NURSING SERVICE POLICY MANUAL

OFFICE OF THE NURSING SUPERINTENDENT

NURSING SUPERINTENDENT'S OFFICE - POLICY MANUAL

REVISION HISTORY

Issue No	Revision Date	Revision Description	Initiated by	Approved by
	23/05/2011	Version 1	Dr. Jayarani Premkumar	Dr. Jayarani Premkumar
	10/10/2011	Version 2	Dr. Jayarani Premkumar	Dr. Jayarani Premkumar
	13/05/2015	Version 3	Dr. Premila Lee	Dr. Premila Lee
	11/01/2017	Nurses Station Management	Dr. Premila Lee	Dr. Premila Lee
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	22/05/2017	Vulnerable patient Care- critically ill	Dr. Premila Lee	Dr. Premila Lee
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	24/10/2021	Risk Assessment & Management	Dr. Premila Lee	Dr. Premila Lee
	30/05/2021	Admission of MLC patient	Dr. Bala Seetharaman	Dr. Bala Seetharaman

	30/05/2021	Online prescription & indent by nurses in certain areas	Dr. Bala Seetharaman	Dr. Bala Seetharaman
	30/05/2021	Internal & external Medications (ward drug supplies)	Dr. Bala Seetharaman	Dr. Bala Seetharaman
	30/05/2021	Dispensing error	Dr. Bala Seetharaman	Dr. Bala Seetharaman
	30/05/2021	Medication spillages	Dr. Bala Seetharaman	Dr. Bala Seetharaman
	30/05/2021	Other spillages	Dr. Bala Seetharaman	Dr. Bala Seetharaman
	30/05/2021	Patient health information-Immunization	Dr. Bala Seetharaman	Dr. Bala Seetharaman
	30/05/2021	Patient health information-Health care associated infections	Dr. Bala Seetharaman	Dr. Bala Seetharaman
	30/05/2021	Patient health information-Disease process	Dr. Bala Seetharaman	Dr. Bala Seetharaman
	30/05/2021	Patient health information-Pain management	Dr. Bala Seetharaman	Dr. Bala Seetharaman
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	21/03/2022	Core values/ Service standards	Dr. Bala Seetharaman	Dr. Bala Seetharaman
	05/12/2022	Inter hospital transfer- Main campus to Ranipet campus	Dr. Bala Seetharaman	Dr. Bala Seetharaman
	05/12/2022	Interhospital transfer – Ranipet campus to Main campus	Dr. Bala Seetharaman	Dr. Bala Seetharaman
	22/02/2023	High risk medication list revision	Dr. Bala Seetharaman	Dr. Bala Seetharaman

	22/02/2023	Policy on medications left by patients	Dr. Bala Seetharaman	Dr. Bala Seetharaman
	28/02/2023	Medication cut strip policy	Dr. Bala Seetharaman	Dr. Bala Seetharaman
	31/05/2023	Version 7	Mrs. Alice Sony	Mrs. Alice Sony
	27/10/2023	Policy on transfer from ward to procedure room/ investi-gation	Mrs. Alice Sony	Mrs. Alice Sony
	27/10/2023	Patient acuity based staff as-signment	Mrs. Alice Sony	Mrs. Alice Sony
	27/10/2023	Policy on DVT Management	Mrs. Alice Sony	Mrs. Alice Sony
	27/10/2023	Policy on care bundle man-agement (CLABSI, VAP,CAUTI)	Mrs. Alice Sony	Mrs. Alice Sony

I. INTRODUCTION

The Nursing Service at the Christian Medical College (CMC), Vellore is an integral part of the Institution and is considered the core of patient care activities. Nurses are an important part of this community and comprise of about 2700 staff. This manual describes all the policies that guide nurses in their dependent, interdependent and independent functioning in the institution.

II. HISTORY

The origin of CMC dates back to 1900 when Dr. Ida Sophia Scudder, the daughter of a medical missionary felt God's call. On one fateful night, three young men sought help from her for their wives who struggled in difficult childbirth. They refused to accept her father's help though he was a trained physician due to the Indian culture and tradition of that time.

Realizing the need for women doctors, she went to America, trained in medicine, specialized in obstetrics and gynaecology, returned to India and started a one bedded hospital. That small initiative has bloomed into the present multi-specialty hospital with medical college and college of Nursing.

III. VISION, OBJECTIVE, AND MISSION STATEMENTS

Vision Statement

Hospital - The Christian Medical College, Vellore seeks to be a witness to the healing ministry of Christ, through excellence in education, service and research.

Nursing Service - The Nursing Service of the Christian Medical College, Vellore seeks to provide Christ centred, compassionate, holistic state of the art quality patient care through nurses excelling professionally in practice, education, management and research.

The Objective / s:

Hospital - The objective of the Christian Medical College, Vellore is the establishment, maintenance and development of Christian Medical College and hospitals in India, where men and women shall receive an education of the highest grade in the art and science of medicine, nursing, or one or other of the related professions, to equip them in the spirit of Christ for service in the relief of suffering and in the promotion of health.

Nursing Service

- To practice the art and science of Nursing in the spirit of Christ
- To provide promotive, preventive and curative care to patients irrespective of their caste, creed and socioeconomic status with compassion
- To equip the practising Nurses with the knowledge, guidance and resources required to provide holistic, evidence based care

Mission Statement:

Hospital

The primary concern of the Christian Medical College, Vellore is to develop through education and training, compassionate, professionally excellent, ethically sound individuals who will go out as servant-leaders of health teams and healing communities. Their service may be in promotive, preventive, curative, rehabilitative or palliative aspects of health care, in education or in research.

In the delivery of health care, CMC provides a culture of caring while pursuing its commitment to professional excellence. CMC is committed to innovation and the adoption of new, appropriate, cost-effective, caring technology.

In the area of research, CMC strives to understand God's purposes and designs, fostering a spirit of enquiry, commitment to truth and high ethical standards. Research may be aimed at gaining knowledge of the fundamental basis of health and disease, at improving interventions or in optimizing the use of resources.

CMC reaffirms its commitment to the promotion of health and wholeness in individuals and communities and its special concern for the disabled, disadvantaged, marginalized and vulnerable.

CMC looks for support and participation in its programmes in education, service, outreach and research, from friends and like-minded agencies in India and abroad, in a true spirit of partnership.
In its role as a living witness in the healing ministry of Christ, CMC seeks to work in partnership both with the Church in India and the Universal Church, and their institutions.

Nursing Service

Committed to care for patients and their families in the physical, psychological, social and spiritual dimensions maximising the potential for health and productivity or maintaining the patient's comfort and dignity until death.

Strives to develop Nurses personally and professionally to be of sound faith, integrity, ethical conduct and responsible to our society

Advocates the mandate of Christ to excel by developing nurse leaders who will impact nursing practice through diligent management, education and research

Core Values / Service Standards:

- Integrity
- Tolerance
- Team work
- Excellence
- Holistic healing
- Professionalism
- Mutual respect
- Compassion
- Stewardship
- Concern for the marginalized

IV. Quality Policy

The Christian Medical College, Vellore is committed to the healing ministry of Christ by providing excellence in health education, healthcare, research and outreach by continuously improving on its services.

Towards this end, CMC Vellore shall endeavour to

- Treat all patients ethically, with empathy and dignity, within a culture of caring, in the "Spirit of Christ";
- Develop, promote and maintain professional competence and leadership in compassionate patient care through continuous training;
- Ensure safety of patients, students, staff and other stake holders;
- Promote, innovate and adopt new and appropriate, cost effective processes / technology;

- Provide appropriate, state-of-the-art diagnostic, therapeutic and infrastructural facilities;
- Support programmes of education, research, patient care and outreach activities;
- Comply with all relevant regulatory and statutory requirements;
- Meet all enquiries with courtesy;

Ensure that all staff are aware of the Vision, Mission and Quality Policy of the Institution; Ensure that all staff are familiar with the relevant accreditation standards and committed to implement them.

V. OFFICE OF THE NURSING SUPERINTENDENT

The Office of the Nursing Superintendent, known as Nursing Service Office (NSO) is the central hub for all nursing care activities. The Nursing Superintendent is the head of Nursing Service and is assisted by Heads of Department (HOD) / Heads of Unit (HOU) each responsible for one nursing department.

Each HOD is assisted by Nurse Managers (NM) who in turn are assisted by Charge Nurses (CN) who are immediate supervisors of Staff Nurses. Appropriate centralization and decentralization of managerial activities help in smooth functioning of the Department.

The Nursing Superintendent is also assisted by the following administrative members with specific responsibilities in the Office.

Associate Nursing Superintendent 1: Human Resource management and Ranipet campus management

Associate Nursing Superintendent 2: Human Resource Management, Main campus and Peripheral areas management

Associate Nursing Superintendent 3: Chittoor campus management

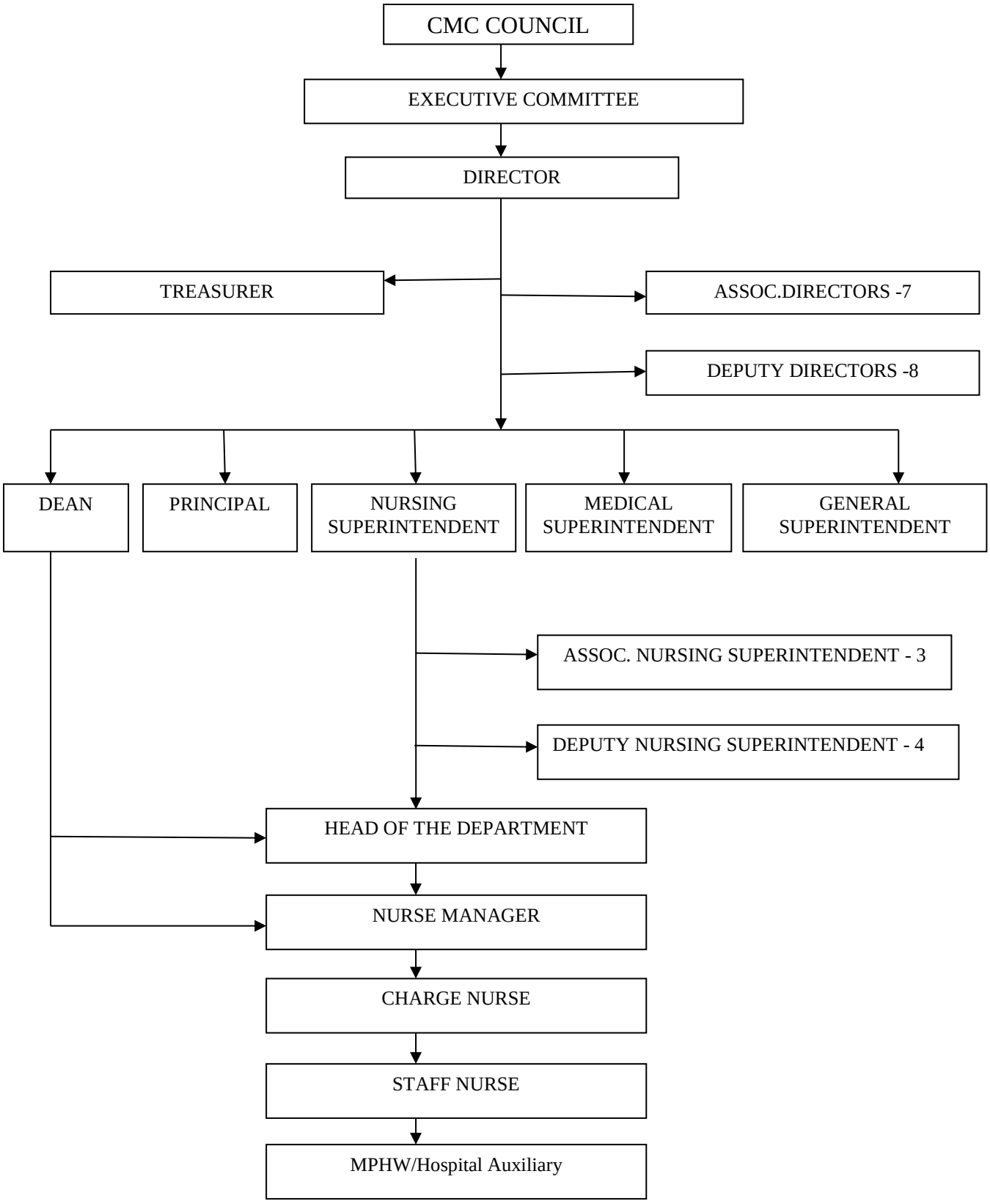
Deputy Nursing Superintendent 1: Quality management, Main campus

Deputy Nursing Superintendent 2: Material management, Main campus

Deputy Nursing Superintendent 3: In-service education, All campuses

Deputy Nursing Superintendent 4: Quality and Material management, Ranipet campus

VI. ORGANOGRAM



VII. ROLE OF THE NURSE

The role of a Registered Nurse (RN) is to provide health care to individuals, families, and communities. The service of Nurses is designed to promote health, prevent illness, and achieve optimal recovery from illness or optimal adaptation to health problems.

VIII. NURSES RIGHTS

- The right to be accorded dignity and honour as nurses.
- Right to practice in accordance with the nursing legislation of the country, the regulatory body and adopt the national ethical code of professional conduct.
- The right to undertake independent nursing practice within the framework of the professional conduct.
- A right to equal remuneration for equal qualification and equal professional expertise as their counterparts, within and outside the profession.
- The right to be included in planning and policy making at all levels of the Health Care system within and outside country.
- Right to access the resources and working conditions, necessary to provide quality care to the clients including in-service training, fair shift assignments, adequate staffing pattern, efficient and effective logistic support and appropriate infrastructure.

IX. NURSES RESPONSIBILITIES

- Accountable for patients assigned
- Responsible for own nursing actions and professional conduct
- Functions within own level of competence and legal scope of practice
- Assesses patients and families, formulates nursing diagnoses and plans for appropriate care
- Implements care based on priority needs and evaluates care
- Takes action to promote provision of safe, appropriate and ethical care.
- Advocates for patients and families

- Updates self in clinical knowledge and current practice.

X. PATIENTS AND THEIR RIGHTS

CMC is a patient centric institution which believes in interacting with the patients empathetically, and actively involving them in decisions regarding their care. We consider it a privilege to provide services that make a difference in peoples' lives. As staff of this Institution, it is important to be aware of the rights of the patient at Christian Medical College.

Patients have the right to:

- Be treated with dignity, respect, consideration of their individual values and belief and privacy during examination, procedures and treatment.
- Be protected from physical abuse or neglect.
- Refuse treatment.
- Confidentiality of all records and communications, to the extent provided by law.
- Participate in decisions about their care and provide informed consent.
- Be informed of the estimated costs of proposed treatment.
- Access information contained in the Medical Record in the form of a Medical Report / Discharge Summary.
- Voice their concerns and complaints with the Patient Advocacy Cell of the Medical Superintendents Office.
- Have the appropriate family member eligible to all the above rights, in case the patient is unable to meaningfully participate in his / her care.
- To seek an additional opinion regarding clinical care

XI. PATIENTS RESPONSIBILITIES

With rights come responsibilities. The Christian Medical College expects our patients to:

- Provide accurate and complete information about their health condition.
- Follow the treatment plan recommended by the treating Doctor.
- Accept responsibility for their actions if they refuse treatment.

- Preserve and produce all the records of their illness.
- Accept responsibility for the safekeeping of their valuables and possessions.
- Abide by the rules and regulations of the hospital including the "No-tobacco Campus Policy".
- Be considerate of the rights of other patients and CMC personnel by assisting with the control of noise, cleanliness and number of visitors.
- Respect the property of others and that of CMC.
- Provide honest information concerning their ability to pay for services and pay bills in time if they have agreed to do so.
- Provide useful feedback about services and policies.
- Treat all healthcare workers with respect.
- Abide by all applicable national, state and local laws.

XII. PATIENT SAFETY

The Nursing Service at CMC prioritizes patients' safety at the highest level. The International Patient Safety Goals help nurses in ensuring safe care

- Goal 1 - Identify Patients Correctly
- Goal 2 - Improve Effective Communication
- Goal 3 - Improve the safety of high-Alert Medications
- Goal 4 - Ensure correct Site, Correct Procedure, Correct Patient Surgery
- Goal 5 - Reduce Risk of Health Care-Associates Infections
- Goal 6 - Reduce the Risk of Patient Harm resulting from Fall

At CMC, measures are taken from admission to ensure safe patient care. Patients and families are instructed about infrastructure, use of side rails, safe use of wash rooms, presence of family member with patient etc.

Safe patient care is ensured by analysing quality indicators like falls, medication errors and pressure sores and taking appropriate measures to prevent the same through system changes or individual correction and appropriate training of Nurses

XIII. QUALITY

Quality of care at CMC is ensured through various mechanisms at various levels. The Office of the Nursing Superintendent ensures quality through a planned annual programme. The Department Quality Managers plan for the entire year and evaluate the implementation of the programme. Basic Nursing Care Audit is done every year and the results are shared on the intranet. Monthly quality audits are also carried on various aspects of quality patient care. Information about quality can be accessed from the intranet. One of the means to achieve uniform quality care is the formulation of policies for functioning which are revised periodically.

XIV. QUALITY IMPTROVEMENT

Quality improvement can be determined by many factors including monitoring system, and leadership

Monitoring: The quality of care is being monitored in the clinical areas by monthly audits and by capturing the key performance indicators

Monthly audits: Annually a plan is made for audits to be done every month which commonly include vulnerable patient care, vascular access device maintenance, Narcotic medication account maintenance, pressure sore assessment & monitoring, Crash cart maintenance, transfusion monitoring etc. The audit is done in all the clinical areas including the peripheral campus areas by the audit nurse in the office of the Nursing Superintendent. The audit is entered, analyzed and report is prepared with the reason for noncompliance and the remedial measures taken. The report is made available in the intranet for access to all the staff.

The audits are presented and discussed in the quality steering committee meeting that happens once in 3 months. The compliance to the standards of care and the reasons for noncompliance are discussed in detail and the recommendations are made for further quality improvement

Basic nursing care audit: Department quality managers are involved in carrying out basic nursing care audits annually. Detailed review and evaluation of selected clinical records by "Nursing department quality managers" are carried out to identify, examine and verify the performance of certain specified aspects of nursing care by using established criteria. The audit reports are analyzed and communicated to the respective clinical areas to make action plan for improvement of quality nursing care.

Key performance indicators: There are Quality indicators which enable us to monitor the quality improvement, they are falls, medication error, pressure sore, extravasation, accidental delining, skin tear, restraint related injury, needle sticks injury and pain management.

These quality indicators are captured every month, entered, analyzed and report is prepared with root cause analysis, corrective and preventive actions are recommended. The report is presented in safety steering committee meeting that happens once in 3 months. Compliance with the standards of care on patient safety and quality is reviewed in depth focusing the reasons for noncompliance, and recommendations for quality improvement are made.

Leadership: Leadership plays a major role in monitoring the quality of care and to implement the plan of action taken for improvement for which the Department Quality managers, Department safety advisors and hand hygiene champions play a major role.

Meetings are arranged 3 months once for all the Department quality mangers during which the report of the audit & quality indicators are discussed and recommendations are made for implementation in the clinical areas. The Department safety advisors are involved actively in the safety aspects of the ward. The hand hygiene champions keep vigilance on hand hygiene practices of the clinical areas. The Link Nurses and Infection control nurse (ICN) keep vigilance on the infection control practice of their clinical area and institution.
There are workshops being conducted annually for all the personnel involved in quality for updating of the standards and policies.

XV. RISK MANAGEMENT

Nursing service plans and implements activities to identify, evaluate and reduce the risk of injury to patients, relatives, staff, students and visitors. Risk management in patient care is collaborated along with Safety cell, Occupational Health team, and Quality Management Cell. The Deputy Nursing Superintendent (Quality) is the member of the Risk assessment and mitigation team who represents the Nursing Service and the subcommittee members appointed for each clinical area.

Nursing service receives and analyses the reports of incidents, falls, medication errors, pressure ulcers, cautery burns, skin tears, restraint related injuries, patient complaints and audits.

Identification of the risks is the clinical areas is done by the appointed subcommittee members using the reports of the audits conducted, facility inspection, nursing care rounds, reports of the quality indicators, and patient complaints.

The various risks that are identified, listed and action plan made by the individual clinical areas is periodically reviewed by the Nursing service along with the subcommittee members to reduce the risks and the related impacts.

1. POLICIES ON ADMISSION OF PATIENT

1.1 Admission to the Ward:

Policy statement: Patient is admitted in the Wards as per Hospital admission policy.

1.1.1. Admission of patient into the ward is from Outpatient Department (OPD), emergency services, Operation Room (OR), day care and direct admissions.

1.1.2. The patient is identified with admission slip/order.

1.1.3. The Nurse ensures admission slip/order has doctor's signature, employment number, hospital number, unit, ward and date of admission.

1.1.4. The Nurse ensures that advance amount is paid.

1.1.5. The status of payment (self, insurance/company/health scheme)) is checked at admission and appropriate payment seal is obtained within 24 hours.

1.1.6. Initial assessment is completed within two hours by the admitting Nurse.

1.1.7. Admissions are informed to the unit doctor on call. If there is no response within one hour, senior doctor on call is informed.

1.1.8. Patient and the patient's attendants are oriented to the ward and hospital by Staff Nurse.

1.1.9. Visitor passes (2) are issued and are collected back at the time of discharge.

1.1.10. Appropriate color coded identification band is applied on the patient after checking vulnerable status.

1.1.11. Patients are admitted with female attendant.

1.1.12. Ornaments and valuables are removed in the presence of the patient's attendant and handed over to the closest patient's attendant and documented in the Nurse's record with signature from patient's attendant.

1.1.13. In the event of refusal / difficulty to remove ornaments, documentation is ensured in the patient's record

1.1.14. The admission advisory is entered online in the bed management program within one hour by the ward clerk during the day and the Nurse by night.

1.1.15. If patient payment is through company or insurance, patient's attendant is sent to CARE (Credit and Reimbursement) section.

1.1.16. The admission office located in OPD issues white and pink sheet, and name stickers to the ward.

1.1.17. The ward clerk obtains consent from the patient/ patient's attendant in the admission record and the pink sheet after adequate explanation.

1.1.18. Close patient's attendant local address and contact number are obtained and documented.

1.1.19. Ward clerk ensures that international clearance is obtained for foreign nationals.

1.1.20. Nurse ensures that incident report copy is present, if patient is MLC.

1.2 Admission to ICUs:

Policy statement: Patient is admitted to the ICU by following the protocols prescribed

1.2.1. Patient is received from OPD, emergency Services, labour room, wards, OR and from other hospitals.

1.2.2. The reasons for patient admission are checked according to the existing criteria.

1.2.3. The patient is identified with admission order.

1.2.4. Initial assessment is completed as per ICU guidelines.

1.2.5. Patient / patient's attendants are oriented to the ICU routine, facilities available, visiting hours, and need for two patient's attendants to be available.

1.2.6. Close patient's attendant's local address and contact mobile number are obtained and documented.

1.2.7. Visitor passes (2) are issued and visitor control is emphasized.

1.2.8. Ornaments and valuables are removed in the presence of the patient's attendant and handed over to the closest patient's attendant and documented in the Nurse's record with signature from patient's attendant.

1.2.9. In the absence of patient's attendants, the valuables are removed by the assigned staff in the presence of another staff and handed over for safe keeping to the Staff incharge.

1.2.10. In the event of refusal / difficulty to remove ornaments, documentation is ensured in the patient's record.

1.2.11. The admission advisory is entered online in the Bed Management programme within one hour by the Ward clerk during the day and the Nurse during the night.

1.3. Admission to Emergency Services Department:

Policy statement: Patients are admitted in the adult emergency department as per the policy prescribed.

1.3.1. The Triage Nurse assesses all patients and completes the Triage Assessment Form online.

1.3.2. Triaging is done as per the 4 – tier prioritization scale.

PRIORITY	PATIENT STATUS	INTERVENTION	TIME
I	Patient requires immediate intervention to sustain life	Transferred to resuscitation bay, seen by Casualty Medical Officer (CMO) and documentation is completed at the earliest.	Immediately
II	Patient is potentially unstable and can decompensate within a short period	Referred to resuscitation bay, handed over to Staff Nurse and CMO	2 Hours
III	Patient does not require immediate medical attention and can be attended to when medical personnel are available	First Aid is provided	4 Hours
IV	Patients with chronic problems with no acute worsening	Direct consultation at triage by CMO	4 Hours

1.3.3. The CMO examines and refers patients to appropriate units as required.

1.3.4. The Triage form is filled online and attached to the patient's record.

1.3.5. The triage Nurse instructs patient's attendants about patient registration and provides visitors pass.

1.3.6. The CMO assesses the patient with burn injury in the vehicle and informs Plastic Surgery first call and patient is transferred based on the doctors' decision.

1.3.7. In the event of disaster / mass casualty, the trauma team is activated as per disaster management guidelines.

1.4. Admission to Pediatric Emergency Department:

Policy statement: Patients are admitted in the pediatric emergency department by following the protocols prescribed.

1.4.1. The Triage Nurse assesses all patients and completes the triage assessment form.

1.4.2. Triaging is done as per the 3 – tier prioritization scale.

PRIORITY	PATIENT'S STATUS	INTERVENTION	TIME
I	Patient requires immediate intervention to sustain life/ Patient with cardiovascular / Airway or Breathing compromise / Low Sensorium	Transferred to resuscitation bay, seen by Casualty Medical Officer (CMO) and documentation is completed at the earliest.	Immediately
II	Patient is potentially unstable and can decompensate within a short period.	Referred to resuscitation bay, handed over to Staff Nurse and CMO.	30 min
III	Patient does not require immediate medical attention but has acute Problems	Receive First Aid as needed	1 Hour

1.4.3. The CMO examines and refers patients as required.

1.4.4. Triage form is attached to the patient's record.

1.4.5. The Triage Nurse instructs patient's attendants about patient registration and provides visitor's pass.

1.4.6. The Nurse and doctor check for evidence of physical sexual abuse of child and the CMO reports to the MS immediately.

1.5. Admission of patient with Chest Pain:

Policy statement: Patients are admitted to the Emergency department by following the policy prescribed.

1.5.1. Patients with history of typical anginal chest pain and referred with documented ST elevation MI are received in ED.

1.5.2. ECG is taken on arrival and patient is assessed for chest pain.

1.5.3. Patient's attendant is sent to the Emergency Service payment counter to register and make payment for ECG and blood test.

1.5.4. OP chart new / old is retrieved online.

1.5.5. Blood samples are taken for cardiac enzymes every 4 hours x 2 times. If results are abnormal/ pain is typical of angina, the physician decides to admit patient to D001 CPU Ranipet campus. Depending on the condition patient is shifted to Ranipet via ambulance accompanied by a doctor and ED technician

1.5.6. If chest pain is atypical and investigations are normal, the patient is discharged with a preliminary discharge summary from CPU with advice to follow up in Cardiology Out Patient Department.

1.5.7. Complete documentation (including charges) is done within one hour.

1.6. Admission to Daycare Facility:

Policy statement: Patients are admitted for day care procedure by following the protocols prescribed.

1.6.1. The patient is identified and admitted after checking the procedure slip and payment details.

1.6.2. The patients / patient's attendants are oriented to the daycare set up, and patients are instructed to remove valuables and hand over to close patient's attendants.

1.6.3. The concerned doctor is informed and documentation is completed.

1.6.4. Instructions are provided regarding pre and post procedural care.

1.7. Admission to Daycare Surgery facility:

Policy statement: Patients are admitted for day care surgery by following the protocols prescribed.

1.7.1. Patients are identified and admitted after checking procedure slip and payment details.

1.7.2. The concerned surgeon &anesthetist are informed.

1.7.3. ID band is applied on the wrist and patients/patient's attendants are oriented to the daycare set up and visitor passes are issued.

1.7.4. Patient is instructed to remove valuables and hand over to the close patient's attendants.

1.7.5. Initial assessment is completed including the surgical safety check list.

1.7.6. Post-surgery care instructions are provided.

1.7.7. Any patient requiring monitoring after 9pm is transferred to respective ward.

1.8. Admission to Burns Unit:

Policy statement: Patients are admitted in the burns unit by following the protocols prescribed.

1.8.1. Burns patient is admitted through Emergency Department and Plastic Surgery OPD.

1.8.2. Plastic Surgery first call sees the patient and organizes admission of the patient in the Burns unit.

1.8.3. The first call sends an incident report to Medical Superintendent's office. Duplicate copy of the same is made available in the OP record.

1.8.4. Payment of advance is ensured and patient's attendants are instructed to donate four units of blood.

1.8.5. The ornaments and valuables are removed in the presence of patient's attendants and handed over to the closest patient's attendant and documented in the Nurses' record with signature from patient's attendant.

1.8.6. The patient's attendants are instructed regarding visitor control and unit routine.

1.9. Admission of International Patients:

Policy statement: International patients are admitted to any unit by following the protocols prescribed.

1.9.1. Admission of the international patients is done only if the patient has registered in the International Liason Office (ILO) and has obtained clearance.

1.9.2. Patients registered in ILO without clearance form may also be admitted. Clearance from ILO is ensured within 24 hours.

1.9.3. In case of emergency admission after office hours, patients can be admitted without registration. Registration and clearance from ILO is ensured within 24 hours.

1.10. Admission of MLC patients

Policy statement: Patients are admitted in the hospital following the protocols prescribed.

1.10.1.Incident report is filled online by the CMO in Emergency Department if the patient is MLC

1.10.2. While admitting the patient in the respective unit, nurse confirms that MLC-incident report is available under bed management.

2. POLICIES ON TRANSFER OF PATIENTS

2.1 Between Wards:

Policy Statement: Patient is transferred appropriately by following the prescribed policy.

2.1.1. All planned transfers are done before 10pm.

2.1.2. The Nurse checks the doctor's order for transferring the patient and informs the patient and patient's attendant regarding transfer.

2.1.3. The Nurse informs the Charge Nurse/ Staff incharge of the ward where the patient is to be transferred.

2.1.4. The Nurse ensures complete documentation of vital signs, appropriate nursing care observations and treatment given before transferring patient, in the Nurses Daily Record.

2.1.5. The Nurse organizes to change relevant details of ward and unit in patient identification and ensures necessary changes are made online for diet orders.

2.1.6. Settlement of bill is done before transfer if the patient is shifted to another category of bed within the same unit and the details are entered online.

2.1.7. The Nurse documents time, mode of transfer, condition of patient and ward articles sent along with the patient.

2.1.8. The Nurse ensures appropriate safe mode of transfer, accompanies patient and ensures skin integrity is checked by receiving Nurse. The Nurse hands over patient, patient care documents, belongings and reports verbally to the receiving Staff Nurse.

2.1.9. The Nurse ensures that only needed medications are available on transfer.

2.1.10. Medication reconciliation is done by handing over all the medications with the 'Doctors Medication Order and Nurses Administration' record and reporting the details verbally.

2.1.11. The Nurse who receives the patient informs the concerned doctor regarding the transfer.

2.1.12. Transfers are updated in the bed management system by the Ward Clerk.

2.1.13. Emergency transfers after 10pm are informed to the Night Supervisor .

2.1.14. Transfer checklist is filled by the Staff Nurse who transfers the patient.

2.1.15. Transfer checklist is signed with the employment number of the transferring and the receiving Staff Nurses.

2.2. From Ward/ Emergency department to ICU:

2.2.1. The Nurse checks the transfer order on the doctor's order sheet.

2.2.2. The Nurse informs the Staff incharge of the ICU about the transfer and ensures that bed is available.

2.2.3. The unit Doctor, Nurse, Hospital Attendant and patient's attendant of the patient accompany the patient from ward to ICU.

2.2.4. Hospital Attendant and patient's attendant of the patient accompany the patient from ED to ICU if stable. When patient is unstable the unit doctor accompanies the patient with the hospital attendant & patient's attendant.

2.2.5. The patient's records, belongings and medication are sent along with the patient and handed over to ICU Nurse.

2.2.6. Medication reconciliation is done by handing over all the medications with the 'Doctors Medication Order and Nurses Administration' record and reporting the details verbally.

2.2.7. The Nurse reports and documents transfer in the transfer checklist and Nurses ICU record.

2.3. From Ward to Operating rooms (OR):

2.3.1. The Nurse verifies completion of the 'Surgical Safety Check list' and preoperative preparation.

2.3.2. The transfer to OR is documented in the Nurses record and necessary items such as patient's chart, ordered medications such as antibiotics and other necessary things as ordered by the Surgeon are taken along with patient.

2.3.3. Medication reconciliation is done by handing over relevant medications and reporting the details verbally.

2.3.4. The Nursing personnel accompany the patient to OR.

2.3.5. The patient is handed over to the OR Nurse after verifying the patient ID.

2.4. From Ward to Procedure rooms:

2.4.1. The Doctor's order regarding the transfer for procedure and appointment is checked and patient and patient's attendant are informed.

2.4.2. The Patient is transferred after the call from procedure room or as per the Doctor's written order.

2.4.3. Transfer is documented in the Nurses record and essential documents and items are sent along with patient.

2.4.4. "The patient transfer checklist-Investigation" is used for documentation.

2.4.5. Patient is accompanied by Hospital Attendant and a patient's attendant.

2.4.6. In case of unstable patients, the unit Doctor accompanies the patient.

2.5. From Ward to OPD:

2.5.1. The Doctor's order regarding the transfer to OPD is checked and patient and patient's attendant

are informed about the same.

2.5.2. The patient is transferred to OPD on call from the MRO of the respective OPD.

2.5.3. Transfer is documented in the Nurses Daily Record and essential documents and items are sent along with patient.

2.5.4. The Patient is transferred to OPD by Hospital Attendant and patient's attendants.

2.6. From ICU to Wards:

2.6.1. The written order for transfer of patient to Ward is checked.

2.6.2. The Nurse ensures patient and patient's attendants are aware of the transfer and informs the Charge Nurse / Staff incharge of the ward about the transfer and the condition of the patient.

2.6.3. The Nurse completes the transfer checklist

2.6.4. The Nurse accompanies the patient to the ward along with a Hospital Attendant and a patient's attendant with all necessary documents.

2.6.5. The patient, documents, belongings are handed over and report is given verbally to the Staff incharge / Charge Nurse.

2.6.6. The Nurse ensures that only needed medications are available on transfer.

2.6.7. Medication reconciliation is done by handing over all the medications with the 'Doctors Medication Order and Nurses Administration' record and reporting the details verbally.

2.6.8. Transfer checklist is signed by the transferring and the receiving Nurses

2.6.9. Transfer is entered online in the Bed management program.

2.7. From ICU to OR:

2.7.1. The Doctor's order is checked.

2.7.2. The patient (if condition permits) and patient's attendants are informed and doctor ensures that consent is obtained from the patient /patient's attendant.

2.7.3. Nurse ensures that pre op-preparation and the Surgical safety checklist is completed (if condition permits).

2.7.4. The patient is transferred with all documents, medications and items to OR. Medication reconciliation is done by handing over relevant medications and reporting the details verbally.

2.8. From OR to ICU:

2.8.1. The OR/ Recovery Room (RR) Nurse checks for stability of the patient and recovery from anesthesia.

2.8.2. Doctor's transfer order and postoperative orders are checked.

2.8.3. The patient's name, hospital number and unit are verified before transfer.

2.8.4. ICU Nurse is informed about the condition of the patient before transfer.

2.8.5. The patient is transferred by the unit surgeon and registered Nurse. Medication reconciliation is done by handing over relevant medications and reporting the details verbally.

2.9. From OR to Wards:

2.9.1. Recovery Room (RR) Nurse checks for stability of the patient and recovery from anesthesia.

2.9.2. The Doctor's transfer order and postoperative orders are checked and informed to the respective ward and the Transfer Coordinator.

2.9.3. The ward Nurse informs the transfer Coordinator to arrange Hospital Attendant for transfer of patient.

2.9.4. The patient's name, hospital number, ward and unit are verified before transfer.

2.9.5. The RR Nurse informs the patient's attendants regarding the transfer.

2.9.6. The RR Nurse reports to ward Nurse of the clinical condition of the patient and hands over the necessary document and equipment.

2.9.7. The Patient is accompanied by the Nursing personnel and Hospital Attendant to the respective ward. Unstable patients are received by Registered Nurse.

2.10. From OPD to wards:

2.10.1. If patient is sent to OPD for procedure or consultation, the ward Staff Nurse is informed by the Doctor/MRO in the OPD about the completion of procedure. The ward Hospital Attendant goes to OPD and transfers the patient to the ward along with the patient's attendant.

2.10.2. If patient is unstable and requires immediate treatment, the Doctor accompanies patient to the ward.

2.11. From main hospital campus to other campuses:

2.11.1. Patients are discharged from main hospital campus before transferring for admission to inter-hospital campuses such as Schell Eye hospital, Rehabilitation Institute, CHAD, Chittoor and RUHSA.

2.12. From other campuses to main hospital campus:

2.12.1. Patients are brought from Rehabilitation Institute to main hospital in ambulance accompanied by Hospital Attendant and patient's attendants for investigations or procedures and transferred back.

2.12.2. Patients are shifted from CHAD hospital in ambulance accompanied by Doctor for admission to main hospital.

2.13. From CMC Hospital to other hospital:

2.13.1. Doctor's order is checked for discharge.

2.13.2. The Nurse ensures patient's attendants are aware of the formalities before discharge.

2.13.3. Consent is obtained from the patient and patient's attendants.

2.13.4. The Nurse ensures that the final bill is paid.

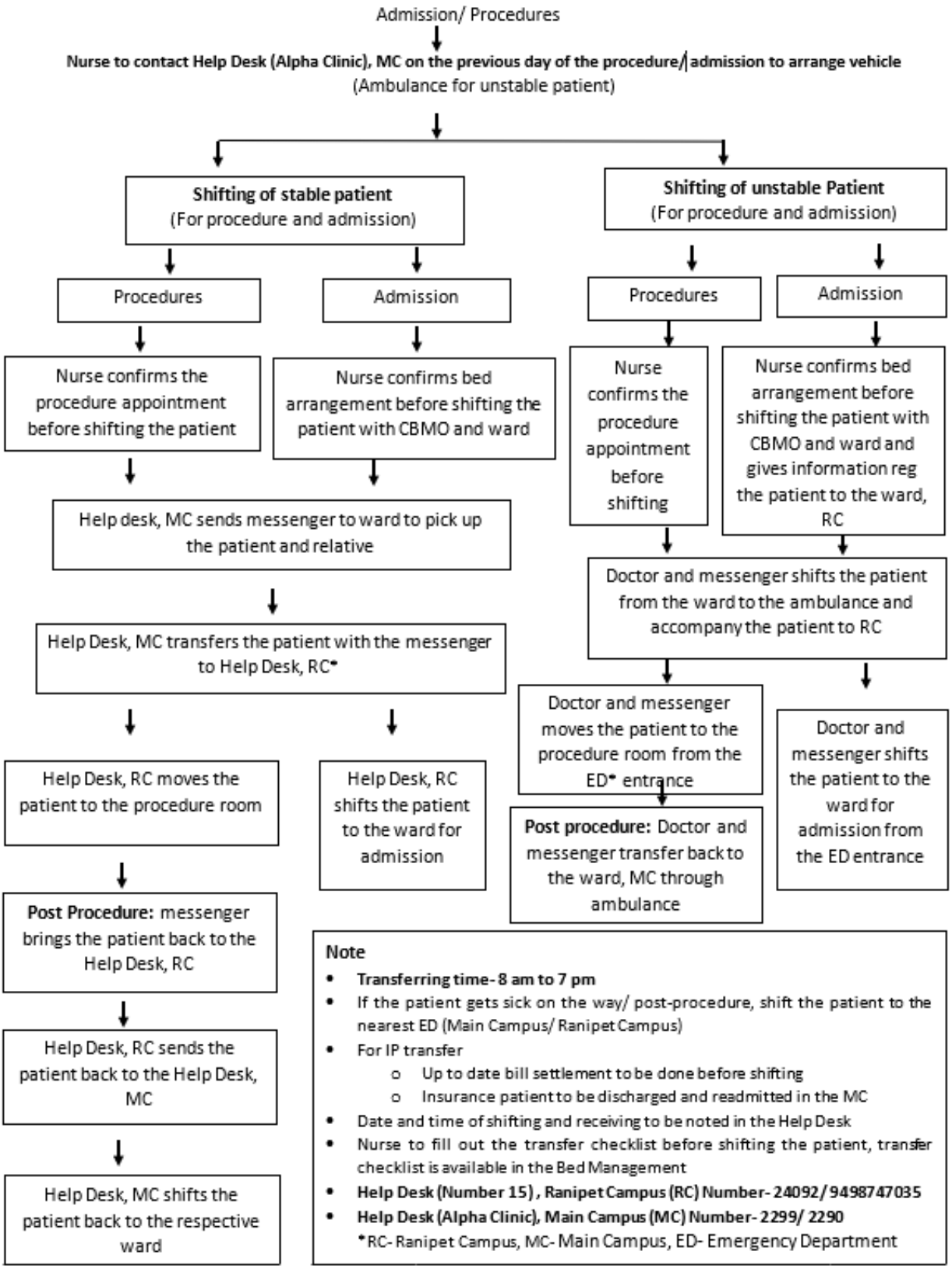
2.13.5. If the patient is sick, patient's attendants are provided assistance to arrange for ambulance.

2.13.6. Patients are discharged before leaving to other hospitals and are readmitted on return.

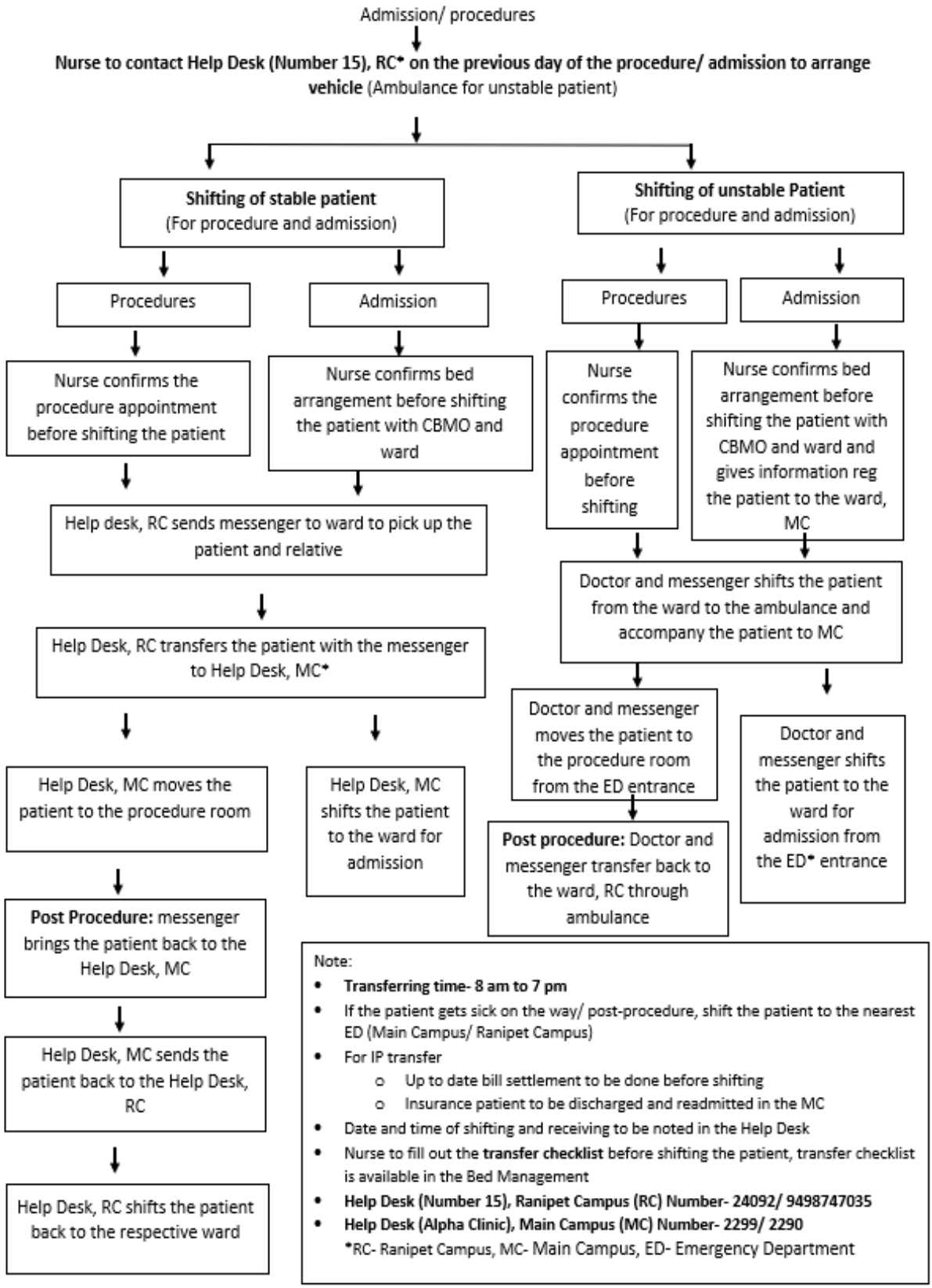
2.13.7. Discharge summary is sent along with patient

2.13.8. Discharge is updated online on Bed management program by the Ward Clerk.

2.14. Protocol for Inter Hospital Transfer- (In-patient) Main campus to Ranipet campus:



2.15. Protocol for Inter Hospital Transfer- (In-patient) Ranipet campus to Main campus:



2.16. **From Ward to procedure room/ Investigations:**

2.16.1. The written order for transfer of patients for investigations/procedure is checked

2.16.2. The Nurse ensures patient and patient's attendants are aware of the transfer for procedure/ investigations.

2.16.3. The Nurse explains about the procedure/ investigation and assesses the condition of the patient.

2.16.4. The Nurse completes the transfer checklist for Investigation/ procedure

2.16.5. The patient is sent along with a Hospital Attendant and a patient attendant with all the necessary documents.

2.16.6. On receiving information from the procedure/ investigation room, patients are received back to the ward by the Hospital Attendant after completion of the procedure/ investigation.

2.16.7. If patient is unstable, the Doctor accompanies the patient to and fro for investigation/ procedure.

2.16.8. If any samples received from the procedure/ investigation room it is documented in the transfer checklist and sent to the specified lab with the request slip as per protocol.

2.16.9. Post monitoring of patients after procedure/ investigation is done and documented in the daily nursing care record.

3. POLICIES ON ASSESSMENT OF PATIENT AND DOCUMENTATION

3.1 Initial Assessment:

Policy Statement: Initial assessment of the patient is done and documented within prescribed time in specified format.

3.1.1. The assigned Registered Nurse is responsible for performing initial assessment of the admitted patient.

3.1.2. Initial assessment and documentation is done within 2 hours of admission and countersigned by the Charge Nurse / Nurse Manager within 24 hours.

3.1.3. The Nurse identifies and prioritizes the problems and needs in the available daily nursing care record.

3.1.4. The Nurse ensures that risk for pain, fall and pressure sore are assessed as per policy and recorded in the initial assessment and the patient monitoring record.

3.1.5. Significant findings are reported to the doctor concerned and documented in the Nurses record.

3.2. Continuing Assessment:

3.2.1. Continuous assessment is done related to identified abnormalities and are recorded and reported as per the patient's condition.

3.2.2. Patients are monitored using the Early warning signs (Adult & Paediatrics) for early detection of clinical deterioration and potential need for higher level of care. It is assessed based on physiological parameters (respiratory rate, heart rate, blood pressure and level of consciousness).

3.2.3. Patients with unstable parameters are notified to the concerned doctor immediately and based on the order given patients are monitored more attentively and considered for transfer to higher care units such as ICU. If in case emergency situation arises the CART team is activated for help.

3.3 Nursing documentation:

Policy Statement: Nursing documentation is standardized as per the prescribed policy

3.3.1. Nursing documentation in the patient record must include the signature of the Nurse, employment number, date and time.

3.3.2. The daily Nursing Care Record is signed by the Charge Nurse / Nurse Manager every shift

3.3.3. Initials are permitted only on 'Doctors Medication Order and Nurses Administration Record (DMONAR).

3.3.4. The Staff Nurse obtains initials of the Staff Nurse / Nurse Manager / Charge Nurse wherever applicable.

4. POLICIES ON HANDING OVER AND TAKING OVER OF PATIENTS

4.1 Patient report (Verbal and written):

4.1.1. The Staff Nurse incharge or Charge Nurse will hand over or receive patient report using the 'Daily Audit Register'.

4.1.2. Reporting of all patients is done at the end of each shift. Appropriate written report is maintained.

4.1.3. Nurse taking over is aware of bed availability and reservation.

4.1.4. Shift incharge hands over relevant unit management details.

4.1.5. Documented report in the 'Daily Audit Register" is signed by the Nurses who are handing and taking over every shift.

4.1.6. Structured handover is followed in all clinical areas using the format of Identification, Situation, Background, Assessment and Recommendations - ISBAR by the shift handing over nurse & shift taking over nurse. It is documented with their signature and employment number in the daily nursing care record of each patient.

5. WARD POLICIES PERTAINING TO PATIENTS

5.1 Patients going out with permission - During day:

5.1.1. On patient's request, a written order is obtained from the Doctor of the unit following an assessment of patient's health status.

5.1.2. The patient and the patient's attendant are informed about the permission and the expected time of return.

5.1.3. Continuation of medication as prescribed (time and dosage) is emphasized before leaving.

5.1.4. The time of leaving and return with a description of the patient's health status is documented.

5.2. Patients going out with permission – During night:

5.2.1. On patients request a written order is obtained from the Senior Doctor of the unit duly signed by the Medical Superintendent before 6pm, following an assessment of patient's health status.

5.2.2. The patient and the patient's attendant are informed about the permission and the expected time of return.

5.2.3. Explanation about continuation of medication as prescribed (time and dosage) is given.

5.2.4. The time of leaving and return with a description of the patient's health status is documented.

5.2.5. Night Supervisor is informed about the permission when he/she comes on rounds.

5.3. Visiting policy and implementation:

5.3.1. All the patients admitted into the wards are given two visitor passes.

5.3.2. The color of the pass is changed every month.

5.3.3. Visiting hours are displayed at the entrance of the ward.

5.3.4. No extra passes are issued. During day time one patient's attendant is allowed to stay with the patient.

5.3.5. Visitors are allowed only during visiting hours.

5.3.6. Visiting Hours:	Monday – Friday	:	4.30 pm – 6.00 pm
	Saturday	:	3.30 pm – 6.00 pm
	Sunday	:	10.00 am – 11.30 am &
			3.30 pm – 6.00 pm
5.3.7. Meal timing:	Breakfast	:	6.00 am – 8.00 am
	Lunch	:	12.00 pm – 2.00 pm
	Dinner	:	6.00 – 8.00 pm

5.3.8. Visitors are not allowed at night.

5.3.9. Security guard ensures visitor control.

5.3.10. Visiting time for ICU's are followed as per protocol of the individual ICU's for both town campus & Ranipet campus.

5.4. Attendant policy and obtaining special permission:

5.4.1. On admission each patient is to have one female attendant.

5.4.2. Without a female attendant, patients are to request for patient assistant with payment.

5.4.3. Patient assistant request form is sent to ANS before 6pm if patient has no female attendant in the night.

5.4.4. One attendant is allowed to stay with the patient during day time.

5.4.5. During night time, only female attendant is allowed to stay with the patient (Exception: MHC)

5.4.6. During night, if the patient is critically ill one male attendant is permitted by ward supervisor or Night Supervisor to stay outside the ward.

5.4.7. In private wards single room, one male or female attendant is allowed to stay during night.

5.4.8. No children are permitted to stay in the ward. In case the patient is a feeding mother of an infant, the infant is allowed to stay under the supervision and care of the patient's attendant.

5.4.9. Written information is provided to the Nursing Superintendent.

5.5. Patient identification policy:

5.5.1. Patients admitted in the hospital are identified with identification band containing patient name, hospital number, unit and ward.

5.5.2. Identification band is applied on patients' wrist at admission and is removed only at discharge.

5.5.3. Patient stickers containing patient name, hospital number, unit and ward are placed on all patient records.

5.5.4. All the patients' investigation samples / specimens are labeled.

5.5.5. Patients are identified by name and hospital number before medication administration, procedure and surgery.

5.5.6. Vulnerable patients are identified with pink ID band.

5.5.7. Patients with similar names are identified with alert stickers on the patient's chart and on the patient roster.

5.6. Policy on patient Chaperone:

5.6.1. If the male doctor is to examine a female patient, a female health care personnel is to accompany him.

5.6.2. If a female doctor is to examine a male patient, another health care personnel is to accompany her.

5.6.3. The wife / significant patient's attendant / another health care personnel is to accompany if a male patient requires personal hygiene care. A significant patient's attendant / female health care personnel is to accompany if a female patient requires personal hygiene care.

5.6.4. Privacy is provided before examining the patient.

6. END OF LIFE CARE

6.1. Care during final stages of life:

Policy Statement: Health care personnel are concerned of the patient's dignity and comfort that guide all aspects of care during the final stages of life.

6.1.1. Patients and their families are prepared for the sequence of events.

6.1.2. Patients are assured that management of their pain and distress will be the highest priority of the health care personnel.

6.1.3. Comfort measures are provided viz, maintaining an open airway, oxygen therapy, positioning for comfort, splinting, controlling bleeding, and relieving pain and providing emotional support.

6.1.4. Family is assured that patient will be treated with respect and dignity at all times and after death the health care personnel will respect the patient's values, religion, and cultural preferences.

6.1.5. For children, cultural and spiritual observation is oriented toward providing an age appropriate understanding of dying, as well as providing the parents and family with meaningful rituals for coping with the death of the child.

6.1.6. Continuous presence of family and friends at the bedside of the dying patient as privately as possible/desirable is allowed.

6.1.7. The Nurse informs the family members about availability of Clergy/Chaplain.

6.1.8. Family is provided with the opportunity to care for their loved one by participating in activities to relieve patient discomfort.

6.1.9. The family members are supported to express their emotions both before and after the death of the patient.

6.2. Coordination of the Health Care Team:

Policy Statement: The end of life care is multi-disciplinary and is coordinated well between all the members at all stages.

6.2.1. The multidisciplinary health care team dealing with the dying patients are (Nurses, doctors, chaplain, social worker, ALS etc.) committed to cooperate and maintain clear communication.

6.2.2. The team has clear goals and strategies for providing end-of-life care. They respond to the psychological, emotional, spiritual and cultural concerns of the patient and the family.

6.2.3. Health care team supervises the critical aspect the end-of-life.

6.3. Care after death:

6.3.1. Death is certified by the Doctor.

6.3.2. Family is informed about the death by the Doctor.

6.3.3. Respect of the deceased is observed (bathing, aligning, dressing etc.).

6.3.4. Families are allowed private time with the deceased and before removal of the body from the unit.

6.3.5. After life services are activated for further arrangements.

6.3.6. Completion of documentation is ensured.

6.3.7. Death certificate is sent to Medical Superintendent's office within 24 hours

6.4. Autopsy:

6.4.1. Autopsy services are not offered in CMC for cases such as unnatural death, brought dead, death within 24 hrs. of admission, MLC, positive for HIV, HCV, H1N1 or HIV HCV status not known,

6.4.2. In case of death of MLC patients, patient's relatives are instructed that it will be done in the Government hospital.

6.4.3. Patient's relatives are given adequate explanation by the doctor that entrails will be removed during autopsy and consent is obtained by the doctor.

6.4.4. Completed autopsy request forms and consent forms are sent to Histopathology department.

7. DISCHARGE POLICIES

7.1. Leaving against Medical Advice (LAMA) and documentation:

Policy statement: All discharges against medical advice are performed as per the prescribed policies.

7.1.1. The concerned unit doctor explains to the patient and patient's relative consequences of discharge against medical advice, documents details in progress sheet and obtains signature of patient's relative..

7.1.2. The doctor informs the consultant as concession can be offered if the LAMA is due to pure financial reasons especially for a treatable condition.

7.1.3. In Emergency Services, the details are documented in the OP chart. The white LAMA form is filled by patient's relatives for patients with altered sensorium.

7.1.4. A discharge summary or at least a preliminary discharge summary is provided with all the relevant investigations before the patient leaves the ward.

7.1.5. The details of LAMA are entered in the admission register in the ward by the ward clerks for statistics and audit purposes.

7.2. Discharge billing:

Policy statement: All discharge billing procedures are performed as per the prescribed policies.

7.2.1. Once the doctor has written 'discharge' in the doctor's order sheet, the patient is informed about the discharge.

7.2.2. Discharge procedure varies based on the type of payment: self / company / insurance/staff / staff dependent/hospital free, etc.

7.2.3. Online discharge clearance slip is entered by the Staff Nurse on the bed management system for patients to be discharged

7.2.4. Doctor enters the "Nil to pay / concession' on the online discharge form for PTP patients and hospital free patients.

7.2.5. Discharge prescription is ordered online and the multipurpose slip (online lab order, prescription and OP referral) is given to the patient's attendants to obtain the medications from the Pharmacy.

7.2.6. The patients' unused medications are returned to pharmacy

7.2.7. All online charges including diet, special procedures, and surgical charges are entered and updated.

7.2.8. Once the discharge bill is ready online, the printed discharge bill is given to the patient to pay

7.2.9. Patient's attendant is guided to pay the discharge bill in the cash counter / or through online transaction.

7.2.10. Discharge bill payment details is viewed online for confirmation.

7.2.11. Patient leaves the ward after obtaining the discharge summary and the discharge instructions.

7.2.12. The patient's status and the time of leaving are documented in the Nurses record.

7.3. Discharge billing for Staff and staff dependent:

7.3.1. A staff dependent bill settlement form obtained from the staff at the time of discharge.

7.3.2. Patient leaves the ward once "can go" is viewed online for confirmation.

7.3.3. If want to clear the bill by paying, bill is given to pay otherwise it automatically goes as salary deduction

7.3.4. Retired staff are to clear the bill before leaving the ward.

7.3.5. Staff and Staff dependent admitted beyond their eligible bed status are charged accordingly.

7.4. Discharge billing for Hospital free patients:

7.4.1. Hospital free patient's discharge bills are settled by the concerned unit.

7.4.2. If patient is already admitted, patient is discharged and then admitted as hospital free patient.

7.4.3. A patient who has paid an advance for admission is not eligible for this facility.

7.4.4. Implants, Medications, CT scans charges are waived only up to 50,000/-

7.4.5. Medication prescription over Rs.10, 000/- per day is not honored.

7.4.6. Facility is not used for admitting patients just to write off investigations.

7.4.7. Only two patients from one unit can be admitted in one period of admission and discharge.

7.4.8. Clinicians have to decide the "Free" status at the time of admission itself and it cannot be changed in between the admission and discharge dates.

7.4.9. Form required for this facility is filled at the time of admission itself. Such amounts will be shown as charity against that unit.

7.4.10. The disease condition should be potentially curable. (Not applicable for RT and Palliative Care patients)

7.4.11. The maximum allotment is Rs.1 lakh per patient.

7.4.12. The sanctioned fund does not cover professional fees.

7.4.13. Diet expenses may be covered, if deemed necessary.

7.4.14. If additional funds are needed, special permission from Medical Superintendent or Director is obtained.

7.5. Discharge billing for Company/ insurance/ government payment:

7.5.1. The discharge slip along with the IP and OP chart is sent to the CARE section

7.5.2. The CARE section issues permission slip for the patients to leave the ward.

7.6. State Health Insurance Scheme:

7.6.1. The STATE INSURANCE SCHEME help desk handles all queries related to the scheme.

7.6.2. Photographs are taken by the designated photographer for all patients under Tamil Nadu Chief Minister Health Insurance Scheme.

7.6.3. The bill is handled by CARE section.

7.6.4. Excess amount beyond the scheme will be absorbed by the Institution.

7.6.5. Further hospitalization is borne by the patient's family.

7.6.6. In case of emergency for a STATE INSURANCE SCHEME patient, toll free number: 1800 4252670 is dialed to obtain an Emergency intimation number.

7.6.7. Patients under any insurance scheme are processed within 24hrs for approval.

7.6.8. Consignment letter is given by CMO/ DMO for emergency surgeries.

7.7. Discharge medication and advice:

7.7.1. Along with the discharge order, the discharge prescription is written by the doctor

7.7.2. The discharge medications are handed over with explanation about the action, dosage and side effects by the assigned staff.

7.8. Handling charts after discharge:

7.8.1. Patient's chart is checked by the ward clerk for completion and sent to MRD.

7.9. Discharge refunds:

7.9.1. Chart with final bill is received from billing section and refund amount is informed to patient and patient's attendants.

7.9.2. Nurse informs patient's attendant that authorized person who signed on the back of the pink sheet has to take the original advance cash receipt with Chris Card and accompany Hospital Attendant to Counter no.105 at Billing section.

7.9.3. If authorized person is not present, then the available patient's attendant's name and relationship is documented with his/her signature in the pink sheet, and countersigned with employment number by the nurse before sending to billing section.

7.9.4. Refunds up to Rs.1, 00,000/- are done by cash and above Rs.1,00,000/- is done by cheque.

7.9.5. For listed company paying patients, treatment is cashless and CARE refunds amount to company.

7.9.6. For unlisted company paying patients, patients deposit the money from company and CARE refunds to company.

7.9.7. For insurance patients who deposited money by self, CARE refunds amount on showing ID proof and original payment receipts between 8.00 am and 6.00 pm on all week days and between 8.00 am and 2.00 pm on Saturdays.

7.9.8. Refund amounts are collected after settlement is received from Insurance company.

7.9.9. Refund is also requested by sending an email to care@cmcvellore.ac.in with patient's name, hospital number and transfer details for refund through NEFT / RTGS or by refund request slip. International patients provide passport number for refunds.

8. SPIRITUAL CARE

8.1. Meeting the religious needs of patients:

Policy Statement: All patients admitted in the ward are assessed periodically for spiritual needs and support will be provided.

8.1.1. The spiritual needs are assessed, provided, and documented in the Nurses record

8.1.2. Patient's religious rights are respected

8.1.3. The Nurse informs the assigned Chaplain about the patient's need

8.1.4. Orientation is given to the patient about morning prayer, chapel services, PA system and chaplain visit.

8.1.5. Information is provided regarding the places of worship within the hospital.

8.1.6. Communion service are provided according to patient's and patient's attendants wish at the bedside for critically ill patients.

8.1.7. Patients are encouraged to attend ward prayer in the morning.

9. POLICIES ON MEDICATION ADMINISTRATION AND MANAGEMENT

9.1 Standing Orders:

Policy statement: The Standing Orders approved by the Nursing Service Board is made available as soft copy on the intranet.

9.1.1. The Standing order is approved by the Nursing Heads of Departments and then endorsed in the Nursing Service Board attended by the Director, Medical Superintendent and General Superintendent.

9.1.2. The standing orders are reviewed every 5 years and whenever required.

9.1.3. All Nurses are oriented to their ward/ department's standing orders and sign a statement saying, they have read the standing orders.

9.1.4. The written order for all the medications listed in the standing order and used in an emergency is to be obtained immediately after the emergency.

9.2. Medication administration:

Policy Statement: The prescribed standard guidelines are followed for all medication administration.

9.2.1. The Nurse adheres to the ten rights of medication administration.

9.2.2. Medications are administered as per the doctor's order written in the 'Doctors Medication Order and Nurses Administration Record' (DMONAR) and documented by the Nurse.

9.2.3. Prescriptions are obtained when two doses of medications are left.

9.2.4. Supervised medication administration is countersigned by the supervisor with the employment number.

9.2.5. Medications administered by students are supervised and countersigned in the Nurses daily care Record.

9.2.6. All parenteral medication administrations by students are supervised and countersigned.

9.2.7. Prescribing and dispensing errors pertaining to medications and consumables are reported as sentinel events.

9.3. Oral Medication:

Policy Statement: The prescribed standard guidelines are followed for oral medication administration

9.3.1. Standard medication guidelines are followed for all medications administered orally.

9.3.2. Medication orders are written by doctors. Medication administrations are documented by nurses in the Doctors Medication Order and Nurses Administration Record (DMONAR) record with signature and employment number.

9.3.3. The ten rights of medication administration are to be followed.

9.3.4. Prescriptions are to be obtained when two doses of medications are left

9.3.5. Medications are withheld in consultation with the doctors and the rationale is documented in the Nurses Record.

9.3.6. Pre assessment of patients is done before administering the medication

9.3.7. Medication label is checked before, during and after administration of medication.

9.3.8. Patients are monitored for therapeutic and adverse effects of administered medication

9.4. Parenteral Medication:

Policy Statement: The prescribed standard guidelines are followed for parenteral medication administration.

9.4.1. ***Subcutaneous / intradermal/ Intramuscular***

9.4.1.1. A minimum of 5 site rotation method is followed for site safety.

9.4.1.2. Strict aseptic technique is followed

9.4.1.3. Used needles are discarded immediately in the "sharps" container

9.4.2. ***Intravenous***

9.4.2.1. First dose of penicillin and penicillin derivatives are administered by the doctor

9.4.2.2. Medication is stored as per the advice given by the manufacturer

9.4.2.3. The type and amount of diluent for reconstitution of the medication is done as per the guidelines of the manufacturer

9.4.2.4. The remaining dose of reconstituted medication is labeled with the date and time of opening

9.5. Procurement of medications:

Policy Statement: Medications are procured from the pharmacy as per the guidelines. Patients and patient's attendants are responsible for their medications. (EXCEPTIONS: MHC, Child Health, ICUs)

9.5.1. ***General inpatients***

Patients are encouraged to buy medication from the hospital pharmacy. If they wish to buy from outside pharmacy they are permitted. Checking of the medication purchased outside is done by the Nurse as per guidelines before administration

9.5.1.1. All prescriptions are checked for patient's information before giving to the patient's attendants

9.5.1.2. Patients and patients' attendant is explained and given the prescription by the doctor/ Nurse.

9.5.1.3. The purchased medications are checked by the Nurse with DMONAR when received in the clinical area (ICUs, Critical areas & duplicate prescriptions only)

9.5.1.4. Prescriptions are to follow new medication order and change in orders.

9.5.1.5. A minimum of two doses are to be available at any time.

9.5.2. ***Private /company payment inpatients/staff & staff dependents inpatients/ Free/ PTP***

9.5.2.1. Duplicate prescriptions are given

9.5.2.2. The prescription is sent to the pharmacy by the Nurses through Hospital Attendants.

9.5.2.3. Medications are checked against the duplicate slip

9.5.3. ***Online prescriptions and indent by Nurses in certain areas***

9.5.3.1. Nurses indent medications from pharmacy online and the same is authorized by the concerned treating doctor.

9.5.3.2. The indented medications are collected from pharmacy as per protocol of respective unit

9.6. Self-administration of medications:

Policy Statement: In-Patients are not permitted to self-administer medications after admission to hospital. (EXCEPTIONS: Practice medicines at MHC, Insulin after education and supervision).

9.6.1. Nurse enquires medications regularly taken by the patient and documents in the Nursing assessment form.

9.6.2. Patients are instructed not to self-medicate after admission.

9.6.3. In areas where self-administration is allowed, it is documented as self-administered.

9.7. Self-administration of Insulin:

Policy statement: Insulin administration by the patient is done under the supervision of the / Nurse.

9.7.1. The technique is taught to the patient by the assigned Nurse /Diabetic Nurse Educator (DNE).

9.7.2. Patient is helped to administer the injection until he is confident to do so.

9.7.3. The Nurse / DNE supervises self-administered insulin procedure and documents as 'self-administered'.

9.7.4. Prefixed insulin syringes are discarded after single use.

Adolescents and elderly

9.7.5. The technique is taught to the closest patient's attendants who will be the caregiver at home.

9.7.6. Thorough explanation of the technique including the type of insulin, peak action time, complications, rotation of sites, and storage is mandatory.

Dosage

9.7.7. Written order is obtained in the insulin order sheet

9.7.8. Patient is explained about the dose and the assigned Nurse / DNE supervises the procedure.

9.7.9. Subcutaneous insulin is administrated half an hour prior to food (excluding insulin analogues).

Documentation

9.7.10. The Nurse documents the insulin in the GRBS sheet and in bracket mentions it as "Self-administered" or "administered by caretaker"

Special Instructions

9.7.11. The medications are labeled and stored in separate boxes in the refrigerator.

9.7.12. Insulin pens are stored with in the case provided by the manufacturers.

9.7.13. The Nurse ensures that the patient takes diet within half an hour following insulin.

Site:

9.7.14. Anterior abdominal wall is recommended for self-administration of insulin.

Education:

9.7.15. Patients and care takers are taught regarding storage, rotation of site, and disposal of needles

9.7.16. Nurses educate on signs and symptoms of hypoglycemia and its management

9.8. Verbal Orders

Policy Statement: Verbal orders are followed only during emergencies as given in the Standing Orders.

9.8.1. Verbal orders from doctors are accepted only during emergency (cardio respiratory arrest, anaphylaxis, shock, seizure attack, hypoglycemia, etc.)

9.8.2. Written orders are obtained from the doctor who gave verbal order immediately or within an hour of the event with date, time, name of the drug, dosage, route, if infusion- infusion rate, signature and employment number

9.8.3. ‘**‘Call out call back’ / Read out Read back** procedure (i.e. The name of the drug, dose, dosage form and route must be called out by the doctor ordering the drug-**Call out/ Read out policy** and the Nurse administering the drug will have to repeat it back/ read it back-**Call back /Read back policy**) is followed for administration of medications during emergency.

9.8.4 . Telephone orders are not accepted at any circumstances.

9.9. Reconstitution of medications:

Policy Statement: Reconstitution of medications are followed as per the guidelines of the manufacturer.

9.9.1. Intravenous infusions:

9.9.1.1. Medications are diluted according to the manufacturer’s guidelines.

9.9.1.2. Following dilution, the medications are loaded separately in different syringes, labelled and administered separately.

9.9.1.3. Diluted medication as infusion is labeled with patient details & medication dilution.

9.9.1.4. Diluted medication as infusion through syringe pump is labelled on the syringe with name of medication, dosage, dilution, date and time of loading syringe.

9.9.1.5. Diluents used for infusion are recorded in the I/ O chart.

9.9.2. Multi Dose Vials:

Policy Statement: Multi dose vials for the same / different patients are followed as per the prescribed guidelines.

9.9.2.1. The medication (vial) is stored in zipper bag labeled with Patient’s name hospital number, dosage, date and timing of opening the vial.

9.9.2.2. The dilution (ml / mg) and remaining dose on the vial for the reconstituted medication is documented.

9.9.2.3. The reconstituted medication is used within 24 hours if the duration is not specified by the manufacturer.

9.9.2.4. The remaining unused medication of the multi dose vials is handed over to the patient at the time of discharge / on cancellation of the order

9.9.2.5. When medications such as Heparin flush, Normal Saline flush, vaccines etc., are used for multiple patients, the vial is labelled with date of opening and appropriate aseptic techniques are followed in using the vial.

9.10. Policy on Narcotic Drug administration and management:

9.10.1. Narcotic drugs:

Policy Statement: All Narcotic drugs are handled as per the prescribed guidelines.

9.10.1.1. All Narcotic drugs are administered only on written order by physician.

9.10.1.2. Narcotic drug order is valid for 24 hours.

9.10.1.3. Prescription is obtained in the narcotic drug prescription.

9.10.1.4. Narcotic prescriptions are collected by the pharmacy department every day before 10 am.

9.10.1.5.The Charge Nurse/ senior Staff Nurse receive the Narcotic drugs from the designated person from the Narcotic drug pharmacy by 11am and documents the strength and the number of drugs received in the Narcotic drug record.

9.10.1.6.Narcotic drugs are kept under lock in designated Narcotic Drug Account cupboard.

9.10.1.7.Narcotic drug cupboard key is carried always by the senior Staff Nurse/Charge Nurse.

9.10.1.8.Stock and balance of the Narcotic drugs are checked every shift verifying the Narcotic drug record and documented in the Narcotic drug checking notebook.

9.10.1.9. Two Registered Nurses are required while opening the Narcotic drug cupboard, taking out the narcotic drug, verifying, loading, administering, discarding the remaining dose and replacing the empty ampoule in the Narcotic Drug Account cupboard.

9.10.1.10. In areas where two nurses are not available during night, the staff has to bleep the night supervisor for administration of narcotic drug.

9.10.1.11. The drug is documented after administration in the Narcotic drug record with the details of the patient, hospital number, service, firm, quantity used, balance, amount discarded if

applicable, date and time with the name and signature of the two registered Nurses. (Administering and the witnessing nurse)

9.10.1.12. Loaded narcotic drugs should not be handed over to other health care team members or to the patients/patient relatives to be administered later.

9.10.1.13. The empty (vials/ampoules/containers) are kept in the Narcotic drug cupboard and are sent to the Narcotic drug section in pharmacy along with Narcotic drug requisition slip

9.10.1.14. Patients on narcotic drugs are monitored for side effects and managed appropriately

9.10.1.15. Side rails are put up to prevent falls.

9.10.1.16. Reorder from the pharmacy is done when all ampoules in one box is used up, checked and signed by the nurse who uses the last ampoule.

9.10.1.17. Unused medication loaded in syringes and accidentally broken ampoules are returned to NDA pharmacy with a written letter through the Head of the Department and the Nursing Superintendent.

9.10.2. Narcotics given as infusions:

9.10.2.1.Load 20 ml dilution instead of 50 ml in patients receiving low doses narcotic drugs as infusions (For eg: Fentanyl infusion rate<0.25mcg/kg/hr).

9.10.2.2.Stopping orders for narcotic infusions:

a) STOP and DISCARD: If this is written, the remaining infusion must be discarded immediately and documented in Narcotic drug record under amount discarded column by two registered Nurses - (discarding and the witnessing nurse)

b) STOP and RETAIN: The remaining infusion is discontinued and retained **in the syringe pump**. This is reassessed every 2 hours over a period of 8 hrs. & restarted as per order when the need arises**. If remaining infusion is not used over the period of 8hrs, it is discarded immediately as per policy.**

9.10.2.3. Purging of narcotic infusion to be done only on written order by the physician.

9.10.2.4. Discarding the remaining narcotic dose:

a) The remaining amount and dosage to be discarded should be flushed in the wash basin witnessed and documented in Narcotic drug record by two registered Nurses - (discarding and the witnessing nurse)

b) If the balance is Nil, it needs to be documented in the Narcotic drug record and signed by the assigned nurse and witnessing nurse.

9.10.2.5. When a patient is expected to get admitted to SICU, narcotics like Inj. Fentanyl or Morphine can be drawn prior to arrival of the patient based on the request of the senior doctor on the floor. This, preferably with benzodiazepine infusion drawn up prior to arrival will help in the smooth transition of ICU sedation while the patient is being settled in the ICU

9.10.3. Narcotics given as Bolus (Intubation/ Invasive procedures/Pain relief/ Palliation)

9.10.3.1. When opioids are used prior to procedures/intubation/palliation, any remaining narcotic drug in the syringe must be discarded within 15 minutes if not used. The balance amount should not be kept for further use.

9.10.3.2. Nurses are requested to counter check with the consultant if the ordered dosage for bolus administration is more than the usual dosage for a non-intubated patient.

9.10.3.3. Discarding the remaining narcotic dose:

a) The remaining amount and dosage to be discarded should be flushed in the wash basin witnessed and documented in Narcotic drug record by two registered Nurses (discarding and the witnessing nurse)

b) If the balance is Nil, it needs to be documented in the Narcotic drug record and signed by the assigned nurse and witnessing nurse.

Adult patients in the ICU or ward (Self-ventilated/not intubated scenario):

All doses should be titrated based on severity of illness, body weight and organ function. Most critically ill patients will need smaller doses and the drug may take slightly longer time for effect. The utmost caution to be taken in patients who are sick, on other medication like midazolam and dexmedetomidine and not on mechanical ventilator.

Acceptable dose for adults **(Self-ventilated/not intubated scenario):**

Drug	**Dosage (Infusion)**	**Dosage (bolus)**
Fentanyl	0.25 to 0.75 mcg/kg/hr	0.10 to 0.50mcg/kg, repeat after 5 minutes, max of two repeat doses
Morphine	0.03 to 0.15 mg/kg/hr	0.05 to 0.15 mg/kg, repeat after 5 minutes, max 2 repeat doses.
Ketamine	Sedation 0.2 to 0.5-mg/kg/hr Analgesia 0.05 to 0.15 mg/kg/hr	0.2 to 0.3mg/kg, repeat after 5 minutes

Paediatric patients in the ICU/wards

Drug	**Dosage (Infusion)**		**Dosage (bolus)**	
	Non- Ventilated	**Ventilated**	**Non- Ventilated**	**Ventilated**
Fentanyl	1-4 mcg/kg/hr	5-10 mcg/kg/hr	1-2mcg/kg	2-5mcg/kg
Morphine	5-10mcg/kg/hr	10-30mcg/kg/hr	0.1mg/kg/dose	0.1-0.2mg/kg/dose
Ketamine	1-2mg/kg/dose		1-2mg/kg/dose	

9.11. Policy on refund of medications:

Policy Statement: Refund for excess medications is done for patients following prescribed guidelines.

9.11.1. All unused / excess medications and consumables are returned once a week and as & when required to the Pharmacy for credit.

9.12. Drug Recall:

Policy Statement: In case of problems with drugs/ batches the drug recall follows the guidelines specified.

9.12.1. Pharmacy drug recall information is displayed on the intranet

9.12.2. Any issue related to drugs are reported to the pharmacy through the Nursing Superintendent. (e.g. Fungal growth in the IV bottle)

9.13. Preparing and administering chemotherapeutic drugs:

Policy Statement: Preparation and administration of chemotherapeutic drugs is done following prescribed guidelines

Pre-preparation

9.13.1. Patient's current height and weight are recorded on the patient's chart.

9.13.2. Body Surface Area (BSA) is calculated.

9.13.3. Absolute Neutrophil Count (ANC) is verified and documented.

9.13.4. Patient's lab reports are verified and checked for the approval of the physician.

9.13.5. Chemotherapy protocol is available in the patient chart

Preparation

9.13.6. The Nurse assigned to the patient is present throughout the preparation of cytotoxic drugs along with the clinical pharmacist / doctor to counter check the drug, dosage, route and dilution.

9.13.7. Cytotoxic drugs are prepared inside the biological safety cabinet (laminar hood) with appropriate personal protective equipment.

9.13.8. Drug is prepared and labeled by the clinical pharmacist / doctor and is counter signed by the Nurse assigned to the patient that day

9.13.9. All the materials which come into contact with the cytotoxic agents are discarded in yellow cover with the cytotoxic symbol and sealed.

Administration

9.13.10. Appropriate personal protective equipment is used.

9.13.11. Chemotherapy drugs are counter checked at the bedside with second Nurse and countersigned after administration.

9.13.12. Chemo-drug which is prepared by one Nurse is administered by another Nurse if the signature of the one who prepared is evident and handed over to the staff incharge. Counter checking by two Nurses is always mandatory.

Extravasations management

9.13.13. Chemotherapeutic agent is stopped immediately.

9.13.14. IV cannula is left in place.

9.13.15. Physician is informed.

9.13.16. Any residual drug from the cannula is aspirated

9.13.17. Anti-dote is prescribed as per protocol.

9.13.18. Extravasation is documented.

9.14. Adverse drug reaction reporting protocol:

Policy statement: All suspected adverse drug reactions are reported immediately online which is available in the intranet under bed management.

9.14.1. Suspected Adverse Drug Reaction (ADR) is reported to the Doctor.

9.14.2. Patient is monitored & doctor's order is followed in case of adverse reaction.

9.14.2. It is documented in the NURSE'S RECORD.

9.15. Reporting medication errors:

Policy statement: All medication errors are reported when identified within 24 hours to the Nursing Services Office.

9.15.1. Medication error is reported to the immediate Nursing supervisor and the doctor (Night – Night Supervisor, Weekend – Supervisors)

9.15.2. The patient is monitored and the doctor's order is followed, if any.

9.15.3. Incident report from is filled by the staff Nurse, the Charge Nurse, Nurse Manager and HOD.

9.15.4. The form is to reach the Office of the Nursing Superintendent within 24 hours of the incident.

9.16. Internal & External drugs: (Ward drug supplies)

Policy statement: The ward medications supplies are determined consultatively and maintained by the wards.

9.16.1. Ward medication supplies are determined by the Head of the unit, Nurse Managers (NM), Charge Nurses (CN) in consultation with the NS

9.16.2. Stock list is prepared and approved by HOD, NS and sent to the Pharmacy head

9.16.3. The approved list is made available on the intranet.

9.16.4. The Staff Nurse checks the medications every shift. (e.g. IV fluids and NDA)

9.16.5. This is counter checked by the Charge Nurse once a week

9.16.6. External medicine cupboard is checked every day.

9.16.7. In case of deficit/ near expiry medication, the Charge Nurse writes through the HOD and NS to the Pharmacy for replacement.

9.16.8. All Internal drugs are checked for expiry date by the CN once a month

9.16.9. Near expiry medications are returned to pharmacy for replacement 4 months before expiry date.

9.16.10 In high use areas like Emergency Department, ICU's, HDU's, Operation Room (OR) and Medical wards the high use medications are kept till the expiry date, and then the expired items to be sent to pharmacy and disposed as per policy.

9.17. Dispensing Error:

Policy statement: Any problem pertaining to the medications procured from pharmacy is intimated immediately to the pharmacy

9.17.1. Any dispensing error is reported as sentinel event

9.17.2. Other problems related to medications dispensed are intimated through Nursing Superintendent.

9.18. High Risk Medication:

Policy statement: All high risk medications are maintained in the ward with care

9.18.1. High risk medications list prepared by the pharmacy is displayed in all the wards

9.18.2. All Nurses are aware of the high risk medications

9.18.3. The high risk medications are stored in a cupboard marked as 'High Risk Medications'

9.18.4. The medications which are kept in the refrigerator should follow the manufacturer's guidelines

9.18.5. High risk medications are double checked by administering nurse & the verifying nurse before and during administration of the medication.

This is applicable for the below category of medication:

1. Adrenergic agonists IV: adrenaline, dobutamine, dopamine, ephedrine, isoprenaline, noradrenaline, phenylephrine
2. Adrenergic antagonists IV: esmolol, labetalol, metoprolol
3. Anaesthetic agents: general - inhaled and IV (e.g., ketamine, propofol)
4. Antiarrhythmics IV: adenosine, amiodarone, lignocaine
5. Anticoagulants:
   - dalteparin, enoxaparin, IV heparin, nicoumalone, warfarin
   - Factor Xa inhibitors: apixaban, fondaparinux, rivaroxaban
   - Direct thrombin inhibitors: dabigatran etexilate
   - Thrombolytics: alteplase, reteplase, streptokinase, tenecteplase
6. Cardioplegic solution
7. Chemotherapeutic agents: oral and parenteral
8. Dextrose hypertonic: 25% and 50%
9. Dialysis solutions: haemodialysis and peritoneal
10. Epidural or intrathecal medications
11. Inotropic medications IV: digoxin, levosimendan, milrinone
12. Insulin: subcutaneous, IV, IM
13. Liposomal drugs: liposomal amphotericin B, doxorubicin
14. Moderate sedation agents IV: dexmedetomidine, midazolam, lorazepam
15. Narcotic drugs IV, transdermal, and oral: fentanyl, morphine, pethidine
16. Neuromuscular blocking agents: atracurium, cisatracurium, pancuronium, rocuronium, sux-amethonium, vecuronium
17. Oral sedation agents for children: triclofos sodium
18. Sodium chloride for injection, hypertonic: 3%
19. Sterile water for injection, inhalation, irrigation (excluding pour bottles): 100 mL or more
20. Sulfonylurea oral hypoglycaemics: glibenclamide, gliclazide, glimepiride, glipizide
21. Total parenteral nutrition (TPN) solutions

Specific Medications

1. Magnesium sulphate: IV/IM
2. Methotrexate oral non-oncologic use: e.g. lupus, psoriasis, severe rheumatoid arthritis
3. Nitroprusside sodium: IV
4. Oxytocin: IV
5. Potassium Chloride: IV
6. Potassium Phosphate: IV
7. Promethazine hydrochloride: IV/IM
8. Thiopentone sodium: IV
9. Vasopressin: IV/intraosseous

Ref: https://www.ismp.org/tools/highalertmedications.pdf (Above List updated July 2023)

9.19. Look alike sound alike medications:

Policy statement: All look alike and sound alike medications are maintained in the ward with utmost care.

9.19.1. The list of lookalike and sound alike (LASA) medications stored as ward stock is prepared by the respective wards based on the global list on the intranet.

9.19.2. The LASA medications are stored in separate boxes identified with eye or ear pictures as appropriate. These are kept physically apart from each other in racks preferably one below the other inorder to avoid mix up.

9.19.3. All Nurses in the respective wards are aware of the look-alike and sound alike medications in the respective wards

9.19.4. Double checking is done for all the look alike and sound alike medications before, during and after administering to the patients

9.19.5. Addition of new LASA medications are reported whenever there is a change in the global list.

9.20. Reconciliation of medication

9.20.1. Reconciliation of medications occur at transition points such as admission, transfer from one unit to another and discharge

9.20.2. At the time of admission, the medication taken by patients previously is documented in the initial assessment form

9.20.3 At the time of transfer, oral report of medication is handed over by the assigned staff nurse of the transferring unit to the transferred unit

9.20.4. At the time of discharge, details of medication is printed in the discharge summary and explained by the assigned staff nurse.

9.21. Medication requiring close monitoring

Policy Statement: Patients are monitored during medication for safe administration of the drug, to identify the effect of the drug, and to capture adverse drug events.

- This is applicable for administration of high risk medications, electrolytes and chemotherapeutic drugs such as:

1. Narcotics

Inj. Morphine: Respiratory rate is monitored before administration. The drug is withheld if the rate is < 16/mt.
Other Narcotics: Vital signs are monitored every 4 hours.

2. Inotropes

Patient will be connected to monitor and the vital signs are documented every hour.

3. Psychotropes

Patient vital signs are monitored every hour and documented.

4. Antihypertensive infusions

Patient will be connected to monitor and the vital signs are documented every hour.

5. Chemotherapeutic drugs

Patients on first dose / cycle of chemotherapy are monitored every hour and those on subsequent injections are monitored before and at the completion of infusion.

6. Electrolytes

Patients on concentrated infusions such are monitored every hour and those on diluted infusions are monitored every 4 hours.

9.22. Cut strips medications:

9.22.1. Medication in strips should have the name of the medication, expiry date, dose & batch number. In case of a single tablet / strips that has been cut it needs to be kept in the pharmacy cover with the necessary information over it.

9.23. Medications left by patients in the ward:

9.23.1. Medications that are left by patients such as tablets, capsules, ampules, vials, etc. in the wards are directly discarded in the yellow bag on the same day.

10. VULNERABLE PATIENT CARE

10.1. Vulnerable patients:

Policy Statement: Patients susceptible to physical or emotional injury are considered vulnerable while in the hospital.

10.1.1. Patients are considered vulnerable when one or more of the following criteria is present:

- Age < 16 years, > 65 years
- Pregnancy
- Vision impaired
- Hearing impaired
- Neurological deficit
- Mentally challenged
- Physically challenged
- Impaired balance
- Suicidal risk
- Violent behavior
- Critically ill
- On sedations

10.1.2. Vulnerable patients are identified on admission and documented in the Nursing assessment and admission record.

10.1.3. Fall risk assessment is done every shift and the score and intervention is documented in the patient monitoring record

10.2. Care of vulnerable patients:

Policy Statement: Vulnerable patients receive special assistance and care throughout their stay in the hospital.

10.2.1. Vulnerable patients are identified on admission and documented in the Nursing assessment and admission record.

10.2.2. Psychosocial needs of vulnerable patients are assessed by the Nurse and appropriate interventions are taken

10.2.3. Measures are taken to prevent pressure ulcers or immobilize vulnerable patients according to the policy

10.2.4. Measures are taken to prevent physical assault by visitors, other patients and health care workers

10.2.5. Patients and family members are educated by the medical and nursing staff on safety and security measures

10.2.6. Informed consent is obtained as per hospital policy

10.2.7. Pink identity tag is applied on the hand of the vulnerable patients

11. POLICIES ON PATIENT FALL MANAGEMENT

11.1. Fall risk assessment and documentation:

Policy Statement: All patients admitted in the hospital are assessed for fall risk within 2 hours of admission and subsequently as per the policy.

Initial Assessment

11.1.1. The risk for falls is assessed for all patients using the "Fall risk assessment tool" (Modified Morse Fall score- for adult & Humpty Dumpty Scale – for Neonates & Paediatrics) within 2 hours of admission and documented in the Nursing assessment and admission record.

11.1.2. The subsequent score is documented within 2 hours in the patient monitoring record.

11.1.3. The score is interpreted as follows:

- No risk (0) - Assess every day.
- Moderate risk (1 – 5) - Assess at the beginning of every shift
- High risk (6 – 10) - Assess every 4 hours

11.1.4. Reassessment is done every day and whenever the patient's condition changes (GCS alteration, tremors, convulsions, Hypoglycemia, Unresponsiveness etc.) if patient is at 'No risk'.

11.1.5. Vulnerable patients are considered as high risk patients and are monitored every 4 hours and the score and intervention is documented in the patient monitoring record.

11.1.6. If the patient is at risk of fall, the patient's attendants and patient assistants are instructed about

- Getting help for mobilization of patients.
- The risk and preventive strategies for fall
- The importance and use of side rails is reinforced

11.1.7. If the patient is at risk of falls, additional need for restraints is assessed and all safety measures are ensured.

11.2. Fall incident management:

Policy statement: All patients after falls are managed immediately according to the policy

11.2.1. The patient is shifted back to the bed

11.2.2. Vital signs and mental status are monitored

11.2.3. The patient is assessed for any external and internal injury

11.2.4. The fall incident is reported to the duty doctor and shift incharge and prescribed orders are carried out after the doctor examines the patient.

11.2.5. Comfort of the patient is ensured.

11.2.6. Psychological support is provided to the patient and family

11.2.7. The event interventions and the care given are documented in the Nurse's record.

11.3. Fall incident reporting:

Policy statement: All patient falls are reported to the Nursing Service within 24 hours of the incident.

11.3.1. The assigned Nurse / Charge Nurse completes the 'Accident report 'form.

11.3.2. The shift incharge reports to the Nurse Manager immediately during the day and Night Supervisor during the night.

11.3.3. Any fall causing major event/hospitalization is made as sentinel event.

12. PATIENT RESTRAINT MANAGEMENT

12.1. Physical restraints:

Policy statement: Physical restraints are applied on patients only if the situation warrants.

12.1.1. Restraints are applied only if patients exhibit restlessness, non-cooperation with intervention/treatment, aggressiveness, and risk of harm to self/others.

12.1.2. The Restraint agreement is concurred by two healthcare professionals (Doctor & Nurse / Nurse & Nurse)

12.1.3. Physical restraint agreement is valid only for 24 hours.

12.1.4. The restraint agreement is reviewed every day.

12.2. Consenting for physical restraints:

12.2.1. The patient's attendant/ patient is explained the need for the physical restraint

12.2.2. Written Consent is obtained by the Doctor or Nurse

12.2.3. Written consent is obtained from the care giver/ next kin/closest patient's attendant

12.2.4. Written Consent is valid only for 24 hours and is renewed every day.

12.2.5. Refusal of patient/ patient's attendant to give consent is reported to the doctor and documented.

12.3 Restraint monitoring:

12.3.1. Monitoring is done and documented every 2 hours in the Restraint Monitoring Form.

12.3.2. The restraint is discontinued when no longer required.

12.3.3. In-service education is held every year to educate Nurses on restraints

12.3.4. All restraint related injuries are reported to the Nursing Superintendent office within 24hrs.

12.4 Chemical restraints:

Policy statement: Chemical restraints are administered as per policy

12.4.1. The doctor prescribes appropriate medication if the patient is at the risk of harming himself / herself / others

12.4.2. The patient's attendants are informed about the need for chemical restraint by the Doctor

12.4.3. Monitoring and documentation is done in the chemical restraints form

12.4.4. The effectiveness of the medication is assessed and documented every 2 hours

12.4.5. Restraint order is valid only for 24 hrs and re-order is obtained when needed.

12.4.6. In-service education is held every year to educate Nurses

13. PAIN ASSESSMENT AND MANAGEMENT

Policy statement: All patients admitted in the hospital are assessed for pain and necessary interventions are carried out.

13.1. Pain Assessment:

13.1.1. Pain assessment is completed within the first two hours of admission and documented in the Nursing assessment and admission record using Wong Baker Scale – for adults and Neonatal infant pain scale for neonates & children.

13.1.2. Allergy to any pain medication is documented in the Nursing assessment and admission record.

13.1.3. All patients are assessed at least once during each shift for pain using the appropriate Pain Assessment Scale and the score and intervention is documented in the patient monitoring record.

13.1.4. The pain score and interventions are interpreted as follows:

- 1 – 3 : Mild pain
- 4 – 6 : Moderate pain
- 7 – 10 : Severe pain

13.1.5. When the pain score is over 3, inform physician

13.1.6 Patients with pain are reassessed 4 hourly for pain (except while patient is asleep)

13.1.7 Pain assessment for patients receiving specific analgesic modalities such as Epidural infusion and patient controlled analgesia are to be consistent with the route and type of analgesia and the findings are documented in the 'Acute Pain Services (APS) sheet'(Applicable in areas where APS is available)

13.1.8 Patient on epidural analgesia and patient controlled analgesia are assessed for pain on arrival from OR / initiation of infusion, first hour, and thereafter every 4 hours. (Applicable in areas where APS is available)

13.1.9 Patients on intrathecal dosifuses and continuous nerve block catheter are to be assessed for pain on arrival from OR / initiation of infusion and thereafter every 4 hours (Applicable in areas where APS is available)

13.1.10 Patients receiving bolus through epidural or nerve block catheter are to be assessed for pain after bolus and then every 30 minutes for one hour (Applicable in areas where APS is available)

13.2. Pain Management:

Policy statement: Pain management is done through pharmacological & non-pharmacological interventions.

9.10.11.The pain management options are discussed with patient, family or care givers.

9.10.12.Non-pharmacological & pharmacologic interventions are initiated to alleviate pain immediately following the assessment.

9.10.13.The Doctor is notified when any type of prescribed pain management regimen is not effective in relieving patient's pain

13.2.4. Changes are made in the treatment in consultation with the physician.

13.2.5. Patient is re-evaluated within an appropriate time frame until pain is tolerable

13.3. Reassessment of pain:

13.3.1. Re-assessment for pain after pharmacological intervention is consistent with the type of the medication and route of administration

13.3.2. Oral / Rectal / Intra Muscular / Subcutaneous / Trandermal / Topical applications - within 30-45 minutes after administration.

13.3.3. IV medication - within 15-20 minutes after administration

13.3.4. Cardiac pain - every 05 minutes (whenever the treatment prescribed warrants the use of nitrates or intravenous medication to manage pain)

13.3.5. Reassessment for pain after non pharmacological intervention is done for every one hour and documented in the daily nurses care record.

13.4. Documentation of Pain Management:

Initial assessment of pain is documented in the Nursing assessment and admission form and subsequent pain assessment is documented in the patient monitoring record.

14. POLICIES ON BLOOD AND BLOOD PRODUCTS

Policy Statement: Blood and blood products transfusion is governed by the policies prescribed by the Department of Transfusion Medicine. Handling of blood and blood product in the clinical area is the responsibility of the Doctor and Nurse.

14.1. Blood transfusion policy and consenting:

14.1.1. Informed consent for blood transfusion is obtained in the 'blood transfusion consent form' by the Doctors. Consent revalidation is obtained by the registered Nurse where standing order permits to initiate the transfusion.

14.1.2. Initiating transfusion of blood & blood products is the responsibility of the Doctor except in areas where Standing orders permit the Nurses to initiate.

14.1.3. The blood component details on the bag and tag is checked by two health care personnel (on**e** of whom should be a doctor) before transfusion and is documented by the registered Nurse.

14.1.4. Patient's name and hospital number on the patient's ID tag is checked and counter checked with the bag.

14.1.5. The Doctor's order for transfusion is verified by the registered Nurse.

14.1.6. Blood is connected only by the Doctor and can be assisted by a Nurse.

14.1.7. Blood is connected by two 'privileged' registered Nurses.

14.1.8. Pre-transfusion vital signs monitoring by the Nurse is mandatory.

14.1.9. Monitoring is done by the Nurses every 15 minutes for the first hour and every hourly till the transfusion is complete and also one hour after transfusion is complete.

14.1.10. Documented in the transfusion monitoring record.

14.2. Transfusion Practice:

Policy Statement: Blood and blood products are transfused according to the policy

14.2.1. Blood and blood components are not to be stored in the ward refrigerator and should be transfused within 15 minutes after arrival to the ward.

14.2.2. The blood or blood product should be brought to room temperature prior to transfusion.

14.2.3. Blood is not warmed, kept in water or left unattended prior to transfusion.

14.2.4. Fresh frozen plasma (FFP) units are thawed in the blood bank on request.

14.2.5. Platelets are transfused immediately. If not, it is agitated manually until the transfusion is initiated.

14.2.6. Multiple units of platelets are transfused one at a time.

14.2.7. Medications / chemicals are not added to the blood / blood product

14.2.8. The bag is checked for clots, turbidity or haemolysis prior to transfusion.

14.2.9. The product is returned to the Blood Bank after informing if the product is not found suitable for transfusion

14.2.10. Documentation is done in the Transfusion Monitoring Record as per procedure.

14.3. Adverse Transfusion Reaction:

14.3.1. Once the blood is connected the patient is monitored for acute transfusion reactions by the Nurse

14.3.2. Any discomfort like fever, chills, breathlessness, back pain, chest tightness, purities, dark colored urine or any oliguria / anuria is reported. The patient / family / care giver is asked to bring to the notice of the Nurse or doctor if any of these symptoms occur.

14.3.3. If any reaction occurs, the transfusion is stopped immediately and the Doctor is informed and ensured the patient is stabilized.

14.3.4. Transfusion reaction form is obtained and filled by the Doctor and sent to the blood bank along with the patient's blood and urine sample, remaining blood product along with the Blood Giving set

14.3.5. The doctors from the Blood Bank investigate the reaction according to the departmental procedure. Besides the hematological tests, blood of the patient and the donor are subjected to biochemical and microbiological tests.

15. PRESSURE SORE PREVENTION, ASSESSMENT AND MANAGEMENT

15.1. Pressure sore prevention, assessment, monitoring and documentation:

Policy Statement: All patients are assessed for the risk of pressure sores within two hours of admission and prevention measures are taken appropriately.

15.1.1. All patients are assessed for risk of pressure sore within two hours of admission using the skin care assessment and monitoring form (Norton Scale / Braden scale).

15.1.2. The risk score is documented in the Nursing assessment form

15.1.3. Preventive measures are taken when score indicates risk.

15.1.4. Reassessment is done every 2 hours for at-risk patients using the skin care assessment and monitoring form

15.1.5. Reassessment is done for pressure sore whenever patient condition changes.

15.2. Management of developed pressure sore:

Policy statement: All patients with developed pressure sore are managed according to the policy.

15.2.1. In the event of pressure sore development, it is reported to the doctor on call and pressure sore management strategies are followed as per guidelines.

15.2.2. The pressure sore report form is filled by the Staff Nurse, endorsed by the Charge Nurse /Nurse Manager and sent to the Office of the Nursing Superintendent within 24 hours.

15.2.3. Care of Pressure sore and the progress of healing is monitored by the Staff Nurses and documented in the daily nursing care record (width, length & staging of pressure ulcer, the amount of exudate, and tissue type.) during bath/ back care/ positioning.

15.2.4. Pressure sore is monitored by the Nursing Staff from Nursing Service once in three days, using PUSH Tool (Pressure Ulcer Scale for Healing) which monitors width, length & staging of pressure ulcer, the amount of exudate, and tissue type.

15.3. Management of pressure sore on admission:

Policy statement: All patients admitted with pressure ulcer are managed according to the policy.

When patients with pressure sore are admitted, the PRESSURE SORE REPORT FORM is filled by the Staff Nurse endorsed by the Charge Nurse /Nurse Manager and sent to the Office of the Nursing Superintendent within 24 hours.

16. MANAGING SPILLS

Policy Statement: All spillages are managed as per policy

16.1. Medication Spillage:

16.1.1 Instruct the Hospital House Keeping Attendant to clean any medication spillage on the floor with any detergent and water followed by mopping the area.

16.1.2 Any spillage on electronic equipment need to be cleaned as per manufactures' instructions.

16.1.3. Medications spillage on the trolleys can be washed with running water.

16.1.4. Any medication that causes stains in the linen should be soaked immediately in the water.

16.2. Other spillages:

16.2.1. Chemical spill, Blood spill and Chemo therapeutic drugss spillage follow special protocols.

17. PATIENT HEALTH INFORMATION

17.1. Patient health education

Policy Statement: Nurses follow the guidelines in providing health information and preparing preventive plan of care as applicable.

17.1.1. Daily plan is made. All patients are educated on the topics such as nutrition, medication,, preventive plan of care, immunization (as indicated) and patients' rights/ responsibilities

17.1.2. Health education is given in a language that patient understands.

17.1.3. Other topics of teaching relevant to the clinical condition of patients are planned and carried out.

17.1.4. Feedback is obtained

17.1.5. Documentation is done in the patient health education form.

17.2. Health education on Medication

Policy statement: All patients and patient's attendants are educated about the medications prescribed to them.

17.2.1. Nurses provide the following information

- Name of the medication
- Purpose of the medication
- Frequency of administration
- Route of administration
- Action and possible side effects
- Special instructions if any (e.g. Insulin with food)
- Food drug interaction
- Compliance as required

17.3. Nutrition and Diet Education- (Normal & Therapeutic Diet):

Policy statement: Patients and family members are educated on the availability of hospital diet and the importance of well-balanced / therapeutic diet.

17.3.1. All patients on normal diet are given information about well-balanced diet (pamphlet is provided)

17.3.2. The patients requiring therapeutic diet are encouraged to take hospital diet / follow the dietary instructions.

17.4. Patient Safety:

Policy statement: Patients are educated about their safety in the Hospital.

Information is given on the following:

17.4.1. Physical safety (Prevention of Falls & Accidents in the ward)

17.4.2. Environmental safety (use of cleansing agents, wet floors)

17.4.3. Food safety and hygiene

17.4.4. Medication safety

17.4.5. Care of valuables and belongings

17.4.6. Reporting on thefts / accidents

17.4.7. Fire safety (No Smoking Policy within the Hospital Premises etc.)

17.5. Special procedures:

Policy Statement: Patients are educated about the pre and post procedural care and monitored according to the policy.

17.5.1. Patients are reinforced on need for the procedure, Schedule for the procedure, pre procedural care, post procedural care, observation for specific complications and self-monitoring at home.

17.5.2. Ensure informed written consent is obtained for all invasive procedures performed in the in-patient and out-patient area.

17.5.3. Patients are monitored at four points such as pre procedure, immediately after procedure, 30 minutes and 60 minutes following the procedure.

17.5.4. Patients who are unstable after 60 minutes following the procedure will be continued monitoring for every 30 minutes until stable

17.5.5. Documentation should include the following

- Date of the procedure
- Time of the procedure
- Name of the doctor performing the procedure
- Condition and cooperation of the patient
- Vital parameters of the patient (before, immediately after, 30 minutes and 60 minutes following the procedure)
- Signature with employment number of the staff assisting

17.5.6. Documentation will be done in the nursing care plan and documentation record or the monitoring record.

17.6. Patient Rights:

Policy statement: All patients are informed about their rights at the time of admission according to the policy.

Patients are informed that they have the right to

17.6.1. Be treated with dignity, respect, consideration of their individual values and belief and privacy during examination, procedures and treatment.

17.6.2. Be protected from physical abuse or neglect.

17.6.3. Refuse treatment.

17.6.4. Confidentiality of all records and communications, to the extent provided by law.

17.6.5. Participate in decisions about their care and provide informed consent.

17.6.6. Be informed of the estimated costs of proposed treatment.

17.6.7. Access to information contained in the Medical Record in the form of a Medical Report / Discharge Summary.

17.6.8. Voice their concerns and complaints with the Patient Advocacy Cell of the Medical Superintendents Office.

17.6.9. Have the appropriate family member eligible to all the above rights, in case the patient is unable to meaningfully participate in his / her care.

17.6.10. Have the right to ask for second opinion.

17.7. Responsibilities of Patients:

Policy statement: All patients are informed about their responsibilities according to the policy

Patients are informed about their responsibility to

17.7.1. Provide accurate and complete information about their health condition.

17.7.2. Follow the treatment plan recommended by the treating Doctor.

17.7.3. Accept responsibility for their actions if they refuse treatment.

17.7.4. Preserve and produce all the records of their illness.

17.7.5. Accept responsibility for the safekeeping of their valuables and possessions.

17.7.6. Abide by the rules and regulations of the hospital including the "No-tobacco Campus Policy".

17.7.7. Be considerate of the rights of other patients and CMC personnel by assisting with the control of noise, cleanliness and number of visitors.

17.7.8. Respect the property of others and that of CMC.

17.7.9. Provide honest information concerning their ability to pay for services and pay bills in time if they have agreed to do so.

17.7.10. Provide useful feedback about services and policies.

17.7.11. Treat all healthcare workers with respect.

17.7.12. Abide by all applicable National, State and Local laws.

17.8. Immunization:

Policy statement : Patients and family are educated about the need of immunization and the avavilability of vaccines (Streptoccocal pneumonia,Influenza, Enteric fever, Hepatitis B, Nisseria meningiditis and Covid)

17.9 Health care associated infections:

Policy statement : Patients and family are educated about preventing Health acre associated infections

17.9.1. Hand hygiene
17.9.2. Avoidance of overcrowding
17.9.3. Personal hygiene
17.9.4. Waste disposal

17.10. Disease process:

Policy statement : patient and family are educated about their specific disease condition, complications and prevention strategies

17.11. Pain Management:

Policy Statement: Patient / family / care giver / patient care assistant are explained about pain management and documented in the daily nursing care record

18. PERIOPERATIVE CARE

Policy Statement: All patients undergoing surgeries receive safe nursing care to prevent adverse incidents during pre-operative, intra-operative and post-operative period.

18.1. Preoperative care:

18.1.1. Nurse ensures that an informed consent for surgery is obtained by the surgeon

18.1.2. Nurse ensures that the correct patient, site and side of surgery is verified and confirmed.

18.1.3. Patients are prepared for surgery and preoperative checklist is completed

18.1.4. Patients and families are informed of the surgery, anesthesia, pre-operative and the post operative care

18.2. On the day of surgery:

18.2.1. Nurse ensures that the pre-operative care, preoperative component of surgical safety check list and pre-operative (On the day of surgery) checklist is completed.

18.3. Intra-operative care:

18.3.1. Registered Nurses function as scrub and circulatory Nurses for surgery

18.3.2. Holding bay nurse carries out sign-in phase I procedure to identify the correct patient for surgery.

18.3.3. Circulating and scrub nurse along with the surgical team carries out sign in Phase II time-out, surgical pause and sign-out phase I to confirm the identity of the patient, including the correct side, site, and surgical procedure.

18.3.4. Nurse ensures safety while handling equipment, instruments, sponges, gauze, cotton, and specimens.

18.3.5. Documentation is carried out as per the perioperative record and surgical safety checklist

18.3.6. Post anesthesia care unit (PACU) nurse carries out sign out phase II following dis charge from the PACU on advice of concerned Anesthetist.

18.3.7. The PACU Nurse transfers the patient to the ward Nurse with significant reports.

18.4. Post-Operative Care:

18.4.1. Patients are provided post-operative care based on the type of surgery and is documented

18.4.2. Patients after surgery are closely monitored during the immediate post-operative period and any sign of complication identified is promptly reported to the concerned unit surgeons.

19. NUTRITION AND DIET REQUIREMENTS OF PATIENTS

Policy statement: The nutritional needs of all patients are assessed, planned and met in collaboration with concerned health care team members considering their therapeutic requirements and preferences.

Patients preferring self-diet is provided information on well-balanced diet/ therapeutic diet. 19.1. All patients getting admitted to the ward is informed of the availability of hospital diet, the options available and the cost.

19.2. Nurse orders diet according to the patient's therapeutic requirements and their preferences.

19.3. All patients, on admission are provided an information sheet on well-balanced diet.

19.4. External feeds are refrigerated till use and is handled in safe and hygienic manner.

19.5. Dietary intake of patients is documented.

19.6. A fluid plan is to be prepared for all patients requiring fluid restriction

19.7. Diet order is to be placed online during the following timings:

– Breakfast - Before 5.00 AM

– Lunch & Tea- Before 10.30 AM

– Dinner - Before 04.30 PM

19.8. For meals requested after the serving time for breakfast / lunch / dinner – only bread, butter, jam and milk is served.

19.9. For those on normal diet the non- vegetarian items are served only during lunch time. Non – Vegetarian items can be served at dinner on prior information and on additional charge.

19.10. Diet order can be changed or cancelled online at patient's request or as per changing therapeutic requirement

19.11. Patients receiving hospital diet will be visited by the dietitian to obtain feedback from patient and to provide dietary advice.

19.12. Diet cancellation of the diet has to be sent to the Dietary Department before 10.30 AM for adjustment in the charges. Cancellations sent after 10.30 AM will carry the entire days' diet charges.

20. INVENTORY MANAGEMENT

Policy statement: Equipment/ supplies are maintained as per the assessed clinical requirement through periodic indenting, inventory, inspection, calibration, condemnation and replacement.

20.1. Metal equipment and furniture:

20.1.1. Inventory is done twice a year (February and August) by the Charge Nurse and the ward clerk. Items as Stretcher/ OR trolley and wheel chairs are checked every day. Repairs are addressed immediately by sending the online job request to the mechanical engineering department.

20.2. Electronic equipment:

20.2.1. It is checked every day by the Technician/Staff Nurse

20.2.2. Defibrillator should be charged continuously and checked for its functioning every shift and documented.

20.2.3. Online job request is sent for any identified repairs and the equipment is sent to the electronic department through the hospital attendant.

20.2.4. Preventive maintenance is done by the electronics department as per schedule.

20.2.5. Calibration of electronic items is done once a year and record is maintained for the same.

20.3. CSSD items:

20.3.1. CSSD Items are inventoried every shift by the Staff Nurse/MPHW/Hospital Auxiliary of the respective wards

20.3.2. Items are checked for expiry date, sterility and shelf life and replacement is obtained as required.

20.3.3. CSSD inventory is done twice a year (February and August) for the institution

20.3.4. CSSD recall is done by providing information on the intranet with specifics of items to be recalled.

20.4. Linen

Linen inventory is done twice a year in the institution and replacement of lost linen is done through Nursing Service**.**

21. ISSUES IN WARDS

21.1 Handling patient complaints:

Policy statement: Patients' complaint is a valuable form of quality improvement exercise and is taken seriously and handled with utmost care.

21.1.1. Any serious complaint is brought to the notice of Charge Nurse and Nurse Manager who listen, talk to the patients and amicably address the complaint.

21.1.2. If unresolved the matter is taken to the Head of the Department and the Nursing Superintendent through the Nurse Manager

21.1.3. If the issue is related to the medical department, it is communicated to the Medical HOD/ Senior Consultant. .

21.1.4. Patient can also be sent to the patient advocacy cell attached to the MS office which will process all the complaints.

21.1.5. Subsequently, a written incident report is sent to the Nursing Superintendents office through proper channel of communication.

21.1.6. Written or oral complaints are received at any of the following points - OPD receptions, MRO counter, Departmental offices, Medical Superintendents office, Nursing Superintendents Office, Directors Office, Ward Nurses stations, General Superintendents office, Feedback/ Complaints boxes, Theatre desk, Security office, Quality Management Cell - Feedback forms.

21.1.7. The concerns and complaints of patients and families are always heard in a nonjudgmental manner and measures are taken to analyze and rectify them. Patients are encouraged to report their grievance in writing as it serves as a record to collate and analyze systems.

22. REPORTING INCIDENCES

Policy statement: Prompt identification and reporting of incidence and adverse events aid in root cause analysis and enhance quality of patient care through systems improvement.

22.1. List of sentinel events:

The following are considered as sentinel events and are to be reported online immediately:

Event	Incidences	Reported by
Surgical	Surgery performed on the wrong body part	OR Nursing/ Surgical Nursing
	Surgery performed on the wrong patient	OR Nursing/ Surgical Nursing
	Surgery performed on wrong side	OR Nursing/ Surgical Nursing
	Wrong surgical procedure performed on the wrong patient	OR Nursing/ Surgical Nursing
	Retained instruments in patient discovered after surgery procedure	OR Nursing/ Surgical Nursing
	Patient death during / within 24 hours of the surgical procedure	OR Nursing/ Surgical Nursing
	Anesthesia related event including spinal complications	OR Nursing
Patient protection	Discharge of an infant to the wrong person	All nursing departments
	Absconding patients	All nursing departments (existing protocol)
	Any fall causing incidents/ injuries	All nursing departments
	Patient suicide, attempted suicide, or deliberate self-harm resulting in serious disability	All nursing departments
	Intentional injury to a patient by a staff member, another patient, visitor, or other	All nursing departments
	Any incident in which a line designated for oxygen or other came to be delivered to a patient and contains the wrong gas or is contaminated by toxic substances	All nursing departments
	Accidental self-extubating or tube block leading to hypoxic sequelae	All nursing departments
	Accidental catheter and drain removal	All nursing departments
Environmental	Maternal death or serious disability associated with labour or delivery in a low-risk pregnancy	Maternity Nursing
	Neonatal hypoxic injury during labour	Maternity Nursing
	Unexpected cardiac arrests in the ward	All nursing departments

Criminal	Abduction of a patient: adult/child	All nursing departments
	Physical assault (Patient/staff)	All nursing departments
	Sexual assault on a patient within or on the grounds of health care facility	All nursing departments
General	Fire	All nursing departments (existing protocol)
	Mob violence	All nursing departments (existing protocol)
	Any other anticipated incidents	All nursing departments (existing protocol)

22.1.1. Any of the above sentinel events has to be reported using online form with required details.

22.1.2. Sentinel events should be reported within 24 hours

22.2. Abduction in wards:

Policy statement: Any abduction in the ward is identified and addressed immediately and appropriately.

22.2.1. Any event of abduction noticed by the Staff Nurse is immediately informed to the security service with leading detail.

22.2.2. The event is documented and reported to concerned health team members.

22.2.3. Inform this as sentinel event.

22.2.4. Child abduction is considered as Code pink (To refer QMC Safety Cell policy)

22.3. Absconding patients:

22.3.1. When a Staff Nurse identifies that a patient has absconded, the incident is documented and reported immediately to security office and the concerned health team members.

22.3.2. The completed absconded patient report form is sent to MS office and security office through NSO within 24 hrs. Copies of the report goes to Medical records Office and Treasurer's office.

22.3.3. The IP bill is settled through the medical HOD of the unit.

22.3.4. If the patient is found, inform all concerned team members.

22.3.5. Document the event in the patient's chart.

22.3.6. During night, the event is reported to the Night Supervisor.

22.4. Theft in wards:

Policy Statement: When a Staff Nurse identifies a theft in the ward, the incident is documented and reported immediately to security office and a completed theft report form is sent to MS and security office through NSO.

22.5. Conflict Management:

Policy Statement: Any conflict between patients or health team members is identified and addressed immediately to promote a safe working environment.

Conflict between patients

22.5.1. The event is brought to the notice of Charge Nurse, Nurse Manager or the in- Charge Nurse who enquires both the parties on the reason for the conflict in a composed manner and attempt to solve the issue amicably.

22.5.2. Security officer is informed

22.5.3. If not resolved, inform the HOD through the Charge Nurse and Nurse Manager

22.5.4. If there is any physical assault, the unit doctor, Nursing HOD and the security officer is informed immediately. The incident is then reported as sentinel event.

22.5.5. Any treatment needed is initiated and managed by the team.

22.5.6. Document the event in the chart

22.5.7. An incident report is sent to the Nursing Superintendent within 24 hours

Conflict between patient and staff

22.5.8. Efforts are taken to resolve the issue

22.5.9. Inform the security office and get the help of the security personnel in the ward.

22.5.10. Inform the Charge Nurse/ Nurse Manager/ HOD

22.5.11. Enquiry about the conflict is done by the CN/ NM and the security officer

22.5.12. Incident report is sent to the Nursing Superintendent within 24 hours.

22.6. Fire (To refer QMC Safety Cell policy):
Policy Statement: Any fire in the ward will have to be immediately addressed.

22.6.1. In case of a minor fire, try to put off the fire using the extinguisher in the ward.

22.6.2. Immediately contact the fire officers and inform the following:

- Event
- Location
- Your identity
- Do not panic. Handle the situation appropriately.
- Contain the fire
- Activate fire officer
- Evacuate if necessary

22.7. Lost and found items:

22.7.1. Separate registers are maintained in Wards, Receptions PRO, OPD, offices and theatres with the following details: Date, Item, and Description, Name of the finder, time, Room No/ area of finding the item etc.,

22.7.2. PRO maintains the master lost and found register

22.7.3. Collection Points:

- Wards: Any item found in the room/bed after discharge or in the public areas in wards is to be deposited in the reception with PRO.
- OPD: Items collected in the OPD should be deposited in the respective Receptions.
- Offices: To be deposited in the PRO
- Theatres: To be deposited in the Theatre control desk.
- Common areas: In the main security
- Items received to be entered systematically in the Lost and Found register of the respective areas.
- Lost and Found items are placed in transparent plastic bags for easy recognition of items. The lost and found slip is kept inside the bag with relevant details like place of finding the item, date, item description, name of the finder etc.
- The item is kept locked in the cupboard for lost and found items. Each collection point should have a designated lost and found cupboard.

- In case of credit cards, cash/ jewelry, mobile phones left behind by the Patient / Attendant and if the identity is known, effort must be taken by the respective areas to track the person and handover the item.
- In case a patient claims for his items, the same is handed over to him by following a proper verification process.
- The signature of the patient is taken on the relevant page in the Lost and Found register.
- The items will be held under the custody of the Public Relations Officer (PRO) for a period depending on the value of the item.
    - Valuable items for 6 months
    - Non- Valuable for 3 months
- If the finder is an employee he / she is issued an appreciation letter prepared by the PRO attested by the GS is sent to the employee with a copy sent to the concerned employee's personal file.
- If the item is not claimed during the period specified for valuable/non valuable items is taken to the Lost and Found disposal committee, which meets in the first week of January, April, July and October.
- The lost and found committee is chaired by the GS. The members are the Deputy MS (OPD), PRO, Security officer and representatives from Nursing, Internal audit. The committee will be for a period of two years.
- The list of items to be disposed, along with the proposed mode of disposal is tabulated, verified, signed and sent to the AC for approval.
- After the AC approval, committee will make arrangements to dispose the items in the best possible manner by conducting auctions/ outright sale to shops etc.
- The list of items disposed and the proceeds from the items is tabulated, verified, signed and is sent to the AC.
- The proceeds are deposited in the Poor patient fund.

23. POLICY ON EMERGENCY MANAGEMENT

23.1. Policy on CRASH CART maintenance:

23.1.1. Items in CRASH CART are stored in uniform manner throughout hospital

23.1.2. Items to be stored on top of trolley, draw 1, 2, 3, 4, 5 are specified

23.1.3. Uniform books are used for inventory in all adult, paediatric and neonate care areas (Exception: ICUs, Emergency service)

23.1.4. CRASH CART items are checked once every month by the Staff Nurse / Charge Nurse if not used within a month.

23.1.5. CRASH CART is replenished, checked and documented by the Staff Nurse whenever the seal is broken.

23.1.6. Excess items needed for CRASH CART are stocked separately and the CRASH CART is replenished after every use and after removing expiry items.

23.1.7. Only items needed for emergency are stored in the miscellaneous drawer of the CRASH CART.

23.2 Policy on cart functioning:

23.2.1 The CART has 1 Anesthetist, a Nurse and a Technician from ICU.

23.2.2 The nurse activates CART by calling "75" on the ward telephone.

23.2.3 The nurse initiates BLS algorithm

23.2.4 The pager is carried by the CART nurse in Nursing Service during the day and the Night Supervisor during the night.

23.2.5 For all the resuscitation attended by the CART TEAM documentation is done on the CPR audit form.

23.2.6 The Deputy Nursing Superintendent is part of the CPR audit committee who evaluates the CPR audit forms along with the other member of the CPR audit team every month.

23.3 Policy on staff preparedness for emergency:

23.3.1 All nursing staff are trained and certified in CPR on induction

23.3.2 CPR certification is valid for 2 years

23.3.3 All staff undergoing CPR training are given CPR booklet for revision

23.3.4 Mock drills are conducted every periodically to train the health team members.

23.4 Policy on medication administration during emergency:

23.4.1 The first dose of Inj.adrenaline (1mg IV) to be administered during cardiac arrest by the Staff Nurse as early as possible being a universal standing order throughout the hospital

23.4.2. Every clinical area has specific standing orders which are accessible in the intranet.

24. POLICY ON NURSING STATION MANAGEMENT:

24.1. NURSING STATION FUNCTIONAL WORK ZONE

24.1.1. The Nursing station functions as the primary visibility and contact point for patients, visitors & other health care personnel in all the clinical areas

24.1.2. The Nursing station is located at the center of the ward for easy access.

24.1.3. The Nursing station is the functional work zone with

- Telephones
- Computers /printers
- Storage of medication / narcotics
- Patient files / record maintenance
- Hand washing area
- A refrigerator for storage of certain medication
- Crash CART for easy accessibility & close proximity
- Adequate trolleys are available for efficient patient care

24.2 CRASH CART ARRANGEMENT:

24.2.1 Refer policy on emergency management (no: 23)

24.3 RECORD MAINTENENCE:

24.3.1. All records listed below are maintained at the nurses' station by the charge nurse.

- Daily audit book
- Nurses duty book
- Equipment checking book
- CRASH CART checking book
- Inventory book
- Daily cleaning record
- All additional record in relation to patient care

24.4 NURSE CALL SYSTEM:

24.4.1. The Nursing station has a nurse call system (indicated by light system) in all the private wards.

24.4.2. The call button is located at the patients bed side and the use is demonstrated to the patient during admission.

24.4.3. The nurses who sees the call light will attend to the patient—If it is emergency she will respond immediately. Otherwise the assigned staff will be summoned

24.5. PATIENT ACUITY BASED STAFF ASSIGNMENT

24.6.1. Patients are categorized as critical, semi critical & non-critical using the modified Modbury hospital patient care categorization.

24.5.2. Staff are categorized into grades based on their knowledge & competency.

24.5.3. The assignment is written in the "Staff Patient assignment note" based on the patients condition and staff categorization in each shift.

Patient Categorization: *(Modified from the Modbury Hospital patient care categorization sheet)*

Criteria	**Critical (category IV & V- need maximum assistance & Dependent)**	**Semi critical (category II & III – need moderate & minimal assistance)**	**Non-critical- (independent)**
Degree of Mobility	Confined to bed or chair Infirm	Minimal assistance in & out of bed, Requires assistance to sit up in bed or out of bed	Mobile
Bathing	Sponged in bed or lifted to bath Sponged in bed, requires 2 hourly turns & pressure area care	Can wash himself, limited help & supervision necessary, Requires help & supervision	No assistance required
Feeding	Needs to be fed IVT, tube feeds or needs to be fed	Over sight required, Requires assistance	No assistance required
Toileting	Requires bed pan or urinal or assistance on to commode Incontinent of faeces or urine. May have urinary drainage	May require some assistance to reach toilet, May require wheel chair to attend toilet	No assistance required
Grooming	Requires the attention of staff Requires the attention of staff to maintain the integrity of skin, hair, nails, eyes, nose & mouth	May require some supervision or self-capable Requires staff supervision	No assistance required
Medical surgical Management	Requires treatment, medication & observation, Pre-op requires medium amount of preparation, Post-op major surgery may have IVT, suction & drainage. Intensive nursing care, considerable treatment, medication & observation dangerously ill. Pre-op large amount preparation. Post-op major surgery IVT, suction & drainage	Minimal treatment, Medication & observation Pre-op, no special preparation, Post-op routine care. Some treatment, medications & observation, required pre-op med, Post-op preparation-on IVT, drainage & suction	Nil or, Minimal treatment, Medication & observation Pre-op, no special preparation, Post-op routine care

25. POLICY ON VASCULAR ACCESS DEVICE MANAGEMENT

25. 1 POLICY ON PERIPHERAL VASCULAR ACCESS DEVICE MANAGEMENT

POLICY STATEMENT: All patients admitted in the hospital are assessed for the need of insertion, for maintenance & removal of peripheral vascular access device.

25.1.1 The patient is assessed for the need of Peripheral vascular access device on a daily basis.

25.1.2 The patient & family are informed about need for peripheral vascular access device, need to restrict movement at insertion site & to refrain from tampering with peripheral vascular access device

25.1.3 Transparent semi permeable dressing is used for all Peripheral vascular access site.

25.1.4 The dressing is changed when it is soiled or blood stained or every 72 – 96 hrs.

25.1.5 The Peripheral vascular access device is changed to another site every 72- 96 hrs.

25.1.6 Extravasation / Delining is to be reported within 24 hrs of incidence using the extravasation report form.

25.1.7 The patency of Peripheral vascular access device is maintained

- By flushing 3ml of 0.9% sodium Chloride before & after intermittent use.
- By flushing with 5ml 0.9% sodium Chloride at beginning of every shift if it is not in use.

25.1.8 The Peripheral vascular access device is removed if unused for more than 24 hrs, unless required

25.1.9 The patency & status of IV site is inspected and documented every shift.

25.1.10 Documentation of the following details is done for every Peripheral vascular access device inserted

- Time & date of insertion
- Site of insertion
- Cannula used for insertion
- Dressing materials used
- Date & time of dressing change, if applicable.
- Date & time of removal.

25.1.11 Different colour coding labels are used for the vascular lines & tubes as mentioned below:

- Blue – Inotropes
- Brown – Blood products, Electrolyte corrections
- White – IV fluids & medications
- Red – Arterial line
- Green – Feeding tubes
- Yellow- Epidural lines
- No rushing- medications that should not be rushed that can cause lethal effect leading to sentinel event

25.2 POLICY ON CENTRAL VASCULAR ACCESS DEVICE MANAGEMENT POLICY STATEMENT: All patients admitted in the hospital are assessed for the need of insertion, for maintenance & removal of central vascular access device.

25.2.1 The patient is assessed for the need of central vascular access device on a daily basis.

25.2.2 The patient & family are informed about need for central vascular access device, need to restrict movement at insertion site & to refrain from tampering with device

25.2.3 A written consent is obtained that is valid throughout the hospitalization

25.2.4 A Transparent semi permeable dressing is used for all central vascular access devices.

25.2.5 The dressing is changed when it is soiled, blood stained, damp, loosened or every 7 days by the Doctors / Nurses (Privileged only).

25.2.6 Delining is to be reported within 24 hrs of incidence.

25.2.7 Placement confirmation is done by a physician after an x-ray or ultrasound

25.2.8 The patency of central vascular access device is maintained

- By flushing 5ml of 0.9% sodium Chloride before & after intermittent use.
- By flushing with 5ml of 0.9% sodium Chloride if a lumen of a multi lumen is not being used every 12hrs.
- By flushing weekly with heparin sodium(10units/ml)5ml if the lumen is not in use

25.2.9 The patency & status of IV site is documented every shift.

25.2.10 Documentation of the following details is done for every central vascular access device inserted

- Time & date of insertion
- Site of insertion
- Cannula used for insertion
- Confirmation of the central catheter placement
- Dressing materials Used
- Date & time of dressing change
- Date & time of removal

25.3.Policy on Deep Vein Thrombosis (DVT) Management:

25.3.1. . DVT risk assessment & documentation:

Policy Statement: All patients at risk of developing DVT are assessed as per policy

25.3.1 Well's score is used for assessing the patient

25.3.2. Patients are assessed once in a shift and the score is documented in the flow chart.

25.3.3. The score is interpreted as follows:

- -2 to 0 Low risk for DVT
- 1 to 2 Moderate risk
- ≥3 High risk for DVT

25.3.4. If score is 3 or >3 are informed to the doctor, to follow the necessary intervention as per the advice of the physician.

25.4.Policy on Care bundle Management (CLABSI, VAP & CAUTI)

25.4.1. Care bundle assessment & documentation

Policy Statement: All patients on central line, ventilator and urinary catheter are assessed using the care bundle checklist.

25.4.1. Assessment is done for patients who are on central line, ventilator & urinary catheter.

25.4.2. Care bundle implementation checklist is used for assessment & documentation

25.4.3. Documentation is done in the care bundle implementation checklist once every day on specified predetermined criteria.

VAP BUNDLE : Applicable/Not applicable	
Hand hygiene	Yes / No
Head and elevation 30-45^0	Yes / No
RASS 0 to - 1	Yes / No
Readiness to extubation	Yes / No
Subglottic suction port	Yes / No
ET cuff pressure 20 to 30 cm H_2O.	Yes / No
Oral care Chlorhexidine TID	Yes / No
Can ulcer prophylaxis be stopped ?	Yes / No
Chest physiotherapy	Yes / No

CAUTI BUNDLE: Applicable/Not applicable	
Hand hygiene	Yes / No
Insert urinary catheters using aseptic technique	Yes / No
Can we remove urinary catheter?	Yes / No
Daily catheter care	Yes / No
Maintain a closed drainage system	Yes / No

CLABSI BUNDLE: Applicable/Not applicable

Can we remove the CVC? Yes / No

Hand hygiene before & after line handling Yes / No

Wear sterile gloves when handling the lines Yes / No

Disinfect catheter hubs before accessing catheter Yes / No

Transparent dressings used Yes / No

Site care with Chlorhexidine based antiseptic every 3 days. Yes / No

Last done on _____

Replace administration sets at intervals not longer than 72 hours Yes / No

Last done on _____

26. RISK ASSESSMENT AND MANAGEMENT

Policy Statement: Activities planned and implemented by the Nursing Administration to identify, evaluate, reduce and prevent injuries of the patient and staff of the institution.

26.1. Risk assessment and management of falls, pressure sore, medication errors, accidental de-lining, extravasation, needle stick injury, restraint related injury and infections are monitored continuously.

26.2. Self-reporting, report by colleagues, and supervisors is encouraged to monitor all the risk and injuries to patients

26.3. Audits in the areas of risk will be carried out periodically to validate the data captured

26.4. Information obtained about the risk managed will be analysed every month

26.5. Causes of the events of risks will be studied based on individual incidences

26.6. In-depth analysis will be carried out on the identified causes

26.7. Appropriate measures will be taken to reduce the risk of events

26.8. Information of the incidences of the events of risk will be disseminated to the staff through intranet information

26.9. Report of the risks will be discussed every three months in the safety steering committee and suggestions will be obtained for risk reduction from the multidisciplinary team

26.10. Staff Nurses will be reiterated annually about the risk assessment and management of all the events

26.11. Staff Nurses will be encouraged to follow risk assessment as per policy, report injuries promptly, and follow measures to prevent harm to self and others

27. MASTER LIST OF NURSING DOCUMENTS

Common forms - Clinical

1. Absconded Patient Report
2. Accident Report
3. Pressure sore reports
4. Chemical Restraint Monitoring Form
5. Daily Nursing Care Record
6. Day and night report
7. Graphic (T.P.R.) Chart
8. I.V. Infusion Record (Plan for 24 hours)
9. Intake and Output Record
10. Patient monitoring record (Pressure sore, pain, vascular access, fall risk combined)
11. Patient transfer checklist
12. Transfusion Monitoring Record
13. Visitor pass
14. Nursing Assessment and Admission form
15. Patient health education form
16. Sliding Scale Insulin Infusion Record
17. Daily Nursing Care Record
18. Permission to stay at night
19. Physical restraint monitoring sheet
20. Discharge slip
21. Informed consent- transfusion of blood products
22. GRBS and insulin chart
23. Pharmacy information slip
24. Medication return slip-pharmacy services

Common forms – Office of the Nursing Superintendent

1. Application for proof of residence
2. Application form
3. Application for clinical experience certificate
4. Clinical Appraisal for Staff Nurses in the Operating Rooms
5. Appraisal for the Award of the best charge nurse, staff nurse, MPHW & Nursing Auxiliary-Confidential
6. Confidential Report on Confirmation
7. Confidential report on promotion
8. Confidential Report towards institutional sponsorship for PC.BSC(N) / M.SC(N) / Post Diploma (N)
9. Evaluation of / M.P.H.W.and N.A
10. Performance appraisal for staff nurses
11. Performance Appraisal for Staff nurses in NSO
12. Performance Appraisal for Recovery room nurses in the operating rooms
13. Performance Appraisal for Staff Nurses in Emergency Department
14. Performance Appraisal for Psychiatric Nursing
15. Performance Appraisal for Charge Nurse

16. Performance Appraisal for Charge Nurses in NSO
17. Performance Appraisal for Hospital infection control staff nurses
18. Performance Appraisal for Nurses in CSSD
19. Performance Appraisal for OPD Staff Nurses
20. Performance appraisal for Operating Rooms MPHW and Nursing Auxiliaries
21. Performance Appraisal for project staff & educators(Virology/blood bank/hepatlogy/paediatric/ endocrinology/endocrine/cathlab/resp/renal/lifestyle)
22. Reference Questionnair form Dean/Principal, School/College of Nursing
23. Request for casual/relief staff
24. Reference Questionnaire form
25. Performance Appraisal for MPHW and Nursing Auxiliaries
26. Exit interview for nurses
27. Incident Report (student)
28. Incident report for Staff Nurse/ MPHW/ Nsg. Auxiliary
29. Orientation Check list
30. Nursing Audit Checklist
31. Doctors medication orders & Nurses administration record
32. Theft and loss Report

Speciality forms

Cardiothoracic

1. Intensive Care Chart
2. Protocol for health education-valve replacement-thoracic surgery
3. Cath lab safety checklist
4. Chest pain unit-Nursing assessment-Dept of cardiology
5. Chest pain assessment form- dept. of cardiology
6. Chest pain unit-admission record
7. Admission record
8. SOCRATES - Chest pain assessment
9. Cardiac invasive procedure pre-procedure checklist & monitoring sheet
10. Protocol for health education CABG
11. 24 hour progress sheet
12. Anticoagulant record
13. ABG flow chart
14. TICU regular therapy flow chart
15. ICU/HDU 24 hours flow chart

Child Health

16. Flow chart
17. Fluid chart
18. Nursing care plan-Child health I
19. Nursing care plan-Child health II
20. Nursing care plan-Child health III
21. Dept. of child health flow chart for RASS score
22. Dept. of child health flow chart for I/O chart

Clinical Immunology and Rheumatology

23. Chemotherapy / Biological therapy preparation checklist
24. Chemotherapy / Biological therapy monitoring record

Emergency Medicine

25. Form for handover of patients belongings
26. Accident and Emergency Nurse's Record - Trauma
27. Seizure chart-Nursing documentation
28. Admission record

Endoscopy

29. Patient monitoring form- endoscopy, gastroscopy, bronchoscopy & other procedures

Geriatrics

30. Rudas - cognitive assessment scale
31. Mini-mental state examination (Folstein)
32. Frontal assessment battery
33. Fall risk assessment- screening questions
34. Discharge checklist
35. MontrealCognitive Assessment (MOCA)
36. Initial swallow screen

Maternity

37. Labour record
38. Neonatal 24 hours documentation record
39. Medication chart
40. Neonatal record
41. Checklist for transporting the baby to the theater/lab/ECHO/radiodiagnosis
42. Neonatal foot print record

Mental Health

43. Electroconvulsive therapy- treatment record form
44. Nursing care of patients with physical restraints
45. Nursing care of patients with alcohol withdrawal
46. Progress record
47. Doctors medication orders & Nurses administration record
48. Admission & Discharge checklist

MICU / MHDU

49. Additional medication order sheet
50. Monitoring sheet
51. Nurses booklet
52. Nurses daily assessment & care record
53. Checklist for ventilatory support
54. Monitoring Sheet for Patients in Semi-ICU (Two hourly)
55. Central line maintenance & handling checklist
56. Central line insertion bundle
57. Transfer checklist (for procedure out-side MICU/MHDU)

Neurological Sciences

58. Anticoagulant Record
59. OR Checklist- dept. of neurological sciences
60. NTICU- ICP data sheet
61. Parkinsons disease motor diary-neurology dept.
62. Seizure chart
63. NICU-Respiratory monitoring
64. NICU-Respiratory Record
65. NICU/HAD- Admission notes for traumatic brain injury
66. NICU- Flow sheet
67. COMA Scale
68. Neuro critical care patient OR-ICU transfer record
69. NICU staff handing over sheet
70. Venitilator monitoring record
71. Neuro surgery unit III power chart
72. Protocol for diagnosis of brain death-for organ transplantation

Onco-Hematology

73. Blood product administartion format
74. Chemotherapy administartion Format
75. Doctors chemotherpy orders and Nurs-es adminisrataion record
76. Chemotherapy/ biological therapy preparation checklist
77. Chemotherapy / biological therapy monitoring record
78. Patient monitoring record-chemotherapy infusion > 4 hours
79. Central line dressing record-hickmann's, subclavian, jugular, PICC line
80. TPN request form

Operating Room

81. Perioperative record
82. Sponge Account Record
83. Surgical safety checklist

Ophthalmology

84. Immediate post-operative monitoring sheet
85. Opthalmology Nursing assessment & admission form
86. Daily Nursing care plan & documenta-tion record
87. Doctors order sheet & Nurses medica-tion administration record
88. Frequent medication order and Nurses administration record
89. Surgical safety checklist
90. Day Care Nurses Admission Record
91. Outreach services / cataract admission part II
92. Anesthesia record-recovery/ ICU

Paediatric Surgery

93. 12 Hourly intake-output chart
94. Nursing care plan-Unit I
95. Nursing care plan- Unit II
96. Starvation information sheet- English
97. Starvation information sheet-Tamil
98. Starvation information sheet-Hindi
99. Starvation information sheet-Bengali
100. Starvation information sheet-Telugu
101. Starvation information sheet-Malayalam

PICU

102. Central line insertion checklist
103. Checklist for transport of sick children
104. Transfer out Note
105. 24 hour flow chart

Pulmonary Medicine Unit

106. Checklist for patients on ICD
107. Inhaled medication therapy- respiratory care sheet
108. Bronchoscopy/EBUS/USG guided procedure/Thoracoscopy/ICD checklist

Radiology

109. Radiology Invasive procedure monitoring record
110. IV contrast pre-assessment slip

Rehabilitation

111. Tracheostomy chart
112. Bladder management chart
113. Bowel management chart
114. Health teaching record for traumatic brain injury
115. Health teaching record for spinal cord injury

Renal and Urology

116. Renal transplant investigation
117. Renal transplant progress chart
118. Post-op progress chart
119. Diabetic monitoring sheet
120. IV fluid plan
121. Post kidney biopsy checklist
122. Transplant programme- weekly check up
123. Primary patient care protocol- Hemodialysis unit
124. Hemodialysis treatment record
125. Central venous catheterization procedure form- dept. of Neph
126. AK lab dialysis sheet
127. Standing order for Maintenance Hemodialysis

SICU / SHDU

128. Medical History sheet
129. Nursing care booklet
130. Regular therapy- medication prescription
131. Regular therapy- 24hrs flow chart

Surgical

132. Post-operative checklist
133. Pre-operative checklist for general surgical patients
134. Operating room
135. Dept. of anaesthesia, acute pain service proforma

Vascular

136. Vascular angiogram/ angioplasty/stenting procedures
137. Venous disease-inpatient booklet
138. Arterial disease-inpatient booklet

Day care Ranipet Campus

139. Initial assessment & Nursing care documentation-Kidney biopsy