	Standard Operating Procedure	Document No:
	GENERAL ADMINISTRATION	Date of Issue:

Purpose

- To define the responsibilities of those responsible for governance.
- To ensure that the organization is managed in an ethical manner.
- To define responsibilities of multi-disciplinary committees for overseeing specific aspects of quality and patient safety

To ensure that

- Those responsible for governance support the quality improvement plan.
- The management defines the rights and responsibilities of employees.
- The organization complies with the laid down and applicable legislations and regulations.
- Those responsible for governance address the Facility's responsibility for community.
- Up-to-date drawings are maintained which detail the site layout, floor plans and fire escape routes
- There are proper internal and external sign postings in the organization that use pictorial and are in language that is understood by the patients, families and community.
- There are designated individuals responsible for maintenance of all facilities
- There is a documented operational and maintenance (preventive and breakdown) plan for the facility and infrastructure
- Alternate sources are provided for both, in case of failure
- The organization regularly tests the alternate sources
- There are maintenance plans for water, electricity, heating, ventilation and air conditioning

Scope

Hospital/ CHC/ PHC wide

Responsibility

Superintendent-in-chief (SIC) / Chief Medical Superintendent (CMS) / Medical Superintendent (MS) / Medical Officer In-charge (MO I/c) / Quality Nodal Officer/ Infection Control Officer (ICO) / Hospital Quality Manager (HQM) / Quality Team/ Head of the Departments (HODs)

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POLICY:

- The Facility has a documented Organogram defining clearly the responsibilities of key personnel
- The persons responsible for management support the quality improvement and patient safety plans of the organization
- Quality Nodal Officer/ Hospital Quality manager is coordinator to oversee the Facility wide quality and safety programme.
- The Facility In-charge defines, documents and establishes the following in the Facility:

    a) Mission

    b) Vision

    c) Quality policy

    d) Quality Objectives

OUR MISSION

To establish a system of reliable, timely and good quality health care services with the patient centered approach.

OUR VISION

To be recognized as Public Health Facility providing comprehensive, affordable and equitable health care services to all in ethical and safe work environment.

OUR VALUES

Values are fundamental beliefs that drive organizational behavior and decision making. This also refers to the guiding principles and behaviors that embody how the organization and its people are expected to operate. Values reflect and reinforce the desired culture of the Facility.

Our **Philosophy** is to provide the most accurate and standardized health care services to all our patients without any compromise.

Our **Commitment** is towards achieving excellence in health care practice by not only providing the best technology but also the best care.

Following values are at the core of all the activities and personnel at our Facility:

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- Honesty, transparency and truthfulness in all dealings and communication with both internal and external customers
- Instant care, relief and responsiveness
- Reliability of all procedures and processes
- Safety is considered supreme in all processes, procedures and infrastructure
- Empathy while dealing with patients and attendants
- Respect for life and reduction of misery directs all processes and transactions
- Responsiveness is given due weightage in all transactions
- Doing the things on time and right the first time always
- To create an environment for professional growth and development
- Respect the person irrespective of his position, stature, ethnicity, religion, caste, creed or gender
- Treat everyone in the way you yourself wish to be treated.

QUALITY OBJECTIVES:

- To place quality at the core of service delivery
- To encourage attainment of best practice
- To promote a patient centric service delivery
- To ensure patient visitor and employee safety
- To work towards continuous improvement of health indicators
- Conservation, care and aesthetics whereby we strive to treat the patients by providing excellence in quality health care

The Facility displays the following:

  - The services it provides
  - The services Facility doesn't provide
  - Citizen charter
  - Standard user charges
- The Administration guides the Facility to function in an ethical manner.
- The Facility documents agreements for all the outsourced services such as those given below and monitor them periodically:
  - Maintenance – Air-conditioning, electrical, lifts, all Non medical and Bio-medical equipment etc
- The Facility has set up **multi-disciplinary committees** including Quality & Safety, Infection Control, Bio medical waste management, Drugs & Therapeutics, Death Review, Committee against sexual harassment, Rogi Kalyan Samiti and the membership, responsibilities and periodicity of meetings of each are defined.

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Procedure :

S.N	Activity	Responsibility	Record/ Reference
1.1	The Facility has an organization chart. The chart shows the hierarchy and line of control and functions. Responsibility and authority of key personnel in the Facility are defined.	SIC/ CMS/ MS/ MO I/c	
	Compliance to the Legislative and Regulative requirements:		
2.1	The management of the hospital undertakes the follow activities: 1. Satisfy all statutory requirements as required by the law of the land. 2. Preserve the required acts and licenses in a safe manner facilitating easy retrieval of same in case demanded by an appropriate authority or for internal reference. 3. Display the same for the perusal of the general public in case so required by law. 4. Keep a track of any amendment/ changes in the prevailing law and update the same as per the law. Ensure initiation of timely efforts for the renewal of licenses / registrations / certifications as and when needed	SIC/ CMS/ MS/ MO I/c/ Hospital Quality Manager (HQM)	
2.2	**The Facility is governed by the following statutory requirements:** **1. License :-** a. Building Permit (From the Municipality). b. No objection certificate from the Chief Fire Officer. c. Authorization from District Pollution Control Board for Handling Biomedical Waste. d. X-ray room layout approval from AERB. e. Excise permit to store Spirit. f. Vehicle registration certificates. g. License for the blood bank. h. Authorization for MTP. **2. Acts:-** ▪ Narcotics and Psychotropic substances Act. ▪ Air (prevention and control of pollution) Act, 1981. ▪ Biomedical waste management handling rules 2016. ▪ Amendment Biomedical waste management handling rules 2018		

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- Consumer protection Act, 1986.
- Dentist regulations, 1976.
- Drugs and cosmetics Act, 1940.
- Employees provident fund Act, 1952.
- Equal remuneration Act, 1976.
- Fatal accidents Act, 1955.
- Indian lunacy Act, 1912.
- Indian medical council Act and code of medical ethics, 1956.
- Indian nursing council Act, 1947.
- Indian penal code, 1860.
- Indian trade unions Act, 1926.
- Maternity benefit Act, 1961.
- MTP Act, 1971.
- Minimum wages Act, 1948.
- National building code.
- Negotiable instruments Act, 1881.
- Payment of wages Act, 1936.
- Persons with disability Act, 1995.
- Pharmacy Act, 1948.
- PNDT Act, 1996.
- Protection of human rights Act, 1993.
- BARC, Act.
- Registration of births and deaths Act, 1969.
- Tax deducted at source Act.
- Constitution of India.
- Transplantation of human organs Act, 1994.

Custodian of Acts and Licenses:

- All the acts will be stored centrally in the custody of the Chief Medical Superintendent of the hospital.
- Hospital staff members will have an access to the acts for any reference after obtaining permission from the Chief Medical Superintendent.
- A copy of the licenses will be stored by the individual department under the ambit of the license which will be displayed in the concerned department.
- All original copy of the licenses will be stored centrally under the custody of the in charge clerk in the

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	administrative department		
2.3	All the legal requirements and legislations have been listed and implemented by the concerned departments throughout the Facility.	SIC/ CMS/ MS/ MO I/c/ Hospital Quality Manager (HQM)	
2.4	The Facility has designated Quality Nodal Officer and Quality team who are responsible for implementation of Quality Management System throughout the Facility.	SIC/ CMS/ MS/ MO I/c	Office Order and Records of Committee Meetings
2.5	The management clearly defines the rights and responsibilities of employees at the time of induction.	SIC/ CMS/ MS/ MO I/c	
2.6	The Facility is committed to provide free treatment, free medicines and free diagnostic facilities to all those coming to the Facility. It also organizes free medical camps and participates in outreach programs.	SIC/ CMS/ MS/ MO I/c/ Hospital Quality Manager (HQM) /HODs	
2.7	The Facility has clearly defined and displayed at its entrance, the services available and not available. The Registration and OPD staff verbally conveys to the patient the services Facility cannot provide. When in doubt the admission staff checks with the medical administrative staff or the concerned Consultants / Doctors.	SIC/ CMS/ MS/ MO I/c/ Hospital Quality Manager (HQM)	
2.8	The organization honestly conveys its affiliation and accreditations for specific department or whole hospital.	SIC/ CMS/ MS/ MO I/c	
System for Internal Audits at defined intervals			
	Internal audits are carried out as per the audit plan to assess the compliance and effectiveness of the quality systems. Audits are planned and coordinated by the Quality Nodal Officer/ Hospital Quality Manager and will be conducted by Quality Assurance Team/ Committee. Audits are scheduled as per the status and the importance of the activity and are carried out by auditors independent of those having direct responsibility for the work being performed.		

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	Audit results are recorded and communicated to the auditee. The auditees take timely corrective action on the non-conformities observed during the audit. The action taken is recorded on the non-conformity report, which is submitted to the SIC / CMS/ MS/ MO I/c. Follow up audits are carried out to verify and record the implementation and effectiveness of the corrective action taken as per the documented procedure.		
3.2	• Medical staff participates in this system. • The parameters to be audited are defined by the organization. • Patient and clinician anonymity is maintained. • All audits are documented. • Remedial measures are implemented.		
3.3	• Clinical audit is a professional evaluation of the quality of care rendered to patients. The Facility records are subjected to critical examination. • Medical audit is an evaluative methodology involving the medical staff and administration. This helps in high quality patient care, efficient administrative activities and serves as an incentive to practice of the most modern clinical practice. • The Facility defines the parameters to be audited by the auditors. It does that with a priority to the quality patient care, adequacy of medical records. • It is the policy of the Facility to maintain confidentiality or information about patient and their treatment. So anonymity is maintained about patient and clinician. • All audits are documented the discussed in management review meeting. • Decision regarding remedial measures are usually taken in the Medical Audit / Management review meeting. These remedial measures are implemented properly in the functioning of the		

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	organization. • The organization has policy of documenting all the procedure of medical audit done in the hospital. The audit of the clinical files is done once in a month. The SIC/ CMS/ MS/ MO I/c along with the physician and the in-charge of medical records are the people responsible for medical audit. • The policy of the organization is that after the medical audit the faults found are rectified, the remedial measures suggested are implemented for improvement of patient's care.		
Procedure for control of Documents and Records			
	Documents such as regulations, standards, and other normative documents as well as drawings, software, and specifications, instructions and manuals form part of the Hospital Management System. A copy of each of these controlled documents is archived for future reference and the documents are retained in their respective departments. The procedures and equipment details are retained in respective departments as long as the machine is being used or until condemned. The documents are maintained in paper or electronic media as appropriately required. Documents are identified and established as three levels namely: ♦ Hospital / Facility manual ♦ SOP/ Instruction manuals ♦ Quality Manual ♦ Records The Quality Assurance team ensures that: ♦ Authorized editions of appropriate documents are available at all locations where operations essential to the effective functioning of the Facility are performed. ♦ Documents are periodically reviewed and revised where necessary to ensure suitability and compliance with applicable		

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requirements.

- Invalid or obsolete documents are promptly removed from all pints of issue or use, or otherwise assured against unintended use.
- Obsolete documents are retained for either legal and / or knowledge preservation purposes are suitably marked or destroyed or the record and the record of this is maintained in a separate register.

Management system documents are uniquely identified.

- Date of issue
- Identification of revision status
- Page numbering with the total number of pages
- Identification of the end of the document
- Issuing authority

DOCUMENT CHANGES

Revision of management systems documents is carried out when necessary by the original author. When alternate persons are designated for review, they first familiarize themselves with pertinent background information upon which to base their review and approval.

Any alteration in the text is documented on the document or by way of maintenance of obsolete documents issued prior to review.

Document control system does not follow for the amendments by hand unless there is extenuating circumstances .These amendments shall be marked, initialed and dated only by the HOD, .The amendment shall be brought to three notices of the Medical Superintendent and Quality Assurance Officer and the same shall be reissued in 7 working days of the change being in effect.

maintains documentation status currently in hard and soft versions. describing the changes in documents, its maintenance and its control in the computerized system establishes adequate procedures.

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The Administration makes public the Vision & Mission statements, Quality Policy, **Quality Objectives of the Facility.**			
1.8	• The Facility has a policy statement based on its mission displayed at prominent locations. • The Facility has established Facility's ethical management as per the guidelines of code of medical ethics 2002 published by Medical Council of India.		
The Facility has a designated individual (s) to oversee the Facility wide Safety Programme.			
	The Facility recognizes and attaches greatest importance to, and concern for, the safety of all its patients, the Facility staff and the users of the premises under its control. Consequently the Facility strives to ensure that accidents, incidents and near misses are identified, reported and action taken to help ensure the safety and security. The Facility 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 **Scope of Risk Management** Risk management covers the following aspects: • Environmental Risk • Clinical Risk • Complaints & Grievance Handling (For Patients & Staff) • Mandatory Training related to Risk Management	SIC/ CMS/ MS/ MO I/c	

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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 continual quality improvement

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

Objectives

- An over-view of all incidents is obtained throughout Hospital/ CHC/ PHC by analysis of data, including those submitted
- Any lessons which can be learned from what has gone wrong in one part of Hospital/ CHC/ PHC can be applied generally across the whole Hospital / CHC/ PHC
- Effective reporting to statutory agencies occurs from a centralized managed point

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	• A learning, fair blame culture is fostered • Loss of reputation, or assets, of the Hospital and its staff is minimized and • There is effective implementation of the Hospital's / CHC's / PHC's Risk Management Policy / Strategy. The Hospital/ CHC/ PHC fully recognizes and endorses the need for: • Open reporting of all adverse incidents, accidents and near misses • Being open with patients when an adverse incident has occurred which means apologizing and offering an explanation to patients and caretakers who have been involved in a patient safety incident • Completion of the Incident Reporting Form (IRF) for all adverse incidents, accidents and near misses • Compilation of adverse incident reporting onto the Facility's Incident & Risk Register, including quarterly reporting to the Facility Quality Team. • A systematic approach to incident investigation as set out in this policy and guidance and in particular the thorough investigation of serious incidents as defined in this policy • Sharing of investigation findings within the Facility, so that lessons can be learned (where appropriate) • Appropriate actions implemented following investigation with subsequent evaluation • Support to staff involved and re-education (where appropriate) • Immediate action and onward reporting for serious adverse incidents to limit damage / complications and to alert other external agencies as appropriate • Clear communications and media management where necessary All staff posted in the Hospital/ CHC/ PHC have a duty to report all adverse incidents and near misses as this is an important element of the Facility's risk management strategy.		

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- The Hospital/ CHC/ PHC supports staff who report adverse incidents within a culture which seeks to learn from incidents rather that apportion blame.
- The Facility endorses and supports the need for an open, 'fair blame' culture whereby the root cause of an incident is investigated without unjustly blaming individuals. It is anticipated that this will assist staff to feel able and willing to report all adverse incidents to the Head of the Department or other responsible member of the Facility

Disciplinary proceedings might be considered appropriate where there are grounds for believing an employee has, for example, acted in one of the following ways:

- Intending to cause harm which she/ he knew would result in harm (e.g. deliberately injecting potassium, intentionally removing safety devices)
- Recklessly taking an unjustifiable risk where she/he either knew of the risk or she/he deliberately closed his/her mind to its existence (e.g. administering a non-prescribed controlled drug or carrying out a procedure or performing any task for which she/he lacks the knowledge, skills, qualifications or experience to do competently)
- Negligently bringing about a consequence which a reasonable competent person with his / her skills should have foreseen and avoided
- Illegally by committing a criminal act including circumstances resulting in a police investigation or prosecution

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. are further discussed in the Safety Manual

Laboratory Safety

- Risks associated with the laboratory and safety measures and

	precautions in the laboratory are further discussed in the Standard Operating Procedure of Laboratory or Laboratory Safety Manual. **Radiology Safety** • Risks identified with the radiology department and the safety precautions taken to prevent incidents are discussed in detail in the Standard Operating Procedure of Radiology or Radiology Safety Manual. **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 **Blood Transfusion Reactions** • Any reactions resulting because of transfusing blood or blood components are documented and reported appropriately. Further information is available in the Standard Operating Procedure of Blood Bank or Policy document on Blood Transfusion. **Responsibility of staff in safety issues** • The staff is trained in safety issues of the Facility 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 Facility'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. **Safety inspection and records**: The Facility undertakes periodic inspection of the safety precautions undertaken either internally or with the help of an appropriate external agency. The reports of the safety inspections are reviewed by the Facility's Quality Team/ Committee and the same is submitted to appropriate Government Department / Agency as and when required. The safety Inspection records are maintained with respective departmental authorities. The Quality Nodal Officer or Team may require periodic assessment of the following inventory: ▪ Environmental (lighting, dusts, gases, sprays, noises). ▪ Hazardous materials (flammable and caustic). ▪ Equipment (biomedical equipments etc.). ▪ Power equipment (boilers, motors, etc.). ▪ Electrical equipment (switches, breakers, fuses, outlets, connections). ▪ Hand tools. ▪ Personal protective equipment (safety glasses, ventilators, radiation safety aprons etc). ▪ Personal service/first aid supplies (Medical Check Up). ▪ Fire protection equipment (alarms and extinguishers). ▪ Walkways/roadways (sidewalks, roadways). ▪ Transportation equipment (Ambulances, lifts). ▪ Containers (hazardous waste bags). ▪ Structural openings (windows, doors, stairways). ▪ Buildings/structures (floors, roofs, planter walls, fences). ▪ Miscellaneous (any items not covered above).		

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	Each inspection report records pertinent safety management violations, noncompliance items, and observe deficiencies. Employees directly involved in the use or operation of the facilities or function being inspected is to participate in the inspection process. • The scope of the programme is defined to include adverse events ranging from "no harm" "to sentinel events" • Management ensures internal and external reporting of system and process failures. • The adverse events include '**no harm incidents to sentinel events**'. The 'No harm adverse events' are also reported in the same form as that for 'sentinel events'. They are similarly analyzed and appropriate corrective and preventive actions are taken. The adverse drugs events are not included in this category, which are reported on a separate form. • **Sentinel events:** Any unanticipated event in health care setting setting resulting in death or serious physical or psychological injury to a patient or patients not related to natural course of the patient's illness. The record is maintained for any such incident reported in the Facility. • Implementation of system for internal and external reporting and process failure is reviewed with proper documentation so that corrective and preventive action can be taken timely.		
The Facility has documented procedure for Action Planning			
	• The Facility has established a procedure for defining responsibilities and authority for: o Handling and investigation of: ➢ Accidents ➢ Incidents ➢ Non-conformances o Taking actions to mitigate any consequences arising from accidents, incidents or non-conformances. o The initiation and completion of corrective and preventive action. o Confirmation of the effectiveness of corrective and preventive actions.		

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	Each Department / Service of the Facility participates in the Quality Assurance Program using accepted methods of quality assessment e.g. audits, quality tools as appropriate, continuous quality improvement and risk management. Each department, service, or function uses a systematic and continuous process for planning, monitoring, evaluating, and improving the quality of care. Each department, service or function: • Identifies the scope of services and essential functions; • Identifies measurable indicators to monitor the quality of important functions of care such as incidents, sentinel events, patterns, if available and outcome based indicators; • Plans or develops an intervention to improve the issue identified; • Prioritizes the need for corrective action(s) based on the volume of patients, the degree of risk to patients or staff; the extent to which the issue contributes to problems in patient care and the cost of quantity of resources required to correct the issue; • Documents the action plan; • Any proposed corrective or preventive actions are thoroughly reviewed through the risk assessment process prior to its actual implementation. Corrective and preventive actions taken. • Evaluates, at least quarterly, the effectiveness of quality improvement monitoring process and the effectiveness of the services provided; and • Develops corrective / preventive actions if the initial action is ineffective or continue monitoring the initial action if it is initially effective in correcting the problem.		

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Procedure for Training and CMEs of Facility Staff at defined intervals			
	The Facility provides and promotes training and development of employees for enhancing their skills, improving knowledge and bringing about an overall improvement in their work performance. Quality awareness is imperative and the first step on the path to Quality assurance Program. The role of quality in the quality improvement processes is communicated to all stakeholders of the hospital. The following initiatives would be implemented under the Quality Awareness and Training Plan: • The 'Quality Tools' training is conducted for identified employees for all performance improvement initiatives. • All clinical staff of the hospital is trained in Basic Life Support. • The doctors of the hospital are to be trained on Advanced Cardiac Life Support • All nurses at the time of joining undergo training on required skills. • Training needs of the personnel are identified, established and reviewed to ensure competence. The responsibility for this lies with the administrative department and it does the overall coordination. • Training needs of new recruits especially, nurses and doctors are identified and established. • The responsibility of general training programme is with the Administrative department, while specific job related training is the responsibility of HOD's. Records are kept by the Administrative department and Quality team. The Facility recognizes the importance of training and development activities for employee motivation, skill enhancement, positive effect on productivity, acceptance to change (ex – technology) etc. Training and Development activities are a part and parcel of the overall human resource management activity of the Facility.		

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The training need of the employee is identified (based on the qualification / skill / experience etc) based on any of the following:

- New employee on fresh appointment.
- Horizontal or vertical movement in job.
- Change of technology.
- Competence Assessment by the Facility.

Management ensures that the necessary competence is available for the effective and efficient operation of the organization. Competence of the personnel is assessed on the basis of education, experience, skill and training.

The certificates and licenses (when required) held by all employees, their employment history, special courses or certificates and in-service training as well as data that support procedures and instructions are recorded.

Proof of satisfactory health status of all employees at the time of employment is maintained.

It is ensured that all staff have adequate communication skills including language skill (where appropriate) in order to communicate with patients/clients/their families.

1. **Competency Assessment** of the employee is evaluated on the basis of their track record, previous training details and performance appraisal report (ref # Performance Appraisal Policy).

Competency mapping will be carried out on 1 - 10 weightage scale. The objective criteria and the weightage attached to each will be mentioned as follows:

1 indicates - no knowledge & no skill
2 – 3 indicates - have knowledge but cannot do independently
4 – 5 indicates - have knowledge & can do independently
6 – 7 indicates - have knowledge & can do independently but

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	cannot guide others **8 – 9** indicates - have knowledge & can do independently and can guide others **10** indicates - have knowledge & can do independently and can also develop others Based on the above the human resource management prepares objectives & target for improving competence action plan (through identifying the gaps). If weighted gap is **greater than 6** … the training is highly recommended. weighted gap is **between 3 and 6** … the training is recommended. weighted gap is **between 2 and 3** … the training is useful but no urgency . weighted gap is **1** …. immediate need for training **2. Training Mode**: Training mode (or action plan) includes any one of the following: ❖ Class room training ❖ Facilitated videos ❖ Formal mentoring programs ❖ Guided self study. ❖ External training courses (Government sponsored) ❖ Professional conferences / seminars , etc **3. Provision of Resource for Training**: Adequate resources and funding are provided by the administrative department of the Facility which includes: 1. Designated person responsible for implementing training program 2. Tools to support training program activities 3. Appropriate facilities to conduct training 4. Arranging for external training of the staff 5. Maintaining training records. In order to motivate the staff to attend external training		

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	programmes, allowances are paid to the staffs who attend the designated training programme. **4. Training calendar:** The training calendar indicates the different training programme planned by the administrative department of the Facility for the various class of employee working under its purview. The training calendar (Ref # Monthly Training Plan) is prepared on a monthly basis indicating the training scheduled over the period of one month. However the training calendar indicates the training scheduled by the hospital. Each class of employees is provided with training facility which includes departmental, job specific training aimed at making them more efficient in their particular work responsibility as well as developmental training aimed at bringing about an overall change in the employee hence prepares them to assume increased responsibilities. **5. Training Need Assessment**: The training need assessment of the employee is done by the Administrative Department of the Facility along with the respective departmental head of the individual employee based on the competence matrix and the performance appraisal report of the respective employee. Training need also arises when there is a change in technology or responsibility. Technology change usually happens when a new machine is introduced in the work schedule of the employee hence the need for training arises to enable the staff to use the machine effectively and efficiently. Training need also arises when an employee assumes additional (or new) responsibilities or when the employee is promoted to a higher position carrying more responsibilities hence for better job performance the employee is required to be trained.		

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6. Training Record:

A training record (for internal training as well as training imparted by external trainers in the Facility) for each individual class of employee is maintained where each and every kind of training attended by the employee is recorded along with the signature of each individual employee and the trainer .

External training i.e training attended by the employee outside the Facility environment is recorded in separate external training record also. Employees are required to submit a copy of the certificate awarded by the external agency for the purpose of record keeping in the personal file of the employee.

All personnel file contain a summarized form of the training undertaken by the staff member.

7. Training Effectiveness Evaluation:

Measuring the effectiveness of the training attended by the employee is a very important task for ensuring the usefulness of the training and the degree of knowledge it provided to the trainees.

Evaluating the training effectiveness is a 360* process where in the trainees evaluate the trainer (Ref Trainees Feedback form) and the trainer evaluates the trainees (in terms of objective type of questions relating to topic for training).

Evaluation of the trainer is essential to understand the capability of the trainer to impart useful training. Trainees' evaluation is done to measure the effectiveness of the training imparted and the resultant improvement in the level of knowledge.

8. Records Generated:

1. Training Calendar
2. Training Record (internal and external)
3. Training Feedback Form Record
4. Training Evaluation Record

9. Training Record Form:

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	The training record form is attached in each personnel file which provides a quick view of the training undertaken by the staff member.		
	Procedure for Monthly Review Meeting		
	The Facility holds Quality Team, Infection Control and other committee Meetings on monthly basis. Performance is measured and monitored against the budgeted targets. The administration carries out review to measure the performance of the Facility against the quality indicators. Each department has its own quality objectives and key performance indicators. Departmental leaders ensure effective monitoring, measurement, analysis and improvement of processes in their respective departments.		
1	**FACILITY MAINTENANCE PLAN:** Organization has framed and documented its procedures for operational & maintenance (preventive and breakdown) plan for facility maintenance. This includes all such aspects like facility, building and installations, throughout the whole organization. Preventive maintenance schedules are developed and this is carried on as per the schedule and is an ongoing process. This includes building, electric installations, plumbing, electronic installations, fire safety installations, early warning installations, provision of safe and adequate water etc. There are engineering services personnel and technicians who are involved in facility inspection, Administrator and SIC/ CMS/ MS. Such inspections result in identifying needs for early preventive maintenance that is otherwise not in schedule. Breakdown repair is carried out as per the urgency and criticality of service and facility. Safety is ensured in all such undertakings. A separate budget is there for these activities. Personnel is dedicated for maintenance related complaints as Maintenance in-charge.	S.D.O / Carpenter/ Plumber / Electrician/ Outsourced Helpers	

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1.1	**EMERGENCY REPAIRS AND MONITORING OF RESPONSE TIMES:** There is provision of technicians so that their expertise is available round the clock for emergency services. There is availability of technical manpower in maintenance services. All complaints/ requests for emergency engineering works are sent to maintenance in-charge on phone or writing mentioning the problem area. Date and time of such request, nature of complaint, allotment of job is entered in a complaint attendance register. Technical help is sent, depending upon the urgency of problem and work. Repairs are conducted and an OK Report is communicated by the user of the service to this control room which is entered in the register along with the date and time of completion of such job. The supervisory staff gives a phone call to the unit/ department from where the complaint was attended and takes a feed back on the services provided and problems encountered, if any by them. SIC/ CMS/ MS inspects and signs this report on daily basis. Any specific delays in provision of service or complaints by the users are investigated and necessary corrective and preventive measures are taken. Log books in this regard are maintained by the concerned maintenance unit.	S.D.O / Technical Workers/ Carpenter/ Plumber/ Electricians etc	
1.2	**MAINTAINING EQUIPMENT HISTORY SHEETS AND LOG BOOKS:** It is the duty of the user department to maintain and up-date the history sheet and log book of the equipment that is issued to them or is working in their department or unit. The departmental head keeps a folder in the department that contains files for all equipment containing their history sheets and log books. The whole idea is to track the performance of the equipment and to keep a record of its functioning. This also helps in timely preventive maintenance and calibration of the equipment as per its requirements and renewal of CMC/ AMC before it expires.	S.D.O	LOG Books for D.G. Sets
1.3	A comprehensive list of Facilities/ instruments/ devices (unit wise)– containing all different types of instruments/ devices used/	Concerned Engineer/	

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	available with details such as: • Their Identification • Location • Range of Operation, and Maintenance & calibration requirements	Technician	
1.4	The maintenance and calibration requirements are normally identified using the operational & maintenance manuals. Where maintenance manuals are not available, these are based on knowledge and experience. For all new procured instruments/ devices, it is ensured that these manuals are controlled through the control of External Original Documents	Concerned Engineer/ Technician	
1.5	When any instrument/ device breaks down, Maintenance in-charge is informed. The requirement of maintenance is logged in the complaint attendance register.	Concerned Engineer/ Technician	
2	**Maintenance Process**		
2.1	**Preventive Maintenance**		
	Preventive maintenance schedules are prepared based on manufacturers' recommendations/ review of Preventive Maintenance record. The intimation of preventive maintenance is communicated in advance to the various departments for release of equipment.	Concerned Engineer/ Technician	
	Preventive maintenance schedules are prepared based on manufacturers' recommendations/ review of Preventive Maintenance record. The intimation of preventive maintenance is communicated in advance to the various departments for release of equipment.	Concerned Engineer/ Technician	
2.2	Preventive maintenance is carried out as per Maintenance Schedule and Records using format. The concerned engineer checks the maintenance activities regularly.	Concerned Engineer/ Technician	
2.3	Preventive maintenance is carried out as per Maintenance Schedule and Records using format .The concerned engineer checks the maintenance activities regularly.	Concerned Engineer/ Technician	
2.4	All preventive maintenance jobs done are recorded in History Card maintained for each equipment/ device (unit wise) using format.	Concerned Engineer/ Technician	

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3	**Breakdown Maintenance**		
3.1	Breakdown of an equipment or device is reported to the Maintenance in-charge. The requisition for such repairs is sent on the Breakdown repair form. The concerned technician logs the requirement of maintenance / repair in format of Breakdown.	Concerned Engineer/ Technician	
3.2	All preventive maintenance jobs done are recorded in History Card maintained for each equipment / devices using format.	Concerned Engineer/ Technician	
3.3	Instruments/ devices which are given in AMC (Annual Maintenance Contract) are given to AMC Company for maintenance. A report of failure/ break down is taken from company for monitoring purposes.	Concerned Engineer/ Technician	
4	**Calibration of Devices/ Equipments**		
4.1	A list of all instrument / equipment/ devices requiring calibration is prepared and maintained. The list identifies the measurement instruments by name, type, serial number, location, applicable calibration requirements, date of calibration done and calibration due date. The calibration status is updated continuously.	Concerned Engineer/ Technician	
4.2	This list also indicates, whether calibration is done in house or through external sources. Calibration requiring an outside agency - a contract or purchase order is issued.	Concerned Engineer/ Technician	
4.3	Where required Calibration agency is provided with necessary facilities and support to carry out calibration in the hospital itself.	Concerned Engineer/ Technician	
4.4	Such instruments that are to be calibrated at an outside location are collected and sent to the identified calibration agency.	Concerned Engineer/ Technician	
4.5	The following is checked when calibration is done - • Physical condition of instrument / test equipment • Calibration report verification • Calibration certificate to be obtained from calibration agency and after verification marked as O.K. / Not O.K. • Sticking of calibration sticker	Concerned Engineer/ Technician	
4.6	Calibration history is maintained using format F03/BMD (HC) and calibration certificates filed.	Concerned Engineer/ Technician	

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4.7	Maintenance preserves the machine's accuracy and fitness for use. If equipment is out of calibration or is otherwise not fit for use, it should be withdrawn from use.	Concerned Engineer/ Technician	
4.8	Accessories associated with Test instruments are identified and calibrated along with Test Instruments.	Concerned Engineer/ Technician	
4.9	In case an instrument has an error – the materials already checked by this instrument are quarantined. This lot is re-checked with other instruments which are in order/the same instrument after its re-calibration.	Concerned Engineer/ Technician	
4.10	Persons using instruments are trained on aspects like Do's, Don'ts, handling, storage, safety, preventive maintenance.	Concerned Engineer/ Technician	
5	**Maintenance of Telephone & exchange system**		
5.1	Problems of non-working telephone lines, instruments, etc. (internal / external) or is brought to the notice of the Maintenance in-charge.	Concerned Engineer/ Technician	
5.2	Maintenance in-charge deputes the responsible technician to find the problem and repair it. Problem telephone sets are replaced immediately.	Concerned Engineer/ Technician	
5.3	Cases where the problem is due to external exchange, these are taken up with the external authorities by chief engineer.	Concerned Engineer/ Technician	
5.4	**Replacement/ Renting of Equipment**		
5.5	Non-functioning equipment is replaced with standby equipment wherever possible. The replacement is given either from the stores or from another user department who shares the equipment with this department until their own equipment is repaired/ restored	Concerned Engineer/ Technician	
5.6	An updated list of equipment renting agencies, other sources that can loan equipment along with the contact numbers is maintained with rate list for rentals etc.	Store in-charge	
5.7	Replacement is given by renting or borrowing the equipment from the vendor/ identified renting agencies and from other hospitals until their own equipment is repaired/ restored	Concerned Engineer/ Technician/ Assistant SIC/ CMS/ MS	
5.8	Replaced equipment is checked and calibrated for proper functioning	Concerned Engineer/	

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		Technician	
6	**Disposal of Equipment**		
6.1	Identification of equipment that is to be disposed off	User department with the help of condemnation Committee	
6.2	Preparation of plan for disposing off such equipment	Condemnation Committee	
6.3	Identification of the vendor/ method for disposal of such condemned equipment	In-charge stores along with assistant medical superintendent	
6.4	Final decision on the condemnation and disposal of the equipment	SIC/ CMS/ MS	
7	**Selection of New Equipment**		
7.1	Preparation of demand note for new equipment	HOD User department	
7.2	Compilation of all demand notes for equipment and preparing a list of the same	Bio Medical Engineer	
7.3	Prioritization of equipment for purchase depending upon the resources available and strategic plans of the hospital	SIC/ CMS/ MS & FMS Committee, along with the user departments	
7.4	Finalization of the list of equipment that needs to be purchased	SIC/ CMS/ MS, Facility Management Committee	
7.5	Generation of equipment specifications	User department	
7.6	Finalization of equipment specifications	Purchase committee along with SIC/ CMS/ MS the Facility	
8	**Purchase of Equipment**		
8.1	Purchase order finalization	Purchase committee	
8.2	Processing of purchase order	DGHS LEVEL	
8.3	Selection of vendors	DGHS LEVEL	
8.4	Calling for BIDS & finalization of BIDS	DGHS LEVEL	

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8.5	Selection of vendor	DGHS LEVEL	
8.6	Negotiations and finalization of terms and conditions and payment plans for purchase	DGHS LEVEL	
8.7	Final order placement with the selected vendor	DGHS LEVEL	
8.8	Release of payment	DGHS LEVEL	
8.9	Reporting on proper and adequate supply of equipment as per the TORs	Purchase committee and HOD user department	
8.10	Release of final payment	Accounts department on recommendation of purchase committee	
9	**Updating/ Upgrading of equipment**		
9.1	Generation of demand	User department & SIC/ CMS/ MS of the hospital as per the strategic requirement of the hospital	
9.2	Finalization of demand	SIC/ CMS/ MS	
9.3	All other step are same as those listed in section 7 and 8 above		
10	**Inventorying Equipment**		
10.1	Unpacking of new equipment/ rented equipment/ supplied equipment	Store in-charge in the presence of the representative from purchase committee/ user department	
10.2	Physical inspection for any damages, breakage, missing components	Store in-charge in the presence of the representative from purchase committee/ user	

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		department	
10.3	Checking for completeness of supplied equipment along with accessories, papers, documents, user manuals, software CDs/ DVDs, spares, cables etc.	Store in-charge in the presence of the representative from purchase committee/ user department	
10.4	Checking for functioning of equipment	Store in-charge in the presence of the representative from purchase committee/ user department	
10.5	Completing check list of completeness of the equipment supplied	Store in-charge in the presence of the representative from purchase committee/ user department	
10.6	Taking in the equipment	Store in-charge	
10.7	Signing the delivery note	Store in-charge in the presence of the representative from purchase committee/ user department	
10.8	Allocating an equipment specific inventory number, entering of details of the equipment in the store system, generating appropriate labels of inventory for the equipment and placing such label on the equipment and making relevant entries as per the requirements	Store in-charge	
10.9	Preparing equipment history sheet after making required entries in the same and also initiating the log book of the equipment and	Store in-charge in the presence	

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	handing it over to the user department in a file with clear instructions to them on securing the same and maintaining proper records therein	of the representative from purchase committee/ user department	
10.10	Issuing of the equipment and user manuals to the user department and completing paper work	Store in-charge	
10.11	Inventorying and storing the spares, software supplied, documents etc. for the equipment and securely storing them in lock and key.	Store in-charge	
11	**Records Generation**		
	Breakdown Slip/ Register Preventive maintenance Schedule / Record History Sheet /Log books of the equipment List of instrument requiring calibration Calibration Sticker Calibration Reports Inventory stickers for equipments Inventory list of equipments Down-time & up-time records, equipment wise Purchase records including equipment specifications, vendor details Address book and contact information of all vendors and service centers, agents etc. Condemnation and disposal records		
	Incident Reporting and Risk Management		

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	The hospital / CHC 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 administration is committed to the elimination and or control of all risks. The administration strives to ensure that accidents, incidents and near misses are identified, reported and action taken to help ensure the safety and security. **Risk Terminologies**: **Adverse Healthcare Events: A clinical** event that results in unintended harm to the patient by an act of commission or omission rather an underlying disease or the condition of patient resulting in physical or physiological injury to the patient. **Adverse Health and safety events:** These are defined as ***non-clinical events*** or omissions that cause physical or psychological injury to any person on the premises, such as verbal and/or physical abuse, theft, sharps injuries, falls etc. **Other Adverse events:** These are other non-clinical incident such as fire, security event, equipment failings, service disruptions, utilities failure, that cause loss or damage to persons in hospital or affect the ability of the hospital to meet service delivery targets in any way. **Near Misses:** Apply to all the above categories. A Near miss is defined as an act of commission or act of omission that ***could have harmed*** the patient but did not do so as result only by the virtue of good luck, skillful management and/or prompt evasive action. Eg: the patient received a contraindicated drug but did not experience an adverse drug reaction, prevention (a potentially lethal overdose was prescribed, but the nurse identified the error before administering the medication) or mitigation (a lethal overdose was administered but countered with an antidote).		

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Sentinel event: A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury or risk thereof. Serious injury specifically includes loss of limb or function. Such events are called sentinel event because they signal the need for immediate investigation and response.

Medication Error: Medication error is a part of Adverse Healthcare event. Any ***Preventable event*** that may cause or lead to inappropriate medication use or patient harm, while the medication is in control of the staff. Such events may be caused by gaps in prescribing orders, labeling, packaging and nomenclature, dispensing, or administration etc.

Adverse Drug Reaction: Adverse Drug Reaction is a part of Adverse Healthcare event. An Adverse drug reaction is any noxious, unintended, undesirable, or unexpected response to a drug that occurs at doses used in human for prophylaxis, diagnosis or therapy, excluding therapeutic failure.

Act of commission: e.g. Prescribing a medication that has a potentially fatal interaction with another drug the patient is taking.

Act of Omission: e.g. Failing to prescribe a medication from which the patient would likely have benefited.

Guide on the completion of the Incident Report Form

Section 1: Date of Accident / Incident

State date and time and location of incident, please record fact only.

Section 2: Person involved / affected

Fill in this section if a person is involved in the incident. If more than one person is involved a separate Incident Report form should be used for each person. If a person is not involved, this section can be omitted.

Section 3: Type of Incident / Accident

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Some examples of type of incidents are detailed below to help you decide what type of incident it is.

Clinical Incidents

1. Patient has or may have received sub-optimal care
2. Patient has sustained harm or injury due to care given or not given
3. An unexpected clinical outcome or complication has occurred such as a 'Trigger event'
4. Consent procedure not followed or evidence of failure to warn.
5. When a clinical procedure or guideline has not been followed with a significance consequence for the patient.
6. Patient falls while going to the toilet unaided and sustains an injury.
7. Medication incidents prescribing & administration.

Non-clinical incidents

1. Damage or loss of property or equipment
2. Staff accidents or injuries while carrying out their duties
3. Security incidents such as theft, trespass, violence against the person
4. Fire incidents including false alarms
5. Verbal abuses from a visitor or patient directed toward staff.
6. Environmental damage e.g. atmospheric pollution, dangerous substances entering the drainage systems.
7. Staff may sustain a needle stick injury while preparing/administering patient IV's - this is a non-clinical incident with injury to the member of staff.

Near Miss Incidents

Any incident that did not happen due to discovery or chance must be reported as a **'near miss'** incident. Reporting a near miss event is just as important as reporting an event that actually happened or caused harm. Tick the appropriate clinical or non-clinical near miss.

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Medication Incidents

- The wrong drug or dosage, (This also includes any incident involving blood products and blood transfusion procedures.)
- The wrong route of administration,
- Equipment failure or incident e.g. infusion pump not working properly,
- A patient receives another patient's drugs.
- Doctor mis-prescribing, Pharmacist mis-dispensing or advising, Nurse or Doctor mal-administration.

Verbal abuse & violence

- (Physical or verbal incidents directed at staff, a patient, or visitor)
- A patient throws a cup of tea at another patient
- Sustained patient or visitor swearing or shouting, or behaving inappropriately
- Actual physical or unacceptable verbal assaults on staff, by patients or visitors

Equipment failure / misuse

- Bed hydraulics not working,
- Monitoring equipment is faulty
- Oxygen pipe inlet broken.
- Clinical disposable fails during a procedure

Security incidents

Can involve any damage or threat to property of the Facility, the theft of property or personal belongings and incidents relating to trespass, or unauthorized access

Examples:

- Suspicious person(s) hanging around
- Unauthorized people inside the Facility

Suspected theft, anything unusual noted, e.g. coded door breached

Section 4: Details of Accident / Incident

Provide as much detail as possible regarding the incident. State the facts only and the information that you know that are correct.

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Section 5: Action Taken (include first aid or treatment)

Provide as much information around the actions that were taken immediately after the event.

Section 6: Name / Position

Provide all the details in a legible manner. Stating clearly the time, date and telephone contact number for you (I.e. the person completing the form).

Section 7: Subsequent Action

This section is a very important part of the risk management process; it is an opportunity to prevent future incidents of this type. Detail the actions taken, lessons to be learned and what has been done.

Examples of cause are listed below to help- list not exhaustive.

- **Environment:** a substance on the floor, isolated areas, poor lighting, lack of space, high unit activity
- **Equipment:** equipment is inadequate, unavailable, and poorly designed, misused or inadequately decontaminated.
- **Knowledge base:** Insufficient training, misunderstandings, errors of judgement, inadequate technique and inexperienced staff
- **Patient:** Intoxicated, uncooperative, confused or violent. The effects of their illness may also have contributed to the incident
- **Procedure Problem:** Protocol not being followed, inadequate preparation, labelling or calculating errors and equipment not being checked or assessed
- **Staff:** the staff skills mix, the number of staff, haste in carrying out procedures and distracted, fatigued or stressed staff.
- **Work Practice:** communication failure, insufficient staff, and

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	inability to contact staff, illegible documentation and lack of supervision. Incident Reporting (IR) forms are used to record the details of an incident as soon as possible after the event occurred. Later investigations may result in a different description of the incident as more accurate facts are gathered. Such detail is provided in a separate report. IR forms are not to be altered once completed and staff is made fully aware that IR forms are disclosable in the event of litigation. The person completing the form signs to confirm that he or she has personally recorded and formally reported the incident. Quality Nodal Officer / Hospital Quality Manager are sign to indicate that they have seen the IR form, checked that all sections have been completed and that appropriate management action has been taken or is planned and detailed on the form. If a member of staff is injured and leaves the department before an IR form is completed it is expected from the Quality Nodal Officer / Hospital Quality Manager to complete the form. Statements can be collected later if necessary. **Retention of Records** The Facility keeps a record of all the reportable incidents. Incident forms are retained for a minimum of two years after the incident except where a legal action has been taken, advice shall be sought from the legal advisors. The incident forms are retained at the Quality Assurance Unit of the Facility. The Risk Management Unit will retain all other significant records based on current statutory requirements and best practice.		
	Procedure in the event of Sexual harassment		
	a. **<u>The Recipient</u>**:		

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	i. If the recipient feels that the act is minor and the offender would permanently stop indulging in the same if the recipient were to bring to the notice of the offender how the act is affecting the recipient, then the same may be communicated by the recipient to the offender. ii. The Recipient should consider filing a formal complaint with any member of the Anti Sexual Harassment Committee if the incident or behaviour is serious, absolutely unacceptable, or repeated (especially after telling the offender to stop). b. **Co-employees**: If an Employee is approached by a friend or a co-employee who feels he or she was discriminated against or sexually harassed then the Employee should take any of the following actions: • If the act or incident is a minor one, the approached Employee should first use informal resolution methods such as encouraging or assisting the recipient to approach the offending person directly. • If feasible, the approached Employee should identify the offensive behavior to the harasser and request that it stop. • If the incident is serious or if the above methods fail or would not stop such behaviour then the approached Employee should guide and assist the recipient to file a formal complaint. • If the recipient is a vendor or an outsourced employee, the approached Employee should contact the vendor or outsourced employee's supervisor as well as notify a member of the Grievance Redressal or Anti sexual Harassment Committee. • The approached Employee should take responsibility to see that sexual harassment is stopped and there is no reprisal. c. **Department Heads**: If a Department Head observes or is approached about discrimination or sexual harassment, the Department Head has to take the following course of action: • Advise the recipient of his or her right to seek help through		

	informal methods or through the Anti sexual Harassment Committee, depending on the severity of the case. • Advise the offending person to stop immediately. If the offender is a senior person and the Department Head is unable to initiate any action, he has to report it immediately to any member of the Anti sexual Harassment Committee along with the recipient. • Warn all parties immediately against behavior that may look like direct or indirect reprisal. • Take responsibility to see that sexual harassment is stopped and that there is no reprisal. **Cognizance of Complaints:** • The Committee member who is first informed of the incident or behavior should bring it to the notice of the Head of the Committee. • The Head of the Committee will immediately call for a meeting of the Committee members. • The Committee will authorize one of the Committee members as an Enquiry Officer to hold an enquiry and investigate the complaint with the assistance of the concerned Department Head or a Senior person in the Department. In the case of a vendor or customer, with the assistance of the Vendor or Customer Manager. • Corrective action will be taken as appropriate in the circumstances. • The charges will be investigated with utmost discretion. However, in the course of the investigation, witnesses and any other appropriate parties may be notified and asked to participate as appropriate. Charges of sexual harassment shall be dealt with on the lines laid down by the Government and amended from time to time. • Appropriate action, including termination from the services of the hospital, if necessary, shall be taken against the offending employee, based on the report of the Enquiry Officer. • Serious action will be taken against offenders for retaliatory behavior against individuals who make complaints of workplace harassment or who assist in any investigation of such complaints, apart from the action for the act of sexual harassment. • Any doubts or clarifications on the investigation process or its conduct, by the participant's of the investigation process should be directed to the Enquiry Officer. Any grievances		

	regarding the fairness of the Enquiry process or the proceedings conducted by the Enquiry Officer should be brought to the notice of the Head of the Complaints Committee. **Corrective action by offending Persons:** • Stop and discontinue the behavior immediately. • Apologize to the recipient. If necessary the offending person should request another person, such as a co-employee or his Department Head or any member of the Complaints Committee to guide him in expressing regret for the incident or behavior and to ensure that the confidence of the recipient in him and his relationship with the recipient is restored. • Talk to the recipient and discuss how he could communicate more effectively. • Avoid any reprisal whether direct or indirect. • Seek help from family or friends or qualified counselors who can assist and guide him in preventing from repeating such acts or behavior. • Take responsibility and work to ensure that sexual harassment are stopped.		

CHECKLIST OF CHECKING OF PARKING

Name of official: - _____ _____

Designation: - _____

S.N.	Name of the Item	Yes/No	Yes/No	Yes/No
1	Date of Checking			
2	Whether the Security is in Place			
3	Whether the Staff is in Uniform			
4	Whether the Staff has Id Cards			
5	Whether the Parking Space is Demarcated			

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6	Whether the Parking Space is Clean			
7	Whether Parking for two Wheelers and four Wheelers Separate			
8	Whether the Staff is Courteous in behavior or not			
9	Whether the Staff is Charging Properly from the Vehicles as prescribed in tender			
10	Whether the Vehicles are orderly Parked			
11	Whether the Vehicles are Parked in Common Passages			
12	Whether the Sign ages are properly displayed			
13	Whether the Staff is issuing proper receipts			
14	Whether the Parking Space is Well Lighted at night			
15	Whether the Staffing is adequate			
16	Whether the Staff Member are Exempted or not			
17	Whether the Stickers of Staff Members available or not			
General comments if any:-				
Overall rating of services(Very Good/Good/Satisfactory/Average /Poor):-				
Signature of the Official :				

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CHECKLIST OF CHECKING OF BIO MEDICAL WASTE SEGREGATION,

Name of official: - _____

Designation: - _____

S.N.	Name of the Item	Yes/No	Yes/No	Yes/No
1	Date of Checking			
2	Whether the Staff is in Uniform			
3	Whether the Staff has Id Cards			
4	Whether the Staff is wearing PPE			
5	Whether the Segregation is Proper			
6	Whether the colored bins are available			
7	Whether the IEC is Properly Displayed			
8	Whether the Staff knows about the process of Segregation			
9	Whether foot operated bins are present in the ward			
10	Whether the bins are properly covered			
11	Whether the Puncture proof containers present in the ward			
12	Whether Manual and electric hub cutters available			
13	Whether the needles are treated with Sodium Hypocholoride available			
14	Whether the Sieve twin buckets available			
15	Whether the Staff knows how to chemically treat the needles			

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16	Whether Safety Pit is available			
17	Whether the Waste is being collected by the agency as per norms			
18	Whether the Waste collected by the agency is documented			
19	Whether the agreement with the agency updated			
General comments if any:-				
Overall rating of services(Very Good/Good/Satisfactory/Average /Poor):-				
Signature of the Official :				

CHECKLIST OF GAS MANIFOLD ROOM

Name of official: - _____

Designation: - _____

S.N.	Name of the Item	Yes/No	Yes/No	Yes/No
1	Date of Checking			
2	Whether the Security is in Place			
3	Whether the Staff is in Uniform			
4	Whether the Staff has Id Cards			
5	Whether the manpower is adequate			
6	Whether the manpower is qualified and trained			
7	Whether cleanliness of the room is proper			
8	Whether the cylinders are properly stored			

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9	Whether the cylinders are properly color coded			
10	Whether the alarm signaling the quantity of gases installed			
11	Whether the weight of cylinders is checked or documented			
12	Whether the pressure gauges properly functional			
13	Whether the pipes supplying gases color coded			
14	Whether there is any leakage of gases			
12	Date of last delivery received			
13	Whether the staff is maintaining complaint register			
14	Whether the fire exits in the room properly labeled			
15	Whether the fire cylinders installed in the room			
16	Whether the Staff Member knows how to operate a fire cylinder in case of emergency			
17	Whether fire safety IEC displayed in the room			
18	Whether the no of cylinder stored adequate			
General comments if any:-				
Overall rating of services(Very Good/Good/Satisfactory/Average /Poor):-				
Signature of the Official :				

CHECKLIST OF LAUNDRY

Name of official: - _____

Designation: - _____

Sr. No.	Name of the Item	Yes/No	Yes/No	Yes/No
1	Date of Checking			

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2	Whether the collection of laundry is twice a week			
3	Whether the cleaning is proper			
4	Whether the smell of clothes is proper			
5	Whether the removal of stains is proper			
6	Whether the lot of laundry is received in time			
7	Whether the clothes are torn after washing			
8	Whether the clothes are properly marked			
9	Are the clothes found chang ed on receiving			
10	Is the detergent used checked time to time			
11	It is ISI Marked			
12	Is the staff courteous and humble			
13	Is behavior of the staff proper			
14	Is the staff in proper dress			
15	Does the staff segregate the soiled and non soiled clothes			
16	Is the staff properly trained to chemically disinfect the linen			
17	Is the documentation proper			
18	Is there any pilferage of clothes			
19	Any Comments			
General comments if any:-				
Overall rating of services(Very Good/Good/Satisfactory/Average /Poor):-				
Signature of the Official :				

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CHECKLIST OF SECURITY

Name of official: - _____

Designation: - _____

Sr. No.	Name of the Item	Yes/No	Yes/No	Yes/No
1	Date of Checking			
2	Whether the Staff is in uniform			
3	Whether the Staff is having I cards			
4	Whether the Staff is properly manning entry and exit points			
5	Whether the Staff is courteous and well behaved			
6	Whether the Staff is properly managing crowded areas			
7	Whether the Staff is properly assisting senior citizens			
8	Whether the Staff is properly assisting handicapped			
9	Whether the Staff is properly assisting children			
10	Whether the Staff is properly keeping a watch on the strangers			
11	Whether the staff is properly keeping a watch on the new borns			
12	Whether the staff is trained in use of fire equipments			
13	Whether the staff is frisking unknown strangers			
14	Whether the staff is strategically placed at places where conflict can occur for example Emergency, Mortuary, Labour Room, SIC/ CMS/ MS Room etc.			
15	Any Comments			

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General comments if any:-
Overall rating of services(Very Good/Good/Satisfactory/Average /Poor):-
Signature of the Official :

Prepared by:	**Approved by:**

CHECKLIST OF SANITATION, GENERAL HOSPITAL, SECTOR-6, PANCHKULA

Name of official: - _____

Designation: - _____

S.N.	Name of the Item	Yes/No	Yes/No	Yes/No
1	Date of Checking			
2	Whether the Staff is in uniform			
3	Whether the Staff is having I cards			
4	Whether the Staff is courteous and well behaved			
5	Whether the cleanliness is proper			
6	Whether the frequency of cleanliness is proper i.e. OPD and Office areas two shifts and all patients care areas three shifts			
7	Is there any litter			
8	Are there any surface stains			
9	Is there any order in the checked areas			
10	Is the dusting of chairs , tables , stretchers proper			
11	Is the damp dusting of work station tables being done once daily			
12	Is the damp dusting of telephone , photocopiers , computers etc. being done once daily			
13	Are lobby areas , stair cases , lifts, ramps , roof tops etc. properly scrubbed and cleaned			
14	Is cleanliness of high risk patient care areas i.e. ICU, Emergency , Labs , Pharmacy, Blood Bank, Operation Theater etc. proper			
15	Is the cleaning of visitor areas as SIC/ CMS/ MS Office , Establishment, Finance Department , Doctors Rooms , OPD etc. proper			
16	Are the doors and window glasses cleaned daily before 8.30 A.M.			

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17	Are the passages and common areas cleaned thrice daily			
18	Are the toilets in hygienic and odorless condition			
19	Are the toilets hourly cleaned			
20	Are the toilets including Floor, Walls , Urinals , Commodes , Washbasins, Fixtures etc. cleaned thrice daily			
21	Are the drinking water areas scrubbed with soap and scrubber thrice daily			
22	Are the toilets soap solutions , Naphthalene balls and Urinal cakes checked thrice daily			
23	Are the wards mopped thrice daily			
24	Are the Bed Pans , Urine Bottles shifted to sluice room and cleaned			
25	Are the window grills , ramp railings cleaned at least once daily			
26	Are the rear stair cases of all the floors cleaned twice a week			
27	Are the Work Station, Bidding and Partitions cleaned twice a week			
28	Is the washing of entire hospital in a scheduled manner with soap and water done once a week (Gang washing)			
29	Is the dry and wet mopping of side walls done twice a week			
30	Is polishing of floors done once a week			
31	Is the cleaning and wet mopping of fans and exhaust fans done once a week			
32	Are there any cobwebs present			
33	Is the cleaning of cobwebs done one a fortnight			
34	Is the cleaning of upholstery , carpets , sofas etc. done one a month			
35	Is scrubbing of entire premises , side walls, marble surfaces and tiles done once a fortnight			
36	Is the supply of cleaning agents adequate			

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37	Is the cleaning agent used as per NABH guidelines			
38	Is the cleaning agent of good quality			
39	Are the new and modern cleaning equipments used for the scrubbing of floor etc.			
40	Is the staff wearing PPE while carrying out cleaning			
41	Is the staff properly attending to the complaints of the patients			
42	Is the staff properly attending to the complaints of the hospital staff			
43	Are the supervisors performing their duties in proper manner			
44	Is the attendance of the staff being properly maintained			
45	Is the staff being given adequate wages as per the labour guidelines			
46	Is the contractor maintaining wages register			
47	Are the wages being disbursed in presence of authorized hospital staff members			
48	Any Comments			
General comments if any:-				
Overall rating of services(Very Good/Good/Satisfactory/Average /Poor):-				
Signature of the Official :				

CHECKLIST OF MAINTENANCE(ELECTRICITY, PLUMBER, SEWER MAN, LIFT, COMPUTER, CCTV, BIO-METRIC ETC.)

Name of official: - _____

Designation: - _____

Sr. No.	Name of the Item	Yes/No	Yes/No	Yes/No

Prepared by:	**Approved by:**

1	Date of Checking			
2	Whether the Staff is in uniform			
3	Whether the Staff is having I cards			
4	Whether the Staff is properly trained			
5	Whether the Staff is courteous and well behaved			
6	Whether the Staff is properly equipped			
7	Whether the Staff is attending to the complaints in time			
8	Whether the complaints are documented in a register			
9	Whether the electrical wires properly taped			
10	Whether the electrical equipments having proper plugs			
11	Whether the electrical equipments are in proper working order			
12	Whether there are leaking taps , pipes , waste pipes , jacks , seal traps , bottle traps , jalis etc. in the hospital			
13	Whether the doors and windows properly repaired			
14	Whether the almirahs , table drores, sign boards , notice boards, Signages etc. properly installed and repaired			
15	Are the lifts in proper working order			
16	Are there proper signages in the lift areas			
17	Are the lifts cleaned at least twice daily			
18	Are the lifts, sidewalls cleaned and mopped once a day			
19	Are the telephones in working order			
20	Are the computers in working order			
21	Are the Photocopiers , Printer etc. in working order			

Prepared by:	**Approved by:**

22	Are the CCTV cameras etc. in working order			
23	Is there any problem regarding Internet or Networking			
24	Are the token system is working order			
25	Is the Bio metric Machine in working order			
26	Any Comments			
General comments if any:-				
Overall rating of services(Very Good/Good/Satisfactory/Average /Poor):-				
Signature of the Official :				

INDIVIDUAL TRAINING RECORDS		
Section / Department: -------- ---------	**Designation ----------**	

NAME : ----------

TRAINING ATTENDED :

Sl. No:	Training Attended	Attended From----- to -- ------	Knowledge Acquired	Skills Acquired	Remarks

Prepared by:	**Approved by:**

Prepared by:	**Approved by:**