Internship
at
Civil Hospital, Mohali

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1.1 INTRODUCTION OF THE ORGANIZATION

The Health and Family Welfare Department, Government of Punjab, is committed to provide preventive, promotive and curative health services to the people of state through a network of medical institutions such as sub-centers, subsidiary health centers, primary health centers, community health centers, Sub-Divisional and District Hospitals, Government Medical & Dental Colleges.

The Punjab Health Systems Corporation was enacted through a special act of legislation to provide for the constitution of a corporation for establishing, expanding, improving and administering medical care in the state of Punjab. There are 176 healthcare institutions under PHSC, out of which there are 21 District Hospitals, 34 Sub-divisional Hospital and 119 Community health centre. A wide spectrum of healthcare facilities, preventive, curative and promotive, is provided in these institutions.

Hospital Services at the secondary level play a vital and complementary role to the Primary Health Care System and together form a comprehensive district based health care system.. Both are essential part of a well-integrated health care system. One of the District Hospitals providing secondary healthcare facility in the district of Punjab is, Civil Hospital, Mohali

1.2 ORGANIZATIONAL PROFILE

Civil Hospital, Mohali is a 120 bedded secondary level institute, located in a district of Punjab, Mohali. This healthcare centre was started in late 90's.

The hospital is two storey building with registration, OPD, Pharmacy, emergency, ICU, imaging services, lab, labour room, NBSU, MRD, female ward, immunization room, purchase department, billing department, drug store, laundry and mortuary at the ground floor and OT, dialysis, blood bank, general male and pediatric wards and private rooms at the first floor and de-addiction centre at the second floor.

It is supported by 3 OT's i.e. eye, orthopedic and general surgery.

Civil hospital, Mohali provides the following services:

- General medicine
- General surgery
- Orthopedics
- Pediatrics
- Gynecology
- ENT
- Ophthalmology
- Dermatology
- Lab medicine
- Radiology
- Blood bank
- Dentistry
- Physiotherapy
- Psychiatry

1.3 DEPARTMENTS VISITED

Registration: Patient will attend the OPD registration desk for new patient registration and will inform the following details to the registration clerk:

- Name of the patient
- Age
- Sex
- OP clinic intending to consult or the disease suffering from so that the registration clerk can guide them to the proper OP.
- Employment status

The following patients are exempted from paying the registration charges:

- Member of both houses of the Parliament.
- Member of the Legislative Assembly.
- State Government Employees.
- Freedom Fighter.
- Below Poverty Card (BPL) holders.

Patient is allotted OPD registration number which is valid for the particular calendar year. The OP clinic number of the particular specialty, to be consulted is indicated in the OP case sheet of the patient.

Patients visiting the OPD of the hospital for follow up consultation within 1month from the date of previous consultation will attend the “follow up patient registration counter”. No fee is charged for such patients. A seal is marked in the case sheet of the patient and the same is handed over to the patients who then visit the particular OP clinic.

If the patient arrives 1 month of the prior date of OP consultation, the old registration number of the patient is deemed to be invalid and a re- registration has to be done following the process mentioned for new patient registration.

Admission: Decision regarding the need to admit the patient in the IP facility of the hospital is taken by the treating consultant, which is marked in the case sheet of the patient. Patients are admitted only if the required medical care is available in the hospital.

The doctor informs the patient and the relatives about the need for IP admission and indicates the same in the OP case sheet of the patient.

The admission of the patient is done at the IP registration window. If the patient is to be admitted in the private ward of the hospital, a separate admission form has to be filled which is available with the admission clerk in the admission window.

If the patient is to be admitted in the general wards of the hospital, the patient's details as indicated in the case sheet along with the specific general ward is recorded and IP number is allotted to the patient. The admission fee is collected by the admission clerk and payment receipt is handed over to the patient's relative. The patient is then taken to the specific ward, by the ward boy.

Discharge: Decision regarding discharging the patients rest with the primary treating consultant of the patient who make such decision during his evening rounds on the previous day prior to the discharge of patient and the same is communicated to the patient, relatives ,the concerned ward nursing staff / on duty Medical Officer. However the final decision regarding discharge is made on the basis of the condition of the patient during the morning round of the treating consultant on the scheduled day of discharge.

After final decision to discharge the patient is taken, the treating consultant, resident doctor or nurse in charge prepares the discharge summary of the patient which contains the following information:

- Reasons for Admission
- Investigations performed and summarized information about the results of the investigations
- Diagnosis made
- Record of any procedures (operation, etc) performed
- Condition of the patient at the time of discharge

- Medication instructions
- Follow up Advice
- Emergency contact number of the hospital

One copy of the Discharge Summary is handed over to the patient/relatives and the other copy is attached to the patient's case file**.**

Incase patient/relatives want to get discharged against medical advice; the same is indicated in the patient's case record by the primary treating consultant/medical officer. Records are entered in the LAMA register of the respective patient ward and a written consent is taken from the patient/relatives.

In case of expiry of the patient the primary treating consultant/medical officers/nursing staff informs the patient relatives.

Ward nurse makes necessary preparation for cleaning the body. The on duty medical officer prepares two copies of the Death Certificate and Death Summary which is then stamped. Body is handed over to the patient's relative or kept in the mortuary within an hour of death .Body handed over to the relatives along with one copy of Death Summary and Death Certificate and the other copy is attached to the patient case records.

Billing: In case of discharge of patients admitted in private wards of the hospital, ward nurse forwards the Patient File along with the Discharge summary to the Accounts for clearance.

Accounts departments prepare the final bill of the patient adjusting the advance paid by the patient/relatives at the time of admission. In case any refund has to be made the same is done or the balance if any is collected from the patient / relatives at the accounts section. Final settlement of payment is done, cash receipt prepared and handed over to the patient/relatives and a copy of the same is forwarded to the ward nurse who enters the same in the designated register maintained in the ward.

Emergency: It is located on the ground floor of the department with separate entry and a separate parking for ambulance.

The Emergency Department of Hospital offers comprehensive emergency care 24 hrs a day with one Emergency Medical Officer on duty during the morning and two Emergency Medical Officers in the evening and night shift respectively.

During peak hours, the consultants of all medical services are available in the hospital and can be reached immediately in case of any need and during non peak hours the consultants from each clinical department are available on call basis.

The patient arriving in the emergency department receives initial assessment by the registered nurse and the treatment is initiated according to the level of need. Patients requiring immediate intervention are transferred to the appropriate bed station in the ED to initiate the care process.

The registration process of the patient is also initiated in the ED if the patient condition permits. In case of life threatening situations the registration and consent process are postponed so as to facilitate the initiation of appropriate emergency care.

In case admission of the patient is necessary, the EMO / Consultant on duty make the decision for admission and authorize it.

After the necessary admission procedure is completed, the ED nurse confirms the availability of bed on the floor and shifts the patient along with his documents and reports.

In case of transfer of patient to other hospital due to non-availability of any facility, the decision is taken by the EMO. The availability of drugs and equipments in the ambulance is checked and a nurse is arranged to take care of the patient during the transfer. Transfer out form with patient's details, diagnosis, treatment performed, investigation results is handed over to the patient's attendant and details of transferring hospital are entered in patient's medical record.

In case of brought dead patients, the EMO thoroughly examines the patient and on confirmation of death, gives brought dead certificate to the patient's relatives. The hospital informs the local police for further disposal of the body.

In case of death on arrival EMO goes into the detailed history of the patient to arrive at the probable cause of death. On the basis of this, death certificate is issued and arrangements for release of the body are taken after settlement of hospital dues.

Pharmacy: Located adjacent to the emergency department.

Central medical store directorate is responsible for meeting the bulk of the pharmaceutical requirement of the hospital. The hospital makes periodic indent request to the CMSD.
The indent request is made on the basis of the reorder level for various pharmaceutical item used in the hospital. The supply of pharmaceutical item to the hospital is based on a fixed budget decided annually by the CMSD in collaboration with other government authorities under the Health and Family welfare, Government of Punjab.
CMSD ensure that the EDL is strictly adhered by the medical professionals and the healthcare facilities at various level under the purview of Health and Family Welfare, Government.

Few pharmaceutical products are purchased from the vendors who are already in contract with the hospital and in case of emergency; purchase can be done form nearby medical store under the supervision of SMO/EMO.

All pharmaceutical items are arranged alphabetically in the racks so that easy access is facilitated.
Narcotics are kept under lock and key in a cupboard. It is handled only by pharmacy in-charge or senior pharmacist.
A list of sound alike medicines is mentioned with the pharmacy in-charge and the same are stored separately.
Prior to dispensing the Medicine the pharmacist verifies the following details in the prescription:

- Name of the Patient, registration number
- Name of the drugs, dose and route prescribed.
- Name and Signature of the Prescribing Doctor along with the date and time.

Expiry Date of the item is checked prior to dispensing of the item by the pharmacist.

In case of inpatient, pharmacist issues the drugs to the nurse-in-charge.

Laboratory: It has provision of services in the following areas:

- Hematology

- Clinical pathology
- Biochemistry
- Serology

In case of outpatient, treating Doctor prescribes the required laboratory test in the OP case sheet of the patient. The clerk collects charges for the prescribed test, enters the details in the designated register. Patient visits the sample collection area of the laboratory department along with the payment receipt and OP sheet. Patient's laboratory requisition slip is made and details including the name of the patient, age, sex, sample identification number, tests to be performed, referring doctor are entered in the record register. Patient's name, type (OP/IP), sample identification number and sample type is also mentioned on the container used to collect the sample which is then sent to the laboratory to perform prescribed tests.

In case of inpatient, the ward nurse collects the sample and sends it to the laboratory along with patient's details.

All the test reports generated are signed by authorized laboratory personnel.

Radiology: The department provides following services:

- X-ray
- Computerized radiography
- Ultrasound

In case of outpatient, the radiological procedure is performed as prescribed by the consultant on the OP sheet of the patient. The clerk collects charges for the prescribed test, enters the details in the designated register. The patient visits the department along with the payment receipt and OP sheet. Patient's test requisition slip is made and an identification number is given to the patient. The prescribed tests are performed and the patient is sent to the consultant with the reports duly signed by the radiologist with date and time. The reports are dispatched after taking patient's/receiver's sign.

In case of inpatient, the nurse informs the department of the procedure to be performed. The patient is sent to the department with patient's case sheet. Tests are performed and reports duly signed by the radiologist, are handed over to the nurse/patient/attendant.

Biomedical waste management

According to the Punjab Pollution Control Board, the following color coded bins are used in Civil Hospital, Mohali, to segregate biomedical waste.

Table 1.1: Segregation of biomedical waste

Color coded bins	**Biomedical waste**
Yellow	Infectious waste like material contaminated with blood e.g. cotton, body parts
Blue	Solid waste like tubing, catheters
White	Sharp waste
Green	General waste

Bins have hand and foot operated lids and biohazard sign on it.

Monthly training is provided to the nursing staff and class IV employees regarding proper segregation of biomedical waste and a record register is maintained for the same.

Biomedical waste is disinfected and mutilated before final disposal.

Syringes are cut with the help of hub cutters before chemically disinfecting it with 1% sodium hypochlorite, at the source of generation.

Plastic waste like IV sets, bottles, latex gloves, catheters are cut by scissors and disinfected with 1% sodium hypochlorite for 1 hour before final disposal.

Blood bags and sharp waste like slides are disinfected with 5% sodium hypochlorite for 1 hour before finally disposing them off.

Liquid waste from laboratory is chemically treated with 4% sodium hypochlorite for 4-5 hours and then drained.

The hospital has provision of wheel barrows to collect the waste, from every department of the hospital in color coded plastic bags. There is a predefined route of carrying the biomedical waste to the collection centre build outside the hospital where the waste is not stored beyond 48 hours.

Record related to amount of biomedical waste generated in terms of weight, is maintained in the hospital.

The hospital does not have provision of treating biomedical waste i.e. incinerators, microwave, which is outsourced.

Issues: The hospital does not have provision of personal protective equipment at every nursing station, for the staff handling biomedical waste.

Blood bank: It is located on the first floor of the hospital and deals only with the transfusion of whole blood.

The department is divided into blood collection room, refreshment room, apheresis room, room for carrying out various tests and room for storage of whole blood.

Following records are maintained in the blood bank:

a. Blood donor record: It indicates serial number, date of bleeding, name, address and signature of the donor with other particulars of age, weight, hemoglobin, blood grouping, blood pressure, medical examination, bag number, and recipients detail for whom donated in case of replacement donation, category of donation (voluntary/ replacement) and deferral records and signature of Medical Officer in charge.

b. Master records for blood: It indicates bag serial number, date of collection, date of expiry, quantity in ml., ABO/Rh group, results of testing HIV, malaria, V.D.R.L., hepatitis B and hepatitis C, name and address of the donor with particulars, and signature of medical officer/ in charge.

c. Issue register: It indicates serial number, date and time of issue, bag serial number, ABO/ Rh group, total quantity in ml. , name and address of the recipient, group of recipient, name of the hospital and unit/ ward, details of cross-matching report, indication of transfusion and issued by.

d. Register for diagnostic kits and reagents used: Name of the reagent/ kit, details of batch number, date of expiry and date of use.

e. Records of purchase, stock in and stock out of disposable needles, syringes and blood bags.

f. Record of report sent to state AIDS control Society.

Issues: Adverse transfusion reaction record forms and needle stick injury record forms were not available and there were no such records maintained.

The staff of blood bank was made aware of adverse transfusion reaction (annexure 3) and needle stick injury record forms (annexure 4) and was being told to maintain a separate register for the same.

Medical records department: The Medical Record Department is responsible for proper storage, retrieval and maintenance of confidentiality and security of the record.

MRD is located on the ground floor of the hospital.

It maintains the records in proper accessible manner. All records are placed year and then month wise.

Handing over of records as & when required for administrative purposes is done by getting a slip signed by the person receiving the record e.g. for follow up of in-patients by the Consultants as well as by the Patients, for MLC.

Patient's relatives require a written authorization from the patient for obtaining information from the medical records. Such information is not given in original; a Xerox of the same is handed over to the patient and signature taken in specific format.

The medical record of a patient contains the documents arranged in a sequence of –

- Admission form
- Case sheet comprising of:-
    1. Medical History
    2. Clinical findings
    3. Investigations ordered

4. Treatment instituted
5. Progress reports
6. Consent form for surgery or specialized procedures
7. Anesthesia check record, if applicable
8. Notes on surgical/ special procedures, if applicable
9. Name, date and signature of treating doctor.
10. Laboratory reports in chronological sequence of their ordering
11. Films along with their reports

Narrative Summary with a discharge form is placed in the first position, so that the review can be quickly done.

Following are the records maintained in the department:

- Total number of OPD
- Total number of admissions
- Total number of discharge
- BOR
- ALOS
- Death rate
- Maternal death rate
- Neonatal death rate
- Total number of normal deliveries
- Total number of caesarian section

Laundry: This department is located outside, at the backside of the hospital. The matron is responsible for timely supply of clean and adequate linen to the user departments.

Soiled linen is collected and fetched from various departments by the housekeeping staff. Linen from OT, wards etc soiled with blood and other body fluids are washed at the respective point of generation for removal of the stain and are then send for autoclaving. After autoclaving the linen, the same is the collected for laundry. The matron is responsible for maintaining a register containing details regarding the type of linen, their number, respective ward/unit from where they are collected. The washed linen is then verified by the matron by cross matching with details entered in the register and then the linen is distributed to the user department.

Mortuary: It is located outside, at the backside of the hospital and has 6 refrigerators for storage of dead bodies.

After receiving the dead body the mortuary staff cleans the dead body and wraps it in sterile linen and puts it inside the cold chamber under appropriate temperature/ environmental conditions.

Dead bodies preserved in the mortuary are issued only after written instruction for the same by either the Senior Medical Officer or Emergency Medical Officer on duty.

Details regarding the dead body and the receiver of the same are entered in the Mortuary register. The information documented is as follows:

- Name of the person
- Age of the person
- Sex
- Address
- Name of receiver
- Relationship with the expired person
- Address of the receiver

Signature of the receiver is obtained in the specified column of the register and the dead body is issued to him.

Purchase department: The Department undertakes centralized purchasing of all materials for the hospital. The Material Management department purchases the items on the following two basis: reorder level and request for purchase of items from the User Department or Management.

In case of purchase of general items like stationary, the hospital purchases the required products from the identified vendors at the rate fixed.

The decision to purchase any equipment for the hospital is taken by a multidisciplinary committee known as purchase committee. The committee evaluates the need for any equipment in commensurate with the scope of services provided by the hospital and purchases it through either tender or quotation from three suppliers.

Once the item is received by the hospital, it is verified by the store in-charge, supplier and a representative from the purchase committee, against the order placed. After the clearance of verification of the material, the transaction is made in goods inward register and the invoice of the supplier is forwarded to the accounts for payment.

Transaction regarding the issue of the material to the user department is recorded in goods issue register.

The department prepares a monthly report of the Purchase summary (category wise), items issued during the month and the closing stock at the end of each month and submits the report to the Senior Medical Officer for evaluation.