This is regarding the Matter raised Under Rule 377 in Lok Sabha by Dr. Anand Kumar, Hon'ble Member of Parliament (Lok Sabha) regarding to frame guidelines and ensure transparency in ventilators usage by private hospitals.

In this regard to frame a Guideline and ensure transparency in ventilators usage by private hospitals a committee was constituted under the Chairmanship of Dr. Sujata Chaudhary, Addl. DGHS, Dte.GHS as given below, and a meeting of the committee was held on to discuss the guidelines.
The details of committee members:

1. Dr. Loveneesh G Krishna, Addl. DGHS, Dte.GHS
2. Dr. Amita Bali Vohra, DDG(P), Dte.GHS
3. Dr. Anirbam Hom Chaudhary, HoD, Dept. of CCM, Safdarjung Hospital
4. Dr. Ranju Singh, HoD, Dept. of Anesthesia, LHMC Hospital
5. Dr. Sanjay Kumar, HoD, Dept. of Emergency Medicine, LHMC Hospital
6. Dr. Neerja Banerjee, HoD, Dept. of Anesthesia, Dr. RML Hospital
7. Dr. Kavita Sharma, HoD, Dept. of Anesthesia, Safdarjung Hospital
8. Dr. Ranvinder Kaur, HoD, Dept. of CCM, Dr. RML Hospital
9. Dr. Vimmi Rewari, Dept. of Anesthesia, AIIMS Delhi
10. Dr. Rupali Roy, ADG, Dte.GHS

As per the inputs received from Experts the guidelines and to ensure transparency in ventilators usage by private hospitals was finalized. The same is placed at Annexure.

Annexure

Guidelines for Transparency in Ventilator Usage by Private Hospitals

Context & Need:

- Ventilator support is a critical, life-saving measure indicated in cases of airway obstruction, respiratory failure, neurological impairment, cardiac arrest, trauma, drug toxicity, and other critical illnesses.
- With the rising geriatric population and increasing demand for Intensive Care Unit (ICU) services, there is an urgent need for ventilator practices that are ethically sound, transparent, and accountable.
- These guidelines aim to enhance decision-making transparency and prevent unwarranted ventilator use. They are grounded in the core bioethical principles of:

    a. Autonomy: Respecting patient choices and informed consent
    b. Beneficence: Acting in the best interest of the patient
    c. Non-maleficence: Avoiding harm through unnecessary or prolonged interventions
    d. Justice: Ensuring fair and equitable access to ventilator support

- The guidelines apply to both invasive and non-invasive ventilation modalities. They do not cover other oxygen delivery systems such as face masks, nasal prongs, or High-Flow Nasal Cannula (HFNC).

Indication of Admission*:

- The indication for initiating mechanical ventilation must be clearly documented in the patient's medical records, specifying the underlying condition and rationale for ventilator support.
- **Caregiver Consent**: Informed consent must be obtained from the patient's caregivers or legal representatives, unless patient is unattended/has no attendants. This includes:

    a. Explanation of the clinical need and expected outcomes
    b. Discussion of potential risks and limitations
    c. Clarification of the nature of invasive or non-invasive ventilation

- **Cost Disclosure**: The daily cost of ventilator support and associated ICU care must be transparently disclosed to caregivers at the time of consent, ensuring financial clarity and preparedness.

***The MoHFW guidelines for Intensive Care Unit Admission and Discharge Criteria shall be referred along with this guideline.**

Ventilator Use & Monitoring:

- It is recommended that indications be well defined for invasive and non-invasive ventilation; the following practices are recommended:

    a. Clear Indication Criteria
        - Establish and document well-defined clinical indications for both invasive and non-invasive ventilation modalities.
        - Criteria should be based on evidence-informed protocols and tailored to patient-specific needs.

    b. Daily Objective Assessment:
        - Objective assessment should be done by using standardised scores daily
        - Ensure assessments are documented consistently to support clinical decision-making and continuity of care.

    c. Time-limited trials (48–72 hours) for uncertain prognosis/outcomes reassess daily to determine continuation, escalation of ventilator support based on clinical progress.

- It is recommended that daily counselling sessions with patient attendants be undertaken to communicate prognosis, care plans, and ventilatory status of patient.
- Maintaining thorough documentation of patient condition and clinical changes, Arterial Blood Gas (ABG) values, Vital signs, Weaning attempts and responses should be done
- Equip Health Facility / Hospitals with real-time dashboards and ventilator registers to track usage, patient status, and outcomes. These systems may be digital or physical, but must be accessible, regularly updated, and integrated into clinical workflows.

Ethical & Communication:

To uphold patient dignity, foster trust, and ensure ethical decision-making, the following practices are recommended for all health facilities and hospitals:

1. Transparent Communication from Day One

• Initiate open, honest, and culturally sensitive communication with family members at the time of admission or initiation of ventilatory support.

• Clearly explain prognosis, treatment options, limitations, and potential outcomes to support informed decision-making.

2. Early and Ongoing Documentation: From the first day of care, maintain thorough documentation of Prognostic assessments, Estimated and actual costs of care Clinical outcomes and changes in condition. This documentation should be updated regularly and made accessible to relevant stakeholders.

3. Record and respect patient advance directives, including, Do Not Resuscitate (DNR) orders, Do Not Intubate (DNI) preferences. Ensure these directives are documented in the

patient's medical record and communicated to the care team. Facilities should have protocols for verifying, updating, and honouring these directives.

Financial & Transparency Measures:

To promote accountability, reduce financial distress, and uphold ethical billing practices, the following measures are recommended for all health facilities and hospitals:

- Standardized and Transparent Cost Structures: Establish uniform ventilator charges across departments and facilities to prevent discrepancies and ensure fairness.
- Maintain an itemized list of consumables used during ventilatory care (e.g., circuits, humidifiers, filters), with clear pricing.
- Publicly display the cost of ventilator-related services and consumables in patient-accessible areas (e.g., billing desks, ICU waiting areas, and hospital websites).

Usage-Based Billing:

- Ventilator charges should be levied only when the equipment is actively used for patient care.
- Facilities must ensure accurate documentation of ventilator usage duration and mode (invasive/non-invasive) to support fair billing.

Audit, Oversight & Grievances:

- Health Facility / Hospital shall be responsible to conduct regular monthly internal audits for all cases involving ventilator use exceeding 14 days. Audits should assess for Clinical justification for continued ventilation, Documentation completeness, Communication with family members and Compliance with institutional guidelines
- Health Facility / Hospital shall be responsible to maintain comprehensive records of Patient mortality, Clinical outcomes, Duration and type of ventilatory support. Reports should be archived securely and made available for review by oversight bodies.
- There shall be Multidisciplinary committee to look into cases of prolonged ventilation > 2 weeks in the Health Facility / Hospital.
- Health Facility / Hospital shall implement time-bound grievance redressal mechanisms accessible to patient families and caregivers.