Gap Analysis of Emergency Department According to NABH Standards

By

Priyanka Kundrai

Dissertation submitted for the partial fulfillment of the

MBA Hospital and Health Management

Academic year, 2015-2017

The IIHMR University, Jaipur

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INSTITUTE OF HEALTH MANAGEMENT RESEARCH
(WHO Collaborating Centre for District Health System Based on Primary Health Care)

IIHMR UNIVERSITY

TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Dr.Priyanka Kundrai** student of **MBA Hospital and Health Management** from The IIHMR University, Jaipur has undergone internship training at EHCC hospital, Jaipur from 6 Feb, 2017 to 5 May, 2017.

The Candidate has successfully carried out the study designated to her during internship training and her approach to the study has been sincere, scientific and analytical.

The Internship is in fulfillment of the course requirements.

I wish her all success in all her future endeavors.

Col.(Dr.) Ashok Kaushik
Dean, Academic and Student Affairs
The IIHMR University, Jaipur

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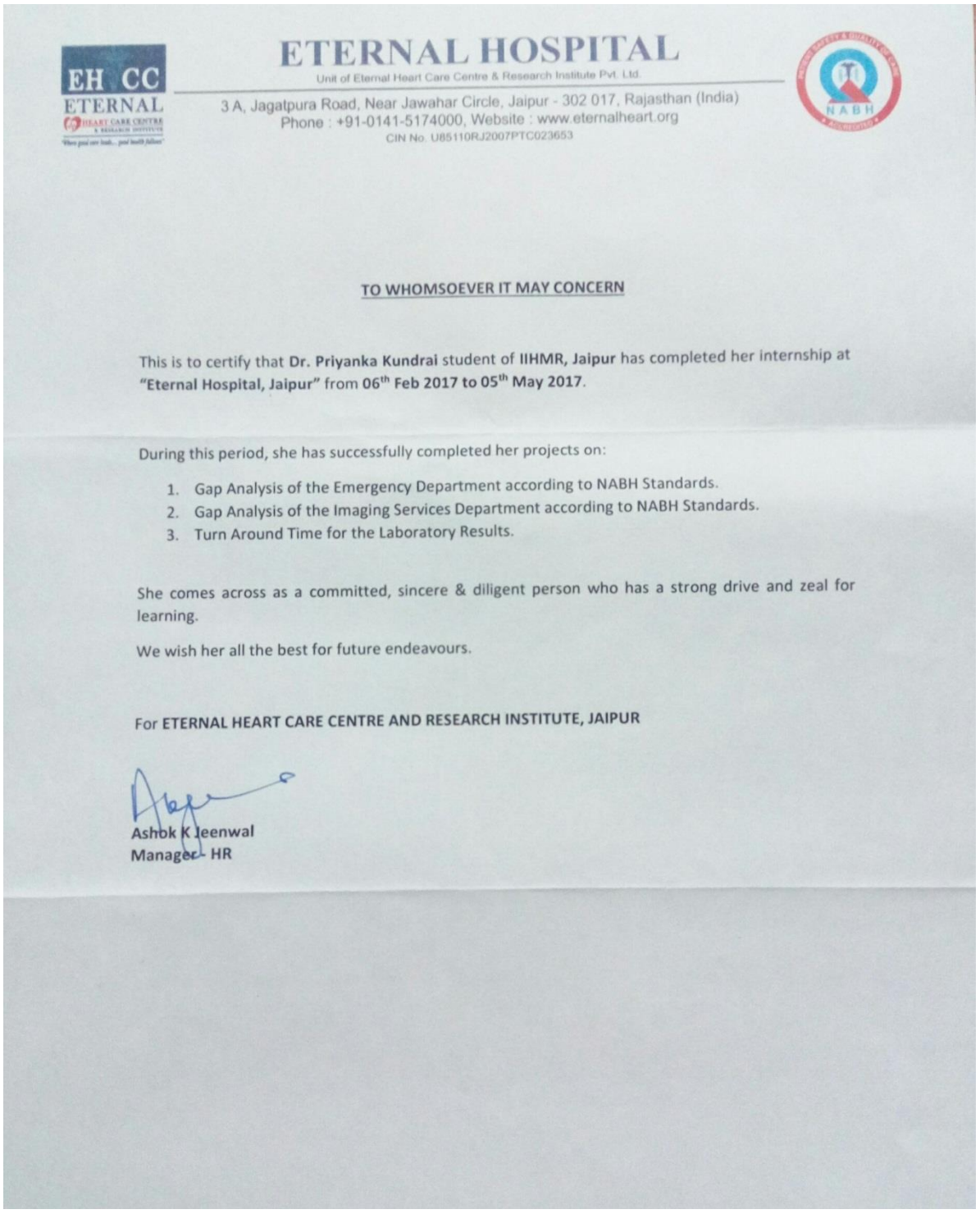

ETERNAL HOSPITAL

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TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Dr. Priyanka Kundrai** student of **IIHMR, Jaipur** has completed her internship at **"Eternal Hospital, Jaipur"** from **06th Feb 2017 to 05th May 2017**.

During this period, she has successfully completed her projects on:

1. Gap Analysis of the Emergency Department according to NABH Standards.
2. Gap Analysis of the Imaging Services Department according to NABH Standards.
3. Turn Around Time for the Laboratory Results.

She comes across as a committed, sincere & diligent person who has a strong drive and zeal for learning.

We wish her all the best for future endeavours.

For **ETERNAL HEART CARE CENTRE AND RESEARCH INSTITUTE, JAIPUR**

Ashok K Jeenwal
Manager - HR

IIHMR UNIVERSITY

Appendix F (Certificate of original work)

THE IIHMR UNIVERSITY, JAIPUR

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled Gap Analysis of the Emergency department according to NABH Standards and submitted by (Name) Dr. Priyanka Kundrai Enrollment No. 0325 under the supervision of Dr. P. R. SODANI for award of MBA in Hospital and Health/ Pharmaceutical / Rural Management/ Human Resource Management in Health and Hospitals of the University carried out during the period from 6th Feb 2017 to 5th May 2017 embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other institute or other similar institution of higher learning.

Priyanka Kundrai

Signature

THE IIHMR UNIVERSITY, JAIPUR

CERTIFICATE BY SCHOLAR

This is to certify that all ethical issues have been considered while collecting data for my dissertation titled ...Gap Analysis of Emergency department at ...EHCC hospital according to NABH Standards.....

Priyanka Kundra

Signature of student

ACKNOWLEDGEMENT

'What we have to learn to do, we learn by doing'-Aristotle

In this dissertation I learnt and had an experience of the healthcare industry. This practical approach has helped me in preparing myself as a healthcare Administrator. This project won't have been completed without the support of senior faculty; hereby I would like to take this opportunity to thank them.

I would thank all those who gave me the chance and always motivated me to accomplish this project. I want to thank Dr. P R Sodani (Dean Training and my Guide) for giving me permission to commence this project in the first instance.

I furthermore like to thank EHCC Hospital especially Mr. Subroto Das (Vice President Human resources) to let me do my internship in their hospital.

I am deeply indebted to Dr. Manmeet Makkar (Operational Medical Director, EHCC) and Ms. Kirti Khemkar (Head Quality) for continuously guiding and supporting me.

I also thank all other people of EHCC Hospital, Jaipur who helped me make this report a meaningful one.

Dr. Priyanka Kundrai

20^{th} batch

MBA HM

IIHMR, JAIPUR

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LIST OF ABBREVIATIONS

EHCC – Eternal Heart Care Centre

NABH - National Accreditation Board for Hospitals and Healthcare Providers

QCI- Quality Council of India

ICU- Intensive Care Unit

ER- Emergency Room

ED – Emergency Department

MLC – Medico Legal Cases

OPD- Out Patient Department

OT – Operation Theatre

PTCA- Percutaneous Transluminal Coronary Angioplasty

UHID- Unique Hospital Identification

IPID- In Patient Identification

ACLS- Advanced Cardiac Life Support

BLS- Basic Life Support

HCO- Health Care Organization

HMIS- Hospital management Information System

SOP- Standard Operating Procedures

OMD- Operational Medical Director

MRD- Medical Record Department

BP- Blood Pressure

TAT- Turn around Time

GCS- Glasgow Coma Scale

CVS- Cardiovascular system

PR- Pulse rate

RS- Respiratory System

ABD- Abdomen

CNS- Central Nervous System

L/E- Local examination

O/E- On Examination

CSSD- Central Sterile Supply Department

LAMA- Leave against Medical Advice

DOR- Discharge on Request

1. INTRODUCTION

1.1.NABH

National Accreditation Board for Hospitals and Healthcare Providers (NABH) which is a constituent board of Quality Council of India (QCI). It was established with the purpose of providing accreditation to health associated firms. NABH came into existence with the motto of improving health care & bringing in up gradation in quality and safety of patients all throughout. It is supported by various stakeholders, that include healthcare industry, patients, Government, and it has full functional autonomy in its operation.

NABH provides accreditation to healthcare organizations in an unbiased manner.

International Society for Quality in Healthcare (ISQua) has come up with "Standards for Hospitals accreditation", 4th Edition, December 2015 and it was created by NABH for a period of 4 years. Once it is approved by ISQua, it is authenticated that NABH standards are in accordance with the international benchmarks which are set up by ISQua. The hospitals that are accredited by NABH have international acceptance.

1.1.1. International Linkage

- NABH is an Institutional Member and also a Board member of the International Society for Quality in Health Care (lSQua).
- NABH is a member of the Accreditation Council of International Society for Quality in Health Care (ISQua).
- NABH is on board of Asian Society for Quality in Healthcare (ASQua).

1.1.2. Organizational Structure:

Fig: 1

1.1.3. Vision

- To be top most national healthcare accreditation and quality up gradation provider, with global benchmark

1.1.4. Mission

- To operate accreditation and allied programs in collaboration with stakeholders focusing on patient safety and quality of healthcare based upon

national/international standards, through process of self and external evaluation.

1.1.5. Scope /objectives

- Accreditation of healthcare facilities
- Quality promotion: initiatives like Safe-I, Nursing Excellence, Laboratory certification programs (not limited to these)
- IEC activities: public lecture, advertisement, workshops/ seminars
- Education and Training for Quality & Patient Safety
- Recognition: Endorsement of various healthcare quality courses/ workshops

1.1.6. Standards and Objective Elements

- A standard is one that describes the overall structures and processes that must be defined in an organization to enhance the quality of care
- Objective element is a component that can be measured for a standard.

1.1.7. Benefits of Accreditation

1.1.7.1.Benefits to HCO

- Raises levels of continuous improvement.
- Stimulates the HCO to showcase their quality care.
- Stimulates the confidence of the society in the organization.
- It sets up a benchmark so that it can be the best.

1.1.7.2.Benefits to Patients/Customers

- Patients/customers are the biggest beneficiary.
- Provides high quality of care and patients satisfaction.
- Patients get services by credentialed staff.
- Rights of patients are respected and protected.

- Patients satisfaction to be monitored on a regular basis.

1.1.7.3.Benefits to Staff

- Employees are quite satisfied in their jobs as they have the chance for regular learning, pleasant working conditions enhances their leadership skills and also provides them a sense of ownership.
- Overall development of employees and creates leadership skills for quality improvement

1.1.7.4.Benefits to Others

- Third Parties can evaluate on this basis.
- Provides access to certified information on level of care

1.2.EMERGENCY DEPARTMENT

Emergency department should be managed by Advanced Cardiac Life Support Certified post graduates, and must be eligible for handling all type of emergencies. The health care center must have advanced cardiac ambulances which are fully equipped with life supporting drugs and instruments and are managed by trained professionals. The care starts even prior to the patient comes to the hospital and this improves survival rates. The emergency department should be working 24x7. Its purpose is to provide relief to the patients and the manage the patients arriving at the hospital with acute medical and surgical emergencies which may include injuries by road traffic accidents, or any other form of accidents, sudden attacks of illness, head trauma, Physical abuse, poisoning, fever, burns, etc. without any biasness. The services that are provided in the emergency department range from providing sporadic, primary, acute (comprehensive) care to all the patients. These services are essential for patient care and

therefore must fulfill the needs of patient and the clinical personnel whom is providing care to patients. The Emergency Department in the Hospital should maintain certain standard of services as well as, strive for continuous improvement in the quality care provided to the patients.

1.3. NABH STANDARDS FOR EMERGENCY DEPARTMENT IN HOSPITALS

The setting of Healthcare across the world is changing with the arrival of new healthcare delivery models. Development of the Emergency Medicine is one such development in India. India have recognized Emergency Medicine as a new specialty leading to a post graduate degree (MD/DNB). India will have over 100 Post Graduate Training Programs in Emergency Medicine. This is an arrival of comprehensive departments of Emergency Medicine at healthcare facilities across India. Today hospitals in India have felt the need to focus on the development Emergency Medicine Departments (ED) because the quality of care provided here reflects the level of care of the hospital. Providing quality Emergency Medical Care is crucial. It is the right of every patient who comes in through the door of the ED to get quality and safe acute care.

However there are not many trained experts in Emergency Medicine and there are no standards to guide the functionality of the Emergency Department. The ED becomes the place for overflowing of not only emotions and patient ailment but also for a cluster of occasions to make medical errors.

Here is an opportunity to win against the challenges and come up with new standards and processes to provide the patients coming in EDs quality acute care

1.3.1. Summary of Chapters, Standards and Objective Elements

TABLE : 1		
Chapters	**No. of Standards**	**No. of Objective Elements**
Access, Assessment and Information (AAI)	11	56
Patient Care and Rights (PCR)	7	49
Management of Medication (MOM)	7	48
Hospital Infection Control (HIC)	3	9
Continuous Quality Improvement (CQI)	4	20
Responsibilities of Management (ROM)	3	13
Facility Management and Safety (FMS)	7	29
Human Resource Management (HRM)	5	21
Total	47	245

2. METHODOLOGY

2.1. Study Design

- Descriptive study

2.2.**Setting**

- Emergency Department of EHCC Hospital, JAIPUR

2.3.**Duration of Study**

- 3 Months

2.4.**Objectives**

- To assess the existing service delivery standards of Emergency Department at EHCC HOSPITAL JAIPUR
- To identify the gaps in terms of structure , process and outcome
- To recommend alterations in structural designs, process of the facilities to meet the requirement.
- To give recommendations on measures to be taken to fulfil the gaps.

2.5.Data Collection

2.5.1. Data Collection Tool

- Checklist NABH emergency self-assessment toolkit which includes 8 chapters, 47 standards and 245 objective elements. The chapters are:

    - Chapter 1 - Access, Assessment and Information (AAI)
    - Chapter 2 - Patient Care and Rights (PCR)
    - Chapter 3 - Management of Medication (MOM)
    - Chapter 4 - Hospital Infection Control (HIC)
    - Chapter 5 - Continuous Quality Improvement (CQI)

- Chapter 6 - Responsibilities of Management (ROM)
- Chapter 7 - Facility Management and Safety (FMS)
- Chapter 8- Human Resource Management (HRM)

2.5.2. Data Collection Method

- Reviewing of Hospital Manuals, Policies, Records (e.g. - Register of these departments), HMIS and interaction with hospital staff and patients.

While direct observation, interview with hospital staff and patients and analyzing the hospital records, the NABH emergency self-assessment toolkit would be used. The NABH emergency toolkit consists of:

1. Implementation (Yes/No): Whether the objective is implemented in the department or not
2. Documentation (Yes/No): If the objective is implemented, whether there is proper documentation regarding the same or not.
3. Evidence: If there is proper documentation of the said objective, then evidence will be collected regarding the same.
4. Score (0/5/10): Once all the above criteria is fulfilled score would be given as follows:

- Compliance to the requirement :10
- Partial compliance to the requirement: 5 (if any of the samples is found to be noncomplying out of total samples selected.
- Non-compliance to the requirement: 0
- Not applicable: NA

5. Evaluation criteria during final assessment:

- No individual standard should have more one zero to qualify.
- However, no zero is accepted in the regulatory/legal requirements.
- The average score for individual standard must not be less than 5
- The overall average score for all standards must exceed 7.

3. RESULTS

3.1.Gaps Identified

TABLE :2						
OBJECTIVES	**POLICY NO**	**DOCUMENTATION**	**IMPLEMENTATION**	**EVIDENCE**	**SCORE**	**REMARKS**
The Emergency Department should have an easy and direct access from the approach road / main gate.		N	Y	map, photograph, c.g,sop(ED)	5	Should be documented in scope of services of emergency department.
An alert mechanism is activated upon arrival of the patient. Staff should be trained to respond promptly to the alerts.		N	N	No call bell, security guard is present at the gate.	0	There should be an alert mechanism in form of bell so that the staff when busy gets aware of patient arrival
Staff is aware and trained on the policies and procedures to guide the availability of diagnostic services.	RAD SOP	Y	N		5	Briefing of the policies & SOP must be done to the staff in the form of continuous learning.

Information is exchanged and documented during each staffing shift, between shifts and during transfers between units/departments.	EHCC & RI / NM/ 0140	Y	N	Emergency register is used as handover register by staff between shifts. For in house transfer there is a in house transfer form.	5	Proper handover should be done with sign off. Handover should also be done in between the ER doctors.
Documented policies and procedures are in place for patients leaving against medical advice and patients being discharged on request.	AAC 11 & COP 02	Y	N	There are documented policies. In case of refusal consent is taken on a blank sheet. There is no refusal form present.	5	There should be a proper refusal form for LAMA / DOR patients
Staff providing direct patient care is trained and	COP 04	Y	N	BLS training is conducted	5	BLS training should be conducted

periodically updated in cardiopulmonary resuscitation				for the nurses and doctors.		on a regular interval for all the ER staff including GDA and ambulance drivers.
Assignment of patient care is done as per current good practice guidelines.	NURSING MANUAL.	Y	N	Assignment of patient care is done according to the availability of the staff.	5	Assignment of staff must be done as per good practice.
Audit of medication orders/prescription is carried out to check for safe and rational prescription of medications and corrective and/or preventive action (s) is taken based on the analysis where appropriate.		N	N		0	Audit of prescriptions should also be done in ER.
The emergency committee is multidisciplinary and meets at		N	N	no emergency committee	0	There must be an emergency management

regular intervals.						committee comprising of key members of ER.
Monitoring also includes unplanned return to Emergency Department within 72 hours with the similar complaints.		N	Y	Data monitoring done by quality department	5	Though it is implemented but nowhere documented and ER staff also not aware about it.
Monitoring includes data collection to support further study for improvements		Y	N	Not done specifically for emergency department	5	This should be done specifically for ER department by the quality department,
The organization documents employee rights and responsibilities.	PRE 01.	Y	N	NO POSTER PRESENT	5	There should be a poster on patients right & responsibilities as well as employee rights and responsibilities
The provision of space shall be in		N	Y		5	Proper documentati

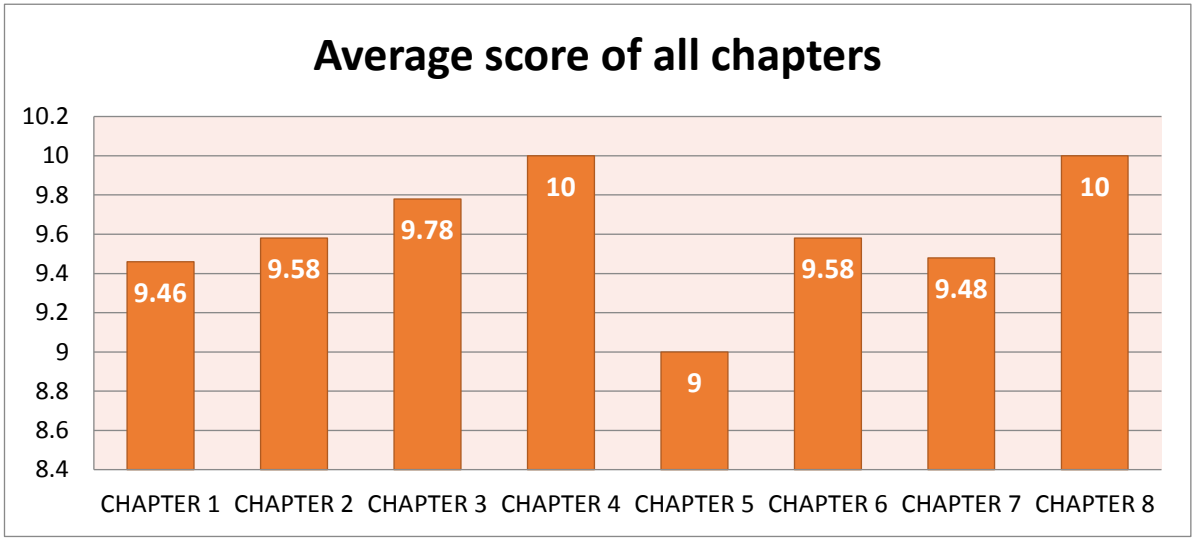
accordance with the available literature on good practices (Indian or international standards) and directives from government agencies.						on to be done.
Emergency staff is trained in the hospital's disaster management plan.	HOSPITAL SAFETY MANUAL	Y	N	No mock drills conducted.	5	Periodically mock drills to be conducted so as to prepare staff for disaster management plan
The disaster management plan in the Emergency Department is tested at least twice a year	FMS 01 & HOSPITAL SAFETY MANUAL	Y	N	No mock drills conducted.	5	Periodically mock drills to be conducted so as to prepare staff for disaster management plan

3.2.Analysis

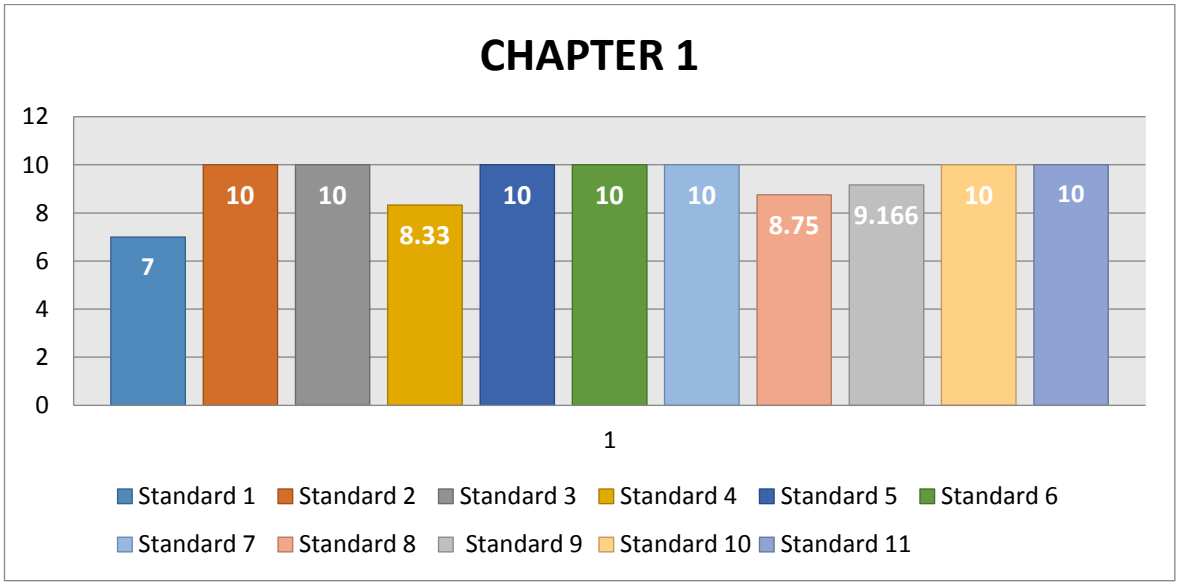
TABLE : 3		Score	Score
Chapter 1 : Access, Assessment and Information (AAI)	Standard 1	7	9.46
	Standard 2	10	
	Standard 3	10	
	Standard 4	8.33	
	Standard 5	10	
	Standard 6	10	
	Standard 7	10	
	Standard 8	8.75	
	Standard 9	9.166	
	Standard 10	10	
	Standard 11	10	
Chapter 2 : Patient Care and Rights (PCR)	Standard 1	10	9.79
	Standard 2	9	
	Standard 3	9.28	
	Standard 4	10	
	Standard 5	10	
	Standard 6	10	
	Standard 7	10	
Chapter3 : Management of Medication (MOM)	Standard 1	10	9.78
	Standard 2	10	
	Standard 3	8.88	
	Standard 4	10	
	Standard 5	10	
	Standard 6	10	
	Standard 7	10	

Chapter 4 : Hospital Infection Control (HIC)	Standard 1	10	10
	Standard 2	10	
	Standard 3	10	
Chapter 5 : Continuous Quality Improvement (CQI)	Standard 1	8	9
	Standard 2	10	
	Standard 3	9.28	
	Standard 4	8.75	
Chapter 6 : Responsibilities of Management (ROM)	Standard 1	10	9.58
	Standard 2	9.28	
	Standard 3	10	
Chapter 7 : Facility Management and Safety (FMS)	Standard 1	9.166	9.48
	Standard 2	10	
	Standard 3	10	
	Standard 4	10	
	Standard 5	10	
	Standard 6	8	
	Standard 7	10	
Chapter 8 : Human Resource Management (HRM)	Standard 1	10	10
	Standard 2	10	
	Standard 3	10	
	Standard 4	10	
	Standard 5	10	
	TOTAL SCORE		**9.628**

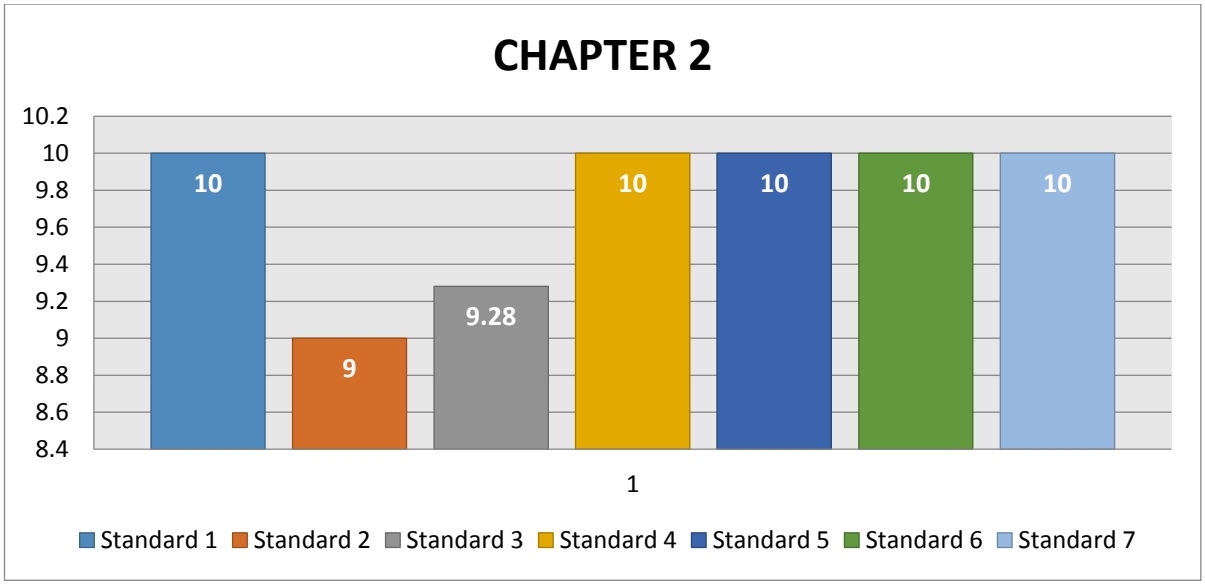
3.2.1. Graph 1:Aggregate Score



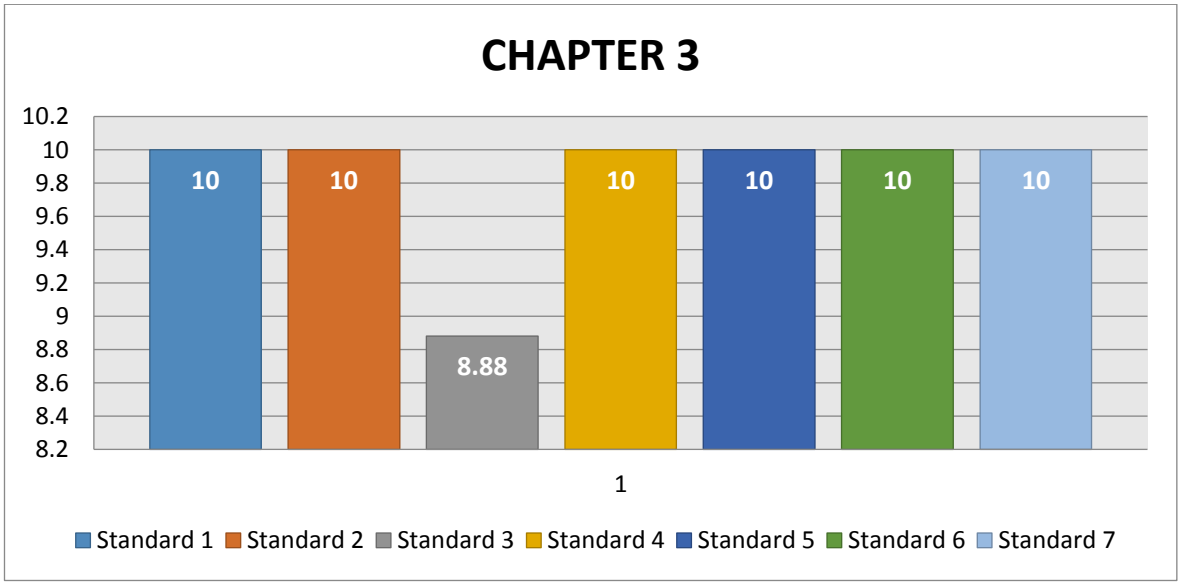
3.2.2. Graph 2: Average Score for Access, Assessment and Information (AAI)



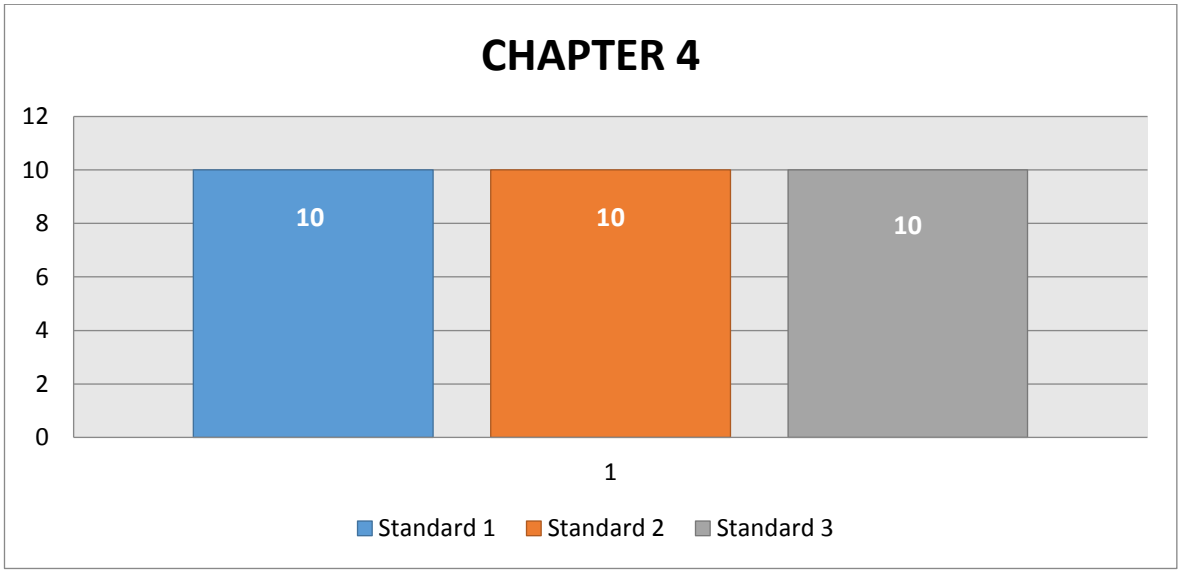
3.2.3. Graph 3: Average Score for Patient Care and Rights (PCR)



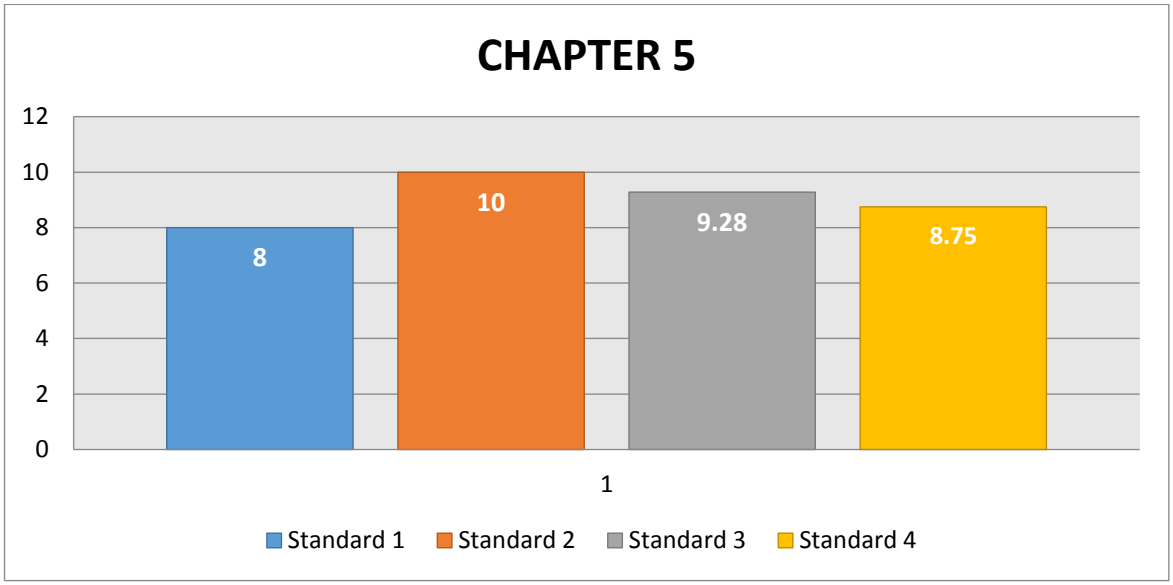
3.2.4. Graph 4: Average Score for Management of Medication (MOM)



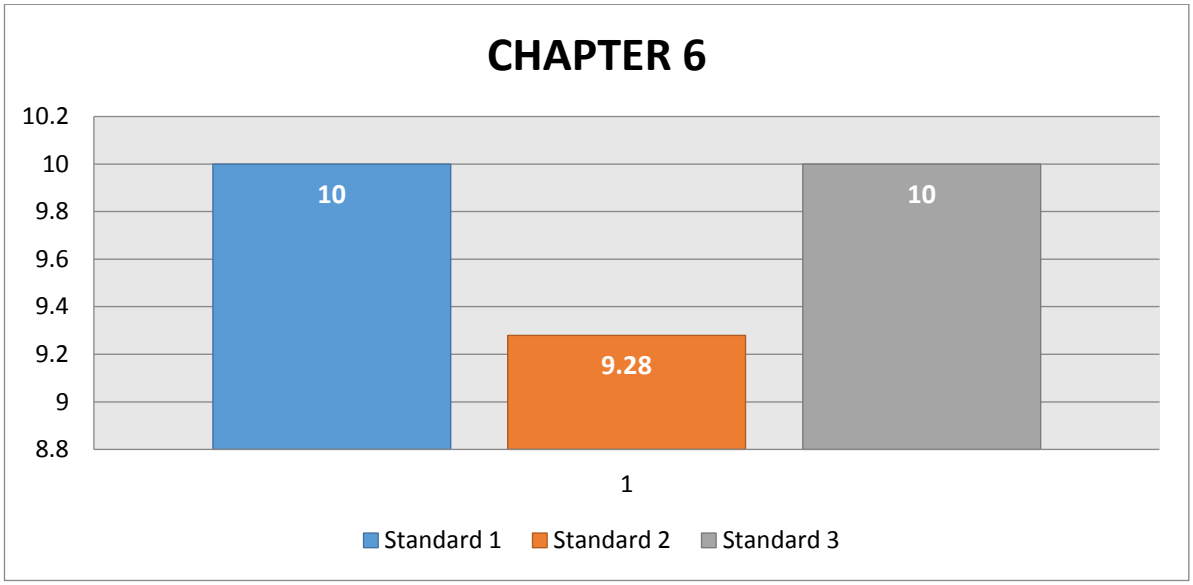
3.2.5. Graph 5 : Average Score for Hospital Infection Control (HIC)



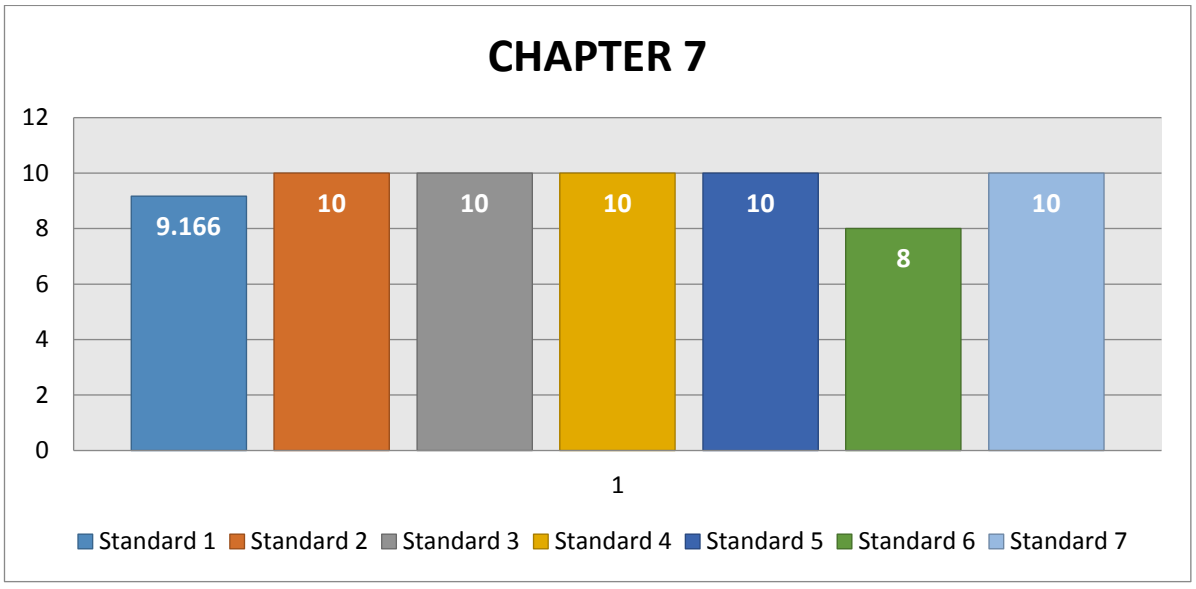
3.2.6. Graph 6: Average Score for Continuous Quality Improvement (CQI)



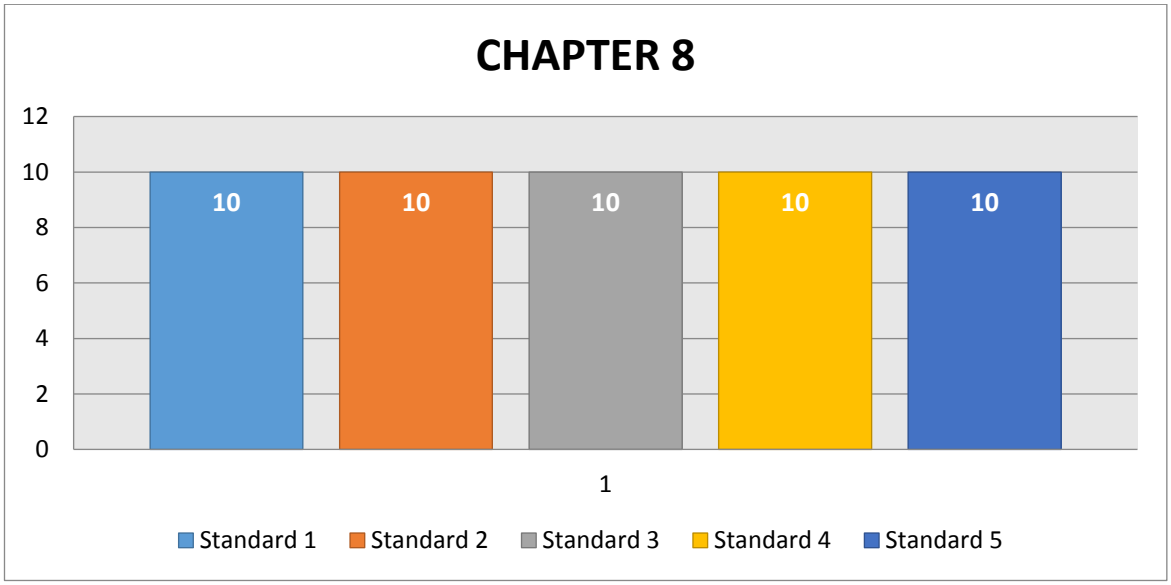
3.2.7. Graph 7: Average Score for Responsibilities of Management (ROM)



3.2.8. Graph 8: Average Score for Facility Management & Safety (FMS)



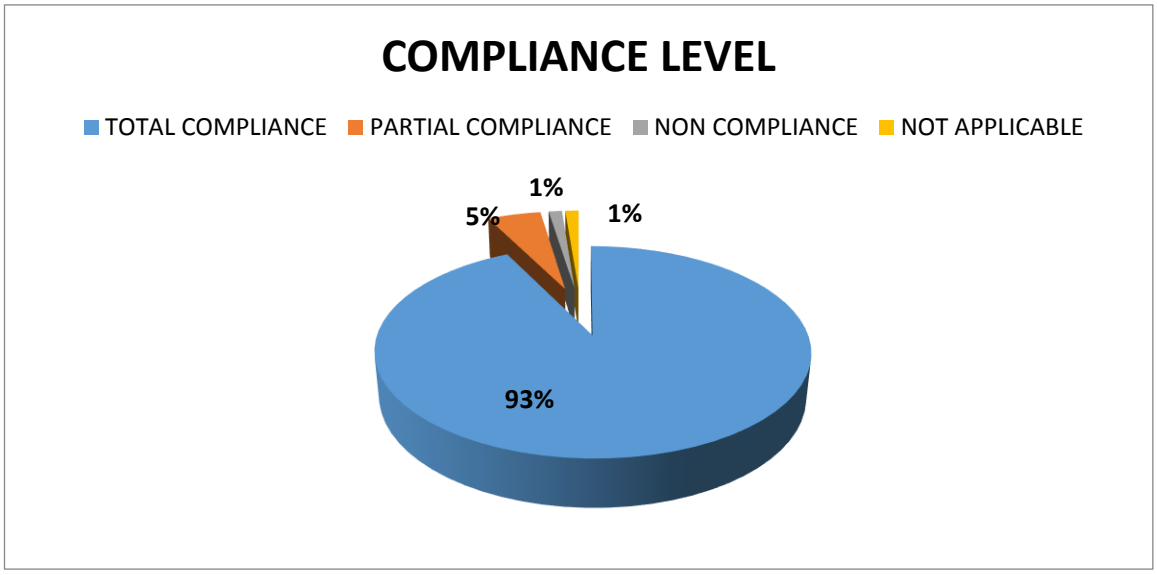
3.2.9. Graph 9: Average Score for Human Resources Management (HRM).



3.2.10. Compliance Level

TABLE : 4		
TOTAL OBJECTIVES		245
TOTAL COMPLIANCE	92.60%	227
PARTIAL COMPLIANCE	4.89%	12
NON COMPLIANCE	1.22%	3
NOT APPLICABLE	1.22%	3

Graph:10



4. DISCUSSION

4.1.Emergency Department at EHCC

Emergency department in EHCC is managed by BLS trained doctors and nurses, and are qualified enough to manage all the emergency situations. EHCC has cardiac Ambulances which is equipped with all the emergency drugs and equipments and is managed by trained doctors and nurses. So the treatment starts even before patients arrival to emergency department, thus improving the survival rates. The emergency department is functional 24 X 7.

4.2.**Purpose**

To carter patient with relief and the manage the patients arriving at the hospital with acute medical and surgical emergencies without any biasness.
Length of stay in triage: 4 hours (average)

4.3.Pillars of Emergency:

- Pre Hospital Care
- Good Communication
- Good Transportation
- Good Hospital

4.3.1. Pre Hospital Care

- Advanced disease Detection
- Advanced Reporting
- Advanced Response
- On the scene care
- Care during transportation

- Transfer to health care organization

4.3.2. Good Communication

The hospital receptionist is responsible for attending the call & sending the Ambulance within 10 minutes. The ambulance has to be loaded with GPS system & phones for communication

4.3.3. Good Transportation

- Ambulance loaded with lifesaving drugs
- Trained doctors, Nurses, Driver & other staff

4.3.4. Good Hospital

- Good Quality ER Department with trained Staff

4.4.Objectives

- To triage all patients reporting to ED.
- To make available best in class treatment.
- To analyze, treat, admit and provide referral and follow up.
- To ensure that patients receive treatment according to guidelines.
- To instigate lifesaving treatment.
- To provide end of life care. (Mentioned in sop but not practiced)

4.5.**Scope**

Scope of services of the ED range from providing sporadic, primary, acute(comprehensive) care to all the patients who seek immediate medical attention and to referral cases.

4.6.Emergency Care Service Provided

The ED service covers assessment, recovery and dealing of all the emergency conditions; it involves services of the following types:

1. Cardio-pulmonary emergencies.
2. Surgical Emergencies
3. Trauma Related Emergencies
4. Medico Legal Emergencies
5. Endocrinal Emergencies
6. Obstetrics & Gynecological Emergencies
7. Infectious Emergencies
8. Ambulance Services

Services which are yet to begin:

1. Burns Critical Care (although hospital accommodates burn patient but it still doesn't have dedicated burn unit)

4.7.Hospital Emergency Department:

- Location: Ground Floor
- Separate Entry
- Two Way Swinging Door
- 9 Bedded

4.7.1. Emergency Department Layout:

- **Administrative Area & Observation Area**
- **Critical Area**

4.7.1.1.Administrative Area & Observation Area

- Reception & Billing- 1 Staff each shift.
- Waiting Area for Attendants
- 3 Observation Beds

4.7.1.2. Critical Area

- 5 Critical beds
- Nursing station
- Medicine store

4.8.Emergency Department (ED) Classification of Capability & Staffing

- The Emergency Department provides 24 X 7 treatment facility all through peak hours; the consultants of all medical services are offered in the hospital and can be reached instantly in case of any need.
- During non-peak hours the consultants are available on call. In case of accident involving numerous individuals at a time all consultants and staff members responsible to provide critical can be called as per the requirement.

4.8.1. **Responsibilities**

Staff present at the unit is expected to work proficiently to save lives. Staff responsible are, In-charge ED (Dr.Hemant Garg), doctor on duty, other residents, nursing in charge (Mr. Om Prakash Tiwari), Emergency Co- coordinator (Ms Mandavi), nurses, GDA and other departments who work in coordination with the emergency department.

4.8.2. **Roles of ED Staff Members**:

(A) **Operational Medical Director: Dr. Manmeet Makkar**

- Complete Management Of ER

(B) **Medical Coordinator:**

- Assisting OMD In Complete Management OF ER
- Preparing Duty Roaster for ER staff

(C) **Receptionist/ Billing Assistant:**

- Counselling of patient attendants
- Registration & Billing of patients
- Arranging & sending Ambulance for patient pick& Drop
- Record Maintenance of ER

(D) **Doctors:**

- Treating & Stabilizing ER patients

(E) **Nursing**:

- Assisting Doctors in Treatment Of Patients
- Maintaining Stock of Medicines

(F) **Nursing Orderly**:

- Shifting of Patients in ER & Other Wards, OT, Diagnostics & assisting Nurses

(G) **Housekeeping:**

- Wet & Dry Swabbing of ER department

4.9.PATIENT REGISTRATION

A. IF patient is with Relative

- Receptionist asks the patient details.
- Registration form is filled by attendant.
- Billing is done at the billing Counter.

B. If Patient is brought by some unknown person

- Receptionist asks housekeeping Staff to check patient Wallet/purse, pockets.
- Patient Relatives/friends/police is informed
- In meanwhile patient treatment starts

C. MLC Cases

- Police informed by Security in charge
- First Aid given to Patient
- On arrival of Police other formalities done
- Further treatment done if Required

D. If patient Brought Dead

- Documentation Done by ER staff
- Police is informed for formalities (suspicious cases)
- Dead body handed over to Relative/ friends

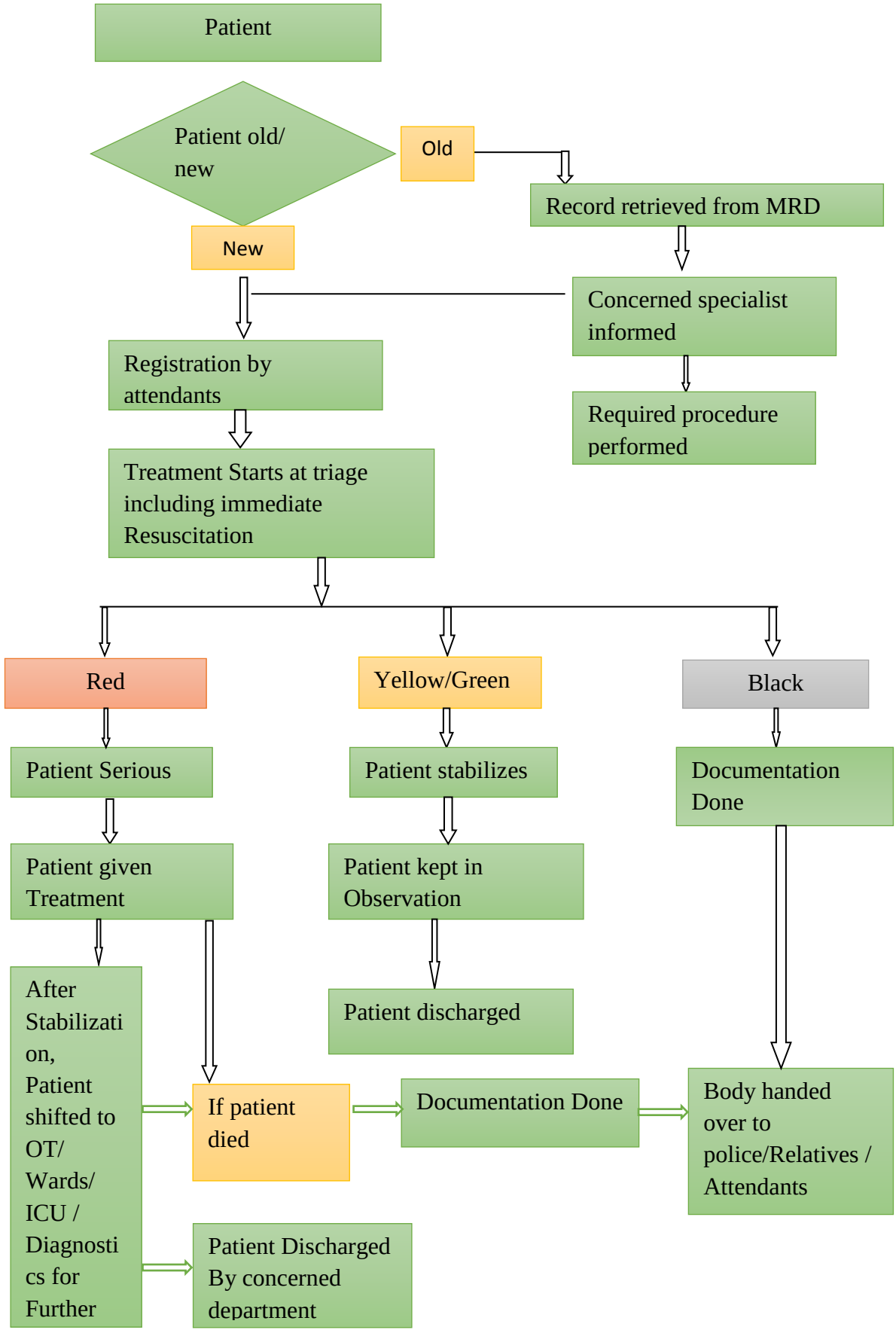
E. If Patient Left Against Medical Advice

- It is duty of ER coordinator to take written consent from patient attendant

F. If the Patient/Attendant is not in condition to pay the Bill

- It is the duty of ER Department to Stabilize the patient & then transfer the patient to Government Hospital in Hospital Ambulance(Legal Implication)

Fig: 4 PATIENT FLOW CHART



4.10. Patient Initial Screening Exam

1. The initial assessment will be done by the doctors and nursing staff for emergency patients.
2. TAT for the initial assessment will be 10 minutes.
3. The Initial assessment will include ascertaining the level of consciousness, recording blood pressure, Pulse, temperature, Spo2, random blood sugar .
4. The initial assessment will ascertain the condition of the patient whether stable or unstable and appropriate measures will be taken.
5. Initial Assessment will include nutritional assessment of patient
6. initial assessment by the medical officer will include the following criteria:

➢ **Assessment criteria for non-Road Traffic Accident patients include:**

- Presenting History:
- Past Medical History:
- Allergies:
- O/E:
- Temp. ,BP , PR, Spo2-,
- CVS/RS/ABD/CNS:
- Investigations done:
- Provisional diagnosis:
- Treatment given:
- Course of action: outpatient/admission/transfer out/references

- **Assessment criteria for Road Traffic Accident patients include:**

- Presenting history:
- Past medical history:
- Allergies:
- Last meal:
- O/E:
- Level of consciousness- , GCS, Pupils, Temp-, BP- ,PR
- CVS/RS/ABD/CNS:
- L/E:
- Investigations done:
- Provisional diagnosis:
- Treatment given:
- Course of action: outpatient/admission/transfer out/references
- MLC initiated
- The assessment done on arrival of patient is documented.

4.11. Admitting Patients from the Emergency Department

- In case admission of the patient is necessary, Consultant makes the decision for admission and authorizes it.
- The ED nurse is informed if the patient is to be admitted.

- Admission to the ICU is approved by the attending Consultant.
- After the patient representative makes the necessary admission procedure & admission is confirmed, patient is transferred to the floor by the ED nurse staff on duty along with the housekeeping staff.
- The ED nurse communicates with the nurse in charge of the floor and confirms the availability of the bed and initiates the transfer of the patient to the floor admitted.
- Exceptions occur in cases of life and death emergencies. The patient will be transferred to the ICU directly from the ED and registration & documentation may be postponed.

4.12. Medico Legal Cases (MLC)

4.12.1. MLC CASES TYPES:

- Road Traffic Accident
- Assault Injury Cases
- Poison Cases
- Burns
- Snake Bite
- Suicidal cases
- Death Due to Un natural cause
- Unattended unconsciousness

4.12.2. Brought Dead

- Look for / Ask about any suspicious signs: Poisoning, Strangulation –mark around neck / abnormal signs, Any external injuries
- Expose the body completely and look for any sings
- Palpate the head and look for any hematoma
- If a female, ask history of married life and if it is less than 7 years register it as MLC
- Register all brought dead cases as medico-legal case if death has occurred unexpectedly or from an unexplained cause
- After complete examination and confirmation by clinical evaluation death & is confirmed, the individual should be declared as Brought in Dead (BID) and the accompanying relatives/friends must be explained and informed about the probable cause of death The police should be informed immediately. The police will do the further disposal of the dead body after inquest. The Emergency Medical Officer will render necessary assistance.

4.12.3. Death on Arrival

If a patient has sudden Cardio-Respiratory Arrest on arrival at the Emergency Room, the patient has to be resuscitated as per ACLS protocols. Once death is confirmed the case should be treated as death on arrival, and necessary documentation should be done. Doctor should go into the detailed history of the patient and arrive at the probable cause of death. On the basis of this, cause of death certificate should be issued and arrangements for release of the body are taken after settlement of hospital dues.

4.12.4. Handling of Death & Release of Dead Body

Death of a patient is handled carefully with concern without self-righteousness. Counseling of next of kin with sympathy is given at most importance. The dead body is released as soon as possible after completion of all formalities.

Acknowledgement for receipt of the body and the casualty Certificate is obtained from Next of Kin/Legal representative. Handing-over of the body is a Solomon occasion and it is ensured that hospital staff takes due care and concern in this respect. Due arrangements are made if preserving the body in the mortuary is found necessary.

4.12.5. Death Certificate:

In charge, doctor on duty should certify the cause of death in the Death Certificate after careful and thorough examinations of the patient after discussing with the concerned consultant. Death certificate is initiated if the death occurs within the hospital, unless there are grounds and evidence to the contrary. The cause of death should be well documented and a copy of the Death certificate should be filed along with the medical documents of the deceased patient.

4.13. Consent for Treatment

Consent is the documented proof of patient wanting to have treatment or not. Documentation is a must and as well as it’s a legal obligation & responsibility.

4.14. Codes In ER

TABLE: 5		
CODE	**SITUATION**	**EXT NO**
Code Blue	Individual disaster	66
Code Yellow	External Disaster	67
Code Red	Fire Disaster	67
Code Grey	Non Fire Disaster	67
Code pink	Baby Missing	67
Code Purple	Fight or Fight Likely	67

4.15. Disaster Preparedness Plan

4.15.1. Response Time

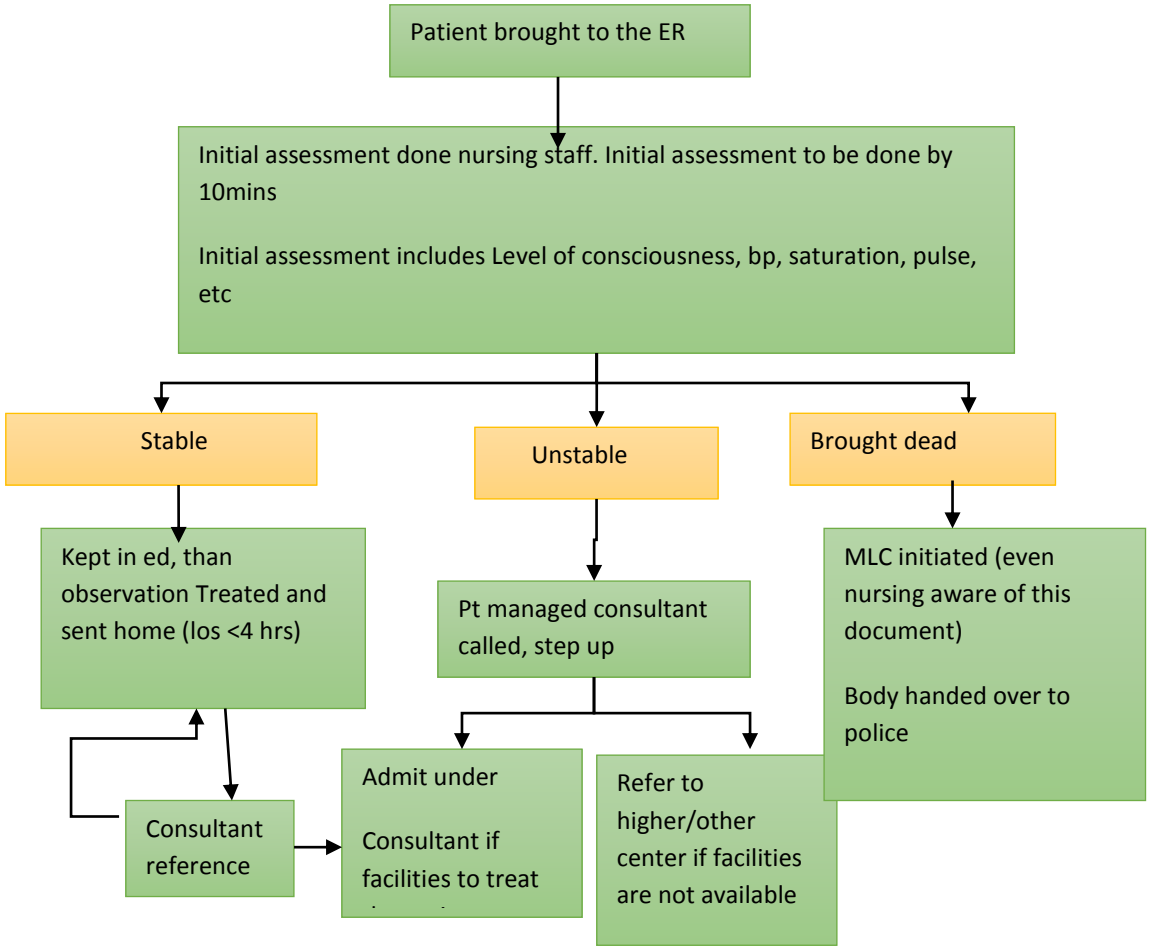
All patients coming to the ED for treatment will be given care by qualified medical team in a timely manner consistent with the acuteness of their illness. The Nurse assessment at the triage is done without delay. All patients arriving in the ED are examined and attended by doctors without delay. Staff in the Ed does not wait for patients to get registered or to have UHID. The Consultants of particular department are called & they attend to the patient immediately during the regular hours of operations of the OPD. During after hours, Consultants on call are contacted immediately upon need. Treatment to patients who are critical is initiated immediately without any delay for the purpose of documentation and consent.

4.15.2. Triage

Emergency Department patients will receive prompt initial assessment by a registered nurse (all the nurses in Ed are qualified to conduct initial assessment) and will have emergency care initiated according to their level of acuteness. The preferred outcome of the triage process is that all Emergency Department patients will receive useful treatment according to time-honored priorities.

Emergent patients requiring immediate intervention are transferred to the appropriate bed station in the ED to initiate the patient assessment & care process. The registration process of the patient is also initiated in the ED if the patient condition permits. In case of limb and life threatening situations the registration and consent process are postponed so as to facilitate the initiation of appropriate emergency care. The severe patients are treated and transported first, while those with lesser injuries are transported soon after. This sorting is done to actually see which patient has to be taken care immediately and which patient can wait.

Fig: 5



4.16. Ambulance Services

AMBULANCE: An ambulance is a used for transfer of sick and injured patients between two places of treatment.

4.16.1. Role of Ambulance Services:

- Ambulance is an outreaching limb of hospital based medical service
- To Transport sick & injured as quickly &comfortable to hospital
- To provide prompt treatment & care

EHCC has 2 fully equipped ambulances round the clock.
Emergency department: keeps record of all the patients admitted here. E.g. Assessment sheets, pre triage, doctor notes and investigations performed.

4.16.2. Findings about Ambulance at EHCC Hospital Jaipur:

- Number of ambulance: 2 Cardiac Ambulances
- Number of staff present in ambulance: 3 in each (1 Nurse,1 GD, 1 Driver), (1 Doctor is present if patient is very critical)
- Response Time: ambulance has to leave within 10 minutes of receiving the call.
- Facility: 24 Hours
- Ambulance has all the necessary equipment's just like emergency department, for e.g., oxygen, monitoring, ECG, defibrillator, ventilator.
- High risk medicines
- Specifications regarding oxygen cylinder: 2 big cylinder and 1 small cylinder and at 40 mm oxygen cylinder needs to be refilled.
- 1 stretcher: used to transport patient.
- 1 scoop: primarily used for lifting heavy patients.
- 1 spine: primarily for spinal patient.
- 1 attendant for 1 patient

- No traffic rule: if patient is critical, otherwise abide to traffic rules.
- Daily (3 hourly) check from the checklist regarding inventory
- 2-4 calls daily for the ambulance (hospital ambulance).
- Daily Cleaning of the ambulance
- Pillow cover and bed sheets are changed after every patient.
- Not all GD and drivers are BLS (BASIC LIFE SUPPORT) trained.
- Fire extinguishers: present 2 big cylinders.
- No toll tax for ambulance
- 1cell phone in ambulance.

4.16.3. EQUIPMENT'S OF AMBULANCE

- BP Apparatus
- Stethoscope
- Portable Suction apparatus
- Hand operated Bag Mask(Size3, 4, 5)
- Oxygen Cylinder
- Oropharyngeal Airways
- Mouth to Mouth Artificial Ventilation Airways
- Universal Dressing & Sterile Gauze Packs
- Bandages
- Obstetrical Kit
- Anti-poison Kit
- ECG machine
- Defibrillator

- Respirator
- Ambubag
- Portable X ray Machine
- Torch
- Phone
- GPS System In Ambulance
- Essential Life Saving Drugs & Fluids

4.17. Emergency Department Equipment's:

- Centralized Piped Oxygen & suction
- Wall Mounted Manometer
- Airways & Resuscitation bags
- Portable Defibrillator, ECG,& Monitoring Oscilloscope
- Respiratory Aids
- Special Medications, Intravenous fluids
- Essential Life Saving Drug Kit
- Sufficient Bandages, drugs & plaster
- 2 wheel Chair
- 1 Trolley

[ER Equipment's: Checked & monitored 3 times a day by Nurse in Charge]

4.18. Documents Maintained In ER:

4.18.1. Registers

- ER Patient register
- Transfer out Register
- Minor procedure Register
- MLC Register
- Trop T Rapid Register
- Blood Sample Register
- CSSD Register
- Ambulance D/c Register
- MRD Register
- Bio Medical Equipment Complaint Register
- Gluco Strip Register
- Death Register
- Daily Checklist register

4.18.2. Forms

- OPD Prescription
- MLC Information Form
- Radiology Requisition Form
- Triage Assessment Form
- Triage Nursing Assessment Form
- Pathology Form
- Admission Form
- HIV Consent Form

- In house Transfer Form
- Billing Activity Sheet
- Progress Notes
- Nursing Admission Assessment Form
- Informed Consent For High Risk
- CAG Notes Form
- Nursing Log for CATH Procedures
- Consent for Radiology Form
- Blood Donation Form
- Consent for Operation/Procedure Form
- PTCA Notes Form
- Post Procedural Orders Form
- Informed Consent Form for Cardio Vascular & related Procedures.

4.19. **Storage of Medicines in Emergency Department**

- All Emergency medications are available 24 hrs. in the ER
- All Emergency medications are replenished by the nurse on duty after every patient use.
- Medication inventory / Crash cart is checked by the nurse on duty with each shift change, to detect loss or theft.
- Narcotics drugs are not kept in ER department and indent is made when patient gets admitted. Narcotics drugs are kept in double lock in IPD pharmacy.

- Narcotic drugs is released only on the signed requisition of the in charge emergency department.
- Working condition of the ER equipment's is checked by the nurse on duty with each change in shift.
- Any Malfunction /nonfunctioning of the equipment is brought to the notice of the nurse in charge and the emergency co coordinator and work order is raised.

4.20. Infection Control in ED

- All Emergency staff undergoes training on infection control
- All Emergency staff follows the infection control procedures as laid down by the infection control Committee.
- All Needle stick injuries is reported through incident report to the chief medical officer
- Swabs are taken from the nose, axilla, groin, bedsores (if present) of patients fulfilling those criteria and sent to lab and will be informed to the Respective unit nurse on handing over the patient.
- Since ED is one of the high risk areas standard precautions are taken by the staff at all times.
- Equipment cleaning and sterilization is supervised by the nurse in charge.
- Proper biomedical waste management protocols are followed.

5. CONCLUSION

The study revealed that the average score of Emergency Department is 9.628 which make the hospital eligible for appearing for final assessment, as minimum score required was 7. The area of concern lies with implementation of policies and procedures as documentation is almost covered.

The Emergency Department has :

- 92.6 % Compliance
- 5% partial compliance
- 1.22% non-compliance.
- The individual standard has overall scores not less than 5
- Individual chapter has aggregate score not less than 7.
- No individual standard has more than one zero.

The Aggregate scoring Emergency Department is 9.628 and in accreditation stage as per NABH standards and is fit for accreditation. Few gaps are identified, if fulfilled, will help in improving the efficiency of department and hospital to attract and accommodate more patients with better patient care.

6. RECOMMENDATIONS

- A proper alert mechanism should be there in form of bell so that even if staff is busy, they will be intimated about patient arrival.
- There must be a proper waiting area with adequate seating capacity.
- Emergency gate should be used only for emergency patient and OPD patients and staff should not be allowed entry from here.
- There must be a proper refusal form for LAMA/ DOR patients.
- There must be a proper refusal form for procedures.
- There must be a proper refusal form for MLC.
- There must be a proper consent form for ambulance.
- Emergency beds can be marked as cardiac beds, trauma beds, pediatric bed and general beds.
- Formulation of Emergency management Committee: It would be composed of representative from different disciplines related to emergency department. This committee would analyze the policies, procedures and plans that are designed to cater the emergencies and would evaluate their effectiveness for continuous quality improvement and for management of disasters.
- There must be regular training on BLS for all the staff of ER including GDA and ambulance drivers.
- Proper handover should be maintained by ER staff with signing off. Handover must also be done between ER doctors after every shift.
- TAT monitoring should be done for average time for ER admission.
- Briefing of the policies & SOP must be done to the staff in the form of continuous learning.
- There should be a poster on patient's right & responsibilities as well as employee rights and responsibilities

7. APPENDIX

Policies and SOP of hospital related to emergency department:

- AAC 01 -POLICY ON SERVICES PROVIDED BY THE HOSPITAL.
- AAC 02 - POLICY ON ACCESS TO CARE. (IT DEFINES THE RIGHT TO ACCESS CARE FOR THE PATIENT PRESENTING IN ETERNAL HOSPITAL.)
- AAC 03 - POLICY ON REGISTRATION OF PATIENTS. (THERE IS A REGISTRATION FORM WHICH CONTAINS NAME, AGE, SEX AND ADDRESS. ONCE THE PATIENT IS REGISTERED A UHID NUMBER IS GENERATED.)
- AAC 04 - POLICY ON ADMISSION OF PATIENT.
- AAC 08 - POLICY ON TRANSFER IN OF PATIENTS.
- AAC 09 - POLICY ON TRANSFER OUT OF UNSTABLE PATIENTS.
- AAC 10 - POLICY ON TRANSFER OUT OF STABLE PATIENTS. (ALL THE PATIENTS WHO ARE BEING TRANSFERRED TO EXTERNAL FACILITY SHALL BE PROVIDED WITH CASE SUMMARY MENTIONING THE STATUS OF THE PATIENT, SIGNIFICANT FINDINGS, TREATMENT GIVEN IN THE HOSPITAL AND REASON FOR TRANSFER. THEY SHOULD HAVE MONITORING DATA AT THE TIME OF TRANSFER.)
- AAC 11 - POLICY ON DISCHARGE OF PATIENT.
- AAC 12 - POLICY ON CONTINUUM OF CARE.
- AAC 13 - POLICY ON ASSESSMENT OF PATIENT. (TO FOLLOW A UNIFORM PROTOCOL FOR INITIAL ASSESSMENT OF PATIENTS REQUIRING HEALTHCARE SERVICES IN OPD, IPD AND EMERGENCY SERVICES BASED ON CLINICAL REQUIREMENTS. INITIAL ASSESSMENT AT THE TIME OF ADMISSION FOR RESIDENT

DOCTORS/ CONSULTANTS IS 30 MINUTES FOR CRITICAL PATIENTS AND 1 HOUR FOR NON CRITICAL PATIETNS.)

- AAC 14 - POLICY ON RE-ASSESSMENT OF PATIENTS. (CONTINUED ASSESSMENT AND REASSESSMENT OF DOCTORS SHALL BE DOCUMENTED IN INITIAL ASSESSMENT SHEETS, TRIAGE ASSESSMENT FORM AND DAILY PROGRESS NOTES. FOR NURSES, INITIAL NURSING ASSESSMENT, VITAL RECORD CHART, I/O CHART, NURSING DAILY ASSESSMENT, INVESTIGATION FLOW CHART, NURSES CARE PLAN, TRIAGE NURSING ASSESSMENT FORM. FOR DIETICIANS NUTRITION ASSESSMENT FORM, DIET SHEETS. FOR PHYSIOTHERAPISTS PHYSIOTHERAPY ASSESSMENT FORM AND PROGRESS NOTES.)
- AAC 22 - POLICY ON TRIAGE/ PATIENT DISTRIBUTION.
- AAC 25 - POLICY ON PRIORITISING OF PATIENTS.
- E.R SOP NO 3.9 - POLICY ON DISCHARGE ON REQUEST OR LEAVING AGAINST MEDICAL ADVICE.
- E.R SOP NO 3.6 - POLICY ON DISCHARGE SUMMARY.
- E.R SOP NO 3.2 - ADMISSION AND OBSERVATION
- E.R SOP NO 3.4 - ADMISSION TO ICU.
- E.R SOP NO 3.7 - POLICY ON INDENT PROCESS.
- MOM 02 - POLICY ON HOSPITAL DRUG FORMULARY (THE FORMULARY HAS BEEN DEVELOPED BY THE DRUG COMMITTEE.
- MOM 02 - (MOM 02/7.0) - POLICY ON NON FORMULARY DRUGS. (ETERNAL HOSPITAL SHALL OPERATE UNDER A CLOSE FORMULARY SYSTEM THAT HELPS ASSURE THE QUALITY OF DRUGS USED AND CONTROLS COST. IT IS CONTINUALLY REVISED. IT IS MADE AVAILABLE AT ALL PATIENT CARE AREAS THIS SHALL

BE REFERRED WHENEVER REQUIRED PRESCRIPTION OF MEDICINE.)

- MOM 03 -POLICY ON ACQUISITION OF MEDICINE. (TO PROVIDE DETAILS OF METHOD OF PROCUREMENT OF STOCK FROM HOSPITAL PHARMACY.)
- MOM 04 - POLICY ON STORAGE OF MEDICATIONS. (TO ESTABLISH A SAFE AND EFFICIENT PROCEDURE FOR STOCKING MEDICATIONS IN THE PHARMACY, central STORE, OT STORE AND NURSING CARE AREAS. INVENTORY CONTROL IS BY ABC AND VED MECHANISM.)
- MOM 05 - POLICY ON STORAGE OF MEDICATION AND AMBULANCE.
- MOM 06 - POLICY ON REPLENISHMENT OF EMERGENCY DRUGS. (TO ENSURE AVAILABILITY OF MEDICINES AT THE TIME OF EMERGENCY. ADEQUATE AMOUNT OF EMERGENCY MEDICINES SHALL BE STOCKED AT ALL TIME IN THE CRASH CART.
- MOM 07 - POLICY ON PRESCRIPTION OF DRUGS. (ONLY A REGISTERED MEDICAL PRACTITIONER SHALL PRESCRIBE MEDICATION. ALL MEDICATION ORDERS SHALL BE IN WRITING AND SIGNED BY THE PHYSICIAN. ALL MEDICINES PRESCRIBED FOR THE PATIENT SHALL BE ENTERED IN THE PHYSICIAN ORDER SHEET IN CHRONOLOGICAL ORDER. THE NAME OF THE DRUG SHALL BE CLEARLY MENTIONED IN LEGIBLE WRITING. ALL ENTRIES MUST BE DATE AND TIMED. THE ROUTE, DOSAGE, STRENGTH AND FREQUENCY OF ADMINISTRATION OF THE DRUG MUST BE CLEARLY INDICATED BY THE DOCTORS AND ADMINISTRATION TIME SHOULD BE TRANSCRIBED BY THE NURSING STAFF IN MAR SHEET.
- MOM 08 - POLICY ON VERBAL ORDERS.
- MOM 09 - POLICY ON SAFE DISPENSING OF MEDICATIONS. (CHECKS SHALL BE DONE AT PHARMACY AND NURSING STAFF ON DUTY.)

- MOM 10 - POLICY ON SAFE ADMINISTRATION, MONITORING AND DOCUMENTATION OF MEDICATION. (ALL MEDICATION WILL BE ADMINISTERED BY REGISTERED NURSES. IF A NURSE PREPARES

  MORE THAN ONE SYRINGE AT THE TIME OF ADMINISTRATION EACH SYRINGE SHALL BE LABELLED BEFORE PREPARATION OF SECOND SYRINGE. IT IS MANDATORY FOR THE NURSE TO CHECK 2 PATIENT IDENTIFIERS BEFORE ADMINISTERING THE MEDICATION. MEDICATION WILL BE GIVEN AS PER THE PRESCRIBING PHYSICIAN ORDERS. THE MEDICATION LABEL IS CHECKED BY THE NURSE FOR CORRECT DRUG, STRENGTH AND TIME. CHECK THE DRUG CHARTS FOR THE LAST RECORDED DOSE OF MEDICATION BEFORE ADMINISTERING THE PRESCRIBED DRUG. ALL MEDICATIONS SHALL BE ADMINISTERED USING 10 RIGHTS OF MEDICATION ADMINISTRATION. THE REGISTERED NURSE ADMINISTERING THE MEDICATION SHALL RECORD THE MEDICATION ADMINISTERED IN THE PATIENT'S RECORD WITH SIGNATURE IN APPROPRIATE SPACES AS SOON AS MEDICATION IS GIVEN.)

- MOM 11 - POLICY ON SELF ADMINISTERING OF MEDICATIONS.

- MOM 12 - POLICY ON SAMPLE AND HOME MEDICATION.

- MOM 14 - POLICY ON CONTROLLED SUBSTANCES. (STORED IN DOUBLE LOCKED CABINETS WHEN NOT IN USE. STORAGE AREAS WILL BE SECURED AND SHALL BE ASSESSABLE ONLY TO DESIGNATED AND AUTHORISED PERSONNEL. PROPER ENVIRONMENTAL CONTROL WILL BE MAINTAINED.

- MOM 17 - POLICY ON REPORTING OF MEDICATION ERROR. (IT SHOULD BE REPORTED ON PATIENT SAFETY EVENT REPORTING FORM IMMEDIATELY. REPORTING SHOULD BE DONE IMMEDIATELY. DOCUMENTATION CAN BE DONE WITH IN 24 HOURS.

- MOM 18 - POLICY ON ADVERSE DRUG REACTION.
- MOM 20 - POLICY ON HIGH RISK MEDICATION. (ALL HIGH RISK MEDICATIONS MUST BE COUNTER CHECKED/ INDEPENDENT DOUBLE CHECKED BY THE IN CHARGE/ SHIFT IN CHARGE WHO MUST COUNTER SIGN THE CHART.)
- MOM 25 - POLICY ON HOSPITAL DRUG AND CONSUMABLE STORAGE AND CONTROL.
- MOM 26 - POLICY ON NEAR EXPIRY MEDICATION. (MEDICATIONS WHICH HAVE EXPIRY DATES IN NEXT 3 MONTHS WILL BE CONSIDERED AS NEAR EXPIRY MEDICATION.)
- RADIOLOGY SOP NO 3.1 - POLICY ON STANDARD OPERATING PROTOCOLS FOR RADIOLOGY DEPARTMENT. (RADIOLOGY SERVICES SHALL BE AVAILABLE 24 HOURS A DAY, 365 DAYS A YEAR FOR ALL EMERGENCY INVESTIGATION.)
- RAD SOP NO 3.2 - POLICY ON APPOINTMENT AND DISPATCH PROCEDURES FOR RADIOLOGY INVESTIGATION.
- HIC 01 - POLICY OF PREVENTION AND CONTROL OF INFECTIONS. (TO PROVIDE A PROGRAM FOR SURVEILLANCE, PREVENTION AND CONTROL OF HOSPITAL ASSOCIATED INFECTIONS AMONG THE PATIENTS INCLUDING OUTPATIENTS, INPATIENTS, STAFF AND VISITORS.)
- HIC 07 - POLICY ON HAND HYGIENE.
- HIC 08 - POLICY ON PREVENTION OF NEEDLE STICK INJURIES.
- HIC 09 - POLICY ON MANAGEMENT OF BIOMEDICAL WASTE AND HANDLING OF THE SAME.
- COP 01 - POLICY ON UNIFORM CARE OF PATIENT. (PATIENT SHALL BE ESCORTED FROM THE EMERGENCY DEPARTMENT TO RELATED

WARDS UNDER SUPERVISION OF EMERGENCY PERSONNEL. THE CONSULTANT SHALL PRACTICE EVIDENCE BASED MEDICINE FOR CARE OF PATIENT TILL DISCHARGE.)

- COP 02 - POLICY ON EMERGENCY CARE OF PATIENTS.
- COP 03 - POLICY ON AMBULANCE SERVICES.
- COP 04 - POLICY ON CARDIOPULMONARY RESUSCITATION.
- COP 05 - POLICY ON USE OF BLOOD AND BLOOD PRODUCTS.
- COP 07 - POLICY ON RESTRAINTS.
- COP 08 - POLICY ON CARE VULNERABLE PATIENTS.
- COP 09 - POLICY AND USE OF CONSCIOUS SEDATION.
- COP 10 - POLICY ON USE OF DEEP ANAESTHESIA AND DEEP SEDATION.
- COP 15 - POLICY ON MANAGEMENT OF PAIN.
- COP 23 - POLICY ON PREVENTION OF PROCEDURES RELATED TO ADVERSE EVENTS.
- COP 24 - POLICY ON END OF LIFE CARE.
- OPD SOP 4.1 - POLICY ON REGISTRATION OF OPD PATIENTS.
- OPD SOP 4.3 - POLICY ON BILLING OF OPD PATIENTS.
- PRE 01 - POLICY ON PATIENT RIGHTS AND RESPONSIBILITIES.
- PRE 02 - POLICY ON PATIENT CONSENT.
- PRE 04 - POLICY ON PATIENT/ VISITORS COMPLAINTS.
- FMS 04 - POLICY ON SAFETY AND HEALTH TRAININGS. (THE SAFETY COMMITTEE SHALL DEVELOP VARIOUS PROGRAMS IN COMPLIANCE WITH ENVIRONMENTAL AND SAFETY STANDARDS. THESE WOULD INCLUDE TRAININGS ON CHEMICAL HYGIENE, ELECTRICAL SAFETY , FIRE SAFETY, PERSONAL PROTECTIVE

EQUIPMENT, LADDER SAFETY, RADIATION SAFETY, WASTE MANAGEMENT, RIGHT TO KNOW AND NEW EMPLOY ORIENTATION.)

- CQI 01 - POLICY ON IMPROVING ORGANISATION PERFORMANCE.
- CQI 02 - POLICY ON VARIANCE REPORTING.
- NM 0248 - POLICY ON AMBULANCE SERVICES.
- NM 0140 - POLICY ON ENDORSEMENT TO NEXT SHIFT.
- NM 071 - POLICY ON DOCUMENTATION AND NURSES NOTE.
- IMS 02 - POLICY ON DOCUMENTING AND ACCESSION OF MEDICAL RECORDS.
- MRD POLICY - AUTHORISATION TO MAKE ENTRY IN PATIENT FILE. (FOLLOWING STAFF ARE AUTHORISED TO MAKE ENTRY IN MEDICAL RECORDS: MEDICAL DOCTORS, NURSES, PHYSIOTHERAPISTS, DIETICIAN AND MRD STAFF.)
- HRM 01 - POLICY ON MANPOWER PLANNING.
- HRM 03 - POLICY ON ON BOARDING. (ONCE THE HIRING DECISION IS MADE TO RECRUIT A CANDIDATE, THE RECRUITER WILL COLLECT DOCUMENT LISTED IN THE POLICY. THE HR. EXECUTIVE ENSURES THAT ALL DOCUMENTS ARE COLLECTED WITHOUT ANY DEVIATION.)
- HRM 05 - POLICY ON COMPETENCY ASSESSMENT AND PERFORMANCE APPRAISAL.
- HRM 06 - POLICY ON PRE EMPLOYMENT HEALTH CHECK UP.
- HRM 07 - POLICY ON EMPLOYEE HEALTH CHECK-UP.
- HRM 08 - POLICY ON GRIEVANCE HANDLING.
- HRM 09 - POLICY ON DISCIPLINARY ACTIONS.
- HRM 11 - POLICY ON OCCUPATIONAL HAZARD.

- HRM 18 - POLICY ON TRAINING AND DEVELOPMENT.
- HR SOP 4.1 - POLICY ON MANPOWER PLANNING.
- HR SOP 4.3 - POLICY ON PRE EMPLOYMENT CHECK UP.
- HR SOP 4.4 - POLICY ON INTRODUCTORY TRAINING.
- FMS 01 - POLICY ON FACILITY MANAGEMENT AND SAFETY. (IT IS ACCOMPLISHED BY SAFETY COMMITTEE WHICH SHALL OVERSEE ALL ASPECTS OF FACILITY SAFETY. CHIEF ENGINEER AND CHIEF SECURITY OFFICER SHALL BE RESPONSIBLE FOR DAY TO DAY MANAGEMENT OF FACILITY SAFETY. A COMPREHENSIVE SAFETY INSPECTION IS DONE TWICE A YEAR IN PATIENT CARE AREAS AND OVER A YEAR IN OTHER AREAS. PROPER HAZARDOUS MATERIAL HANDLING AND STORAGE SHOULD BE DONE AND ASSESSMENT TO BE DONE BY HAZMAT TEAM. THERE IS WRITTEN POLICY FOR DISASTER MANAGEMENT. ALL MEDICAL EQUIPMENT'S ARE UNDER PREVENTIVE MAINTENANCE SCHEDULE EITHER BY IN HOUSE BIO MEDICAL DEPARTMENT OR ANNUAL MAINTENANCE CONTRACT. THERE SHALL BE PROBATION FOR SAFE DRINKING WATER ALONG WITH ALTERNATIVE SOURCES IDENTIFIED IN CASE OF EMERGENCY. THE UTILITY SHALL BE AVAILABLE ALL THE TIME IN THE HOSPITAL. FOR ALTERNATE SOURCES OF ELECTRICITY THERE SHALL BE UPS AND GENERATOR POWER SUPPLY AVAILABLE.)
- FMS 02 - POLICY ON HOSPITAL SAFETY. (TO PROVIDE A SAFE AND HEALTHY WORK PLACE FOR ALL PATIENTS, VISITORS AND EMPLOYEES.)
- FMS 03 - POLICY ON SAFETY COMMITTEE. (TO ADDRESS ALL ISSUES REGARDING SAFETY, HEALTH AND ENVIRONMENT IN THE HOSPITAL AND TO ENSURE COMPLIANCE OF ALL REGULATORY REQUIREMENTS BY SAFETY COMMITTEE OF THE HOSPITAL.)

- FMS 05 - POLICY ON COMPRESSED GAS HANDLING, STORAGE AND ACCESS.
- FMS 09 - POLICY ON EMERGENCY EVACUATION PLAN.
- FMS 12 - POLICY ON HAZARDOUS MATERIAL SPILL.
- FMS 22 - POLICY ON APPROVAL FOR ACQUISITION AND IMPLEMENTATION OF PATIENT RELATED EQUIPMENT'S.
- FMS 23 - POLICY ON MANAGEMENT OF EQUIPMENT SERVICE AND MAINTENANCE.
- BME SOP 4.2 - POLICY ON EQUIPMENT MAINTENANCE AND CALIBRATION.
- BME SOP 4.3 - POLICY ON EQUIPMENT BREAKDOWN AND TROUBLESHOOTING.
- BME SOP 4.6 - POLICY ON GAS MANIFOLD SYSTEM. (TO INSTALL, COMMISSION AND MAINTAIN GAS MANIFOLD SYSTEM IN AN EFFICIENT AND COST EFFECTIVE MANNER.)
- BME SOP 4.7 - POLICY ON COMPRESSED GAS HANDLING, STORAGE AND ACCESS. (TO PROVIDE GUIDELINES CONCERNING THE SAFE HANDLING AND USE OF COMPRESSED GAS CYLINDERS.)
- SECURITY SOP 4.18 - POLICY TO REDRESS AND MANAGE UNTOWARD FIRE INCIDENTS.(IN ORDER TO PREVENT OR MINIMIZE DAMAGE TO PROPERTY AND LIFE OF THE PEOPLE DUE TO FIRE IT IS IMPORTANT TO IMPLEMENT EFFECTIVE PREVENTIVE AND ACTIVE CONTROL OVER FIRE INCIDENT IN FACILITY)

8. REFERENCES

- file:///C:/Users/admin/Desktop/priyanka_dissertation/Emergency_Brochure.pdf
- file:///C:/Users/admin/Desktop/priyanka_dissertation/Draft_Emergency_Medical_Services.pdf