1.0

POLICY ON END-OF-LIFE CARE

LHMC-EOL-POL-2026-029-V1.0

Lady Hardinge Medical College & Associated Smt. Sucheta Kriplani And Kalawati Saran Children Hospital New Delhi-110001

(Applicable to LHMC, Smt. Sucheta Kriplani Hospital & Kalawati Saran Children Hospital)

22/04/2026

GOVERNMENT OF INDIA
MINISTRY OF HEALTH & FAMILY WELFARE
DIRECTORATE GENERAL OF HEALTH SERVICES
LADY HARDINGE MEDICAL COLLEGE & ASSOCIATED HOSPITALS
SHAHEED BHAGAT SINGH MARG, NEW DELHI-110001

Details of the Document

Document Name	POLICY ON END OF LIFE CARE
Document No.	LHMC-EOL-POL-2026-029-V1.0
No. of pages:	08
Date created:	17/01/2026
Prepared By	Name: Dr. Banarsi Designation: Additional Medical Superintendent Signature
Reviewed By	Public Grievance Committee, LHMC
Approved by:	Name: Dr. Manoj B Jais Designation: Medical Superintendent Signature 22/04/26 Name: Dr. Sarita Beri Designation: Medical Director Signature 22/04/26

Responsibility of updating:	Chairperson Critical Care Committee

POLICY ON END-OF-LIFE CARE

POLICY IDENTIFICATION

Field	Details
Policy Title	Policy on End-of-Life Care
Policy Code	LHMC-EOL-POL-2026-029-V1.0
Domain	Clinical Governance / Patient Rights
Category	Policy
Prepared By	Dr. Banarsi, Additional Medical Superintendent
Reviewed By	Medical Superintendents (SSKH & KSCH)
Approved By	Director LHMC
Date of Approval	_____
Effective From	_____
Review Due On	_____ (After 3 Years)

1. PREAMBLE

Lady Hardinge Medical College & Associated Hospitals (LHMC, SSKH & KSCH) are committed to providing compassionate, ethical and patient-centred care throughout the continuum of illness, including at the end of life. End-of-life care aims to relieve suffering, respect patient autonomy, preserve dignity and support families when cure is no longer possible.

This policy provides a structured framework for delivery of end-of-life care, decision-making regarding limitation or withdrawal of life-sustaining treatment, palliative care, communication with patients and families, and compliance with prevailing legal, ethical and professional guidelines.

2. OBJECTIVES

The objectives of this policy are to:

- Ensure dignified, compassionate and quality end-of-life care
- Respect patient autonomy, values and preferences
- Provide symptom control, comfort and psychosocial support
- Guide ethical and legal decision-making in end-of-life situations
- Support families and caregivers during terminal illness and bereavement

---

3. SCOPE

This policy shall apply to:

- Lady Hardinge Medical College (LHMC)
- Smt. Sucheta Kriplani Hospital (SSKH)
- Kalawati Saran Children's Hospital (KSCH)

It shall be applicable to:

- Adult and paediatric patients with life-limiting or terminal illnesses
- ICU, wards, emergency and palliative care settings
- All doctors, nursing staff, paramedical staff and counsellors involved in patient care

---

4. DEFINITIONS

End-of-Life Care: Care provided to patients with advanced, progressive or terminal illness where the focus shifts from cure to comfort and quality of life.

Life-Sustaining Treatment (LST): Medical interventions that prolong life such as mechanical ventilation, vasopressors, dialysis or artificial nutrition.

Withholding or Withdrawal of LST: Decision not to initiate or to discontinue life-sustaining treatment when it no longer provides benefit.

Palliative Care: Holistic care aimed at relief of pain, symptoms and psychosocial distress.

---

5. GOVERNING PRINCIPLES

- Respect for patient dignity, autonomy and values
- Beneficence and non-maleficence
- Shared decision-making with patients and families

- Ethical and legal compliance
- Multidisciplinary approach to care

---

6. GOVERNANCE STRUCTURE

6.1 Competent Authority

The Director /Medical Superintendents/ Principal, LHMC shall be the Competent Authority for implementation of this policy.

6.2 End-of-Life Care Committee

An End-of-Life Care / Ethics Committee shall oversee implementation and provide guidance in complex cases.

6.3 Treating Team

The treating consultant and clinical team shall be primarily responsible for end-of-life care decisions and implementation.

---

7. IDENTIFICATION OF END-OF-LIFE SITUATIONS

Patients may be considered for end-of-life care when:

- Disease is advanced, irreversible and incurable
- Prognosis is poor despite optimal treatment
- Burden of treatment outweighs potential benefit

---

8. COMMUNICATION & SHARED DECISION-MAKING

- Honest, compassionate and clear communication with patient and family
- Discussion of prognosis, goals of care and treatment options
- Documentation of discussions and decisions

---

9. CONSENT & ADVANCE DIRECTIVES

- Informed consent shall be obtained for end-of-life decisions
- Advance directives or living wills, if available, shall be respected
- Decisions for incapacitated patients shall involve legally authorized representatives

10. WITHHOLDING / WITHDRAWAL OF LIFE-SUSTAINING TREATMENT

- Decisions shall be taken by treating team in consultation with family
- Ethics / End-of-Life Care Committee opinion may be sought
- Decisions shall comply with Supreme Court of India guidelines and applicable law
- Comfort care shall always be continued

11. PALLIATIVE & SUPPORTIVE CARE

- Adequate pain and symptom management
- Psychological, emotional and spiritual support
- Nursing care focused on comfort and dignity

12. CARE OF FAMILY & BEREAVEMENT SUPPORT

- Counselling and emotional support to family members
- Respect for cultural and religious practices
- Bereavement support as appropriate

13. DOCUMENTATION & RECORD KEEPING

- Clear documentation of assessments, discussions and decisions
- Consent forms and committee recommendations shall be part of medical record

14. TRAINING & AWARENESS

- Training of healthcare staff on end-of-life care principles
- Sensitization on ethical and legal aspects

15. MONITORING & QUALITY IMPROVEMENT

- Periodic review of end-of-life care practices
- Feedback from families and staff

16. COMPLIANCE & ACCOUNTABILITY

Non-compliance with this policy shall attract administrative action as per institutional rules.

17. REVIEW & AMENDMENT

This policy shall be reviewed every three years or earlier if required due to changes in legal or clinical guidelines.

18. EFFECTIVE DATE

This policy shall come into force from the date of approval by the Competent Authority.

19. APPROVAL

Issued with the approval of the Director LHMC & Associated Hospitals.

ANNEXURES

Annexure – I: End-of-Life Care Assessment & Decision Form

Patient Name	UHID	Diagnosis	Prognosis	Decision	Signatures

Annexure – II: Consent for Withholding / Withdrawal of Life-Sustaining Treatment

Treatment	Reason	Consent Given By	Relationship	Signature	Date

Annexure – III: Palliative Care Plan

Symptoms	Management Plan	Responsible Staff	Review Date

Annexure – IV: End-of-Life Care Committee Opinion Format

Case Summary	Recommendation	Members Present	Date

All annexures form an integral part of this policy and shall be implemented and monitored by the End-of-Life Care / Ethics Committee.

End of Policy Document

C-F

POLICY ON REFERRAL & CONTINUITY OF CARE

LHMC-RCC-POL-2026-026-V1.0

Lady Hardinge Medical College & Associated Smt. Sucheta Kriplani And Kalawati Saran Children Hospital New Delhi-110001

(Applicable to LHMC, Smt. Sucheta Kriplani Hospital & Kalawati Saran Children Hospital)

22/04/2026

GOVERNMENT OF INDIA
MINISTRY OF HEALTH & FAMILY WELFARE
DIRECTORATE GENERAL OF HEALTH SERVICES
LADY HARDINGE MEDICAL COLLEGE & ASSOCIATED HOSPITALS
SHAHEED BHAGAT SINGH MARG, NEW DELHI-110001

Details of the Document

Document Name	POLICY ON REFERRAL & CONTINUITY OF CARE
Document No.	LHMC-RCC-POL-2026-026-V1.0
No. of pages:	08
Date created:	17/01/2026
Prepared By	Name: Dr. Banarsi Designation: Additional Medical Superintendent Signature
Reviewed By	Public Grievance Committee, LHMC
Approved by:	Name: Dr. Manoj B Jais Designation: Medical Superintendent Signature: 22/04/26 Name: Dr. Sarita Beri Designation: Medical Director Signature 22/04/2026

Responsibility of updating:	HOD A&E

POLICY ON REFERRAL & CONTINUITY OF CARE

POLICY IDENTIFICATION

Field	Details
Policy Title	Policy on Referral & Continuity of Care
Policy Code	LHMC-RCC-POL-2026-038-V1.0
Domain	Clinical Services / Patient Rights / Clinical Governance
Category	Policy
Prepared By	Medical Administration & Clinical Governance Cell
Reviewed By	Medical Superintendents (SSKH & KSCH)
Approved By	Director / Principal, LHMC
Date of Approval	
Effective From	
Review Due On	(After 3 Years)

1. PREAMBLE

Lady Hardinge Medical College & Associated Hospitals (LHMC, SSKH & KSCH) provide tertiary-level healthcare services and receive referrals from multiple primary and secondary healthcare facilities. Equally, certain patients may require referral to other institutions for services beyond the scope or capacity of LHMC.

Effective referral systems and continuity of care are essential to ensure patient safety, seamless transition of care, optimal clinical outcomes and patient satisfaction. This policy establishes

standardized procedures for referral and continuity of care within and outside LHMC and its Associated Hospitals.

---

2. OBJECTIVES

The objectives of this policy are to:

- Ensure timely and appropriate referral of patients
- Maintain continuity and coordination of patient care
- Facilitate safe transfer of clinical responsibility
- Enhance communication between referring and receiving facilities
- Reduce delays, duplication of services and adverse outcomes

---

3. SCOPE

This policy shall apply to:

- Lady Hardinge Medical College (LHMC)
- Smt. Sucheta Kriplani Hospital (SSKH)
- Kalawati Saran Children's Hospital (KSCH)

It shall be applicable to:

- OPD, IPD, Emergency, ICUs and specialty units
- All inter-departmental, inter-hospital and external referrals
- All healthcare professionals involved in patient care

---

4. DEFINITIONS

Referral: Process of transferring responsibility of patient care from one healthcare provider or facility to another for specialized evaluation, treatment or investigation.

Continuity of Care: Ongoing management of a patient's health across different levels, settings and stages of care.

---

5. GOVERNING PRINCIPLES

- Patient safety and best clinical interest
- Timely access to appropriate level of care

- Clear communication and documentation
- Informed consent and patient involvement
- Accountability and coordination among providers

---

6. GOVERNANCE STRUCTURE

6.1 Competent Authority

The Director / Medical Superintendents/ Principal, LHMC shall be the Competent Authority for implementation of this policy.

6.2 Oversight

Medical Superintendents and Concerned HODs shall oversee referral practices and continuity of care.

---

7. TYPES OF REFERRALS

7.1 Internal Referrals

- Referral between departments or specialties within LHMC
- Proper documentation and handover of care

7.2 External Referrals (Outgoing)

- Referral to other hospitals for services beyond scope or capacity
- Referral after stabilization of patient

7.3 Incoming Referrals

- Patients referred from peripheral or other hospitals
- Assessment and triage upon arrival

---

8. INDICATIONS FOR REFERRAL

- Need for super-specialty care
- Non-availability of services, equipment or expertise
- Requirement of advanced diagnostics or procedures
- Patient preference where appropriate

9. REFERRAL PROCESS

- Clinical assessment and decision by treating consultant
- Explanation to patient/attendant and informed consent
- Preparation of referral note with relevant clinical details
- Arrangement of transport and escort if required

10. CONTINUITY OF CARE

10.1 During Referral

- Stabilization prior to transfer
- Proper handover to receiving facility

10.2 After Referral / Discharge

- Clear follow-up instructions
- Coordination with primary care or referring facility
- Continuity through OPD follow-up or tele-consultation where applicable

---

11. COMMUNICATION & HANDOVER

- Structured referral and handover documentation
- Direct communication between referring and receiving clinicians wherever feasible

---

12. DOCUMENTATION & RECORD KEEPING

- Referral notes, consent forms and transfer records
- Copies retained in patient medical record

---

13. SPECIAL SITUATIONS

- Emergency referrals
- Paediatric and neonatal referrals
- Obstetric referrals
- Medico-legal cases

---

14. ROLES & RESPONSIBILITIES

- Treating Consultant: Clinical decision and referral
- Nursing Staff: Coordination and documentation
- Medical Administration: Oversight and facilitation

---

15. TRAINING & AWARENESS

- Training of staff on referral protocols
- Patient education on referral and follow-up process

---

16. MONITORING & AUDIT

- Periodic audit of referral patterns and outcomes
- Review of delays, adverse events and feedback

---

17. COMPLIANCE & ACCOUNTABILITY

Non-compliance with this policy shall attract administrative action as per institutional rules.

---

18. REVIEW & AMENDMENT

This policy shall be reviewed every three years or earlier if required.

---

19. EFFECTIVE DATE

This policy shall come into force from the date of approval by the Competent Authority.

---

20. APPROVAL

Issued with the approval of the Director LHMC & Associated Hospitals.

ANNEXURES

Annexure – I: Referral Form (Internal / External)

Patient Name	UHID	Diagnosis	Reason for Referral	Referred To	Signature

Annexure – II: Patient Transfer & Handover Checklist

Stabilized	Documents Attached	Escort	Transport	Remarks

Annexure – III: Continuity of Care & Follow-up Plan

Diagnosis	Follow-up Location	Timeline	Responsible Unit

All annexures form an integral part of this policy and shall be implemented and monitored by Medical Administration and Clinical Governance Committee.

End of Policy Document

AD-

POLICY ON ADVANCE DIRECTIVES (LIVING WILL)

LHMC-AD-POL-2026-030-V1.0

Lady Hardinge Medical College & Associated Smt. Sucheta Kriplani And Kalawati Saran Children Hospital New Delhi-110001

(Applicable to LHMC, Smt. Sucheta Kriplani Hospital & Kalawati Saran Children Hospital)

22/4/26

GOVERNMENT OF INDIA
MINISTRY OF HEALTH & FAMILY WELFARE
DIRECTORATE GENERAL OF HEALTH SERVICES
LADY HARDINGE MEDICAL COLLEGE & ASSOCIATED HOSPITALS
SHAHEED BHAGAT SINGH MARG, NEW DELHI-110001

Details of the Document

Document Name	POLICY ON ADVANCE DIRECTIVES (LIVING WILL)
Document No.	LHMC-AD-POL-2026-030-V1.0
No. of pages:	07
Date created:	17/01/2026
Prepared By	Name: Dr. Banarsi Designation: Additional Medical Superintendent Signature
Reviewed By	Public Grievance Committee, LHMC

Approved by:	Name: Dr. Manoj B Jais Designation: Medical Superintendent Signature: 22/04/26 Name: Dr. Sarita Beri Designation: Medical Director Signature
Responsibility of updating:	Name: Chairperson Bio Medical Waste Committee Designation: HOD Microbiology

POLICY ON ADVANCE DIRECTIVES (LIVING WILL)

POLICY IDENTIFICATION

Field	Details
Policy Title	Policy on Advance Directives (Living Will)
Policy Code	LHMC-AD-POL-2026-030-V1.0
Domain	Patient Rights / Clinical Governance / Ethics
Category	Policy
Prepared By	Dr. Banarsi, Additional Medical Superintendent
Reviewed By	Medical Superintendents (SSKH & KSCH)
Approved By	Director / Principal, LHMC
Date of Approval	_____
Effective From	_____
Review Due On	_____ (After 3 Years)

1. PREAMBLE

Lady Hardinge Medical College & Associated Hospitals (LHMC, SSKH & KSCH) are committed to respecting patient autonomy, dignity and informed decision-making. Advance Directives, also known as Living Wills, enable patients to express their preferences regarding

medical treatment and end-of-life care in advance, in the event that they become incapable of making decisions later.

This policy provides a structured framework for recognition, verification, implementation and documentation of Advance Directives in accordance with the Supreme Court of India guidelines, ethical principles and applicable laws.

---

2. OBJECTIVES

The objectives of this policy are to:

- Respect patient autonomy and right to self-determination
- Provide clarity on implementation of Advance Directives
- Guide clinicians and administrators in ethical and legal compliance
- Prevent unnecessary or unwanted life-sustaining treatment
- Ensure consistency with End-of-Life Care and Informed Consent policies

---

3. SCOPE

This policy shall apply to:

- Lady Hardinge Medical College (LHMC)
- Smt. Sucheta Kriplani Hospital (SSKH)
- Kalawati Saran Children's Hospital (KSCH)

It shall be applicable to:

- Adult patients capable of making informed decisions
- All clinical departments, ICUs, wards and emergency areas
- Doctors, nursing staff, medical administrators and ethics committee members

---

4. DEFINITIONS

Advance Directive (Living Will): A written statement by a person of sound mind specifying preferences regarding medical treatment, including refusal or withdrawal of life-sustaining treatment, in the event of future incapacity.

Life-Sustaining Treatment (LST): Medical interventions that prolong life, such as mechanical ventilation, dialysis, vasopressors or artificial nutrition.

Surrogate / Legally Authorized Representative (LAR): Person authorized to take healthcare decisions on behalf of the patient when the patient lacks capacity.

5. GOVERNING PRINCIPLES

- Respect for patient autonomy and dignity
- Voluntary, informed and non-coercive decision-making
- Beneficence and non-maleficence
- Transparency and legal compliance
- Multidisciplinary and ethical oversight

6. ELIGIBILITY FOR MAKING ADVANCE DIRECTIVE

- Adult (18 years or above)
- Person of sound mind and decision-making capacity
- Free from coercion or undue influence

7. CONTENTS OF ADVANCE DIRECTIVE

An Advance Directive may include:

- Preferences regarding life-sustaining treatment
- Conditions under which treatment may be withheld or withdrawn
- Appointment of a surrogate / LAR
- Values and beliefs guiding care decisions

8. FORM & VALIDITY OF ADVANCE DIRECTIVE

- Must be in writing and signed by the individual
- Attested by two independent witnesses
- Countersigned by a Judicial Magistrate of First Class / Notary (as applicable)
- Can be modified or revoked by the individual at any time

9. RECEIPT & REGISTRATION OF ADVANCE DIRECTIVE

- Advance Directive shall be submitted to the hospital during admission or OPD visit
- Verified and recorded by Medical Administration / MRD

- Copy shall be placed in the patient's medical record

---

10. IMPLEMENTATION OF ADVANCE DIRECTIVE

- Treating team shall assess clinical applicability
- Hospital Ethics / End-of-Life Care Committee shall review
- Decision shall be documented and communicated to family
- Comfort and palliative care shall always be ensured

---

11. ROLE OF ETHICS / END-OF-LIFE CARE COMMITTEE

- Verification of validity of Advance Directive
- Guidance in complex or disputed cases
- Ensuring compliance with legal and ethical standards

---

12. DISPUTE RESOLUTION

- Any dispute regarding interpretation or implementation shall be referred to the Ethics Committee
- Legal consultation may be sought if required

---

13. DOCUMENTATION & RECORD KEEPING

- All Advance Directives and related decisions shall be documented
- Records shall be preserved as per record retention policy

---

14. TRAINING & AWARENESS

- Sensitization of healthcare staff on Advance Directives
- Patient and public awareness initiatives

---

15. COMPLIANCE & ACCOUNTABILITY

Non-compliance with this policy shall attract administrative action as per institutional rules.

---

16. REVIEW & AMENDMENT

This policy shall be reviewed every three years or earlier if required due to changes in law or Supreme Court guidelines.

---

17. EFFECTIVE DATE

This policy shall come into force from the date of approval by the Competent Authority.

---

18. APPROVAL

Issued with the approval of the Director LHMC & Associated Hospitals.

ANNEXURES

Annexure – I: Advance Directive (Living Will) Format (Indicative)

Name	Age	Address	Preferences	Surrogate	Signatures

Annexure – II: Verification & Registration Checklist for Advance Directive

Parameter	Verified (Yes/No)	Remarks

Annexure – III: Committee Review & Implementation Record

Patient	Directive Reviewed	Decision	Committee Members	Date

All annexures form an integral part of this policy and shall be implemented and monitored by the Ethics / End-of-Life Care Committee.

End of Policy Document

POLICY ON PATIENT CONFIDENTIALITY & DATA PRIVACY

LHMC-PCDP-POL-2026-031-V1.0

Lady Hardinge Medical College & Associated Smt. Sucheta Kriplani And Kalawati Saran Children Hospital New Delhi-110001

(Applicable to LHMC, Smt. Sucheta Kriplani Hospital & Kalawati Saran Children Hospital)

[redacted]

22/04/26

GOVERNMENT OF INDIA
MINISTRY OF HEALTH & FAMILY WELFARE
DIRECTORATE GENERAL OF HEALTH SERVICES
LADY HARDINGE MEDICAL COLLEGE & ASSOCIATED HOSPITALS
SHAHEED BHAGAT SINGH MARG, NEW DELHI-110001

Details of the Document

Document Name	POLICY ON PATIENT CONFIDENTIALITY & DATA PRIVACY
Document No.	LHMC-PCDP-POL-2026-031-V1.0
No. of pages:	08
Date created:	17/01/2026
Prepared By	Name: Dr. Banarsi Designation: Additional Medical Superintendent Signature
Reviewed By	Public Grievance Committee, LHMC
Approved by:	Name: Dr. Manoj B Jais Designation: Medical Superintendent Signature: 22/04/26 Name: Dr. Sarita Beri Designation: Medical Director Signature

Responsibility of updating:	Concerned AMS

POLICY ON PATIENT CONFIDENTIALITY & DATA PRIVACY

POLICY IDENTIFICATION

Field	Details
Policy Title	Policy on Patient Confidentiality & Data Privacy
Policy Code	LHMC-PCDP-POL-2026-031-V1.0
Domain	Patient Rights / Information Governance
Category	Policy
Prepared By	Dr. Banarsi, Addl. Medical Superintendent
Reviewed By	Medical Superintendents (SSKH & KSCH)
Approved By	Director LHMC
Date of Approval	
Effective From	
Review Due On	(After 3 Years)

1. PREAMBLE

Lady Hardinge Medical College & Associated Hospitals (LHMC, SSKH & KSCH) recognize that protection of patient information is a fundamental ethical, legal and professional obligation. Confidentiality and privacy of health information are essential for maintaining patient trust, dignity and safety.

This policy establishes a comprehensive framework for safeguarding patient confidentiality and ensuring secure handling of personal and health data in compliance with applicable laws, government guidelines and accreditation standards.

2. OBJECTIVES

The objectives of this policy are to:

- Protect confidentiality and privacy of patient information
- Ensure secure collection, storage, access and sharing of health data
- Prevent unauthorized disclosure or misuse of patient information
- Comply with legal, ethical and regulatory requirements
- Promote staff awareness and accountability regarding data privacy

---

3. SCOPE

This policy shall apply to:

- Lady Hardinge Medical College (LHMC)
- Smt. Sucheta Kriplani Hospital (SSKH)
- Kalawati Saran Children's Hospital (KSCH)

It shall apply to:

- All patient-related information (paper and electronic)
- Medical records, registers, reports and images
- All staff, students, trainees, contractual and outsourced personnel
- Third parties handling patient data on behalf of the institution

---

4. DEFINITIONS

Patient Information: Any information that identifies a patient or relates to their health, treatment or payment for healthcare.

Confidentiality: Obligation to protect patient information from unauthorized disclosure.

Data Privacy: Right of individuals to control collection, use and disclosure of their personal information.

Authorized User: Person permitted to access patient information for legitimate purposes.

---

5. GOVERNING PRINCIPLES

- Patient information shall be used only for legitimate care, legal, academic or administrative purposes
- Minimum necessary access shall be followed
- Transparency and accountability in data handling
- Compliance with laws, regulations and ethical standards

6. GOVERNANCE STRUCTURE

6.1 Competent Authority

The Director /Medical Superintendent/ Principal, LHMC shall be the Competent Authority for implementation of this policy.

6.2 Data Privacy & Confidentiality Committee

A Data Privacy & Confidentiality Committee / Nodal Officer shall oversee compliance, breaches and corrective actions.

7. COLLECTION & USE OF PATIENT INFORMATION

- Information shall be collected only as required for patient care and legal purposes
- Patients shall be informed about use of their information
- Consent shall be obtained where required

8. ACCESS CONTROL

- Access to patient information shall be role-based
- Physical and electronic safeguards shall be implemented
- Sharing of passwords or credentials is prohibited

9. DISCLOSURE OF PATIENT INFORMATION

Disclosure shall be permitted only:

- With patient consent
- For continuity of care
- As required by law, court orders or statutory authorities
- For approved teaching and research with safeguards

10. ELECTRONIC DATA SECURITY

- Secure IT systems with authentication and audit trails
- Regular data backup and disaster recovery mechanisms
- Protection against cyber threats and breaches

---

11. PHYSICAL SECURITY OF RECORDS

- Secure storage of paper records
- Controlled access to Medical Records Department
- Safe disposal of confidential documents

---

12. DATA BREACH MANAGEMENT

- All suspected or actual breaches shall be reported immediately
- Investigation and corrective actions shall be undertaken
- Affected individuals and authorities shall be informed as required

---

13. TRAINING & AWARENESS

- Regular training on confidentiality and data privacy
- Orientation for new staff and students

---

14. MONITORING, AUDIT & COMPLIANCE

- Periodic audits of data privacy practices
- Monitoring of access logs and records

---

15. RIGHTS OF PATIENTS

Patients have the right to:

- Privacy and confidentiality of their information
- Access their medical records as per policy
- Seek correction of inaccurate information

16. COMPLIANCE & ACCOUNTABILITY

Violation of this policy shall attract disciplinary action as per institutional rules and applicable laws.

17. REVIEW & AMENDMENT

This policy shall be reviewed every three years or earlier if required due to changes in law or technology.

18. EFFECTIVE DATE

This policy shall come into force from the date of approval by the Competent Authority.

19. APPROVAL

Issued with the approval of the Director / Principal, LHMC & Associated Hospitals.

ANNEXURES

Annexure – I: Confidentiality Undertaking by Staff

Name Designation Department Signature Date

Annexure – II: Data Breach Incident Reporting Form

Date Nature of Breach Data Involved Immediate Action Reported By

Annexure – III: Authorized Access Register (Indicative)

Name Role Area of Access Validity Period Approval

All annexures form an integral part of this policy and shall be implemented and monitored by the Data Privacy & Confidentiality Committee.

End of Policy Document

V1.

Policy on Patient & Visitor Education

LHMC-PVE-POL-2026-062-V1.0

Lady Hardinge Medical College & Associated Smt. Sucheta Kriplani And Kalawati Saran Children Hospital New Delhi-110001

(Applicable to LHMC, Smt. Sucheta Kriplani Hospital & Kalawati Saran Children Hospital)

GOVERNMENT OF INDIA
MINISTRY OF HEALTH & FAMILY WELFARE
DIRECTORATE GENERAL OF HEALTH SERVICES
LADY HARDINGE MEDICAL COLLEGE & ASSOCIATED HOSPITALS
SHAHEED BHAGAT SINGH MARG, NEW DELHI-110001

Details of the Document

Document Name	Policy on Patient & Visitor Education
Document No.	LHMC-PVE-POL-2026-062-V1.0
No. of pages:	0
Date created:	17/01/2026
Prepared By	Name: Dr. Banarsi Designation: Additional Medical Superintendent Signature
Reviewed By	Public Grievance Committee, LHMC
Approved by:	Name: Dr. Manoj B Jais Designation: Medical Superintendent Signature 22/04/26 Name: Dr. Sarita Beri Designation: Medical Director Signature

Responsibility of updating:	Name: Chairperson Bio Medical Waste Committee Designation: HOD Microbiology

POLICY ON PATIENT & VISITOR EDUCATION

POLICY IDENTIFICATION

Field	Details
Policy Title	Policy on Patient & Visitor Education
Policy Code	LHMC-PVE-POL-2026-062-V1.0
Domain	Patient Rights / Patient Safety / Quality of Care
Category	Policy
Prepared By	Quality & Patient Safety Cell
Reviewed By	Additional Medical Superintendents (SSKH & KSCH)
Approved By	Director / Principal, LHMC
Date of Approval	_____
Effective From	_____
Review Due On	_____ (After 3 Years)

1. PREAMBLE

Lady Hardinge Medical College & Associated Hospitals (LHMC, SSKH & KSCH) recognize that informed patients and visitors play a vital role in improving health outcomes, patient safety and quality of care. Education of patients and visitors enhances understanding of disease conditions, treatment plans, preventive measures, hospital rules and patient rights, thereby promoting shared responsibility in healthcare delivery.

This policy establishes a structured framework for providing consistent, accurate and appropriate education to patients and visitors across LHMC and its Associated Hospitals.

2. OBJECTIVES

The objectives of this policy are to:

- Empower patients and visitors with relevant health information

- Improve patient safety and treatment compliance
- Promote infection prevention and healthy practices
- Enhance patient satisfaction and experience
- Ensure compliance with NABH Patient Rights and Education standards

---

3. SCOPE

This policy shall apply to:

- Lady Hardinge Medical College (LHMC)
- Smt. Sucheta Kriplani Hospital (SSKH)
- Kalawati Saran Children's Hospital (KSCH)

It shall be applicable to:

- All patients (OPD, IPD, Emergency, Day Care)
- Visitors and attendants
- All healthcare professionals involved in patient interaction

---

4. DEFINITIONS

Patient Education: Structured process of providing information to patients to improve health literacy and participation in care.

Visitor Education: Information provided to attendants and visitors regarding hospital rules, safety and infection prevention.

---

5. GOVERNING PRINCIPLES

- Patient-centred and culturally sensitive approach
- Clear, simple and understandable communication
- Respect for patient dignity, privacy and rights
- Continuity and reinforcement of education
- Documentation and evaluation

---

6. GOVERNANCE STRUCTURE

6.1 Competent Authority

The Director / Principal, LHMC shall he the Competent Authority for implementation of this policy.

6.2 Oversight

Patient & Visitor Education activities shall be coordinated by:

- Quality & Patient Safety Cell
- Nursing Services
- Departmental Heads

---

7. CONTENT OF PATIENT & VISITOR EDUCATION

Education may include but is not limited to:

- Patient rights and responsibilities
- Disease condition, investigations and treatment plan
- Medication usage and adherence
- Pain management and symptom reporting
- Infection prevention (hand hygiene, cough etiquette)
- Fall prevention and safety precautions
- Blood transfusion safety and consent
- Discharge instructions and follow-up care

---

8. MODES OF EDUCATION

- Verbal counselling by doctors, nurses and allied staff
- Printed IEC materials (leaflets, posters)
- Audio-visual aids
- Display boards and signage
- Digital platforms where available

---

9. EDUCATION AT KEY POINTS OF CARE

- At registration and admission
- During treatment and procedures
- At discharge
- During follow-up visits

---

10. VISITOR EDUCATION

- Hospital visiting hours and rules
- Hand hygiene and infection control practices
- Restrictions in ICUs, isolation areas and OTs
- Safety and security guidelines

---

11. SPECIAL POPULATIONS

- Paediatric patients and parents
- Geriatric patients
- Illiterate or low-literacy patients
- Patients with special needs

---

12. DOCUMENTATION & RECORD KEEPING

- Documentation of patient education in medical records
- Maintenance of IEC material inventory

---

13. TRAINING & COMPETENCY

- Training of staff in communication and patient education skills
- Periodic refresher programs

---

14. MONITORING & EVALUATION

- Patient feedback and satisfaction surveys
- Periodic audits of education practices

---

15. COMPLIANCE & ACCOUNTABILITY

Non-compliance with this policy shall attract administrative action as per institutional rules.

---

16. REVIEW & AMENDMENT

This policy shall be reviewed every three years or earlier if required.

---

17. EFFECTIVE DATE

This policy shall come into force from the date of approval by the Competent Authority.

---

18. APPROVAL

Dr. Sarita Beri
Director, LHMC & Associated Hospitals, New Delhi-110001

ANNEXURES

Annexure – I: Patient Education Documentation Format

Date	Topic Educated	Mode	Educator Name	Patient / Attendant Signature

Annexure – II: Visitor Education Checklist

Area	Information Provided	Compliant (Yes/No)

Annexure – III: List of Standard IEC Materials

- Patient Rights & Responsibilities
- Hand Hygiene & Infection Prevention
- Fall Prevention
- Medication Safety
- Discharge & Follow-up Care

All annexures form an integral part of this policy and shall be implemented and monitored by the Quality & Patient Safety Cell.

End of Policy Document

POLICY ON NON-DISCRIMINATION

LHMC-ND-POL-2026-032-V1.0

Lady Hardinge Medical College & Associated Smt. Sucheta Kriplani And Kalawati Saran Children Hospital New Delhi-110001

(Applicable to LHMC, Smt. Sucheta Kriplani Hospital & Kalawati Saran Children Hospital)

GOVERNMENT OF INDIA
MINISTRY OF HEALTH & FAMILY WELFARE
DIRECTORATE GENERAL OF HEALTH SERVICES
LADY HARDINGE MEDICAL COLLEGE & ASSOCIATED HOSPITALS
SHAHEED BHAGAT SINGH MARG, NEW DELHI-110001

Details of the Document

Document Name	POLICY ON NON-DISCRIMINATION
Document No.	LHMC-ND-POL-2026-032-V1.0
No. of pages:	07
Date created:	17/01/2026
Prepared By	Name: Dr. Banarsi Designation: Additional Medical Superintendent Signature
Reviewed By	Public Grievance Committee, LHMC
Approved by:	Name: Dr. Manoj B Jais Designation: Medical Superintendent Signature: 22/04/26 Name: Dr. Sarita Beri Designation: Medical Director Signature

Responsibility of updating:	Concerned AMS

POLICY ON NON-DISCRIMINATION

POLICY IDENTIFICATION

Field	Details
Policy Title	Policy on Non-Discrimination
Policy Code	LHMC-ND-POL-2026-032-V1.0
Domain	Patient Rights / Human Resources / Ethics
Category	Policy
Prepared By	Dr. Banarsi, Additional Medical Superintendent
Reviewed By	Medical Superintendents (SSKH & KSCH)
Approved By	Director LHMC
Date of Approval	_____
Effective From	
Review Due On	_____ (After 3 Years)

1. PREAMBLE

Lady Hardinge Medical College & Associated Hospitals (LHMC, SSKH & KSCH) are committed to providing equitable, respectful and dignified healthcare and a safe working environment for all individuals. Discrimination in any form is contrary to the values of public service, medical ethics and constitutional principles.

This policy establishes a clear framework to prevent discrimination and to promote equality, inclusiveness and respect in patient care, education, employment and institutional functioning.

2. OBJECTIVES

The objectives of this policy are to:

- Ensure equal access to healthcare services without discrimination
- Promote a respectful and inclusive workplace and academic environment
- Prevent discriminatory practices in patient care and employment
- Establish mechanisms for reporting and addressing discrimination
- Ensure compliance with constitutional, legal and regulatory provisions

---

3. SCOPE

This policy shall apply to:

- Lady Hardinge Medical College (LHMC)
- Smt. Sucheta Kriplani Hospital (SSKH)
- Kalawati Saran Children's Hospital (KSCH)

It shall be applicable to:

- Patients and their attendants
- Faculty, residents, interns and students
- Nursing, paramedical and administrative staff
- Contractual, outsourced staff and visitors

---

4. DEFINITIONS

Discrimination: Unfair or unequal treatment of a person or group based on protected characteristics.

Protected Characteristics: Characteristics including but not limited to gender, age, caste, religion, ethnicity, disability, socioeconomic status, nationality, language, health condition or any other status protected by law.

---

5. GOVERNING PRINCIPLES

- Equality and dignity of all individuals
- Fairness and impartiality in service delivery
- Respect for diversity and inclusion
- Zero tolerance towards discrimination
- Compliance with constitutional and legal mandates

---

6. NON-DISCRIMINATION IN PATIENT CARE

- No patient shall be denied care on discriminatory grounds
- Clinical decisions shall be based solely on medical need and urgency
- Special attention shall be provided to vulnerable groups
- Communication shall be respectful and culturally sensitive

---

7. NON-DISCRIMINATION IN EMPLOYMENT & EDUCATION

- Equal opportunity in recruitment, training and career progression
- Fair treatment in duties, evaluation and disciplinary processes
- No discrimination in academic activities or assessments

---

8. RESPONSIBILITIES

- All staff shall adhere to non-discrimination principles
- Supervisors and HODs shall ensure compliance in their areas
- Administration shall promote awareness and enforcement

---

9. REPORTING & REDRESSAL MECHANISM

- Complaints of discrimination may be reported to:
  - Grievance Redressal Committee
  - Medical Superintendent / Administration
  - Appropriate statutory committee (e.g., POSH, SC/ST Committee)
- Complaints shall be examined promptly and fairly

---

10. PROTECTION AGAINST VICTIMIZATION

- Complainants and witnesses shall be protected against retaliation
- Confidentiality shall be maintained to the extent possible

---

11. TRAINING & AWARENESS

- Regular sensitization programs on equality and diversity
- Display of Patient Rights and Non-Discrimination commitments

---

12. MONITORING & COMPLIANCE

- Periodic review of complaints and corrective actions
- Integration with internal audit and quality systems

---

13. COMPLIANCE & ACCOUNTABILITY

Any violation of this policy shall attract administrative or disciplinary action as per applicable rules.

---

14. REVIEW & AMENDMENT

This policy shall be reviewed every three years or earlier if required due to changes in law or institutional needs.

---

15. EFFECTIVE DATE

This policy shall come into force from the date of approval by the Competent Authority.

---

16. APPROVAL

Issued with the approval of the Director LHMC & Associated Hospitals.

ANNEXURES

Annexure – I: Non-Discrimination Commitment Statement (Display Format)

"Lady Hardinge Medical College & Associated Hospitals are committed to providing healthcare and services without discrimination on any grounds. All individuals shall be treated with dignity, respect and fairness."

Annexure – II: Discrimination Complaint Reporting Form

Date Name (Optional) Nature of Complaint Location Supporting Details

Annexure – III: Register of Discrimination Complaints

Sl. No. Date Nature of Complaint Committee Status Action Taken

---

All annexures form an integral part of this policy and shall be implemented and monitored by the Administration & Grievance Redressal Committees.

End of Policy Document

IPB

POLICY ON HANDLING OF PATIENT BELONGINGS

LHMC-HPB-POL-2026-033-V1.0

Lady Hardinge Medical College & Associated Smt. Sucheta Kriplani And Kalawati Saran Children Hospital New Delhi-110001

(Applicable to LHMC, Smt. Sucheta Kriplani Hospital & Kalawati Saran Children Hospital)

22/04

GOVERNMENT OF INDIA
MINISTRY OF HEALTH & FAMILY WELFARE
DIRECTORATE GENERAL OF HEALTH SERVICES
LADY HARDINGE MEDICAL COLLEGE & ASSOCIATED HOSPITALS
SHAHEED BHAGAT SINGH MARG, NEW DELHI-110001

Details of the Document

Document Name	POLICY ON HANDLING OF PATIENT BELONGINGS
Document No.	LHMC-HPB-POL-2026-033-V1.0
No. of pages:	08
Date created:	17/01/2026
Prepared By	Name: Dr. Banarsi Designation: Additional Medical Superintendent Signature
Reviewed By	Public Grievance Committee, LHMC
Approved by:	Name: Dr. Manoj B Jais Designation: Medical Superintendent Signature: 22/04/26 Name: Dr. Sarita Beri Designation: Medical Director Signature

Responsibility of updating:	Chairperson patient safety Committee

POLICY ON HANDLING OF PATIENT BELONGINGS

POLICY IDENTIFICATION

	Details
Policy Title	Policy on Handling of Patient Belongings
Policy Code	LHMC-HPB-POL-2026-033-V1.0
Domain	Patient Rights / Nursing Services / Administration
Category	Policy
Prepared By	Dr. Banarsi, Additional Medical Superintendent
Reviewed By	Medical Superintendents (SSKH & KSCH)
Approved By	Director LHMC
Date of Approval	_____
Effective From	_____
Review Due On	_____ (After 3 Years)

1. PREAMBLE

Lady Hardinge Medical College & Associated Hospitals (LHMC, SSKH & KSCH) are committed to safeguarding the dignity, rights and property of patients admitted to the hospital. Patients may be required to hand over or secure their personal belongings during admission, transfer, treatment or emergency situations. Proper handling of patient belongings is essential to prevent loss, damage, disputes and distress.

This policy establishes a standardized framework for safe custody, documentation, handling, storage and return of patient belongings in LHMC and its Associated Hospitals.

---

2. OBJECTIVES

The objectives of this policy are to:

- Ensure safe handling and custody of patient belongings
- Prevent loss, theft or damage to patient property
- Define clear responsibilities of staff
- Establish transparent documentation and accountability
- Provide a fair mechanism for resolution of grievances

---

3. SCOPE

This policy shall apply to:

- Lady Hardinge Medical College (LHMC)
- Smt. Sucheta Kriplani Hospital (SSKH)
- Kalawati Saran Children's Hospital (KSCH)

It shall be applicable to:

- All inpatients admitted to wards, ICUs and emergency areas
- All healthcare and support staff involved in patient admission and care

---

4. DEFINITIONS

Patient Belongings: Personal items belonging to the patient such as clothing, footwear, spectacles, mobile phones, documents, money, jewellery and other valuables.

Custody: Responsibility for safekeeping of patient belongings during hospital stay.

---

5. GOVERNING PRINCIPLES

- Respect for patient dignity and property
- Transparency and proper documentation
- Shared responsibility with patient/attendant wherever feasible
- Special care during emergencies and transfers

6. GENERAL GUIDELINES

- Patients and attendants shall be advised not to bring valuables to the hospital
- Hospital shall not be responsible for valuables retained by patients against advice
- Clear signage and information shall be displayed

7. HANDLING OF BELONGINGS AT ADMISSION

- Belongings shall be inventoried at the time of admission
- Inventory shall be prepared in presence of patient/attendant
- Both parties shall sign the inventory form
- One copy shall be given to the patient/attendant

8. SAFE CUSTODY & STORAGE

- Valuables may be handed over to attendant or deposited as per hospital practice
- Designated storage areas shall be used where available
- Belongings shall be properly labelled and secured

9. HANDLING DURING TRANSFER / PROCEDURES

- Belongings shall accompany the patient or be safely stored or handed over to concerned investigating officer with receipt.
- Inventory shall be updated during inter-ward or ICU transfers

10. HANDLING IN EMERGENCY / UNCONSCIOUS PATIENT

- Inventory shall be prepared by staff in presence of two witnesses
- Details shall be recorded in medical/nursing notes
- Belongings shall be handed over to attendant as soon as available

11. HANDLING OF BELONGINGS ON DISCHARGE

- Belongings shall be returned to patient/attendant against acknowledgment
- Inventory shall be verified at the time of discharge

---

12. HANDLING IN CASE OF DEATH

- Belongings shall be inventoried carefully
- Handed over to legal heir/authorized person with proper documentation
- Hospital protocols for deceased patient management shall be followed

---

13. LOST / UNCLAIMED BELONGINGS

- Lost belongings shall be reported immediately
- Inquiry shall be conducted by ward in-charge/administration
- Unclaimed belongings shall be recorded and disposed of as per rules

---

14. ROLES & RESPONSIBILITIES

- Nursing staff: Inventory, documentation and custody at ward level
- Ward In-charge: Supervision and compliance
- Medical Administration: Oversight and grievance handling

---

15. DOCUMENTATION & RECORD KEEPING

- Inventory forms and acknowledgment receipts shall be maintained
- Records shall be preserved as per record retention policy

---

16. GRIEVANCE REDRESSAL

- Complaints shall be addressed through Patient Grievance Redressal mechanism

---

17. TRAINING & AWARENESS

- Staff shall be trained on this policy
- Patients shall be informed at admission

18. COMPLIANCE & ACCOUNTABILITY

Non-compliance with this policy shall attract administrative action as per institutional rules.

19. REVIEW & AMENDMENT

This policy shall be reviewed every three years or earlier if required.

20. EFFECTIVE DATE

This policy shall come into force from the date of approval by the Competent Authority.

21. APPROVAL

Issued with the approval of the Director LHMC & Associated Hospitals.

ANNEXURES

Annexure – I: Patient Belongings Inventory Form

Patient Name	UHID	Item Description	Quantity	Signature

Annexure – II: Acknowledgement for Receipt of Patient Belongings

Patient Name	UHID	Received By	Relationship	Signature	Date

Annexure – III: Register of Patient Belongings (Ward Level)

Sl. No.	UHID	Patient Name	Date	Custody Details	Remarks

All annexures form an integral part of this policy and shall be implemented and monitored by Nursing Services and Medical Administration.

End of Policy Document

POLICY ON INFORMED CONSENT

LHMC-IC-POL-2026-034-V1.0

Lady Hardinge Medical College & Associated Smt. Sucheta Kriplani And Kalawati Saran Children Hospital New Delhi-110001

(Applicable to LHMC, Smt. Sucheta Kriplani Hospital & Kalawati Saran Children Hospital)

GOVERNMENT OF INDIA
MINISTRY OF HEALTH & FAMILY WELFARE
DIRECTORATE GENERAL OF HEALTH SERVICES
LADY HARDINGE MEDICAL COLLEGE & ASSOCIATED HOSPITALS
SHAHEED BHAGAT SINGH MARG, NEW DELHI-110001

Details of the Document

Document Name	POLICY ON INFORMED CONSENT
Document No.	LHMC-IC-POL-2026-034-V1.0
No. of pages:	07
Date created:	17/01/2026
Prepared By	Name: Dr. Banarsi Designation: Additional Medical Superintendent Signature
Reviewed By	Public Grievance Committee, LHMC
Approved by:	Name: Dr. Manoj B Jais Designation: Medical Superintendent Signature: 22/04/26 Name: Dr. Sarita Beri Designation: Medical Director Signature

Responsibility of updating:	Name: Chairperson Bio Medical Waste Committee Designation: HOD Microbiology

POLICY ON INFORMED CONSENT

POLICY IDENTIFICATION

Field	Details
Policy Title	Policy on Informed Consent
Policy Code	LHMC-IC-POL-2026-028-V1.0
Domain	Patient Rights / Clinical Governance
Category	Policy
Prepared By	Dr. Banarsi, Additional Medical Superintendent
Reviewed By	Medical Superintendents (SSKH & KSCH)
Approved By	Director LHMC
Date of Approval	
Effective From	
Review Due On	(After 3 Years)
Version	V1.0
Supersedes	Nil
Confidentiality Status	Public

1. PREAMBLE

Lady Hardinge Medical College & Associated Hospitals (LHMC, SSKH & KSCH) are committed to respecting patient autonomy, dignity and rights. Obtaining valid informed

consent is a fundamental ethical, legal and professional obligation prior to any examination, investigation, procedure, treatment or participation in research.

This policy establishes a standardized framework for obtaining, documenting and managing informed consent in clinical care, procedures, surgery, anesthesia, blood transfusion and research activities across LHMC and its Associated Hospitals.

---

2. OBJECTIVES

The objectives of this policy are to:

- Ensure respect for patient autonomy and right to information
- Standardize informed consent practices across departments
- Ensure legal and ethical compliance in patient care
- Enhance patient understanding, trust and participation in care decisions
- Reduce medico-legal risks arising from inadequate consent

---

3. SCOPE

This policy shall apply to:

- Lady Hardinge Medical College (LHMC)
- Smt. Sucheta Kriplani Hospital (SSKH)
- Kalawati Saran Children's Hospital (KSCH)

It shall be applicable to:

- All clinical departments
- OPD, IPD, Emergency, ICUs and Operation Theatres
- All doctors, residents, interns and nursing staff
- Procedures, investigations, treatment, surgery and research

---

4. DEFINITIONS

Informed Consent: Voluntary agreement of a patient or legally authorized representative, given after receiving adequate information about a proposed intervention.

Implied Consent: Consent inferred from a patient's actions in non-invasive, routine care.

Express Consent: Consent explicitly given verbally or in writing.

Legally Authorized Representative (LAR): Person authorized to give consent on behalf of a patient incapable of doing so.

---

5. GOVERNING PRINCIPLES

- Consent shall be voluntary, informed and documented
- Adequate information shall be provided in understandable language
- Patient shall have the right to ask questions and refuse treatment
- Consent may be withdrawn at any time
- Emergency care shall not be delayed for consent where life-threatening

---

6. TYPES OF CONSENT

- Implied consent (routine examination)
- Verbal consent (minor procedures)
- Written informed consent (surgery, anaesthesia, invasive procedures, blood transfusion, research)

---

7. INFORMATION TO BE DISCLOSED

The following information shall be explained:

- Diagnosis and nature of illness
- Purpose and details of proposed procedure or treatment
- Risks, benefits and possible complications
- Alternatives including option of no treatment
- Likely outcome and prognosis

---

8. WHO CAN GIVE CONSENT

- Adult patient with decision-making capacity
- Parent / legal guardian for minors
- Legally Authorized Representative for incapacitated patients

---

9. WHO SHALL OBTAIN CONSENT

- Treating doctor or a competent member of clinical team

- Consent shall not be delegated to unauthorized personnel

---

10. CONSENT IN SPECIAL SITUATIONS

- Emergency: Life-saving treatment without consent as per law
- Minors: Consent from parent/guardian; assent from child where appropriate
- Mentally incapacitated patients: LAR consent
- Medico-legal cases: As per legal provisions
- Research: Separate informed consent with Ethics Committee approval

---

11. DOCUMENTATION & RECORD KEEPING

- Consent shall be documented in prescribed formats
- Forms shall be dated, timed and signed
- Consent forms shall be part of medical record

---

12. LANGUAGE & COMMUNICATION

- Consent shall be obtained in a language understood by patient
- Interpreter support shall be used where necessary

---

13. REFUSAL & WITHDRAWAL OF CONSENT

- Refusal or withdrawal shall be documented
- Patient shall be informed of consequences

---

14. TRAINING & AWARENESS

- Training of staff on consent procedures
- Sensitization on legal and ethical aspects

---

15. MONITORING & AUDIT

- Periodic audit of consent documentation
- Corrective actions for deficiencies

16. COMPLIANCE & ACCOUNTABILITY

Non-compliance with this policy shall attract administrative or disciplinary action as per institutional rules.

17. REVIEW & AMENDMENT

This policy shall be reviewed every three years or earlier if required due to changes in law or guidelines.

18. EFFECTIVE DATE

This policy shall come into force from the date of approval by the Competent Authority.

19. APPROVAL

Issued with the approval of the Director LHMC & Associated Hospitals.

ANNEXURES

Annexure – I: General Informed Consent Form (Indicative)

Patient Name	UHID	Procedure	Risks Explained	Signature	Date

Annexure – II: Surgery & Anaesthesia Consent Form

Surgery Planned	Anaesthesia Type	Risks	Alternatives	Signatures

Annexure – III: Consent for Blood / Blood Component Transfusion

Indication	Blood Component	Risks	Consent

Annexure – IV: Refusal / Withdrawal of Consent Form

Patient Name	Procedure	Reason for Refusal	Signature	Date

All annexures form an integral part of this policy and shall be implemented and monitored by the Medical Administration.

End of Policy Document

Policy on Patient's Right

LHMC-QS-POL-2026-054-V1.0

Lady Hardinge Medical College & Associated Smt. Sucheta Kriplani And Kalawati Saran Children Hospital New Delhi-110001

(Applicable to LHMC, Smt. Sucheta Kriplani Hospital & Kalawati Saran Children Hospital)

GOVERNMENT OF INDIA
MINISTRY OF HEALTH & FAMILY WELFARE
DIRECTORATE GENERAL OF HEALTH SERVICES
LADY HARDINGE MEDICAL COLLEGE & ASSOCIATED HOSPITALS
SHAHEED BHAGAT SINGH MARG, NEW DELHI-110001

Details of the Document

Document Name	Policy on Patient's Right
Document No.	**LHMC-QS-POL-2026-054-V1.0**
No. of pages:	0
Date created:	17/01/2026
Prepared By	Name: Dr. Banarsi Designation: Additional Medical Superintendent Signature
Reviewed By	Public Grievance Committee, LHMC

Approved by:	Name: Dr. Manoj B Jais Designation: Medical Superintendent Signature 22/04/26 Name: Dr. Sarita Beri Designation: Medical Director Signature
Responsibility of updating:	Name: Chairperson Bio Medical Waste Committee Designation: HOD Microbiology

PATIENT RIGHTS POLICY

Lady Hardinge Medical College & Associated Hospitals, New Delhi

---

PATIENT RIGHTS POLICY

POLICY IDENTIFICATION DETAILS

Field	Description
Policy Code	LHMC-CL-POL-2026-054-V1.0
Domain	Clinical Services
Category	Policy
Issuing Office	Additional Medical Superintendent
Approved By	Director, LHMC & Associated Hospitals
Date of Issue	DD/MM/YYYY
Effective From	DD/MM/YYYY
Review Due On	DD/MM/YYYY
Version	V1.0
Supersedes	Nil
Confidentiality Status	Public Document

APPLICABILITY

This policy is applicable to all patients, attendants, visitors and healthcare providers of Lady Hardinge Medical College, Smt. Sucheta Kriplani Hospital and Kalawati Saran Children Hospital.

APPROVAL

Dr. Sarita Beri
LHMC & Associated Hospitals, New Delhi-110001

1. PURPOSE

The purpose of this policy is to safeguard the dignity, autonomy, safety and rights of all patients receiving care at LHMC & Associated Hospitals and to ensure that patient care is delivered in an ethical, respectful, transparent and non-discriminatory manner in accordance with national guidelines and NABH standards.

---

2. SCOPE

This policy applies to:

- All inpatients and outpatients
- Emergency, OPD and IPD services
- All doctors, nurses, paramedical staff, students, contractual staff and outsourced personnel

---

3. DEFINITIONS

Patient: Any individual receiving medical care, diagnosis or treatment at LHMC & Associated Hospitals.

Attendant: A person authorised by the patient to assist during hospital stay.

Healthcare Provider: Any medical, nursing or allied health professional involved in patient care.

---

4. POLICY STATEMENT

LHMC & Associated Hospitals are committed to providing patient-centred care that respects the rights, dignity and individuality of every patient, irrespective of gender, age, religion, caste, socioeconomic status or disability.

---

5. PATIENT RIGHTS

Every patient has the right to:

5.1 **Right to Respectful and Non-Discriminatory Care**
Receive courteous, respectful and equitable care without discrimination.

5.2 **Right to Information**
Receive complete and accurate information regarding diagnosis, treatment options, risks, costs and prognosis in a language understood by the patient.

5.3 **Right to Informed Consent**
Give informed consent before any procedure, investigation or treatment, except in emergencies.

5.4 **Right to Privacy and Confidentiality**
Have personal health information protected and examinations conducted in privacy.

5.5 **Right to Safety and Quality Care**
Receive care in a safe environment following standard clinical protocols.

5.6 **Right to Choose and Seek Second Opinion**
Seek a second opinion and choose among available treatment options.

5.7 **Right to Access Medical Records**
Access copies of medical records as per applicable rules.

5.8 **Right to Transparency in Charges**
Be informed about applicable charges, free services and entitlements.

5.9 **Right to Grievance Redressal**
Voice complaints and receive timely redressal without fear of reprisal.

5.10 **Right to Dignity at End of Life**
Receive compassionate and dignified end-of-life care as per law and guidelines.

---

6. RESPONSIBILITIES OF PATIENTS & ATTENDANTS

Patients and attendants are expected to:

- Provide accurate medical information
- Follow hospital rules and treatment plans
- Respect healthcare workers and other patients
- Use hospital resources responsibly

---

7. ROLES & RESPONSIBILITIES

Designation	Responsibility
Director	Overall oversight
Medical Superintendent	Implementation and monitoring
Heads of Departments	Departmental compliance
Nursing In-charge	Patient education and support
Patient Grievance Committee	Redressal of complaints

---

8. COMPLIANCE & MONITORING

Compliance with this policy shall be monitored through:

- Patient feedback and satisfaction surveys
- Grievance records and analysis
- Internal audits and NABH assessments

---

9. AWARENESS & COMMUNICATION

- Display of Patient Rights Charter at prominent locations
- Information through IEC materials and hospital website
- Orientation of staff and students

---

10. DOCUMENTATION & RECORDS

- Informed consent forms
- Grievance registers
- Patient feedback records

Records shall be maintained as per record retention policy.

---

11. REVIEW & AMENDMENT

This policy shall be reviewed every three years or earlier if required due to statutory or regulatory changes.

---

12. REFERENCES

- Charter of Patient Rights, MoHFW, Government of India
- NABH Hospital Accreditation Standards
- Consumer Protection Act, 2019

---

13. ANNEXURES

- Annexure I: Patient Rights Charter (Display Version)
- Annexure II: Grievance Redressal Flowchart

(End of Policy Document)

5-V

POLICY ON EMERGENCY SERVICES

LHMC-ES-POL-2026-025-V1.0

Lady Hardinge Medical College & Associated Smt. Sucheta Kriplani And Kalawati Saran Children Hospital New Delhi-110001

(Applicable to LHMC, Smt. Sucheta Kriplani Hospital & Kalawati Saran Children Hospital)

22/04/26

22/04/2026

GOVERNMENT OF INDIA
MINISTRY OF HEALTH & FAMILY WELFARE
DIRECTORATE GENERAL OF HEALTH SERVICES
LADY HARDINGE MEDICAL COLLEGE & ASSOCIATED HOSPITALS
SHAHEED BHAGAT SINGH MARG, NEW DELHI-110001

Details of the Document

Document Name	POLICY ON EMERGENCY SERVICES
Document No.	LHMC-ES-POL-2026-025-V1.0
No. of pages:	08
Date created:	17/01/2026
Prepared By	Name: Dr. Banarsi Designation: Additional Medical Superintendent Signature
Reviewed By	Public Grievance Committee, LHMC
Approved by:	Name: Dr. Manoj B Jais Designation: Medical Superintendent Signature Name: Dr. Sarita Beri Designation: Medical Director Signature

Responsibility of updating:	HOD A&E

POLICY ON EMERGENCY SERVICES

POLICY IDENTIFICATION

Field	Details
Policy Title	Policy on Emergency Services
Policy Code	LHMC-ES-POL-2026-025-V1.0
Domain	Emergency Medicine / Clinical Services / Patient Safety
Category	Policy
Prepared By	Dr. Banarsi, Additional Medical Superintendent
Reviewed By	Medical Superintendents (SSKH & KSCH)
Approved By	Director LHMC
Date of Approval	
Effective From	
Review Due On	(After 3 Years)

1. PREAMBLE

Lady Hardinge Medical College & Associated Hospitals (LHMC, SSKH & KSCH) provide round-the-clock emergency medical services to patients requiring immediate assessment, resuscitation and stabilization. Emergency services form a critical component of patient care and must function efficiently, ethically and without discrimination.

This policy establishes a standardized framework for delivery of emergency services to ensure timely access, patient safety, quality care, continuity of treatment and compliance with legal and regulatory requirements.

---

2. OBJECTIVES

The objectives of this policy are to:

- Provide timely, accessible and quality emergency care 24×7
- Ensure prompt triage, resuscitation and stabilization of patients
- Standardize emergency care processes and protocols
- Ensure compliance with legal, ethical and patient rights requirements
- Promote coordination with diagnostic, specialty and referral services

---

3. SCOPE

This policy shall apply to:

- Lady Hardinge Medical College (LHMC)
- Smt. Sucheta Kriplani Hospital (SSKH)
- Kalawati Saran Children's Hospital (KSCH)

It shall be applicable to:

- All patients presenting to emergency departments
- Medical, surgical, obstetric, paediatric and trauma emergencies
- All healthcare professionals and support staff working in emergency areas

---

4. DEFINITIONS

Emergency Medical Condition: A condition requiring immediate medical attention to prevent serious harm or death.

Triage: Process of prioritizing patients based on severity of condition.

Stabilization: Medical management to ensure airway, breathing and circulation before definitive care or transfer.

---

5. GOVERNING PRINCIPLES

- Right to emergency care without discrimination
- Timeliness and prioritization based on clinical urgency
- Patient safety and dignity
- Ethical and legal compliance
- Continuity and coordination of care

---

6. GOVERNANCE STRUCTURE

6.1 Competent Authority

The Director/Medical Superintendents / Principal, LHMC shall be the Competent Authority for implementation of this policy.

6.2 Oversight

Medical Superintendents and HOD Emergency Department shall oversee emergency services.

---

7. EMERGENCY SERVICES PROVISION

- Emergency services shall be available 24×7
- Adequate staffing of doctors, nurses and paramedical staff
- Availability of essential drugs, equipment and consumables

---

8. TRIAGE & INITIAL ASSESSMENT

- All patients shall undergo triage on arrival
- Standard triage protocols (Red/Yellow/Green) shall be followed
- Documentation of triage category and time

---

9. MANAGEMENT & STABILIZATION

- Immediate resuscitation as per standard protocols
- Stabilization prior to admission, transfer or referral
- Early involvement of specialty teams where required

---

10. ADMISSION, TRANSFER & REFERRAL

- Admission or transfer as per ATD and Referral policies
- Inter-hospital transfers only after stabilization
- Proper documentation and handover

---

11. MEDICO-LEGAL CASES (MLCs)

- All medico-legal cases shall be registered and documented
- Treatment shall not be delayed for medico-legal formalities
- Intimation to police as per law

---

12. CONSENT & PATIENT RIGHTS

- Emergency care shall not be denied due to inability to pay or lack of consent
- Informed consent shall be obtained whenever feasible
- Respect for patient rights and confidentiality

---

13. DOCUMENTATION & RECORD KEEPING

- Maintenance of emergency case sheets and registers
- Accurate recording of time, interventions and outcomes

---

14. SAFETY & SECURITY

- Measures to ensure safety of patients, staff and attendants
- Coordination with hospital security services

---

15. DISASTER & MASS CASUALTY MANAGEMENT

- Emergency department sball be integrated with hospital disaster plan
- Preparedness for mass casualty incidents

---

16. TRAINING & COMPETENCY

- Regular training in emergency care, BLS, ACLS and trauma management
- Mock drills and skill upgradation

---

17. MONITORING & QUALITY IMPROVEMENT

- Periodic review of emergency service indicators
- Audit of response times, outcomes and adverse events

---

18. COMPLIANCE & ACCOUNTABILITY

Non-compliance with this policy shall attract administrative action as per institutional rules.

---

19. REVIEW & AMENDMENT

This policy shall be reviewed every three years or earlier if required.

---

20. EFFECTIVE DATE

This policy shall come into force from the date of approval by the Competent Authority.

---

21. APPROVAL

Issued with the approval of the Director LHMC & Associated Hospitals.

ANNEXURES

Annexure – I: Emergency Triage Form

Patient Name	UHID	Time of Arrival	Triage Category	Vital Signs	Signature

Annexure – II: Emergency Admission & Stabilization Checklist

Airway	Breathing	Circulation	Investigations	Remarks

Annexure – III: Emergency Referral / Transfer Form

Diagnosis	Stabilized	Destination	Escort	Time	Signature

All annexures form an integral part of this policy and shall be implemented and monitored by Emergency Services & Medical Administration.

End of Policy Document

Policy on Provision of Transgender-Inclusive and Gender-Affirming

LHMC-QS-POL-2026-050-V1.0

Lady Hardinge Medical College & Associated Smt. Sucheta Kriplani And Kalawati Saran Children Hospital New Delhi-110001

(Applicable to LHMC, Smt. Sucheta Kriplani Hospital & Kalawati Saran Children Hospital)

GOVERNMENT OF INDIA
MINISTRY OF HEALTH & FAMILY WELFARE
DIRECTORATE GENERAL OF HEALTH SERVICES
LADY HARDINGE MEDICAL COLLEGE & ASSOCIATED HOSPITALS
SHAHEED BHAGAT SINGH MARG, NEW DELHI-110001

Details of the Document

Document Name	Policy on Provision of Transgender-Inclusive and Gender-Affirming
Document No.	**LHMC-QS-POL-2026-050-V1.0**
No. of pages:	0
Date created:	17/01/2026
Prepared By	Name: Dr. Banarsi Designation: Additional Medical Superintendent Signature
Reviewed By	Public Grievance Committee, LHMC

22/04/2026

Approved by:	Name: Dr. Manoj B Jais Designation: Medical Superintendent Signature 22/04/26 Name: Dr. Sarita Beri Designation: Medical Director Signature
Responsibility of updating:	Name: Chairperson Bio Medical Waste Committee Designation: HOD Microbiology

Draft Policy Title and Preamble

Title:

"Policy on Provision of Transgender-Inclusive and Gender-Affirming Health Care at LHMC & Associated Hospitals, New Delhi"

Preamble:

This policy is issued in pursuance of the Transgender Persons (Protection of Rights) Act, 2019 and the Transgender Persons (Protection of Rights) Rules, 2020, which mandate non-discriminatory access to health care, provision of gender-affirming procedures, and development of health manuals in line with international standards such as World Professional Association for Transgender Health (WPATH).

The policy also takes note of national guidance, including DGHS Standard Operating Procedures for medical treatment of transgender persons, and internationally recognised WPATH Standards of Care (SOC-8) to frame context-appropriate protocols for an Indian government teaching hospital.

1. Objectives and Scope

I. To ensure that all transgender and gender diverse persons receive safe, dignified, stigma-free and non-discriminatory health care at LHMC & Associated Hospitals, including gender-affirming services as feasible within institutional capacity.

II. To institutionalise standardised protocols for registration, triage, admission, clinical assessment, mental health support, endocrine and surgical care, and follow-up, drawing upon DGHS SOPs and WPATH SOC-8, with necessary adaptations to Indian legal, ethical and resource constraints.

Scope:

I. Applies to all departments, units, staff, and outsourced service providers functioning under LHMC & Associated Hospitals.
II. Covers outpatient, inpatient, emergency, ICU, operation theatre, diagnostic, mental health, endocrine, surgical, reproductive health, HIV/STI, and support services for transgender persons of all ages, including those in various stages of social or medical transition.

2. Legal and Normative Framework

The Act and Rules prohibit discrimination against transgender persons in health care and require government institutions to ensure access to services including gender-affirming surgery, hormone therapy, HIV services, and a health manual aligned with WPATH standards.

DGHS has issued Standard Operating Procedures for medical treatment of transgender persons, which public hospitals are expected to adopt/customise; this policy will operationalise those SOPs within LHMC & Associated Hospitals.

International Reference (WPATH SOC-8):

WPATH SOC-8 emphasises person-centred, evidence-based, multidisciplinary, and individually tailored gender-affirming care to optimise physical health and psychological well-being.

The standards stress respect for bodily autonomy, informed consent, non-pathologisation of gender diversity, and rejection of any "conversion"-type interventions.

3. **Definitions (Working, For Hospital Use)**

Transgender person: As defined in the Transgender Persons (Protection of Rights) Act, 2019 and Rules, including trans men, trans women, non-binary and gender-nonconforming persons whose gender does not align with sex assigned at birth.

Gender-affirming medical interventions: Hormone therapy, puberty suppression where applicable, gender-affirming surgeries, and ancillary procedures (e.g. hair reduction, voice interventions) as recognised in DGHS SOPs and WPATH SOC-8 and permissible under Indian law.

Gender-affirming care: A holistic approach including primary care, mental health, sexual and reproductive health, HIV/STI services, and social support that affirms a person's gender identity and expression.

4. Institutional Arrangements

LHMC & Associated Hospitals shall establish a "Transgender Health & Gender-Affirming Care Committee (THGACC)" under the Chairpersonship of the Director, with MS, HoDs (Psychiatry, Endocrinology/Medicine, Surgery, Obstetrics & Gynaecology, Paediatrics/Adolescent Clinic, Dermatology, Anaesthesia), Nursing Superintendent, Social

Work, Legal/Vigilance, and a representative from the Internal Complaints Committee as members.

The THGACC will:

Oversee policy implementation, periodic review, and compliance with statutory obligations and DGHS SOPs.

Approve clinical protocols and consent formats based on WPATH SOC-8, adapted to local context.

Dedicated Nodal Officer and Clinic:

A senior faculty member (e.g. from Psychiatry/Endocrinology/Medicine) shall be designated as "Nodal Officer (Transgender Health)" to coordinate clinical pathways, referrals, and grievances related to transgender health care.

LHMC shall endeavour to run a structured "Transgender Health & Gender-Affirming Clinic" (weekly or more frequent), involving a multidisciplinary team and providing a single-window point of contact for transgender persons.

5. Non-Discrimination, Registration and Access

No transgender person shall be denied registration, consultation, admission or any procedure on grounds of gender identity, expression, legal documentation status, or stage of transition; any such denial will be treated as a serious misconduct.

Registration software and physical records shall be modified to include gender fields beyond binary (e.g. male/female/transgender/other) in line with government norms and TG Rules, 2020.

Admission, Bed and Ward Allocation:

As far as feasible and respecting privacy, ward allocation shall be based on self-identified gender, following national guidance (e.g. TG Rules requiring separate wards or designated facilities where possible).

Where a separate ward is not available, the hospital shall provide reasonable accommodations (e.g. cubicle partition, curtains, separate bathroom use where practicable) while ensuring safety and dignity.

6. Clinical Protocols – General Principles

All clinical protocols shall reflect WPATH SOC-8 principles of individualised assessment, shared decision-making, proportionality of interventions, and evidence-based risk-benefit evaluation, while complying with Indian laws and DGHS SOPs.

Transgender health care shall not be contingent upon unnecessary psychiatric pathologisation; mental health assessments, where required, should focus on capacity, comorbidities, and support rather than "proving" identity.

Informed Consent and Capacity:

For adults with decision-making capacity, gender-affirming interventions should be based on informed consent after comprehensive counselling on risks, benefits, alternatives, reversibility, and fertility implications, using standardised consent forms approved by THGACC.

For adolescents and children, protocols shall strictly follow WPATH SOC-8 age-specific recommendations, Indian medico-legal norms, and DGHS SOPs, including parental/guardian involvement where required by law.

7. Mental Health Services

The Department of Psychiatry (and Clinical Psychology, where available) shall provide trans-affirmative mental health care, focusing on support, coping, assessment of coexisting conditions, and preparation for social/medical transition as appropriate.

Mental health professionals shall follow trans-affirmative practice guidelines (e.g. TISS mental health guidelines and WPATH SOC-8 mental health chapters) and explicitly avoid any conversion or reparative therapies.

Services to be Provided:

Pre- and post-procedure counselling for hormone therapy and surgeries, crisis intervention, suicide risk management, and family counselling when requested or clinically indicated.

Referral linkages to community-based organisations and peer support groups may be facilitated, without compromising confidentiality.

8. Endocrine and Medical Gender-Affirming Care

The Department of Endocrinology/Medicine shall establish written protocols for initiation and monitoring of gender-affirming hormone therapy (GAHT) based on WPATH SOC-8 and DGHS SOPs, adapted to available medicines, lab facilities and cost considerations.

Baseline evaluation should include relevant history, physical examination, mental health inputs when appropriate, and necessary investigations; ongoing follow-up shall monitor efficacy, side-effects, and adherence.

Key Protocol Elements (Illustrative):

Eligibility criteria focusing on persistent gender incongruence, informed consent, reasonable expectation of adherence, and absence of absolute contraindications, with flexibility to individualise care.

Standard monitoring schedules for hormone levels, metabolic parameters, and organ function in line with DGHS and WPATH guidance.

9. Surgical Gender-Affirming Care

Surgical departments (Plastic Surgery, General Surgery, Urology, ENT, Gynaecology, etc.) shall progressively develop capacity for gender-affirming surgeries (e.g. chest reconstruction, genital surgeries, facial gender-affirming procedures) as permitted by infrastructure, training and DGHS SOPs.

Surgery pathways shall include structured multidisciplinary assessment (mental health, endocrine, anaesthesia, relevant surgery), optimisation of comorbidities, and detailed informed consent, including specific risks and expectations.

Prioritisation and Referral:

Until full in-house capacity is available, the hospital may:

Provide pre- and post-operative care while referring for complex procedures to designated centres as notified by MoHFW/State.

Maintain a list of empanelled centres (e.g. AB PM-JAY or other schemes) for gender-affirming surgeries for appropriate referral and financial coverage.

10. Primary, Reproductive and HIV/STI Care

All departments shall ensure that primary care, emergency care, reproductive health services, and screening programmes (e.g. cervical or breast cancer where relevant) are accessible to transgender persons without discrimination.

HIV/STI services shall be delivered in accordance with NACO guidelines, recognising transgender persons as a key population for targeted interventions, testing, treatment and prevention.

Sexual and Reproductive Health:

Gynaecology, Obstetrics, Urology and related departments will provide respectful care for fertility preservation options, contraception, pregnancy care (where applicable), and management of reproductive tract conditions aligned with the individual's anatomy and gender identity.

Counselling about fertility implications of hormones and surgeries shall be integrated before initiation of gender-affirming interventions.

11. Infrastructure, Privacy and Support Services

As far as feasible, LHMC & Associated Hospitals shall create or earmark gender-neutral or transgender-friendly toilets and changing facilities in high-volume patient areas, in line with Rules, 2020 and government advisories.

Privacy safeguards (curtains, screens, separate counselling rooms) shall be ensured during examinations and procedures for transgender persons, particularly for intimate examinations and peri-operative care.

Support and Navigation:

Social work/medical social service units will assist with documentation, linkages to welfare schemes, insurance queries, and grievance redressal for transgender patients.

Frontline staff (reception, security, nursing orderlies, outsourced staff) shall receive basic orientation to address transgender patients respectfully and to avoid harassment or misgendering.

12. Capacity Building and Curriculum

Being a teaching institution, LHMC shall integrate transgender health (including legal rights, WPATH-aligned clinical guidelines and DGHS SOPs) into undergraduate, postgraduate, nursing and paramedical teaching programmes, as required by the Act's mandate to review medical curricula.

Regular CME/CNE sessions on transgender health and gender-affirming care shall be organised at least annually by THGACC in collaboration with relevant departments and community stakeholders.

Training Content (Indicative):

Legal framework, stigma and discrimination, basics of gender identity, communication skills, clinical pathways for hormone and surgical care, mental health aspects, and ethical issues in minors.

13. Documentation, Insurance and Financial Aspects

Clinical documentation shall respect the person's self-identified name and pronouns, while also recording legal name where required for medico-legal or billing reasons; staff shall be trained to handle this sensitively.

Billing and insurance desks shall be oriented about schemes applicable to transgender persons, including coverage under AB PM-JAY or other central/state programmes that provide free or subsidised gender-affirming care at empanelled hospitals.

Data and Reporting:

De-identified data on transgender service utilisation, procedures and outcomes may be maintained for quality improvement and reporting to competent authorities, ensuring confidentiality.

14. Grievance Redressal, Safeguards and Ethics

Any incident of denial of care, abuse, harassment, or breach of confidentiality involving a transgender person shall be reportable to the Medical Superintendent and THGACC, and may be escalated to existing institutional mechanisms (Patient Grievance Cell, ICC, Ethics Committee) as appropriate.

Disciplinary action may be initiated against staff found to be engaging in discriminatory or abusive behaviour towards transgender patients, consistent with service rules and the penal provisions under the Act.

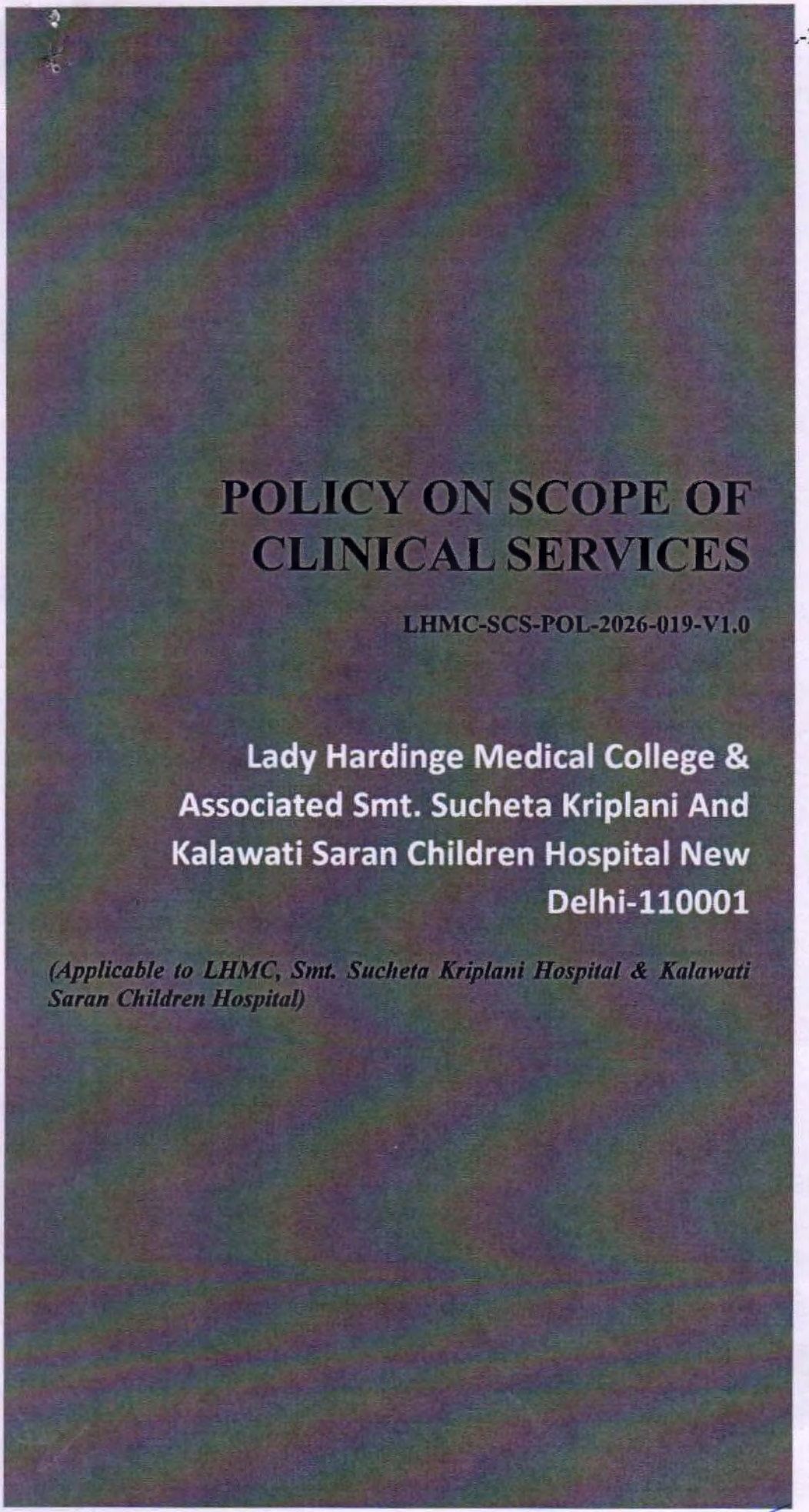
Ethical Oversight and Research:

Research on transgender health shall follow national ethical guidelines, ensure community participation where feasible, and avoid any coercive or pathologising approaches, aligning with WPATH SOC-8 values of respect, autonomy and human rights.

15. Implementation, Review and Amendments

This policy shall come into effect from the date of approval by the Director, LHMC & Associated Hospitals, and will be disseminated to all departments, units, and outsourced agencies through office orders and orientation sessions.

The THGACC shall review the policy and associated clinical protocols at least once every two years, or earlier if there are significant legal, DGHS, or WPATH SOC-8 updates, and recommend revisions to the competent authority.



POLICY ON SCOPE OF CLINICAL SERVICES

LHMC-SCS-POL-2026-019-V1.0

Lady Hardinge Medical College & Associated Smt. Sucheta Kriplani And Kalawati Saran Children Hospital New Delhi-110001

(Applicable to LHMC, Smt. Sucheta Kriplani Hospital & Kalawati Saran Children Hospital)

GOVERNMENT OF INDIA
MINISTRY OF HEALTH & FAMILY WELFARE
DIRECTORATE GENERAL OF HEALTH SERVICES
LADY HARDINGE MEDICAL COLLEGE & ASSOCIATED HOSPITALS
SHAHEED BHAGAT SINGH MARG, NEW DELHI-110001

Details of the Document

Document Name	POLICY ON SCOPE OF CLINICAL SERVICES
Document No.	LHMC-SCS-POL-2026-019-V1.0
No. of pages:	07
Date created:	17/01/2026
Prepared By	Name: Dr. Banarsi Designation: Additional Medical Superintendent Signature
Reviewed By	Public Grievance Committee
Approved by:	Name: Dr. Manoj B Jais Designation: Medical Superintendent Signature 22/04/26 Name: Dr. Sarita Beri Designation: Medical Director Signature

Responsibility of updating:	Name: Chairperson Bio Medical Waste Committee Designation: HOD Microbiology

POLICY ON SCOPE OF CLINICAL SERVICES

POLICY IDENTIFICATION

Field	Details
Policy Title	Policy on Scope of Clinical Services
Policy Code	LHMC-SCS-POL-2026-019-V1.0
Domain	Clinical Services / Clinical Governance
Category	Policy
Prepared By	Dr. Banarsi, Addl. Medical Superinterndent
Reviewed By	Medical Superintendents (SSKH & KSCH)
Approved By	Director / Principal, LHMC
Date of Approval	22/01/2026
Effective From	23/01/2026
Review Due On	(After 3 Years)

1. PREAMBLE

Lady Hardinge Medical College & Associated Hospitals (LHMC, SSKH & KSCH) provide comprehensive tertiary-level healthcare services along with teaching, training and research. Clearly defining the scope of clinical services is essential to ensure patient safety, optimal utilization of resources, clarity of roles, and compliance with regulatory and accreditation requirements.

This policy outlines the scope, range and limitations of clinical services provided at LHMC and its Associated Hospitals.

---

2. OBJECTIVES

The objectives of this policy are to:

- Define the scope and range of clinical services offered
- Ensure delivery of safe, evidence-based and quality care
- Clarify service availability for patients and staff
- Support planning, resource allocation and referrals
- Ensure compliance with NABH and regulatory requirements

---

3. SCOPE

This policy shall apply to:

- Lady Hardinge Medical College (LHMC)
- Smt. Sucheta Kriplani Hospital (SSKH)
- Kalawati Saran Children's Hospital (KSCH)

It shall cover all:

- Outpatient, inpatient and emergency services
- Diagnostic and therapeutic services
- Super-specialty and specialty clinical services

---

4. DEFINITIONS

Clinical Services: Healthcare services directly related to diagnosis, treatment, prevention and rehabilitation of patients.

Scope of Services: Range of clinical services and procedures that an institution is equipped, staffed and authorized to provide.

---

5. GOVERNING PRINCIPLES

- Patient safety and quality of care
- Evidence-based clinical practice
- Availability of qualified personnel and infrastructure

- Ethical and legal compliance
- Continuous evaluation and improvement

---

6. GOVERNANCE STRUCTURE

6.1 Competent Authority

The Director LHMC shall be the Competent Authority for approval and modification of scope of clinical services.

6.2 Clinical Governance Committee

The Clinical Governance Committee shall oversee definition, review and monitoring of clinical services scope.

---

7. CLINICAL SERVICES OFFERED

7.1 Outpatient Services

- General OPD services in all clinical specialties
- Specialty and super-specialty clinics
- Preventive, promotive and follow-up services

7.2 Inpatient Services

- Admission and inpatient care in medical, surgery, Orthopaedics, Eye, ENT, Dental, Dermatology, Psychiatry, Radio-oncology, neurology, Chest & TB, , Obstetric, Gynaecological and Paediatric, paediatric Surgery, Neonatology specialties
- ICU and high-dependency care as per availability

7.3 Emergency Services

- 24×7 emergency medical and surgical services
- Triage, stabilization and emergency interventions

7.4 Diagnostic Services

- Laboratory services (pathology, microbiology, biochemistry)
- Radiology and imaging services

7.5 Surgical & Procedural Services

- Elective and emergency surgeries
- Anaesthesia and perioperative care

7.6 Support & Allied Clinical Services

- Blood bank and transfusion services
- Physiotherapy, rehabilitation and palliative care

---

8. LIMITATIONS OF SERVICES

- Services shall be provided only where trained manpower, infrastructure and equipment are available
- High-risk or specialized procedures beyond institutional capacity shall be referred appropriately
- Services may be temporarily restricted due to resource constraints or emergencies

---

9. REFERRAL & TRANSFER OF CARE

- Clear referral pathways shall be followed
- Stabilization prior to referral shall be ensured
- Proper documentation and communication shall accompany referrals

---

10. COMMUNICATION OF SCOPE OF SERVICES

- Scope of services shall be displayed on hospital website and notice boards
- Patients shall be informed about service availability and limitations

---

11. MONITORING & REVIEW

- Periodic review of services offered
- Evaluation based on outcomes, safety indicators and resource availability

---

12. TRAINING & COMPETENCY

- Clinical services shall be delivered by credentialed and competent professionals
- Continuous training and skill upgradation

---

13. DOCUMENTATION & RECORD KEEPING

- Maintenance of service directories and departmental records
- Documentation of service changes and approvals

---

14. COMPLIANCE & ACCOUNTABILITY

Non-compliance with this policy shall attract administrative action as per institutional rules.

---

15. REVIEW & AMENDMENT

This policy shall be reviewed every three years or earlier if required.

---

16. EFFECTIVE DATE

This policy shall come into force from the date of approval by the Competent Authority.

---

17. APPROVAL

Issued with the approval of the Director LHMC & Associated Hospitals.

ANNEXURES

Annexure – I: Department-wise Scope of Clinical Services (Indicative)

Department	OPD	IPD	Emergency	Procedures Offered

Annexure – II: Service Limitation & Referral Record

Date	Department	Service Not Available	Reason	Referral Made To

---

All annexures form an integral part of this policy and shall be implemented and monitored by the Clinical Governance Committee.

End of Policy Document