carried out in parallel to treatment.

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

5.1 **Patients can be admitted from the following areas:**

- Admission from Outpatient Clinics: Patients may be directly admitted from one of the Outpatient Clinics.
- Admissions from the Casualty : Emergency Room patients requiring inpatient admission must have the Admission recommendation by treating consultant.
- Admission of Outpatient Observation Patients: When an under observation patient is determined to require inpatient care, based on recommendation by treating consultant the patient can be admitted.

6.0 PROCEDURE

6.1 REGISTRATION PROCESS

6.1.1.1 Patient approaches Reception to avail consultation.

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

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

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

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

Old and new registrations have separate counters

6.2 ADMISSION PROCESS

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

6.2.1.2 Admissions are referred from OPD department and Causality.

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

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

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

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

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

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

6.3 POLICY ON NON –AVAILABILITY OF BEDS

1.0 PURPOSE

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

2.0 PROCEDURE

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

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

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

6.4 MLC CASES:

6.5 In case of patients involved in medico legal cases the patient is referred to Dr. D. Y. Patil M.B.B.S. college in the campus

6.6 A list of MLC cases is shown below:

6.6.1 Poisoning.

6.6.2 Injury with sharp object / fire arms.

6.6.3 Burns especially in women.

6.6.4 Drowning.

6.6.5 Death / Injury in a woman.

6.6.6 Road accidents / Industrial accidents.

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

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

6.6.9 Where the cause of death is not certain.

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

1.0 PURPOSE

To define Policy & Procedure for transfer of the patient of Dr. D. Y. Patil College of Ayurved, Hospital And Research Centre.

2.0 SCOPE

This Policy & procedure is applicable to patient who undergoes Transfer or referral where the required services are not available.

3.0 DEFINATIONS

Medically unstable condition- The term **"Medically Unstable Condition"** means -

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in -

Placing the health of the individual (or, with respect to a pregnant women, the health of the woman or her unborn child) in serious jeopardy, Serious impairment of bodily functions Serious dysfunction of any bodily organ or part.

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

4.0 RESPONSIBLITIES

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

5.0 POLICY

5.1 REFERRAL OF UNSTABLE PATIENT TO OTHER CENTRE

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

5.2 TRANSFER OF STABLE PATIENTS

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

6.0 PROCEDURE

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

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

6.3 The Dr. D.Y. Patil College of Ayurved, Hospital & Research Centre staff member shall obtain the details of the patients' emergency medical condition and contact Admitting Desk. Admitting Desk shall verify that beds are available.

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

6.5 Similarly, when resources matching the patient needs are not available at Dr. D. Y. Patil College of Ayurved, Hospital & Research Centre l patients shall be transferred Dr. D. Y. Patil Medical College (MBBS) in the Campus that can meet the patient's needs. The Consultant / Residential Medical Officer shall contact the faculty of the receiving hospital to ensure that eligibility guidelines are met.

7.0 RECORDS

6.1 OPD Case paper.
6.2 Referal Note

8.0 REFERENCE

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

AAC 04 - POLICY AND PROCEDURE ON PATIENT INITIAL ASSESSMENT

1.0 PURPOSE

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

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

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

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

2.0 SCOPE

This procedure applies to all Patients treated at Dr. D. Y. Patil College of Ayurved, Hospital & Research Centre

3.0 DEFINITION

ASSESSMENT

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

4.0 RESPONSIBILITY

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

4.2 Patient assessment at Dr. D. Y. Patil College of Ayurved, Hospital & Research Centre is an ongoing process that begins before the Patient is admitted and continues throughout treatment.

5.0 POLICY

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

6.0 PROCEDURES

6.1 INITIAL ASSESSMENT

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

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

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

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

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

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

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

6.1.8 Analysis of information from initial assessment drives the following

6.1.8.1 Initial treatment and upashay.

6.1.8.2 Other specialized treatment needs like panchkarma.

6.1.8.3 Pathyahar

6.2 CONTENT OF THE INITIAL ASSESSMENT

6.2.1 IN PATIENT

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

6.2.2 OUT PATIENT

Outpatient case paper is predefined.

OPD case paper has the following parameters

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

Outpatient Follow-up visit form has the following parameters

a) Provisional diagnosis / diagnosis
b) Medicines
c) Vitals
d) Investigations
e) Treatment and follow-up

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

a) Patient name
b) Personal data (like Sex, Age, Height, Weight),
c) Clinical history,
d) Quick examination (as appropriate)
e) Present illness
f) Investigation (if any) and
g) Medications.

6.4 DOCUMENTATION

Assessment and Reassessment are to be documented by

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

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

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

1.0 PURPOSE

1.1 To provide continuous care to the patients admitted in Dr.D.Y.Patil Hospital.

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

2.0 SCOPE

This procedure applies to all Patients treated at Dr. D. Y. Patil College of Ayurved, Hospital & Research Centre

3.0 RESPONSIBILITY

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

3.2 Patient reassessment at Dr. D. Y. Patil College of Ayurved, Hospital & Research Centre is an ongoing process that begins before the Patient is admitted and continues throughout treatment.

4.0 POLICY

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

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

5.0 PROCEDURES

5.1 REASSESSMENT

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

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

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

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

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

ii. When a Patient is transferred from one setting to another setting. Example: OT to ward.

iii. At the time of discharge.

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

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

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

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

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

5. 1. 10 The patient and Patient family is involved in discharge planning process, as appropriate by Treating Doctor or his / her Team Member.

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

6.5 DOCUMENTATION

Reassessment are to be documented by

- Consultants, Medical Officer, Registrar, Houseman
- Nurse

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

AAC 06- POLICY AND PROCEDURE ON LABORATORY SERVICES

1.0 PURPOSE

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

2.0 SCOPE

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

3.0 RESPONSIBILITY

3.1 Head of the department,
3.2 Consultant
3.3 Laboratory technicians,

4.0 ABBREVIATION

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

5.0.REFERENCE

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

6.0 POLICY

6.1 8 hours laboratory services are provided at Dr. D. Y. Patil College of Ayurved, Hospital & Research Centre, Pimpri, Pune
6.2 Laboratory services are in consonance with the hospital scope of the services:
6.2.1 Hematology
6.2.2 Serology

2.0 Dr. D. Y. Patil College of Ayurved, Hospital & Research Centre clinical laboratory will engage competent personnel for technical work which includes technicians and Professionals. Dr. D. Y. Patil College of Ayurved, Hospital & Research Centre ensures that all staff of Laboratory Services is appropriately trained.

2.1 Without written request from the treating doctor, sample shall not be drawn from the patient and Criteria for written request are as follows: Name of the patient; Age/Sex; IPD or OPD. No; Test examinations clearly indicated; Doctor's Name, Signature, date and time.

2.2 Criteria for labeling the samples.

All samples must be labeled with Name of the patient, sex, age, IPD or OPD.No, date and time of sample taken.

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

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

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

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

2.6.1 Lab. No.,

2.6.2 Age & Sex,

2.6.3 OPD No. /IPD No.,

2.6.4 Name of the patient & Consultant,

2.6.5 Signature of the person sending the sample and receiving the test report.

2.6.6 ID. No. & Name of the external Lab,

2.6.7 Test results.

2.6.8 The above record is maintained in a separate register, named outsource Register

AAC 07 - POLICY AND PROCEDURE ON LABORATORY QUALITY ASSURANCE

1.1 PURPOSE

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

2.1 SCOPE

The patients referred to the Laboratory by Consultants will have quality service of investigations

3.1 RESPONSIBILITY

3.1 Head of the department,

3.2 Laboratory technicians,

4.0 ABBREVIATION

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

5.0 DEFINITION

6.0 REFERENCE

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

7.0 POLICY

7.1 The laboratory quality assurance programme is documented. Internal quality control is taken care of . External quality assurance is done with the Vellore Clinical Laboratory & is documented
7.2 The laboratory is capable of the performing the analysis and verification.
7.3 Maintenance of equipment is done periodically.

8.0 PROCEDURES

AAC 08 - POLICY AND PROCEDURE ON LABORATORY SAFETY PROGRAMME

1.2 PURPOSE

To provide safety for the staff in the laboratory.

2.2 SCOPE

The Staff working in the laboratory should be free from risk & hazards.

3.2 RESPONSIBILITY

3.1 Head of the department,

3.2 Laboratory technicians,

4.0 ABBREVIATION

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

5.0 DEFINITION

6.1 REFERENCE

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

7.1 POLICY

7.2.1 The organization takes care of safety of work force and equipment
7.2.2 The Safety programme is aligned with the safety programme as whole organization.
7.2.3 Handling & disposal of infectious & Hazardous material is done with standard precautions. It is documented.
7.2.4 Staff undergoes training regarding safe practices.
7.2.5 Adequate safety devices are available in the lab.

8.0 PROCEDURES

AAC 09 - POLICY AND PROCEDURE ON IMAGING SERVICES

1.0 PURPOSE

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

2.0 SCOPE

All patients who receive services from imaging department.

3.0 RESPONSIBILITY

3.1 Radiologist,

3.2 Radiography Technician

4.0 ABBREVIATIONS

4.1 NABH : National Accreditation Board For Hospitals And Healthcare Providers

4.2 AAC : Access, Assessment and Continuity of Care

5.0 DEFINITION

6.0 REFERENCE

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

7.0 POLICY

7.1 Compliance with legal requirement:

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

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

7.1.3 Training of department staff.

7.2 Diagnostic Imaging includes the following:

7.2.1 X-ray

7.2.2 Ultrasound and Colour Doppler.

7.2.3 The Radiology Department is working 2 days / week on Wednesday & Thursday

7.3 Identification of patient:

7.3.1 Dr. D. Y. Patil College of Ayurved, Hospital & Research Centre, Pimpri, Pune. is ensured that all the patients are identified prior to carrying out their investigations.

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

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

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

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

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

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

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

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

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

7.9 Qualified staff for department:

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

7.9.2 Only qualified, credentialed and authorized clinician Dr. Vishal Patil , MD Radiology is responsible for conducting or supervising all radiology procedures and reporting. He visits the organization 2 days/ week i.e. on Wednesday & Thursday.

8.0 PROCEDURE

8.1 Radiology equipment:

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

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

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

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

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

8.2 Qualified personnel:

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

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

8.3 Waiting time for procedures and results:

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

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

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

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

8.4 Reporting

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

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

8.4.3 If there is emergency need patient is sent to Dr. D. Y. Patil Medical College (MBBS) in the campus.

ANNEXURE A

TURN AROUND TIME FOR USG SCANNING RESULTS (ULTRASOUND SCAN)

SL. NO.	PROCEDURE	TAT
01	USG ABDOMEN AND PELIVS	10 MINS.
02	OBSTETRICS	15 – 20 MINS.
03	TRANS VAGINAL SCAN	10 MINS.
04	KNEE JOINT	20 , MINS.
05	SCROTUM	10 – 15 MINS.
06	THYROID	10 – 15 MINS.
07	BREAST	10 – 15 MINS.

08	COLOUR DOPPLER STUDY	ARTERIAL DOPPLER	15 – 20 MINS.
		PERIPHERAL VASCULAR ARTERIES	15 – 20 MINS.
		VENOUS DOPPLER	15 – 20 MINS.
09	SMALL PARTS eg. shoulder, elbow, wris		10 MINS.

X-RAYS:

All types of plain X-ray

Timeframe to dispatch the report - 30 Minutes

TURN AROUND TIME FOR X-RAY RESULTS

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

06	HAND / AP / LATERAL / OBLIQUE	03	20 MIN
07	PELVIS / AP / LATERAL	02	15 MIN
08	BOTH HIP / AP / LATERAL	04	25 MIN
09	SACRUM / COCCYX / AP / LATERAL	02	20 MIN
10	WHOLE SPINE / AP / LATERAL	02	15 MIN
11	KUB PLAIN	01	10 MIN
12	ABDOMEN ERRECT	01	10 MIN
13	FUMER / AP / LATERAL	02	15 MIN
14	KNEE / AP / LATERAL / AXIAL	03	20 MIN
15	LEG / AP / LATERAL	02	15 MIN
16	ANKLE / AP / LATERAL	02	15 MIN
17	FOOT / AP / LATERAL / OBLIQUE	03	20 MIN
18	CALCANEUS / LATERAL / AXIAL	02	15 MIN

9.0 REFERENCE

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

AAC 10 - POLICY AND PROCEDURE OF IMAGING QUALITY ASSURANCE

1.1 PURPOSE

There is established quality assurance programme.

2.1 SCOPE

All patients who receive services from imaging department.

3.1 RESPONSIBILITY

3.1 Radiologist,

3.2 Radiography Technician

4.0 ABBREVIATIONS

4.1 NABH : National Accreditation Board For Hospitals And Healthcare Providers

4.2 AAC : Access, Assessment and Continuity of Care

5.0 DEFINITION

6.1 REFERENCE

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

7.1 POLICY & PROCEDURE

7.1 The quality assurance programme includes maintenance of the equipments.
7.2 The institute is also planning to replace the conventional machinery into digital.

AAC 11 - POLICY AND PROCEDURE OF IMAGING SAFETY PROGRAMME

1.2 PURPOSE

There is established radiation safety programme.

2.2 SCOPE

All staff working in a imaging Department

3.2 RESPONSIBILITY

3.1 Radiologist,

3.2 Radiography Technician

4.0 ABBREVIATIONS

4.1 NABH : National Accreditation Board For Hospitals And Healthcare Providers

4.2 AAC : Access, Assessment and Continuity of Care

5.0 DEFINITION

6.2 REFERENCE

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

7.2 POLICY AND PROCEDURE

7.1 The safety programme is aligned with the safety programme of the organization.

7.2 Handling, usage & disposal of radio active & hazardous materials are as per statutory requirements. The material is disposed as per guidelines.

7.3 The staff has radiation safety devices like lead aprons , Shields & dosimeters

7.4 All the workers of the imaging services have been provided with TLD badges for monitoring of their individual exposures to radiation as part of radiation safety program. Regular monitoring of these badges has been out sourced and a record for the same is maintained in the radiology department, of Dr. D. Y. Patil College of Ayurved, Hospital & Research Centre, Pimpri, Pune.

7.4 Imaging technician is trained in safety measures.

7.5 Imaging signage are prominently displayed.

AAC 12 - POLICY AND PROCEDURE ON PATIENT CARE

1.3 PURPOSE

To provide Patient care in continuous & multidisciplinary nature

2.3 SCOPE

All patients who receive services from Dr. D.Y. Patil College of Ayurved, Hospital & Research Centre, Pimpri, Pune

3.3 RESPONSIBILITY

3.1 MS
3.2 DMS
3.3 RMO
3.4 Consultants
3.5 Paramedical Staff
3.6 Technical Staff
3.7 House Keeping Staff

4.0 ABBREVIATIONS

4.1 NABH : National Accreditation Board For Hospitals And Healthcare Providers

4.2 AAC : Access, Assessment and Continuity of Care

5.0 DEFINITION

6.3 REFERENCE

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

7.3 POLICY & PROCEDURE

7.1 During all phases of care there are qualified resident Doctor (Dy. Registrar / Houseman), Consultant, Nurse. These people work as team & the record on OPD/ IPD case paper sheet shows that.
7.2 There is effective communication in all care providing departments.
7.3 Information about the patients care & response to treatment is shared among medical, nursing & other care provider
7.4 Information is exchanged & documented by nurses in their overbook & Doctors take regular rounds, Communicate & give overs verbally.
7.5 The IPD Case Papers files are the total record & they are kept in the nursing station.
7.6 Referral to other department done for opinion with proper referral notes.

AAC 13 - POLICY AND PROCEDURE ON DISCHARGE PROCESS

1.0 PURPOSE

To provide guidelines for the discharge of in-patients from Dr. D. Y. Patil College of Ayurved, Hospital & Research Centre

2.0 Scope

All the patient admitted in Dr.D.Y. Patil College of Ayurved, Hospital & Research Centre, Pimpri, Pune

3.0 RESPONSIBILITY

3.1 Consultant
3.2 RMO
3.3 Medical Officer
3.4 Registrar
3.5 Houseman
3.3 Nurse on Duty

4.0 ABBREVIATIONS

4.1 NABH : National Accreditation Board For Hospitals And Healthcare Providers

4.2 AAC : Access, Assessment and Continuity of Care

4.0 DEFINITION

6.0 REFERENCE

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

5.0 POLICY

5.1 Discharge procedures is followed to ensure patients are discharged effectively and efficiently, allowing for optimal utilization of available resources.

5.2 An authorized hospital discharge shall only be made by an order from the primary consultant. However, a patient may discharge himself/herself against medical advice.

5.3 The Consultant or his designee shall document discharge instructions in the patient's medical record at the time of anticipated discharge.

5.4 A Discharge Summary is prepared.

5.5 The Ward Sister shall be the responsible person to ensure compliance with this policy.

6.0 PROCEDURE

6.1 The discharge process is discussed with patient & Family by on duty Doctor & Paramedical staff.

6.2 Discharge card summary is given to the patient.

6.3 Documentation at Registration Counter is done .

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

AAC 14 - POLICY AND PROCEDURE ON DISCHARGE SUMMARY

1.0 PURPOSE

To provide guidelines for the discharge summary of in-patients from Dr. D. Y. Patil College of Ayurved, Hospital & Research Centre

2.0 Scope

All the patient admitted in Dr.D.Y. Patil College of Ayurved, Hospital & Research Centre, Pimpri, Pune

3.0RESPONSIBILITY

6.5 Consultant
6.6 Registrar
6.7 Houseman
3.4 Nurse on Duty

4.0 ABBREVIATIONS

4.1 NABH : National Accreditation Board For Hospitals And Healthcare Providers
4.2 AAC : Access, Assessment and Continuity of Care
4.3 DAMA : Discharge Against Medical Advise

7.0 DEFINITION

6.0 REFERENCE

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

2.0 POLICY

2.1.1 DISCHARGE SUMMARY

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

2.1.2 The discharge summary shall contain:

The reason for admission

1. Name of the Patient
2. Unique ID No.
3. Date of Admission & Discharge
4. Significant findings
5. Any diagnosis
6. Procedures performed
7. Significant medications administered
8. Condition at discharge
9. Discharge medications and follow-up instructions

2.1.3 In case of death, the discharge summary includes the cause of death

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

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

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

3.0 RECORDS

In patient Record

4.0 REFRENCE

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

Annexure

a) OPD card with UID

b) OPD Case paper

c) IPD Case Paper

d) Laboratory Documents

e) External Quality Assurance – Vellore

f) Imaging Services- Legal Documents

g) Discharge Card

h) Discharge Summary