STANDARD OPERATING PROCEDURES (SOPs)

FOR
General Administration Services & Equipment Managment (10)

EQUITY WITH QUALITY

Book 1

Department of Health & Family Welfare, GNCTD

SOP for Support Services, Ist Edition: August; 2016
Quality Assurance Cell
Delhi State Health Mission
Department of Health and Family Welfare
Government of NCT of Delhi

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his document has been prepared by the Expert Committee comprising of:

Sr. No.	Name	Designation	
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2.	Dr. Shakti	Lok Nayak Hospital	Member
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The SOPs have been prepared by a Committee of Experts and are being circulated for customization and adoption by all hospitals. These are by no means exhaustive or prescriptive. An effort has been made to document all dimensions / working aspects of common processes / procedures being implemented in provision of healthcare in different departments. This document pertains to Department of Support Services, General Administration & Equipment Maintanance. The individual hospital departments may customize / adapt / adopt the SOPs relevant to their settings and resources. The customized final SOPs prepared by the respective Departments must be approved by the Medical Director / Medical Superintendent and issued by the Head of the concerned department. HOD shall ensure that all stakeholders are trained and familiarized with the SOPs and the existing relevant technical guidelines / STGs / Manuals mentioned in the SOPs are made available to the stakeholders.

DETAILS OF THE DOCUMENT

----------HOSPITAL

Address:

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AMENDMENT SHEET

S.No.	Page no.	Date of amendment	Details of the amendment	Reasons	Signature of the reviewing authority	Signature of the approval authority

CONTROL OF THE DOCUMENT

The holder of the copy of this manual is responsible for maintaining it in good and safe condition and in a readily identifiable and retrievable form.

The holder of the copy of this manual shall maintain it in current status by inserting latest amendments as and when the amended versions are received.

The Manual is reviewed atleast once a year (or in between SOS if so required) and is updated as relevant to the Hospital policies and procedures.

The Authority over control of this manual is as follow:

Prepared By	**Approved By**	**Issued By**
Name: Designation : HOD /Dept. In charge Signature:	Medical Superintendent Name: Signature:	Quality – Nodal Officer Name: Signature:

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Distribution List of the Manual

Sr. No.	Officials	Signature of Officials receiving copy

1. General Administration

1.1 Purpose: To promote a quality culture and place quality at the core of service delivery.

1.2 Scope : Hospital Wide

1.3. Responsibility: Medical Superintendent and Quality Assurance Officer.

1.4. Procedure:

Activity/Descripition	Responsibility	Ref. Doc./Record
1.4.1 System of Internal Assessment		
❖ Internal Assessment Based on National Quality Assurance Standards (NQAS) checklist shall be conducted quarterly. ❖ Prepares Internal Assessment schedule. ❖ Internal Assessment Schedule shall be communicated consultation with Medical Supdt. In well in advance to the Concerned department ❖ Trained and assigned assessor, who is independent of Quality those having direct responsibility for the specific department or areas being assessed, conducts the ❖ Internal Assessment (Competency to be verified). ❖ A summary report of each assessment, listing the findings are made and any non-compliance found during the assessment are recorded in the GAP & Status Report by the internal assessor and submitted to Medical superintendent and head / in-charge of the Department assessed for appropriate and timely corrective action. Assessor and Assessee both shall sign the GAP & Status Report (GSR) • The In-charge responsible for the department audited takes appropriate and timely corrective and preventive action on non- compliances/Partial Compliance found during the assessment in consultation with the Quality- Nodal Officer, preferably within **3 weeks** of issuing the GSR, and inform the Assessor to close the non-compliances/Partial Compliance with objective evidence. • Failure to implement agreed corrective action(s) should be reported to the Medical	HOD/MS/Quality-Nodal officer	**Annexure :1**, GAP & Status Report (GSR) Format **Annexure:2**, Details of Documents

superintendent/Quality - Nodal Officer. The Internal Assessment outcome and CA/PA Status **1.4.2 Control of documents and records** Documents such as regulations, standards, and other normative documents, drawings, software, and specifications, instructions and manuals shall be controlled and archived for future reference and the documents shall be retained in their respective department. The procedures and equipment details are retained in respective department as long as the machine is functional or until condemned .The documents are maintained in paper or electronic media as appropriately required. Three types of Document are Internally generated, namely: • Quality Improvement manual • SOP/ instruction manuals • Records 1.4.2.1 The responsibility for preparation, and review of internally generated documents is of the concern HOD/DEPT. INCHARGE , which must be reviewed **half yearly** and recorded in amendment sheet. 1.4.2.2 Each Internally generated Document i.e. SOP/Work Instruction has the Details of the Document on the First page, Second page as the Amendment Sheet , and third page as control of Document 1.4.2.3 Invalid or obsolete documents are promptly removed from all points of issue or use, or otherwise assured against unintended use. 1.4.2.4 Obsolete documents are retained for either legal and / or knowledge preservation purposes are suitably marked "**Obsolete Copy"** and the record of this maintained in a separate register. **1.4.3 Quality Team** The composition of the Quality Team at the Hospital are as follows: 1. Medical Superintendent: Chairperson. 2. I/C Operation Theatre/Anaesthesia , Surgeon	Quality-Nodal Officer	**Annexure:3,** Amendment Sheet **Annexure:4,** Control of Document Operational Guideline for Quality Assurance for Public Healthcare facilities **Annexure 5:** Quality Objective Monitoring Sheet

3. I/C Obstetrics and Gynaecology 4. I/C Lab services (Microbiologist/ Pathologist): for enforcing IMEP & BMW protocols. 5. I/C Nursing. 6. I/C Ancillary Services. 7. I/C Transport. 8. I/C Stores. 9. I/C Records. 10. 10.I/C Disaster Management 1.4.3.1 **Monthly Review Meeting**: Hospital Quality Team conducts Monthly review meeting with an agenda for improving Quality of Services, Assessment Score, GAP Report & Status, and Improvement Methodology etc. 1.4.3.2 **Quality- Nodal Officer** is responsible for coordinating overall quality assurance program in the Hospital. **1.4.4 Quality objectives** All the Departments have Quality Objectives **(At least 3)** and are displayed at the Suitable Location 1.4.4.1 Quality objective framed by the Department Head/Incharge based on SMART framework. **(a)** Orient the Department staff about the objective and displayed where it is Visible to all staff. **(b)** Quality Objective reviewed in every Six month by the HOD/Incharge and status shall be updated Quarterly which is communicated to the Medical Superintendent in quality objective Monitoring sheet and also disscuss in the quality Team Review Metting.		
1.4.5 Quality policy Quality Policy is prepared by the Medical Superintendent in consultation with the Hospital Quality team 1.4.5.1 Policy is Displayed in Hindi and English Language At below mention areas OPD Area Admin Area IPD Area Etc.	Medical Superintendent	

1.4.5.2 **Hospital staff is oriented about the Hospital Quality Policy** **1.4.6 Training** **<u>Training and CMEs of Hospital staff at defined intervals</u>** • There should be an induction training module for every department. In induction staff is informed about the general organization of the department and about the SOP of concerned / assigned task. • Hospital should invest in training and skill development of their employees as per the need and requirement. • Special training session to be conducted for different category of staff for filling of medical record forms. • Hospital should have a regular program for training of staff in BMW, IC, PPE, Soft Skills, 5 S, PDCA, 6 Sigma, Mistake Proofing, Pareto, Prioritizations etc. • Hospital should maintain record of all training conducted and list of staff trained in each session. • CME's for hospital staff to be conducted on regular intervals. • Capacity building and training of trainers should also be done at regular intervals **1.4.7 Committee for reviewing maternal death and near miss.** 1.4.7.1 Composition of the Committee • Hospital superintendent • Nodal Officer (Obstetrician from the Dept) • At least two obstetricians/MO in OBG department as members • One Anesthetist • One blood bank MO • Nursing representative • One physician • Periodicity Monthly and as and when required. • Report is prepared in such a manner that it should not only reflect the event but it should create some knowledge and experience for use in future (So as to avoid similar incidence in future). • Finding to be communicated to the department for remedial action.	Quality-Nodal officer HOD of concerned department for induction and M.S/Concemedin charge for training and CMEs	Induction register Training Register CME Register Maternal Death Review Guidebook,NRHM http://www.nrhmorissagov.in/writereaddata/Uploaded/Documents/Maternal Near Miss operational.Guidelines.pdf http://www.wbhealth.gov.in/notice/guide child death review.pdf

Note: CCTV footage wherever available should be examined; as it provide valuable information and evidence about the sequence of events of the case. ❖ **Committee for Reviewing Newborn death** • Composition of the Committee • Hospital superintendent • FNO (Pediatrician) • One Anesthesiologist • Nurse posted in pediatrics • DNS • Periodicity Monthly and whenever a child death is reported • Report is prepared in such a manner that it should create some knowledge and experience for use in future (So as to avoid similar incidence in future). • Finding to be communicated to the department for remedial action. Note: CCTV footage wherever available should be examined as it provide valuable information and evidence about the sequence of event of the case.		
1.4.8 Committee for Medical and death audit • Composition of the Committee • Medical Superintendent • MRO/I/c MRD • HOD of all Major department for remedial action. **Sample size: As per Annexure 11** **1.4.9 Drug and therapeutic committee for Prescription audits** • Composition of the Committee • Medical Superintendent • Hod's of all Major Department • HOD pharmacy/Ic pharmacy • Periodicity Monthly • Action Taken Report/Advisory Collection of Prescription sample size finding to be communicated to the department for remedial action		**Annexure:6&7, Format for medical and death audit** **Annexure:8,** Format for Prescription Audits

1.4.10 Patient satisfactory surveys(PSS) 1.4.10.1 PSS Conducted at periodic intervals • PSS shall be taken up every month and data collected shall be analyzed. • **Sample Size:** As per the patient load.Statiscally correct sample can be referred from **Annexure** • There shall be one person designated to co-ordinate satisfaction survey. • Result of patient satisfaction survey is recorder and disseminated concerned staff. • Patient feedback form are available in Hindi/English language • Employee satisfaction survey shall be conducted once in a year. • There is producer for analysis of Employee satisfaction survey • There is producer for root cause analysis of Employee satisfaction survey. • Facility prepares the action plan for the areas of low satisfaction.		**Annexure:9 10** IPD/OPD PSS Format **Annexure:11** Details of Methodology and about action are Annexed as
1.4.11 Internal Movement of Document • There is established system for internal movement of documents and communication • General notices and information are displayed at notice board at relevant points. • There is system of removal of old notices and updating		
1.4.12 Equipment Maintenance • The facility has established system for maintenance of critical equipment. • All equipment shall preferably be covered under AMC/CAMC/CAMC shall be done for all costly and life saving equipment. • Hospital shall have established system for		

contract management of Equipment. • There is system to maintain records of down time of equipment.		
1.4.13 Disaster Management • Disaster management manual shall be available with the Casually Medical officer. • Regular training & Mock drill shall be conducted and recorded. • All the Hospital staff should be aware of the Disaster Management plan of the Hospital		**Delhi Dept. of Disaster Management, NDMA**
1.4.14 PURCHASE Hospital procures services and goods by following The policies and procedures laid by the Ministry of Finance/Finance Dept.Govt od NCT of Delhi.		**Policies and procedure for procurement of work** http://www.du.ac.in/du uploads/rti/structureCPWG.pdf **Policies and procedure for procurement of goods** http://finmin.nic.in/the_ministry/dept_expenditure/acts_4ProGod.pdf General financial Rules 2005 Delegation of financial power rules 2012 Delhi

ANNEXURE

GAP REPORT & STATUS (GRS)

Audit Report No.:- **Date of Assessment:-**

Department:-

Name of the Assessor:

Name of the In-charge (Assesses):

(1) S. No.	(2) Non Compliance (Measurable Element No.)	(3) Non Compliance Statement (GAP Statement)	(4) Gap Classification	(5) Severity (Sever/ Moderate/Low)	(6) Action		(7) Timeline	Status Compliance Achieved/Not Achieved
					(6A) Required	(6B) Responsible		
1								
2								
3								
	Partial – Compliance (Measurable Element No.)							
1								
2								
3								
Signature of Auditor :-								
Signature of Auditee :-								

2. DETAILS OF THE DOCUMENT (FIRST PAGE)

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3. AMENDMENT SHEET (SECOND PAGE OF DOCUMENT)

AMENDMENT SHEET

S.No.	page no.	Details of the amendment	Reasons	Signature of the preparatory authority	Signature of the approval authority

4. CONTROL OF THE DOCUMENT (THIRD PAGE OF THE DOCUMENT)

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5. QUALITY OBJECTIVE MONITORING SHEET (SAMPLE)

Sr. no	Quality Objective	Measurable Parameter	Baseline	Target	Timeline	Responsibility	Status Quarter 1	Status Quarter 2	Status Quarter 3	Status Quarter 4
1	To decrease waiting time in OPD	Minutes	45	35	1 year	Staff Nurse	42	40	39	35

6. MEDICAL AUDIT FORM[1]

I – PERSONAL PARTICULARS

1. Ref ID of the Patient File:		
2. MRD reference No:		
3. Age & Sex	---------- Male/ Female	
4. Religion:		
5. Category	APL/ BPL/ Others (Please specify)	
6. Name of Ward/Department:		
7. Admitted through OPD/EMERGENCY (Please tick appropriate box)	OPD	Emergency
8. Date of Admission & time	dd/mm/yy	-------- hrs
9. If referred from another Health Facility (Please tick appropriate box)	Yes	No
10. Name of the Hospital (if transferred-in from another Health Facility)		
11. General condition at time of admission	Critical/ Poor/ Fair/ Stable	
12. Name of Treating Physician/Surgeon:		
13. Provisional Diagnosis on Admission:		
14. Final Diagnosis (Preferably with ICD No.)		
15. Date of Discharge/Transfer-out:		
16. If transferred out, please state the reason		

II ADEQUACY OF DOCUMENTATION:

Sr No	Document	Not Available (Score – 0)	Available – (Score – 1)
1.	Case Sheet		
2.	Investigation Reports		
3.	TPR Chart		
4.	Input/output Chart		
5.	Consent Form		
	Average Score		

[1] Not to be initiated for Medico-legal cases

III. RECORD KEEPING: [2]

Sr No	Notes	0	1	2	3	4	5
1.	Personal Particulars						
2.	Notes on Admission						
3.	Records of daily round by doctor(with date and time)						
4.	Pre Anesthetic Check up(If applicable[3])						
5.	Operation Notes(If applicable)						
6.	Post Operative Note (If applicable)						
7.	Discharge/Referral Summary						
8.	Follow up instructions						
	Total						
	Average Score						

IV. ADEQUACY OF CLINICAL CARE:

[2] Quality of Inputs/ clinical note writing. Excellent – 5, Very good – 4, Good – 3, Fair – 2, Satisfactory – 1, Poor - 0

[3] If Not applicable please leave this row as blank. Please do not enter '0', if this is not applicable.

Sr No	Notes	0	1	2	3	4	5
1.	Time-lag between admission and specialist consultation (if indicated)						
2.	Period between admission and availability of Investigation reports						
3.	Adequacy of Investigations						
4.	Time-lag between presumptive diagnosis and final diagnosis						
5.	Prescription of Generic Drugs						
6.	Blood transfusion (any delay)						
7.	Timeliness of decision for discharge/ transfer - out						
	Total						
	Average Score						

V. OVERALL SCORE:

	Average Score	Weightage	Formula	Total
1. Adequacy of Documentation		15%	Average Score x15/5	
2.Record Keeping		20%	Average Score x20/5	
3.Clinical Care		65%	Average Score x65/5	
Score Percentage				

VI. Recommended actions -

VII. Signatures of Audit Committee Members -

7. DEATH AUDIT FORM

Name of the Hospital……..

1. Case Details-

a)Ref. ID of the Patient:…… b).Age: ..... c) Sex: .....

d) Date of Admission: ..... e) Time of Admission ……

f) Date of Death: ..... g) Time of Death……

(h) Admitted through (Emergency/OPD)……..

h) Death Occurred At : (Ward/ OT/ Emergency/Labour Room/ICU/Other)…….....

2. Cause of Death:

	S. No.	Cause of Death	ICD10 Code	Approximate interval between onset and death
Underlying cause of death				
Disease or condition directly leading to death *	(a)	…….. due to (or as a consequence of)		
Antecedent caused Morbid conditions, if any, giving rise to the	(b)	…….. due to (or as a consequence of)		

above cause, stating the underlying condition last	(C)	…….. due to (or as a consequence of)		
Contributory conditions				
Other significant conditions contributing to the death but not related to the disease or condition causing it.		…… …… ……		

**This does not mean the mode of dying, e.g. heart failure, respiratory failure. It means the disease, injury or complication caused death.*

3. Method used for confirming the Clinical Death

	Method	**Yes**	**No**
a)	No Pupillary reflex		
b)	Pupils Fixed & Dilated		
c)	No Peripheral or Central Pulsation felt		

	Procedures	Yes	No	Details
a)	History Taken			
b)	Examination Done			
c)	Provisional Diagnosis arrived			
d)	Investigations Ordered			
e)	Treatment/Instructions given			
f)	Treatment/Instructions followed by nursing staff			
g)	Time taken to start the treatment after arrival of patient/ Development of Complication			
h)	Was there any delay in providing the treatment? If yes, elaborate the cause			
i)	Was consent Taken before procedure/Treatment			
j)	Was police informed in case of MLC			
k)	Was MLC documented			
l)	Was prognosis explained to the patient relatives			
m)	Was CPR given			
n)	Patient Records depicts continuity of care			
0)	Death notes written on BHT at the time of death			
p)	Was Patient referred from some other facility. If yes give the details.			

4. Treatment Details –

q)	Was consultation taken from other specialists for treatment			
r)	Was patient required referral to higher center. If yes why patient couldn't			
s)	Was treatment given appropriate according to clinical protocols			
t)	Was there any misjudgment in diagnosis and deciding treatment line?			

5. Adherence to Death Protocol –

	Procedure	**Details**
a)	Who Declared Death	
b)	Who among the next of kin was given information	
c)	Body packed with hospital or patients linen	
d)	Where body was kept before handed over to kin/police	
e)	In the case of MLC Body handed over to Police	

6. Root Cause Analysis-

	Causes	**Description**	**Explanation**
	Man		Skill Gaps, Lack of Adequate Manpower, Lack of coordination etc.
	Machine		Non availability of any equipment, equipments not working, obsolete equipment
	Method		SOPs, Protocols, Standard Precautions
	Material		Drugs, Medical Gas, Regents, consumables
	Measurement		Any error in measurement, Diagnosis
	Environment		Physical environment, Patient relatives, any other outside intervention

7) Inference of Root Cause Analysis -

……

……

……

8) Remarks for Improvement

……

……

……

9) Name & Signature of Members of Audit Commitiee

Name	**Signatutre**
1.	
2.	
3.	
4.	

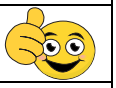
Date of Audit: ……; Time: ……..

S. NO.	Item	Yes /No		Score achieved	Remarks
1	Complete Name of the client	1	0		
2	Age in years (≥ five in years) In case of < five years (in months)	1	0		
3	Date of consultation-day/ month /year	1	0		
4	Sex of the client	1	0		
5	Legible handwriting	1	0		
6	OPD Registration Number	1	0		
7	**Medical component**	Xx	Xx		
i.	Presumptive / definitive diagnosis written	2	0		
ii.	Brief history Written	1	0		
iii.	Salient features of Clinical Examination recorded	1	0		
iv.	Investigations advised	Yes	NO		
v.	Medicines advised mostly available in the Dispensary	Yes	No		
vi.	Medicines advised partially available in the dispensary/Medicines advised not available in the Dispensary	Yes	No		
vii.	Dosage schedule / doses clearly written	1	0		
viii.	Duration of treatment written	1	0		
ix.	Date of next visit (review) written	1	0		
x.	In case of referral, the relevant clinical details and reason for referral given	1	0		
xi.	The required precautions / do's and don'ts recorded	1	0		(If none required then also gets 1)
xii.	Prescription duly signed (legibly)	1	0		
	Total Score				

For items recorded correctly , appropriate score is awarded . For items 7 iv, v, vi no score shall be given but the response shall be recorded as yes / no.

3. Recommendation of the members of the committee 4. Signature of the members of the committee

आई0पी0डी0 रोगी प्रष्नावली/फीडबेक

	सूचक	निम्न स्तरीय	सामान्य	अच्छा	बहुत अच्छा
					
1	अस्पताल में पर्याप्त सूचनापट्ट व विभागों, दिशा आदि की सूचना				
2	पंजीकरण कराने में कुल समय	30 मिनट से ज्यदा	10–30 मिनट	5 मिनट मे	तुरंत
3	रजिस्ट्रेशन काउंटर में अस्पताल के कर्मचारियों का व्यवहार				
4	डिस्चार्ज प्रक्रिया (यदि सतुष्ट नही तो नीचे सुझाव दें)				
5	वार्ड की साफ–सफाई का अनुभव				
6	शौचालय व स्नानघर की साफ–सफाई				
7	चादर/बेड तकिया कवर की स्वच्छता				
8	अस्पताल परिसर व नालियों की साफ–सफाई				
9	डॉक्टरों द्वारा नियमित जांच व देखभाल				
10	डॉक्टरों द्वारा मरीज के प्रति व्यवहार				
11	जांच/परामर्श, सलाह में दिये गये समय संतुष्टि				
12	सेवा उपलब्ध कराने में नर्सों की शीध्रता व सजगता				
13	वॉर्ड में 24 घंटे नर्सों की उपलब्धता				
14	नर्सों द्वारा मरीज की प्रति व्यवहार				
15	वॉर्ड बॉय/महिला (कर्मचरियों) की उपलब्धता व उनके द्वारा मरीज के साथ व्यवहार				
16	अस्पताल में दवाई की उपलब्धता				
17	अस्पताल में जांच : लेब जांच एक्सरे इत्यदि की उपलब्धता				
18	अस्पताल में भोजन वितरण की समयबद्धता				
	अस्पताल में दिये गये भोजन की गुणवत्ता				
19	अस्पताल में दिये गये उपचार व सेवाओं सं संतुष्टि				

1 इस अस्पताल व इसकी सेवाओं में सुघार के लिए सुझाव

2 इसी अस्पताल में ईलाज के लिए आने का कारण

3 क्या आप इलाज के लिए इस अस्पताल की सेवाओं को पुनः प्राप्त करना चाहेंगे

दिनांकः आयुः लिंगः पुरूष/महिला आई0पी0डी0 नम्बरः फोन न0

11.PSS METHODOLOGY

Methodology

Patient/Client satisfaction surveys are the integral part of Quality Improvement program at facility level. It gives the valuable information about patient perception and experience about the quality services, which of course will guide service providers to further improve the processes and service delivery. Apart from taking patient feedback a Patient Satisfaction improvement program includes analysing feedback given by patients, root cause analysis to identify the causes of low satisfaction, preparing action plan and taking corrective actions to complete the continual improvement cycle (Plan-Do-Check -Act). Following is a brief description of different steps for patient satisfaction program.

1. **Plan** –
   a. **Periodicity**- Plan for frequency of Patient Satisfaction Survey. Large secondary care hospitals like districts hospitals can have survey on monthly basis. Smaller facilities like PHC and CHC may take patient satisfaction on quarterly basis.
   b. **Stationary** – Translate patient satisfaction survey in local language and ensure that formats are available in adequate no. at OPD clinics/registration counter/May I Help you desk and Nursing station in ward. The above-mentioned formats can be used for conducting outpatients and In-patients satisfaction survey.
   c. **Responsibility-** Designate who will be taking and collecting feedback. Hospital Manager / Quality Manager may be responsibility to coordinate the program
   d. **Sample Size –** For getting valid results sample size should be adequate. Following table gives simple guidance how much should be the Sample size based on patient load in previous quarter. It should not be less than 30 for being statically valid.

Population (OPD Attendance/ IPD Admissions)	Sample Size (Number of patients to be surveyed)			
	Margin of Error -10% Confidence Level -90%	Margin of Error -10% Confidence Level -95%	Margin of Error - 5% Confidence Level -90%	Margin of Error -5% Confidence Level -95%
10	9	9	10	10
20	16	17	19	20
50	29	34	43	45
100	41	50	74	80
200	51	66	116	132
300	56	73	143	169
500	60	81	176	218
1000	64	88	214	278
3000	67	94	249	341
5000	67	95	257	257
10000	68	96	264	370
15000	68	96	266	375
20000	68	96	268	377
30000	68	96	269	380
50000	68	96	270	382
100000	68	96	270	383

2. **Do-**

Patient feedback should be taken as per decided plan and sample size. While taking feedback it should be taken care of that all departments are equally covered specially the services having high case load like ANC clinic, Maternity ward etc. Feedback should also represent patient those can not give feedback by their own like illiterates, disabled and

children's through affirmative measures like verbal feedback from illiterate patients and feedback from parents for new-born and children. Exit feedback should be preferred from who have already availed the services e.g. Like at Pharmacy counter for OPD and at the time of discharge in IPD . Filled forms should be collected and submitted to coordinator.

3. Check – Feedback collected should be collated and analysed. Analysis should generate overall as well as area/attribute wise score. Lowest performing two attributes should be identified and root cause analysis should be done for them.

4. Act- Action plan should be prepared on causes identified during root cause analysis including corrective and preventive action to be taken, time line and person responsible for taking action. Compliance to action should be reviewed monthly.

Following illustration shows the process and steps of Patient Satisfaction Improvement Program –

Employee Satisfaction Survey Form

Dear colleague

I appreciate your role and contribution in service delivery by our hospital. Your personal views on the followings attributes in the table shall help us in objectively looking at the level of our happiness, wellbeing and motivation and in taking initiatives for their improvement.

Please tick the appropriate box and drop the questionnaire in the Suggestion box

S.No.	Attribute	Poor	Fair	Good	Very Good	Excellent	No comments
1	Distribution of Work load amongst the staff						
2	Clarity of roles` and responsibilities						
3	Housing facility available for Staff						
4	Coordination and cooperation of your co workers in discharging your duty						
5	Building ,Infrastructure of the hospital						
6	Availability of basic office/ working Equipment / tools						
8	Appreciation/recognition for your good work						
9	System for appraisal and Promotion						
10	Opportunities for Training & skill development						
11	The existing Grievance Management system in the hospital						
12	Opportunities for expressing opinion/views on work related topic						
13	Leadership by hospital in charge						
14.	Availability of personal protection equipments (Gloves, masks etc.						
14.	Availability of amenities like clean toilets , drinking water and Air Cooling/heating						
15.	Security and safety of staff in the hospitals.						
	Overall Score						

2-SOP FOR HUMAN RESOURCE MANAGEMENT

2.1 Purpose:

To provide guideline instruction for efficient and effective management of the Human Capital of the hospital.

2.2 Scope:

Extends to all employees working under the purview of the hospital and includes both permanent and outsourced staff.

2.3 Responsibilities :

The manual establishes uniform policy for management of Human Resource in the hospital for the implementation of the specified policy and procedures.

2.4 Manpower Planning:

Responsibility for manpower planning for the hospital rests with the Ministry of Health and Family Welfare , Government of Delhi. The authorities at the state ensures availability of the right mix of manpower required to provide quality healthcare services taking in to consideration the patient load, number of beds, number and type of procedures, type and level of care, specializations, infrastructure etc The assessment of manpower requirement in each department/division is periodically reviewed depending on increase or decrease of workload, technological changes or any other relevant factor. In case any new staff is required to effect continuity of care either directly or indirectly, the same is communicated to the state authorities who are responsible for the approval and provision of the required manpower. The documents related to the staff assessments as well as approvals are maintained separately as an essential element of the manpower planning process.

2.5 Credentialing Policy:

The Health and Family Welfare Department has defined pre-requisite qualification for each and every position to be filled. The criteria includes the basic educational qualification required for the each and every position ,experience if any required , registration with professional bodies (such as MCI , NCI etc), special qualification in terms of training etc. It is mandatory to follow the credentialing policy for filling any vacant post either by external recruitment or by internal recruitment .The policy also identifies the need for verifying the credentials so as to ascertain their genuinity and thereby avoid any fraudulent practices. Usually every employee is required to submit attested copy of the credentials as per the policy.

2.6 Classification of Employees:

The hospital employees are classified into two broad categories:

a) **Permanent Staff** – The permanent staff of the hospital are grouped in four classes as per the educational qualifications, experience, seniority level, nature of work etc of the individual staff. The four class are as follows :

- Class 1
- Class II
- Class III
- Class IV

The decision in relation to inclusion of an employee in a particular class depends on the policy of the primary employer i.e. the Ministry of Health and Family Welfare. How ever the above mentioned criterias provides the necessary guideline for such decisions.

b) **Probationers** - Any newly employed staff recruited by the Ministry of Health and Family Welfare for the hospital is usually placed on a probationary period which varies according the position in which the staff is employed.

c) **Outsourced Staff**: - The hospital employees outsourced staff who can be further classified as :

- Contractual staff under the purview of Ministry of Health and Family Welfare, Government of Delhi.
- Staff outsourced from the Hospital (Government sponsored NGO).
- Staff outsourced from other NGOs like the Red Cross Society, District Blindness Care Society etc.

d) **Nature of Staff Outsourced:** -

The types of staff outsourced by the hospital are specified below:

- Specialist Consultants 1-9
- Paramedical Staff
- Nursing Staff
- Administrative Staff
- Dietary Services Staff
- Security Staff
- Sweepers, etc.

e) **Deputation** : Inorder to cope with immediate shortage of staff or as and when necessary the Ministry of Health and Family Welfare deputes the required manpower periodically to satisfy the need of the situation. However it is generally ensured to provide for permanent manpower (if hence required) once the immediate need is satisfied.

f) **Trainees**: The hospital receives trainees periodically for specific time periods.

g) **Contractual Labour** : The hospital employees contractual labours on a daily wage basis for performing various unskilled jobs as and when necessary.

2.7 Recruitment of Staff

The recruitment of staff for the hospital (excluding outsourced staff as mentioned) is carried out by the Ministry of Health and Family Welfare, Government of Delhi. All vacancies arising out of creation of new positions, consequential vacancies on account of internal lateral / vertical movement, transfer ,retirement , resignations etc are communicated to the state authorities who after due consideration undertakes the necessary steps to fill the gaps either by internal promotions , transfers (internal or external) , deputation or by fresh recruitment .

Positions which are outsourced and are to be filled at the hospital level, the creation of vacancy is notified to the appropriate outsourcing authority who is responsible for filling the vacant (existing /new) position.

a. Procedure:

The recruitment of the staff by the State Authorities is done following the policy and

procedures as per the guidelines of the State Authorities.

Incase of outsourced staff, the respective authorities through which the staff is to recruited is responsible for conducting interviews as per their policy. However prior to the actual job placement of the selected staff in their respective positions, they are evaluated by the M.S / Add M.S to ascertain the suitability of the selected staff for the position. This is done to ascertain whether the staff is competent enough to assume the responsibilities within the ambit of the position and thereby monitoring the quality of staff recruited by the outsourcing organization.

b. Appointment:

The respective recruiting authorities (example the Health and Family Welfare Department – Government of Delhi, Outsourcing agencies etc) are responsible for the appointment of the designated staff. All the appointment related procedures are satisfied as per the policy of the specific authorities. A detailed verification of the candidate's educational qualifications, experience, background etc is carried out by the respective authorities prior to their actual job placement.

All the employees recruited by the Health and Family Welfare Department are required to undergo a mandatory pre-employment medical check up .They are also required to submit name and contact two person who could be contacted for reference about the candidate .It is also the policy of the department to conduct police verification of the candidate incase required .Only after satisfactorily clearing all the appointment related formalities along with

the medical check, the appointments letters are issued to them. Incase of staff outsourced, the hospital conducts pre-employment check up prior to the job placement of the staff.

All employees recruited by the Health and Family Welfare Department are given a copy of their job responsibilities, service conditions, benefits and other employment related issues .The staff recruited for positions which are outsourced are given a copy of their job responsibilities after they are interviewed by M.S / Add M.S.

c. Induction:

The hospital conducts induction program for the all newly joined employees including those who are placed on deputation to acquaint them with the hospital , its mission and vision , its policies , its organization structure , management personals , employee rights and responsibilities etc.

Induction training provide by the hospital is a half day affair and is conducted as and when required.

d. Employee Orientation:

In order to get the employee started on a positive note and to provide them with required knowledge to perform their job, each individual employee is oriented at the specific departmental level.

The orientation training is provided to the employee at the department under the supervision of the respective department in-charges. During the course of orientation training the newly staff is trained on the various systems and procedures, protocols followed by the department in discharge of their daily duties .On successful completion of job orientation, it is expected that the newly joined staff has acquired the requisite capabilities to perform the duties and responsibilities attached to the job/position.

e. Performance Management:

The hospital management prepares and forwards a confidential report (CR) on annual basis for each employee of the hospital under the purview of Ministry of Health and Family Welfare, Government of Delhi.

The Confidential Report (Ref Confidential Report Format #) is a detailed report relating to the performance of the employee against certain preset criteria including the trainings attended by the concerned employee over the last one year period .The Confidential Report is an objective method of evaluating the performance of the employee which the Health and Family Welfare Department takes into consideration for decisions relating to promotion , transfer ,increments and in formulating training plan for the different class of

employee. However the Confidential Report is not the only objective criteria for such decision, length of service of the concerned employee is also taken into consideration while such decisions are taken. While the focus is on reducing subjectivity and enhancing objectivity so as to achieve fair appraisal of performance, it is also used as a tool for assessing the strengths and weaknesses as well as the potential of the employees.

2.8 Service Conditions:

Each employee is governed by the terms and conditions of his service as laid down in the service rules book (Ref: Service Rule Book) of the Health and Family welfare department , Ministry of Health and Family Welfare – Government of Delhi. The Service Rules are made available to each employee on joining the service. The service conditions contain broadly training, period of probation/extension, leave, working hours, attendance and punctuality , promotion and transfer criteria, grievances redressal, misconduct, sexual harassment, disciplinary actions and procedure, separation etc.

a. Training: The management has to recognizes the importance of providing adequate training to the staff for empowering them with skills which would improve their work performance. Need for training is also identified when there is a change in technology or an employee is transferred or promoted to a position carrying new/additional responsibilities .Training aspect also includes induction and job orientation training provided to each new employee .The hospital has a detailed training manual which explains the hospital's policy in relation to training and development of its staff (Ref # Training and Development Policy:).

b. Terms of Employment: Prior to the joining of the employee, details relating to his terms of employment such as his period of probation/training, compensation package during training period and post training period, employee benefits like provident fund, HRA, medical benefits, leave, transfer and promotion criteria, procedure for reimbursement of official tours and allowances accruing to such tours etc are informed to them and a service rule book in this regard is provided.

c. Disciplinary Actions and Grievance re- addressal :

The service rule book clearly states the disciplinary actions that can be observed against the employee for any misconduct or negligence in work performance and the procedure for such action incase any discrepancy is found in the employee .The disciplinary actions is based on the principle of natural justice and is an objective process. All efforts are made to

ensure that there is no subjectivity in any disciplinary action taken against the employee and the employee is given a fair chance to protect his/her shelf. The employee has the right to appeal to the appropriate higher authorities incase they are not satisfied with the decision taken by the lower level authority. The service rule books also address the issue of staff grievance readdressal procedure which aims to establish an effective mechanism to readdress employee grievances. The grievance reddressal procedure is explained to each and every employee at the time joining duty. Ministry of Health and Family Welfare, Government of Delhi has formulated a Grievance Redressal Mechanism for all the employees working its healthcare facilities. Hospital abides by the above mentioned procedure to readdress the grievance of the employee. The procedure advices the Head of the Department, Supervisors etc from time to time to put in their best efforts, to examine the grievances submitted in a better manner at different stages and redress the grievances expeditiously. The genuine grievances of the employee are attended to by the managerial personnel in a well established manner and this procedure i.e. Grievance Redressal Procedure An employee who has a grievances can take up the matter with his immediate superior who shall after due consideration shall dispose of the same within twenty four hours of bringing to his notice for redressal.In case the head of the department or immediate superior is unable to resolve the matter within twenty four hours, it shall be referred to the Human Resource Management Department of the hospital who after due consideration forms a committee under the chairmanship of the M.S / Add M.S to resolve the issue. If the committee is unable to effectively readdress the employee grievances at the hospital level, the employee has the right to seek readdressal from higher level authorities. The procedure is explained in detail in the Service Rule Book of the employee.

2.9 Employee Health:

a. Pre-**employment check up** - The health and family welfare department recognizes the importance of a healthy workforce to provide the desired services to the public. Hence it is mandatory for each and every new selected candidate to undergo mandatory pre-employment check. Only candidates found medically fit **are** given the appointment letter .The record of the same is documented in the personal file of the employee. Apart from the permanent employee of the hospital for whom it is mandatory to under go pre-employment medical check as per the policy of the Health and Family Welfare Department, Hospital, has to make it mandatory for all the contractual employees also to under go pre-employment medical check up. The basic aim is to have a healthy workforce capable committed and fit to provide the required health care services (directly or indirectly) to the public.

b. **Annual Medical Check up and Vaccination Drive**: Hospital has to introduce a system to undertake an annual health check up of all its employees so as to assess their level of fitness and a record of the same is maintained in the personal file of the employee. The hospital also conducts1-9 periodic vaccination program for its employees such as vaccination against Hepatitis B, Tetanus etc and a record of the same is documented.

c. **Occupational Health and Safety:** he hospital Management has to quality work environment by taking adequate preventive measures to reduce occupational health hazards. In so far as safety of the employees in the work place is concerned the hospital has laid down policy with regard to protection against fire, infection control, handling of dangerous equipments, safety against exposure to radiation. Similarly employees who are exposed to patients and those required to handle waste are given proper training in handling the waste as well as universal precautions.

   In case of accidents or injury sustained by employees while at work immediate medical attention would be directed The Service Rule Book addresses such incidents and the procedure to be followed in details. The entire hospital premise is strictly declared as no smoking zone. As regards evacuation of employees incase of emergency due to fire, natural calamity or any disaster, these matters are covered in detail.

2.10 SUPERANNUATION:

Every employee shall compulsory retire as per the policy of Ministry of health and Family Welfare, Government of Delhi on a date:

- Attains the age of 60 years
- Is declared medically unfit

However an employee may be given an extension post retirement if found medically fit and is willing to continue with the responsibility. The length of such extension would be decided by the Health and Family Welfare Department

2.11 INVOLUNTARY SEPARATION:

Procedure regarding involuntary separation i.e. other than resignation is laid down in the service rules which deal with misconduct, disciplinary action and termination of service.

2.12 PERSONAL RECORDS

The Establishment department shall maintain a personal file of each employee with records relating to his employment , educational qualification , health status , registration with professional bodies , training record , warning or disciplinary actions taken if any , appointment letter etc.

However it is the policy of the Health and Family Welfare Department to preserve the confidential reports (CR) separately as it is very confidential in nature and has very limited access.

3-SOP FOR LAUNDRY SERVICES (IN-HOUSE)

3.1 Purpose:

To provide process, instructions and methodology for Management of Laundry process in the hospital with the aims that

- Safe and dependable supply of clean linen
- Safety to workers
- Minimization of inventory loss

3.2 Scope:

This applies to the management of hospital's linen ensuring adequate cleaning of the linen for better hygienic hospital environment and their proper accountability.

3.3 Responsibility

Nursing Superintendent is directly responsible for this process; she is responsible for Availability of adequate linen stock and Timely supply. Laundry service is outsourced

3.4 Collection of Laundry Items:

Soiled linen is collected and fetched from various departments by the housekeeping staff, register is maintained by Nurse in charge.

The linen consist of

- Bed linen
- Body linen
- Operation theatre linen
- Staff linen
- Department/service linen.

After linen is collected, these are segregated as area wise and record of this maintained.

Aprons, staff uniforms etc are kept separate from the other linens and are packed separately.

3.5 Autoclaving of the linen:

All hospital linen is autoclaved for disinfection prior to washing.

Linen from OT, wards etc soiled with blood and other body fluids are washed in the dirty utility area of the respective point of generation for removal of the stain and are then send for autoclaving.

3.6 Collection of Linen for washing

After autoclaving the linen, the same is the collected by the outsourced agency providing laundry services.

The matron in charge is responsible for keeping an account of the number and type of linen taken by the outsourced agency for washing. A register containing details regarding the type of linen, their number, respective ward/unit from where they are collected etc.

3.7 Delivery of Washed Linen:

The washed linen are delivered in the linen store by the outsourced agency.

The matron in charge is responsible for physical verification of the linen at the time of delivery by cross matching the same with the details entered in the concerned register.

This is done to ensure that there is no discrepancy with the number , type of linen and their condition etc as entered in the register while collection of the same by the outsourced agency for washing.

3.8 Returning the Linen collected from Wards

The linen is returned to the user departments by the housekeeping staff of the hospital and record of the same is entered in the concerned register.

3.9 Condemnation

a. The Laundry Condemnation Committee:

- Medial Superintendent
- Nursing sister
- MOI/c General store
- MOI/c Laundry
- Nodal officer of all departments
- Nodal officer NABH

b. Condemnation Procedure:

- The committee will meet once the identification and segregation of torn, unusable badly soiled linen comprising of bed sheets, pillow covers, gowns, draw sheets, towels, blankets, shoe covers is complete.
- The committee will inspect each and every item of linen meant for discard and recommend for their condemnation and replacement.
- List of items approved for condemnation has to be prepared by matron incharge for linen.
- The committee will be empowered to approve the condemnation of linen.
- At the time of purchase of linen, the life of each category of linen items should be procured from the supplier. This will be a mandatory provision while placing the purchase orders. Linen items approaching expiry should be segregated and inspected by the committee to decide further course of action; i.e. whether to write off or recommend their use for further specified time.
- A condemnation certificate will be issued by the committee duly signed to the laundry section. After getting the certificate, the stores section will be requested to take appropriate steps for the proper disposal of the condemned linen.

- The laundry and purchase sections should ensure procurement of good quality detergent, soap, bleach, etc. to avoid undue damage to the linen.
- Replenishment of linen items condemned by the committee should be immediately done by the general stores in order to maintain adequate inventory level and to ensure smooth functioning of the hospital services.

4-SOP FOR LAUNDRY SERVICES

4.1 Introduction

Laundry is a support service which ensures, prevention of hospital infection but also contributes to improving the image of the hospital in the eyes of public.

4.2 Aim

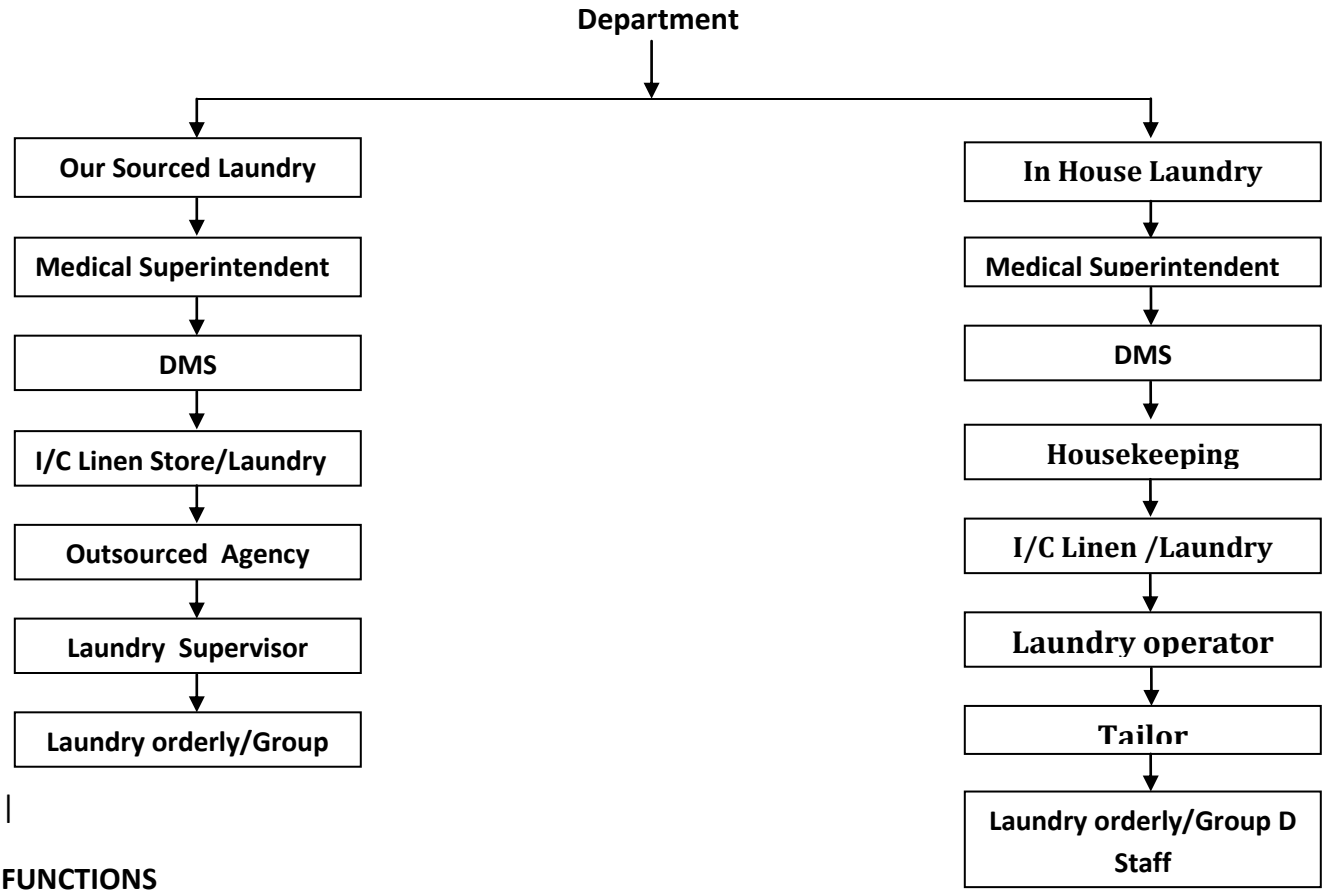
The aim of the Laundry Department is to provide adequate supply of clean linen to all the hospital departments conforming to highest standards of cleanliness and hygiene immediately and constantly for routine and emergency use from a central place.

4.3 Objectives

The objectives of the Laundry Department are as follows:

- To ensure adequate supply of linen to user departments as per requirement.
- Provide linen free of dirt and stains to all User Departments.
- Take steps for prevention of cross-infection.
- Monitor and enforce controls necessary to prevent spoilage (wear & tear due to washing) of linen and reduce the frequency of linen turn over by increasing its lifeperiod.
- Maintain record of effectiveness of cleaning, disinfection and turnover.
- Stay updated regarding developments in the field in the interest of efficiency, accuracy and provision of better patient care.

4.4 DEPARTMENTAL STRUCTURE OF LAUNDRY DEPARTMENT



FUNCTIONS

Functional flow of activities in Laundry is as follows:

(a) Receipt of Articles:

To receive used and dirty linen from various user departments like operation theatres, ICUs, emergency, IPD, OPD and radiology etc.

(b) Cleaning & Disinfection:

All reusable linen is thoroughly cleaned with bleaching powder/ caustic soda and disinfected using disinfectants depending upon the type of linen.

(c) Washing:

After disinfection linen is washed in the washing area by following proper guidelines.

(d) Inspection and Assembly:

Each item to be washed is inspected for wear & tears, defects, stains and then appropriately put in the washing machine. After washing, the linen is drained off for excess water using hydro extractor and dried in drier before assembling for press in the pressing machine. The operation of the machines shall be entrusted to responsible and fully trained person. It should be kept in a state of good maintenance and repair.

(e) Clean Linen Storage :

Clean linen is stored in the central linen store. Clean storage environment is designed primarily to prevent contamination of Clean Linen.

(f) Distribution:

Refers to distribution of clean goods to the patient care areas and ge: Clean linen is stored in the central linen store. Clean storage environment is designed primarily to prevent contamination of Clean Linen.

STANDARD OPERATING PROCEDURES

A. Segregation of linen: Segregation of linen is done at source as per below mentioned categories:

Safe Handling of used linen

Linen must be handled and segregated as follows in different color coded bags]: Bag Color Linen Type

1. Green	1. Dirty linen
2. Yellow	2. Soiled linen and infected linen

There should be minimal handling of infected linen and if it is to be handled, PPE should be used by the handlers.

B. Collection of linen and internal transportation of linen:

Every morning, the Laundry attendants go to different areas and collect the dirty linen bags in linen transport trolleys. There must be separate trolleys for transporting clean and dirty linen. The trolley used for transporting dirty linen should have two compartments for carrying dirty linen in one and soiled & infected in the other.

Whenever the attendant collects the linen, the number of different types of linen items received is entered in the record by the Sister I/C of the concerned area. A separate register has to be maintained in different areas for the same. Linen transport trolleys should be closed.

C. Washing of linen:

1. Soiled & Infected Linen:

Sluicing is carried for removing heavy soil by putting the linen in the sluicing machine. The linen is treated with hot water and for stain removal & disinfect chemical (bleaching powder) are used depending upon the type of stain.

- At 65 degree Celsius the wash cycle is for ten minutes.
- At 71 degree Celsius the wash cycle is for three minutes.

After rinsing the sluiced linen is wash as normal. If sluicing machine is not available, then it can be done manually after using proper PPE.

D. Dirty Linen:

Dirty linen (non infected linen) is to be washed in the first batch . Before washing linen should be weighed and each batch should weigh less than or equal to the established guidelines of the washing machine. Water temperature should be checked on a daily basis, if not as per requirement the same is to be reported to the Hospital administrator for further action.

E. SOP for drying and extracting:

- Purpose is to remove the excess water from the washed linen.
- Ensure weight of the batch of linen is as per the guidelines provides for the extractor.
- The dryer enables to remove moisture from the linen, at set temperature.
- Ensure that the dryer is working as per standards and the heat generated is accurate.
- Each and every piece of linen should be checked for damages, and damaged pieces should be handed over to the linen supervisor.

F. Mending of linen

- After washing and drying of the linen, linen with minor defects or which needs repair is segregated.
- Linen with minor defects will be sent to the tailor for mending and repair.
- Laundry In charge will receive the linen with major defects (after wash) and will separately store.
  It for future condemnation as per hospital policy & simultaneously he will stock out such linen from the stock.

G. Ironing

Bed sheets, draw sheets, pillow covers, patient cloths, staff uniforms, table cloths, hand towels etc. are to be ironed through the flat work iron.

H. Distribution of linen:

The clean linen items are stored in the central storage area before distribution. The clean linen is issued to user departments in the linen transport trolleys on the basis of indent raised by the nursing in-charges. This linen is stored in the sub store room of the user department. Record of linen issued is maintained by the central store and record of linen received is maintained by respective sister in-charges.

REGISTER MAINTINANCE:

1) Records to be maintained in Central linen Room: Laundry Supervisor is responsible for maintaining following registers.

- Daily Receipt and dispatch register.
- Stitching and mending record of linen.
- Master stock register : for the available stock and new procurement.

2) Records maintained in the sub stores of the user department: Sister I/C of the concern department are responsible to maintain these registers on daily basis.

- Record of dirty linen sent to the laundry.
- Record of clean linen received from laundry.

3) Condemned items register – to be maintained by linen in-charge determining the items condemned.

4) Equipment register - The Laundry supervisor will maintain an equipment register, where by the down time of the equipment, the repairs carried out and by which party – In-house or AMC, preventive maintenance, calibration.

5) The laundry supervisor will also maintain a register determining the number of laundered, which will be tallied with the stock registered of the Linen supervisor on a daily basis.

QUALITY CONTROL:

a) Evaluation of appropriate staffing levels by skill, position, availability and shifts.
b) Evaluation of appropriate inventory control and physical stock checking.
c) Evaluation of the condemnation and disposal techniques.
d) Evaluation of the working of the laundry equipment.
e) Review of overall quality of laundry services.
g) Patient Feedback

OUT SOURCED LAUNDRY:

(a) ***Collection of linen***:

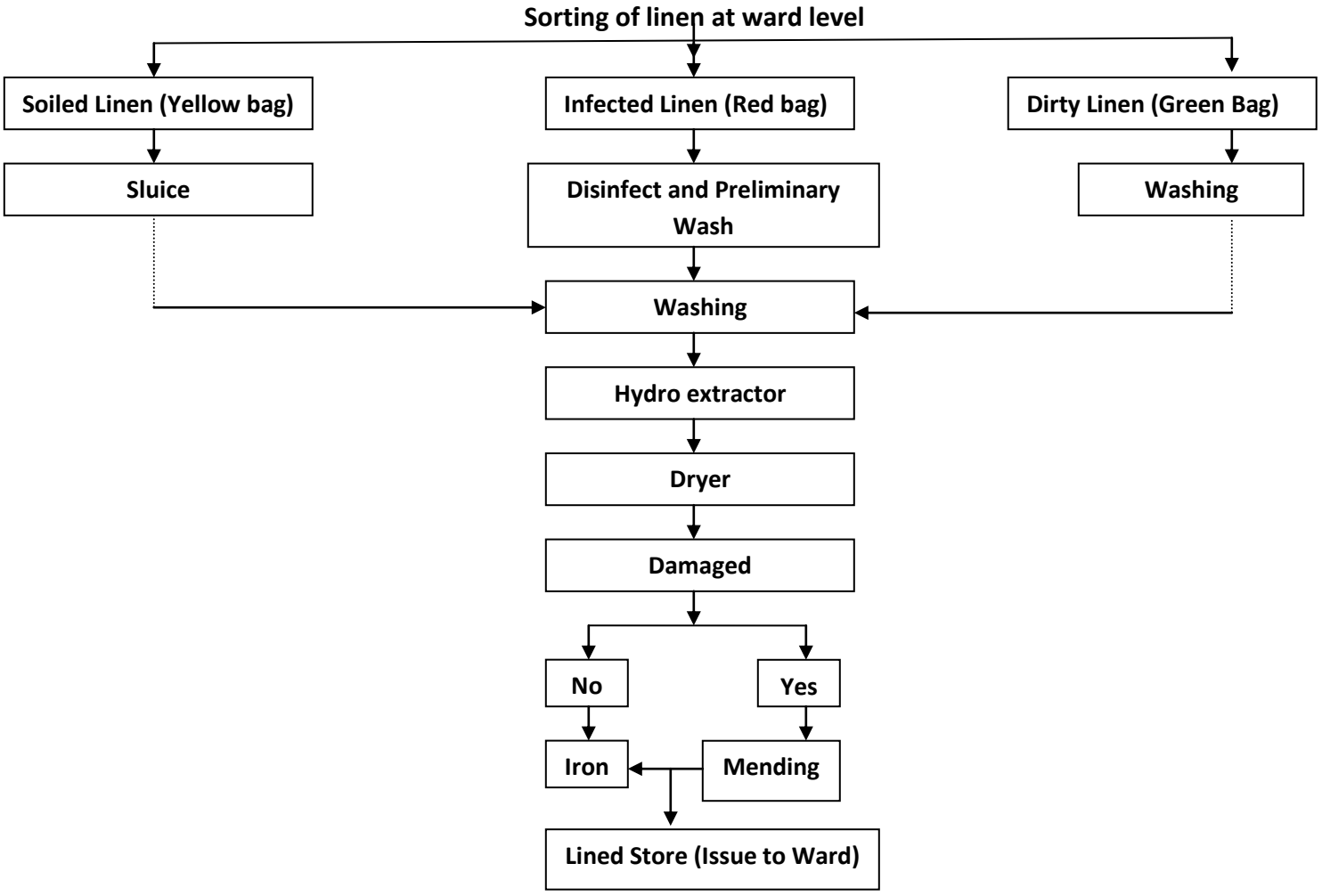
Soiled linen is collected from various departments by the housekeeping staff and register is maintained by Nurse in charge.

(b) ***Delivery of Washed Linen*:**

The washed linen is delivered to the central linen store by the outsourced agency. The linen store in charge is responsible for physical verification of the linen at the time of delivery by cross checking the same with the details entered in the concerned register. This is done to ensure that there is no discrepancy with the number, type of linen and their condition etc as entered in the register while collection of the same by the outsourced agency for washing.

(c) ***Register maintained*:** A laundry issue and receipt register is maintained to keep a track of all items collected for washing by the outsourced agency and delivered back after washing.

ACTIVITY FLOW: The Laundry Department usually works in following manner



QUANTIFICATION OF HOSPITAL LINEN

Hospital should have 6 sets of linen per bed. It is calculated as per following:

1. One already in use (on bed).
2. One ready to use (in sub store).
3. On en-route to laundry.
4. One in washing cycle in laundry.
5. Two in stock (in central store).

e.g:

Requirement of linen per bed may be calculated as;

1. Bed sheets : 6 Per bed
2. Draw sheet : 6 per bed
3. Pillow cover : 4 per bed
4. Blanket : 4 per bed
5. Pillow : 2 per bed
6. Mortuary sheet : 6 per bed
7. Patient Dress: 4 pairs
8. Towel: 2 per bed
9. Doctor's coat : 3 per Doctor
10. Doctor's towel : 6 per ward

OT linen, labor room and procedure room linen is determined based on anticipated workload. Thus for a 200 bedded hospital approximately 1200 bed sheets are required.

5-Dietary, Nutrition & Food Services

5.1 Introduction

Department of Dietetics is a paramedical department, which forms an integral part of every in-patient's therapeutic care during their hospital stay.

The main purpose of the Dietary Department is to provide nutritious food to patients such that it improves the nutritional status of a hospitalized patient, keeping in mind restriction of certain nutrients as part of the therapy, by planning meals with the use of nutritional knowledge and to ensure that it is served in an attractive and acceptable manner to all patients admitted in the hospital.

5.2 Scope

The department of dietetics caters to the needs of the patients in the various areas of the hospital. It aims at providing therapeutic diets to all patients admitted in the hospital appropriate to their disease conditions and to counsel patients who are referred to the Dietitian.

5.3 Process Summary

Working of Dietary Department

Process	Description
In patient visit	All in patients are visited daily to ensure that they get therapeutic diets according to their diagnosis.
Out patient diet counseling	Patients' 24-hour diet recall is taken and modified suitably to achieve the required restrictions without much alteration in their daily routine.
Translation of diet orders to patient menu	The Individual patient given diet sheets is filled out by sister. The therapeutic diets are mentioned on the diet sheet with the pts. CR No. and bed nos.
Tasting of in patient food	Ward diet sheet are filled by sister in the general wards therapeutic diets according to the patient diagnosis. The food prepared is tasted and evaluated based on their taste, appearance, and texture. Special remarks are added when necessary.

The diet sheets are prepared by the ward sister Incharge / staff one day advance. Diet sheet is filled according to the general diet patient & therapeutic dieted patient & in the same manner the children ward also. for children also. In general diet, 3 types of diets are give of patients.

1. Chappati Diets
2. Rice Diets
3. Khichri Diets

Therapeutic diets include

1. Diabetics Diets
2. Low Protein Diets
3. Liquid Diets
4. High Protein Diets
5. Salt Restricted Diets
6. Low Cholestrol & Low Fat Diets

Distribution:

The ward orderly brings their ward trolley with therapeutic trays to kitchen. The therapeutic trays are laid in therapeutic kitchen & the general food is collected in the food trolley and then distributed to the patient in their respective wards.

The distribution slips are given to the head cook which are calculated according to the census of the indoor patients & head cook distribute the slips to the orderly after taking receiving on the master slip and then the food is distributed to the wards.

5.4 Definitions & Abbreviations

5.4.1 Definitions

5.4.1.1 Clear Liquid Diet

Is a highly restrictive diet and is of little nutritive value. The aim of the diet is mainly to provide calories and electrolytes as a means of preventing dehydration and reduce colonic residue to a minimum. Clear liquids include clear, transparent liquids such as Coconut water, Barley water, Arrowroot kanji, Clear soups and strained fruit juices.

5.4.1.2 Full liquid Diet

Is one that includes foods that are liquids or liquidify at room temperature. The main purpose of this diet is to provide oral nourishment that is well tolerated by patients who are acutely ill and who are unable to swallow or chew solid foods or otherwise recovering from a surgery.

5.4.1.3 Semi Solid diet

It is basically a soft diet in a pour able consistency. It includes porridges, thin khichdi, and blended rice with dal, rasam or curd. It is a transition between a liquid and a solid diet.

5.4.1.4 Soft Solid diet

This diet is a diet of soft consistency and includes well cooked, soft and steamed foods like Idli, dal, double cooked rice, soft cooked vegetables.

5.4.1.5 Normal diet

Is a balanced diet including optimum amount of food from each food groups so as to meet the nutritional requirements of the patients.

5.4.1.6 Weight reducing diet/Calorie restricted diet

It is a diet limited in total calories to a prescribed level significantly below normal requirements. Foods highly concentrated in calories like fats and sugars are restricted.

5.4.1.7 Diabetic Diet

Is one in which the dietary intake is carefully controlled day to day; it implies assurance that total amounts do not increase calorie consumption above the optimum level, as well as appropriate consistency in timing, division, amounts and characteristics of carbohydrates consumed.

5.4.1.8 Low fat, Low Cholesterol diet

Is the diet in which both the amount and the type of fat are limited to a prescribed level. These diets are designed to lower elevated levels of serum cholesterol and other lipids in an effort to reduce risk of heart diseases.

5.4.1.9 Salt Free & Salt Restricted Diets:

Are prescribed for patients with renal disorders or cardiac patients where in the salt amount is a restricted quantity per day. For eg. 3g salt restricted, 5g salt restricted etc.

5.4.1.10 Neutropenic Diet

Is a sterile diet which provides only well cooked foods and eliminates those foods which may be potentially pathogenic, such as curd, buttermilk, fresh fruits, fruit juices and vegetable salads. It is advised for people in a post organ transplant state or people under going chemotherapy

5.4.1.11 Renal Diet

Is a normal diet modified in terms of protein, sodium, potassium, fluid content to suit the patient's requirement.

5.4.1.12 Ryles tube feeding

Liquids or blenderized diets designed to provide essential nutrients in a form that will easily pass through a tube. Tube feeding may be conveyed either through naso gastric tube or through a gastrostomy or jejunostomy. They may vary from a homogenized or blenderized mixture of foods selected from a normal diet to food combinations carefully formulated to meet specific therapeutic needs.

5.4.1.13 Total Parenteral Nutrition:

Total Parenteral Nutrition (TPN) is a means by which protein, energy, nutrient, and metabolic requirements are delivered by direct venous infusion for patients who are unable to tolerate, absorb, or accumulate sufficient nutrients by enteral route. Calorie, Protein and Fat requirements are calculated according to the patients BEE, and Consultants decision. The infusion rate is then calculated and Parental products are selected. Care is taken in selection and administration of TPN products, to avoid wastage, as these are very expensive. Administration is done by nurses and Doctors through Central route in TPN.

5.5 Abbreviations

ABBREVIATIONS	FULL FORM
DM	Diabetes mellitus
Cal	Calories
TCW	Tender Coconut Water
CVS	Clear Vegetable Soup
TS	Tomato Soup
ARK	Arrowroot Kanji
OJ	Orange Juice
AJ	Apple Juice
LJ	Lime Juice
PJ	Pineapple Juice
OJ	Orange Juice
SLJ	Musambi Juice/ Sweet Lime Juice
VS	Vegetable Soup
BM	Buttermilk
B.EGG	Boiled Egg
B.VEG	Boiled Vegetable
T	Tea
M	Milk
C	Coffee
SI	South Indian Meal
NI	North Indian Meal
N/D	Normal diet
RTF	Ryles Tube Feed
NGF	Naso Gastric Feeds
NBM	Nil by Mouth
NPO	Nil Per Oral
BMI	Body Mass Index
IBW	Ideal Body Weight

Sweeper **3.2 Job Descriptions**

3.2.1 **Dietician:**

POSITION GUIDELINES
Key areas of responsibility: • Therapeutic care of inpatient dietary needs. • Inpatient and outpatient diet counselling.
Main Job Tasks • Plan menus for inpatients in co-ordination with Sr. Dietician & Dietician • Provides dietary advice during preventive health check clinics/camps • Counsel outpatients referred by the consultants • Visits inpatients on a daily basis and ensures dietary needs are met • Modifies diet to suit pati • Takes steps to ensure that hygiene standards are maintained in the Kitchen • Participate in any programme related to nutrition. • Training of interns

6 Departmental Procedures

6.1 In patient

6.1.1 Diet protocol on admission

6.2 Out Patient

6.2.1 Diet Counseling

7 Departmental Policies:

7.1 Diet prescription and Counseling

Scope: Hospital wide

Distribution list: Dietetics

Policy:

1. Initial assessment
   a. Every patient admitted in the hospital, is met by the Dietitian irrespective of the type of diet he / she is on. (Unless the patient is NPO).
   b. The Dietitian does the nutritional assessment during the ward rounds. (ref: Annexure 1)
   c. Dietician interacts with the treating doctor, patient and patients relatives to help them understand the diet requirements and to plan the nutritional therapy.
2. Prescription
   a. The Dietitian prescribes Nutrition supplements for the in patients when required, and the Nurse indents the same from the pharmacy, out patients are given a prescription.
   b. All patients on liquid diet are given liquids 2nd hourly from 6am to 10pm unless the doctor recommends otherwise.
   c. Ryle's tube feeds are provided depending on the frequency and quantity mentioned by the concerned doctor.
   d. Diabetic patients receive the diabetics diets according to the menu cards but their choice is limited to the set hospital menu. (Unless the dietitian permits otherwise).

e. Special diets like renal diets, bland diets are marked for the patients by the dietitian.

3. **Counseling**
   a. All patients referred by a doctor for diet advice are counseled and given a diet chart at the time of discharge.

7.2 Diet service

Scope: Hospital wide

Distribution list: Dietetics

Policy:

1. Types of Diet Service:
   There are three types of inpatient diet service: (decentralized distribution)
   a. Liquid Diet
   b. Solid Diet
   c. Semi Solid Diet
2. **Liquid Diet Service**:
   a. Is provided to the patients who are unable to take solids following a surgery, in labour or according to the patient's clinical condition.
   b. Patients are served liquids 2nd hourly. There are 9 feeds given throughout the day starting 6am to 10pm unless specified otherwise. Liquid service can be a clear liquid or full liquid.
   c. Liquid Diet Service Timings:
      6am, 8am, 10am, 12noon, 2pm, 4pm, 6pm, 8pm, and 10pm. From kitchen liquid diets are given at the time of breakfast, lunch and dinner.
3. **Solid Diet Service + Semi Solid Diet**
   a. Is provided for the patients who can consume solids. These are again based on patients' clinical and physiological conditions.
   b. Solid Diet Service Timings:

On rising Bed tea	7.30am
Breakfast Mid morning	 7.45am-8.30am
Lunch	12noon – 1pm
Dalia	3pm – 4pm
Dinner	6pm – 7pm

7.3 Nutritional assessment & reassessment

Scope: Hospital wide

Distribution list: Dietetics

Policy:

1. Nutritional assessment will be done for all patients irrespective of what type of diet (eg; normal, diabetic, renal, liquid etc.) they may be prescribed.
2. Reassessment will be done for people on special diets only, as and when there is a diet change (for eg; liquid diet to soft diet, RT feed to soft diet etc)
3. Reassessment will not be done for patients who remain on normal diets through out their hospital stay.
4. Reassessment will be documented in the patients' progress notes.

6. Documents, Templates and Stationary:

6.1 **Documents**

S No:	**Form**	**Area**
1	Kitchen diet order sheet-Master sheet	
2	Liquid diet sheet- Distribution slips	Ward wise
3	Tasteing record	
4	Diet sheet of a ward	

6.2 **Templates**

S No:	**Form**	**Area**
1	Patient Education templates- Diet charts	
2	Nutritional Assessment	

7. **Annexure**

NUTRITION ASSESSMENT SCREENING FORM

Patients name: Diagnosis:

Date of Admission: Consultant:

Age:. Sex: Ht: Wt:

Presence of oedema: Yes / No

Religious beliefs: ……

Diet habit:

Diet prescription instructions by treating consultant:

Evaluation criteria (please tick)

ADULTS	PAEDIATRICS		
Weight loss > 5 kg / month		Unexplained weight loss	

Geriatric , surgery patients > 75 yrs		Multi trauma / stress . sepsis	
Difficulty chewing and swallowing		Malnutrition	
New onset diabetes mellitus		Inborn errors of metabolism	
Renal failure		Renal failure	
Liver disease		Liver disease	
Cardiac disease		Cardiac disease	
Malnutrition of cachexia		Enteral nutrition support	
Multiple trauma, burns or stress		Parenteral nutrition support	
Diarrhoea and / or vomiting > 4 days		DKA / new onset diabetes	
Enteral / Parenteral nutrition support		Cystic fibrosis	
Multiple births / lactating		Obesity	

Pregnancy with complications		Diarrhoea and / or vomiting >4 days	
Pressure ulcers		Cancer	
Current cancer undergoing treatment		NICU	
Peptic ulcer disease			
HIV/ AIDS			
Any other:		Any other:	

Nutritional intervention required: Yes ☐ No ☐

Assessment date:

Assessment time:

Imp: Store sample food served to patient for 24 hrs.

Quality Plan

Quality control procedures

- Procuring,storing,cleaning,cooking,distribution,adherence to timings,care of trolley before during & after distribution.
- Setting out accurate specifications for each food items .i.e. exact sizes, weights, numbers etc.required.
- Checking food for quality.
- Personal hygiene of the kitchen workers.
- Cleanliness of the environment and equipment.
- Good behavior of staff/workers in terms of their being courteous,soft spoken and alert in their movement.
- To ensure that the diet sheet of the patients should be correctly filled out by the staff nurses a training program after every three months is arranged.
- Periodic Health check-up and immunization of the kitchen worker is done and also done if required in between.

6 - Housekeeping Services

6.1 Objectives:

- Maintain Hospital premises clean, orderly and hygienic.
- Round the clock supervision and directions of schedule activities.
- Establish and maintain procedures to ensure standard of quality.
- Infectious and non-infectious waste disposal.
- Disinfection of contaminated areas.
- Common safety precautions
- Correct and/or report safety hazards
- Clear outcome statements in compliance benchmarks and Key Performance Indicators (KPI).

6..2 Functions :

1. Daily cleaning : Moping, Dusting and Cleaning.
1. Scheduled Project Work: Washing and Scrubbing windows, carpets, waxing floors etc.
2. Trash removal: (i) Emptying Trash Cans (ii) Relining Trash Cans with color coded bags .
3. Furniture moving
4. Room Cleaning after discharge of patients
5. Infection control measures
6. Lost and found
7. Pest control

6.3 Types of House Keeping Services

A. OUT SOURCEING OF HKS:

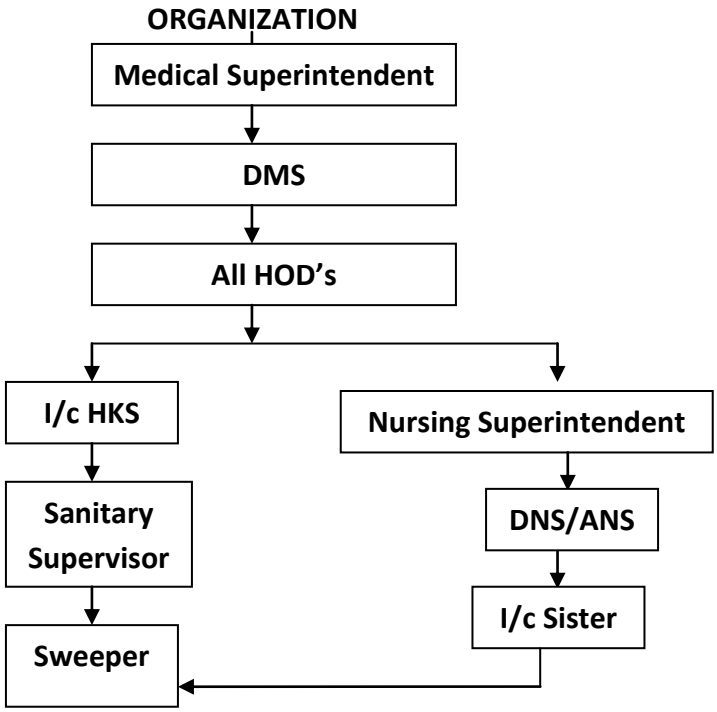
Services on contract

- hospital supervision
- better service
- cost containment

B. IN HOUSE SERVICES:

Hospital employed staff on regular basis

- service managed by hospital sanitation staff
- hospital resources



6.4 SOP for Cleaning procedures

Hospital area are classified for cleaning purpos :-

A. Hospital Patient Care Areas

1. <u>High Risk Areas</u>
   - OT Labour Room
   - Isolation Room

2. <u>Medium Risk Areas</u>
   - Patient Wards
   - Emergency
   - Laboratory

2. Low Risk Areas

- Consultant Room
- OPD area

B. Non Patient Care Areas

- Corridors
- Toilets
- Elevators
- Outer Area

6.5 SOP for Cleaning of OT

- Sweeping: In morning and at the end of days work .
- Moping : Run a dust mop over the floor.
- Disinfection:

o Pour a hospital approved disinfectant solution on the floor

o Allow to stand for 15 minutes.

o Wipe out and leave it for dry.

o Application of anti bacterial germicidal solution: (at the end of each day).

o Equipments mounted on walls or ceiling.

o Hanging light fixtures

o All operating room furniture

o Any waste container etc

- Cleaning of OT Room between each operation- begin by bagging and removing all cloth items.
- Fumigation: As per schedule

6.6 SOP of Cleaning of Isolation Room

- Before entering the room put on gloves, gown and mask.
- Use routine cleaning for the room with germicidal solution.
- Clean furniture and every surface of the room including door knobs, telephone etc.
- Clean toilet of room as per protocol, clean the fittings of the washroom with disinfectant.
- Discard the patient linen in yellow bag.
- After complete cleaning, wash hands and open the door with tissue paper.

6.7 SOP for cleaning of

a. In patient wards

b. Emergency

c. Laboratory

d. OPD Rooms

e. Non-patient care areas

f. Toilets

g. Elevators

h. Checklist for cleaning of Toilets

Checklist for cleaning of Toilets:

Date	Cleaning Time	Done by	Sign of supervisor	Remarks
1. ……	……	……	……	……

6.8 SOP of Lost and Found

- Reporting of lost and found of any article:- with housekeeping supervisor.
- Lost and found register:- entry of details by housekeeping supervisor.
- Housekeeping Supervisor to contact the patient or concerned persons to either claim or further instructions.
- If not claimed:- the article is kept under custody of Matron for six months and afterwards disposed off as decided by hospital authorities.

6.9 Pest Control

To eradicate pests like rats, flies, mosquitoes, lizards, ants, silver fish and termites from hospital premises; including

1. Fly Control
2. Household Disinfestations
3. Rodent Control Measures
4. Vector control
5. Fogging
6. Fumigation

6.9.1 SOP of Pest Control

- Starting from one side, all areas have to be sprayed daily.
- Pest control book:- Every evening pest control book to be checked by pest control incharge/ housekeeping supervisor.
- Any complaint received to be lodged in a complaint format.

6.9.2 Pest Control Complaint Format

Date:
Type of complaint.....
Area.....
Complaint given by.....
Given to.....
Received time .....

Time complaint attended.....

Measures taken.....

6.10 Bio- Medical Waste Management

- Segregation
- Labeling
- Record Keeping

6.11 Housekeeping Services- Record Maintenance (Checklist) registers:

- ATTENDANCE REGISTER
- FUMIGATION REGISTER
- ROOM CLEANING REGISTER
- BIO - MEDICAL WASTAGE REGISTER
- TRAINING REGISTER
- LOST AND FOUND REGISTER

Housekeeping Checklists for departments

Sl. No.	Areas	Activity	8 AM to 2PM	2 PM to 8PM	8 PM to 8 AM
1.	Floor	Mopping			
2.	Walls	Cleaning with wet cloth			
3.	Ceilings	Cobwebs			
4.	Lights and other fixtures	Dusting			
5.	Furniture , Curtains	Cleaning			

(to be signed by Nurse incharge)

Once in 15 days(date of changing with signature)

7-SOP FOR MORTUARY

7.1 STANDARDS TO BE OBSERVED

- The dignity and respect of the dead needs to be maintained in general under all circumstances. The hospital is not absolved of responsibility until the dead person is duly handed over with dignity to the next of kin of the deceased.
- If a person expires in the hospital, the body is not to be placed on the floor or otherwise kept carelessly. It should not be treated in a way that might hurt the sentiments of the next of kin. Hospital staff should be sensitized in this regard.
- The dead body must be released directly from the ward/ ICU (non-MLC cases), if it requested by the legal heirs as unnecessary delay may cause decomposition and inconvenience to the relatives.
- Where mortuary facilities exist, the body should be wrapped properly in clean linen sheets and transported by deploying stretcher, ambulance or trolley, to the mortuary premises where it should be placed under cold storage.
- It is the responsibility of the hospitals that in hospital death cases the dead bodies properly identified and to tag /label them appropriately to maintain their identity.
- The body should be wrapped in a plastic/waterproof sheet in order to prevent soakage of the cloth sheet.
- The mortuary is to be kept free of rodents to prevent mutilation and 1-8damage to the dead bodies, and anti-rodent measures should be regularly undertaken.
- In cases requiring post mortem examination, the body should be handed over to Investigating Officer for further handing over to the next of kin of the deceased, without delay. The dignity of the dead person should be maintained at all times during handling and the body should be wrapped in a waterproof/ plastic sheets with proper markings.
- Due care and sensitivity should be shown in handling dead bodies, in other words, the treatment given to them should be in tune with the standards of civilized society and consistent with the human rights of the deceased.
- All hospitals, public and private, should maintain due dignity of dead persons under all circumstances. Dead bodies need to be handled with due respect and seriousness.

Hospital, especially those having mortuaries attached to them, should be actively involved in sensitizing their staff and should lay down standard protocols in this regard.

- All hospitals with mortuary should review the status of infrastructure of mortuaries and undertake on priority their repair, maintenance, up-gradation or modernization as the case may be so that the bodies can be kept I safe, 1-8hygienic and ethically mandated conditions.
- Mortuary should normally receive dead bodies from associated hospitals and dead bodies sent by designated police station for post mortem. Dead bodies other than those mentioned above should not be collected without permission of Mortuary In-charge/ Hospital administration.
- No dead body should be received and stored in the cold storage without any identity tags.
- Dead bodies normally should not be retained in the cold storage for more than 72 hours. Hospital administration/ Hospital social worker should take appropriate action for disposal/handing over the dead body (non-MLC) to its relatives.
- Dead body of medico-legal cases in cold storage shall remain under the custody of police and only handed over to them.
- No unauthorised person should be allowed to be present at the time of medico-legal autopsy.
- Dead body after post mortem examination should be handed over to the Investigating Officer (I.O.) of the case.
- Regular medical Check-up and adequate preventive measures for communicable diseases to be taken for staff who are handling and managing dead bodies.

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7.2 Standard Operating Procedures for handling and storage of dead bodies

7.2.1 Aim:

- To provide respectful, timely and professional receiving, handling, transport and storage of dead bodies.

7.2.2 Objectives:

- To shift dead bodies from the hospital wards as and when requested in a timely and professional manner.

- Ensure safe transport and storage of dead bodies in Mortuary till they are handed over to the appropriate custodians.
- Handing over the body to the appropriate custodian under receipt.
- Maintain proper records of incoming and outgoing dead bodies.
- Maintain the dignity of the dead throughout.

7.2.3 Functions:

- Shifting of dead bodies from hospital wards.
- Storage of dead bodies until they are taken away for final disposal.
- Safe preservation of the bodies to prevent any deterioration/decomposition.
- Physical security against theft of bodies/body parts.
- Handing over the bodies to the Investigating Officer (in case of MLC bodies)/ authorised next of kin (in case of non-MLC bodies) after proper identification of the body and the recipient.
- Maintenance of record of all bodies received and handed over to custodians.

7.3 Transport of Dead Body to mortuary:

After death the body should be labelled with the help of water proof lockable bands (any fixed colour, separate for MLC and Non MLC bodies) tied to one of the extremities, preferably right wrist. Identification data should be carefully recorded on these bands. In addition, in Medico-legal Cases, these bands should be stamped in red ink with the letters 'M.L.C.'Nursing staff on duty in the ward should ensure that surgical operation/ drainage site if any is properly dressed before that body is wrapped. Nursing staff on duty in the ward should ensure that dead body is wrapped in leak-proof sheets/ plastic bag before it is handed over to next of kin or mortuary attendant.

When the body arrives at the mortuary the staff should receive bodies in courteous, sensitive and professional manner. They should receive the duly wrapped and labelled body along with relevant records (death certificate) and after confirming the identity of the deceased. They should shift the body on removable stretcher/ ambulance and transport it carefully to the mortuary. They should always operate with their safety and security in mind and should wear Personal Protective Equipment (PPE). At no time during the process of shifting or handling, should the body be kept on the floor.

7.4 Intake procedure and maintenance of Mortuary Register:

- Identify the body by the ID band.
- Death Certificate particulars should be matched with ID band.
- Record the body received in the Body Register of Mortuary.
- Following columns should be there in Body Register (a long, thick and durable register):

  - Serial number
  - Name
  - Age
  - Sex
  - Address
  - Identification mark if unknown.
  - Hospital registration number
  - MLC/ non MLC
  - Date and Time of death
  - Date and Time of receiving the body in Mortuary
  - Body brought from
  - Signature of On-Duty Mortuary staff after receiving the body
  - Date and time of handing over the body to next of kin/Investigating officer
  - Particulars of person receiving the body like name, signature, contact number, address and relation with the deceased
  - Signature of On-Duty Mortuary staff handing over the body.
  - Arrange for storing the body in cold storage.
  -

7.5 Body storage:

- Store in proper refrigerated storage cabinets or shelves in a refrigerated room at a temperature of 3.5 to 6.5 degrees Celsius.
- All the cabinets/racks should be properly numbered and a place should be there outside for pasting the identity slip.
- The rack number where the body is kept should be mentioned over the case file of the deceased.
- Store Infected/ decomposed dead bodies in separate freezes.
- Ensure that there is no access for rodents/pests into the body storage area.
- Keep body storage area clean and free from any such matter which may attract rodents/ pests.
- There should be power back-up around the clock.
- The cold storage room/ cabinet should be kept under key and lock.The opening of cold storage and releasing of body should only be permitted by authorised person.

7.6 Releasing a body:

- Confirm the particulars of the body to be released.
- Verify the identity of the recipients/kin.
- Locate and retrieve body from refrigerated storage by matching the cabinet/rack number.
- Assist in transferring the body to hearse van with due care and dignity.
- Sign body out of body register.
- Note down recipient's particulars with signatures.
- In MLC cases body is to be received by Police officials only.
- Hospital should provide coffin cloth to wrap the body free of cost

Universal precaution:

According to the concept of Universal precautions, all human blood and body components, and Other Potentially Infectious Material (OPIM) are treated and handled as if known to be infected for HIV, HBV and other blood borne pathogens.

OPIM includes the following human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood and all body fluids in situations where it is difficult or impossible to differentiate between body fluids.

a) Personal Protective Equipment:

Personal protective equipment (PPE) shall be used to prevent skin and mucous membrane contact with blood and OPIM. These may include the use of gloves, masks, protective eye wear, face shields, shoe covers, plastic aprons/gowns with full sleeves or some form of full arm protection, hair bonnet, cut resistant gloves, and laboratory coats. Additional PPE may be required depending on the particular case circumstances.

b) Hand washing:

Hand and other skin surfaces shall be washed with soap and water immediately after contact with blood or OPIM. Hands shall be washed each time gloves or other PPE are removed.

c) Disposal of Biohazardous waste and Chemicals:

Biohazardous/ chemical waste disposal is a routine part of the work of the mortuary unit. All items in this category are to be handled with the minimum standard of protective equipment consisting of gloves, masks, and some forms of arm protection/ gown. The highest degree of risk should be assumed with all biohazardous waste due to the variety of unknown factors involved. With this in mind, proper protective measures should always be taken. Biohazardous waste should be disposed as per prescribing guidelines.

7.7 Mortuary Security:

- All mortuary staff must sign the book at the security guard desk at the beginning and at the end of the shift of duty.
- Bodies should be handed over to authorised person after proper verification of their identities.
- Beyond reception area all areas of the mortuary should be 'Restricted' area meant only for authorised staff only.

6.8 Sanitation:

- Sanitation of the mortuary premises should be maintained at all times.
- Cleaning/ sweeping should be done at least twice in a shift and as and when required.
- Pest control measures should be undertaken by professional agencies on regular basis.
- Room/ post-mortem table should be disinfected as and when required on case to case basis.
- There should be a provision for Ultra Violet light and fumigation of dissection area.

7.9 Monitoring:

a) <u>Daily Check register for:</u>

- Temperature of cold storage.
- Cleanliness and hygiene of mortuary and surroundings.
- Availability of water.
- Any complaints received.
- Any incident of theft of body/ body parts.
- Any incident of mutilation of body/ body parts.
- Any incident of handing over body to the wrong claimant.
- Any incidence of deterioration/ decomposition of body due to poor environmental control/preservation.
- Any sign of presence of rodents/pests/ animals in mortuary.
- Proper disposal of biomedical waste.

b) <u>Monthly Check Register with action taken for:</u>

- Functionality of equipment
- Any leakage in water pipes
- Any gaps in doors/ windows, seepage in walls/ floors
- Wear and tear of infrastructure/ equipment/ instruments
- Disposal of complaints, if any.

Timings for receiving the papers for conducting the post-mortems to be displayed outside the mortuary:

Working days: 9.00 A.M. to 3.00 P.M.

Saturdays, Sundays and Gazetted Holidays: 9.00 A.M. to 12.00 P.M

8 - Ambulance Services

8.1 Purpose:

To provide an appropriate from of transport for the patients who due to certain medical reasons are unable to make there way to hospital or trauma center.

8.2 Scope:

- To Provide First Aid to the Patient
- Resuscitation
- To provide appropriate medication enroute to Hospital Shift of patient from on place to another.

8.3 Responsibility person:

Chief Medical Officer Casualty and Team

8.4 Staffing and Job Description: (Add training of staff in BLS & ACLS)

8.4.1 Emergency Room in-charge:

Coordinating the Ambulance services for effective transfer of patient to the emergency department.

8.4.2 Ambulance Service In-Charge. :

- Vehicle maintenance for road worthy conditions on a daily basis.
- Preparation of duty roster (on shift basic) for the ambulance drivers.
- Documentations of Daily Report of Ambulance Movement
- Daily check up of Equipments of various ambulances.
- Receiving Call and arranging the Ambulance as per call requirements,
- Issuing instructions to the Ambulance driver for departure.
- Submission of Ambulance Report to the Higher Authority on a day to day basis.
- Keeping a track of the ambulance driver's movement through the Control system.

8.4.3 Ambulance Driver:

- Make sure your vehicle is roadworthy and faults reported to MOI/c transport for repair.
- Properly dressed with clear identity.
- Be clear about the location of the incident and nearest safe rout.
- Observe the Highway Code road traffic rules and regulation.
- Park the Ambulance in a safe, suitable position for easy departure.
- Prepare the medical to receive the patient, opening rear door and coordinate

- Assist the medical attendant and deal with other causalities as required by the incident.
- Before leaving the incident spot check to make sure all the equipment has been returned to the ambulance.
- Close and secure the rear doors.
- Ensure a safe, smooth and comfortable journey.
- Park the Ambulance in suitable entrance to shift the patient to emergency room.
- Give return report about the drive to the MO.
- Always maintain the Logbook.

8.4.4 Nurses (Nursing Sister/Brother):

- Always attend to emergency call. Ensure the Ambulance is fully equipped all functioning and ready to use for all emergencies.
- Check for the availability of emergency drugs and see that they are easily access and look for Date of Expires.
- Message to Ambulance control, arrival on the scan, and give initial feed back of the incident.
- Quickly assess the priority for patient care, and give instruction to the Driver.
- Give required First aid at the location, reassure he patient / relative.
- Shift the patient comfortably into the Ambulance, and carry out tasks in consolations with the doctor if accompanying.
- Instruct the driver to head for the Hospital.
- Always travel with the, patient not in the cabin with the driver.
- Keep monitoring patient, and take appropriate decisions.
- Give brief report on the patient's condition, terminate given on arrival.
- Document the patient's detail in conjunction with the sister in the Emergency room.

8.4.5 Ambulance Vehicle: (This is in process for upgradation to ALS & BLS Ambulances)

The Hospital has a fleet of Basic and Advanced Life support ambulance which are fully equipped to support patient in need of advance life support. The Ambulance fleet consists of:

- Advanced Life Support Ambulance: One
- Basic Life support Ambulance: One
- Facilities are available for quick access of the ambulances, adequate and marked space for ambulance parking.
- Ambulance is manned by trained personnel, who are trained in ACLS & BCLS.
- Ambulance checklist
- Ambulance equipments and emergency medications are checked daily.

8.5 Flow Chart.

Operating Procedure:

Ambulance Service for escorting the patient to the hospital:

- Call is received in the Help line Number
- The concerned person in the control Room records the address, the condition of the patient etc which is documented in the incoming call register maintained by the Ambulance service department.
- On the basic of the Condition of the patient the Emergency Medical officer coordinates the team and decides kind of Ambulance and the team to be dispatched. In case of serious patient the resident doctor and nursing staff accompanies the ambulance crew in the advanced Life Support ambulance.
- The Ambulance control room keeps regular contact with the Ambulance crew through mobile phones to keep an update of the progress.
- Once reaching the site, consent is taken from the patient representative for the transport of the patient. The crew assists in transferring the patient to the ambulance after providing the necessary initial medical attention the patent is secured in the ambulance and transported to the hospital. Throughout the process the ambulance crew keeps in contact with the Ambulance control Room and updates about the status of the patient.
- The Ambulance Crew coordinates with the Emergency Department staff for the smooth transfer of the patient to the ED bed.

AMBULANCES SERVICES FOR TRANSFER OUT OF PATIENTS:

The hospital's Ambulance Service is also available for transferring outpatient from the hospital.

Operating Procedure

The Ambulance Service In-charge explains the patient or the patient representative about the charge for the Ambulance services. Once the patient / relatives conform, the ambulance services in-charge makes the necessary arrangement in condition with clinical team under whom the patient admitted.

Depending on the patient's medical condition the appropriate Ambulance type and trained staff to accompany the patient is chosen to facilitate the transfer of the patient.

9 - Radiation Safety Manual

9.1 SCOPE OF RADIATION SAFETY:-

- The Hospital Radiation Safety program applies to all locations where x-ray radiation-producing machines are used.
- It applies to all workers in the radiology department and all patients visiting the radiology department.

9.2 Radiation Safety Policies

Policy : Statutory Requirements
SOURCE : AERB Safety Code, Medical Diagnostic X-ray Equipments & Installations

- **Scope:** Radiology
- **Distribution List:** Radiology
- **Policy:**

The Atomic Energy Regulatory Board (A.E.R.B) is entrusted with the responsibility of developing and implementing appropriate regulatory measures to ensure radiation safety. Statutory requirements with regard to radiation safety are as follows:

9.3 X-Ray Room Layout

LOCATION OF X-RAY INSTALLATION The rooms housing diagnostic X-ray units and related equipment are located as far as feasible from areas of high. occupancy and general traffic, such as maternity and paediatric wards and other departments of the hospital that are not directly related to radiation and its use.

LAYOUT The layout of rooms in an X-ray department aims at providing integrated facilities so that handling of X-ray equipment and related operations can be conveniently performed with adequate protection. The number of doors for entry to the X-ray room is kept to the minimum. The doors and passages leading to the X-ray installation permit safe and easy transport of equipment and non-ambulatory patients. The dark room is so located that the primary X-ray beam cannot be directed on it.

ROOM SIZE The room housing an X-ray equipment is spacious enough to permit installation, use and servicing of the equipment with safety and convenience for the operating personnel, the servicing and the patient. The room size is not less than 25 sq.m. for a general purpose X-ray machine.

SHIELDING:- Appropriate structural shielding is provided for the walls, the ceiling and the floor of the X-ray room so that the doses received by workers occupationally exposed to radiation and the members of the public are kept to a minimum and shall not exceed the annual effective dose equivalent limits of 50 mSv and 1 mSv respectively. The doors of an X-ray room provide the same shielding as that of the adjacent walls, in case persons are likely to be present in front of them when the X-ray unit is energized. Appropriate shielding is provided for the dark room to ensure that undeveloped X-ray films stored in it will not be exposed to more than an air kerma rate of 10µGy per week (approximately 1.13mR per week.

OPENINGS & VENTILATION Unshielded openings, if provided in an X-ray room for ventilation or natural light etc. are located above a height of 2 meters from the ground/floor level outside the X-ray room.

EQUIPMENT LAYOUT The X-ray equipment is installed in such a way that in normal use the useful beam is not directed towards control panel, doors, windows or areas of high occupancy. The useful beam is directed towards unoccupied areas and away from the dark room. Sufficient area is left all around the X-ray table for safe and free movements of equipment-trolley, radiology staff and service personnel.

CONTROL PANEL In the case of diagnostic X-ray equipment operating at 125 kV or above the control panel is installed in a separate control room located outside but contiguous to the X-ray room and provided with appropriate shielding, direct viewing and oral communication facilities between the operator and the patient.

WAITING AREAS Patient waiting areas is provided outside the X-rays room.

WARNING LIGHT & PLACARD An appropriate warning placard is posted outside the X-ray room.

OPERATIONAL SAFETY COMMISSIONING When a diagnostic X-ray equipment is newly installed/reinstalled in a new location/the equipment is subjected to major repairs or structural modifications are carried out in the existing installation shall not be commissioned unless a radiological protection survey conducted by the **R.S.O** or any other person duly authorized by the competent authority has confirmed adequate protection and operational safety in the X-ray installation. Records of all such surveys shall be maintained for inspection of the competent authority.

PERIODIC INSPECTION Periodic inspection of the X-ray equipment, the lead rubber protective clothing and the safety/shielding features of the X-ray room will be conducted to assure replacement

of defective components/items affecting radiation safety. Records of all such inspections to be maintained.

OPERATION OF X-RAY EQUIPMENT The X-ray equipment should be so operated that the primary beam is directed towards the areas of minimum occupancy. Only the patient whose radiological examination is to be carried out shall be allowed in the room except under conditions specified.

CONTROL PANEL When the control panel is in the X-ray room itself, the panel is located as far away from the X-ray unit/chest stand as possible and duly shielded by a protective barrier.

FURNISHINGS The X-ray room has only essential furniture and & fixtures facilities required for the examinations so as to discourage the presence of uninvolved staff or patients in the room.

ASSISTANCE TO PATIENT Holding of children or infirm patients for X-ray examinations, if required are done only by an adult relative or escort of the patient and not by a staff member.Protective aprons are provided to persons rendering such help. Immobilisation devices are used to prevent movement of children during exposure. In no case shall the film or the X-ray tube is held by hand.

SAFETY OF STAFF All efforts are made to conduct the X-ray examination in such a way as to achieve the desired result with minimum of exposure to the patient/staff. Measures such as use of protective clothing, optimum exposure settings, minimisation of retakes and optimum film processing techniques are employed for this purpose.

OPERATIONAL STAFF No persons other than those specifically concerned with a particular X-ray examination stay in the X-ray room during radiological examination. The X-ray unit is not to be operated by any unauthorized person.

MOBILE EQUIPMENT A mobile X-ray unit is used with appropriate safety measures to protect the public In the vicinity. Minimum occupancy, maximum distance from occupied areas shall be employed for the purpose.

SERVICING OF UNIT Servicing of X-ray equipment are undertaken only by such technologists who have been authorized by the competent authority on the basis of their expertise and radiation protection background to undertake this job safely. In addition to the personnel monitoring

devices, the service personnel must use appropriate radiation survey meters and direct reading dosimeters for on the spot verification of their working conditions.

9.4 Patient Protection

EXAMINATION REQUIRMENT Any X-ray examination should be prescribed **only** after a critical evaluation of the patient's condition in order to avoid unnecessary exposures. In the event of doubt on the advisability of an X-ray examination the matter is resolved by the radiologist in consultation with the referring physician. Clinical indications, provisional diagnosis and information required from X-ray examination should be stated by the referring physician.

TRANSFER OF RECORDS All radiographs (on requisition) are given to patients to enable transfer of radiographs from one institution to another encouraged to avoid repeat examinations.

QUALITY ASSURANCE A new diagnostic X-ray equipment is not to be used unless all the appropriate quality assurance tests are performed satisfactorily. Quality assurance tests must be repeated periodically to ensure continued good performance. Any defects noticed must be corrected before recommissioning the unit.

FLOUROSCOPY REQUIREMENT No fluoroscopic examination should be conducted if the required information can be obtained from radiography.

PATIENT DOSE REDUCTION All efforts are made to keep the patient dose as low as technically achievable. Appropriate techniques such as use of high efficiency film screen combinations, minimum field size, minimum fluoroscopic time and field size, minimum fluoroscopic time and tube current be employed for this purpose in day-to-day practice of radiology.

ELECTIVE RADIOLOGICAL EXAM. Elective radiological examinations of the lower abdomen and pelvis of women in the reservicesive age are to be carried out preferably within the first 10 days from the onset of menstruation. However the examination of Female are performed if the clinical condition of the patient needs immediate X- ray Examination.

FOETAL PROTECTION Radiological examination of the lower abdomen and pelvis of a pregnant woman are to be conducted only when considered absolutely essential, in which case it shall be so conducted that the foetus receives minimum possible radiation dose. In all other X-ray examinations of the pregnant women of the lower abdomen and the pelvis are covered with a protective shield.

ORGAN SHIELDS Aprons/ shields are employed to shield the reservicesive organs of the patient unless it would interfere with the information desired. Thyroid shields are to be used where necessary.

EXAMINATIONS OF CHEST Photoflurography and radiography of the chest should be performed with a focus to receptor distance of at least 120cm.

RECORDS Records of all radiological examinations are to be maintained for follow-up and future reference. Reports, and if possible radiographs, are to be given to the patient for future reference.

9.5 Radiation Protection Programme

FUNCTIONS OF R.S.O The Radiological Safety Officer (RSO) implements all radiation surveillance measures, conduct periodical radiation protection surveys, maintain proper records of personnel doses, instruct all radiation workers on relevant safety measures, educate and train new entrants and take appropriate local measures including the issuance of clear administrative instructions in writing to deal with radiation emergencies. The RSO ensures that all radiation measuring and monitoring instruments in his custody are properly calibrated and maintained in good condition.

PERSONNEL MONITORING Appropriate personnel monitoring devices are used by all
PREGNANT WORKERS radiation workers. Once pregnancy of a radiation worker is established, she shall not receive more than 10 mSv (1rem) at a uniform rate during the remaining period of her pregnancy.
TRAINEES Medical students/trainees does not operate X-ray equipment except under the direct supervision of authorized operating personnel.

STORAGE OF RADIATION Storage of undeveloped X-ray films and personnel monitoring
SENSITIVE MATERIALS devices are done appropriately in areas protected from X-rays and other radiation sources in the installation.

10 - Risk Management Manual

10.1 Purpose

Hospital recognizes and attaches greatest importance to, and concern for, the safety of all its patients, hospital staff and the users of the premises under its control. Consequently the hospital strives to ensure that accidents, incidents and near misses are identified, reported and action taken to help ensure the safety and security.

The hospital is committed to the elimination and or control of all risks. Risk management is seen as integral part of:

- Delivering the highest standard of patient care.
- Continuous quality improvement.
- Protecting the hospitals resources ensuring that these remain available for patient services.
- Maintaining the statutory obligation to maintain safe systems of work.

10.2 Scope of Services /Risk Management

Risk management covers the following aspects:

- Environmental Risk.
- Clinical Risk.
- Complaints & Grievance Handling (For Patients & Staff).
- Mandatory Training related to Risk Management.

10.3 Hospital Risk Management Safety Committee

a) Philosophy

Hospital is committed to provide the highest possible quality of care in an environment that is of minimal risk to its patients, visitors, employees, and medical staff. Essential to the achievement of the objective is risk management, its systematic process of identifying, evaluating, and addressing potential and actual risk.

The emergence of risk management as an operational component of Quality Assurance Program is the result of a variety of factors, such as the increased use of hospital services, rising hospital cost, government, and self-policing, greater patient expectations, adverse claims

experience, higher court settlements, escalating insurance premiums, and the need for self-insurance and risk assumption programs. The factors that mandate risk management programs in hospital will have an even greater impact in the future.

b) Objectives

Risk management programs as an integral part of Quality Assurance Program shall provide a visible focal point and appropriate institutional perspective by:

- Enhancing the quality and standard of care.
- Minimizing the risk of medical or accidental injuries, and losses.
- Achieving liability cost containment and economic protection.
- Increasing employee and staff acceptance of and participating in the risk management program.
- Coordinating and integrating current policies, functions, programs, and committees in the risk management processes.
- Improving program effectiveness and efficiency through administrative direction and control.

c) Functions and Responsibilities

The many varied facets of the Risk Management Program functions and responsibilities include, but are not limited to:

- Risk detection procedures, including analysis of quality assurance data, incident reports, patient and staff complaints, malpractice claims, inspections of the physical plant, preventive maintenance, staff development, and audits of policies and procedures.
- Delineation and assignment of staff level functions in gathering risk management data.
- Encouragement of physicians to report incidents and instances of inappropriate care.
- Administrative responsibility for risk management through delegated authority of
- Quality Assurance Committee functions.
- Centralization for the coordination and integration of risk management activities with quality assurance.

10.4 Process of Risk Management

- Identification of Potential Risks & Hazards

- Evaluate the likelihood and degree of risk
- Documentation & Reporting of Risks and Incidents & near misses
- Implementation of Corrective actions & Control Measures to reduce, prevent incidents
- Review and monitor risk management process for continuous quality improvement

10.5 Risk Terminologies

- Adverse Health Care Event: Any incident or omission arising during clinical care and causing physical or psychological injury to a patient.
- Hazard: Anything which has the potential to cause harm. (This can include articles, substances, plant or machines, methods of work, the working environment and other aspects of work organization.)
- Risk: The likelihood, high or low, that somebody or something will be harmed by a hazard. The extent of risk will depend on, the likelihood of harm occurring, the potential severity of harm, the frequency of the occurrence.
- Near Miss: An event had it not been for luck or good management would have resulted in an adverse incident.
- Clinical Risk: The probability of any incident, accident or near miss which would result in an injury or a near miss to a patient.
- Adverse Incident: An incident which did result in harm.

10.6 Categories of Incidents

Generally incident occurrences fall into two categories – indirect patient care and direct patient care.

Examples of incidents relating to Indirect Patient care are inclusive of the following but not limited to:

- Fire
- Security
- Violence & Aggression
- Environmental

Examples of Direct Patient care are inclusive of the following but not limited to:

- Drug Error & Adverse Clinical Event
- Failure/Incorrect Diagnosis

- Incorrect Reporting
- Any non-compliance to standard procedure
- Unexpected death
-

10.7 Incident Reporting

The aim of incident reporting is to learn from experiences and to improve practice. The hospital encourages an open culture within the organization that is intended to encourage staff, patients & other users to report incidents.

When an accident, incident or near miss occurs, prompt action is taken to deal with the immediate situation. Once the incident is safely under control follow-up action is taken to prevent any recurrence of the accident, incident or near miss. An Incident Reporting Form is completed at the earliest opportunity and submitted to a member of the Risk Management Committee. All accidents, incidents and near-misses are reported. Serious accident, incident and near misses are reported immediately by discussing it directly with a member of the Risk Management Committee.

10.8 Incident Investigation

It is the responsibility of the MR receiving the incident report to investigate the incident. The object of investigating an incident is to confirm what happened and to establish how and why the incident occurred.

This can be achieved by determining:

- The immediate/primary cause(s)
- Any underlying/secondary cause(s)

10.9 Collect Evidence

The available evidence could be either in the form of written incident reports/witness statements or a verbal statement recorded from witnesses/injured persons. For incidents involving equipments the equipment in question is quarantined and investigated to find the root cause (e.g. : any lapses in maintenance of equipment, user mistake etc.)

10.10 Analyze Evidence

The collected evidence and forms are analyzed to establish what precautions were in place to prevent the incident & what actually happened and why it happened. The cause of the incident is analyzed to

find out whether it was due to any active failures like hazards in work places, incorrect work practice & lapses or due to any underlying causes like working conditions (working environment / Training / information / Maintenance / equipment / Policies or procedures)

10.11 Report Findings of Investigations

On completion of an investigation the true level of injury / loss / other damage will be apparent, the investigator will review the incidents and action plan(s) will be compiled to address the immediate and underlying causes of all incidents. All these are documented and reported to the Medical Director for review.

10.12 Corrective Actions & Control Measures

Appropriate corrective actions & control measures are taken in coordination with the staff in the concerned department. Responsibility is delegated to staff with appropriate levels of responsibility and target dates for completion identified. Progress towards completion of the action plan and the effectiveness of any action taken are monitored by the Medical Director.

10.13 Safety Policy & Manual

Hospital wide safety measures & precautions are discussed in detail in the Safety Manual Document (Ref #_____)

10.14 Fire Safety Policy

The fire safety policy covers all aspects of fire prevention & fire safety with an objective to:

- Provide and maintain safe means of escape from premises
- Provide and maintain adequate means of alerting staff in the event of fire.
- Provide and maintain adequate firefighting equipment.
- Provide adequate training to all members of staff (by organizing fire drills)

Liaison will be maintained at all times with local Fire Authorities on all matters concerning fire safety.

10.15 Fire Fighting & Evacuation Procedure

The hospital has a general fire fighting and evacuation procedure. This procedure identifies the actions required by staff to ensure the safety of all users of the hospital.

High-risk areas in the hospital are identified & all fire safety precautions are taken. High Risk Areas in the hospital include the following:

1. Operation Theatres
2. ICU
3. Radiology
4. Pharmacy
5. Stores
6. Kitchen
7. Gas Manifold Room
8. Electrical Maintenance Room etc.

Further risk and safety measures relating to fire safety is discussed in detail in the fire safety policy in the hospital's safety manual (Ref # _____)

10.16 Security

The security department and their personnel are responsible for maintaining safety of the staff, patient and other users of the hospital in situations like violence & aggression, disasters etc.

10.17 Laboratory Safety

Risks associated with the laboratory and safety measures and precautions in the laboratory are further discussed in the Laboratory Safety Manual (Ref # _____)

10.18 Radiology Safety

Risks identified with the radiology department and the safety precautions taken to prevent incidents are discussed in detail in the Radiology Safety Manual (Ref # _____)

10.19 Adverse Drug Reaction

All incidents relating to adverse events due to drugs used in treatment of patients are discussed in the policy on Adverse Drug Reactions (Ref # _____)

10.20 Blood Transfusion Reactions

Any reactions resulting because of transfusing blood or blood components are documented and reported appropriately. Further information is available in the policy document on Blood Transfusion (Ref # _____)

10.21 Responsibility for staff in safety issues

- The staff is trained in safety issues of the hospital so that they are able to handle safety issues in case of any incidents or accidents.
- To take reasonable care of the health and safety of themselves and other persons who may be affected by their acts or omissions.
- To report any hazard or unsafe working practices to their manager or other person in authority, as soon as it is possible to do so, to enable the hazard to be rectified.
- The failure of a member of staff to observe his or her duty in this respect will be regarded as misconduct and will be treated as such in accordance with the hospital's disciplinary procedure.
- All members of staff are required to attend induction and annual update training in health and safety matters (like fire safety drills etc,) as arranged by hospital and their department supervisors.

11-Security Manual

11.1 Purpose

To provide instructions and system for Physical and Infrastructure Security related requirements:

- For reviewing the requirements related to Physical and Infrastructure Security
- To provide security to doctors & staff working in hospital.

11.2 Scope

This covers all infrastructure & services provided by hospitals such as

- Infrastructure & hospital property
- Control & flow of visitors
- Safety of Patients (in as well as outpatient)
- Safety from all infiltrators.
- VIP Security

11.3 Responsibilities

- Security committee headed by Addl .M.S (Admin) monitors the security arrangements in monthly meetings.
- Authorized officer is MOI/c security under guidance of Medical Superintendent and another authorized MOI/c is also attached to security.

11.4 Process

a) Allocation / posting of Security Staff at various entry points

Security staff is positioned at different entry gates and indoor wards. A duty roaster is also prepared.

Special duties are also assigned for VIPs, based on the information received. In this hospital gate pass system is existing. Security staff takes rounds of wards also and control the flow of visitors.

b) Keys Control

Keys of outer doors are with-in custody of security staffs/ Hospital Chowkidars and handing over/ taking over takes place. Inside keys of department rooms are kept with the persons authorized by respective department Incharge.

Outer gates with locks are not opened after duty hours, without the permission of competent officer.

11.5 Security Structure

In hospital, there are two types of security guards. There is designated Security officer of the hospital to look after the security arrangement of the hospital.

- Hospital Security Guards/Chowkidars:
- DGR Guards: - (Out sourced) through sponsored Agencies by DGR

a. Purpose:

- To provide a safe and secure working environment, to the patient, especially the elderly and pediatric patients, the patient visitors and the staff of the organization.
- To safeguard the expensive and sophisticated equipment of the organization and to minimize the possibility of thefts and pilferage.
- To Monitor CCTV round the clock & inform other security personal for corrective & preventive action.

b. Scope:

- This policy applies to all, the areas within and the immediate premises of the hospital.

c. Responsibilities and Authority:

The Responsibility for implementing this policy shall lie with the Administration / Security Officer / Security Supervisor / Marshals / Security Guard.

d. Definitions and Abbreviation:

SO	=	Security Officer
SS	=	Security Supervisor
SG	=	Security Guard
M	=	Marshal

e. Procedure:

- Ensure all the Security Guards are on all the defined location (Ref. tender document).
- Ensure that the unnecessary crowd does not gather at floors (Patient Areas).
- Check the Fire Exit seals and fire extinguisher at the various locations in the hospital.
- Ensure that the books/ registers are maintained adequately up to the time of verification at all the locations.
- SO / SS / M / SG needs to be polite, remain ever alert, pay due respect / courtesy to all.
- SO / SS / M/ SG needs to report all unusual occurrence / abnormalities to S.O. Immediately. In the absence of S.O., he has to report to M.O. I/c Security

- SO / SS will ensure that patrolling is done on every 2 hours during the day time (08:00 AM – 08:00 PM) and 1 ½ hourly basis during the night (08:00 PM – 08:00 AM) in the identified areas.
- SO / SS needs to ensure that the guards at all stations fulfill their Job responsibilities**.**
- The security supervisor along with the security guard will carry out security rounds, of the premises, at regular interval. The beat record is maintained in the round register.

11. 6 Handing Over / Taking Over Policy

a. Purpose:

To have a proper handing over and taking over mechanism to avoid the communication gap between Security Officer, Security Supervisor & Security Guard while change of shift

b. Scope:
Change of every shift of Security Supervisor / Security Guard

c. Responsibilities and Authority:
Marshal/ Security Officer / Security Supervisor / Security Guard

d. Procedure:

- Before, "Taking-over charge" he will check the following Register/Books physically check/count the keys, ensure that action are completed in all respect by the outgoing Security Supervisor take suitable action on the pending matters, messages if any. Hand over / Take over the following: -
  - Log Book (Lost and Dept Keys
  - Registers & Books
  - Found – Register / Incidence reports if any)
- Any important event / information occurred during the shift must be mentioned in the occurrence register.
- Hand over lost & found material to the next security supervisor.
- Taking over security personnel must sign in the occurrence / floor wise register with due date & time.

11.7 Training Policy/Induction

a. Purpose:

To give all Marshals/ Security Officers / Security Supervisors / Security Guards, regular and appropriate training & induction

b. Scope:

All new Marshals & old Security Officers / Security Supervisors / Security Guards.

c. Responsibilities and Authority:

Hospital Administration / M.O. I/c Security / Training Officer / Security Officer

d. Procedure:

- A Training Calendar needs to be prepared one week in advance on a monthly basis and submitted to the M.O. I/c Security.
- The Training Program must cover all the Security personnel.
- Training Program attendance register should be maintained with Date, Time, and type of program, Name of person attending with signature.
- The Training Program attendance register must also be signed by Training Officer, Security Supervisor & M.O. I/c Security.

11.8 Gate Pass

a. Purpose

To ensure the safety of the Hospital Infrastructure.

b. Scope:

All movable / immovable assets of the hospital

c. Responsibilities and Authority:

SS Office / Security Officer

d. Procedure:

- The gate pass is a must for any material to be taken out of the hospital premises on Returnable / Non-Returnable basis.
- The Gate Pass (Returnable / Non-Returnable) is issued by the Concerned Department Head / Authorized person (Materials, CSSD, House Keeping, Bio-Medical etc) in triplicate.
- The gate passes needs to be completely filled including S.No., Date, Quantity, like date of return (in case of returnable gate pass only), Sender Department, Material Taken by, Authorized Signature.
- The concerned department keeps one copy, sends one copy to security & hands over one copy to the person taking out the material.
- Once the copy is received from the concerned department, the security does a check regarding the material mentioned in the gate pass and takes the individual signature of the person taking the material out and puts the security seal including Date & Time.
- Security ensures that all follow – up action is taken in case of returnable Gate Pass if it is not returned by the due date, by sending the reminder to the concerned department on a monthly basis.

- Security will responsible for proper accounting of Returnable and Non Returnable Gate passes.
- In case if the third party misplaces the Gate Pass the same is verified from records and a signature on it is taken from the third party with reason of loss.
- In case if the Gate passbook is lost from the concerned department the same must be reported to security so that they will block serial nos. of missing gate passes.

11.9 Manpower Deployment

a. Purpose:

To efficiently deploy security personnel for the safety of infrastructure / patients / employees / visitors.

b. Scope:
Entire Hospital Premises

c. Responsibilities and Authority:
M.O. I/c Security / Security Officer / Security Supervisor

d. PROCEDURE:

SO / SS must ensure that all the new security personnel joining must undergo the designed training & induction program for security.

- SO / SS will check & ensure that all guards wear neat and clean uniform, have proper hair cut and shave, shoes polished etc.,
- SO / SS will conduct parade/roll call and ensure all guards report 15 minutes before the commencement of duty. Will brief them on duties assigned on day-to-day and special instructions if any. Needs to randomly cross verify and ensure that they understood and execute the same without fail.
- SO / SS will ensure that all posts are manned. If any post is unmanned for reasons of shortage of manpower reported; then posts critical are to have guards. At the same instance, immediately call Security Agency to provide replacement, and inform to SO.
- SO / SS will ensure that Master Roll Sheet / Attendance is up date and submitted to Agency.
- SO / SS will go for checking all the posts and ensure all the books / registers maintained are adequate and maintained upto the time of his verification.
- SO / SS to ensure that the proper handing over and taking over is happening between the guard posted between two shifts.
- SO / SS to ensure that the guard posted follows procedures as instructed.
- SO / SS must be informed by the security guard in case he/she leaving the post for whatever reason.

11.10 Lost And Found

a. Purpose:

To ensure the safety, recording and handing over of lost and found articles

b. Scope:

All unclaimed articles found in the premises of Hospital, New Delhi.

c. Responsibilities and Authority:

Security Officer / Security Supervisor

d. Definitions and Abbreviation:

SO	=	Security Officer
SS	=	Security Supervisor
M	=	Marshal
PS	=	Police Station

e. Procedure:

As soon as information regarding a lost and found article comes to the Security Officer / Security Supervisor (s)he reaches the spot and collects the same.

11.11 Job Responsibility

a. Purpose:

To provide clear-cut job responsibilities to all the security personnel for overall efficiency of Security Management at hospital, New Delhi.

b. Scope:

All security staff employed at hospital, New Delhi.

c. Responsibilities and Authority:

Nodal Officer/ Security Officer / Security Supervisor/All the eligible employees

d. Security Supervisor:

- Supervisor on his / her stipulated shift will report for duty smartly turned out 15 minutes prior to commencement of duty as per schedule.
- He / She will check & ensure that all guards wear neat and clean uniform, have proper hair cut and shave, shoes polished etc.,
- He / She will conduct parade/roll call and ensure all guards report 15 minutes before the commencement of duty. He will brief them on duties assigned on day-to-day basis and special

instructions if any. He needs to randomly cross verify and ensure that they understood and execute the same without fail.

- He / She will ensure that all posts are manned. If any post is unmanned for reasons of shortage of manpower reported; then posts critical are to have guards. At the same instance, he will immediately call the agency to provide replacement, and inform this to the SO.
- Before, "Taking-over charge" He / She will check the following Register/Books physically check/count the keys, ensure that action are completed in all respect by the outgoing Security Supervisor take suitable action on the pending matters, messages if any. Hand over / Take over the following: -
- Dept Keys
- Registers & books
- Log book (lost and found – Register / Incidence reports if any)
- Emergency Bell checking book
- He / She will randomly check the incoming materials along with DC / Invoice / Bills with the records in the register. He will not allow any material without proper Gate Pass duly signed by authorized signatory (List to be made available at side the register).
- He / She will ensure that all follow – up action taken in case of returnable Gate Pass if not returned by due date (Whenever material return physically check and receive).
- He / She will responsible for proper accounting of Returnable and Non Returnable Gate passes.
- He / She will ensure that Master roll sheet /Attendance is up date
- He / She will go for checking all the posts and ensure all the books / registers maintained are adequate and maintained up to the time of verification.
- He / She will collect the patient occupancy list as per schedule form the Front Office staff; to identify and allow Attendant's accordingly and Visitors to meet patient during visiting hours.
    - He / She will submit all records, registers for inspection and information of S.O. on a daily basis.
    - He / She will be polite remain ever alert, pay due respect / courtesy to all.
    - He / She will report all unusual occurrence / abnormalities to S. O. immediately. In the absence of S.O., he has to report to M.O. I/c Security.

11.12 Duties and Responsibilities of a Security Guard

- He / She will report for duty 15 minutes prior to duty time, with proper turnout.
- Will report to the Supervisor on duty and take details of posts to be manned duty detailing
- He / She will help in receiving Patient's in Emergency.
- He / She will address all respectfully, and guide the Patients and Visitors. He shall stop attendants and visitors from bringing into the hospital Flowers, eatables, other personal belongings besides basic needed items required for admission. Visitors shall be educated

about the hospital policy not to allow healthy infants and young children into the inpatient areas.

- He / She will attend to all phone calls. Receive and Record messages and instructions given by hospital personnel who identify themselves.
- He / She will open the offices whenever required with the record of the individual holding proper consent.
- If anything unclaimed is found, He / She needs to bring to the notice of S.O. or Supervisor on duty. Make a record of the same in the register provided.
- He / She will guide attendants visiting Patients during visiting hours.
- He / She will escort the duty Cashier to the Bank when required.
- He / She will ensure attendants policy is followed strictly.
- He / She will ensure that patients do not leave the premises; if found in an unexpected place help them to get back to ward.
- He / She will relieve all the security personnel for lunch break/ natural calls.
- He / She will check the Depts. and ensure they are locked and sealed where ever required.
- He / She will assist Security Supervisor in all respects, in his tour of duty.
- He / She will maintain the KEY HANDLING REGISTER.
- He / She will frisk House Keeping Boys and Pantry Boys whose shift off time, make a record of it.
- He / She is holding the in – out register for House Keeping Boys and Pantry Boys.
- He / She will Hand over / Take over the following: -
  - Dept Keys
  - Registers & books
- The Duplicate keys shall be kept in safe custody of the administration and used only when the original is lost / misplaced.
- All offices, stores and medical areas not in use after normal working hours, will be kept locked thereafter.
- All areas must be locked when not in use.
- Keys to any area shall be used only by the staff authorized to do so.
- The Group Master key for all areas will be with the each level security guard and with the Administration.
- Whenever a new key is required the same shall be obtained from the administration after signing in the Key Register and entering his/her name and date of issue.
- In case of loss of keys the Administration shall be informed immediately. A duplicate key shall be given or the lock shall be changed by the administration after levying an appropriate penalty.
  - Log book
  - Phone directory

- He / She will ensure that all incoming and outgoing Materials properly entered in the register.
- He / She will responsible for the proper accounting of Returnable and Non Returnable Gate passes.(if any irregularities he will bring to the notice of SO / Supervisor immediately).
- He / She will ensure that only patient's relatives; attendants are only using waiting areas.
- He / She will maintain record of patient's relatives, attendants whom he allots the waiting areas.
- He / She will maintain the proper handing / taking over record with his duty reliever.
- He / She will inform any suspected person roaming nearby to the Supervisor / SO immediately.
- He/ She will ensure that the working personnel of the hospital are not endangered physically.
- He / She will call the attendees of patients in OT/SICU as and when required.
- He / She will check all depts. / rooms and lock the same after closing.The Duplicate keys shall be kept in safe custody of the administration and used only when the original is lost / misplaced.
- All offices, stores and medical areas not in use after normal working hours, will be kept locked thereafter.
- All areas must be locked when not in use.
- Keys to any area shall be used only by the staff authorized to do so.
- The Group Master key for all areas will be with the each level security guard and with the Administration.
- Whenever a new key is required the same shall be obtained from the administration after signing in the Key Register and entering his/her name and date of issue.

- In case of loss of keys the Administration shall be informed immediately. A duplicate key shall be given or the lock shall be changed by the administration after levying an appropriate penalty.
- He / She will ensure that the depts. / rooms are open for cleaning, and closed after cleaning.
- He / She will have through patrolling rounds in the nighttime.
- He / She will report all unusual occurrence / abnormalities to Security Supervisor / S O immediately.
- He / She will be accountable for all security concern in the area allotted to him / her
- He/ She shall prevent entry of street dogs & cattle etc. into the premises of hospital. If these are seen, he will immediately drive animals out of the hospital premises.
- He/ She shall ensure that flowers, plants, trees & grassy lawns are not damaged either by staff or by outsiders.

11.13 Duties and Responsibilities of a Marshal

- He / She will report for duty 15 minutes prior to duty time, with proper turnout.
- Will report to the Supervisor on duty and take details of posts to be manned duty detailing
- He/ She will protect Medical staff & Hospital Property from anti social elements.
- He/ She will ensure that no one is allowed to carry weapons or any harmful equipment inside the designated areas/ premises of hospital.
- He/ She will follow the instructions given by the hospital authorities from time to time.

Note:

1. Unwanted Lights, exhaust fans, Air conditioners are switched off.
2. Periodically, inspect toilets – to note if plumbing facilities are intact and monitor staff grouping and wasting time.

11.14 Responsibilities of the Security Department

a. Purpose:

To define clearly the scope and responsibilities of the Security Department

b. Scope:

Is applicable to all personnel of the security department

c. Responsibilities and Authority:

Security Officer / Security Supervisor / Security Guard

d. Definitions and Abbreviation:

SO = Security Officer

SS = Security Supervisor

HOD = Head of the Department

e. PROCEDURE:

- Safeguarding all physical property and all locations of the Hospital campus.
- Controlling entry and exit of patients relatives and visitors
- Supervising the working of the access control system at various locations of the hospital
- Maintenance of records of men and material movement.
- Deployment and proper utilization of all security personnel
- Prevention from theft, pilferage and damage any hospital property
- Prevention of fire and accident
- Response to fire or any internal and external disaster such as bomb threat,floods, earthquake, major accident.
- Prevention of wastages or misuse of resources and facilities, in particular water and electricity.

- Securing all departments after staff has left for the day.
- Prevention and detection of crime
- Liaison with local police/fire brigade and allied authorities
- Ensure day-to-day operation are carried without and hindrance
- Assist/ensure any additional or any special events are carried out successfully
  - Preparation and submission of daily security reports highlighting any untoward event.
  - Guiding patients to use of the Patient attendant lounge.
  - Patrolling at frequent intervals various locations of the hospital.
  - Train all staffs in accidents prevention, fire prevention and fire fighting.
- Assist and guide the management in maintenance of safety and security at all times.

11.15 Key Management

a. Purpose:

To safeguard the expensive and sophisticated equipment of the organization and to minimize the responsibility of thefts and pilferage

- The Duplicate keys shall be kept in safe custody of the administration and used only when the original is lost / misplaced.
- All offices, stores and medical areas not in use after normal working hours, will be kept locked thereafter.
- All areas must be locked when not in use.
- Keys to any area shall be used only by the staff authorized to do so.
- The Group Master key for all areas will be with the each level security guard and with the Administration.
- Whenever a new key is required the same shall be obtained from the administration after signing in the Key Register and entering his/her name and date of issue.
- In case of loss of keys the Administration shall be informed immediately. A duplicate key shall be given or the lock shall be changed by the administration after levying an appropriate penalty.

b. Scope:

This policy applies to all, the areas within and the immediate premises of the hospital. The policy also applies to the various keys in the hospital and its duplicates.

c. Responsibilities and Authority:

The Responsibility for implementing this policy shall lie with the Administration and the security personnel. The responsibility of the keys held by the user department shall lie with them.

d. Definition and Abbreviation:

Nil

e. **Procedure:**

- The original key of any department will be with the user department. The duplicate of the same shall lie with the administration.
- In case of the patient areas the original keys of cupboards and patient rooms shall lie with the nursing in charge of that particular level. Whenever a patient is admitted he will be given one set of cupboard keys by the nursing staff. The same shall be retrieved from the patient before his discharge by the nursing staff.
- The Duplicate keys shall be kept in safe custody of the administration and used only when the original is lost / misplaced.
- All offices, stores and medical areas not in use after normal working hours, will be kept locked thereafter.
- All areas must be locked when not in use.
- Keys to any area shall be used only by the staff authorized to do so.
- The Group Master key for all areas will be with the each level security guard and with the Administration.
- Whenever a new key is required the same shall be obtained from the administration after signing in the Key Register and entering his/her name and date of issue.
- In case of loss of keys the Administration shall be informed immediately. A duplicate key shall be given or the lock shall be changed by the administration after levying an appropriate penalty.

12. MANUAL FOR OPERATIONS
DEPARTMENT OF MEDICAL RECORDS

12.1 Scope

This document is provided in order to have uniform system to ensure the following: (a) Proper maintenance of medical records.
(a) Maintenance of integrity and confidentiality of medical records.
(c) Submission of required data of government authorities.
(d) Providing required data to public as and when desired.

12.2 Process Summary

S.N	Process	Details
1.	**Hospital Management System (HIMS)**	a) Maintenance of all IPD **ELECTRONIC HEALTH RECORD** b) Scanned documents of all MLCs c) All Statistical record through HIMS
2	**Statistics**	a) Compiling daily hospital census and daily reports to authorized personnel. b) Updating statistics of all OPD and IPD census to monthly statistics. c) Send daily, weekly, monthly & yearly reports to higher authorities d) Reporting of notifiable disease to MCD as and when asked for.
3	**Discharge summary**	a) Collecting discharge files from all the wards. b) Discharge prints provided as requested by Doctors.
4	**Maintenance of medical records**	a) Systematic maintenance of records. b) Check deficiencies in the records and ensure proper assembling and filing according to date of Admission & Deptt. Wise viz month wise. c) Modification of personal particulars. d) Keeping of month wise death records separately.
5	**Birth & Death Certificate**	a) Uploading Birth and Death records to the municipal corporation of Delhi. b) Birth and Death Register Updating. c) Modification of personal particular after obtaining necessary documents. d) Issuance of required papers of case record as and when asked by individual.
6	**MLC**	a) Maintaining hospital copy of all MLC intimations. b) Handing over injury report to the Police when requested by I.O. c) When any I.O. requested for MLC reporting the same is reported from concerned M.O and handed over the injury report to the Police,I.O.
7	**Retention of records**	a) Retention of records as per Govt. of NCT & hospital policy.

8	**Misc.**	a) Issue medical records to authorized personnel for audits/research purposes on approved of competent authority. b) Public dealing at 12:00 to 1 PM daily. c) Summon related correspondence as well as attending Court. d) Issue Medical Record as per RTI Act.
9.	**Planning work**	a)Preparation of Annual Plan & Budget b)Exp. details as feedback of budget for onward submission to Planning & Finance, GNCTD c) Creation of posts & Incumbency position of hospital. c) Continuation of Temporary posts d) Daily, monthly, quarterly & Annual Reports related to Plan & Budget.

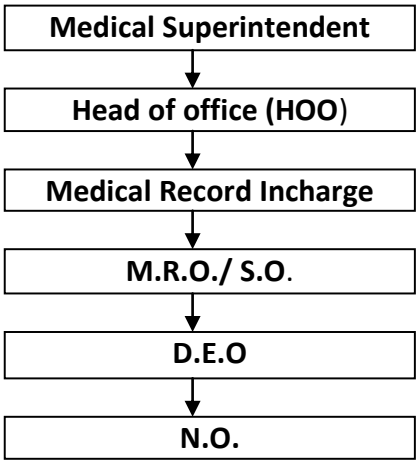
12.3 Definitions & Abbreviations

Medical record is important " **Patient forgets but record remembers'** the record is valuable to many individuals and groups: patients, physicians, health care institutions, research teams, teachers and students , National health agencies, and international the-Health organizations.

O.P	Out-Patient
I.P.	In-Patient
MR	Medical Records
M.R.A	Medical Records Assistant
M.R.D	Medical Records Department
I.C.D	International Classification of Diseases
MRD	Electronic medical records digitization
CR.No.	Serial No of IPD patients
MRO	Medical Record Officer
ER	Emergency room
ALOS	Average Length of Stay
MLC	Medico legal Case
D.A.M.A	Discharge Against Medical Advice
Dept.	Department
H.A.	Health Authority

12.4 Departmental Hierarchy

- Hierarchy Chart



12.5 Job Description

a) Medical Records Incharge

Key areas of responsibility:
Shall organize and manage the Medical Records Department with appropriate system and provide effective service to the patients.

Main job Tasks:

- To establish, organize and manage the medical records department with appropriate systems to provide an effectiveservice in the hospital.
- To develop policies and procedures relating to the Medical Records Department in accordance with the Health Directorate / Ministry of Health.
- To review the Medical Records of admission patients and emergency patients to ensure that they include all important document and pertaining information.
- To participate and assist the quality assurance, utilization review, infection control and other committees and programs.
- To prepare monthly statistics reports concerning the hospital activities carried out and to submit to concerned authorities any suggestion for improvement.
- To observe professional ethics and to protect the confidentiality of information from unauthorized person to keep medico legal record under safe custody and to attend the court

proceeding whenever required.

- To participate and assist in research program to develop new methods and procedures for improving administrative activity.
- To supply patient files in accordance with the established procedures for medical caremedical education. Medical training, medical care evaluation management and legal purpose.
- To maintain and protect medical records in accordance with the policies relating to preservation and destruction.
- To co operate with the medical (consultants) patients, health agencies, other hospitals
- and legal authorities for smooth and efficient function of the hospital in general and medical records department in particular.
- To carry out any other duties and functions related to medical records sarvices as instructed by the Medical Superintendent.
- To collect medical, administrative, and other statistics required by the hospital and to provide health information for planning and evaluation of health care.

❖ **HIMS :**

- All data related to patients activity in OPD/IPD/Emergency/OT etc. are retrieved through HIMS application. In this way an Electronic Health Record of all admissions/death are maintaining in HIMS.
- All original MLC documents are scanned and attached to patients CR No. for recordkeeping.
- All census are maintained/retrieved through HIMS date of hospital and are submitted online/offline to concerning authority.
- To ensure that all the registers are completed and maintained by the medical records deptt.
- To correspond with various individuals and institutions. This includes furnishing of information to courts on summons, police station for Medico legal cases , insurance claims correspondence etc.

b) Medical Records Officer & Support Staff

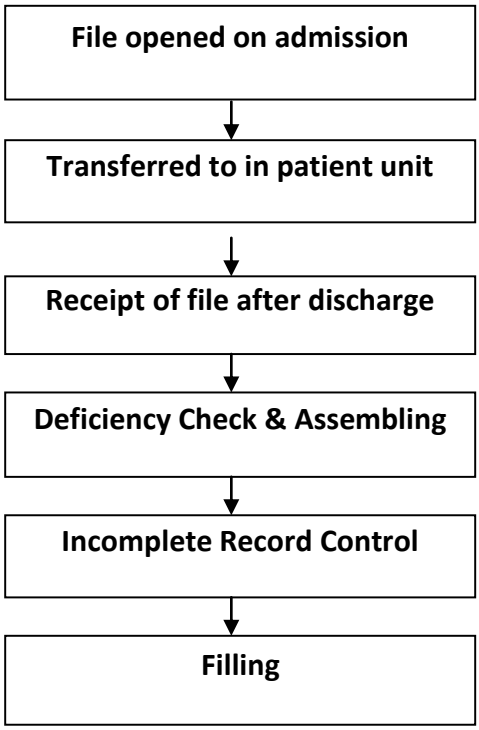
Keys areas of responsibility:
To Assist the MRO in maintaining the MRD Department and updating records on daily basis.

Main Job Tasks

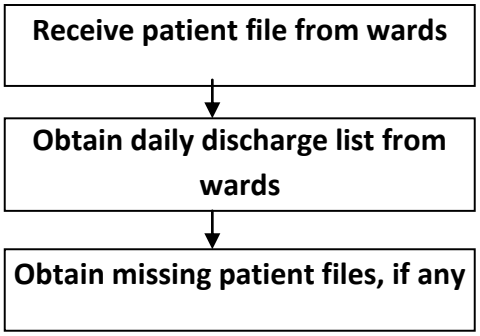
- Shall report to Medical records officer.
- Shall carry out technical analysis to evaluation of medical records in accordance department filling and retrieving system.
- Shall evaluate documentation for deficiencies in the patient medical files and to arrange for completion of records with co-operation of medical and nursing staff.
- Shall protect medical records especially medico legal case from unauthorized disclose, so as to maintain confidentiality.
- Shall take care one of more medical records units and to assist department and administrative systems.
- Shall assemble and process records as per the established procedures.
- Shall observe medical ethics as recommended for medical records professionals.
- Shall perform any other work related to medical records as instructed by his or her direct or immediate chief from time to time.
- Shall scan all the discharge files and other required reports.

12.6 Departmental Procedures

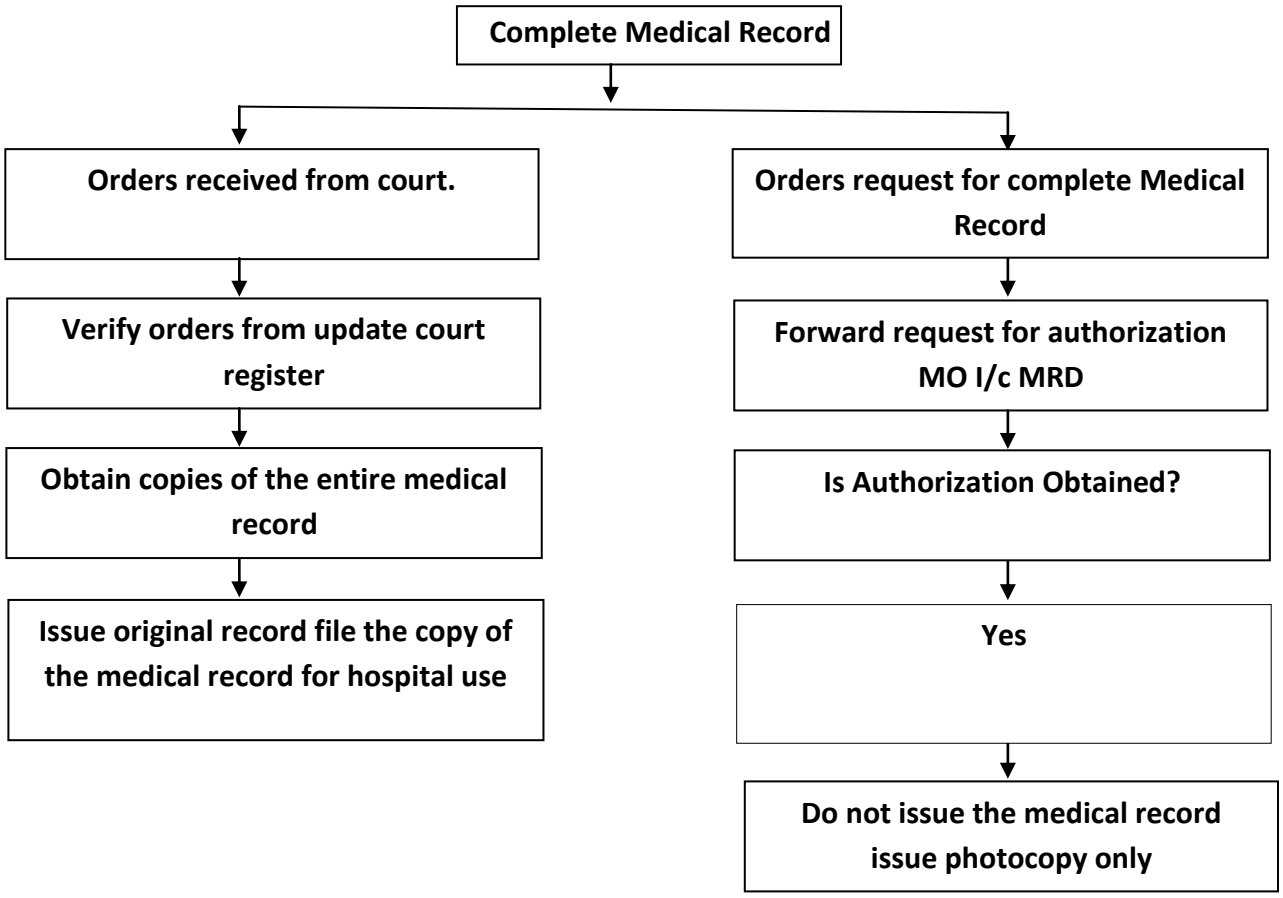
a) In-patient Flow Chart



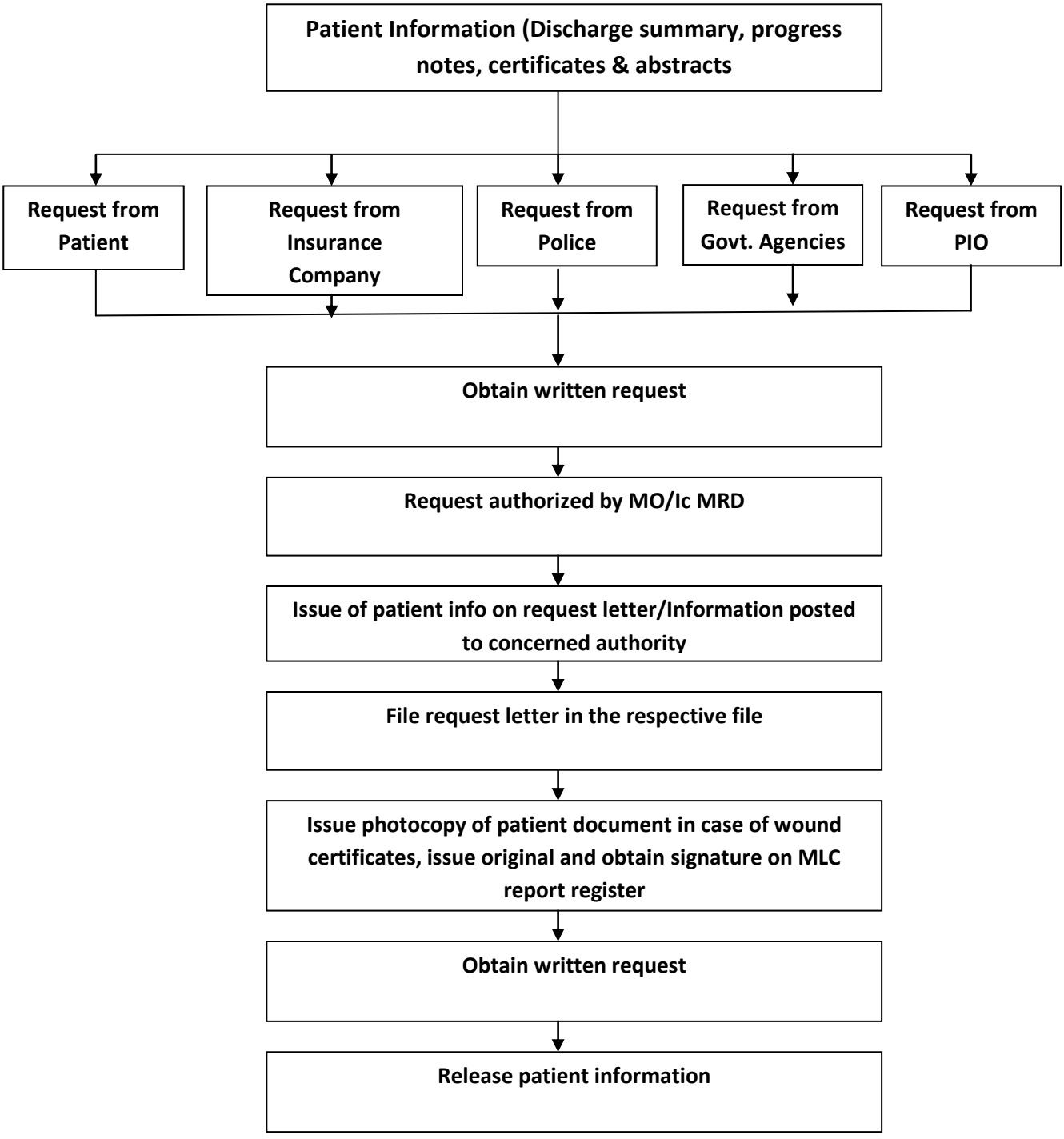
b) Received Discharge Records



c) Issue of Medical Record



d) Release of Patient Information



12.7 Assembly of Medical Record

a) Assemble patient files in prescribed standard order:-

- Discharge summary
- IP Consent form
- Consent for anesthesia and surgery
- Anesthetic record
- ICU chart
- Antibiotics and Regular charts
- Observation chart
- Diabetic management chart
- Nursing 24hr fluid balance chart
- Referral letter
- Admission summary sheet
- Other treatment records patients.
- Nursing charts.

b) Keep incomplete records separately (according to treating consultant) pending follow up and completion.

12.8 Departmental Policies

12.9 Statutory Recruitment
Scope : MRD
Distribution list: MRD
Policy:

a) Hospital Medical Records can be documentary evidence as per the Indian Evidence Act. 1872, as amended up to August 1, 1952, 1961 and Medical Records are generally subpoenaed to court in the following types of cases:

b) Personal injury Suits (Accident etc.)

c) Criminal Cases (Assault, Murder etc.,)

d) Worker's Compensation (Factory Accident, Disabilities etc.) Act.

e) L.I.C cases (Death claims / Injury /Accident)

f) Malpractice Suit (An action for malpratice may be brought against the hospital and its employees in a civil or criminal court.)

g) Patient Will Cases (A Patient may have made a will during his hospital stay)

h) Authorization for Operation (An operation, or even a medical examination carried out without consent expressed or implied of the person concerned, will usually amount to actionable assault.)

i) Death Claims (Family pension, insurance claims etc.)

12.10 The Income Tax Act:

Under the section 38(5) of the Income Tax Act 1922, No Prior Permission from the patient in necessary to Show the records to the IT Department.

12.11 Patient Leaved the Hospital against Medical Advice:

If Patient is being L.A.M.A. the signature of patient or relative should be obtained in a prescribed form(This is done at word /Casualty level)

12.12 Medical Record Storage : Prepared by Medical Record Incharge

Scope: MRD
Distribution list: MRD
Policy:

a) The numbering system of Medical records file shall be in accordance with Allotted at admission counter. The files shall be arranged and stored in medical records room. The CR.No. Shall reflect on the file.

b) Only authorized users can view / retrieve the medical records.
c) In MRD only inpatients records are kept for patients enquiry.

12.13 Retention period of Medical Records: Prepared by Medical Record Head

Scope: MRD
Distribution list: MRD

Policy:

- All Medico legal patient records Permanent
- All the Death records shall be maintained for Permanent
- Manual In-patient records (Other than medico-legal) will be retained 10 years
- The other records and registers, detailed below, are retained for the period mentioned against each:-

a)	Birth Register & Birth Forms	Permanent
b)	Death Register & Death Forms	Permanent
c)	MLC Register	Permanent
d)	Statistics Files	10 years
e)	OPD Registers	10 years
f)	Important Circulars file and miscellaneous circular file	Permanent
g)	Dispatch Register of Birth and Death reports to the Sub-Registrar of births and deaths office	Permanent
h)	Death report file	Permanent
i)	RTI related Medical Record Correspondence	Permanent

12.14 Departmental Safety: Prepared by Medical Record Incharge

Scope: MRD
Distribution list: MRD
Policy:

- Medical Record Officer is responsible for maintaining safety standards, developing safety rules, supervising and training personnel in departmental standards.
- Observe standard precautions at all times.
- Smoking is prohibited in the hospital.
- Do not permit rubbish to accumulate.
- Notify facilities department immediately of improper illumination and ventilation.
- Minor spills, i.e. water will be cleaned by the employee who discover tthe spill. Thi will be done immediately.
- Obey wrning signs.
- File drawers and cabinet doors shall be closed when not in use. Open only one drawer at a time. Evenly distribute material to prevent the file cabinet from being unbalanced and tipping over.
- Wear suitable clothing (avoid high heels or jewelry)
- Frequently inspect cords, plugs, switches, for damage. Report any defects such as frayed cords, broken plugs etc. immediately.
- Observe Standard Precautions at all times.
- Safety and dignity of female employees is to be maintained . Any lapse to be forwarded to higher/appropriate authorities for redressal/action.

12.15 Destruction of Medical records: Prepared by: Medical Record Incharge

Scope: MRD
Distribution list: MRD
Policy:

a) Destruction of medical records will be carried out in accordance with the retention policy of the hospital.

12.16 Policy Audits on Medical Records : Prepared by Medical Record Incharge

Scope: MRD

Distribution list: MRD

Policy:

a) Audit of all medical records of discharged inpatients will be carried out by the MRD staff.
b) Results of the audit will be shared with the medical and nursing staff with a view to improve quality of the records.

12.17 Reports

a. REPORT TITLE: Daily census		
DEPT. MRD	Frequency: Daily	Prepared by: Nursing staff
		Approved by: Medical Record Incharge

b. REPORT TITLE: Statistics		
DEPT. MRD	Frequency: Daily	Prepared by: Medical Record Officer
		Approved by: Medical Record Incharge

The report format includes preparation of the following types of statistics.

- Over all OPD Statistics.
- OT/Procedure / Delivery statistics
- O P Department wise Statistics.
- I P Department wise Statistics.
- Ward wise % Bed Occupancy Statistics.
- Month wise Total Statistics.
- Daily OPD & IPD Statistics.

MRD staff shall prepare the Statistics as per the Management requirements.

12.18 Quality plan – Quality Indicators

a) To fill deficiency checklist of discharged inpatient records within 24 hours of receipt. To rectify all deficiencies within a week of discharge.

b) Coding of medical records as per International Classification of Disease with in 7 days of discharge.

C) To send the birth and death reports to corporation authority within stipulated 21 days.

12.19 Forms/ Documents

a) Forms

- Birth report.
- Corporation Delivery Reports Register.
- Daily Census entry maintained by HIMS.
- Form 4-Medical Certificate Cause of Death.
- Monthly Statistical file.
- Insurance Company file.
- LIC Certificate and file Govt., insurance certificate file.
- Name and Other Correction file.
- MRD Circular(required) file.
- Outside Correspondence file.
- Govt., Letters file.

b) Registers

- Birth Register.
- Death Register.
- Birth Intimation Register.
- Death Intimantion Register.
- Court Register.
- Issue of file to Mortality Meeting Register.
- MLC Register.
- Hospital Statistics register.

c) Seals

Maintaining the Rubber Stamp in Medical Records Department

- I/C MRD.
- MRO.
- MRD Deptt.

STANDARD OPERATING PROCEDURE

NAME OF THE HOSPITAL

ACCONTABILITY PAGE

SOP TITLE: Standard Operating Procedure for Repair and maintenance of hospital equipments

SOP NUMBER: H&FW/R&M/01

VERSION: 1.1

NUMBER OF PAGES: _____

AUTHOR: _____

INTENDED LOCATION: All departments

EFFECTIVE DATE: 01/07/2016

REVIEW PERIOD: 06 MONTHS

AUTHORIZED BY

_____

SIGNATURE

NAME/DESIGNATION/SEAL

APPROVED BY

_____

SIGNATURE

NAME/DESIGNATION/SEAL

13-Standard Operating Procedure for OPD

13.1 Purpose:

This Standard Operating Procedure for Hospital equipment maintenance provides policy and procedures for repair and maintenance of various category of medical equipments installed in different departments/units of the Hospital, in order to provide quality medical care to the patients in an efficient manner. Many of the patient care services are essentially dependent on the equipments, without the appropriate equipment hospital cannot provide desired or committed service to the patient or the community, thus a reliable, dependable and sustainable repair and maintenance program is essential for every hospital and health care institution. The objectives of the hospital repair and maintenance program is to keep all the medical equipments in highest working order through its timely maintenance repair and condemnation and replacement of the equipment in a cost effective manner.

13.2 Scope:

This SOP covers all the processes applicable to all user department using equipments and machinery for delivery of patient care services. Repair and maintenance program starts from installation of equipments its use repair and maintenance finally its condemnation disposal and replacement.

13.3 Responsibility:

HOD, of the user department , technicians and repair and maintenance nodal officer , technical staff.

HOD User department:

- They will be responsible for maintaining the functional status of all equipments under their department and will promptly ensure that these equipment function smoothly /repaired and without lengthy downtime. They will keep liaison with the company maintaining the machine, officer in-charge R&M officer in-charge of purchase in this regard.
- They will be responsible for installation of new equipments in their department, and for overall supervision and monitoring of all sanctioned repair and maintenance work in their department.

- Develop standard operating procedures to cost effectively use all maintenance and repair resources.

- Calibration and standardization of equipments with respect to patient and operator safety.

- Establish a work control and priority system to ensure equitable service to all elements and units.

- Implement a command preventive maintenance and repair program to ensure cyclic inspection and service to all equipment.
- Maintenance of log book History sheet of all equipments under their control with help of the in charge R&M.

• Report monthly/quarterly/ annually regarding status of the equipment/ utilization, down time up time etc.

In Charge of repair and maintenance:

- In charge repair and maintenance will be responsible for repair of equipment in a timely manner (including assistance to HOD's of user department in the hospital on receipt of a formal request).
- Processing of all file work related to any and all repair and maintenance related request as per local policy and procedures from the user department.
- Evaluate all medical equipment at least quarterly/ half yearly for the specific purpose of recommending replacements/ condemnation based upon repair histories and life expectancies and condition of the equipment.
- Condition codes all equipment. In order to carry out its functions, the medical equipment maintenance and repair program is required to complete the following task:

Technical staff:

- Daily upkeep of the equipment, its proper cleaning and preventive maintenance

Sister in-charge of user department:

❖ Responsible for maintenance of :

- List of all equipment installed in the department.
- Maintains file for all equipment installed in the separately in which the history sheet, log book, service reports, Expenditure sheet, operation manuals, AMC /CAMC records are kept.

- Appraise status of all equipment installed in the department quarterly to the repair and maintenance branch.

Aim and objectives.

- Minimal downtime for all essential and life saving equipments, no equipment should remain nonfunctional for more than thirty days in hospital/ healthcare system.

- Provision of CAMC /AMC of all vital and costly equipment.
- Efficient system for regular service and maintenance of equipments hospital furniture/ and office furniture.
- Creation of a dependable system for breakdown/ repair service.
- Efficient system of procurement and condemnation and equipment procurement.

13.4 Procedure:

S.No.	ACTIVITY	RESPONSIBILITY	REFERENCE
13.4.1	**Installation of equipment in user department.**		

1.	User departments should take following steps while a equipment is installed in the department.
	• Register the equipment in the MIS module.
	• Get the Operating manual of the equipment from the firm along with instructions on care and maintenance of the equipment. Convert them to SOP and place it with the equipment for ready reference by the users. Get a hard copy as well as a soft copy of Operating manual from the supplier.
	• Get your manpower trained on the operation maintenance and care of the equipment during the installation of the equipment in your department.
	• Must Know DO's and Don'ts and also display them prominently with the equipments.
	• Create an "**EQUIPMENT FILE"** with following document. A copy to be kept with the user department.
	  • Copy of Supply order along with terms of supply, guarantee and warrantee clause.
	  • Copy of performance guarantee if any.
	  • Copy off installation report.
	  • Care and instruction and operating manual.
	  • Make the equipment history sheet with the following information's.
	• Document all events of malfunction, repair and maintenance with date and time in the log book.
	• Keep the terms and conditions of each contract and for every equipment (Guarantee, Warrantee, AMC, CAMC, Work Orders etc.) for future reference and use in the event of breach.
	Document the utilization, annual cost of maintenance, down time, for all equipment. (Recording of utilization of life saving equipments such as defibrillators and stand by equipments is not actually required.
		HOD User department
		
		Sister I/C User department	

Fault repair process for equipments has been divided in to two groups. • **Equipments under Guarantee (Repair and parts both covered) and equipments covered under (CAMC)comprehensive annual maintenance contract.** • **Equipments under Warantee (Repair is covered and cost of parts only to be paid) and equipments covered**			

	under (AMC)annual maintenance contract.		
13.4.2	**SOP for repair of equipments under Guarantee/ CAMC**		
	• Report the fault/ Malfunction to the vendor/ supplier, simultaneously report the same to the repair and maintenance branch of the hospital through HOD of the user department. • Record the event with date and time in the log book of the particular equipment. • As the equipment is under guarantee / CAMC no charges for repair or parts are payable. • Get the repair done. • Obtain a service report from the engineer after the equipment has been checkced by the user/ technical person (functioning satisfactorily or not). • Record the event with date and time in the log book of the equipment. • File a copy of service report in the equipment file. • Note the downtime in the log book of the equipment, if it is more than 24 hours. • Calculate downtime of all equipment at the end of the contract or if it exceeds the permissible limit during the contract. • Report the excess downtime to repair and maintenance branch. • A necessary step as per the term of the contract to be taken.	Sister I/C User department.	Fault reporting performa / request for repair (Annexure-1) Log Book (Annexure-2)
13.4.3	**SOP for repair of equipments under Warrantee/ AMC (Cost of repair is covered under the contract but cost of the parts is to be paid.)**		

1.	• Report the vendor / supplier as soon as the malfunction or fault is detected by the user department.
	• The equipment may require a simple repair or may require replacement of some part.
	• If only repair is required it should be done by the engineer , no cost applies.
	• If some parts need replacement, ask the engineer to give an estimate for pair (cost of the part)
	  • NOTE: Department/ Repair and maintenance branch must get a price list of spare parts from the vendor before the start of AMC contract/ or on the expiry of the guarantee period of the equipment. (as the case may be)
	  • Get the price list approved by the HOD user department, repair and maintenance committee.
	• Forward the requisition of repair along with service report, estimate and essential information sheet in the equipment file to the repair and maintenance branch through HOD user department.
		Sister I/C User department
		
		HOD User department
			Format for essential information sheet (Annexure-3)
			
			Fault reporting performa / request for repair (Annexure-1)

2.	• Repair and maintenance branch processes the file for approval of R&M committee / I/c R&M (As per policy of the Hospital).	Dealing clerk R&M branch.	

	• After approval of the R&M (I/C or committee) the file is sent for administrative approval and financial sanction of the Medical superintendent. • After the approval of the competent authority the vendor is informed/ work order is issued as per the terms of the contract with a copy to the user department. • Department get the repair work done. • Check the equipment for its proper functioning by the user of the equipment. • Work completion certificate is issued to the vendor. • Invoice/ bill is obtained from the vendor. • File along with work completion certificate is forwarded to repair and maintenance branch after successful and satisfactory repair of the equipment.	I/c R&M HOD User department	
13.4.4 SOP for repair of equipments not covered under any con (Cost of both repair and cost of the parts is to be paid.)			

	• Department must list such equipments which are not covered under any AMC or CAMC contract.
	• A LTE/ or advertized tender enquiry needs to be done as per provisions laid down in GFR.
	• Only urgent and essential repairs can be done under this rule, and hence department must list all such items, and plan a repair and maintenance of such equipments in advance.
	• However procurement of services and parts from single source may be resorted to in following circumstances.
	  • It is in the knowledge of the department that only a particular firm is manufacturing the equipment.
	  • For standardization of machinery / or its spare parts to be compatible with the existing.
	  • In emergency situations, s reasons for such decisions should be recorded in file.
		In-charge repair and maintenance	

134.5 SOP FOR CONDEMNATION OF EQUIPMENTS			
1	Preparation of list of instruments / equipment separately by user department in GFR form -17	Sister I/C, Technician	GFR Form-17
2	For equipments department must enclose history sheet of the equipment along with last service report of the vendor/ engineer maintaining the equipment	Sister I/C, Technician	Appendix-4 History sheet
3	Inspection of the equipments / instruments by HOD user department/ Departmental condemnation committee with signatures on the GFR Form-17	HOD user department	
4	Forwarding of proposal of condemnation to the standing condemnation board.	HOD user department	Dully signed GFR Form-17
5	Inspection of the stores by the standing condemnation board, and approval as per the TOR	Standing condemnation board	TOR for standing condemnation board
6	Standing condemnation board recommends condemnation, fixes reserve price along with a 10 or 20% STA clause (Subject to approval) and proposes a mode of disposal as per the rules.	Standing condemnation board	

7	The recommendation is forwarded to the HOD (Competent authority for condemnation of articles up to 10 lakhs) and finance department is competent authority for articles valued more than 10 lakhs.	Competent authority	Delegation of financial power rules
8	Once the recommendation has been approved by the competent authority process for disposal should be initiated immediately, as per rules.		
9	For articles costing less than 2 lakhs can be auctioned through limited/ open auction.	Nodal officer condemnation/ disposal	GFR rule -199
10	Articles above 2 lakhs should be auctioned through MSTC.		MSTC
11	Evaluation of offers: if the highest bid price is more than the reserve price the articles may be offered to the bidder.	Nodal officer condemnation/ disposal	
12	In case the highest bid price is less than the reserve price, but more than the STA clause the standing condemnation board once again go through the reserve price take a decision either to recommend disposal at the highest bidder if the difference is less than the STA clause.	Standing condemnation board	
13	Whenever STA clause has been used to recommend highest bidder re-approval of competent authority is required	Competent authority	
14	In case the bid price is less than the reserve price and also less than the STA clause standing condemnation board should review the reserve price and recommend a re-auction.	Standing condemnation board	
15	Approval of revised reserve price and STA clause and re-auction by competent authority	Competent authority	
16	Re-auction		
17	Repeat step 10 to 12 to effect the sale to the highest bidder or else repeat step 13-15 at least twice.		
18	Immediately after obtaining the approval of competent authority to declare the item surplus/obsolete/unserviceable, an OM containing details of items its value quantity and head of account to be issued, and also convey them the items to be written off from the books of accounts/ stock registers, with a copy to the accounts functionary and PAO	Chairman condemnation board	
19	Once the items has been disposed it should be entered in the form GFR-18	Chairman condemnation board	form GFR-18
20	In case three consecutive auctions fails articles can be disposed off at its scrap value with the approval of competent authority in consultation with finance division.		GFR Rule -200
21	In case hospital/ department is unable to sale the item at its scrap value it may adopt any other method of disposal including destruction of item in a eco friendly manner.		GFR Rule -200
22	After condemnation and disposal department may ask for replacement against the condemnation of the said item as per current requirements	Store and purchase office	

Annexure-1, Fault reporting Performa

REPAIR AND MAINTENANCE

REPAIR FORM

To be forwarded by user department, Along with service report, estimate, or proposal (for AMC/CAMC/ whichever is applicable.

	NAME OF DEPARTMENT /UNIT	
	NAME OF EQUIPMENT	
	SERIAL NO OF EQUIPMENT	
	DATE OF MALFUNCTION / BREAKDOWN / CEASATION OF FUNCTION	
	DETAILS OF MALFUNCTION / BREAKDOWN / CEASATION OF FUNCTION.	
	DATE AND TIME AND NAME OF SERVICE ENGINEER CALLED.	
	SIGNATURE OF TECH/NUR. STAFF	SIGNATURE OF HOD
FOR REPAIR AND MAINTENANCE DEPARTMENT USE		
	Service department call detail	
	Date of visit	
	Service report no and date	
	Estimate date and amount.	
	Date proposal moved	
	Date of issue of supply order	
	Date equipment made functional	
	Date of payment	

SIGNATURE I/C R&M

Date of	DETAIL OF WORK (BREAKDOWN, PMS, NON WORKING Etc...)	Date of call for Repair	Date of completion of Repair	Signature ward/Dept

Annexure- 2 Equipment Log Book

TOTAL NO OF DAYS EQUIPMENT WAS NOT-FUNCTIONAL- _____ DAYS

X 100

ESSENTIAL INFORMATION SHEET FOR EQUIPMENT		
1	NAME OF THE EQUIPMENT	
2	WHEATHER COVERED UNDER (PLEASE TICK)	
3	DATE OF INSTALLATION	
4	COST OF EQUIPMENT	
5	AMOUNT SPENT ON EQUIPMENT TILL DATE	
	(a) ON AMC/CAMC	
7	(b) ON REPAIR	
8	DETAILS OF REQUISITE REPAIR (As per service report of the engineer)	
9	Estimated guarantee of the required repair as per the vendors estimate.	
10	Estimated guarantee of the required repair as per the estimate of HOD of the user Department.	
11	IS MACHINE IS UNDER AMC/CAMC OR NOT	
	IF YES ; VALIDITY PERIOD	
	IF NO; PLEASE GIVE REASON, AND WHEATHER IT IS REQUIRED OR NOT	
12	JUSTIFICATION OF HOD FOR THE REPAIR	
13	ANY OTHER INFORMATION (ENCLOSE SEPRATE SHEET)	
NOTE : TO BE FILLED BY USER DEPARTMENT, FOR EVERY REPAIR WORK AND SEND TO BE		

FORWARDED TO R&M BRANCH WITH REPAIR FORM, SEVICE REPORT AND ESTIMATE IF ANY

Name of Department

Annexure-3 Essential information sheet

Signature Sister I/C Signature HOD

Annexure -4 Equipment history sheet

Equipment History Sheet	
Name of Department :	
Name of Equipment	
Serial No of the Equipment	
Date of Procurement	
Cost of Equipment	
Date of Installation	
Name of Supplier	
Address of supplier	
Contact Details of Supplier	
Name and Tel. No. of Contact Person	
Spare part Inventory if any	
Technical Manual if any	
AMC if yes	
Guarantee Period	
Warrantee Period	
Life of Equipment if any	
Up time / Down time (Annual)	
Annual cost of Maintenance	
Comments of User Department regarding	

Utilization & Essentiality of Equipment	
History of Repairs if any	
Remarks	

Signature Sister I/C Signature HOD User Department

Annexure 5- Equipment utilization report

QUARTERLY REVIEW OF UTILISATION OF EQUIPMENT AND MACHINES INSTALLED IN THE HOSPITAL

NAME OF THE HOSPITAL……..QTR. **I/ II/ III/ IV**

NAME OF DEPARTMENT/ UNIT OF HOSPITAL	NOMENCLATURE OF EQUIPMENT/ MACHINERY INSTALLED	DATE UPTO WHICH GUARANTEE/ WARRANTY / AMC EXISTS	NUMBER OF DAYS ON WHICH IT REMAINED UNSERVICEABLE AND REASON THEREOF	NUMBER OF DAYS PER QUARTER IT WAS UTILIZED	NUMBER OF BENEFICIARIES WHO WERE SERVED	HOURS PER DAY THE MACHINE WAS UTILIZED ON AN AVERAGE DURING THE QUARTER	NUMBER OF PATIENTS IN WAITING LIST, IF ANY	REMARKS

REMARKS:								
i. All vital equipments should be identified by Medical Supdt. Discipline wise/ unit wise for this review.								
ii. If more than one equipment is available of a particular category say X-Ray Machine then reporting of all the equipments should be made seperately.								

Annexure-6 TERMS OF REFERENCE (TOR) FOR CONDEMNATION BOARD

- Duly constituted condemnation boards shall meet at least twice a year and examine the requests received from department/s for condemnation in duly filled GFR form-17 by departmental condemnation committees..
- In case there is no formal request is received by the board the board must consider issuing circular / calling requests for condemnation from all user departments of the facility.
- On receiving the request from the department, board shall meet and consider the requests submitted by the departments.
- boards while considering condemnation of any article, condemnation boards shall use the following check list:
    - That condemnation is being done in accordance with guidelines available in GFR (Rule 196-202) and other orders and guidelines issued by Government for condemnation and disposal.
    - That equipment/ article under consideration has outlived its life, is non-functional and/ or beyond economic repair/ surplus is of no use for the department/ obsolete/ and record their recommendation accordingly.
    - That equipment has passed its useful life/ prescribed life.

- That equipment cannot be cannibalized or put to some other use in a cost effective manner.
- That condemnation disposal and its replacement will add to the efficient delivery of services.
- That putting the equipment to further use may compromise the safety of patient or the medical staff using it.
- That no environmental safety/ Biomedical waste handling and disposal rules/ Radioactive element handling rules or any other rules regulations are being violated while recommending condemnation and disposal of an article.
- In case it comes to the notice of the condemnation board that an particular item becomes unserviceable due to negligence, fraud or mischief on the part of a Government servant, the board prepares a report and send it to the competent authority for enquiry and fixing the responsibility for the same.

❖ After ensuring the above the board member shall either issue a recommendation certificate (A sample format of recommendations of condemnation board is annexed as Annexure-5) or sign the GFR-17(As per Delegation of financial power) Report for further consideration competent authority.

❖ When price of any article to be condemned is/are not available with the department, condemnation board may use following for fixing a price of the article in GFR-17

- Price of similar item procured in the department.
- May ask other Govt. hospitals for price.
- Prevailing market price of such article.

❖ Board while recommending condemnation must also recommend reserve price of the condemned article and mode of disposal. While fixing the reserve price the committee shall take overall condition of the item vis-à-vis the market price of such second hand product or exchange price of such items when given by the OEM or the authorized vendor who supplied the equipment.

- ❖ The standing condemnation board will decide the reserve price for disposal of such store. Ideally reserve price should be kept in a sealed cover and shall be opened after opening of bids to compare the reserve price with bid price
    - **Guide price:** is the price that something is expected to be sold especially in an auction.
    - **Reserve price:** 'Reserve Price' a minimum amount that the owner of an item puts up for auction; will accept as the winning bid in the auction. The reserve price prevents the auction from being won at a price that is lower than the item's owner will accept.
    - **Book Value:** of an item is its cost minus the accumulated depreciation.
    - **Residual value:** residual value is the estimated amount that it will be worth at the end of its useful life. Some manufacturer for certain equipments may provide residual value or buy back value of their equipments after end of its useful life.

Board while fixing reserve price of the article may consider following:

- Whether the article/s condemned can fetch more than 10 % of the purchase price in present condition? If yes fix the reserve price accordingly, and if No; consider the following.
- Ask the OEM (???) to give a buyback offer for the equipment.
- Try to value the article based on its composition and its scrap value.
- Try considering depreciation
- 10% for mechanical Equipment, Steel furniture
- 15% for Electromechanical and other hybrid equipments and instruments
- 20 to 25 % for technology based equipments.
- The Most important yard stick of the value of the condemned article is when it is auctioned transparently. To get a fair value of the items try to auction the article through MSTC e auction with a STA clause.
- If first e auction fails to fetch the reserve price and even the STA limits, board should consider reducing the price after evaluation of bids. Try re-auction after reducing the price accordingly.
- If re-auction also fail board in consultation with competent authority may consider reducing the reserve prices to match the highest bidder.

- If there is no bidder; consider disposing such articles by open auction inviting local scrap dealers. As further auction through same portal may not likely to be successful or fetch more price, more over delay may cause unnecessary inventory carrying cost and may pose safety hazard also.
- To sum up board should try fix a reasonable reserve price for auction, auctions and re-auctions after reducing the price should be done quickly at least twice, and then a open auction with bigger STA clause should be tried.
- If every thing fails items can be disposed off at its scrap value (last highest bidder) with the approval of the competent authority in consultation with the accounts functionary. (See rule -200 of GFR)

- In case department is unable to sell the item even at scrap value, any other mode of disposal including destruction of the item in a ecofriendly manner may be considered.

दिल्ली सरकार

आप की सरकार

Department of Health & Family Welfare, GNCTD