GSR INSTITUTE OF CRANIOMAXILLOFACIAL AND FACIAL PLASTIC SURGERY

PRE FINAL MANUAL

PATIENT RIGHTS AND RESPONSIBILITIES

POLICY:

All the patients and their families visiting the Hospital have the following rights. These rights shall be respected and protected by the organization and staff of the hospital. Patients and families may bring to the notice of the Hospital Administrator, any instance of violation or perceived violation of these rights.

Following shall be done to comply with fulfillment of patient rights and education.

- Display of patients' rights at convenient places throughout thehospital
- Information of rights of patients shall be communicated to them and their families in a format and language that they understand, at the time of admission or enquiry through verbal communication and suitablehandouts.
- Staff shall be made aware of their responsibility towards protecting of patients and family rights. Patients' rights shall be included as a topic in departmental training and orientationactivities.
- Violation of patient rights is recorded, reviewed and corrective / preventive measures taken by the in charge of concerneddepartment

These rights shall be addressed and followed by hospital as per documented hospitalpolicies.

Right to address special preferences, spiritual and cultural needs. Right to information and education

Right to Dignity

Right to Privacy/Confidentiality

Right to protect against physical abuse and neglect. Right to choose alternative treatment

Right to eek second opinion Right to informed consent.

Right to make suggestions and complaints Right to access clinical records

Patient responsibilities

1. To provide correct & detailed history of your health problem to yourdoctor.
2. To follow the treatment plans established by the consultant doctor, nurse, and the healthcareprofessionals
3. To be aware that you are solely responsible for the consequences in case of discontinuation of treatment prescribed by the care provider during the hospitalstay
4. To understand that in case you leave against medical advice it will be at your ownrisk
5. To pay all the hospital bills in timelymanner
6. To co-operate with the staff for maintaining the cleanliness and administrative procedures of thehospital
7. To be responsible for the belongings they carry in thehospital.
8. To follow the hospital rules andregulations.

Special notes:

- ✓ Your feedback is always welcomed without affecting the care provided to you.
- ✓ GSR Hospital respect their patients and treats all on an equalplatform.
- ✓ For any queries & concerns, or for lodging a complaint, Manager Operations can becontacted.

POLICY ON PROTECTION OF PATIENT RIGHTS

POLICY

Patient and family rights are documented.

These rights shall be respected and protected by the organization and staff of the hospital.

Following shall be done to comply with fulfillment of patient rights and education.

- Display of patients' rights at convenient places throughout thehospital.
- Information of rights of patients shall be communicated to them and their families in a format and language that they understand, at the time of admission or enquiry through verbalcommunication.
- Staff shall be made aware of their responsibility towards protecting of patients and familyrights.

PROCEDURE:

S. No.	Procedural steps	Responsibility
1.	Display of Posters on Patient's Rights & Responsibilities at key areas of hospital	Manager Operations
2.	Patient information / visitor's information hand-book can be provided at the time of admission.	Medical coordinator
3.	Staff education programs through regular training & induction training for new recruits about patient rights& responsibilities.	Manager Human Resource
4.	On regular basis patient grievances for violation of their rights shall be addressed to the management. Corrective and preventive measures shall be taken.	Manager Operations

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Patient rights support individual beliefs, values and involve the patient and family in decision making processes.

a. GSR Hospital has respect for personal dignity and privacy during examination, procedures andtreatment.
b. GSR Hospital ensures that the patient rights are protected from physical abuse orneglect.
c. GSR Hospital keeps treating patient information asconfidential.
d. GSR Hospital values the patient right for refusal oftreatment.
e. GSR Hospital obtains informed consent before carrying outprocedures.
f. GSR Hospital informs and take consent before any research protocol is initiated.
g. GSR Hospital provides all assistance and information on how to voice a complaint.
h. GSR Hospital provides information on the expected cost of thetreatment.
i. GSR Hospital has a provision to provide an access to his/ her clinicalrecords.

GENERAL CONSENT POLICY

1.0 POLICY:

- General consent shall be taken from all patients being registered and admitted in the hospital. General consent must be obtained from an adult patient with decision-making capacity, or person legally authorized to consent on behalf of the patient. If consent is not obtained (for e.g., in case of unattended, unconscious patient), the reason must be documented in the patient medical record.

- General consent shall be taken in written with patients / relative's signature at the time of admission and as implied consent at the time of registration

2.0 PURPOSE:

The purpose of obtaining a patient's general consent is to ensure that patient is informed about the routine medical and nursing care that will be provided to the patient based on which he takes decision of getting registered and admitted in this hospital.

General consent is not an alternative to Informed Consent. Informed consent shall be taken in all situations.

DEFINITION :

General Consent: - consent to and authorize the attending physician, other physicians and healthcare professionals who may be involved in care to provide such diagnosis, care and treatment considered necessary or advisable by physician(s).

3.0 SCOPE: -

Scope of general consent includes consent for clinical consultation, admission, disclosure of information required for clinical management (under confidence), routine medical examination (physical examination, palpation, percussion, auscultation), routine lab and imaging investigations, general nursing care, diet and physiotherapy assessment and counselling

4.0 RESPONSIBILITY:

Reception staff, Management

5.0 DISTRIBUTION:

Reception

6.0 PROCESS DETAILS:

General Consent

1. When a patient comes to a doctor for treatment of an ailment implies that he is agreeable to medical examination in the general sense. This is implied consent and would encompass physical examination (not intimate examination), palpation, percussion, auscultation .General consent to treatment and release of information.
2. General consent is taken during admission of inpatients. The General consent form is attached to the case file
3. The patient shall sign the General Consent form. In case the patient is not in position to sign the general consent form then a surrogate decision maker can sign the form on behalf of the patient
4. Consent shall be taken in language understood by the patient / relative.
5. Components of general consent to treatment and release of information form shall be explained clearly to the patient and / or relative in the language understood by them
6. Name of the patient, relative, Relation of the relative and signature of the person giving consent shall be properly endorsed.
7. In case of Medical Emergency consent need not be obtained. The reason shall however be documented in patient's medical file.
8. The general consent form indicates consent given by the patient or patient's representative for undergoing minor procedures such as suturing, dressing, injections (routine), routine investigations etc.
9. When patient is incapable of independent decision making then a surrogate decision maker can sign the form on behalf of the patient

a. The scope of the general consent form is clearly motioned in the form and are as follows:

i. Consent for all routine diagnostic tests and procedures, including diagnostic x-rays, the administration and/or injection of pharmaceutical products and medications,

ii. Consent to dispose of specimens taken for laboratory or pathology examination.

iii. Consent to Release personal health information to other healthcare providers treating the patient during this hospitalization.

iv. Authorize and direct the Hospital, release to government agencies, insurance carriers, or others who are financially liable for patient's hospitalization and medical care, all information needed tosubstantiate payment for such hospitalization and medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

v. Patients agree and admit for information about the approximate cost of treatment / package. The cost of medical treatment depends on the number of days of hospitalization, area of hospitalization, investigations performed, drugs and consumables used procedures and surgeries performed, professional fee charged and variety of other factors. Estimate given is only a rough indication of the approximate costs towards hospitalization. **The final bill may therefore vary significantly from the estimate.**

b. Patient/Patient's attendant signs the General Consent form. The consent form is also signed by Admitting personnel from Front Office

7.0 REFERENCES: Nil

8.0 RECORDS AND FORMATS:

Consent Forms, Case Files

9.0 SUPERSESSION DETAILS:

In case of new document this heading will be excluded.

This document supersedes the earlier version <Doc No……., Revision dated……...>w.e.f. …….

BROAD GUIDELINES FOR OBTAINING WRITTEN CONSENT

- General consent during admission authorizing the medical staff for procedures like administration of medication, placement of intravenous accesses, dressings, investigating the patient etc.
- All Surgical procedures specific consent and need for alteration of surgical technique during the operation
- Consent for all kind of anesthetic procedures and administration of anesthetic drugs
- Consent for administration of medication
- Consent of ancillary invasive procedures like central line insertion, intravenous access, chest tubes, lumber puncture, tracheostomy etc.
- Consent for elective ventilation or emergency ventilation as necessary
- Consent specifying risk coverage
- Consent before HIV testing of each patient
- Consent before blood transfusion
- Before taking photographic records of all patients

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POLICY ON GENERAL CONSENT

PURPOSE:

The purpose of obtaining a patient's general consent is to ensure that patient is informed about the routine medical and nursing care that will be provided to the patient based on which he takes decision of getting registered and admitted in this hospital.

General consent is not an alternative to Informed Consent. Informed consent is taken in all situations.

SCOPE:

Scope of general consent includes consent for clinical consultation, admission, disclosure of information required for clinical management (under confidence), routine medical examination (physical examination, palpation, percussion, auscultation), routine lab and imaging investigations, general nursing care, diet and speech assessment and counselling.

POLICY:

General consent shall be taken from all patients being registered and admitted in the hospital. General consent must be obtained from an adult patient with decision- making capacity, or person legally authorized to consent on behalf of the patient. If consent is not obtained (e.g., in case of unattended, unconscious patient), the reason must be documented in the patient medical record.

General consent shall be taken in writing with patient's/ relative's signature at the time of admission and as implied consent at the time of registration.

PROCEDURE:

Implied Consent (Applicable at the time of registration)

When a patient comes to a doctor for treatment of an ailment implies that he is agreeable to medical examination in the general sense. This is implied consent and would encompass physical examination (not intimate examination), palpation, percussion, auscultation.

General consent to treatment and release of information

- Written general consent with signature is obtained at the time of admission-by-admissionExecutive
- Consent is taken in language understood by the patient /relative
- Components of general consent to treatment and release of information form is explained clearly to the patient and / or relative in the language understood bythem
- Name of the patient, relative, Relation of the relative and signature of the person giving consent is properlyendorsed.
- The consent form is attached in patient'sfile
- In case of Medical Emergency also it is mandatory to obtain consent from relatives and also brief
- them about the condition of patient, risk involved and the cost /expenditureincurred.

POLICY FOR INFORMED CONSENT

POLICY:

The consent of the patient / family for appropriate evaluation and treatment is obtained on the requisite consent form written/ typed (in Hindi / English whichever language the patient / family understand).

Consent is to be given by

- The patient, unless he or she is a minor, under effect of alcohol or other sedative drugs
- If patient is incapable of informed decision making, consent shall be obtained from next of kin / parent / guardian, as per law of theland.
- In case of unidentified patient in unconscious condition, treating doctor shall take a decision in life threatening circumstances. Parallel to it, inform police station.

Information to patient

Patients / families are informed in detail about the scope of specific consent by the consultant in charge or member of his team, taking into account patient's psychological features, culture, and educational level.

The information includes the following

- Information on risks, benefits, alternatives of the procedure to beperformed
- Who will perform the requisiteprocedure
- Their right to reject the procedure or seek additional information or seek secondopinion
- Use of anesthesia and of whichtype
- During the course of operation/procedure, unforeseen conditions may be revealed or encountered which necessitate surgical in addition to or different from those contemplated at the time of initialdiagnosis.

- If photographing or televising of the operation / procedure has to be done, for the purpose of medical, scientific or educational studies, is included in informedconsent

Patient is explained the details in language that they understand. In case of language problem/ consultant are busy then appropriate personnel from within the hospital

Called to translate and communicate the information in language that patient / family understand.

Following format used for taking informed consents as applicable

- **High Risk Consent** – For all procedures which bears a significant amount of risk to patient's life or limb.
- **Consent for Anesthesia**– For patients undergoing general / regional anesthesia
- **Consent for Surgery** – For all majorsurgeries
- **Consent form** – For all other types of situations in which informed consent is required

Informed consent from the patient / family is taken whenever patient is undergoing any of the following procedures

1. Transfusion of blood or any other bloodproduct
2. Fine needle aspiration cytological studies(FNAC)
3. Any surgicalprocedure
4. Intubation
5. Cosmetic SurgicalProcedure

If patient is not aware of the diagnosis or is incapacitated, the lead care giver signs the consent.

In emergency situation doctor on duty can sign the consent or give verbal affirmation for any procedure.

INFORMED CONSENT

The informed consent is taken considering the hospital protocols which includes –

1. Taking consent before the procedure
2. Surgeon or his team member performing the procedure will explain and take the signature.
3. Patient has to sign the consent and in case he is incapable then has to be obtained from next of kin/parent/guardian.
4. At least one witness has to sign the consent.
5. Fresh consent is required in case of change in treatment modality.

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PATIENT INFORMATION AND EDUCATION

POLICY:

Patients and their family members are educated in the language they can understand. Patient education includes:

- Safe and effective use of medication and the potential side effects of the medication.
- About diet andnutrition.
- Aboutimmunizations
- About their specific disease process, complications, prevention strategies and preventinginfections.

PROCEDURE:

S. No.	Procedural steps	Responsibility
1.	Evaluation of psychosocial status depending upon the stability, counselling is planned.	Medical coordinator
2.	The comfortable language of the patient is chosen	Medical coordinator
3.	Depending upon the medical advice the procedure or the disease & its estimated prognosis is explained.	Medical coordinator
4.	Depending upon the disease pattern specific diet requirements& restrictions is informed.	Medical coordinator
5.	Detailed post discharge follow up schedules in prevention of further complications &disease progress is explained.	Medical coordinator and team member
6.	Importance of ongoing treatment & importance of regular medication in controlling the disease is Explained	Medical coordinator and team member
7.	Medicine Administration & Drug interaction, importance of time in dosage maintenance	Medical coordinator and team member
8.	Importance of personal hygiene in maintaining good health & also infection control measures to prevent cross transmission	Medical coordinator and team member
9.	Patients Rights & responsibilities is explained	Hospital Administrator/Manager Operations /Admission Executive

INFORMATION TO PATIENT

Patients and their families are explained in detail by the consultant or his team member about the expected outcomes of the undergoing treatment.

The care plan is prepared by the consultant and is explained to patients and their family members. In case during the treatment the care plan is modified considering religious, cultural and spiritual views limiting to statutory requirements of the hospital then also the same is explained to the family.

Patients and their family members are kept informed about the results of all the diagnostic tests and their inferences on the treatment and progress.

Patients and their family members are counseled about the clinical condition of their patients from time to time which includes explaining about improvement, deterioration or any complications occurring.

Patients and their family members are provided with multi disciplinary counseling by the doctors involved in the treatment plan of the patient.

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PATIENT RIGHT TO KNOW THE EXPECTED COST

POLICY:

Billing of GSR HOSPITAL patients is done as per the schedule of charges/Tariff list. A general Tariff list is displayed at the reception area for all the patients. The Hospital staff at reception helps the patients in cases of specific tariff.

Uniform and transparent pricing is followed for all the patients and financial counseling about the estimated cost of treatment shall be done by the Hospital Administrator/Manager Operations. Any patient who asks for details of billing or expenses incurred is provided relevant details to his satisfaction.

Interim Receipt during stay in the Hospital and one final bill at the time of discharge is given to patient. These bills clearly state the details of expenditure incurred by the patient till discharge.

In case of any confusion or discrepancy in settling bills, or with regard to policy and protocols, billing personnel shall contact Hospital Administrator/ManagerOperations.

INFORMATION ON EXPECTED COSTS

The patients and their families are informed about the costs:-

- when the patient is transferred from one care setting to another,
- in case there is change in care plan,
- change in patient's condition,
- Unplanned requirement of surgery.

PATIENT FEEDBACK

The feedback from patients or their family members is captured physically. The feedback forms are separate for out-patients and in-patients.

In addition to feedback the hospital also captures patient's experience through a feedback book kept in reception to take the suggestions from patients and their families for further improvement.

The hospital has a proper mechanism to lodge patient complaints which is reported through feedback forms, suggestion box kept in OPD area and a feedback book kept in reception. These complaints are compiled and analyzed with corrective and preventive actions. These are also informed to Medical Superintendent. The patients are thereby called by the staff to address their complaints.

Written complaint if made by patient is filed and entered in the complaint register thereby a number is allotted to each complaint. A committee thereafter looks into the complaint and presents a report for further actions if needed.

The patient and family members are made aware of the feedback mechanism by providing forms to every patient and a box with display signage.