Summer Training at
PricewaterhouseCoopers Private Limited,
Gurgaon, Delhi

To Study the Gaps and Device Standard Operating Procedures for Hospital Departments

By
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Under the guidance of
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MBA Hospital and Health Management
2015-2017

The IIHMR University, Jaipur
2016

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

IIHMR UNIVERSITY

CERTIFICATE

To Whomsoever It May Concern

This is to certify that **Mr. Archit Karnik,** student of MBA Hospital and Health Management, from The IIHMR University, Jaipur has undergone Summer Training Project at **PricewaterhouseCoopers Private Limited, Gurgaon** from **4th April to 3rd June, 2016.**

The Candidate has successfully carried out the study designated to him during summer training and his approach to the study has been sincere, scientific and analytical. This training is in fulfillment of the course requirements.

I wish him success in all his future endeavors.

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

Dr. Sandesh Sharma
Associate Professor
The IIHMR University, Jaipur

pwc

June 03, 2016

To Whomsoever It May Concern

This is to certify that **Mr. Archit Karnik (Emp Id: 726258)** has undergone his training with the **India Advisory** division, **Gurgaon** from **April 04, 2016** to **June 03, 2016**. He was associated with **Consulting** SBU.

He has exhibited a keen interest in learning and has positive attitude. He is sincere and hard working. The efforts put in by him for the project and the analysis of the subject carried out during the training was outstanding.

We wish **Archit Karnik,** the best in his future endeavors.

Varun

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ACKNOWLEDGMENT

I would hereby like to express my profound sense of gratitude to **Dr. Rana Mehta, Leader, Healthcare**, for giving me the opportunity to carry out my summer internship at PricewaterhouseCoopers Private Limited under their experienced and highly qualified team members. Equally I am thankful to **Mr. Abhishek P. Singh (Associate Director)** for his invaluable guidance during the training period.

Heartiest thanks to my People Manager**, Dr. Ashwani Aggarwal** who despite of their busy schedule and workload was able to find time for my project and impart the knowledge that paved a way for better understanding of the fundamentals and their applications alike.

I duly acknowledge the help, direct or indirect of the whole department and staff members of the organization for providing all the facilities for training and conductive conditions for my project. The knowledge gained herein and the practical experiences learnt will be invaluable in the long run.

I would also like to thank my project guide **Dr. Sandesh Sharma, Associate Professor, IIHMR Jaipur**, for their help, cooperation and wholehearted encouragement. Their assistance enabled me, to overcome many obstacles during my project study.

Archit Karnik

Gurgaon

4th June,2016

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1. Observational Learning:

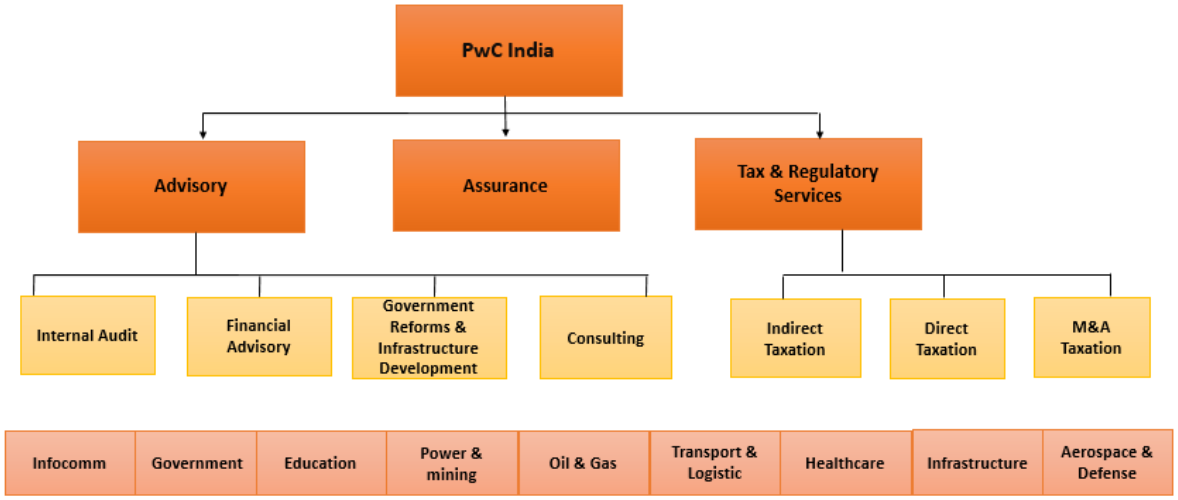
1.1 Introduction:

PricewaterhouseCoopers is a multinational professional services network headquartered in London. It is one of the Big four auditing firms founded in 1998 serving in various areas worldwide. The offices are located in 756 locations, 157 countries of the world. The firm consists of three service lines that are assurance, advisory and tax. The largest share is constituted by the assurance that is 45%. It acts on the theory of global reach and use of resources to help governments, businesses and healthcare industry players accomplish their missions in today's dynamic and competitive environment. PwC provides health organizations with expert guidance regarding healthcare issues in their local markets as well as on operating in global markets.

This brand is developed with a broad mix of service lines. PwC is known for maintaining working relationships with clients to improve operational performance in many functional areas. The global network of firms provides comprehensive advisory services such as management consulting, business assurance, tax, finance, advisory services, human resources solutions and business process outsourcing services. The distinguishing and value adding feature is experience in various industries and functional areas.

PricewaterhouseCoopers Private Limited (India) was incorporated on 26th March 1983. It is one of the largest providers of consulting and advisory services in India, giving services to the private and the public sector and various governments, with a strong team of more than 6000 professionals in various industry segments. In India, PwC has offices in Ahmedabad, Bangalore, Chennai, Delhi-NCR, Hyderabad, Kolkata, Mumbai and Pune.

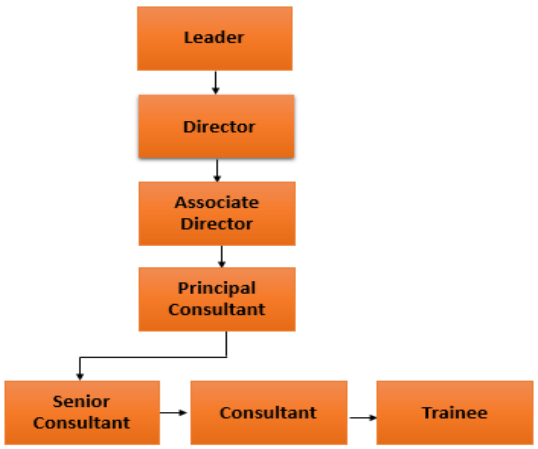
The diagram below summarizes PwC India's key service offerings:



PwC India Healthcare

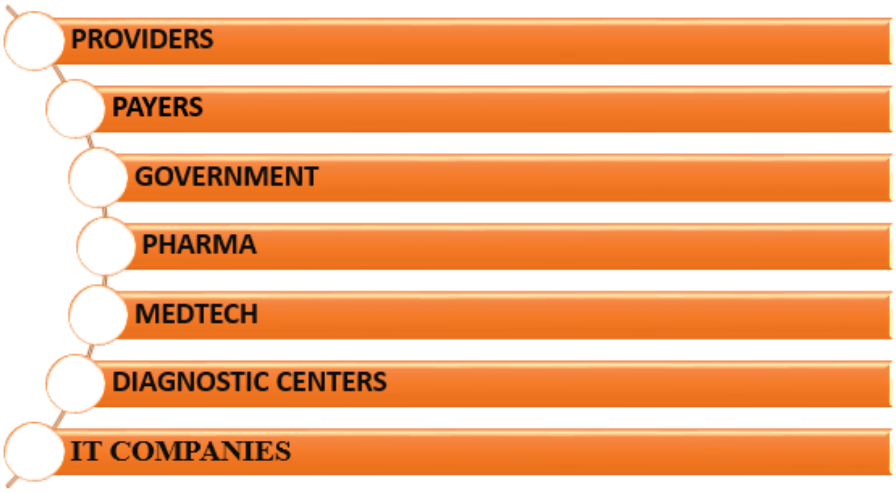
Healthcare is adopted by all the industries in one or the other form. The leadership initiatives of the firm benefits the client. The variable experience is highly valuable to clients as healthcare becomes increasingly interconnected with other industries. The relevant best practices that emerge from engagements with other industries are tried to be incorporated into the healthcare to get the best results. The client team consist of a broad range of experts, including medical practitioners, clinicians, nurses, biomedical and pharmaceutical specialists, and health policy experts. PwC has a team of dedicated professionals with practical experience and understanding of the industry.

PwC Healthcare Team Organogram



PwC provides business insights to the new entrants, private investors and investors working on the model of the public private partnership. The firm explores mergers and acquisitions to expand the services and sustainability. It works in providing solutions and best practices to firms providing healthcare.

CLIENTALE OF PwC HEALTHCARE



PwC India Healthcare has its engagement with more than 3,000 healthcare organisations around the world representing the entire healthcare delivery spectrum: integrated delivery systems, hospitals, academic medical centres, research institutes, physician organisations, and pay-for and managed care organisations, employers, acute and sub-acute care sites, home health agencies, medical device and diagnostic and life sciences

Precisely, PricewaterhouseCoopers' Healthcare Advisory Services practice focuses exclusively on the health and non-profit sectors, and provides a broad range of integrated business advisory services for health institutions, both under the public sector and private sector domain.

Mission statement of PwC

PricewaterhouseCoopers mission is to provide an unrivaled level of service and to contribute to the sustained growth of the economy through the execution of vigorous, fair, and high-quality audits based on clear leadership and creative teamwork.

Code of Conduct

PwC experience means:-

1. Invest in teams and relationships
2. Share and collaborate with clients and team members.
3. Put ourselves in each our client's shoes
4. Focus on enhancing the client value.

Given this solid foundation, it helps plan and execute high-quality audits that are based on a comprehensive understanding of our client's strategies, objectives, and plans, to ensure that clients will have an experience that is unrivaled.

1.2 Mode of Data Collection

Data was collected by the method of observation & by interviewing the officials from various departments.

1.3 Department Wise Observation

PwC healthcare vertical has a division of team into three locations deputed in Delhi, Mumbai, & Bangalore. The teams working at various locations are engaged in multiple projects with clients.

1.4 Conclusion

Observational studies concluded that the organization functions as a knowledge provider for multiple healthcare verticals in planning and commissioning of their projects as per their needs with a diverse workforce of healthcare strata.

TO STUDY THE GAPS AND DEVICE STANDARD OPERATING PROCEDURES FOR HOSPITAL DEPARTMENTS

1. Background

Concern with the quality of healthcare service is not new and, when clients seek hospital services, they aim to regain their health, solve problems and normalize dysfunctions. For clients to enjoy quality services, a management system is needed which acknowledges their needs, establishes standards and attempts to keep up these standards with a view to client as well as personal satisfaction.

The need for quality system evaluation in hospitals is well established. **Standard Operating Procedures (SOPs)** have been found to be of immense use in ensuring quality, proper working, training and favourable outcomes. Thus they are an essential pre-requisite for any quality initiative. However lack of basic standards including standard operating procedure (SOPs) for hospitals makes this a difficult job.

The best way to begin standardization is to understand how the whole process occurs and, in this case, a systematic representation is required. A best quoted example is the Standard Operating Procedure (SOP), which describes each critical and sequential step one has to perform in a task in order to assure its expected result, to increase performance, improve efficiency, and ensure quality through systemic homogenization.

Standard operating procedures (SOPs) manual serves as an important tool for the implementation of good clinical practice standards & for fostering a good institutional culture. It is only through adherence to SOP's that an organization sustains quality of services and its growth.

Standardized Protocols help establish a benchmark for quality & uniformity of services throughout & is an essential requirement for sustaining confidence of the personnel both generating & rendering services within the country and at the global scale as well.

2. Rationale

Most of the reviews demonstrate a positive perception of the personals owing to various factors such as efficiency, quality, safety etc. The goal of the project is to analyse gaps and to device standard operating procedures for the respective departments of the hospital. The following information may support the management to understand the pitfalls & improve the departmental efficiency.

3. Literature Review

A primary research was conducted based on certain thematics within the hospital itself as well as other hospitals to yield the exact reasons for standardization & to focus on secondary data based on literature review.

On secondary research front a literature search was performed to identify published studies related to the views on standardization of services & its need. The search was limited to full paper articles published in English. However, this review gives a broad reflection of substantial research performed across different countries, with a contribution from Indian studies as well.

According to the study **Standard Operating Procedures in Hospitals - A Reality Check** by *S.Bedi, S.D. Behera* shows that awareness regarding SOPs is high in the tertiary hospital among both clinicians and nursing staff, whereas in Secondary Hospital, 50% of the doctors and nurses (approx.) are aware. A majority of doctors in both hospitals informed that there are no written guidelines in their workplace. In cases where these are available, very few were provided with a copy of guidelines, and to none in Tertiary care hospital [(1)]

A study by *Ellingsen, Rodkin* [(2)] shows that hospital management sees standardization as a means of efficiency associated with an "overall good". From their perspective, standardization promotes timeliness and reduces disparity in care. Assessing every process that could lead to a mistake is crucial, that is why standardization is ideal in preventing errors. Standardization limits possibilities for errors to occur, significantly reducing patient risk. Healthcare managers believe that standardization fosters an environment of quality patient care by creating a workplace that is resilient to inevitable human error with the benefit of reduced expenditure

In a study of WHO on **Standardization in patient safety: the WHO High 5s project** by *Leotsakos et al*. showed that SOP-specific performance measures have been designed to assess how effectively participants are using the SOP and to detect any reductions in patient safety-related problems. The standardized performance measures include SOP process measures and outcome measures. Standardization of SOP performance measures ensures data reliability and comparability.

Thus failure in adherence to SOPs is due to lack of appropriate training for those expected to follow standardized processes resulting in failure to establish the standardized process as the default position[(3)].

A study conducted by *Giselle Patricia Guerrero* on **Standard Operating Procedures: use in nursing care in hospital services** to verify the existence and use of Standard Operating Procedures (SOP) by nursing teams described that the majority of participants (95.40%) reported no difficulties in understanding, but several difficulties for using the manual, such as: lack of time, absence of some procedures, difficult understanding, not everyone complies with it, obsolete techniques, poor dissemination, difficult access, lack of material in the unit, disorganized manual, absence of indexes, extensive content, lack of figures or pictures, long time to review the manual, among others.

Nonetheless, several benefits were also mentioned: allows correct performance of procedures, prevents errors, provides more safety to clients and employees, standardizes and updates techniques, clarifies doubts, controls expenses, diminishes the level of infections, saves nurses' time, assures good nursing care, among others[(4)].

4. Problem Justification

Despite of the existence of standardized operating procedures & measures there are certain loopholes which effect the delivery of healthcare services to the clients & hinders the image of health service facilities in terms of their sustainability & growth. The focus should not only be in terms of improvement of technology or economical services but the radar should also extend its range towards the applicability of systematic & sequentially arranged processes to have a streamlined flow of work.

The major blocks suspected in the study are absence of standard set of protocols to perform the departmental functions leading to ambiguous understanding of the general & specific standards of services.

5. Research Questions

- What is the need for standardization in hospital departments?
- What are the challenges faced by the departments due to absence of standards?

6. Objective

- To study the availability of standard operating protocols in the hospital departments
- To find out the gaps related to standard operating procedures in the hospital departments
- To formulate/device SOPs for departments

7. Methodology

7.1 *Research Design*

Research has been designed as a Qualitative Study involving Descriptive study design. The method of data collection includes unstructured In-depth Interviews based on certain study points for analysis

7.2 *Study Setting*

The study was conducted amongst the various Department Heads in a 400 bedded trust funded hospital in Delhi.

7.3 *Sampling*

For the Qualitative analysis Non probability sampling was utilized in which purposive & snowball sampling technique was used. Head of various departments in the hospital were selected for conducting the study.

7.4 *Sample*

Inclusion Criteria

Head of Departments, Doctors, Managers and the allied departmental staff of IPD, OPD, Emergency and Medical Records Department were included in the study

Exclusion Criteria

Patients were not included in the study

7.5 *Study Tool*

For data collection, In-Depth interviews of selected participants were conducted, which were followed up by discussions regarding the process flow in their respective departments. These discussions were documented and critically analysed as to how the absence of standards affected the overall functioning of departments & the employees' conduct.

Not only it accelerates shortcomings but also hampers the organization' by impairing of departments & uprooting allied shortcomings.

8. Findings

The study based on the above research questions revealed the following findings:

- **Availability of SOPs**
  - Research showed that there are no existing standard operating procedures in these departments or even if they are present they have not been designed as per the best practice.
  - It has brought up the issue that concerned department persons are not aware about their specific responsibilities of what part of the job they need to perform.
  - Staff known to standards either have modified the procedures as per their feasibility or are handling multiple work roles due to ambiguity in segregation of task.
  - The staff had not been provided any sort of training relating to the process nor any manual and the only ideology behind learning the process is on job.
- **Challenges**

  Analysis of the interviews revealed the following shortcomings of selected departments:
  - Inpatient Department
  - Outpatient Department
  - Medical Records Department
  - Emergency Department

Department: Outpatient Department	
Process Issues	▪ **No separate counter for registration, admission & billing for investigations prescribed for OPD patients.** ▪ **No separate counters for old and new patients.** ▪ **No advance appointment system available for registration with a particular physician for a particular date and time.**
HR Issues	▪ **Unavailability of attendant & assistants in OPD for patients and doctors respectively** ▪ **Absence of a front office staff supervisor**
Infrastructure Issues	▪ **Patient record data entry system unavailable** ▪ **Absence of proper signage for the direction to patients**

Department: Inpatient Department	
Process Issues	▪ **Medications are being procured and administered by patient's attendant** ▪ **No regulations on patient visitors (number & timings) in the ward** ▪ **No check on bed availability at the admission counter** ▪ **Allowance of outside eatables in the IPD** ▪ **Daily census registered not maintained in the department** ▪ **Copy of lab reports not given to the patients at the time of discharge**
HR Issues	▪ **Invariably high patient load on ward nurses due to lack of sufficient staff**
Technical Issues	▪ **Billing services uncoordinated at the time of clearance of dues during patient discharge**

Department: Medical Records Department	
Process Issues	▪ **For the demarcation of medico legal cases no separate color coding of files**
HR Issues	▪ **Insufficient staff creates excessive workload**
Technical Issues	▪ **Over reliance on manual methods for record keeping instead of an information management system**

Department: Emergency Department	
Process Issues	▪ **Security guards are not able to coordinate with the emergency staff at the time of patient admission & exchange of duties**
HR Issues	▪ **NA(Not Available)**
Infrastructure Issues	▪ **Triage area not demarcated through separate color coding method**

9. Result

The research study shows that there is a minimal awareness regarding standard procedures in the departments, the SOPs were either not available or if available were inappropriately drafted without clear specification of job roles for each person

10. Recommendations

- **Outpatient Department**
  - A separate counter for each of the registration, admissions & prescribed investigations billing
  - Segregation of old and new patients at the counter, assurance that this method is being followed
  - An ideal system for the management of appointments for specific physicians
  - Allotment of an assistant & attendant to Doctors and for patient management respectively
  - Deployment of a supervisor to coordinate & ensure the efficient working of front office staff

- Optimal usage of the information management system at front office to ensure correct patient details
- Placement of signage at appropriate locations for guiding the routes to various departments

- **Inpatient Department**
  - Dispatch of information regarding availability of beds at the admission counter itself to the patients
  - Strict rules & regulations to be followed for persons visiting the patient only on specific time schedule with permitted number of visitors
  - Indenting of medications for inpatients through the nursing stations & administration of medications under the supervision of adequately trained staff
  - Strict control on outside eatables not to be provided to patients in the department
  - A daily census register to be maintained regularly
  - A complete summary must be provided to the patients at the time of discharge with a copy of all reports attached
  - Adequate number of nursing staff must be deployed in the wards to handle the patient load as described in the standard guidelines
  - Complete billing information must be provided before discharge with transparency to facilitate in the clearance of financial dues

- **Medical Records Department**
  - Reliance on manual record keeping must be transformed to optimum usage of data management system to ensure data safety & confidentiality
  - Medico legal case files must be stored separately with a different color coding from regular patient record files
  - Appropriate staff employment to distribute the departmental work equally

- **Emergency Department**
  - Triage area should be clearly marked as per the standard guidelines to avoid any ambiguity
  - Security guards must be well informed about their duties to perform the actions in sync with the emergency department staff

11. Conclusion

Standard Operating Procedures form an integral part for the unobstructed functioning of hospital departments. The absence of these procedures not only raises a question mark on the functioning but also on the quality of services that are being provided. For maintaining the sustainability and the growth factor sequential arrangement for the procedure is a must for each and every department. Major highlights were gaps found relating to human resource, operational processes and technical operations.

For overcoming the loopholes standard operating procedures referring to standards suggested by various accreditation bodies & ideal practices were formulated for implementation in the departments.

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Annexure

STANDARD OPERATING PROCEDURES

OUTPATIENT DEPARTMENT

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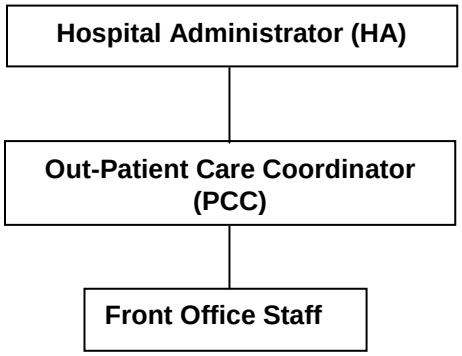
1. Introduction

An **outpatient department** is the part of a hospital designed for the treatment of **outpatients (walk-in patients)**, people with health problems who visit the hospital for diagnosis or treatment.

2. Purpose

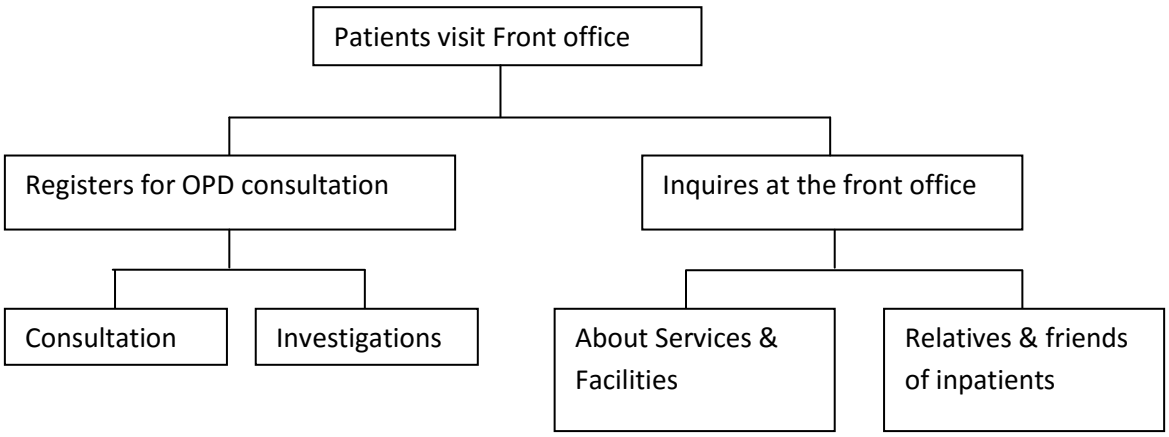
To provide prompt and pleasant service to the patients by coordinating various related activities in a uniform and prescribed manner.

3. Department structure



Key stakeholders
Billing officer
Lab technician
Doctor
OPD attendants
OPD nurses

4. Process Flow



5. SOP's for Sub process

5.1 Enquiry and Appointment handling

Process Definition	**Enquiry and appointment handling**	
Interfaces with	• Front office • Doctors / Consultant • Nursing Team	
S.no.	**Activity**	**Responsibility**
5.1	**New patient**	
A.	The new patient shall be greeted and asked if he wishes to meet a specific Consultant.	Front Office Staff
B.	In case the patient wishes to meet a specific consultant, the patient shall be asked to specify the date and time of the appointment that the patient would prefer.	Front Office Staff

C.	The availability of the consultant on the date and time which the patient has requested shall be checked.	Front Office Staff
D.	The patient shall be informed accordingly	Front Office Staff
E.	In case there is no appointment slot available for the date and time that the patient has requested, the appointment for the next available date and time which is acceptable to the patient shall be given.	Front Office Staff
F.	In case the patient does not have a choice of a specific Consultant, the nature of the health complaint shall be ascertained.	Front Office Staff
G.	The names of the Consultants in the appropriate specialty shall be informed to the patient.	Front Office Staff
H.	The patient shall be asked for a convenient date and time to fix the appointment.	Front Office Staff
I.	Accordingly, an appointment with the Consultant shall be given to the patient.	Front Office Staff
J.	The patient / attendant shall be informed that the OPD patient number is valid for one year and that the patient needs to get the repeat registration done after this period.	Front Office Staff
K.	OPD file shall be prepared and handed over to the patient/ attendant.	Front Office Staff
L.	Patient shall be requested to bring the OP file with him during every visit. OPD feedback form shall be handed over to the patient. Patient shall be requested to fill it at his convenience and	Front Office staff

	hand it over to the Front Desk Staff.	
M.	Patient hands over the OPD slip to the respective OPD attendants and attendant sends the patients for consultation on the basis appointment scheduling.(First come first serve basis)	OPD attendant

5.2	**Existing patients**	
A.	The name of the Consultant who has been treating the patient on the previous occasions shall be confirmed.	Front Office Staff
B.	The date and time of the Appointment that the patient would like to have shall be obtained.	Front Office Staff
C.	The availability of the consultant on the date and time which the patient has requested shall be checked.	Front Office Staff
D.	The patient shall be informed accordingly.	Front Office Staff
E.	In case there is no appointment slot available for the date and time that the patient has requested, the appointment for the next available date and time which is acceptable to the patient shall be given.	Front Office Staff
F.	OPD registration number shall be requested from the patient, and the date of the patient's last visit to the hospital shall be checked in the software.	Front Office Staff

5.3	**Appointments in advance**	
A.	At the time of issuing the appointment, an entry in the system shall be made and maintained for each Consultant.	Front Office Staff
B.	The date and time on which the appointment has been requested shall be confirmed.	Front Office Staff
C.	The name, OPD registration no. and telephone number of the patient shall be entered in the system.	Front Office Staff
D.	The patient shall be informed to be present 15 minutes in advance on the day of the appointment, so that he can register (in case of new patient).	Front Office Staff
E.	The patient shall be requested to telephonically inform the desk in case he wishes to cancel the appointment	Front Office Staff

5.4	**Billing**	
A.	Every patient who walks into the registration/billing area shall be attended to within 5 minutes, on 'first come first serve' basis.	Front Office Staff
B.	Patient shall be billed after checking on the appointment/scheduling. Walk-ins shall be scheduled in according to the availability of the consultant and patients shall be informed regarding the waiting period.	Front Office Staff
C.	In case the patient is not registered, he/she shall be registered after recording all details including full name, date of birth, address, marital status, contact number and referral doctor.	Front Office Staff
D.	In case the patient is pre-registered, the OPD billing shall be done through the OPD billing module.	Front Office Staff

E.	Payment shall be collected from the patient (either cash or credit card) and the bill together with receipt shall be given to the patient.	Front Office Staff
F.	Patient shall be instructed on the next steps	Front Office Staff

5.5	**Cross consultation**	
A.	If the patient wants second opinion for the same consultation, patient visits registration counter again. The appointment schedule for the alternate (for second opinion) consultant is checked in the system.	Front office staff
B.	If the patient is referred by the consultant for a consultation in some other department as well, patient visits registration counter. After checking the appointment schedule for the respective department, new appointment is scheduled for the patient.	Front office staff
C.	OPD slip is generated and handed over to the patient.	Front office Staff
D.	On the basis of availability, appropriate appointment is scheduled for the patient and patient is directed towards department.	Front office staff

5.6	**Consultant on Leave**	
A.	If the consultant is on leave than appointment schedule for the alternate consultant is checked in the system or the patient is given another appointment for the same consultant.	Front office staff
B.	If the patient prefers to visit the alternate consultant for a consultation then new appointment is scheduled for the patient.	Front office staff
C.	OPD slip is generated and handed over to the patient.	Front office Staff

D.	On the basis of availability patient is directed towards department.	Front office staff

INPATIENT DEPARTMENT

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1. Introduction

This document consists of the process flows & sub – processes of In-Patient Department Management at HIMSR hospital.

The inpatient department is one of the most important department in the hospital. The patients are admitted for providing care and close monitoring. The inpatient is admitted in the hospital, stays overnight or for several days and is treated through medical and nursing care.

2. Purpose

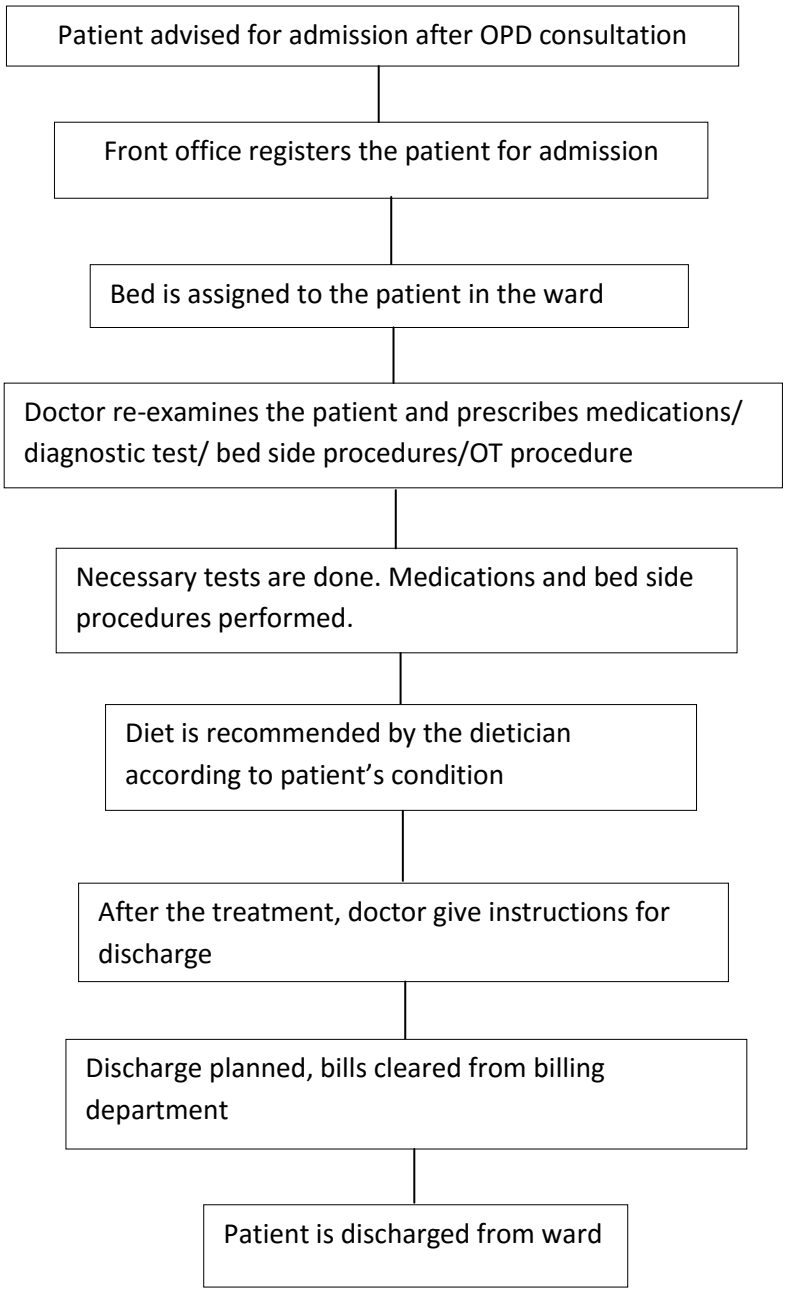
- To establish, implement & maintain a system for patient admission in order to provide IPD services offered by the hospital.
- To provide guideline instructions for all staff members involved in the inpatient care to meet the needs and expectations of patients.
- To enhance patient satisfaction on continual basis.

3. Department Structure/ Key Stakeholders

Admission front office
Patient care coordinator[1]
Billing officer
Resident doctor in ward
IPD nursing Incharge
Ward nurse

[1] Patient care coordinator will also acts as Financial counselor.

4. Process Overview



5. SOP's for sub processes

5.1 Registration and Admission

Process Definition	**Registration and Admission**
Interfaces with	• Admission front office • Consultant • Doctor on duty • Sister in charge

S.no.	**Activity**	**Responsibility**
A.	Patient visits the OPD/emergency for doctor's consultation.	Consultant
B.	Depending upon the doctor's assessment, patient is advised admission (in writing on the admission slip) to one of the different inpatients areas of the hospital like Ward, ICU, and labour Room.	Consultant
C.	Patient goes to the admission counter. The personal details are updated and a unique inpatient number is generated. The charges are taken at the admission counter.	Admission Front office staff
D.	Allocation of beds and ward is done on the basis of number of bed availability.(This information is available in the system). If the bed is available sent to the billing counter and if not available patient is sent to concerned doctor for reference.	Admission front office staff
E.	Patient goes to the billing counter and the estimation of treatment cost and stay is provided. Some part of the total cost is deposited if possible. Patient is directed to the ward.	Billing officer
F.	The ward nurse receives the patient. Patient/Attendant hand over admission slip. She/he confirms the identity of the patient and reviews the admission notes /instructions and acts on any urgent instructions by admitting doctor.	Ward nurse
G.	Bed is allocated based on clinical and personal needs of the patient and availability of beds.	Ward nurse
H.	Ward Nurse records the patient details and the bed no. in the patient admission register and the system.	Ward nurse

I.	Valuables like jewellery, mobile and cash is handed over to the patient relatives. Patient is instructed to not keep any valuables with them.	Ward nurse
J.	Consent is signed by the patient admitted in the ward. In case patient/ Next to Kin is illiterate then the thumb impression of the patient is taken which is witnessed by a neutral person.	Ward nurse
K.	Once patient is settled in the ward, nurse conducts a nursing need assessment within 90 minutes of getting admitted in the ward.	Ward nurse
L.	The assessment of the patient is done by the duty doctor after the admission of the patient and records are maintained**.**	Doctor on duty
M.	The consultant under which patient is admitted to the department should assess in 24 hrs.	Consultant

5.2Patient care

Process Definition	**Patient care**	
Interfaces with	• Doctor on duty • Sister incharge • Ward nurse	
S.no.	**Activity**	**Responsibility**
A.	**Monitoring patient's vitals**: The timing for measuring the vitals is checked as per Doctor's order or 6 hourly.	**Ward nurse / Doctor on duty**
B.	**Handling of Medical Devices and instrument Procedure for Hospital -** All medical devices and instruments are cleaned after each patient use in accordance with procedures for Hospital Infection Control. All the measuring equipment used in patient care are regularly calibrated in accordance with manufacturer's instructions and procedure for Infrastructure and equipment maintenance. All Medical devices and equipment are appropriately stored with access to authorized individuals only.	**Ward Nurse**
C.	Nurse informs the dietary department/ Kitchen for	**Ward nurse**

	patient diets according to the doctor/Dietician advice	
D.	**Medical Documentation** –Patient's complete medical records are entered in the HIS [Hospital information system] and patients physical records. Deletion and alterations in the patient's physical records are countersigned. Entries to medical records are made as soon as possible and before the relevant staff members goes off duty. Consent form and resuscitation status statements must be clearly recorded in medical records.	**Consultant** **Doctor on duty** **Nurse**
E.	**People living with HIV AIDS -** Confidentiality of such patient is be maintained in all cases. Patient is not isolates/segregated. Beds of such patients are not labelled/ marked which denotes their HIV positive status.	**Doctor on duty** **Nursing incharge** **Nurse**

5.3 Prescription and Administration of medications

Process Definition	**Prescription and Administration of medications**
Interfaces with	• Doctor • Nurse

S.no.	**Activity**	**Responsibility**
A.	Medications are prescribed in the legible notes with drug name, dosage, route of administration and frequency. The doctor should also consider the allergies and ongoing medications.	**Consultant**
B.	Before administering any drug- name of the drug, time of administering the medication, dosage, route of administration and in case of oral drugs, whether to give before or after food is thoroughly checked from the medication chart of the concerned patient. In case of any discrepancy in name doctor on duty /Pharmacist is consulted and generic name is matched. It is made sure that medication is not discontinued in the Medication Chart. Drug is kept in proper storage and checked for any signs of damage by the nurse. Date of expiry and batch no. of the drug is checked and in case of any discrepancy, head nurse and Pharmacists	**Doctor on duty** **Ward nurse**

	are informed.	
C.	**Preparation** – For oral drugs, after washing the hands, pills are dropped in a small cup and handed to patient. This is done immediately prior to giving drugs and not in advance. Only non-enteric coated pills are broken for administrations. If the medication is liquid, the bottle is shaken and correct dose is poured in a measuring cup.	**Doctor on Duty** **Ward Nurse**
D.	**Administration** - Name of the patient is confirmed by asking the patient/attendant or wristband if available. Oral drugs are administered using sufficient amount of water/liquid or as per special instructions from the doctor's order.	**Doctor on Duty** **Ward Nurse**
E.	**Monitoring/ Recording**-After ensuring the drug has been administered, the nurse records the time and dose in medication chart. If complete dose is not given because of any reason (like vomiting of oral drugs) it is recorded in nursing chart and informed to doctor on duty. The medication records should be reviewed every day for the drugs administered.	**Doctor on Duty** **Ward Nurse**
F.	Patient is monitored for adverse effects and Doctor on Duty is informed in case of any such event. Storage and disposal of remaining drugs is done as per procedure for Hospital Waste Management.	**Doctor on Duty** **Ward Nurse**

5.4 Transfer of the patient within the hospital

Process Definition	**Transfer of the patient within the hospital**	
Interfaces with	• Doctor/ consultant • Nursing Incharge • Ward nurse • Ward boys	
S.no.	**Activity**	**Responsibility**
A.	Doctor recommends patient transfer to other department (emergency, other IPD wards). The sister In charge of the other ward is informed by the ward nurse. The patient is escorted /sent to the other department with all the medical records and drugs by ward boy. Nurse In charge of both the wards enters the	**Doctor on duty** **Ward nurse** **Ward boy**

	details in their register.	
B.	If the condition of patient worsens in ward, the treating doctor is immediately informed and treatment is given as per the doctor's advice or patient is shifted to ICU (If available) or any other appropriate department as per the doctor's advise	**Doctor on duty** **Ward nurse** **Ward boy**
C.	Orphan/ Unidentified/ Patients in need without any attendant are specially monitored. Efforts are made to appoint someone from local NGOs/ volunteers who can take care of non-clinical needs of these patients. Names of all such patients are reported to local police.	**Doctor on Duty** **Ward Nurse**
D.	OT transfer- The doctor writes the surgery/procedure required by the patients. The OT incharge is informed one day prior to surgery. Patient is escorted /sent to the ward with all the medical records. Consent of the patient/attendant is taken before the surgery.	**Doctor on Duty** **Ward Nurse** **Ward boy**
E.	In case of referral to other hospitals the final decision is taken by the doctor. Patients are advised of preferred hospitals. For referral, ambulance services are provided.	**Doctor** **Nursing incharge** **Ward boy**

5.5 Ward management

Process Definition	**Ward management**	
Interfaces with	• Nursing Incharge • Ward nurse	
S.no.	**Activity**	**Responsibility**
A	**Inventory -** Nurse maintains record of the patient progress, treatment offered, stocks of inventory & medicines in the ward. Ward nurse keeps record of the changed linen at defined frequency preferably in morning hours.	**Sister In charge**
B	**Handover -**At the end of each shift nurse on duty hands completes the patient records and hands over the patient details to the nurse in the next shift.	**Sister In charge**
C	**Indenting -** All the drugs and consumables required are indented by the Sister in-charge on a regular basis. For specific drugs and consumables sisters raise the	**Sister In charge**

	indent according to the requirement. The indent is on system that goes to the respective department.	

5.6 Bed side procedures and diagnostic test

Process Definition	**Bed side procedures and diagnostic test**	
Interfaces with	• Nursing incharge • Ward nurse • Technician	
S.no.	**Activity**	**Responsibility**
A.	If any laboratory test is required, nurse collects the sample and send it to the laboratory through ward boy. If a nurse if unable to collect the sample, laboratory technician is informed who comes and collects the sample.	**Ward nurse** **Ward boy**
B.	In case, X-Ray, ECG or USG needs to be done, nurse informs the concerned technician, and at appointed date & time the patient is transferred to the concerned department for the investigation. The patient is transferred by ward boy.	**Nurse** **Technician**
C.	Bed side procedures are performed by nurse / resident doctor depending on the type of procedure and patient's condition.	**Nurse / Doctor on duty**

5.7 Discharge of the patient

Process Definition	**Discharge of the patient**	
Interfaces with	• Doctor • Nursing incharge • Accountant • Housekeeping	
S.no.	**Activity**	**Responsibility**
A.	Assessment of the patient is made on daily basis. When the patient's condition is up to the level of discharge, the physician writes discharge note in the patients IPD file and prepares a discharge slip. In case of MLC patient, Police is informed before the patient is discharged	**Doctor** **Nursing incharge**

B.	Nurse ensures that all items issued to the patient are returned back	**Nurse** **Technician**
C.	Patient/Attendant is directed to billing counter to clear the dues. The final payment slip is generated and handed over to the patient/attendant.	**Nursing incharge** **Accountant**
D.	Patient / attendant hands over the final payment slip to the nurse who completes other requisite discharge formalities. Briefing is done to the patient/attendant about the follow up, prescribed medicines, precaution to be taken and diet. Patient is then discharged from the ward.	**Nursing incharge / Doctor on duty**
E.	After discharge of patient, the relevant register/record such as IPD register/Diet Register is updated.	**Nursing Incharge**
F.	The housekeeping staff is informed about the patient discharge by the ward nurse. The used linen such as bed sheets, pillow cover etc. is taken away for cleaning by the housekeeping staff.	**Housekeeping staff**
G.	If a patient leaves the hospital against medical advice / without informing the ward nurse / doctor, police is informed and record of the same is maintained.	**Doctor** **Nursing incharge** **Patient care coordinator**
H.	If a patient wants to leave the hospital but as per the treating doctor she/he is not fit for discharge, a declaration is signed by the patient/ Next to Kin in the language she/he understands on medical records. In case patient/ Next to Kin is illiterate then the thumb impression of the patient/attendant is taken on the declaration which is witnessed by 2 neutral people. LAMA summary is prepared and the patient/attendant is handed over the same.	**Doctor on duty** **Nursing incharge**

Visiting hours and patient satisfaction survey

A.	**Visiting hours-**Visiting hours for outsiders for meeting the patients are 9 to 10 AM and 4 to 6 PM. Any visitors having no patient in the hospital including Media Person and police are not allowed in the wards without prior permission from Medical Superintendent and Head of department.	**Patient care coordinator**
B.	Patient Satisfaction Survey is done on predefined patient satisfaction format.	**Patient care coordinator**

Records in the IPD

Sl. No.	Name of Records	Record No.	Minimum Retention Period
01	**IPD Register**		
02	**Patient Registration**		
03	**MLC Register**		
04	**Discharge Register**		
05	**Diet Register**		
06	**Laundry register**		
07	**Death record register**		
08	**Diet Register**		
09	**Stock Register**		
10	**Indent Register**		

Process efficiency criteria

Sr. No.	Activity	Process Efficiency Criteria	Benchmark/Standard/ Target
1	**Patient Care**	**Average Length of Stay**	
2	**Clinical Care**	**Proportion of Patients Discharged**	
3	**Clinical Care**	**Adjusted Death Rate(Death after 48 hours of admissions)**	
4	**Housekeeping**	**Hygiene Score**	
5	**Nursing Care**	**Nurse to Patient Ratio**	
6	**Equity**	**Proportion of BPL Patients admitted**	
7	**Patient Satisfaction**	**Patient Satisfaction Score for IPD**	
8	**Utilization**	**Bed Occupancy Rate**	
9	**Utilization**	**Bed Turn Over Rate**	
10	**Patient Care**	**LAMA Rate**	
11	**Patient Care**	**Patient Safety Score**	
12	**Patient Care**	**No. of Adverse drug reactions**	

EMERGENCY DEPARTMENT

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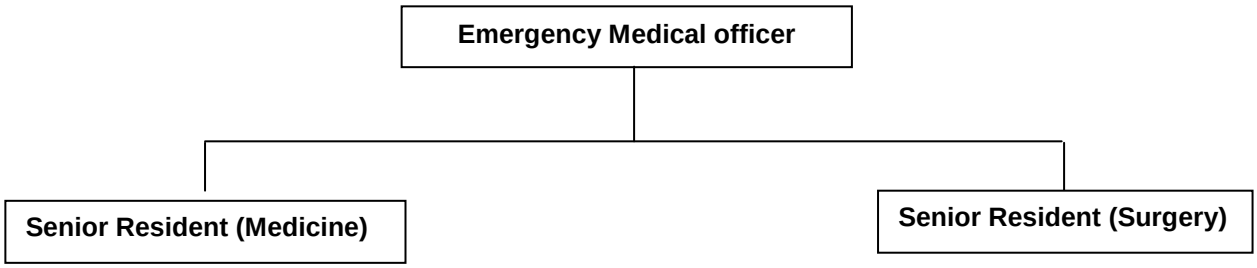
1. Introduction

Accident & emergency department, is a medical treatment facility specializing in emergency medicine for the acute / immediate care of patients who are present without prior appointment; either by their own means or by that of an ambulance. The emergency departments of hospitals operate 24 hours a day.

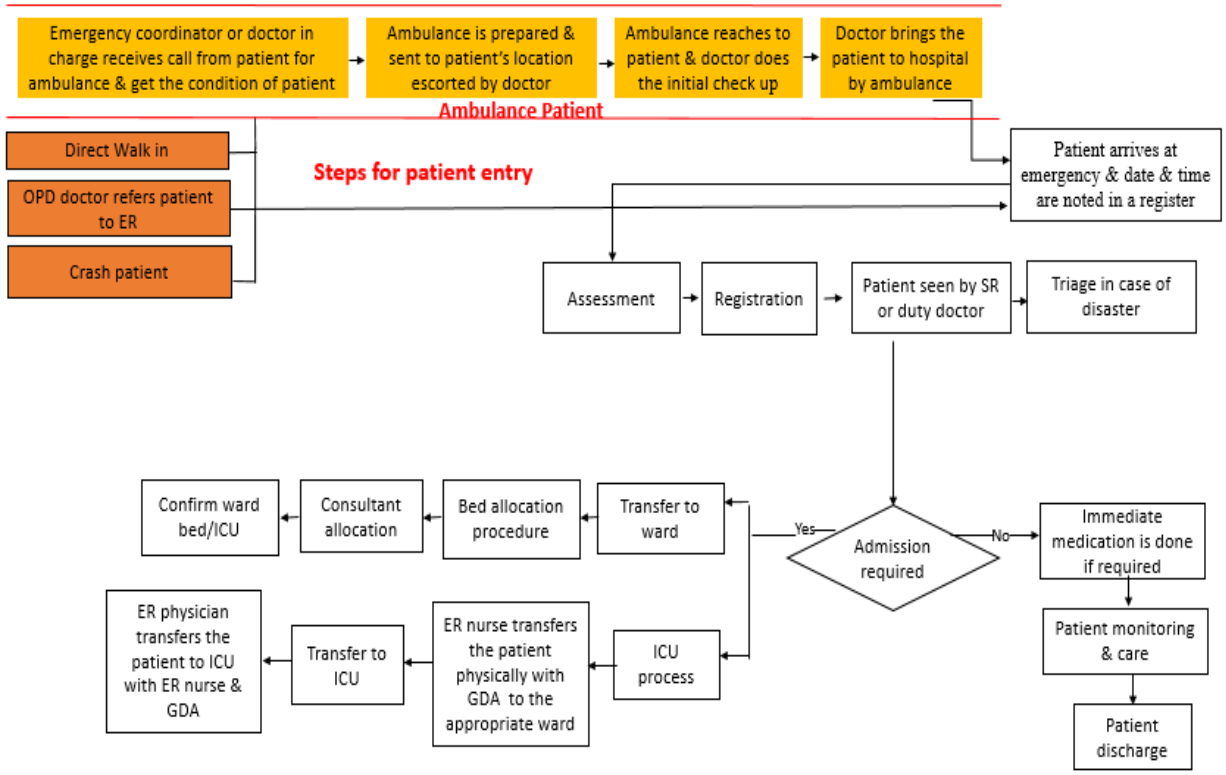
2. Purpose

To provide prompt and pleasant service to the patients by coordinating various related activities in a uniform and prescribed manner.

3. Department structure/Key Stakeholders



4. Process Flow



5. SOPs Ideal process

5.1 Patient's entry to emergency

Process Definition	**Patient's entry to emergency**	
Interfaces with	• Doctors / Consultant • Nursing Team • Departmental staff	
S.no..	**Activity**	**Responsibility**
A.	Ambulance: Emergency department of the hospital is called up by the attendant. Call should be taken by the coordinator/ Team Leader and is informed about the condition of patient.	Emergency department staff
B.	Direct walk in: During OPD working hours if a patient walks into emergency he/she is directed to go to the concerned OPD after registration at the counter patients are registered at the emergency registration counter.	Emergency department staff
C.	Crash: All crash cases are separately identified by a centralized system. MLC number is provided at the registration Counter.	Emergency department staff
D.	OPD referred: In cases of OPD referred patients the concerned consultant examines the patient and directs him/her to the emergency department.	Emergency department staff
E.	Coordinator must send the ambulance & inform Emergency Head. If the patient is suffering from cardiac problem, a well-equipped cardiac ambulance is sent.	Emergency department staff
F.	After the receipt of confirmation call driver must leave the premises in 10 minutes.	Emergency department staff
G.	Person deputed at the entrance gate should note down the exit time of ambulance	Emergency department staff
H.	On the arrival of patient security guard must inform the emergency department.	Emergency department staff
I.	A GDA & one security staff must escort the patient to the triage area.	Emergency department staff
J.	The department should always insist on capturing time of entrance since this will help in identifying the time of entry of patient into the ED and the various services rendered to him in line with timelines.	Emergency department staff
K.	Regular time entry also helps in getting a physical proof of the actual time of patient arrival in cases of any casualty as sometimes the registration date /time is entered late in hospital	Emergency department staff

5.2 Treatment at Emergency

Process Definition		**Treatment at Emergency**	
Interfaces with		• Doctors / Consultant • Nursing Team	
S.no.		**Activity**	**Responsibility**
A.	After bringing the patient to emergency department ABC(airways, breathing & circulation) assessment must be done to categorize the medical care required		Emergency department staff
B.	In the meantime initial assessment form to be filled by nurse		Emergency department staff
C.	As per the triage categorization first aid treatment should be administered & coordinated by team leader		Emergency department staff
D.	Based on the criticality of the patient a decision is made by the ED duty doctor either to inform the intensivist in ICU, OT manager & surgeon for OT procedure or a concerned consultant		Emergency department staff
E.	Emergency physician coordinates with the respective consultant who in-turn checks the patient's status & decides further steps to ensure patient stability • If the condition is found stable and requires primary care only / no admission is required, appropriate treatment is given, patient's attendant clears all dues and the patient is discharged once deemed fit. • If the patient requires further observation and care, he is sent to the observation room in the ER, where the nurse in-charge takes care of the patient. • If the patient requires admission, admission formalities are completed and the patient is transferred to the respective ward of the consultant. • If the patient requires any medical procedure, the consultant of the respective department on duty is informed. The OT nurse is informed by the emergency nurse and the patient is shifted in coordination.		Emergency department staff

5.3 Patient Transfer

Process Definition	Patient Transfer	
Interfaces with	• Doctors / Consultant Nursing Team	
S.no.	**Activity**	**Responsibility**
A.	Patient's condition is observed in the observation room and according to his condition, patient is transferred to a suitable department [Minor OT, ICU, ICCU, PICU, ward etc.] after informing the respective consultant. • Cardiac resuscitation room should be equipped with the crash cart containing essential and emergency drugs, defibrillator, pulse oximeter, cardiac monitor, ECG machine etc. • OT room attached with ER, should be equipped for carrying out minor OT procedures. • In Case of critical patients, after providing the life support treatment and stabilizing patient's condition, the patient is shifted to the ward or ICU depending on the condition of the patient.	Emergency department staff
B.	In case the services essential for the treatment of the patient are not available in the hospital, patient is provided with the best available care. Condition of patient is explained to the attendant and the patient is referred to the alternate hospital with required support through ambulance.	Emergency department staff

5.4 Brought Dead Patient

Process Definition	**Brought Dead Patient**	
Interfaces with	• Doctors / Consultant • Nursing Team • Ward Boy	
S.no.	**Activity**	**Responsibility**
A.	Patient's brought dead are recorded as medico-legal case if death has occurred unexpectedly or from an unexplained cause. Patient is checked for any possible signs of life, appropriate history is taken, and any suspicious sign(s) of injury / struggle / poisoning / homicide / suicide etc. is recorded.	Emergency department staff
B.	The individual is declared as Brought in Dead (BID) and the accompanying relatives/friends are explained about the probable cause of death. They are given a Brought Dead Certificate.	Emergency department staff
C.	The local police station is informed.	Emergency department staff

5.5 Death in ER

	Death in ER	
A.	Death of a patient who was alive when brought in the ER, is treated as death in emergency department once all resuscitation methods have been deployed. Necessary documentation is done explaining the medical history, time and cause of death.	Emergency department staff
B.	Death certificate is issued by CMO and arrangements for release of the body are taken. A copy of death certificate is retained along with the medical documents.	Emergency department staff

5.6 Handling & Release of Dead Body

	Handling & Release of Dead Body	
A.	Death of a patient is handled carefully with concern without complacency. Counselling of next of kin with empathy is of importance. All help in shifting the body from the hospital is extended to the next of kin. The dead body is released as soon as possible after completion of all formalities.	Emergency department staff
B.	Acknowledgement for receipt of the body and the Death Certificate is obtained from Next of Kin/Legal representative with handing-over of the body to patient relatives. It is ensured that hospital staff takes due care and concern in this respect. If there is an expected delay in handing over the body to the relatives/attendant, due arrangements are made to preserve the body in the mortuary.	Emergency department staff Ward boy Nurse on duty
C.	A security staff of the hospital is present till the departure of the deceased and ensures orderliness in handing over the body to the next of kin.	Emergency department staff

5.7 Discharge

Process Definition	**Discharge**	
Interfaces with	• Doctors / Consultant • Nursing Team	
S.no..	Activity	Responsibility
A.	The consultant should check the patient's status & decide further steps to ensure stability	Emergency department staff
B.	If the condition is found stable and requires some basic treatment, the treatment is given & patient is said for a discharge	Emergency department staff
C.	Attendant clears all his dues and the patient exits as soon as declared fit to go home.	Emergency department staff

6. TRIAGING

The policy of prioritizing patients is based on the urgency of their individual need for medical care. Under normal working conditions, patients shall be triaged and allotted beds in the ER as per the urgency of their medical needs.

During external disasters (Code Red) patients shall be triaged as Red, Yellow, Green and Black according to the following criteria:

- **Red**

  First Priority, Most urgent, Life-threatening shock or hypoxia is present or imminent, but patient can be stabilized and, if given immediate care, shall probably survive.

  Examples Red:

  - Compromised airway
  - Respiratory arrest or severe respiratory distress or SpO2 < 90
  - Cardiac arrest
  - Hypotension (BP < 90 mm Hg)
  - Trauma patient who is unresponsive or requires immediate fluid resuscitation
  - Overdose with a respiratory rate of 6.
  - Severe bradycardia or tachycardia with signs of hypo-perfusion.
  - Chest pain, pale, diaphoretic, blood pressure 70/palp.
  - Anaphylactic reaction.
  - Baby that is flaccid.
  - Hypoglycaemia with a change in mental status.

- **Yellow**

  Second Priority, Urgent, Injuries have systemic implications or effects, but patient is not yet in life threatening shock or hypoxia; although systemic decline shall ensue and given appropriate care, patient seems able to withstand a 45 to 60 minute wait without immediate risk.

  Examples of Yellow: Following diagnosis with stable blood pressure. Tachycardia / dyspnoea may or may not be present

  - Acute abdominal pain
  - Gastro-intestinal bleeding
  - Acute arterial occlusion
  - Fever in immuno-compromised patients
  - Testicular torsion
  - Acute renal failure
  - Ectopic pregnancy
  - Spontaneous abortion
  - Rule out meningitis

- Acute Cereb-vascular accident
- Vomiting / diarrhoea in children
- Acute asthmatic attack
- Pleural effusion
- Spontaneous pneumothorax
- Road traffic accident with transient loss of consciousness.

➢ **Green**

Third Priority, Non-urgent, Injuries are localized and without immediate systemic implications; with a minimum of care, patient generally does not deteriorate for up to several hours.

➢ **Black**

Dead, No distinction can be made between clinical and biologic death in a mass casualty incident, and any unresponsive patient who has no spontaneous ventilation or circulation is classified as dead.

The above colour coded ID Bands shall be used during a Code Red.

7. LIST OF EQUIPMENTS TO BE AVAILABLE IN AMBULANCE:

- O2 filled cylinder (small) with flow meter.
- Stethoscope.
- Ambu bag with mask
- Suction apparatus
- Suction catheter.
- Laryngoscope with blade
- Glucometer
- BP (Blood Pressure) apparatus
- ET (Endotracheal tube) Stillet
- IV Fluids with stand
- Portable stretcher
- Torch
- Scissors
- Cardiac Monitor
- Dressing Materials
- Bandage
- Pads & Bandage
- Sterile Dressing Tray
- Emergency medicines
- Sterile Scissors.
- Thermometer.
- Bed pan & urine pot
- Disposable sanitary bag.
- Syringes and needles

- Mackintosh and extra linens
- IV tubing
- Foley's catheter and
- Nasogastric tube

MEDICAL RECORDS DEPARTMENT

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1. Introduction

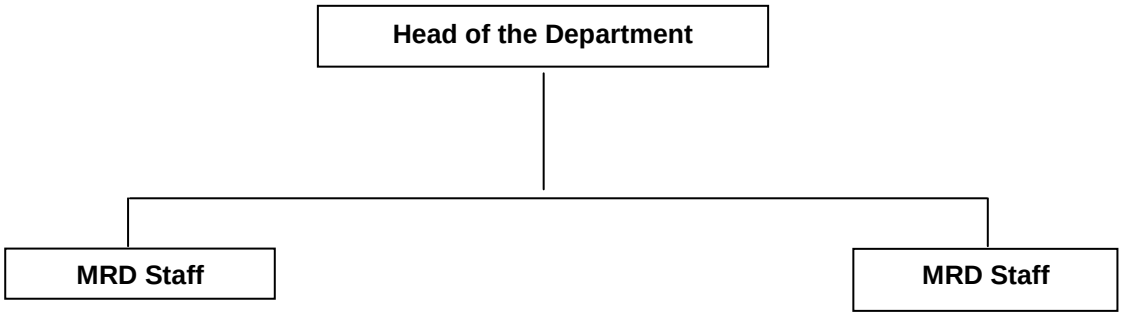
The medical records department manages the physical records for each individual patient, which comprises of a patient's complete medical history. Medical records are confidential documents and there are ethical and legal issues surrounding these records, such as degree of third-party access. There should be appropriate storage and disposal of these records.

Medical records department manager is responsible for safety of controlling access and updating of medical records.

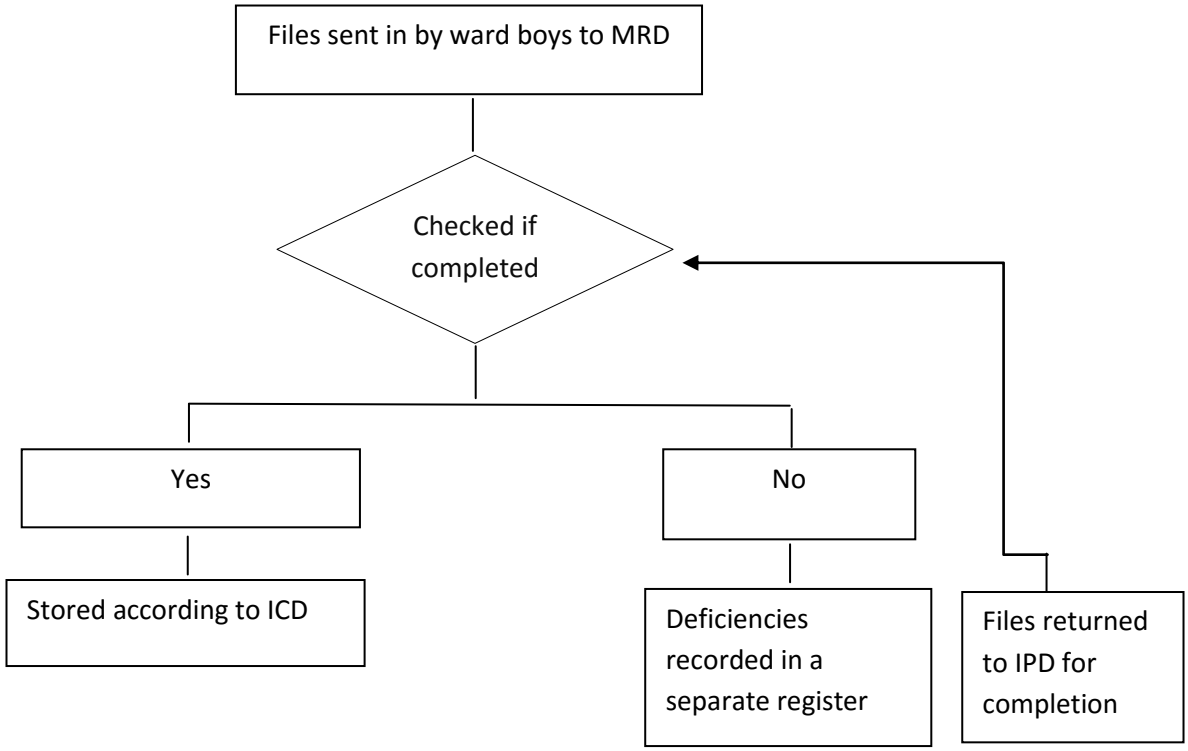
2. Purpose

To provide prompt and pleasant service to the patients by coordinating various related activities in a uniform and prescribed manner.

3. Department structure/Key Stakeholders



4. Process Flow



5. SOPs Ideal Process

5.1 Patient record maintenance & handling

Process Definition	**Patient Record Maintenance & Handling**
Interfaces with	• Doctors / Consultant • Nursing team

S.no.	**Activity**	**Responsibility**
A.	With the admission of patient a file is generated for keeping the record.	Front Office
B.	Admission sheet, prescription, consent form is duly filled & attached in the file	Ward nurse
D.	All the diagnostics reports, progress sheet should be kept in the file	Ward nurses
E.	After the discharge of the patient, file is sent by nurses to MRD with a ward boy. After the receipt of file in the department an entry is made in the register	Nurses/MRD staff
F.	Staff should check the files for the completeness of records. In case of incompleteness of medical records the files are sent back to the concerned department.	Medical records department
G.	Staff should check the ICD code/hospital's own code for mapping the procedures and diseases	Medical records department
H	Details of the code should be entered in the file against procedures and diseases	Medical records department
I.	In case of medico legal cases, records should be kept in a different colored file & stored under lock & key	Medical records department
J.	Storage of files in rack should be as per code and date.	Medical records department

5.2 Death Records handling

Process Definition	**Death records handling**
Interfaces with	• Doctors / Consultant • Nursing team • Public legal authorities

S.no.	**Activity**	**Responsibility**
A.	Record Charts of the expired should be dispatched to MRD along with the death notification form within 24 hrs of the death.	Nurse in charge of respective department
B.	Concerned doctor should assure death notification form completion in all respects with documentation of death events along with date & time in a progress note.	Doctor on duty & concerned consultant
C.	A death Register including serial no., IP number, name of the diseased, age, sex, address, DOA,DOD, time of death, name & date of procedure, no. of days from the procedure till death, number of days of stay, place & cause of death, name & address of informer should be maintained.	Medical records department

D.	Records should be placed under lock & key with the IP number for tracing.	Medical records department
E.	Original death notification form must be delivered to the Municipal Corporation of Delhi and obtain date and the signature of the receiving concerned official of Death registration Office.	Medical records department
F.	Assistance should be provided to the attendants by the medical records department staff as and when they need any information regarding issue of Death certificate.	Medical records department
G.	A copy of the death details should also be forwarded to medical superintendent office	Medical records department

5.3 Insurance claims

Process Definition	**Insurance claims**	
Interfaces with	• Doctors / Consultant • Nursing team • Public legal authorities	
S.no.	**Activity**	**Responsibility**
A.	The claimant should submit a blank prescribed insurance claim form (s) to the Medical Records Department along with required supporting documents.	Claimant
C.	Necessary service charges from both the parties should be collected.	Medical records department
D.	The respective inpatient record charts are retrieved & tallied with those provided with the claimants.	Medical records department
E.	The inpatient records along with blank insurance claim form are sent to the respective consultant for completing them within a time frame of three days	Medical records department
F.	Completed forms along with the records should be returned back to the Medical Records Department	Consultant
G.	The claimant must be informed to collect the completed forms. In case if it is the insurance authorities that have approached, then the forms should be dispatched to them.	Medical records department
H.	Before handing over or dispatching, the completed insurance forms should be xeroxed and those xerox copies should be kept in the patient medical records for future reference	Medical records department

5.4 Amendment & Correction in original registration records

Process Definition	**Amendment & Correction in original registration records**	
Interfaces with	• Doctors / Consultant • MRD • Nursing team • Public legal authorities	
S.no.	**Activity**	**Responsibility**
A.	If a written request is received from patient's relatives asking for any correction in original registration records of the patient undergoing treatment they shall have to produce a proof of the same or an affidavit**.**	Medical records department
B.	In case of correction in death certificate, the Original affidavit along with a forwarding letter from MRD countersigned by MS, shall be forwarded to MCD (Municipal Corporation of Delhi) for necessary Amendment / Correction.	Medical records department
C.	If any wrong information is sent to Death registrar, as per original record of the patient, then Medical Records shall issue an amendment letter and a copy of it will be given to attendant.	Medical records department
D.	Photocopy of the affidavit along with a forwarding letter is filed in the Death File	Medical records department

6. Inpatient Medical Records

S.no..	**Name of the Record**	**Authorized Person for Entry**
A.	Admission form	Doctors ,Medical records technicians
B.	Admission slip	Doctor
C.	History and finding on admission	Doctors, Resident Doctors and Casualty Medical Officer
D.	Initial Assessment of Nurses	Staff Nurse In Charge
E.	Dietary Initial Assessment form	Dietician
F.	Transfer Information Sheet	Doctors and Nursing Staff
G.	Progress Report	Doctors
H.	Laboratory Investigation Reports	Pathologist and Registrar
I.	Radiology Investigation Reports	Radiology Doctor
J.	Cardiology Investigation Reports	Cardiologist
K.	Neurology Investigation Reports	Neurologist
L.	Consent Forms	Consulting Doctor

7. Retention Period of Medical Records shall be as follows:

IPD record	07 years
Death/MLC	Not to be destroyed
Death register	Not to be destroyed
MLC registers	Not to be destroyed
Emergency registers	10 years

Required registers:

- **MR file deficiency summary** – Provides no. of discharges for a particular date/month & out of those, total no. of complete / incomplete files and if incomplete then in which aspect.
- **File deficiency report** – Particulars of the file (IPID, Name, and DOD) for a particular doctor.
- No. of Death cases, MLCs and Pre triage patients.
- No. of patients of particular disease.