GSR INSTITUTE OF CRANIOMAXILLOFACIAL AND FACIAL PLASTIC SURGERY

COP MANUAL

COP -1

Uniform Care

POLICY:

Every patient is provided with uniform clinical care irrespective of cast, creed, religion, region, paying capacity, category of bed or behavior of patient with staff.

Patient with same health problem receives the same quality of health care throughout the organization by the qualified professionals.

Health care providers (Doctors & Nurses) follow best practices in accordance with standard norms of medical practices.

As a policy for provision of uniform clinical care following are observed for all emergency patients

PROCEDURAL STEPS: (Guidelines for COP)

1. Any patient seeking emergency medical services is screened & first aid care to be provided ifrequired.
2. First aid is provided to the emergency patient, which shall be continued at least for 4 hours to stabilize the patient. Afterwards as per the economical condition & choice of the patient's admission procedure shall bedone.
3. If admission required, according to the category of choice patient admission isdone.
4. Every patient admitted should has care provider & this should be informed to the patient
5. Every patient admitted in the hospital has an identified care provider (primary consultant) who bears the responsibility of complete & uniform clinical care of the patient. Patient record shall be provided to care provider **to facilitate** the exchange ofinformation.

6. Complete registration with patients' demographic & generic information in theregister.
7. A general consent formality is obtained from all thepatients.
8. All medico-legal cases are informed to the police (As per MLCList)
9. The patient is escorted to the related wards under the supervision of Emergencypersonnel.
10. Further comprehensive assessment of the patient is done at respective wards and detailed line of treatment plan shall be received from admitting consultant and will be explained to thepatient.
11. All consultants practice evidence based medicine practices for the care of the patient tilldischarge.
12. The treatment plan is counter signed by the consultant clinician within 24 hours.
13. Information shall be exchanged and documented during each staffing shift , between shifts and during transfer between units/departments
14. Every patient has an up to date medical record which reflects the clinical care given to the patients. All clinical records are be signed, named, timed & dated by the person makingentries.
15. Resuscitation is done for the patients (As per code bluedocument).
16. Any special consultant choice is inquired & available consultant list isgiven.
17. In case of non affordable patients further treatment after stabilization at emergency dependent on decision of MedicalSuperintendent.
18. Multi disciplinary and multi speciality care is provided to the patient wherever it is required. Whenever the patient requires care from other disciplines, the organization follows defined protocol which involves, consultation from the concerned specialist and referred for further management to reduce any adverse event and improve patient satisfaction.

19. The organization has a uniform process for identification of patients. The organization gives a UHID to all the patients at the time of registration who are visiting to the hospital for the first time. UHID remains same even if the patient visits many times for treatment. That UHID is used for further monitoring of the patients. For all the patients admitted in the hospital, aadhar card is mandatorily asked for and is filed.

The organization also uses an ID bands and a sticking on the patient when admitted in the ward for easy identification.

Nutritional therapy is provided to patients consistently and collaboratively on need basis.

Nutrition is a basic need of life and thus plays an important role in health promotion and disease prevention. Malnutrition should be considered and treated as an additional disease, as it has been shown to worsen clinical outcomes and to increase morbidity, mortality, and complication rates, thus causing additional costs . However, malnutrition is preventable and mostly reversible with early adequate nutritional therapy. It often remains undetected due to lack of awareness, knowledge, and clinical protocols to identify and treat this problem within hospitals.

Dietary counseling of the patients are done by the dietician, a diet plan is given to all the patients A nutritional reassessment is done on few patients and the diet plan is modified accordingly. The organization also document the patients who are malnourished and has poor weight gain. Proper dietary counseling for them is done from time to time

Evidence Based Medicine:

POLICY:

Consultants and other medical professionals shall practice, as far as possible, evidence based medicine for clinical management of their patients. Evidence based medicine shall be uniformly followed for all categories of patients.

Clinical departments shall develop clinical protocols for managing specific disease conditions. Diseases which are commonly encountered in a department shall have a protocol of clinical management, which is developed collaboratively by all the specialist of the department, taking in to account best clinical practices having an evidence of success.

Consultants and other medical professionals shall keep updating their knowledge on current best practices, new researches and newer process of clinical management. Doctors shall attend conferences, CME and share knowledge amongst them to improve their knowledge on latest acceptable clinical practices.

Medical audit committee shall audit the medical records as per document 'Medical audit and shall evaluate the treatment provided with evidence based or best practices.

In house Continuing Medical Education

CME (Continuing Medical Education) shall be conducted on regular basis. Latest topics on clinical management are taken up and all doctors are encouraged to attend the CME and share knowledge.

Evidence-based medicine categorizes different types of clinical evidence and ranks them according to the strength of their freedom from the various biases that beset on medical research.

1. It is the conscientious, explicit and judicious use of the current best evidence in making decision about the care of theindividual
2. It also implies making medical decision and applying the same to patients based on the best external evidence combined with the physicians clinical expertise and the patientsdesires

Safe and Secure environment for vulnerable patient

- To ensure a safe environment for all vulnerable patients the hospital trains all staff members to be sensitive to suchmatters.
- Providing anti slip mats in the bathrooms and other surfaces that may need them physically ensures a safe and secure environment and providing beds with guard rails are available and used when the needarises.
- Provision of facilities and on-site inspections to the vulnerable group of patients such that they are safe from abuse, are ensured by themanagement.

POLICY:

The GSR INSTITUTE OF FACIAL PLASTIC SURGERY ensures that vulnerable patients (elderly, physically and / or mentally challenged and children) are protected from abuse, which we define as a violation of an individual's human or civil rights by any other person. A coordinated approach is used to manage any reported instance or suspicion of abuse against vulnerable patients admitted to the hospital.

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- Protect the vulnerable patients from abuse
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Training of the staff

Each department related with patient care includes 'care of vulnerable patient' as a topic in their departmental training programme. Staff is trained for care of vulnerable patients with respect to

- Understanding and recognizing vulnerable patients
- Principles of staged, step down care
- Moving and handling of vulnerable patients.
- Training in prevention and management of falls, unconscious patients, supervised feeding decubitus ulceration (its prevention and care), interacting with caretakers for continued care.

Informed consent

- Informed consent shall be taken as per informed consent policy

PROCEDURE TO FOLLOW IN CASE OF ABUSE OF VULNERABLE PATIENT

S.NO.	PROCEDURAL STEPS	RESPONSIBILITY
1.	When a case of abuse of a vulnerable patient is suspected or disclosed, the main consideration is the protection of the vulnerable patient.	All hospital staff
2.	When such an event occur the Nursing Superintendent is immediately informed. She / He will then inform the primary consultant. The concerns are documented in the medical records by the first person to report the abuse.	First person identifying the abuse / Nursing Superintendent
3.	Hospital Administrator forms the investigating team. The medical administrator decides whether social services or the police need to be informed.	Hospital Administrator
4.	A detailed investigation is carried out.	Team
5.	If the vulnerable adult is judged to be mentally competent, he can reject offers of assistance and refuse intervention.	Team
6.	If the investigating team cannot resolve the situation, appropriate social services are informed and a multi agency meeting is convened to resolve the issue	Hospital Administrator
7	All these proceedings to be recorded and maintained by Hospital Administrator.	Hospital Administrator

POLICY:

COP-2

Emergency Care

No Emergency care are attended here only surgical postoperative emergency medical services irrespective of caste, creed or paying capacity. Hospital Staff shall be well qualified and trained in emergency care policy /procedures.

Surgical post operative Emergency care has to be provided by emergency unit on 24 X 7 bases. Admission or discharge to home or transfer to another organization from hospital isrecorded.

All patient vital signs & complaints are recorded. Depending upon the situation required treatment is started. Resuscitation / Treatment are started as per the requirement. Required investigations are done.

Clinical consultant is informed & details of line of medical management will be recorded.

After stabilizing the patient, the patient shall be shifted to respective ward.

PROCEDURE:

S. No.	Procedural steps	Responsibility
1.	As soon as the postoperative emergency emerges necessarytreatment is provided by onduty fellow.	On duty fellow
2	If the patient requires any urgent radiology / pathology investigation the needful shall be done	On duty fellow
3	Any such investigation done at emergency is entered to the proper registers and informed to the ward to avoid replication	On duty fellow
4	Any patient who requires isolation due to any infection is informed to the ward before bed arrangement	On duty fellow

Primary survey Airway

- **Observe mouth and upper airway for airmovement**
- Open airway if needed: Use head tilt chin lift in medical patients; chin lift or jaw thrust in traumapatients.
- Protect cervical spine from movement in appropriate traumapatients.
- Clear upper airway with finger (gloves on) a weep or suction asnecessary.

Breathing

- Expose chest and observe chest wallmovement.
- Note respiratory rate, noise andeffort.
- Treat respiratoryarrest.
- If respiratory rate is less than 12/min or breathing appearsinadequate
- Assist respirations with bag & mask and 100%O_2.
- **Consider Intubation**if:

- Observe nail colour and check for signs of hypoxia with the help of pulseoxy meter
- Look for life-threatening respiratory problems and brieflystabilize: 1-open or sucking chestwound.

- large flailsegment
- tensionpneumothorax
- GCS<8
- Gaspingrespiration
- Blood/Secretions in throat in an unconsciouspatient

Circulation

- Try to controlheamorrhage and surgical site exposure
- Palpate for pulse
- Positive Carotid pulse implies> 60systolic
- Note pulse quality and generalrate
- Capillary refill on trunk for paediatric patients & from nail inadults

Secondary survey

Secondary survey is the systemic assessment of the entire patient. It should be performed after:

- Primarysurvey
- Stabilization and initial treatment of life-threatening airway, breathing, or circulatorydifficulties
- Cervical immobilization asneeded

The purpose of the secondary survey is to uncover problems which are not life threatening, but which could be injurious or could become life threatening to the patients in future.

HEAD AND FACE

- Observe for deformities, asymmetry,bleeding
- Palpate for deformities, tenderness, andcrepitus
- Recheckingairway
- Eyes: pupils, foreign, contact lenses,tearing
- Nose: deformity, bleeding, discharge or movement of Alanose
- Ears: bleeding, discharge, bruising behindears

NECK

- Recheck for deformity or tenderness if not alreadyimmobilized
- Observe for wound, neck vein distention, and use of neck muscles for respirationalteredvoice and medical alert tags
- Palpate for crepitus, tracheal shift & trachealtug

CHEST

- Observe for wound, chest wallmovement
- Palpate for tenderness, wound, fracture, crepitus, unequal rise ofchest
- Have patient take deep breath-observe for pain, symmetry, and air leak from wounds
- Auscultate chest for rales, wheezes, rhonchi or decreased breath sounds & any abnormalheart sounds.

Emergency Services

In case of discharge to home or transfer to another organization, discharge note is given to the patient.

Admission,discharge to home or transfer to another organization is documented in the casualty assessment form where all the details are mentioned . Demographic information, clinical findings, first aid treatment given and also whether the patient is getting admitted or transfer to home or another organization after the patient condition stabilizes. A documentation is also done in the casualty department.

Prevention of patient overcrowding is planned and crowd management measures are implemented.

- The organization strategizes to prevent crowd in the emergency area, OPD area as well in the ward. There is an public address system which is involved in the management of the crowd and queue management
- In the emergency area, only patient with one attendant is allowed to enter the department till the assessment gets completed.
- There is a visitor's time mentioned in the reception area when they are allowed to meet their patients to avoid crowding.

Patients waiting in the emergency are reassessed. A modification in the care plan is made after reassessing the patient'scondition coming in the emergency department after assessing the condition.

Handling of Medico Legal Cases:

POLICY:

Any patient seeking emergency medical services is screened & first aid care to be provided if required.

Doctor on duty shall decide whether a case is a medico legal one. All MLC shall be notified to the police as per Document.

- All MLC is recorded and marked asMLC.

MLC records are stored separately under secure custody

ABBREVIATION

MLC: Medico Legal Cases

MRD: Medical RecordDepartment OPD: Out Patient Department

IPD: In patient Department **PROCEDURE:**

S. No.	Procedural steps	Responsibility
1.	Event are recorded in detail with mentioning the date, time & place of the event & involvement of person & vehicle during the event	Medical officer
2.	If event to be informed to police, it Should first informed to the patients about the policy.	Medical officer
3.	Process of MLC is explained to each patient	Medical officer
4.	A written consent is obtained from all the MLC cases, after clarification of all doubts.	Medical officer / Staff Nurse
5.	After confirming with patient / relative, a	Medical officer /
	communication is made to respective police station.	Staff Nurse
6.	All MLC cases after registration, a separate file is issued for IPD cases & should be marked “MLC”	Reception Executive/Staff Nurse
7.	Clinical notes are entered in IPD / OPD case paper & in a MLC form book.	Medical officer
8.	MLC notes & patient’s data is entered in the register also.	Reception executive

9.	A separate register is maintained for each MLC cases with required data at emergency.	Staff Nurse
10.	Counter sign from police station is achieved from representative of police stations in a manual patient's MLC form.	Staff Nurse
11.	Police representative details in the form of police station with phone No., designation & buckle No. of representative is noted in MLC form	Doctor /Nursing
12.	Time of informing police & time of arrival of police is entered in MLC form.	Staff Nurse
13.	All MLC cases registered with the hospital is always being informed to Medico-legal consultant immediately.	Doctor
14.	Any patient, registered under MLC, expires during hospitalization – Post mortem is a mandatory procedure & patient's body is handed over topatient's relative but it should be handed over to respective police station for post- mortem to be performed to local district hospital.	Doctor
15.	Case summary is provided to the police at the time of handing over the dead body for submission of the same at district hospital	Doctor
16.	All MLC cases at the time of discharge are informed to same police station.	Staff Nurse
17.	Patients / relative sign is obtained in our MRD file about handing over of the documents & reports.	Staff Nurse
18.	After the discharge, MRD files of all MLC cases are separately stored & should be under control of a designated person under Lock and Key.	MRD personnel
19.	MRD person preserves signed certificate till police authority collects it.	MRD
20.	At the time of handing over the certificate to police the designation & BUCKLE No. of the police representative is noted in second copy & sign of the police is taken.	MRD
21.	Original injury certificate is issued to police & not to patient or relatives.	MRD

Triage:

PURPOSE:

- If faced with large number of casualties need to prioritisemanagement
- Aim is to 'do the best for themost'
- Triage is the sorting of casualties by priority oftreatment
- Performed by a 'Triage officer'(who is nominated by Medical Superintendent) who assesses casualties without givingtreatment
- Divides patients intocategories
- Casualties may be given coloured triagelabel

POLICY:

Triage is initiated whenever faced with a situation of mass casualties.

The senior nurse of the emergency department functions as a triage nurse and initiates the triage activity when required. She also informs other staff about occurrence of mass casualties

Triage categories

Cat	Definition	Colour	Treatment	Example
P1	Life-threatening	Red	Immediate	Tension pneumothorax
P2	Urgent	Yellow	Urgent	Fractured femur
P3	Minor	Green	Delayed	Sprained ankle
P4	Dead	Black		

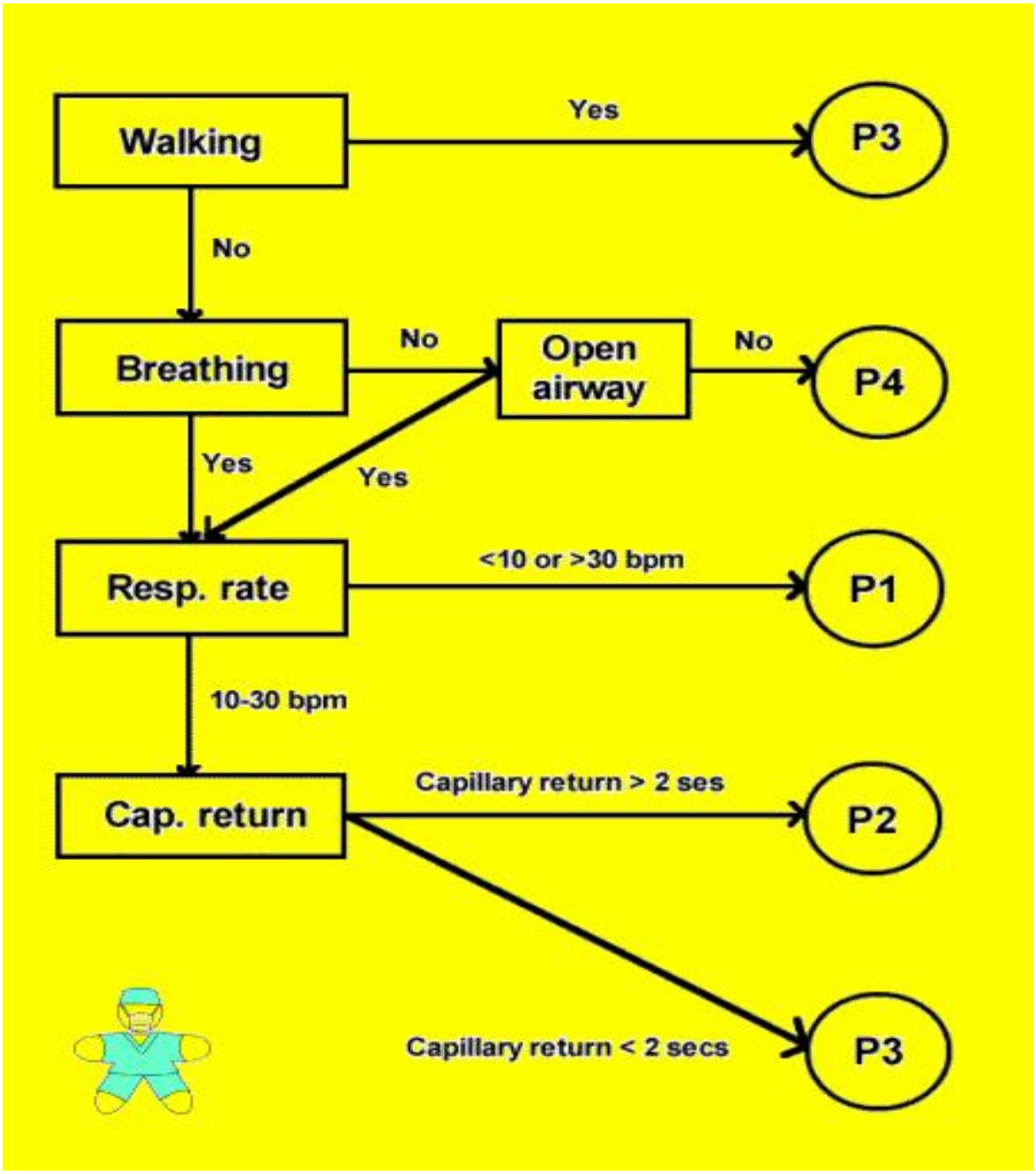
Methods of triage

Triage can be performed rapidly by assessing

- Airway
- Response to verbalcommand
- Respiratoryrate
- Circulation rate: Pulse rate or capillaryreturn
- Pupillaryreaction

Scene assessment

- Recognize environmental hazards to rescuers, secure area fortreatment
- Recognize hazard for patient, protect from furtherinjury.
- Identify number of patients, initiate triage ifappropriate.
- Observe position of patient, mechanism of injury andsurroundings.
- Identifyyourself



- Contact dispatch if hospital resources require mobilization, asks for back up ifneeded.
- Triage is not applicable because of capacity constraint in the emergency room of the hospital

Ambulance Service

Following kinds of ambulances are kept/made available to commensurate the scope of services provided by the GSR INSTITUTE OF FACIAL PLASTIC SURGERY

- Ambulance with Basic life support facility which is**outsourced**.

Checklist of equipments and Medication in Ambulance

POLICY:

Ambulance personnel shall maintain the equipments and medicines in the ambulance as given in the checklist below. These equipments and medicines shall be checked on daily basis and prior to dispatch of ambulance.

The record of these checks shall be maintained in a checklist register with date, time, name and signature of the person performing the check and name and signature of person performing the crosscheck.

It shall be ensured that all equipments and medicines in the checklist are available in the ambulance and in appropriate workingcondition.

If there is deficiency in availability of any of the equipment or medicine, same shall be intimated to 'Emergency doctor on duty' and his permission taken before dispatch of ambulance.

Equipment required in the basic Life Support Ambulance

a. Stethoscope
b. sphygmomanometer
c. emergency drugs andsupplies
d. Cotton &Bandage
e. Sprit
f. portable oxygen cylinder withregulator
g. wheel type stretcher withstraps
h. cervical collar(adult/paediatric)
i. resuscitatorbags
j. Equipments for intubation &resuscitation
k. Mobile / other communicationdevices
l. Torch

COP-3

PURPOSE:

Appropriate and uniform use of resuscitation efforts in cases of medical emergencies

RESPONSIBILITY

Code Blue Team

TEAM:

This should consist of

Consultant,

Medical Officer in emergency and Nurses

POLICY:

Resuscitation efforts shall be given uniformly across the hospital for all patients, the hospital staff and visitors who are in need of it.

It is the policy of the hospital to have a code blue team available 24 hours a day. Code Blue team is called by the unit in charge to provide advanced cardiac life support whenever it is required in thewards.

CODE BLUE:

It is a code created for the purpose of urgently calling a team of specialist to a particular place to give advanced cardiopulmonary resuscitation to an individual who has experienced cardiopulmonary arrest.

Arrangements for providing resuscitation efforts

Following arrangements have been made for providing resuscitation and code blue team functioning

1. Crash cart with all necessary life saving drugs and equipments is available on each floor and accessible to all patient areas. Crash cart is kept ready and inspected daily and used only during medical emergencies
2. Constitution of a code blue team to provide uniform resuscitation in all patient areas. The team members are certified in Advanced cardiac life support and basic cardiac lifesupport
3. Designation of a code blue coordinator to co-ordinate the functioning and trainings required for resuscitationactivities.
4. A dedicated line with dial number for dialing in case of cardiacarrest.
5. Display of code blue number in all patientareas
6. A code blue reporting form to collect information regarding cardiac resuscitation provided for further analysis and quality assurance of theprocess
7. Provision of training on basic life support to all nursing and medical staff (once in every 3month)

PROCEDURE:

CODE BLUE TEAM & RESPONSIBILITIES

- The code blue cardiopulmonary resuscitation team consists of 2 qualified individuals. Each member of the team has been assigned specific duty during resuscitationeffort.

CODE BLUE TEAM –

(1) Anesthetist is responsible to manageairway.

(2) Medical Officer in emergency is responsible for chest compression and defibrillator.

(3) Nurse is responsible for taking IV lines and introducing medications as per the instructions of the teamleader.

(4) All emergency duty doctors will be trained for ACLScourse

AVAILABILITY

- The code blue teams are on call for twenty-four hours a day, everyday.

ANALYSIS OF EVENT

- Post event analysis shall be done by *Hospital Safety Committee (Multidisciplinary committee)* and corrective & preventive action shall be taken on the basis offindings.

POLICY:

COP-4

Blood and blood products are used rationally and only on advice of the treating physician.

Informed consent from the patient / relative is obtained whenever use of blood or blood products is contemplated.

GSR INSTITUTE OF FACIAL PLASTIC SURGERY **DO NOT store any blood or blood component.**

Blood Transfusion Policy

The organization has an MOU with the outsourced blood bank. The blood is transported from the external blood bank safely and properly.

Transfusion of blood and blood components is done safely only if ordered by the treating doctor. The order is written by the treating doctor if any premedication is required before transfusion, rate of transfusion.

The protocol for blood transfusion as followed by the organization:

A CBC is done for the patient, if found by the physician that any blood component is required, a blood product requisition slip is filled where in all the information is duly filled, name of the patient, bed no,reg no/uhid,consultant ,date and time, blood group .

Blood sample of the patient for cross match and the requisition form is sent to the blood bank. After receiving the blood in the hospital it is administered only when it attains the room temperature.

The patient is monitored periodically to assess any transfusion reaction and is recorded if any.

ADMISSION ANDDISCHARGECRITERIA TOHDU

1.0 POLICY:

- HDUsadmissionand/ordischargeshallbedecidedbytreatingphysicianasper documented admission and dischargecriteria.
- HDUshalltrytokeep5-10%ofitsbedsvacantatanygiventimeforemergency cases.

2.0 PURPOSE:

Toensureasmoothprocessfortheadmissionanddischargeofpatient'saccordingto their condition**.**

3.0 ABBREVATIONS:

HDU:HIGH DEPANDENCY UNIT

CPAP: Continuous Positive airwayPressure

4.0 SCOPE:

PatientsrequiringconstantmonitoringareadmittedintoHDUand stablepatients who can betransferred to thewards after discussion with the consultant incharge

5.0 RESPONSIBILITY:

HDU in charge

6.0 DISTRIBUTION:

Consultants/RMOand NursingIn-charge.

7.0 PROCESSDETAILS:

7.1 **DescriptionOfTheProcess**

HDU's admission and / ordischargeshall be decided bytreatingphysician (Registrar& above) and as per documented admission and discharge criteria given below.

HDU shalltrytokeep5-10 %ofits bedsvacantatany giventimeforemergency cases.This shall bedonebydischargingstable cases asearlyas possible.

Guidelineforadmissionand discharge:

A. Admission criteria based on objective parameters

❖ **Vital signs:**

- Pulse < 40 or > 150 beats / minute.
- Systolic arterial pressure < 80 mm Hg or 20 mm Hg below the patient's pressure
- Mean arterial pressure > 120 mm Hg (if monitored)
- Respiratory rate > 35 breaths / minute

- **Laboratory value (newly discovered) outsourced**
- Serum Sodium < 110 mEq/ L or > 170 mEq/L
- Serum Potassium < 2.0 mEq/ L or > 7.0 mEq/L
- Pa O_2< 50 mm Hg
- pH < 7.1 or 7.7
- Serum Glucose > 800 mg/dl
- Serum Calcium > 15 mg/dl
- Toxic level of drug or other chemical substance in a hemodynamically or neurologically compromised patient.
- **Electrocardiogram**
- Sustained ventricular tachycardia or ventricular fibrillation.
- Complete heart block with hemodynamic instability (SHDU)
- **Physical findings (acute onset)**
- Unequal pupils in an unconscious patient
- Anuria
- Airway obstruction
- Coma
- Continuous seizures
- Cyanosis

I. Admission Criteria

a. Admission criteria to HDU

- Patient who are with post operative complication ,palliative & critically ill palliative, unstable in need of intensive treatment and monitoring that cannot be provided outside the HDU. Usually these treatments include ventilator support, continuous vasoactive drug infusions.
- Shock needing inotrope for support
- Severe acidosis
- Uncontrolled seizures
- High Dose oxygen requirements fio 2 >50% with respiratory distress
- Mechanical(additional) support of organ function
  - Respiratory – ventilation / CPAP
  - Renal– Electrolyte imbalance.

- Hepatic –Hepatic encephalopathy & coagulation abnormality

- Patient requiring support of 2 or more organ system even when this does not include the respiratory system (multi system involvement)
- Potentially reversible serious patient condition

- Patient who are palliative & critically ill palliative, unstable in need of intensive treatment and monitoring that cannot be provided outside the HDU. Usually these treatments include ventilator support, continuous vasoactive drug infusions.
- Surgical patients' refractory shock
- Surgical patients' in severe acid base abnormality/metabolic abnormality
- Trauma including head injury
- Respiratory failure due to any cause with potential to require non-invasive /invasive mechanical ventilation.
- Any condition deemed to require HDU care by treating consultant in discussion with HDU doctor in charge.

II. Discharge Criteria

a. Discharge criteria in HDU

- Substantial resolution of the problems responsible for admission.
- Haemodynamically stable.
- There is no requirement for mechanical ventilation /airway protection.
- No requirement for invasive haemodynamic monitoring.
- Discontinuation of medications/ treatments requiring haemodynamic monitoring
- Patients are usually not discharged from the HDU. They are transferred to Ward or Post HDU or Ward as decided by the treating team.
- At time of the transfer, further treatment plan, IV Fluid orders and investigations to be followed are carefully documented in the file.

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- The criteria for Shifting patient from HDU are

- Haemodynamically Stable
- Improved sensorium, Post extubation-stable for at least 24 hours.
- Reversal of initial condition for which patient was admitted to HDU.

- Patients who do not require mechanical, requiring critical care and nursing are generally treated in Post HDU, or post OP room (Surgical and allied branches).

- Patients are shifted from HDU/ Post OP as per the decision of the treating consultant, if they are deemed not require further critical care, and be managed in wards.

COP-5

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3.	Hospital Administrator form the investigating team. The medical administrator decides whether social services or the police need to be informed.	Hospital Administrator
4.	A detailed investigation is carried out.	Team
5.	If the vulnerable adult is judged to be mentally competent, he can reject offers of assistance and refuse intervention.	Team
6.	If the investigating team cannot resolve the situation, appropriate social services are informed and a multi agency meeting is convened to resolve the issue.	Hospital Administrator
7.	All these proceedings to be recorded and maintained by Hospital Administrator	Hospital Administrator

COP-6

Obstetrics is out of scope of service of the Hospital.

GSR INSTITUTE OF FACIAL PLASTIC SURGERY DO not take Obstetrical Patients.

COP-7

GSR INSTITUTE OF FACIAL PLASTIC SURGERYDO not take Neonatal/ Pediatric Patients out of scope of service of the Hospital.

COP-8

Procedures of Sedation:

POLICY:

A doctor or a nurse on advice of doctor administers sedation.

The person administering and monitoring sedation is different from person performing the procedure.

Intra procedure monitoring of the patient under sedation is be done. This includes monitoring of following

- Heartrate
- Cardiacrhythm
- Respiratoryrate
- Bloodpressure
- Oxygensaturation
- Level ofsedation
- Any other parameter asrequired

Post sedation, patient's vitals is monitored at regular intervals (as decided by person administering sedation) till the patient recoverscompletely

Documented criteria are followed to decide appropriateness of discharge from recovery area.

PROCEDURE:

Sr. No	Procedure Steps	Responsibility
1.	Patient is kept Nil By Mouth (NBM) for specified period before administration of sedation.	Staff Nurse
2.	Anesthetist is responsible for performing sedation	Anesthetist
3.	All monitoring equipments is made ready	Technician & Nursing staff
4.	Patient is explained about procedures & informed consent is to be taken before administration of sedation.	Anesthetist
5.	Recording of all vital sign parameters are done continuously in Operation Theater	Anesthetist
6.	Patients shall not be transferred unless & until it fulfills the criteria of discharge from recovery.	Anesthetist
7.	Any adverse event or side effect shall be recorded & informed to concerned Anesthetist &consultant as soon aspossible.	Medical officer/Staff Nurse

COP-9

Administration of Anesthesia

PURPOSE:

For safe and effective administration of anesthesia and monitoring of patients

RESPONSIBILITY:

Anesthesiologist

POLICY:

Indication and type of anesthesia (other than local anesthesia) is recorded in medical file.

Pre-anesthesia assessment is done for all patient requiring anesthesia's (routine and emergency), shall be done before wheeling in the patient to Operation Theatre.

The pre-anesthesia assessment is result into an anesthesia plan which is recorded in medical file

Consent is taken from patient before anesthesia (general or local) administration as per document no.

Intra procedure monitoring of the patient under anesthesia is done and recorded. This includes monitoring of following

- Heartrate
- Cardiacrhythm
- Respiratoryrate
- Bloodpressure
- Oxygensaturation

Post sedation, patient's vitals are monitored at regular intervals till the patient recovers completely.

Documented criteria are followed to decide appropriateness of discharge from recoveryarea

PROCEDURE:

Sr. No	Procedure Steps
1.	The record should include documentation of: **Pre-anesthesia Evaluation** A. Patient interview to assess: • Medical history • Anesthetic history • Medication history B. Appropriate physical examination. C. Assignment of ASA physicalstatus. D. Formulation of the anesthetic plan and discussion of the risks and benefits of the plan with the patient or the patient's legalrepresentative. E: Informed consent for the administration of anesthesia
2.	The anesthesiologist, before the delivery of anesthesia care, is responsible for: 1. Reviewing the available medical record. 2. Interviewing and performing a focused examination of the patient to: a. Discuss the medical history, including previous anesthetic experiences and medical therapy. b. Assess those aspects of the patient's physical condition that might affect decisions regarding preoperative risk and management. 3. Ordering and reviewing pertinent available tests and consultations as necessary for the delivery of anesthesia care. 4. Ordering appropriate pre operative medications. 5. Ensuring that consent has been obtained for the anesthesia care. 6. Documenting in the chart that the above has been performed.
3.	**Intraoperative / procedural anesthesia (time-based record of events)** A. Immediate review prior to initiation of anestheticprocedures: • Patientre-evaluation • Check of equipment, drugs and gas supply B. Monitoring of the patient (e.g., recording of vital signs). C. Amounts of drugs and agents used, and times of administration. D. The type and amounts of intravenous fluids used, including blood and blood products, and times of administration E. The technique(s)used. F. Unusual events during the administration of anesthesia.(Any adverse Event) E. The status of the patient at the conclusion of anesthesia.

4.	THESE STANDARDS APPLY TO POST ANESTHESIA CARE IN ALL LOCATIONS. Standard I All Patients Who Have Received General Anesthesia, Regional Anesthesia Or Monitored Anesthesia Care Shall Receive Appropriate Post anesthesia Management.
5.	1. A Post anesthesia Care Unit (Recovery) or an area, which provides equivalent post anesthesia care (for example, a Surgical Intensive Care Unit and Recovery) shall be available to receive patients after anesthesia care. All patients who receive anesthesia care shall be admitted to the Recovery area or its equivalent except by specific order of the anesthesiologist responsible for the patient'scare. 2. The medical aspects of care in the Recovery area (or equivalent area) shall be governed by policies and procedures that have beenreviewed and approved by the Department of Anesthesiology.
6.	**Standard II** A Patient Transported To The Recovery Shall Be Accompanied By A MemberOf The Anesthesia Care Team Who Is Knowledgeable About The Patient's Condition. The Patient Shall Be Continually Evaluated And Treated During Transport With Monitoring And Support Appropriate To The Patient's Condition.
7.	**Standard III** Upon Arrival In The Recovery Area The Patient Shall Be Re-Evaluated And A Verbal Report Provided To The Responsible Recovery Area Nurse By The Member Of The Anesthesia Care Team Who Accompanies The Patient.
8.	The patient's status on arrival in the Recovery shall be documented by the recovery nurse. 1. Information concerning the preoperative condition and the 2. Surgical/anesthetic course shall be transmitted to the Recovery nurse. 3. The member of the Anesthesia Care Team shall remain in the Recovery until the Recovery nurse accepts responsibility for the nursing care of the patient.

9.	**Standard IV** The Patient's Condition Shall Be Evaluated Continually In The Recovery room. The patient shall be observed and monitored by methods appropriate to the patient's medical condition. Particular attention should be given to monitoring oxygenation, ventilation, circulation, level of consciousness and temperature. During recovery from all anesthetics, a quantitative method of assessing oxygenation such as pulse oximetry shall be employed in the initial phase of recovery.
10.	**Post anesthesia** A. Patient evaluation on admission and discharge from the post anesthesia care unit. B. A time-based record of vital signs and level of consciousness. A time-based record of drugs administered their dosage and route of administration throughout the recovery stage. D. Type and amounts of intravenous fluids administered, including blood and blood products. E. Any unusual events including post anesthesia or post procedural complications. Post anesthesia visits

COP-10

PURPOSE :

Care of Patient Undergoing Surgery

To promote patient safety by providing guidelines for verification of correct site, correct procedure, and correct patient for invasive/surgical procedure(s).

SCOPE:

This policy applies to all invasive/surgical procedure including bedside invasive procedures performed. This policy does not apply to venipuncture, peripheral IV placement, insertion of nasogastric tube or insertion of a catheter.

POLICY:

Surgical procedures are performed by surgeons who are privileged after necessary credentialing, by the hospital for that procedure.

All patients who have to undergo surgical procedure (planned or emergency) have a pre-operative assessment done and a provisional diagnosis written, prior to surgery. The pre-operative assessment and provisional diagnosis is done by the operating surgeon. Pre-operative orders are explained properly to unit staff & shall be documented. Informed consent shall be obtained prior to surgery as per document 'informedconsent'

Floor staff informs the theatre staff about the plan ofsurgery. Prevention of adverse events in surgical patient isfollowed.

The operating surgeon documents (or sign) the operative notes which includes information on procedure performed post-operative diagnosis and status of the patient before shifting.

Post-operative plan of care is documented by operating surgeon in medical records of the patients. This post-operative plan shall include advice on IV fluids, medications, care of wounds, nursing care, observing for any complication and other aspects as required.

PROCEDURE:

	Procedure Steps	Responsibility
	Pre operative orders are confirmed before shifting the patient from ward to operation theatre	Anesthetist/surgeon
	Nil by mouth status is to be confirmed before shifting the patient from the wards	Staff nurse
	Patient should be sent to OT with case paper and reports and required escort on stretcher/wheelchair one hour before scheduled time of operation after confirming from the theatre in-charge	Staff nurse
	Attending surgeon and anesthetist clinically examine the patient and report just before starting the operation	Anesthetist /Surgeon
	All aseptic precautions maintained throughout the procedure time by all Operation theater (OT) staff	Operation theater (OT)staff
	Patient is assessed by the surgeon and anesthetist decide necessity of keeping the patient at post operative recovery room	Surgeon/anesthetist
	Patient is transferred from recovery room as per the std.	Surgeon/anesthetist
	Intensive monitoring of post operative patients at wards is done every one hour for next four hours or as per the intimation by the consultant.	Staff Nurse

Prevention of Adverse Event in Surgical Patients

POLICY:

Personnel involved in care of surgical patients shall take all necessary measure to reduce the risk of occurrence of adverse events in surgical patients.

Adverse events in surgical patients, which are preventable, occur due to neglect, human errors or due to improper co-ordination. For e.g. Surgery on wrong site, surgery on wrong patient, or wrong surgery on the patient etc.

Following are re-emphasised for surgical patients

1. Proper identification of the patient (through identification tag, name and medicalrecord)
2. Proper identification of the site after identification of patient and through the medicalrecords.
3. Proper identification of surgery to be performed (through medicalrecord)

PROCEDURE FOR SURGERY 'TIME OUT':

	Procedure Steps	Responsibility
	Scheduling: The following information is must when scheduling an invasive/surgical procedure: ❖ Correct spelling of the patient's fullname ❖ In-patientnumber ❖ Consent for Procedure to be performed. ❖ Any discrepancies should be clarified with consultant	Staff Nurse
	Pre-procedure/preoperative verification The Surgeon & anaesthetist will verify patient's identity by asking • Patient's full name • Date of birth • Procedure/surgery to be performed. If patient is minor, incompetent or sedated, or not able to speak then in such cases ask the near blood relative or legal guardian to give the details.	Surgeon & anaesthetist
	If any discrepancy is found at any point, the case must stop from proceeding until resolved.	Surgeon& anaesthetist

POLICY FOR HANDING OVER OF BIOPSY SPECIMEN

PURPOSE:

1. Handing over of tissue specimen for histopathological examination /immunohistochemistry analysis via patient /relatives/attendants for all IPD patients.

2. Handing over of tissue specimen for histopathological examination/immunohistochemistry analysis via patient /relatives/attendants for all OPD patients.

POLICY:

1. As soon as the surgical procedure is completed, the specimen is prepared by a trained /duly qualified O.T technician/staff in a 10% formalin solution. The necessary details are entered in the O.T biopsy register in the prescribed format and biopsy request form to be prepared and signed by the operating surgeon.
2. The O.T staff will ensure that the specimen along with the duly filled biopsy form is handed over at the sample collection area to an authorized person as designated by the pathology incharge.
3. In case of any breach in the aforementioned procedure for example patients relative / attainder denying receiving the specimen or their inability to submit the specimen at the collection area etc. Any such events have to be reported immediately and promptly to the theatre incharge/ medical superintendent for an immediate action.

With an outbreak of the recent COVID-19,which has become a pandemic is a viral pneumonia The virus is recognized as novel corona virus[2019-nCOV] which causes COVID-19.

The **signs and symptoms** include fever, cough, shortness of breath and respiratory symptoms. In severe cases, the infection can cause pneumonia, severe acute respiratory symptoms and sometimes death. According to WHO, the incubation time for the COVID-19 infection can range from 1-14 days, and is commonly 5 days. It is suggested that the virus can **stay virulent** on infected surfaces from 3hrs to 9 days.

The typical **routes of transmission** for COVID-19 are either via a direct transmission via cough, sneezing or droplet infection or via contact transmission via oral, nasal and eye mucous membranes. Studies have shown that the disease can be transmitted directly or indirectly through saliva.

The movement of patients within the healthcare facility should be limited except for emergency CASES to prevent the spread of respiratory diseases including covid -19 within the facility. Promptly identify and isolate patients with possible COVID-19 and inform the correct facility staff and public health authorities. **Communicate about COVID-19 with your patients.** Provide updates about changes to your policies regarding appointments, providing non-urgent patient care by telephone. Consider using your facility's website or social media pages to share updates. The hospital has been divided into 2 different zones. **Red and Orange** zone.

Red zone- Which includes reception, waiting area, surgical OPD, dental OPD , casualty medical store, pathology sample collection room, general ward, nursing station, OT, OT waiting area, private rooms, HDU and the nursing station . PPE should be mandatory in these areas and worn by the health care personnel.

Orange zone includes basement, stairway, office, central store.

Patient and the visitors entering the hospital care facility are been explained about the importance of social distancing time and again. Patients and relatives in the ward has been explained to wear mask all the time. Patients who are coming in the OPD has been told to sit in the reception area with keeping in mind social distancing norm. Relatives of the patient has been told to wait in the basement area unless been called by the staff.

All healthcare workers preparing, moving, and receiving patients are aware of the conditions of these patients and have been trained in all relevant procedures, e.g. where to find PPE and how to use it. If possible, visitors are checked for symptoms before entering the facility. Rules are in place for the access of visitors to the facility and to the ward (e.g. one visitor a time) Hand hygiene procedures are explained to the visitors before entering and after leaving the hospital premises.

All visitors are informed about self-monitoring and reporting for acute respiratory symptoms as described in the guidelines A record of all visitors and patients who are entering the hospital premises is being noted.

Reference

1.https://www.cdc.gov/flu/pandemic-resources